Individual-Group Dynamics in a 12-Step Fellowship:

Identification, Service, and Recovery in Overeaters Anonymous

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Abstract

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Self-help/mutual-aid groups, relative to other forms of voluntary association, continue to thrive. Many of these groups follow the 12-Step model of Alcoholics Anonymous. One such organization is the fellowship of Overeaters Anonymous, a group for those with a desire to stop compulsively overeating and/or recover from other eating disorders. I analyze this group using mixed methods and relying on data I collected primarily from 2010 to 2012, including 151 participant surveys, 16 group surveys, 30 interviews, and 366 discrete observations of 21 OA groups (i.e., meetings) located in a large Pacific Northwest city. In this dissertation, I explore 12-Step groups as sociological phenomena, addressing identification processes, the effects of costly behavioral dictates on group members, and the diverse determinants and types of recovery experienced by members.

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DEDICATION

To John Cardinali

CHAPTER ONE: INTRODUCTION

> But in another sense small groups may not be fostering community as effectively as many of their proponents would like. Some small groups merely provide occasions for individuals to focus on themselves in the presence of others. The social contract binding members together asserts only the weakest of obligations. Come if you have time. Talk if you feel like it. Respect everyone's opinion. Never criticize. Leave quietly if you become dissatisfied (Wuthnow 1994: 6).

I first learned about the growth of small groups, in particular self-help groups, while reading *Bowling Alone* (Putnam 2000). Putnam referenced Wuthnow (1994, 1998) on the effects of membership in small groups. Reading Wuthnow's *Sharing the Journey: Support Groups and America's New Quest for Community*, I was struck by the above remarks. The sentences paradoxically fully captured and fully missed key aspects of 12-Step groups.

On the one hand, "come if you have time", though arguably true of voluntary associations in general, accurately describes the variable-dose treatment that Alcoholics Anonymous (AA) and its successors provide. (What one's sponsor requires is a separate matter, but working with a sponsor is also not required.) "Talk if you feel like it" and "Leave quietly if you become dissatisfied" reflect the same idea: 12-Step members often tell newcomers to "take what you like and leave the rest." "Respect everyone's opinion" seems to mirror the tradition placing "principles above personalities" and also the "group conscience" format of business meetings in which everyone has a right to be heard and to participate in decisions. "Never criticize" could be construed as reference to the 12-Step rule of "no cross-talk", which means that members should not interrupt the speaker or comment upon his or her share during the meeting.

On the other hand, is it true that self-help groups (which are majority constituted by 12-Step fellowships) are "not fostering community"? That they promote a focus on oneself, and exact from members only the "weakest of obligations"? In his 1998 book, Wuthnow writes about 12-Step participants: "To be sure, the very groups they join may perpetuate their obsession with themselves, rather than directing their energies toward serving others" (1998: 25). Thus, the origin of my scholarly interest in these groups was innately sociological and elicited many questions. Why do support groups, in particular 12-Step fellowships, present a counter-trend to the associational decline Putnam (2000) documents? How solidaristic are these groups? How do they survive solely on member contributions of money and service if they are populated by self-involved individuals struggling with addiction or other personal difficulties?

Perhaps the most obvious and socially important question concerning 12-Step fellowships was the last to occur to me: how do individuals struggling with their own addictions or personal problems, without specialized training and without input from treatment providers, form groups that enable individuals to experience recovery? I remember when this question first occurred to me. I was sitting with a friend in a 12-Step group of about 130 people, listening to a member talking about how wondrously his life had changed since he joined the group. He said: "I don't know how it works, and I don't think I want to know." I was intrigued by this statement, along with the phrase describing one's higher power as "the god of my *not* understanding," and finally the common 12-Step instruction to "act as if" (you understand, you believe, you have faith, you are willing, etc.). Such statements suggest that 12-Step recovery processes are largely mysterious. I wondered how much and how well they could be explained. Only after years of study have I concluded that there is no *one way* in which 12 Step works.

Background on 12-Step Fellowships

The 12-Step phenomenon is generally traced back to the meeting of two alcoholics, Ohio-based Dr. Bob Smith and Bill Wilson, a New York businessman, in 1935. Bill Wilson had established a fledgling sobriety after decades of uncontrolled drinking accompanied by financial ruin. Aware of his vulnerability, he developed the conviction that he had to work with other alcoholics to remain sober. The two men enjoyed eventual success sobering up fellow alcoholics, and worked to articulate in writing the suggested program of recovery they felt had saved them, formalized as the 12 steps. Early AA was tremendously influenced by Wilson's association with the Oxford Group, a Christian fellowship focused on redemption through means such as confession, moral restitution, and working with others.

In 1939 the program's primary piece of literature, titled "Alcoholics Anonymous" and referred to as the Big Book, was published (and became the organization's name). The book was written to assist alcoholics who were not under the direct tutelage of any of the early AA members. In 1937 the first group not involving Bill Wilson or Dr. Bob was started in Cleveland, and a year later, a board of trustees was founded. Media coverage in 1939 and 1941 brought tremendous growth, as did endorsements by the medical community, as hospitals began to host meetings. Three years later, AA's founders formally handed over control to the newly elected General Service Board. In 1950, the 12 traditions—rules by which all groups would operate—were adopted at AA's first annual convention. Thus was established the 12-Step organizational form that is universally credited for the survival and indeed remarkable growth of 12-Step fellowships.

Twelve-Step participation continues to increase. AA's membership has grown to more than 100,000 groups and two million members worldwide (Alcoholics Anonymous 2014). There

are hundreds of offshoot 12-Step programs, including well-established and large organizations such as Al-Anon (a support group for family and friends of alcoholics started by Bill Wilson's wife Lois in 1951), Narcotics Anonymous and Gamblers Anonymous (both founded in 1953), Overeaters Anonymous (1960), and Debtors Anonymous (1982). Although the focus of these fellowships varies, they share a common goal—individual recovery based on the 12 steps developed for Alcoholics Anonymous—and organizational structure—based on AA's 12 traditions (see appendix A). According to these traditions, 12-Step fellowships must be self-supporting (rely solely on member contributions); refrain from taking public positions; respect group autonomy except in matters affecting the fellowship as a whole; and respect the anonymity of members.

Overeaters Anonymous began as a meeting of three women in Los Angeles, California. Its founder, Rozanne S., had attended meetings of Gamblers Anonymous to support a friend and thought there should be a similar resource for those like herself who struggled with overeating. The program was initially designed for compulsive eaters, but over time expanded to include those suffering from anorexia, bulimia, and other eating disorders. The OA website explains, "In OA, you'll find members who are extremely overweight, even morbidly obese; moderately overweight; average weight; underweight; still maintaining periodic control over their eating behavior; or totally unable to control their compulsive eating. The only requirement for membership in OA is a desire to stop eating compulsively" (Overeaters Anonymous 2014a).

OA's world service office reports that the program currently includes 6500 registered groups in over 75 countries with a total estimated membership of over 60,000 members (Overeaters Anonymous 2014a). OA registers and publishes its groups and periodically surveys its membership. As of 2010, OA was 87% female (compared to 85% in 2002 and 88% in 1992).

According to its 1992 survey, the average OA member was 44 years old and the average length of membership was 4.3 years (see Appendix D for more recent data on the fellowship).

Overeaters Anonymous is by far the largest eating- and food-related 12-Step fellowship. There are a number of splinter fellowships that began as coalitions of groups *within* OA operating according to rules and ideas that were not endorsed at the fellowship level. Eventually these groups left OA and many eventually formed new 12-Step groups. This characterizes GreySheeters Anonymous (GSA), an organization named after the color paper the food plan was originally printed on, which was officially established as an independent fellowship around 1998. Food Addicts in Recovery Anonymous (FA) was established around the same time. FA started forming within OA in the early 1980s. These groups were called “90-day meetings” for their policy that attendees were not supposed to speak in meetings until they had achieved 90 days of abstinence. As of the last FA census in 2009, membership totaled 4000.

HOW (“Honesty, Openness, Willingness”) groups existed for a long time within the OA fellowship. Once OA began to require that groups uphold the traditions by *not* requiring adherence to a specific food plan, the HOW groups split into two. One set stayed within the OA fellowship (OA-HOW, discussed in chapter four), and the other formed a new fellowship, Compulsive Eaters Anonymous-HOW (CEA-HOW), in 1996. Eating Disorders Anonymous (EDA), founded in 2000, is unique in that it does not endorse abstinence or “any rigidity” around food: “Balance—not abstinence—is our goal.” EDA also does not endorse the disease concept (Eating Disorders Anonymous 2014). Finally, a new eating disorders fellowship called Anorexics and Bulimics Anonymous (ABA) was founded in Edmonton, Canada, in 1993. Some of these fellowships are quite small, and their presence is primarily online or through moderated phone meetings that allow interaction of individuals from around the world. One of the reasons

why Overeaters Anonymous has become an umbrella organization for multiple eating disorders (e.g., anorexia, bulimia) is likely due to its name recognition and relative ubiquity.

While recent study of 12 Step has been greatest in the addictions field, these groups are innately sociological. They involve a variety of foundational issues in sociology and other social sciences, such as the question of group versus individual interests and the production of collective goods; the social management of shame and stigma; the process and consequences of group identification; the formation, maintenance, growth, decline, and dissolution of groups; and the effects of service and social support on health and well-being.

I address some of these issues in the chapters of this dissertation. In order to provide additional context for the analytical chapters, chapter two provides a comprehensive discussion of the data and methods employed, and references data collection instruments that are found in the appendices. While the analytical chapters have their own data and methods sections, the information provided in the second chapter contextualizes the larger research project. The dissertation uses mixed methods and relies on data the author collected primarily from 2010 to 2012, including 151 participant surveys, 16 group surveys, 30 interviews, and 366 discrete observations of 21 groups (i.e., OA meetings). Chapter two describes efforts to increase the representativeness of the sample, and compares the Pacific Northwest urban sample with data from periodic surveys of the OA fellowship. Observational data was methodically collected according to predefined categories, primarily for quantitative analysis. However, meeting observations also provided a “feel” for similarities and differences across individual groups, and helped situate comments made by interviewees about particular meetings.

Analytical Chapters

In chapter three I explore the antecedents of very strong identification as a member of Overeaters Anonymous. I begin by discussing the importance of identification as a group member. With respect to voluntary associations in general, identification as a group member increases participation in and service to the group. With respect to 12-Step groups specifically, alcohol and other drug (AOD) outcome studies have shown that identification correlates with sobriety.

I find that individuals with the highest level of OA identification share certain cognitive and behavioral characteristics. Specifically, controlling for length of time in program, the odds of very strongly identifying as an OA member are increased by higher levels of identification as a compulsive overeater and endorsement of OA ideology or tenets. The odds of high identification were also predicted by "working the program", as indicated by having a sponsor and completing more of the 12 steps. Finally, correlated with high identification as an OA member were both socializing with other members after the meeting and attendance at more emotional meetings.

In this chapter I devote particular attention to the meaning and salience of the addict identity to participants as expressed in interviews, with reference to both narrative studies of Twelve Step and literature from the OA and AA fellowships. I consider the importance of identification as a Twelve-Step member, focusing on members' own understandings of and orientations toward their OA affiliation. Finally, I also utilize interview data to illustrate the importance of emotional expression in meetings and its relationship to identification.

Chapter four is a case study of commitment and investment in voluntary associations, focusing on organizational characteristics, in particular the cost of participation. I apply insights from work on volunteering and voluntary associations to understand the divergent experiences of

participants in a more costly subgroup of meetings within the larger OA fellowship. These meetings require adherence to a more structured food plan: weighing and measuring one's food and abstaining from sugar and white flour. They also require, on average, more reading, journaling, and regular contact with a sponsor.

I find that participants within the subset of meetings that impose greater demands on members are much more likely to occupy a group service position and spend more time sponsoring other members. These participants also exhibit greater levels of belief and commitment. I posit that this heightened belief and commitment serve to increase the quality of the collective good (i.e., the meeting), which in turn contributes to the improved recovery outcomes—less frequent relapse and more weight loss—found within the costlier subgroup. I conclude by discussing the implications of costliness for the maintenance of these and similar associations.

Finally, in chapter five, I explore recovery in OA. In the last few years we have seen increasing attention and debate concerning the prevalence and costs of obesity (and its classification as a disease), the addictive properties of food, and the classification of binge eating as a distinct eating disorder with severe consequences. At the same time, though over a longer period, the addictions field has accumulated evidence supporting the efficacy of Twelve-Step treatment (principally studying AA), begun to incorporate measures of 12-Step-specific change mechanisms, and increasingly recognized the merit of assessing quality of life outcomes in addition to alcohol and drug consumption.

In this context, I consider the utility of an essentially free and community-based treatment method—the 12-Step fellowship of Overeaters Anonymous. While 12 Step is the most utilized treatment modality in the alcohol and drug field, it is not widely used in eating disorder

treatment. In order to best approximate the range of outcomes detailed in 12-Step literature, I use a multi-faceted index that assesses improvement in the following areas: addiction and its consequences (i.e., preoccupation with food and physical health), emotional/mental health, spiritual life, and relationships (i.e., family and social life). In addition, I use more standard indicators of recovery from eating disorders: current abstinence; frequency of relapse; weight change, including number of pounds lost or gained, if applicable; and having achieved a healthy weight.

In line with studies of AA, I find that both frequency and duration of meeting attendance, spirituality, endorsement of OA ideology, and various measures of social engagement with other OA members predict recovery outcomes. Two noteworthy findings were the importance to members' recovery of emotional expression in meetings, and the fact that sponsoring other OA members was positively associated with all four standard measures of eating disorder recovery. While there was less survey evidence in support of elements of working the program such as having a sponsor and working the steps, both were emphasized as critical by interviewees. Analysis of interviews also revealed service as important to recovery, though the most frequently cited "cause" of recovery was a relationship with a higher power of one's own understanding. Finally, interview respondents indicated the value of emotional and spiritual recovery received through program, and survey results showed that the highest number of respondents experienced improvement in their emotional/mental health, followed by spiritual life.

This dissertation makes a number of contributions to sociology and related disciplines. First, it explores individual-group dynamics in an understudied form of voluntary association that has shown remarkable persistence and growth during a period of associational decline. These groups are entirely reliant upon member contributions of service and money, and even

limit the annual amount any member can contribute (for AA and OA at least, to $5000). As with churches, participation in more costly groups (i.e., ones that require greater sacrifice) brings rewards to participants through a process that begins with a selection mechanism of weeding out less committed members and proceeds through signaling and social learning processes among members.

A step is made toward linking ethnographic, literary, and anthropological accounts of identity transformation in 12 Step with sophisticated outcome research utilizing experimental methods. The construction and transformation of identity is both a narrative project achieved through reading, listening to, and eventually telling recovery tales, but also a critical generator of recovery, solidarity, and service within the group.

Finally, this dissertation contributes significantly to what we know about the interior workings of and variation within 12-Step fellowships. The variation is largely attributable to the considerable autonomy allowed both groups (i.e., meetings) and sponsors, both of which are conduits for 12-Step ideology and the practical program of recovery. I seek to understand 12 Step on its own terms (Kurtz 1993) and assess the contribution to recovery of its many elements. Ultimately, this research reveals that the number of slogans in 12 Step may be seen as indicative of the number of change mechanisms entailed in 12-Step recovery.

In chapter two I turn to a general discussion of the data and methodology of the dissertation and the larger research project of which it is a part. Each of the three analytical chapters (three through five) that follow are intended as stand-alone studies, complete with their own literatures, data and methods, and findings. In the concluding chapter, I summarize the findings unique to each study, discuss their implications, and then elaborate insights from the project as a whole (i.e., spanning the three analyses).

CHAPTER TWO: DATA AND METHODS

> We cannot declare A.A. such a closed corporation that we keep our knowledge and experience top secret. If an A.A. member acting as a citizen can become a better researcher… then why not? Everybody gains, and we have lost nothing. AAWS, Inc. *AA's Twelve Steps and Twelve Traditions* (1981, page 171)

In this brief chapter I provide more detailed background on the methodology of the study; each of the three analytical chapters contains a Data and Methods section elaborating the methods and data specific to its production.

Human Subjects and 12-Step Traditions

Studying a 12-Step fellowship requires that all research be executed with 12-Step traditions (formal operating procedures) in mind (See Appendix A). For example, my study design took into account the tradition that prohibits OA from taking positions on "outside issues," including research. Hence, I did not use meeting time to discuss or advertise my study, and made clear that it was not connected with the fellowship in any manner.

Because 12-Step fellowships are anonymous, I exercised special care in the design and implementation of the study. The OA region trustee I contacted noted the importance of respecting the anonymity of program members and not implying my research is in any way connected to OA. Because OA has no formalized guidelines for researchers, I also adhered to the guidelines provide by AA on outside research (see Appendix C). For example, AA notes the following points:

- The national office will not provide any particular assistance (since groups are decentralized and self-governing), although regional offices may offer guidance and information (but not material assistance or resources);
- Participation of program members must be sought directly and in a way that allows people to give informed consent;
- Traditions of anonymity must be respected; and

- The most productive research has been undertaken by those who are well versed in program literature prior to undertaking the study.

Prior to beginning my research, I had read all the available OA conference-approved program literature along with key AA texts, and had extensive familiarity with the OA fellowship's traditions.

Researcher Positionality

Of great utility to my participant observation was my ability to identify as a compulsive overeater, and my participation in other 12-Step fellowships. An important feature of 12-Step fellowships is anonymity. According to the 11th tradition, 12-Step members are forbidden from breaking their anonymity at the level of press, radio, and films (i.e., identifying as an OA/AA/etc. member while using their last name or physical likeness). The identification piece allowed me to share at meetings, which increased the comfort that members had with both me as an individual and my presence in meetings. While facilitating access and trust, any insider status also brings challenges to research, requiring considerable researcher reflexivity. My methods of mitigating these potential problems included conducting a confidential survey, reading 12-Step critiques to supplement my knowledge of program literature and doctrine, and adopting the stance that most of the popular claims about Twelve Step remain open empirical questions.

I was also genuinely curious about how and under what conditions these fellowships "work" (produce recovery) and what additional effects they might have on members. In terms of participant observation, I had standardized protocols oriented toward collecting objective rather than impressionistic data. Another concern I was careful to address is the possibility that interview subjects would be self-conscious about providing certain answers in a face-to-face interview. Here I utilized knowledge gained from attending several hundred 12-Step meetings

and reading program literature to intuit socially desirable responses (including ones that align with 12-Step doctrine) and prime alternatives.

Instruments and Protocols

I collected data for this project primarily from May 2010 to September 2012. Key documents associated with my data collection efforts are included in the appendices. The longest was the 14-page participant survey (Appendix F). I field-tested and solicited comments on the survey from 10 individuals—including academic colleagues and OA and other 12-Step members—resulting in minor revisions. The participant survey included questions from the General Social Survey (including the National Altruism Survey), the Project on Human Development in Chicago Neighborhoods, periodic Overeaters Anonymous surveys, various AOD assessment tools, and the Social Capital Community Benchmark Survey.

To collect data from my meeting observations (n=369), I used a predefined form (see Appendix G). The meeting observation form fit on a single page, but after a few meetings I had memorized it and so used a small notebook to record the information, then transferred it onto the forms. I used Epidata software for entering data from the meeting observation forms.

Table 2.1 below provides some basic information on each of the meetings included in this study. Instead of putting days and times, I indicated whether they occurred weekday or weekend and at what general time (morning, afternoon, or evening). HOW meetings (which participants considered "stricter" or more "structured") are also distinguished from traditional OA. Finally, the percentages of meeting attendees who are newcomers, who are sponsors (when that is announced), who are men, and who "share" or speak during the meeting are also presented.

While I did not utilize much of this data for the dissertation project, I also collected organizational data by distributing a meeting survey, which asked about meeting characteristics

Table 2.1: Meeting Characteristics

Meeting	HOW meeting	Average # participants	Percentage of shares per attendees	Percent male	Percent sponsors	Percent newcomers	Emotionality of meeting
weekday afternoon	no	15.6	70.3%	9.0%	11.7%	2.6%	-1.6
weekend evening	no	3.6	162.5%	34.4%	not indicated	9.4%	-1.1
weekday evening	no	7.2	105.3%	38.3%	not indicated	3.2%	-0.4
weekday evening	yes	9.0	123.5%	35.2%	11.7%	1.9%	-0.4
weekday afternoon	yes	7.1	89.1%	7.6%	19.6%	6.5%	-0.3
weekday evening	no	6.9	100.9%	10.0%	2.7%	6.4%	-0.3
weekday evening	no	9.6	100.8%	21.7%	19.8%	6.2%	-0.2
weekday evening	no	9.2	56.4%	7.9%	1.0%	1.0%	-0.1
weekday evening	no	12.2	64.8%	13.3%	0.8%	2.7%	0.0
weekend morning	yes	11.7	98.9%	18.2%	14.9%	2.2%	0.1
weekend morning	no	7.5	120.3%	7.0%	4.4%	10.8%	0.2
weekday evening	yes	10.6	61.3%	6.6%	30.2%	5.7%	0.4
weekday evening	yes	3.7	200.0%	0.0%	27.3%	0.0%	0.4
weekday evening	no	18.7	79.4%	11.8%	1.9%	2.7%	0.5
weekend evening	no	16.0	86.5%	18.4%	17.7%	3.8%	0.6
weekend evening	yes	21.2	39.0%	10.7%	22.8%	5.2%	0.7
weekend morning	no	10.8	117.9%	8.6%	not indicated	2.1%	0.8
weekday evening	no	6.6	102.2%	1.1%	not indicated	0.0%	0.8
weekday morning	no	14.8	80.5%	7.5%	18.7%	4.1%	1.0
weekend morning	no	39.1	37.4%	26.1%	22.4%	3.4%	1.1
weekday morning	no	31.7	48.6%	5.3%	35.3%	3.9%	1.2
Grand Averages	**0.29**	**12.5**	**93.0%**	**13.6%**	**15.5%**	**3.8%**	**0.00**

such as average number of meeting attendees and monthly business meeting attendees, frequency of contributions to the larger OA fellowship, availability of OA literature for sale, etc.

Initial Procedures

I needed to complete a variety of tasks prior to implementing my study. The initial tasks consisted of consultation with a variety of relevant parties. First, I had a preliminary meeting with a member of University of Washington's institutional review board (IRB). Then I contacted OA's World Service Office, after which I was directed to discuss my project with the general trustee serving the region in which my study would take place. I was advised, based on OA's policy of not taking positions on outside issues (including research), to not use meeting time or OA's newsletter to advertise my study, and to contact them once I had received IRB approval. In the interim I met with a researcher at UW's Alcohol and Drug Abuse Institute, who has overseen large-scale outcome studies that included AA members. I also obtained a letter from the president of the local OA area intergroup acknowledging (but not endorsing) my study. After I received IRB approval, I conferred with the OA region trustee, and then began my study.

In order to get a tentative count of participants, I attended each of the 21 OA meetings—all of which are classified as "open" meetings, i.e., not restricted to OA members only—located within the Pacific Northwest city limits multiple times. Through these observations, I came to appreciate the degree of variation across meetings, and decided items (variables) that could be observed and "counted" on meeting observation forms. For example, there is considerable variation in the number of 12-Step rituals involved in different meetings: some meetings give "coins" (plastic chips, or metal medallions for significant anniversaries) to members celebrating various lengths of abstinence (e.g., 90 days, 6 months, etc.). Some meetings begin with a round of introductions (first name only, followed by "I'm a compulsive overeater" or bulimic, anorexic,

etc.). Some meetings have sponsors stand and introduce themselves and "qualify" as to their length of abstinence, time in program, and indicate what type of sponsoring they can offer currently (e.g., temporary sponsor, food sponsor, step sponsor).

Also based on preliminary meeting observations, I estimated the size of the local fellowship (as measured by meeting attendees) to be approximately 300. In other words, about 300 men and women attended the 21 weekly meetings found in the sample. Of course, this figure represents some overlap in terms of individuals who attended more than one meeting. Some of my initial attendance and counting occurred during the winter holiday season, when attendance is typically high. The average number of OA meeting participants observed in this Pacific Northwest city during my data collection—270—was a bit lower than my initial estimates. This number comes from averaging attendance counts at 21 distinct OA groups (or weekly meetings), each of which were visited a minimum of 10 times.

In terms of formal data collection, my meeting attendance had three overarching objectives: (1) to complete at least ten meeting observation forms (see Appendix G); (2) to make acquaintance with and speak to participants after meetings, and ask at least one meeting attendee to take the survey each week; and (3) to ask the meeting treasurer to complete an organizational survey. I approached all potential subjects outside the meeting time with a two-sided card that explained the study and provided my university email address and personal phone number. I then verbally explained the study, and if meeting participants were interested, I gave them an information form (some respondents asked me to explain the form rather than have to read it while I waited). The information form took the place of a consent form, as I did not want to risk the anonymity of members by requiring them to write and sign their full names (last names are rarely used in 12-Step meetings).

I made attempts to reduce bias in my selection of participants through a variety of means. About one-quarter of the time, I employed the strategy of asking the person who sat down next to me. I also made a particular effort to solicit a balance of old-timers and newcomers, as I thought this dimension might affect outcomes of interest for the larger study (e.g., identification, contributions to group goods, social capital, and individual recovery). I also sought to include sufficient numbers of men and younger members, as middle-aged women make up the majority of the fellowship. However, I did not solicit individuals who identified as newcomers, since I did not want their early perceptions and experience of Overeaters Anonymous to include a solicitation for research. While my pool of respondents included a member who had only attended the fellowship for a month, this person was attending multiple meetings each week and thus was sufficiently versed in program to complete the survey.

I asked participants to take the survey online, if that was convenient for them, in which case they were given a code to enter the secure website to take the survey. If they did not want to take the survey online, I gave them a paper survey with a self-addressed, stamped return envelope (or in a couple cases mailed surveys, upon request). I used a code on all surveys to locate respondents within groups, and to contact those who had not returned the survey after a reasonable amount of time.

The only bases for excluding respondents were: (1) they had to be at least 18 years old to consent themselves; (2) they had to identify as a member, rather than as an observer (since OA meetings are open, students from various health-related disciplines sometimes attend for classes); and (3) they had to live in Washington state. I decided to stop distributing surveys once I had received 151. That total includes surveys from at least half the average number of attendees at

each of the 21 meetings. The overall response rate for the survey was 86%. There were only three explicit refusals; the rest simply did not return the survey.

I stopped collecting data (using the meeting observation form) after variable numbers of observations, depending on the size of the group, but in all cases made at least 10 observations (i.e., attended 10 meetings) of each group. Data from the group ("organizational") surveys was for the most part not used in this dissertation, and only one variable from the observation forms is used in analyses.

The final stage of data collection—interviews—was undertaken after preliminary analysis of quantitative results. In preparation, I interviewed two OA members using the semi-structured interview protocol to get feedback on the questions, and made small adjustments to increase clarity. Those interviews were not transcribed. For the study, I conducted two types of interviews: a stratified randomly sampled group of survey-takers and key informant interviews. Both types were in-depth and semi-structured.

Within Overeaters Anonymous, there exists a subgroup of meetings that are called HOW, which stands for Honesty, Openness, and Willingness. Six of the 21 meetings in the city were OA-HOW meetings. Because HOW groups are somewhat different in terms of meeting format, have a more uniform and defined method of sponsoring, and because their members weigh and measure their food and abstain from sugar and white flour, I wanted to be certain to get respondents from both traditional OA and OA-HOW meetings.

To do this, I stratified the entire sample (151) of survey-takers by meeting size (small, medium, and large) and type (HOW vs. traditional OA). I then drew 35 respondents randomly using an online random number generator in proportion to the numbers of survey-takers in each cell of Table 2.2 below. I created a list of the 35 potential interviewees in the order they were

selected and asked them to participate in an interview in that order. My goal was to conduct 30 of these interviews, and asked 29 members, but reached a saturation point by the time I finished number 28. All those asked to do an interview consented, except for the 29th individual, who did not respond to my request.

Table 2.2: Stratified Random Sample for Interviews

	Large	Medium	Small
Traditional OA	Weekend AM meeting Weekday AM meeting	Weekday AM meeting Weekday afternoon meeting Weekday PM meeting Weekday PM meeting Weekend PM meeting Weekend AM meeting	Weekday PM meeting Weekday PM meeting Weekday PM meeting Weekend AM meeting Weekday PM meeting Weekend PM meeting Weekday PM meeting
OA-HOW	Weekend PM meeting	Weekday PM meeting Weekend AM meeting Weekday PM meeting	Weekday PM meeting Weekday afternoon meeting

The purpose behind the selection method was to obtain coverage of different sizes and types of meetings while choosing from within those meetings randomly, so as to not introduce additional bias. The second type of interview was a semi-structured "key informant" interview soliciting the views of individuals who have specialized knowledge or experiences relevant to my study (e.g., about service or the history of the local fellowship). I conducted two key informant interviews for the first analytical chapter on costliness in voluntary associations. These two individuals were veteran program members with significant experience in and insight into the HOW program and its history in the city.

Descriptive information about all thirty interviewees is presented in Appendix E. While there were two Hispanic and one black respondent among the 30 interviewed, I did not present racial or ethnic information on respondents since they were few in number. To further protect respondent anonymity, I jittered the age of all respondents plus or minus two years. Of course, pseudonyms are used in place of the names of all respondents.

I conducted all interviews in a location chosen by the respondent: the most frequent location was the respondent's home; after that, a coffee shop or restaurant; one interview was conducted in a vacant room in a church were the OA meeting was held and another was held outdoors at a location the respondent found peaceful. Respondents were not paid for their participation.

Analytical Procedures

In terms of the data produced by these collection methods, I managed all aspects of the process with the utmost care for protecting subjects' identities, which was achieved by following my IRB-approved protocol. I entered the responses on the 74 paper surveys into an SPSS data file using Epidata software. I then double-coded the 74 surveys to check for and resolve any discrepancies. I personally transcribed my interviews, except for the two that were used solely to get feedback on the interview protocol. All interviewees consented to have their interviews audiotaped.

One respect in which the interviews were unusual was that I frequently heard comments such as "That's a very good question, I've never thought about that", or just saw respondents ask for time to really grapple with questions before producing responses. It suggested to me that, with respect to their 12-Step recovery, participants might not always try to analyze *how program works for them*. 12-Step participants are, in fact, advised: "utilize, don't analyze".

Transcribing the interviews myself was useful for getting an overview of responses, and in particular for realizing when I had reached the point where new interviews were not yielding significantly novel information to justify scheduling additional ones. That said, further key informant interviews are planned on the subjects of identification and recovery.

I have used multiple methods for analyzing interview data, and plan additional analysis of transcripts using ATLAS.ti. (The material from the meeting observation forms was almost exclusively transformed into variables for quantitative analysis.) First, prior to analyzing the data for each chapter, I read each transcript and made summary notes on the content. Second, I took some notes on recurring themes, such as the frequency of statements emphasizing the importance of establishing a connection to a higher power. Third, I reread all transcripts after doing the analyses for each analytical chapter, and wrote a memo that detailed evidence supporting or contradicting statistical findings as well as data related to the subject of the chapter not anticipated by survey questions. Therefore, in addition to transcribing the interviews, I have read them through as a group and written memos on them four separate times. I have also read relevant individual transcripts additional times, as I considered alternative hypotheses and explored particular statistical relationships.

While I conducted all interviews after preliminary analysis of the survey data to help inform my interpretation of quantitative findings, I also consulted with various OA members after the surveys were completed. In most cases, the purpose was to first ask for their interpretation of specific findings and then to get feedback on the plausibility of my interpretations.

I used Catalyst software from the University of Washington to host the online survey, which allowed me to download files into SPSS and Excel. I downloaded the data into both programs, since some questions were open-ended and Excel accommodated lengthier responses better than SPSS. I did the majority of my coding and preliminary analyses in SPSS. Once I had a complete dataset integrating data from individual and group surveys and meeting observation

forms, I transferred files into STATA for my formal analyses. Future analyses will manage missing data through regression imputation.

Having provided an overview of the methods and data for this study, I now present my analytical chapters. I begin with the two chapters that have the broadest implications. Chapter four, “Helping Others in a Self-Help Group: Commitment and Investment in Voluntary Associations,” has findings that should be relevant for many different types of voluntary associations, not just self-help groups. Chapter three, “The Correlates of High Identification in Self-Help Groups,” discusses group identification, which correlates with involvement and service in voluntary associations.

The third analytical chapter assesses the process of recovery in Overeaters Anonymous and is situated primarily in the addictions literature. This chapter is lengthier due to the specificity of its focus and the paucity of research on recovery outcomes in Overeaters Anonymous, which contributed to the necessity of using multiple outcome measures. Even in this final chapter, however, there are aspects of 12 Step discussed—such as peer support, service, and spirituality—that are of broad interest to many in the field of public health.

CHAPTER THREE: THE CORRELATES OF HIGH IDENTIFIERS IN SELF-HELP GROUPS

> "Group membership is a potent source of identity and behavior transformation; it affects the way we conceive of and evaluate self, others, and the physical and social world around us; it is capable of deflecting lines of action that a person otherwise might engage in and of encouraging other forms of action" (Donovan: 411).

> "[E]dification by identification is a process of finding or placing oneself and one's own life story in a larger whole. This edification is healing because it is the experience of finding meaning and coherence in one's suffering, and finding oneself as a member of a moral community, as part of a larger whole" (Swora 2001: 380).

> [I]n AA it is not what is different between us that matters most, but what we have in common. *This tradition itself suggests an important area for research, namely the process through which identification occurs, and its role in recovery.* To be sure, my clinical experience suggests that resistance to identifying with other alcoholics is one of the primary sources of resistance to "getting active" in AA, which in turn impresses me as playing a determining role in staying sober (Nowinski 1993: 35 [emphasis added]).

Identification as a member of Twelve-Step groups provides individual benefits. Specifically, it promotes recovery (generally from addiction), the primary purpose of these groups. Project MATCH, the largest randomized study of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) efficacy, has found that self-identification as an AA member is closely associated with abstinence (Moos and Timko 2008). Cloud, Ziegler, and Blondell (2004: 1127) note three intercorrelated items that strongly predict recovery from alcoholism: AA attendance, number of steps completed, and self-identification as an AA member, identifying the latter as the "most significant stepwise variable in two of the three population models."

Identification also benefits the group. First of all, it increases participation, a necessity for most voluntary associations. As self-help expert Kurtz (1997: 57) writes, "An essential element in the success of any open-ended community group is the ability to attract and retain new members." Specifically, Twelve-Step identity is associated with greater participation in self-

help group activities (Ouimette et al. 2001, cited in Moos and Timko 2008: 516). Secondly, group identification has been frequently found to increase service. For example, Sturmer et al. (2008: 6) report that "high-identifiers are also more likely than low identifiers to engage in collective helping such as community volunteerism or assisting group members that are worse off." Studies of volunteering have found that the more an individual identifies as a member of the group, the more they volunteer for that organization (Grube and Piliavin 2000; Musick and Wilson 2008). Given that AA is free and has been found to be as effective in treating alcoholism as professional treatment (Moos and Moos 2006), increased identification in self-help groups could help defray the sizable costs to society of a variety of addictive behaviors (Donovan et al. 2013).

While the ubiquity, accessibility, and efficacy of Twelve-Step fellowships have been widely acknowledged for decades, these groups are understudied "in situ". In a review of existing work on mechanisms of addiction recovery, Kelly, Magill, and Stout (2009: 251) write that most studies "involve treatment samples in the early phases of stabilization and recovery. Little is known about non-treatment AA samples or the process involved in maintaining recovery-related changes over the long term, which may well differ." As identification is a process, while it has been measured in standard outcome research (e.g., AA affiliation scales), understanding this process requires meso-level analysis: the "action" occurs between the group (specifically, the meeting) and its participants.

Research on actual Twelve-Step groups (rather than participants captured through treatment centers or other means) often focuses on identity issues. For example, Rappaport (1993: 239) writes: "A different way to understand mutual help organizations is to view them as normative narrative communities where identity transformation takes place." McIntosh and

McKeganey (2000, cited in Reith and Dobbie 2012: 513) described addicts' accounts of recovery as a process of identity reformation, specifically of reconstructing a spoiled identity.

Since we still lack agreement on Twelve-Step mechanisms of change (Kelly et al. 2011) with respect to a narrow definition of recovery (typically operationalized as days sober), there is an argument for studying these groups from the perspective *the groups themselves adopt*. We also lack comprehensive accounts of how individuals achieve recovery in these groups and for how the groups function in general. Rappaport (1993: 239) argues: "there remains a need for work that uses theories and methods consistent with the experiences of [self-help] members and the ethos of the organizations." Specifically, he advocates trying "to understand the organization's narrative about itself (the community narrative) and how that influences the personal life stories of its members" (Rappaport 1993: 245). While narrative analysis yields significant insight and is the most practical method of studying hard-to-access populations (e.g., through publicly accessible texts and recorded speaker recovery stories), such studies may omit salient mechanisms of both individual recovery and group function, and often cannot easily generalize about larger populations.

In the remainder of the paper, I integrate perspectives from 12-Step and academic literature along with survey, participant observation, and interview data to explore the correlates and significance of identification as a member of Overeaters Anonymous. I begin by providing background information on Twelve-Step groups, including various theories of how they "work". I explain my methodology and describe my data, comparing my local sample of OA participants to that of the North American OA fellowship, and then analyze my survey data pertaining to identification as an OA member. I then present a discussion focused on the findings of interviews designed to explicate and supplement quantitative findings, with some reference to

findings and insights from social identity research. I conclude primarily with implications for future research on identification processes in self-help groups.

Background

The founding of Alcoholics Anonymous (AA) in 1935 was a watershed moment in the history of self-help groups. Not only does AA claim over 2 million members, it has spawned dozens of other self-help fellowships dealing primarily with addiction or other personal difficulties. Overeaters Anonymous (OA) is one of many resulting anonymous self-help/mutual-aid[1] societies that utilize the 12 steps and 12 traditions developed in AA. The 12 steps have been called a "design for living" that promises individuals freedom from their addiction or dysfunctional behavior through spiritual growth.

AA adheres to a disease model that identifies alcoholism as a three-part problem—mental, physical, and spiritual—and locates the solution in working the 12 steps, which brings about a "spiritual awakening". Many other Twelve-Step groups, including OA, embrace AA's "3-fold problem"/disease model. Twelve-Step fellowships eschew hierarchy and centralization in favor of local autonomy "except in matters that affect the fellowship as a whole" (see tradition four). Twelve-Step fellowships have a narrow mission: "helping the addict who still suffers." In order to not compromise that mission, they refuse outside donations and prohibit affiliation with outside enterprises and any engagement in "outside issues" (e.g., political and social debates).

Founded in 1960 in Los Angeles, California, OA is among the oldest Twelve-Step fellowships. While NA and AA in particular are both significantly larger and more studied, neither is optimal for analyzing group identification, as federal data show the participation of

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[1] I agree with Borkman (1999) that Twelve-Step fellowships are more accurately characterized as mutual-aid groups due to their being sites of joint production of individual recovery (the individual needs the group and vice versa), but use the more familiar term self-help for practical reasons.

many meeting attendees to have been court- or employer-ordered (Bower 1997). In contrast, participation in OA is strictly voluntary: two-thirds of members are introduced to OA by a friend/family member/coworker, another Twelve-Step program, or a current OA member (2010 Membership Survey).

Overeaters Anonymous describes itself as a "fellowship of individuals who, through shared experience, strength and hope, are recovering from compulsive overeating" (Overeaters Anonymous 2014). Despite its name, the fellowship includes individuals with a variety of eating disorders, primarily bulimics and anorexics. OA "membership" is informal and self-determined: "No one 'joins' OA in the usual sense of the word. There are no dues to pay or membership applications to be completed... Anyone who says he/she is a member of OA is a member" (Overeaters Anonymous 2014a). Members are typically understood as those who attend meetings, though no formal records are kept. A sign-in sheet is passed at every meeting for individuals to write down their first name and telephone number, if they choose, to facilitate contact between meetings.

Academic Understandings of Twelve Step

The few analyses of Twelve-Step fellowships found in sociological journals tend to focus on either commitment or identity.[2] For example, Donovan (1984) applies Kanter's (1972) model of commitment in communes to explain AA growth (as do Rudy and Greil 1987). I quote from Kanter at length, since she discusses groups—communes—that like Twelve-Step fellowships are on the high end of commitment in terms of both demanding from and giving much to their members. Commitment for Kanter (1972: 65-66) clearly involves identification:

[2] A number of books also discuss identification processes in 12 Step, including Irvine (1999); O'Reilly (1997); Jensen (2000); Rudy (1986); and Wilcox (1998).

> This reciprocal relationship, in which both what is given to the group and what is received from it are seen by the person as expressing his true nature and as supporting his concept of self, is the core of commitment to a community. A person is committed to a group [when] the maintenance of his own internal being requires behavior that supports the social order. A committed person is loyal and involved; he has a sense of belonging, a feeling that the group is an extension of himself and he is an extension of the group.

More work on identity in self-help and Twelve Step comes from the multidisciplinary (e.g., anthropology, history, English) field of narrative discourse (see Jensen 2000 for both an excellent account of the functions of storytelling in AA and a rich understanding of Twelve Step). Beyond that, there is of course a voluminous literature in the addictions field on substance abuse and its treatment. Referencing this literature, which often compares the efficacy of different treatment modalities, Young (2011) discusses the problems of evaluating AA versus other alcoholism treatments. He references a basic misunderstanding of AA's unique focus on *relational* identity, arguing that researchers should focus more on how interpersonal relationships rather than individual characteristics affect recovery in Twelve Step. I begin with discussion of literature on identification processes in these groups, which often occur in the context of relationships.

Reith and Dobbie (2012) discuss problem gambling, noting that study participants from the Twelve-Step fellowship Gamblers Anonymous (GA) described their identities in ways unlike other problem gamblers. They viewed themselves as addicts, even after years of not engaging in gambling behavior.

> As with AA, where individuals internalize an "addiction identity" as they begin to identify with others (Cain, 1991), members of GA reinterpret their past and emerge as "pathological gamblers" through interaction with the group. … For this group, the "problem gambling" persona is core to their self-of-self, with the idea of a fixed, unchanging identity defining who they were, both in the present as well as in the past and future (Reith and Dobbie 2012: 518).

Addressing this shift, Young (2011: 219) explains that "the restrictive and enduring implications of [the addict] identity are illusory, for adoption of the alcoholic identity is an immediate precursor to the far more expansive identity of *recovering* alcoholic." Similarly, though focused on addicts who become professionals in treating addiction, Brown (1991) argues that "one's lingering deviant identity facilitates rather than inhibits" the creation of a recovery identity.[3] Lastly, Cain (1991: 214) writes, "Since alcoholism is an incurable disease, once one is an alcoholic, one remains and alcoholic for the rest of one's life. … The disease is part of one's self." Cain (1991) argues this identity is transmitted through AA literature, discourse in meetings, and one-on-one interactions.

Swora (2001) studies AA through a narrative framework, writing:

> In the process of socialization into AA, the newcomer must learn not only how to tell his or her story, he or she must learn how to listen to the stories of others. In listening to speaker's story, the listener should look for ways in which the story resonates with his or her own experiences, how this new interpretive scheme makes sense not only of the storyteller's life, but the story-listener's life as well. The listener should "identify, not compare" (Swora 2001: 379).

Swora focuses not just on how story-telling promotes the alcoholic identity, but also on how the high emotionality (sadness but also humor) of many of these personal narratives increases a sense of community among participants.

Kurtz (1997: 39) writes about ideology in the context of self-help groups. He argues that group ideologies offer the explanation for and resolution to the problem(s) faced by members, and "reinforce a group's ability to influence its members in attaining the goals for which the group was formed." Rudy (1986: 19) likens the process of AA affiliation to a conversion process, arguing that AA participants have more than just a "technique which helps them stop

[3] Howard (2006), in contrast, analyzes 29 subjects who have *exited* the recovery identity, finding it initially useful but limiting in the longer term.

drinking; they have also found a new life style and philosophy, a new perspective from which to view the world, and a new identity."

While ideology is not a term frequently used within Twelve-Step fellowships, authors (e.g., Borkman 1999; Reissman and Carroll 1995) describe a self-help ideology of egalitarianism, and reliance on "fellow sufferers" rather than professionals. Twelve-Step ideology reflects these views, but has unique aspects as well, including the disease concept, which counters the idea of addiction as a moral failing or lack of willpower. The focus is placed the pitfalls of ego-driven self-reliance ("self-will run riot"), which should be redirected toward faith in and reliance on a higher power, and being of maximum service to others.

While this is more of a macro-level issues, 12-Step fellowships are like Weberian charismatic legitimate orders, except legitimacy is derived from the exceptional characteristics of the *group* rather than a leader. While fledgling AA under Bill Wilson was probably more of a person-focused charismatic order, the fellowship predictably underwent bureaucratization. Critically, however, and in large part due to the creation of the 12 Traditions, AA and its successors averted hierarchy and retained a highly democratic, decentralized structure of self-governing groups.

Social aspects of Twelve Step are poorly measured (Young 2011), with the focus on both sides of the sponsoring relationship. This is unfortunate, as ideology is transmitted first and foremost socially in these groups. Greil and Rudy (1984) describe the importance of ideological encapsulation, which essentially cushions individuals from experiencing doubt when they are confronted with individuals of other belief systems. Young (2011), focusing on the relational aspect of Twelve Step, explains that "In AA, members are encouraged to arrive early and stay

late to practice relationship-building," but laments that outcome research does not account for this or other critical Twelve-Step social practices.

Outcome research addresses sociodemographic characteristics of affiliators, principally to see if Twelve Step works equally well for different groups. Emrick et al. (1993), discussed in detail by Kurtz (1997), conducted a meta-analysis of 107 studies and found that the demographic characteristics—age, gender, education, marital status, employment status, and income—of participants predicted neither their involvement in nor benefit from participation in AA. Seriousness of drinking problem, did, however, predict participation and benefit therefrom. Finally, AA participation correlates with religiosity and personal religious experiences (Kurtz 1997).

Twelve-Step Understandings of Twelve Step

The narrative discourse focus on identification and its social transmission is, of course, not misplaced. Identification is emphasized in Twelve-Step literature as absolutely critical to the recovery process. Indeed, the first of the 12 steps involves identification as an addict, specifically admission of powerlessness over one's addiction and that one's life is unmanageable. The first words all participants utter in a meeting are: "Hi, I'm an alcoholic (overeater/codependent/ gambler/sex addict, etc.)." The first step in AA's *12 Steps and 12 Traditions* reads (2005: 21):

> We know that little good can come to any alcoholic who joins AA unless he has first accepted his devastating weakness and all its consequences. Until he so humbles himself, his sobriety—if any—will be precarious. Of real happiness he will find none at all. Proved beyond doubt by an immense experience, this is one of the facts of AA life.

Similarly, if less pointed in its expression, step one in OA (2002: 6) states that understanding oneself as an addict:

> opened the door to an amazing newfound power. For the first time in our lives, we recognized, acknowledged, and accepted the truth about ourselves. We are compulsive overeaters. We do have an incurable disease. Diabetics who need to be on insulin risk

> blindness and possible death unless they recognize the truth of their diabetic condition, accept it, and take the prescribed medication. So it is with compulsive overeaters. As long as we refuse to recognize that we have this debilitating and ultimately fatal disease, we are not motivated to get the daily treatment for it which brings about our recovery.

However, at the same time, much of the focus in Twelve-Step literature is on behavior. To begin with, if one does not think or feel a certain way—e.g., have faith that a higher power will restore one to sanity or that they can refrain from the addictive behavior—they are advised to "act as if": to pray, go to meetings, make outreach calls, etc. Second, OA, like other Twelve-Step programs, describes working the steps as the "heart of the recovery program." While it is expected that members work the steps with a sponsor, the main AA and OA texts do not exhort members to get a sponsor in order to recover in the same manner as they do step work. The "Big Book" (often called AA's bible) has a chapter "Working With Others" with extensive sponsoring guidance, though the word *sponsor* was not used at that time it was written.

Even though OA's materials were written at a much later point in time (the fellowship initially used AA literature for more than two decades), sponsorship is not featured prominently in OA texts. There is a sponsorship "kit" consisting of pamphlets, and OA's website advises newcomers to learn from and identify with fellow OA members (Overeaters Anonymous 2014b):

> You may recognize your own story when you listen to others share. Listening will help you find others who have what you want, whether it be weight loss, clarity, joy in achieving and maintaining a healthy body weight, or freedom from the obsession of self-destructive eating behaviors. You may want to ask someone you can identify with to be your sponsor. A sponsor will share the experience, strength and hope they've found in Twelve-Step recovery and may help answer the questions you have about the OA program. Please don't hesitate to ask anything.

Sponsorship in OA is one of nine "tools of recovery." The pamphlet OA publishes by the same name reads:

> Sponsors are OA members who are living the Twelve Steps and Twelve Traditions to the best of their ability. They are willing to share their recovery with other members of the Fellowship and are committed to abstinence. ... By working with other members of OA and sharing their experience, strength and hope, sponsors continually renew and reaffirm their own recovery.

Sponsorship is, in many ways, the delivery system for OA ideology and the steps, and for many newcomers, their first recovery relationship. "Fellowship", informal socializing that occurs before but particularly after meetings, is a more bilateral type of relationship and the most common form of informal social interaction in Twelve-Step groups.

Data and Methods

After engaging in prolonged informal observations, I collected the majority of my data from May 2010 to September 2012 from the OA fellowship located in a large Pacific Northwest city. In spring of 2010, the OA fellowship consisted of 21 groups of varying size meeting within city limits. Using attendance data from hundreds of meeting observations, I estimate total numbers of attendees at OA meetings as 270 per week. Some portion of this total attendance count reflects individuals who regularly attend more than one OA meeting each week, and of course, omits any individuals who consider themselves members but are not currently attending meetings.

I collected data by means of a participant survey, an organizational "meeting" survey, 366 structured meeting observations, a stratified random sample of survey-takers, and key informant interviews. I fielded the participant survey (in paper and online form) to more than half of the entire population of active OA participants in the city, soliciting respondents in person before and after meetings, offering an online survey and a paper version. I sought to secure participation of at least half the total participants in each meeting, and employed three different sampling strategies to reduce bias in my selection. First, about one quarter of the time, I asked

the first person who sat down next to me. Second, I made a particular effort to solicit a balance of old-timers and those with less time in program, as I thought this dimension might affect outcomes of interest for the larger study (e.g., identification, contribution to group goods, social capital, and individual recovery). Third, I sought participation by men and younger individuals, as middle-aged women constitute the majority of local participants, and were easier for me to approach. In other words, I sought to avoid compounding homogeneity in a group that already had limited demographic diversity. Finally, since a number of survey questions pertained to the meeting, I tried to solicit participants in a meeting they regularly attended (based on my repeated observations of each meeting and glancing at previous sign-in sheets). The response rate for the participant survey (n=151) was 86%, with only three outright refusals (see Appendix D for sample characteristics and comparison to the national fellowship).

I designed the study with Twelve-Step traditions—group bylaws or operating procedures—in mind. For example, since tradition ten prohibits OA from taking positions on outside issues (including Twelve-Step research), I did not use meeting time to discuss or advertise my study, and made clear that it was not connected with the fellowship in any manner. Prior to starting fieldwork, I consulted with the World Service Office of Overeaters Anonymous, with University of Washington Human Subjects Division, and with researchers who have overseen large-scale outcome studies that included Twelve-Step members.

The anonymous nature of Twelve-Step participation necessitated special care in the design and implementation of my study. Twelve-Step fellowships express a cooperative attitude toward research, while specifying the importance of respecting the anonymity of their members. AA provides comprehensive guidelines to researchers, to which I adhered. This including reading all available OA program literature prior to consenting survey and interview participants,

and studying OA's 12 traditions. All 21 OA meetings in the city were "open", which means that non-members could attend. While OA's 11th tradition forbids members from breaking their anonymity (i.e., identifying as an OA member) at the level of press, radio, and films, all aspects of my research were undeniably facilitated by my ability to authentically relate as a compulsive overeater. Additionally, my membership in multiple Twelve-Step fellowships gave me a shared language and cultural understanding that increased subjects' comfort with me, and presumably increased their willingness to participate in the research.

While increasing access and trust, any insider status also necessitates researcher reflexivity. To mitigate potential problems, I conducted a confidential survey, read Twelve-Step critiques to supplement my knowledge of program literature and doctrine, and adopted the stance that most of the popular claims (both by insiders and outsiders) about Twelve Step remain open empirical questions. In terms of participant observation, I used standardized protocols oriented toward collecting primarily objective rather than impressionistic data. For interviews, I utilized knowledge gained from attending several hundred Twelve-Step meetings and reading program literature to intuit socially desirable responses, e.g., ones that align with Twelve-Step doctrine, and phrased questions in such a way as to normalize a variety of responses.

There are data limitations that should be taken into account when assessing the import of my statistical findings. While every attempt was made to obtain participants representative of the city's population of OA attendees, the sample is not randomly selected. A random sample, of course, was impossible to obtain given the anonymous nature of the population, the decentralized structure and ideology of the organization, and the related absence of membership records. The high response rate (86%) reduces the problem of bias related to non-response. However, biases in complex data collection effort are inevitable: certainly, the less frequently someone attended

meetings, the less likely they were to enter my sample. Those who arrived late and left early were also missed, as my solicitations occurred before and after meetings. I thus expect that my sample omits some who weakly identify as OA members. At the same time, the sample I drew for interviews included three individuals who had stopped attending OA meetings since taking the survey.

I conducted 28 interviews with subjects who took the survey, for the purpose of addressing selection effects, trying to assess the causal direction underlying correlations, and exploring ambiguous survey findings. I chose subjects by taking a random sample (using a random number generator) stratified to ensure sufficient respondents from meetings of different size and format. Of course, since the population of survey-takers was not randomly sampled, the interviews are not a true random sample, but rather reflect an attempt to increase representativeness by reducing bias. All those I asked to do an interview consented. I also conducted two key informant interviews. In terms of observation, I completed a minimum of 10 and maximum of 39 structured observations per group, using a form to record information on variables of interest. In total, I made formal observations of 366 meetings during the study period. No notes were taken on what was said at meetings, to preserve participants' anonymity. While I could have sought permission from group members to record discussions, in my mind that would interfere with the "primary purpose" (promoting recovery) of the meeting.

Variables

The dependent variable of this analysis is a binary indicator of very strong versus lesser levels of identification as an OA member. Since all respondents voluntarily define themselves as OA members, the salient distinction is "very strong" identification. Answer choices to the question, "How strongly do you identify as an OA member?" included: not at all, somewhat, strongly, and

very strongly. Unsurprisingly, no one picked “not at all”. Less than 4% chose “somewhat”; 28% chose “strongly”, and 68% chose “very strongly” (13 people did not answer the question). I created a variable that combined somewhat and strongly identify into one category.

There are seven independent variables in the regression analysis. The first variable, length of OA attendance, measures how long the participant has been in program (which in practice means how long have they been attending OA meetings). This variable is included to control for the general process of group identification increasing with length of membership. The length of attendance for the 150 respondents who answered this question ranged from 30 days to 41 years, with a mean of 10.3 and a median of 6.8 years. In 2002, OA took a survey of its North American membership (and has not reported length of attendance since then). It should be noted that the sample is largely American, as participants were recruited from 246 groups in the US versus 14 in Canada. The duration of attendance for the Pacific Northwest sample is rather similar to that of the larger OA fellowship (which was measured 9 years earlier). Table 3.1 divides the length of attendance into categories to better show the distribution; Table 3.2 compares it to the larger OA fellowship’s, demonstrating general similarity.

Table 3.1

Length of Attendance		
	Frequency	Percent
1 to 3 months	8	5.33
> 3 to 6 months	12	8
> 6 to 12 months	15	10
> 1 to 3 years	17	11.33
> 3 to 6 years	21	14
> 6 to 10 years	21	14
> 10 to 15 years	11	7.33
> 15 to 20 years	15	10
> 20 to 30 years	24	16
30+ years	6	4
Total	**150**	**100**

Table 3.2

Length of Attendance: Pacific Northwest City vs. OA Fellowship		
Duration	PNW city	North America
< 1 yr	23.3%	15.6%
1-2 yrs	11.3%	12.9%
3-5 yrs	14%	12.4%
6-10 yrs	14%	16.1%
10+ yrs	37.3%	43.0%

The second variable indicates whether the respondent currently has a sponsor, which is a mentor who typically guides one through the 12 steps. A full 93% of participants have had an OA sponsor at one time, with 71% of the sample currently having one. The third variable indicates the highest step that a member has completed (1-12; 0 = none), which is statistically significantly correlated with having a sponsor.

Table 3.3: Top Step Worked

Top Step	Frequency	Percent
0	20	13.3
1	0	0
2	6	4
3	16	10.6
4	7	4.6
5	8	5.3
6	3	2
7	4	2.6
8	5	3.3
9	11	7.3
10	0	0
11	2	1.3
12	69	45.7
Totals:	**151**	**100**

Table 3.4: Fellowship

Partake in Fellowship After Meeting	Frequency	Percent
Never	3	2
Rarely	27	18
About half the time	44	29.3
Most of the time	55	36.7
Always	21	14
Totals:	**150**	**100**

The variable I use in the regression analysis to indicate social interaction is “Fellowship”, a measure of socializing with members after meetings. Unlike other social measures in the survey, many of which require interacting outside of the meeting setting, this measure is less influenced by external constraints such as having children or long work hours. Specifically, the survey asked “How frequently do you enjoy ‘fellowship’ after meetings?” Answer choices were never, rarely, about half the time, most of the time, and always.

My fifth variable, Ideology, is intended to measure the degree to which the respondent accepts Twelve-Step ideology (adapted for OA from AA research tool GAATOR 2.1). This variable (alpha = .77) is composed of the following items (to which respondents could answer definitely true, true, false, or definitely false):

1. I have realized things get worse when I compulsively overeat/engage in my eating disorder
2. I have believed that awareness of my higher power is essential to my abstinence
3. I have believed my recovery could only come from a power greater than myself
4. I have recognized the amount of serenity I have is a direct result of the amount of humility I have
5. I have been ready to let my higher power remove my shortcomings

The five components of ideology were reverse coded and then added together, such that a higher score indicated greater acceptance of OA ideology. I have numbered them above in the order of acceptance by participants in my sample. In other words, the first tenet was the most widely accepted; the fifth tenet, the least. Creating the index variable reduced the number of cases to 144; values ranged from 10 to 20, with a mean of 17.2 (s.d. = 2.34).

The sixth variable, religiosity, is based on the question from the 2006 General Social Survey, “To what extent do you consider yourself a religious person?” 150 respondents answered this question as follows: not religious at all (52%); slightly religious (22%); moderately religious (17%); and very religious (9%). The seventh variable, identification as a

compulsive overeater, captures the basic criterion for OA membership. OA's third tradition states, "The only requirement for OA membership is a desire to stop eating compulsively." Respondents were asked to indicate how strongly they identified as a compulsive overeater. Since OA is an umbrella program for a variety of eating disorders, I show the breakdown on levels of identification as an overeater, but also as a bulimic and an anorexic.

Table 3.5: Member Identifications

Variable	N	Very strongly	Strongly	Somewhat	Not at all
Identify OA member	138	68.1%	28.3%	3.6%	0%
Identify overeater	151	80.1%	15.9%	3.3%	.7%
Identify bulimic	148	10.8%	6.8%	12.8%	69.6%
Identify anorexic	149	2%	3.4%	6.7%	87.9%

The final variable used in this analysis is the emotional intensity of the meeting in which the respondent was surveyed. I constructed a subjective measure of this for each meeting by averaging scores of emotional intensity made during observations (minimum of 10) of each meeting. I initially designed the scores to range from 0 ("unemotional") to 5 ("highly emotional"), but in practice found that no meetings were unemotional (all featured some expression of emotion). Thus, the scores of individual meetings ranged from 1.5 to 5. The mean emotionality of a meeting (sum of scores divided by number of observations) ranged from 2.5 to 3.4. To use this variable in analyses, I attached to each participant the mean level of emotionality observed in the meeting in which they were surveyed.

Prior to discussing statistical findings, it is suggestive to consider the five respondents in the sample of 151 who only "somewhat" identify as an OA member. They are all relatively new to program: they have been attending anywhere from six weeks to a year (the median for the sample is 7 years). Three of them have not completed any steps, while two have finished the third step; the median step participants in my study had completed was step 7, while 46% of the

sample completed all 12 steps. Finally, only two of them have a sponsor, and none of them *are* sponsors. Four of the five expressed some degree of identification as a bulimic, with two very strongly identified as such. All scored lower than average (17.4) in terms of embracing OA ideology, with one scoring an 11. Finally, the low identifiers participated less than average in fellowship after meetings, with 2 rarely participating.

Analysis of Survey Data

Returning to the motivation for studying identification as a Twelve-Step participant, outcome studies consistently show that AA identification is associated with positive outcomes. Similarly, in separate regression analyses (available upon request) of this Pacific Northwest OA sample, identification as an OA member is positively associated with: (1) currently serving as a sponsor; (2) the amount of time spent sponsoring; (3) holding a formal service position in the group; and (4) financial contributions to the meeting.

Because of its salience in both Twelve-Step and academic literature, I begin by exploring identification as an addict, or in OA, as a compulsive overeater. However, because of the diversity of food disorders represented within the group, I also report how identifying as having bulimia and anorexia affects identification as an OA member. As shown in Table 3.5, the vast majority of participants identify as compulsive overeaters (96% very strongly or strongly). It should be noted that these three eating disorder identifications can co-occur (some meeting attendees describe struggling to varying degrees with each), particularly in the case of bulimia and overeating. However, the association between identification as an anorexic and an overeater is statistically significant and negative. What is the import of the diversity of eating disorders in a fellowship with a single membership criterion of "a desire to stop eating compulsively"? While the association between identifying as an OA member and as an anorexic and bulimic is

negative, it is only significantly so with respect to bulimics (see Table 3.6). While OA welcomes anorexics and bulimics (and now sells a $2 "Focus on Anorexia and Bulimia" packet), the majority of the discourse in meetings and in the literature centers around compulsive overeating.

Table 3.6

Correlations Between Various Eating Disorders and OA Identification				
Measure	Identify as OA member	Identify as Compulsive Overeater	Identify as Bulimic	Identify as Anorexic
Identify as OA member	--			
Identify as compulsive overeater	.305***	--		
Identify as bulimic	-.188*	-.052	--	
Identify as anorexic	-.082	-.207*	.260**	--

Note: *p<.05, **p<.01, ***p<.001

Given its preponderance among members, the analyses focus on identification as a compulsive overeater. Similar to findings in AA outcome literature (Tonigan 2008a), the degree of identification as a compulsive overeater correlates with the degree to which respondents were affected by problems with food when they first started OA (ranging from not affected at all to severely affected). The initial severity of the respondent's food problem prior to joining OA predicts both degree of identification as an overeater and very strong identification as an OA member (the latter is marginally significant).

The degree of identification as an OA member differed by whether participants currently had a sponsor, χ^2 (2, N =135) = 15.45, p = .000.[4] Of respondents who currently have a sponsor, 78% very strongly identify as an OA member, compared to 44% of those who lack one. Having a

[4] Chi-Square statistics are reported with degrees of freedom and sample size in parentheses, the Pearson chi-square value (rounded to two decimal places), and the significance level.

sponsor correlates with working the steps (of the 94% in the sample who have worked the steps, only 9% did so on their own). There is a strong, statistically significant correlation between how far one has gone in working the steps and one's level of identification with the group.

Table 3.7: Very Strong Identification and Its Predictors

	Very strongly identify	Time attended	Have sponsor	Top step completed	Fellowship	Identify as overeater	Endorse ideology	Religiosity
Time attended	0.323***							
Have sponsor	0.336***	0.029						
Top step completed	0.333***	0.477***	0.263**					
Fellowship	0.329***	0.127	0.227**	0.100				
Identify as overeater	0.335***	0.044	0.171*	0.072	0.084			
Endorse ideology	0.361***	0.26**	0.278**	0.283**	0.163†	0.061		
Religiosity	0.022	0.302***	-0.063	0.084	0.123	-0.052	0.25**	
Emotionality of meeting	0.2191*	-0.038	0.058	-0.001	0.191*	0.178*	0.026	-0.014
†p < .10; *p < .05; **p < .01; ***p<.001								

One of the most well-known steps (even to non-members) is the ninth, which entails the making of amends to those one has wronged. Step nine is viewed by many participants as the most difficult yet transformative step, and there appears to be a relationship between progress on making formal 9th step amends and identifying as an OA member. More than 54% of the sample had worked step nine. Participants show a steady increase in levels of identification with the group as they complete more amends. For example, only about half of those who have made none or at least one amends identify very strongly as an OA member. For those who have made a few, 70% very strongly identify. For those who have completed all or nearly all, 86% very strongly identify, $\chi^2(6, N = 138) = 21.72$, $p = .001$. However, in logistic regression, making amends was not a significant predictor of identification as an OA member.

There is evidence that social interaction serves to reinforce identification with the program. There are statistically significant, positive correlations between identifying as an OA member and how frequently one partakes in fellowship after meetings, how many of one's five closest friends are OA members, and how many members one spends time with socially (in descending order of magnitude). Time spent interacting with sponsees, especially face-to-face, is also positively related to identifying as an OA member. Finally, acceptance of Twelve-Step ideology appears to reinforce identification as an OA member. Such acceptance is, not surprisingly, related to the length of time one has attended OA, and having a sponsor and working the steps.

The one group variable that is statistically significantly correlated with identification as an OA member is the average level of emotion in the meeting in which members were surveyed. Members surveyed in more emotional meetings were almost four times as likely to identify as OA members.

Length of time attending OA increases the odds of identification as an OA member, and remains statistically significant in all models. Working the program—the highly correlated variables for having a sponsor and working the steps—are statistically significant positive correlates of identification as an OA member in all models, though the top step completed is only marginally significant until the final model. Having a sponsor greatly increases the odds of very strong OA identification, though the strength declines over each model. Participating in fellowship roughly doubles the odds of very strong identification.

Acceptance of ideology, a variable correlated with every variable in the model other than religiosity (which is interesting since the ideology measure since focuses on higher power), increases the strength of identification as an OA member, but only attains marginal significance

in the final model. Religiosity decreases the odds of very strong OA identification initially, but loses significance in the final model. Finally, identification as an overeater increases fourfold the odds of very strong identification as an OA member.

The resulting variable is statistically significantly correlated with both identification as an overeater and an OA member, and is a positive correlate in the logistic regression model. While my interview data suggests that emotional expression in meetings facilitates identification, the relationship could work in reverse, as well: when members strongly identify, they tend to share more openly, including emotionally. Based on my observations, I suspect the relationship is circular and that expression of emotion and identification serve to continuously reinforce each other.

In addition, I asked respondents to identify the meeting in which they felt the greatest sense of belonging. Participants tended to select more emotional meetings (based on my subjective ratings) as those in which they felt the greatest sense of belonging. Interestingly, many of these were larger groups. Remember that 68% of the sample very strongly identify as OA members. The meeting with the most "very strong" identifiers (85%) is one of the largest meetings in the city and also has a high level of emotionality. The two meetings with the lowest percentage of very strong identifiers (25 and 44%) contain the least emotional expression.

Table 3.8: Predicting Very Strong Identification as an OA Member

	(1)			(2)			(3)			(4)			(5)			(6)		
	OR	SE	Sig.	OR	SE	Sig.	OR	SE	Sig.	OR	SE	Sig.	OR	SE	Sig.	OR	SE	Sig.
Control																		
Time Attending OA	1.092	0.031	0.002**	1.095	0.024	0.000***	1.086	0.024	0.000***	1.085	0.027	0.001**	1.089	0.034	0.006**	1.092	0.036	0.008**
Program Actions																		
Have a Sponsor				4.514	1.553	0.000***	3.771	1.430	0.000***	3.403	1.408	0.003**	2.818	1.203	0.015*	2.858	1.252	0.017*
Top Step Completed				1.065	0.040	0.092†	1.077	0.042	0.06†	1.068	0.041	0.082†	1.078	0.039	0.035*	1.077	0.042	0.055†
Social																		
Fellowship							1.881	0.563	0.035*	2.120	0.725	0.028*	2.082	0.735	0.038*	2.001	0.716	0.053†
Belief																		
OA Ideology										1.238	0.169	0.118	1.276	0.165	0.059†	1.279	0.161	0.051†
Religiosity										0.590	0.148	0.036*	0.638	0.192	0.136	0.640	0.199	0.151
Identity																		
Identify as Overeater													4.364	1.520	0***	4.013	1.448	0***
Group Characteristics																		
Emotionality of Meeting																3.986	2.689	0.04*
Fit Statistics																		
Log pseudo-likelihood		-78.125			-66.597			-62.892			-56.817			-51.396			-50.563	
Pseudo R^2		0.096			0.212			0.256			0.296			0.363			0.423	
BIC		166.104			152.816			150.310			147.653			141.672			144.864	
N		138			135			135			129			129			129	

†p < .10; *p < .05; **p < .01; ***p<.001
Notes: Odds ratios from logistic regression models with clustering for robust standard errors (in parentheses); the group variable is meeting ID number.
Data: STSS, 2010-2012

Discussion

> I came in [to OA] feeling like this is where I belonged. So I have not changed that opinion. And uh, I would say that, being asked [how much I identify as an OA member] is the first time I ever thought about that. The first meetings I went to were newcomer's meetings, they only read the first three steps. And I just thought, I could see myself on the pages, in a way that is the first time that people understand me, that I am not unique in my disorder. And I identified as an overeater, as an OA member, right away (Angela, 18 years in OA).

Identification as a member of a Twelve-Step group is not uncomplicated. There is a reason why these groups are anonymous: there are many attendees who do not want their participation to be known. There is a considerable amount of societal stigma attached to many addictive behaviors, particularly when they rise to the level of consequences that motivate joining a group. This is illustrated by the comments of Jill, a prominent member of the local OA fellowship, when I inquired as to her level of identification as an OA member and whether it had changed over time.

> Yeah, of course it's changed over the years. When I first came, almost 19 years ago, I didn't want to, I didn't want to do this, I didn't want to be a member of OA! Overeaters Anonymous!? I didn't even want to say it! But, um, it was home. It gave me so much, and now I'm fierce about it. It's the only thing that's ever worked for me.

At the same time, those who remain in the group often come to internalize the identity. 93% of my sample anticipates attending OA indefinitely, and 54% report they would likely or very likely continue to attend OA *even if they could refrain from compulsive overeating without OA*. Below I discuss the correlates of identification as an OA member.

On average, while interviewees were very, often instantly articulate about their identification as a compulsive overeater, most had to give more thought to both their level of identification as an OA member and whether it had changed over time. Interviewees were also less apt to identify a specific factor that affected their OA identification. Some linked it generally to the Twelve-Step program and its suggestions. For example, Ellen noted that her

identification as an OA member increased due to working the steps, having a sponsor, and having “partners in recovery.” Partners in recovery are OA members other than a sponsor with whom one communicates outside of meetings, usually by phone, to support recovery). Nonetheless, the single factor most frequently identified as increasing one’s identification as an OA member was identification as a compulsive overeater. I discuss this factor at length after addressing less-discussed causes.

In most participatory groups (in which members interact directly), one would expect that the longer one has been a group member, the more they will identify as such. John discussed why it took him a while to identify as an OA member:

> Well, I remember at first, the first thing I went to, it was a Sunday evening meeting, and every week for the first quite a few weeks or months I didn’t write my name down [laughs]. Because I didn’t know who these people were, I didn’t know if people would call me and bug me, or what. So, it was I suppose a process of beginning to trust the program and the people and growing in my identification with them and the program.

Perhaps one of the reasons why identification as an OA member takes time is that Twelve-Step groups are rather unique, often noted by participants as unlike any other group they have attended, and unlike “people in real life”, particularly in terms of the level of honesty, vulnerability, and acceptance demonstrated in meetings. Moreover, the other contributing factors to identification as an OA member—be they social, behavioral, or changes in beliefs and attitudes—all take time to have an effect.

<u>Working the Steps</u>

Several of the 12 steps can be viewed as mechanisms for increasing one’s commitment to the group. Kanter (1973: 66) strongly linked commitment to identification: “A person is committed to a relationship or to a group to the extent that he sees it as expressing or fulfilling some fundamental part of himself.” Step one of Overeaters Anonymous reads: “We admitted we were

powerless over food—that our lives had become unmanageable." This step involves recognition of one's difference from most people. As is written in the Big Book, "We learned that we had to concede to our innermost selves that we were alcoholics. This is the first step in recovery. The delusion that we are like other people, or presently may be, has to be smashed" (Alcoholics Anonymous 2001: 30). Step one involves sacrifice and renunciation, both of which Kanter (1972) argues should increase commitment and identification.

Smith et al. (1998: 90) argue that a key mechanism social groups have for providing members an identity is "inculcating in them a normative and moral orientation toward life and the world." Many of the 12 steps, OA's "program of action," are oriented toward providing members with a spiritual solution to their ailment and guidance for living a moral life. Half of the 12 steps (4-9) are focused on taking a personal inventory of one's faults, sharing this with another person, identifying one's character defects and asking them to be removed, and making a list of persons harmed and then making amends to them. Additionally, members are asked to do a shortened version of steps 4-9 daily (the 10th step).

Several interviewees credited the steps with increasing their identification as a compulsive overeater (or in a couple cases, as a bulimic), and a couple singled out the steps as the factor that increased their identification as an OA member. Asked about her level of identification as an OA member, Beth brought up the steps:

> So coming back to your identification, I think working the steps really, really changed the way that I saw myself. I think the steps are so incredibly important, and at the end of the day, for me it's just teaching me how to be a good person. … The heavy-duty ones, 4, 5, 6, 7, 8, you know… you just can't get past those without change. But the actual writing down and going through and listing and having to do amends. I think having to do amends, was, for me, just a real…. especially some of them were just incredibly hard to do. Incredibly hard to do. But they were life-changing. … And I think, that's, if there's one step at all, I think making amends for me is really transformative.

Sponsorship

One thing that sponsors do is bind their sponsees to the program; another is prime the compulsive overeater identity. This is often done quite literally, for example, some sponsors have their sponsees read AA's Big Book and note where they identify with what is written (about addiction); members are also often advised to identify with, not compare themselves to, fellow attendees. Sponsors typically meet weekly with their sponsees, and some have daily phone contact. Indeed, the more time one has had a sponsor in program and the more time one interacts with a sponsor outside of meetings per week, the stronger s/he identifies as an OA member. Individuals with sponsors almost unanimously indicated this relationship was pivotal to their recovery. In response to an open-ended question about the causes of identification as an OA member, five respondents identified having a sponsor. Miriam, asked whether she identified as a compulsive overeater, said:

> I had difficulty accepting that. I came not accepting it. And definitely not identifying with it… I think one of the big transitions was when I finally admitted that I *am* a compulsive eater.
> Interviewer: Did you have any sense of what facilitated that identification?
> Miriam: I think it was a combination of factors. I came at a crisis, and I think within a month I started working with a sponsor, and so I was ready. … It was the combination of a *fabulous* sponsor, an absolutely fabulous sponsor, fab-u-lous sponsor, and my vulnerability. I was ready to work, and to do something. It was a winning combination.

Social Interaction

A variety of measures of social interaction are statistically correlated with identification as an OA member. Those who enjoy fellowship after meetings identify more strongly, as do those who spend time with more OA members socially, as do those with more OA members as their five closest friends. Social identity scholars argue that social interaction (Hogg 2006) and social support (Deaux and Martin 2003) increase identification. One interviewee mentioned the importance of his "OA buddies" to his participation in the program, and another, Tina, described

a declining identification as an OA member since she relocated, leaving behind 30-year close OA friendships she had yet to replicate. Susan, in contrast, increasingly identified as an OA member since moving to the Pacific Northwest, since she came from a city where many lived only during the winter months, which inhibited the formation of enduring social ties within her former OA group.

Identification as a Compulsive Overeater

Twelve-Step fellowships are predicated on the notion of being powerless over one's addiction, and that this is a permanent state. In OA, this understanding equates to identification as a compulsive overeater. To explore the development and consequences of this identification, my interview protocol contained the following question: "I'd also like to ask about your level of identification as a compulsive overeater, and I wonder if that has remained constant or if it has changed at times? As a long-time OA member John explained: "it's been constant. Since I've come I've always recognized that I'm a compulsive overeater and I see it as a lifelong situation that can only be arrested but cannot be cured."

Work on identity theory argues that people desire verification of their identity, even when that identity is negative (Burke and Harrod 2005). I asked all respondents an open-ended question, specifically, "What sorts of things, if anything, do you get from your fellow OA members?" One of my respondents, Jill, who had lost about half her body weight, offered the following response: "I get identification, and validation…the identification is crucial, because I need to know that what I'm doing has worked for someone else, or why the hell would I do it? That they know how I feel or have felt, that they're willing to talk to me and share themselves..."

Identification can be understood in terms of the search for meaning. As Abrams and Hogg (2004: 167) write, "A central motivation as a group member could be to establish the

meaningfulness of one's identity". Indeed, I would argue that in Twelve-Step meetings, one's "deviant" identity and behaviors (be it compulsive overeating, drinking, spending) are really a form of currency, a way of connecting around a shared identity. They affirm that one is in their rightful place, that they belong. As Beth related, being a compulsive overeater and an addict helped her identify in Twelve-Step meetings:

> For me, I'm an addict, so whatever your drug is. So I can go to an NA meeting and identify, go to an OA meeting and identify. It's a drug. So I take it at a much more high-level view, and, OA is the most that I can, the better that I can identify with but I can still go to any of the Twelve-Step processes and feel like I've attended the meeting, and get the message.

Elise discusses her identification as a compulsive overeater and the relief at being understood:

> I think by the time I got here I was 46 years old, and, I had had 30 years of eating compulsively, and this, I mean, I cried through my first six meetings. People were talking about food the way that I thought about food, and the way I handled food. And I have not ever heard that, not in Weight Watchers, not in any of the things that I have tried, and there's been many. So the identification with food controlling me, rather than me controlling food, was very strong from the beginning.

This seemingly immediate identification with the disease was articulated by half of my interviewees, with some knowing in advance of attendance and some realizing "from the first meeting". A recovering alcoholic and bulimic/anorexic, Chloe discussed treatment options for her eating disorder, including seeing a psychologist, but concluded, "I'd rather identify with a fellow addict … it's just such a gift to know that we're not alone."

Elise elaborated the relationship between identifying as a compulsive overeater and identifying as an OA member in response to my asking what sorts of things, if anything, she receives from her fellow OA members: "A sense of belonging… it's crucial to my sense of well-being. There's something very, very primal about a sense of belonging. And as long as I was the outsider compulsive overeater, because I put myself there, I didn't have that."

Beth, who only weakly identifies as a compulsive overeater and strongly identifies as a bulimic discussed her identification as an OA member over time, "It has actually gotten stronger. It's really, really interesting, because I don't identify myself as an overeater, but it's eating, and it's food, and it's a drug." I asked Linda, "To what do you attribute the recovery that you have? What do you think matters most, it could be non-program, or in program…" She replied,

> Having a structure, and a place where I feel understood gives me a sense of belonging, and I've always felt like I had to prove I belonged somewhere, and, without having to bend myself or torture myself or anything, be brutal with myself or drive myself, I have a place where I belong. And that's the biggest thing, I didn't know who I was, I just knew I didn't belong anyplace before, and now I belong. There are places that I belonged somewhat, or part of the time, but I really feel like I belong here. I am a member here. I am privileged to be here. And I'm here for a reason. It's like… I'm home. It sounds kind of clichéd, but, I didn't feel like I belonged with my family as much as I feel I belong here in terms of understanding. Which is really strange for me to be saying…I didn't know I felt this deeply.

Asked to characterize his degree of identification as a compulsive overeater, Bill replied:

> That's a very interesting question. So, I think there's a trajectory that isn't the same as in the other [Twelve-Step] programs. So I definitely started out resisting the label. And I tried on different stuff, sugar addict, um, whether I would say "compulsive" or not, whether I would say "over" or not [laughing]. Yeah, so that's a few years. And then, there was a period where it just didn't matter, that, the program was helping in such a way that I didn't really care what I had to call myself.

Yet he expressed ambivalence, stating "I don't know that I ever really took it in. I'm not sure I ever really owned that label, any of those labels. But it feels like a requirement of membership to say it." Three others discussed the imprecise fit of the compulsive overeater label, and how it was limiting in relation to the nuance of their food and eating difficulties.

<u>Ideology</u>

Ideology proved a consistently strong predictor of identification in my quantitative analysis. As one might expect, no respondents identified program ideology as integral to their participation and recovery. However, the tenets that compose the ideology index in this study are part and

parcel of the 12 steps, in particular, the emphasis on reliance upon a power greater than oneself–be it a religious god, the group, or a natural or cosmic force of some kind—for recovery, and in fact, for all life matters.

This belief in and reliance upon a higher power should not be conflated with religion: in fact, my analysis demonstrates that religiosity decreases identification as an OA member among this Pacific Northwest sample. In contrast, addiction outcome research shows that *joining* a Twelve-Step group is typically more palatable for the religious and spiritually minded, although atheists who participate derive as much benefit as their religious counterparts (Emrick et al. 1993; Kurtz 1997).

I suspect that the negative effect of religiosity on identification as an OA member might relate to the low level of religious participation and identification in this region of the country. It is possible that those who identify as very religious in this sample feel somewhat out of place in a context where participants have such eclectic and non-traditional definitions of a higher power (e.g., one member described his high power as a combination of Jazz and Mount Rainier). Since 12-Step meetings are autonomous, they often take on the cultural orientations of local residents, for example OA members reported more overt religious references in some southern OA meetings relative to those in California, the Northeast or the Northwest.

<u>Emotional Intensity of Meetings</u>

The level of emotion expressed in meetings is predictive of stronger identification as an OA member. Collins (2005) describes the importance of emotion for creating a sense of belonging, as of course does Durkheim (1912). In his discussion of ritual, Collins (2005: 51) remarks that a failed ritual results in low collective effervescence, low “entrainment” and emotional energy, which results in low levels of solidarity and no effect on identity. If we view meetings as rituals,

we can imagine that relatively unemotional meetings do not alter individuals' identity. The positive correlation between meeting emotionality and identification as an OA member supports this idea. Mindful of the role played by emotion and ritual in 12 Step, I asked respondents the question: "Do you think that that expression of emotion affects your experience of the meeting, and your recovery? If so, how?" Respondents almost universally appreciated the expression of emotion, saying it helped them connect in meetings, with the caveat that two individuals expressed discomfort with what they considered "dumping," that is emotional venting without discussing the solution. Chloe explained why emotional sharing at meetings contributed to her recovery: "I'm a more emotional person than mentally-based, and so definitely, a lot of empathy or sympathy, or just identifying, like I strongly identify with people's stories."

Other Factors

Bill, who at one time participated in four Twelve-Step fellowships simultaneously, had left OA by the time of our interview. He spoke compellingly regarding identification in a way that suggested why there might be a reciprocal relationship between recovery and identification. He said his identification as an OA member was related to:

> Sponsorship, certainly, using the other [program] tools, being engaged in fellowship, but bottom line, was I gaining or losing weight. So, if I was losing weight, I'm a functioning member, and if I was gaining weight, then I was on the fringes, or on my way somewhere else. And that was always like my internal… feelings about myself and my body and my weight, defines who I am to the group, and the outside world, is my experience.
>
> Interviewer: That's your experience or your perception? Like you felt that way?
>
> Bill: That's my experience, like that's how I processed that. I don't think I'm speaking about today necessarily, but over those years, it was definitely, if I was losing weight or thin, I was definitely in the group, regardless of how many other unhealthy behaviors were happening.

Asked whether OA had changed the way he saw himself, Bill worried about over-identification: "I do think I got into a space of abstinent is good, not abstinent is bad, not a lot in between." Relatedly, while Cecilia identified very strongly as an OA member, she expressed significant embarrassment over her lack of physical recovery after decades in OA.

There were of course other factors identified by respondents. Three mentioned that service increased their identification as group members, an interesting finding given that the voluntary association literature argues that identification leads to more service. While many credited meeting attendance with increasing their identification as an overeater (which in turn correlates with identification as an OA member), one interviewee, Miriam, considered herself an OA member despite having completely stopped attending meetings two years ago. While the sex of respondents was statistically unrelated with their identification as an OA member, two men noted that the process of identification as an OA member was a bit slower for them compared to their earlier experiences in other, male-dominated fellowships (OA is about 85% female).

Conclusion

Twelve-Step research is inherently challenging. There are considerable barriers to direct research on this loosely defined, anti-bureaucratic and minimally organized population of anonymous groups in situ (Mäkelä et al. 1996), which is why outcome research focuses on Twelve-Step *members*, almost entirely neglecting context. Certainly, it is unusual to capture a quasi-representative sample of a city's Twelve-Step fellowship (see Appendix D). Most study of Twelve Step is based on respondents captured through treatment centers or from the larger population of substance abusers and is focused on identifying the aspects of participation associated with desistance from substance abuse (see Tonigan 2008b for a comprehensive

summary). This is problematic in that, unlike alternative treatment modalities, Twelve-Step recovery is very much a group phenomenon.

While OA is quite similar to AA, NA, GA, and other addiction-based fellowships, there is a critical difference with respect to the nature of recovery. For most of these fellowships, recovery means complete abstention from the addictive substance or behavior. In contrast, OA defines abstinence as "the action of refraining from compulsive eating and compulsive food behaviors while working towards or maintaining a healthy body weight. Spiritual, emotional and physical recovery is the result of living the Overeaters Anonymous Twelve-Step program." In 2011 OA's World Service Business Conference added the section about "working towards or maintaining a healthy body weight," purportedly to address concern with the fact that there are long-time members who remain obese or morbidly obese, which some have argued detracts from "carrying the message" to prospective OA participants.

As many OA participants who also attend AA have argued, one cannot stop eating or simply "put the plug in the jug." Relapse is not uncommon in OA, even among those who have attained a healthy weight. There is also considerable variation in how abstinence is defined among OA members, making it hard to compare recovery outcomes focused on length of abstinence.

Future research should focus on affective attachment, not only to other members, but to the fellowship itself. Identification as an OA member and enjoyment of OA participation are highly correlated. In fact, OA enjoyment is statistically significant in the logistic regression model. However, it is difficult to discern which causes the other, and as with the relationship between identification and expression of emotion, I suspect each reinforces the other.

While I attempted to include questions from AA/NA outcome research to facilitate comparison across 12-Step fellowships, future research might examine the effect of other aspects of ideology than those studied here. The index of ideology used essentially measures internalization of the 12-Step model, neglecting broader aspects of self-help groups, such as self-empowerment, turning help recipients into helpers, and non-reliance on professionals.

Finally, the findings of this study suggest the need for research on the transformative power of identification processes in these groups, and the mechanisms by which they can turn an often life-long source of suffering and shame into a kind of glue that binds participants in a healing community. I quote at length from George, who lost over half his body weight, but gained improved relationships with his children and his employer along the way:

> I think um… (pause) I think at the beginning I did have a sense of that's what I was, that I identified with, but as program grows in me, you know, I grow in the program. I feel more and more like almost as one with this label as a compulsive overeater, like, there is no, you know, I have no doubt in my mind, for the most part, most of the time, there's times when I think I'm cured, but for the most part, I feel like that's exactly what I am and for me, it just sounds beautiful sometimes, like I'm a compulsive overeater, because it means so much more to me than just a problem. Because I don't see it as a problem. I see it as yeah, I'm unique, I'm different, I need to take precautions and work a program. But it just sounds beautiful because in program, while saying that, I experience probably the most emotional growth that I've probably ever had at any point in my life, that I can remember anyway. So, yeah, as time grows, I do feel more, I identify with that label.

Outcome research focuses on identification as an AA member, often as part of an affiliation index, because it predicts recovery. However, this study suggests that Twelve-Step identification may be an outcome worthy of study in and of itself. Certainly longitudinal research is important as a way of determining the directionality underlying identification and its many correlates.

CHAPTER FOUR: HELPING OTHERS IN A SELF-HELP GROUP: COMMITMENT AND INVESTMENT IN VOLUNTARY ASSOCIATIONS

Nonetheless, it was AA—conventionally religious, socially isolating, and doctrinaire—that most impressed me in its ability to offer real, even lifesaving, hope and support to those seriously hurting and failing in this world, precisely because of its cultlike rigidity and insistence upon ideologically limited and repressive ideas and terms and rituals.

Rapping (1996: 101)

Introduction

Voluntary associations—formal organizations in which participation is freely chosen and not financially remunerated—are an important part of civic life, one with beneficial consequences that extend beyond those derived by participants. The salutary effects of these associations include, but are not limited to: facilitation of volunteering; socialization into civic orientations, including concern for the welfare of other people; the creation of a more engaged citizenry; and the accrual by participants of psychological, financial, and health benefits.

Although many lament the decline of civic engagement and voluntary participation, four out of ten Americans participate voluntarily in small groups, with self-help groups constituting the third largest type after Sunday schools and bible studies (Wuthnow 1994). Self-help groups have grown rapidly since the 1970s (Kurtz 1997), though accurate recent data is lacking. Borkman (1999) reports that 7% of the US population attended self-help groups in one year. Looking at Alcoholics Anonymous attendance alone, Room (1993) reports that over 13% of Americans have ever attended a meeting, and over 5% did so in the last year.

Borkman (1999) describes self-help/mutual aid as a new form of volunteering characterized by the volunteer helping others while simultaneously receiving help. However, all volunteering tends to contribute to individual well-being (Wilson 2000). It is associated with improved employment outcomes, in part through skills acquisition and networking (Musick and

Wilson 2008). This activity is also associated with greater mental health, likely through social integration and enhancing one's self-concept, improved physical health, and decreased mortality (Musick and Wilson 2008).

Moreover, voluntary associations are socially important as primary sites of volunteering (Grube and Piliavin 2000). Most volunteers—perhaps as high as 85 percent—work as part of an organization (Penner 2002). The Bureau of Labor Statistics reports that 26.5% of Americans volunteered, that is did unpaid work through or for an organization, in the year ending in September 2012. In 2011, the number of volunteers reached a five-year high, as 64.3 million Americans volunteered approximately 7.9 billion hours valued around $171 billion (Corporation for National and Community Service 2014).

Tocqueville (2000) is the most famous proponent of the socializing aspects of voluntary associations, arguing that in these groups, individuals both habituate to and come to desire serving the interests of others. In this vein and focusing on social capital, Putman extolls the contribution of voluntary associations to the civic health of countries, while others (Musick and Wilson 2008; Wilson 2000) note the importance of volunteering for civic engagement. Putnam (1995: 67) defines social capital as "features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit," and uses indicators such as the percentage of individuals who served on a committee of a local organization in the last year and density of civic and social organizations. He argues that states high in social capital have better performing schools, greater child welfare, less violent crime, better health, lower tax evasion, greater tolerance, and more economic equality (Putnam 2000). Volunteering has been found to increase political engagement, knowledge and interest, as well as participation in

protests and demonstrations (Musick and Wilson 2008). The more active the member in their voluntary association, the greater the civic returns.

Since voluntary associations produce benefits for participants and society at large (see, however, van Deth and Smerli 2010), an important question is how these groups sustain themselves. Voluntary associations rely on the contributions of their members for survival, and as such are typically subject to problems of free- and cheap-riding, wherein some members do not contribute (or under-contribute) to the common welfare of the group. Absent mechanisms of coercion, this can lead to suboptimal good provision and even group dissolution in some cases.

Knoke (1990) argues that in order to survive, voluntary associations must provide members with valued goods and services worth as much as they receive. Knoke emphasizes that organizational incentives need not be private goods (e.g., they can be normative or social), and even if private, they need not be and typically *are not* utilitarian incentives. He argues that member contributions are attributable to “public- and private-goods inducements offered by organizations, and heterogeneous motivations among members” (Knoke 1990: 37).

Among those who study religious voluntary associations, “strictness”—equated with costliness—has been proposed as a novel solution to the dilemma of collective good provision. Iannaccone (1992, 1994) and Stark and Finke (2000) predict that strictness should reduce some of the problems attendant on congregations and other voluntary groups, for which monitoring and sanctioning participation is difficult. Iannaccone (1994: 1182) defines strictness in terms of costs: “the degree to which a group limits and thereby increases the cost of nongroup activities.” He argues that strict demands strengthen churches by raising overall levels of commitment, average rates of participation, and the benefits of membership (Iannaccone 1994). In contrast, Stark and Finke (2000: 143) define strictness in terms of tension with the environment, by which

they mean the "degree of distinctiveness, separation, and antagonism between a religious group and the 'outside' world." They propose that the more tension a group has with its surroundings, the more all encompassing and costly the commitment required of members (Stark and Finke 2000).

In general, the context of volunteering, including the costliness of membership, is generally understudied in favor of easier-to-measure individual correlates, such as values, attitudes, and resources (Musick and Wilson 2008). When context is measured, it typically is operationalized as a geographic area. In an annual review on the topic of volunteering, Wilson (2000: 215) argues that these under-studied contextual variables, including organizational features, remain a "fruitful field for exploration" (see also Grube and Piliavin 2000).

In keeping with this notion, I focus on how costliness, in the form of both behavioral demands and tension with the environment, affects the individual and the group in voluntary associations. Specifically, I examine this issue within the fellowship of Overeaters Anonymous (OA), a 12-Step group patterned after Alcoholics Anonymous (AA). I study the population of OA meetings (N=21) in a large city in the Pacific Northwest, approximately one-third of which follows a more structured (in lay terms, stricter) approach that exists in some degree of tension with the larger fellowship.

12-Step fellowships are entirely self-supporting, meaning they are reliant upon member contributions, and provide non-excludable goods (minimally, meetings) that if provided to anyone must be provided to all who decide they are members. Participation is not only voluntary, but motivated by self-interest: one typically does not join a 12-Step group to help other people (the group Al-Anon, for friends and families of alcoholics, is likely an exception).

Because financial contributions are voluntary (if encouraged), groups experience varying degrees of solvency.

I argue that costliness increases member commitment and contribution, first by acting as a selection mechanism. It does so by deterring the participation of less committed members, which has a number of consequences beyond raising average levels of commitment. First, overall rates of service to the group increase, high cost having filtered out "free-" or "cheap-riders". The cost of participation also filters out those who are more doubtful (the opposite of "true believers"), increasing levels of belief among those who remain. In self-help groups, which are organized around mutual sharing, support, and modeling, increased belief and commitment at the group level result in a higher quality joint good. In the 12-Step context this means more solution-focused, convincing testimony about recovery and more evidence that the program "works", signaling to members the rationality of investment. This enhances all members' recovery and enjoyment of participation, which in turn motivates additional participation in and contribution to the group.

The work reviewed suggests that to thrive, voluntary associations must provide a level of goods to their members that equals or surpasses their contributions. Therefore, groups that are costly to belong to must provide greater benefits in order to sustain themselves. This paper explores the relationship between costs and benefits by analyzing whether those who participate in the costlier subgroup of Overeaters Anonymous have higher levels of commitment, provide more service to the group, exhibit stronger belief, and experience higher returns to participation in the form of greater recovery.

Data and Methods

In order to examine the consequences of variation in the costliness of group participation for member commitment and contributions, I compare the experiences of members in OA-HOW, a stricter OA subgroup, with those of members in the larger fellowship (hereafter referred to as "traditional OA").

Overeaters Anonymous is a 12-Step self-help group, a "fellowship of individuals who, through shared experience, strength and hope, are recovering from compulsive overeating" (Overeaters Anonymous 2014a). Despite its name, the fellowship includes those afflicted with a variety of eating disorders, including anorexia and bulimia. As previously stated, participation is voluntary, and membership is self-determined: individuals are members if they say they are. Members are typically understood as those who attend meetings, though no formal records are kept. A sign-in sheet is passed at every meeting for individuals to write down their first name and telephone number, if they choose, to facilitate contact between meetings. Overeaters Anonymous is not a diet club, and as such does not proffer any particular eating or exercise regimen. What *is* prescribed is the 12-Step program (see Appendix A), which provides a "design for living" and a means of spiritual growth to counteract addiction.

OA-HOW (hereafter referred to simply as HOW) is a subgroup that emerged within the national OA fellowship in the mid-1970s that offers participants additional structure—essentially a variety of behavioral prescriptions, including requirements about participation and dietary guidelines (i.e., no sugar or white flour and weighed and measured portions). In lay terms, it is "stricter" than traditional OA. In addition, the HOW subgroup exists in some degree of tension within the larger OA fellowship: indeed, some HOW meetings left the OA fellowship in the mid-1990s over disagreements concerning food plans and participation requirements. Those that

remained within OA had to make some modifications (such as stopping the practice of promoting a food plan to members), yet retain their distinctive character.

To investigate the consequences of variation in costs of group participation, I collected data primarily from May 2010 to September 2012 (after lengthy informal observations) from a large Pacific Northwest city's OA fellowship. Specifically, I conducted a participant survey, an organizational survey, both randomly sampled and key informant interviews, and structured observations. I first address the participant survey, which I fielded to more than half of the entire population of active OA participants in the city, soliciting respondents in person before and after meetings, offering an online survey and a paper version. I employed three different sampling strategies, with the goal of obtaining at least half the number of participants in each meeting and reducing bias in my selection of participants. First, about one-quarter of the time, I asked the person who sat down next to me. Second, I made a particular effort to solicit a balance of old-timers and newcomers, as I thought this dimension might affect outcomes of interest for the larger study (e.g., identification, contribution to group goods, social capital, and individual recovery). Third, I sought participation by men and younger individuals, as middle-aged women constitute the majority of local participants. The response rate for the participant survey (n=151) was 86%.

Studying this population requires that all research be executed with 12-Step traditions, formal operating procedures, in mind (see Appendix A). For example, my study design took into account the tradition that prohibits OA from taking positions on "outside issues" (including my research). Hence, I did not use meeting time to discuss or advertise my study, and made clear that it was not connected with the fellowship in any manner. In designing my study, I consulted with the World Service Office of Overeaters Anonymous, with University of Washington

Human Subjects Division, and with researchers who have overseen large-scale outcome studies that included 12-Step members.

Because 12-Step fellowships are anonymous, I exercised special care in study design and implementation. 12-Step fellowships express a cooperative attitude toward research, while specifying the importance of respecting the anonymity of their members. For example, AA provides comprehensive guidelines to researchers, to which I adhered. Prior to beginning my research, I had read all available OA program literature, and had extensive familiarity with the fellowship's traditions. Of great utility to my participant observation was my ability to identify as a compulsive overeater,[5] and my participation in other 12-Step fellowships. This allowed me to share at meetings, which increased the comfort that members had with both me and my presence in meetings.

While facilitating access and trust, any insider status also brings challenges to research, requiring considerable researcher reflexivity. My methods of mitigating these potential problems included conducting a confidential survey, reading 12-Step critiques to supplement my knowledge of program literature and doctrine, and adopting the stance that most of the popular claims about 12-Step remain open empirical questions. In terms of participant observation, I had standardized protocols oriented primarily toward collecting objective rather than impressionistic data. To address the possibility that interview subjects would be self-conscious about providing certain answers in a face-to-face interview, I utilized knowledge gained from attending several hundred 12-Step meetings and reading program literature to intuit socially desirable responses, e.g., ones that align with 12-Step doctrine, and prime the alternative.

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[5] According to OA's 11th tradition, members are forbidden from breaking their anonymity at the level of press, radio, and films.

There are limitations associated with the data. While every attempt was made to obtain participants who are representative of the larger population of OA members in this Pacific Northwest city, the resultant sample is not randomly selected, as would have been ideal, but impossible given the anonymous nature of the population and the anti-hierarchical structure and ideology of the organization. The high response rate (86%) reduces the problem of bias related to non-response. However, biases in data collection are inevitable and other sources exist. Most assuredly, the less frequently someone attended meetings, the less likely they were to enter my sample. Those who arrived late and left early were also missed, as my solicitations occurred before and after meetings. Accordingly, I expect that participants in my sample may be more committed and likely to hold service positions. For example, 65% of the sample has served as a sponsor, compared to 59% of those in OA's international fellowship (see Appendix D). However, I do not expect this possible bias to affect HOW more or less than traditional OA.

I conducted 28 interviews with subjects who took the survey, for the purpose of addressing selection effects, trying to establish the direction of causality underlying correlations, as well as explicating survey findings. I chose subjects by taking a random sample (using a random number generator) stratified by meeting size and whether the meeting was part of HOW or traditional OA. My intent was to reduce bias while ensuring sufficient respondents from meetings of different size and format. However, since the population of survey-takers was not random sampled, the interviews are not a true random sample. All those I asked to do an interview consented. I also conducted two key informant interviews focused on the HOW program. Finally, I completed a minimum of 10 (and maximum of 39) structured observations per group, using a form to record information on variables of interest. In total, I made formal observations of 366 meetings. No notes were taken on what was said at meetings, to preserve

participants' anonymity and the integrity (in 12-Step language, the "primary purpose") of the meeting.

Variables

The survey incorporates a variety of measures related to recovery, including: change in weight since joining OA; frequency of relapse; whether the respondent has achieved a healthy weight; and whether one is currently abstinent, which OA defines as "the action of refraining from compulsive eating and compulsive food behaviors while working towards or maintaining a healthy body weight" (www.oa.org). I assessed improvement in multiple areas since joining OA: emotional/mental health, spiritual life, preoccupation with food, family life, physical health, and social life. I also inquired about duration of respondents' attendance at OA, along with the degree to which they were affected by their problems with food when they first started OA to measure baseline severity.

The survey also contained questions concerning contributions to the group, including currently holding a formal service position, and attendance at the regional OA service body. There are several measures related to sponsorship, a form of mentoring vital to 12-Step fellowships. I assess currently versus ever having a sponsor, the same for *being* a sponsor, how quickly one became a sponsor, time spent sponsoring and being sponsored, whether sponsoring is required by one's sponsor, maximum number of sponsees, etc.

An index variable captures the frequency with which OA members use various prescribed practices of the program: prayer, meditation, making phone calls, and reading OA literature (alpha = .68). Another index variable, *ideology*, measures the degree to which the respondent accepts 12-Step tenets (adapted for OA from GAATOR 2.1). This variable is composed of the

following items, to which respondents could answer definitely true, true, false, or definitely false (alpha = .77):

- I have been ready to let my higher power remove my shortcomings;
- I have recognized the amount of serenity I have is a direct result of the amount of humility I have;
- I have believed my recovery could only come from a power greater than myself;
- I have realized things get worse when I compulsively overeat/engage in my eating disorder;
- I have believed that awareness of my higher power is essential to my abstinence.

Two variables capture degree of identification as both an OA member and as a compulsive overeater. Finally, several variables concern religion and spirituality. Two taken from the 2006 General Social Survey ask to what extent a respondent considers her/himself a spiritual person and a religious person. Respondents also indicated changes in their spirituality and religious participation since entering the program.

The Case

OA is one of many anonymous self-help/mutual-aid societies patterned after Alcoholics Anonymous (founded in 1935 and currently claiming over 2 million members), in the sense that it utilizes the 12 steps and 12 traditions developed in AA. The 12 steps are a suggested way of living designed to give individuals freedom from their addiction or dysfunctional behavior through a focus on spiritual growth. AA adopts a disease model of alcoholism that identifies the malady as a three-part problem—mental, physical, and spiritual—and locates the solution in working the 12 steps. Many other 12-Step groups, including OA, embrace AA's "3-fold problem"/disease model. 12-Step fellowships are anti-hierarchical and self-governing, not accepting outside donations, and prohibiting affiliation with outside enterprises and position-taking on "outside issues".

I study OA in particular because it is among the larger and older 12-Step fellowships. Founded in 1960 in Los Angeles, California, OA currently estimates its membership as approximately 54,000 members, with 6,500 meetings registered in over 75 countries (Overeaters Anonymous 2014a). While AA and Narcotics Anonymous are both larger and have received more study, neither is an optimal site for analyzing social dilemmas: federal data indicates that many members are required to participate by employers or judges (Bower 1997: 63). Unlike AA and NA, courts do not order participation in OA. Based upon its 2010 membership survey, OA reports that two-thirds of members are introduced to OA by a friend/family member/coworker, another 12-Step program, or a current OA member. Additionally, the membership profile of OA more closely resembles the socio-demographic profile of other self-help and small groups in general than does AA, which is about 65% male.

At the time that observations began in 2010, the OA fellowship was comprised of 21 groups of varying size meeting within city limits. Using attendance data from 366 discrete observations, I estimate total numbers of attendees at OA meetings as 270. Some portion of this total attendance count reflects individuals who regularly attend more than one OA meeting each week. 6 of the 21 groups in the city are part of the costlier subgroup HOW; in consultation with long-time HOW participants, I estimate the city's HOW active participants as approximately 50-60 members.

HOW stands for "Honesty, Open-mindedness, and Willingness" and is costlier in the sense of having more behavioral prescriptions and proscriptions, but also in terms of existing in some, albeit variable, degree of tension with the larger OA fellowship as something of a "splinter group." OA-HOW describes itself as "a segment of OA that practices a more structured version of the 12-Step program for those who believe they require it" (OA-HOW 2014). HOW groups

"offer a structured and disciplined approach [and were] formed in the belief that our disease is absolute and therefore only absolute acceptance of the O.A. program will offer any sustained abstinence to those of us whose compulsion has reached a critical level" (OA Mid-Peninsula 2014).

HOW follows the OA program with some important differences in emphasis and requirements. It operates according to the same 12 steps and traditions as traditional OA, and is not given any special recognition. HOW meetings are treated as "special emphasis" meetings (such as those for gays and lesbians, for men, etc.) that are allowed under OA's tradition four: "Each group should be autonomous except in matters affecting other groups or OA as a whole." By the same token, tradition three dictates "The only requirement for OA membership is a desire to stop eating compulsively," which means that HOW cannot restrict its meetings to those who follow HOW.

Adherence to the HOW program on average entails many more behavioral requirements (costly in terms of effort and time) than traditional OA participation. For example, HOW members are asked to write daily for the first 30 days, answer 30 questions (many of which involve doing 12-Step reading), and read their writing to sponsors daily over the phone. HOW members are advised to attend at least 3 meetings a week (OA reports most members attend 1-2 times per week) and make 3 outreach phone calls per day, in addition to daily calls to a sponsor and sponsee (traditional OA makes no formal recommendation). HOW members have daily telephone contact with their sponsors at a prearranged time. There is tremendous variation in how people are sponsored in traditional OA, but daily "live" contact is not the norm. Finally, HOW members abstain from sugar and white flour and weigh and measure their food. Members

typically commit their daily food types and amounts to their sponsors. This level of accountability is a form of cost, though one that benefits many.

Findings

I first use interview data to illustrate how OA participants perceive and relate to the HOW program, beginning with the understanding of strictness (Iannaccone 1992, 1994) that refers to costly behavioral dictates. Susan, who practiced HOW for a couple years, described it as "a very restrictive, very set program that you have to follow, and um, my sponsor was really good with me, and I went through what I think everybody does, for the first 30 days I read and wrote every day, talked to my sponsor in the morning, submitted my food plan for the next day, called if I was going to alter it." One member succinctly summarized the difference as HOW being "more stricter [sic], more disciplined". Bill discussed his struggle with the behavioral dictates of the HOW program:

> And all of it was too much. And there were things I refused to do, like the three phone calls a day, I think I did that for a week once. So, yeah, it seemed like too much. Like filling a void. In a very practical way. So, they're still trying to build up some self-reliance, is what I think. And yet, I think HOW works better than regular OA, at least in some respects.

Bill's observations suggest that HOW in particular may provide collective goods that serve as a close substitute for the addiction that motivates participation in 12-Step groups. Jamie (a traditional OA who once tried HOW), recognized that the behavioral dictates of the HOW program worked well for some members, but expressed the view that "there are also parts of it where I feel like food can still rule your life as much as it did when you were bingeing, because of the amount of rigidity and preparation, and for me it's about being able to live my life and go out to dinner with friends."

I now turn to indications of costliness in the Stark and Finke (2000) sense of tension with the external environment. Several members of traditional OA reported reactions against or negative feelings about the HOW program. Kim remarked, "Um, sometimes it feels like a cult within OA. […] like you can't find out unless you join." Peggy shared, "My impression of people that work the HOW program is that, well, I shouldn't say this, but a lot of people I think are emotionally stunted from dealing so much with food." Cindy, when asked about her impressions of HOW, reported, "You know, it's evolved over time. I didn't used to like it. I thought they were, you know, Nazis. But, I guess I've had some resentments, like occasionally I'll be at a meeting, and the speaker will be a member of HOW, even though it's not a HOW meeting. I don't think that they should mix." I asked if Cindy's perceptions of HOW had changed over time, and she replied, "I'm impressed with how well it seems to work for people. But I don't like the people any better, I don't like their program any better, you know what I mean?" In response to my trying to clarify her reasons for not attending HOW, Cindy told me, "Yeah, I guess I'm put off by the rigidity. And my friend is very much against HOW, and that influences me too." George, who selectively worked parts of the HOW program but defined himself as a member of traditional OA, commented at length on what makes HOW unique:

> [W]hat I like about HOW, is that the HOW folks, what my impression is, is that it does work for the folks in there. And I've seen it be disastrous for other folks, and I think it's a personality thing. Um, we can take anything good and just make it shitty and abusive. You know? I know I can, anyway. And I've kind of seen that happen, if I can say that. But what I like about the HOW program is that they say what other folks in OA are maybe too nice or afraid to say, really kind of call it like it is.

Long-time HOW member Maureen noted that there are some individuals who react negatively to HOW: "I think there is a lot of misinformation in regular OA, based on fear."

The tension between HOW and traditional OA members played out at the organizational level, as well. Five interview respondents described how one of the largest (non-HOW) OA

meetings in the city has dealt with tensions between HOW and traditional OA members in its midst. One complained "the frequency of talking about HOW [in a traditional OA meeting] is bewildering to me. [People] kind of advocating for it. […] And it has scared people off, in my experience." I asked Julie, who identifies off and on as a HOW member, whether there are many differences between HOW and regular OA meetings. She answered:

> Yes. I feel like when you go into a HOW meeting there's a definite attitude there like, this is how we do it, this is what we know that works, if you're willing to go to any lengths I'll be your sponsor, if you know your way hasn't worked, try our way. It's very black and white, it's very matter of fact. I would say that the HOW groups almost try to discourage you […] from following HOW, unless you think you're really ready for it.

Another traditional OA member, Cecilia, who has been in the program for over 40 years described significant tensions when the local service bodies of HOW and traditional OA merged:

> We had a struggle […] when they first tried to incorporate HOW. There's always been some tension, which was a little bit uncomfortable for me, but it worked out. And we have a gal who represents HOW. They told them that they had to let everybody come to meetings, not just let the people who were successful share. You know, this HOW meeting, when HOW first came, you couldn't share or identify, unless you were abstinent.

Melissa, who spent the majority of her OA tenure in the HOW fellowship but who at the time of the interview was in traditional OA, described some tension at the city's largest HOW meeting:

> Because it focuses very strongly on the HOW principles, I think it can intimidate newcomers, like, once they're able to get some information and talk to people and understand that they don't have to do it that way, I think it's good, but at first it can be—and I think I felt this way when I was new—it can be kind of intimidating and it feels a little bit too intense. If you just want to come and sit there and listen, um, it, can give the impression that there's a certain way that you're required to do it and that's it. And that can be really overwhelming if you're not in the right place and you're not ready.

She later expounded the costs of such tension: "when I was at regular OA meetings it was really important for me to put that away, so I could see how I was similar to these people in a very basic kind of way, and I was really conscious of not wanting [HOW] to be a dividing kind of

thing, something that separated me from other people." She further noted that she rarely felt judged in a HOW meeting, and "the only time that I've worried about that is if I shared about my HOW Program in a regular OA meeting where people sometimes may be sort of sensitive about that."

While it is clear that HOW exists in the OA fellowship with some degree of tension, it is not universal, and there are definite indications that progress has been made on ameliorating some of the discord between the two groups. Indeed this has been a priority for some in leadership positions. For example, when I asked a long-time HOW member whether there were many differences between HOW and traditional OA, she remarked, "No. I like [this city] in that, there is no prejudice, I feel, it's pretty well integrated. I don't think it was always like that. I remember years ago when HOW first came [here], I was here, and there was a lot of resistance. But I don't see it anymore." When asked explicitly whether there was any tension between HOW and traditional OA, Jill replied:

> It's really lessened. […] There was a retreat [focused on unity that] was fabulous, and it did so much to unify us, to help us to see that these differences are very small differences and that we really need to just practice love and tolerance. For however we need to work our program, there is no one right way. And when I first came into HOW, there were real, it was HOW or the highway. HOW or the highway, and people who went to OA-HOW meetings did not go to regular OA meetings. They did not go to regular OA meetings.

I commented, "Oh, wow. That's not the case now." Jill replied, "No, there's a lot of crossing. Both ways. But I'll tell you, there really wasn't in the early days, and that's changed in the time that I was in HOW." Having illustrated different aspects of the costliness of participation in the stricter subgroup of OA, I now discuss implications of these cost differences for participants and groups.

Because I was interested in the consequences of participation in the costlier subgroup of OA, I first examined whether there were differences between those who joined each group. First of all, it is noteworthy that about half of my respondents have at some point participated in the HOW program, whereas only 25% currently participate. As it turns out, traditional OA participants are similar in sociodemographic terms to those in HOW. Among HOW members, the male/female ratio, the relationship (single versus in a relationship) and employment (unemployed, retired, employed) status mirrors that of traditional OA members. The following differences are not large enough to attain statistical significance. The average age for HOW members is 54.3 years old, compared to 48.5 for those in traditional OA. On average, members of HOW have higher incomes, work 7 hours more per week and spend about 6 more hours per week caring for dependents, relative to traditional OA members. Finally, HOW members have participated in OA for an average of 11.9 years; traditional OA members for 8.9.

Beyond these summary statistics, I sought to investigate whether a different "type" of person or compulsive overeater self-selects into HOW versus traditional OA, which might explain divergent outcomes by group. Based on my interviews, I identified a couple primary routes for entrance into the HOW program. The most prevalent appears to be a sort of trial-and-error method of last resort, whereby someone tries traditional OA but cannot achieve recovery. The second route is generally sponsor-related: an OA member is attracted by the recovery and/or personality of the sponsor who happens to only sponsor through the HOW method.

Finally, on occasion a person just attends HOW, usually not knowing what it is, and starts working that program rather than traditional OA. The largest HOW meeting is on a Sunday evening, a time that works for many people's schedules. Additionally, 3 of the 4 meetings that occur in the geographically isolated western part of the city are HOW meetings, increasing the

odds of exposure to HOW for those who live in that area. I present interview excerpts that demonstrate different paths to entry and speculate about whether these paths are of consequence for the outcomes—commitment, service, recovery—I examine.

Again, most members come to HOW only after trying traditional OA. As HOW member Bill explained, "I think most people end up in HOW after a series of failures in OA." Julie also described similar reasons for attending HOW: "Well, when I was going to regular OA I couldn't get abstinent, and they told me in that meeting, go to [HOW], people there get abstinent." When asked about why she decided to participate in HOW, Jill explained: "For 8 years I just did regular OA, and um, you know, I did get a bunch of different kinds of recovery, […] but it wasn't what I needed." Another respondent chose HOW because in traditional OA she "didn't find consistent abstinence […] they were constantly relapsing, there was some working of the steps, but not much".

The second route to HOW is through attraction to a HOW sponsor. George explained that the sponsor he wanted worked the HOW program and "if I wanted him as a sponsor, that's what I had to do." Jamie related a similar story: "I had probably only been in program for about like, I think it was three months. I wasn't feeling that great a connection with my current sponsor and I felt a connection with another member, and so when I asked her to sponsor me she said she sponsored HOW, and I was willing to try it at that point because I wanted to work with her." So, too, did Susan: "Well, I liked the person who became my sponsor. That person had what I wanted, and lost a lot of weight, was working hard in the program, was very dedicated to OA as a whole. And that person was HOW and I didn't know that much about HOW, so I got started in HOW that way."

I conducted two key-informant interviews with prominent members of the HOW community, each with about two decades in OA in the city. I asked both if a different type of person was attracted to HOW, compared to traditional OA. Maureen replied:

> I don't think so. I mean, Jill was in regular OA first. Patty was in regular OA for seven years and she didn't get abstinent. So a lot of people come to HOW, they don't want to. […] I'm thinking of all the people I know… Yeah, I don't think so. I mean, I think people come to HOW because they have to.

Similarly, Jill expressed the view that "nobody would do OA-HOW if there was another option. I certainly wouldn't." Another decade-long HOW participant felt there was "just as severe a problem, just as severe addiction" in traditional OA, and my survey found no difference in baseline severity of food problem for those in HOW compared to traditional OA. The majority (12) of traditional OA participants I interviewed described their reasons for *not* attending HOW as being related to perceived excessive rigidity or more structure than was required—this in spite of the fact that a few of them weigh and measure their own food to some degree.

To summarize, some members begin HOW "accidentally", some due to sponsor choice, and many more turn to HOW only after trying traditional OA, reasons that should not explain differences in belief, commitment, or proclivity to perform service for the group. On the other hand, the fact that many try HOW after failing to achieve recovery in traditional OA may have bearing upon recovery outcomes. For example, desperation ("powerlessness" in 12-Step terminology) is believed to be a necessary condition for 12-Step recovery. AA's *12 Steps and 12 Traditions* reads: "Under the lash of alcoholism, we are driven to A.A., and there we discover the fatal nature of our situation. Then, and only then, do we become as open-minded to conviction and as willing to listen as the dying can be" (2013: 24). If a disproportionate percentage of HOW members are convinced of their

powerlessness, this might increase their odds of recovery. However, this does not explain why they could not achieve recovery in traditional OA with the same sense of powerlessness. At the same time, though desperation may drive many to try HOW, the strictness appears to drive many away: note that half the sample had at some point worked HOW, but only one quarter are current members.

Having considered what motivates participation in HOW, I now report on the consequences of variation in cost of participation. To control for features of selection into OA meetings, I used generalized linear models (linear, logistic, or multinomial, as appropriate) with robust clustering of standard errors accounting for sampling by groups to determine the significance of differences between HOW and traditional OA. Due to the small size of my sample, I report p-values below .1.

Commitment

Identification as an OA member can be seen as indicative of commitment. Greater numbers of HOW participants very strongly identify as OA members, compared to those in traditional OA: 77% vs. 65% (p=.000). In a multivariate regression controlling for time attended OA, having a sponsor, and identifying as an overeater, current HOW membership remains a statistically significant predictor (p=.000) of identification as an OA member. Another way to measure commitment is by assessing differences in the degree to which individuals engage in prescribed group activities. HOW members use OA-prescribed program tools—telephone, reading, journaling, etc.—more frequently than those in traditional OA (p=.020). However, in multivariate analyses controlling for time attended OA and having a sponsor, HOW participation is no longer statistically significant.

In terms of commitment to abstinence and to working the program, Jill remarked, "Oh, I think there's more commitment within OA-HOW. I don't know. That's my sense about it. I think maybe people who do OA-HOW really get how sick they are. Um and you know, they're willing, there's a maybe greater willingness to do what they have to do in order to recover." Maureen offered a different view on whether there are differences in the level of commitment:

> I don't know. It's such an individual thing. You know, some people just come and talk…. But I think in HOW you can't, if you're going to be in HOW, it's more structured, so you're going to have to call your sponsor, and make your phone calls, and stuff. I think in regular OA, this is just a guess on my part, that some people do all that stuff and some people don't.

Interviewer: So some of it may be pretty structured and that looks like commitment.
Maureen: It looks like commitment… well, there's more involvement. There's more connection, there's more often. I mean, if you're only talking to somebody once a week, how much experience, strength, and hope can you do in a half hour once a week, as opposed to a half an hour every day...

While Maureen was equivocal on whether HOW members are more committed, the degree of structure required is certainly a mechanism for weeding out those who are less interested and willing. Asked to describe the largest HOW meeting, Melissa portrayed a high degree of commitment:

> Definitely in that meeting there are a lot more long-time people that really know each other and have a strong fellowship. I feel like that meeting is very supportive of newcomers, really actively tries to pull them into the fellowship and support them and really help them realize they're not alone. Also, there's a pretty high level of abstinence, people who know what they need to stay abstinent, and firmly believe they are where they're supposed to be. […] They really have strong conviction in the type of program they're working.

<u>Service</u>

HOW members are more likely to currently hold a formal service position than those in traditional OA. Controlling for length of time attending OA, highest level of education completed, income, age, sex, as well as acceptance of OA ideology and identification as an OA

member, being in HOW is associated with a three times increase in the likelihood of currently holding a service position.

Table 4.1: Correlations: Current Service and Its Predictors

	Service Position	*Current HOW member*	Education	Income	Age	Male	Ideology	Identification as OA member
Service Position	--							
Current HOW member	.157 †	--						
Education	.097	.152†	--					
Income	.108	.072	.212*	--				
Age	-.116	.188*	-.034	-.005*	--			
Male	.148†	-.025	-.057	.029	.090	--		
Ideology	.024	.221**	.057	-.079	.192*	-.020	--	
Identification as OA member	.064	.134	.171*	.319***	.137	.006	.374***	--
Time in OA	-.171*	.094	.072	-.059	.404***	-.055	.260**	.344***

†p < .10; *p < .05; **p < .01; ***p<.001

Table 4.2: Predictors of Current Service Position[a]

	(1)		(2)		(3)	
Sociodemographics						
Education	1.14	(.12)	1.16	(.11)	1.17	(.13)
Income	1.05	(.06)	1.05	(.07)	1.03	(.07)
Age	.98†	(.01)	.99	(.01)	.99	(.01)
Male	2.04*	(.67)	2.52**	(.89)	2.85**	(1.09)
Attitudinal						
OA Ideology			1.07	(.07)	1.04	(.08)
Identify OA member			.21	(.46)	1.44	(.51)
Membership Characteristics						
Current HOW member					3.18**	(1.33)
Time attended OA					.96†	(.02)
LL	-92.393		-80.132		-75.317	
Wald chi2(7)	8.72		10.04		30.02	
N	141		124		124	

†p < .10; *p < .05; **p < .01; ***p<.001
[a] Odds ratios from logistic regression models with clustering for robust standard errors (in parentheses); the group variable is meeting identification number.
Source: STSS, 2010-2012.

While more HOW members (53% versus 41%) have attended meetings of the regional OA service body, which is open to any and all OA members, the difference is not statistically significant. The greater degree of service positions offered and filled in HOW meetings compared to regular OA (a score of 11 versus 9.3 out of 16), also failed to achieve statistical significance, perhaps due to the small number (6) of HOW meetings. Jill, one of my key informants, reported a sense that "people in HOW might be a little more willing to step up and do service." When asked how he would characterize the difference between HOW and traditional OA meetings, Bill noted the "consistency of service by abstinent people." Melissa, who spent over three years in HOW, opined: "The group of people was very supportive and involved. It's kind of a more hands-on type of, a more actively supportive fellowship." Regarding service, she said, "we've ended up with a pretty good group of people helping, you definitely get a good cross-section of people."

Sponsorship

Sponsoring—one-on-one mentoring of members through the 12 steps—is an important part of service in 12-Step fellowships. The difference in rates of ever having been a sponsor for HOW members (81%) versus traditional OA members (60%) is statistically significant. Current HOW members are 2.8 times more likely to have ever sponsored than their counterparts in traditional OA ($p=.005$). The number of *current* sponsors is also greater for HOW (58%) compared to regular OA (36%). Current members of HOW are 2.4 times more likely to currently be a sponsor than those in traditional OA ($p=.013$). (For reference, 89% of HOW members currently *have* a sponsor, compared to 65% of those in traditional OA.)

HOW members are *willing* to work with a higher number of sponsees at one time ($p=.060$), and indeed *do* work with more sponsees ($p=.024$). HOW members also become

sponsors much earlier in their program than traditional OA members (p = .028). For example, 48% of HOW members became a sponsor within the first six months of being in program, compared with 14% of those in traditional OA. There is no clear difference in being required to sponsor by one's own sponsor, so this does not explain the greater sponsorship in HOW. HOW members spend more time engaged in the service of sponsoring: 83 minutes per week compared to 47 minutes for traditional OA (p=.060). In multivariate models, the differences in sponsorship variables by current HOW participation lose significance; instead, whether one currently has a sponsor appears determinant. However, it is noteworthy that HOW members spend more time talking with their sponsors, and this result retains significance in multivariate models controlling for time attended OA and severity of problem with food.

Belief

A principle element of belief is internalization of OA ideology. HOW members ascribe more fully to 12-Step ideology than do their counterparts in traditional OA (p=.023). Another part of belief is identification as a compulsive overeater (see step 1, Appendix A), the one requirement of OA membership. 87% of HOW compared to 78% of traditional OA members very strongly identify as compulsive overeaters (p=.000). For example, Julie thought, "going to HOW made me identify more. Yeah, since I've been going to HOW, I feel like I've learned about how out of control my eating really is, in much greater detail than when I went to regular OA."

Yet another component of belief is spirituality (deemed essential to 12-Step recovery, see steps 2, 3, and 11, Appendix A). HOW members rate themselves as slightly more spiritual and about identically religious as their counterparts in traditional OA. However, an interesting pattern emerges when examining changes in spirituality since entering program. While 90% of traditional OA members report that their spirituality has increased, 100% of HOW participants

claimed the same. Despite the statistically significant differences between HOW and traditional OA on different measures of belief, current HOW membership was not a significant predictor of belief in multivariate models controlling for length of attendance, having a sponsor, and number of steps worked. With respect to belief, Melissa described her observations of the largest HOW meeting in the city: "It was definitely going to that Sunday night meeting and hearing people's convictions and how strongly, how well it worked for them and how strongly they believed that, that convinced me that HOW might be a good place to start."

Recovery

HOW members differ from traditional OA members on a variety of recovery outcomes. First, 84% of HOW members' weight has decreased since they first joined OA, compared to 59.3% of those not currently in HOW. In multinomial logistic regression models, HOW members were 46% more likely than their counterparts in traditional OA to have had their weight decrease, relative to remaining the same (p=.032). Second, HOW members have experienced relapse less frequently. For example, 26.3% of HOW members report never having experienced relapse since joining OA, compared to 5.4% of those in traditional OA (p=.001).[6] In multivariate models predicting both weight loss and relapse, including controls for time attended OA, whether one currently has a sponsor, spirituality, and highest step completed, current HOW membership remains a statistically significant correlate of recovery.

92% of HOW members report improvement with respect to their preoccupation with food, compared to 80% for traditional OA. A greater proportion of those in HOW also report improvement in their physical health since joining OA, although this difference is not

[6] Because one cell contains an expected count of 4, I created a variable that combined "never" and "rarely" experiencing relapse versus "somewhat frequently" and "frequently". Being a current HOW member reduced the odds of experiencing frequent relapse by 42% (p<.05).

statistically significant. HOW members are 2.23 times more likely to be currently abstinent than traditional OA members (p=.086).

Of those reporting weight loss, HOW members have lost an average of 5 more pounds (43 versus 38) than traditional OA members, despite the largest weight loss, 200 pounds, being that of a traditional OA member. In addition, slightly (3%) more HOW members than traditional OA members have achieved a healthy body weight; however, neither difference is significant. In terms of qualitative evidence, many members—when asked about whether there are any differences between traditional OA and HOW—remarked upon the differential physical recovery of HOW members. Angela, a traditional OA member, remarked, "I've watched people, the regular OA members that have shifted into HOW, and their physical recovery was tremendous." Helen described the single difference between HOW and traditional OA members as "more abstinence" among HOW members; Cindy generalized "the thin people I know that are in OA are people who work HOW." One member said, "There are more people that have quite a few years [of abstinence], I would say," while another had heard, "the people in HOW are really the ones with the long-term recovery."

Alluding to the higher quality good produced among members of the stricter subgroup of OA, Elise observed "more recovery" and Melissa reported "more focus on the solution". Maureen also described a greater focus on recovery from compulsive overeating:

> I think people in HOW talk more about the food and abstinence. My experience with regular OA is they talk about their lives sometimes and all kinds of other things, but they don't talk about the concrete, the abstinence, I overate the other day, and this is what I'm dealing with and I'm doing a fourth step. I don't hear a lot of that in regular OA, I hear a lot of that in HOW.

Interviewer: It is a recovery from food program.

Maureen: It is. It's not recovery from codependency, it's not recovery from, you know, depression, it's recovery from food addiction. […] And so we're there for help with that.

Similarly, Bill remarked: “HOW is tied to weight loss. And there is a really big difference, right, where OA, at least [here], is about acceptance of body image. Ultimately, acceptance of self. And that is good! It’s great in fact, if there aren’t those big highs and lows [with weight]. And HOW on the other hand is about controlling the disease that brought us here in the first place.” Finally, five interviewees described becoming abstinent within OA only after they started working HOW.

Discussion

By definition, voluntary associations are reliant upon member contributions, and Knoke (1990) makes a compelling argument that groups cannot demand of members more than they provide. How then does cost of participation shape commitment and investment in voluntary associations? Previous work on costliness (Iannaccone 1994; Stark and Finke 2000) suggests that it generates selection processes that increase both commitment levels and the value of the good produced by the group. Additional but related outcomes, I argue, are enhanced belief, and at least in the context of 12-Step groups, greater recovery. All of these goods are strong motivations to participate in and contribute to voluntary associations.

My basic argument is that strictness increases collective good production by reducing the participation of less committed members, mitigating the free- or cheap-rider problem. Costliness also helps eliminate the participation of those who believe group ideology less. Value alignment between participant and organization—which can be measured by belief among participants—has proven a predictor of service to the group (Musick and Wilson 2008). Increased belief and commitment at the group level result in a higher quality joint good, which in many self-help groups translates into recovery, and/or the ability to address personal difficulties.

However, the mechanism is not simply selection. Modeling and signaling are key processes in sustaining groups, both in relation to commitment and service contributions but also with respect to belief. First, abstinent, active members model recovery and service to other participants. Second, the presence of members willing to contribute to the group by taking on service positions signals to others that commitment to and investment in the group are rational. Few want to perform service in a context in which they feel taken advantage of, such as in a group where others will not volunteer.

Signals operate in other ways, too. In the 12-Step context belief is critical, though considerations of efficacy are important for all voluntary associations. Recovery is a costly endeavor and individuals are unlikely to “do the work” (of the 12 steps) unless they can reasonably expect a payoff. The commitment and belief of long-term abstinent members signal the benefit of embracing 12-Step ideology for newcomers and struggling members. Their ability to be abstinent demonstrates program efficacy, so long as struggling members are able to identify as having the same problem as those modeling recovery. In particular for chronic strugglers and for addicts in general, signals that investment is rational are critical because part of their path to wellness is suspending disbelief—by accepting that they are not terminally unique, that there is a solution for their chronic problem, etc.

Many, if not all, of these relationships are reciprocal and reinforcing. For example, commitment likely enhances belief: Project MATCH, the largest randomized study of AA efficacy, has found that self-identification as an AA member is closely associated with abstinence (Moos and Timko 2008). Belief, in turn, likely increases commitment: Individuals who have an alcoholic or addict identity (part of belief) are more likely to join and, importantly, *remain* in self-help groups (Kelly and Moos 2003). And commitment, namely group

identification, has been frequently found to increase service: Sturmer et al. (2008: 6) report that "high-identifiers are also more likely than low identifiers to engage in collective helping such as community volunteerism or assisting group members that are worse off." Finally, service likely increases recovery: Sponsoring has been shown to increase abstinence (Zemore, Kaskutas, and Ammon 2004).

Returning to the specifics of my study, I examine two groups, both with the same general purpose (recovery from compulsive overeating), but with differing costs associated with participation due to membership requirements and tension with the external environment. It is clear that members of the stricter subgroup HOW, compared to their counterparts in traditional OA, incur greater costs. However, these costs are offset by the benefits of membership, including enhanced belief and improved recovery outcomes. In turn, the group benefits from a steady, reliable core of participants and more service contributions, through both formal service positions and sponsoring, both of which are critical to sustaining the group.

My first basic question was whether, as theories predict, costliness increases commitment. We care about organizational commitment as it is a primary cause of service to the group (Penner and Finkelstein 1998). I expected that HOW members will exhibit stronger commitment than traditional OA members. HOW members demonstrate commitment through greater usage of 12-Step tools (writing, reading program literature, telephone, and prayer) and meeting attendance. They more strongly identify as OA members. Beyond its relation to service, commitment increases belief. Baker (2010: 452) argues that committed members provide the group with "certitude and enthusiasm about 'moral correctness'." Such members have a sense of purpose for themselves and for the group that is "socially and emotively compelling."

Again, certitude is a valuable commodity in 12-Step programs, which rely heavily on belief in a higher power and in the utility of the moral psychology of the steps. But certitude concerning group goals is undoubtedly compelling in all voluntary associations, given the importance of normative incentives to volunteering (Knoke 1990). Of the various commitment measures, it is worth perhaps separating identification as a group member out for particular focus, given its relation to contributions to voluntary associations. Echoing Tocqueville, Knoke (1990: 42) emphasizes the importance of identification processes for contributions to collective goods:

> Responding to collective action situations is partly an identification process in which the membership role is internalized along with specific affective bonds both to other members and to the symbolic representation of the group as a whole. The resulting sense of "oneness" between person and group strengthens the member's motives for contributing personal resources to the organization.

Studies of volunteering have found that the more an individual identifies as a member of the group, the more they volunteer for that organization (Grube and Piliavin 2000; Musick and Wilson 2008).

My second question about the consequences of strictness relates to contributions of time and effort to the group. I found that HOW members are more likely to hold a service position than their counterparts in traditional OA. HOW members serve at a higher rate, despite the fact that only one of them reported their primary motivation being that their sponsor *required* them to hold a service position (compared to 11, or 15% of traditional OA members).

Sponsoring is the backbone of 12-Step programs, and arguably the most essential form of service that can be offered. Sponsors help retain new members by binding them to the program, guiding them through the steps, and inculcating them in 12-Step ideology and culture. As expected, HOW members sponsor more than their counterparts in traditional OA, and spend

much more time engaged in this critical form of service. HOW members are *willing* to work with, and in fact *do* work with, a larger number of sponsees. Committed HOW members model this service, making it normative for new members to become sponsors. Accordingly, participants in HOW begin sponsoring much earlier than their traditional OA counterparts.

Costliness also augments belief among participants. HOW members more strongly identify as compulsive overeaters (as step one requires). HOW members have internalized 12-Step ideology to a greater degree than have those in traditional OA, for example, believing that their recovery could only come from a power greater than themselves. A belief in a higher power, and a willingness to turn one's life over to a higher power, are the cornerstones of 12-Step programs (note that this higher power need not be "God"). HOW members reported larger increases in spirituality compared to traditional OA members, with 100% of the HOW sample reporting an increase in their spirituality since beginning program.

If costliness is associated with production of a higher quality or quantity of collective goods, this should manifest itself in differential rates of recovery (a collectively produced commodity) for more costly groups (see Iannaccone 1998; Ellison 1993; and Scheitle and Adamczyk 2010). The survey and particularly the interview results generally prove consistent with this idea. Compared to those in traditional OA, more HOW members have lost weight, they are more likely to be abstinent, and they have experienced relapse less frequently—this despite the fact that they report similar initial levels of difficulty with food. Of course, the determinants of recovery from eating disorders are complex and multi-faceted, and unlike in the field of substance abuse, 12-Step is not the dominant approach of eating disorder treatment centers and professionals (Cooper and Fairburn 2009). It is not my intention to reduce the problem of recovery to one of cost of participation. However, and in keeping with previous research on

recovery from a variety of afflictions, I do argue that the consequences of costliness—meetings with higher levels of commitment (Donovan 1984; Zemore, Subbaraman, and Tonigan 2013), service (Pagano et al. 2004; Witbrodt and Kaskutas 2005), and belief (Kelly et al. 2011; Ronel and Libman 2003)—bode well for the recovery prospects of individual members.

Conclusion

This paper explored the consequences of variation in the cost of participation within the fellowship of Overeaters Anonymous in a large Pacific Northwest city. In line with studies of voluntary associations, including religious groups, there are divergent experiences and outcomes for participants in the costlier subgroup. Beyond shedding light on the consequences of participatory costs, the comparison of these two groups serves as a lens to examine voluntary behavior in general, and allows us to reconsider the presumed polarity between self- and other-interest, and the line dividing public and private goods.

Self-help and 12-Step groups are communities of status-equals in which both the benefits that accrue to the individual and the survival of the group depend upon all. While many lament the decline of membership organizations and fear the consequences for our nation's civic health (Putnam 2000; Skocpol 2003), Wuthnow (1994) argues that the growth of self-help groups may help redress declining levels of identification with and participation in community. He argues that:

> If small groups are to go beyond mere encouragement they may have to foster deeper levels of commitment than they have to date. […] And the deeper, life-and-death commitments that have developed in many twelve-step groups may need to be extended to other settings as well (Wuthow 1994: 188).

The premise of self-help can be seen in the popular line of an OA prayer: "together we can do what we could never do alone." Stated differently, recovery in self-help groups is a collectively produced commodity, the production of which requires the efforts and contributions of more than

the individual seeking recovery. Should participants be able to remedy their problem with all its attendant suffering on their own, they would have done so long before joining a group for that purpose. The same is true of many voluntary associations: people join them to obtain desired goods—often social or psychological—that are difficult or impossible to individually produce. High-cost groups may experience fewer difficulties in the production of joint goods. Compared to other voluntary associations, 12-Step groups can be viewed as very costly, which may contribute to the remarkable proliferation and endurance of this organizational form (Kurtz 1997).

At the same time, voluntary associations would be wise to heed Iannaccone's (1994) admonition that groups perceived as excessively strict will have trouble attracting and retaining members, as the costs of participation may outweigh the benefits. To that end, McBride (2007) argues that allowing some free-riding is key for religious group survival. For example, it is a tradition in OA to tell newcomers to not make a financial donation. It should be noted that previously there were stricter programs than OA-HOW in the city, and that these programs have largely failed to maintain a presence. A couple interviewees speculated that part of the reason that these programs did not survive was due to excessive strictness. Indeed, the HOW program analyzed in this study has markedly decreased its strictness over the years, including eliminating abstinence requirements for speaking at meetings, which may have contributed to its persistence.

Mixed-methods approaches are well-suited to capturing the interplay between organization and participant in small groups of all kinds. At the same time, some of the contribution of this study is specific to the selection of a 12-Step fellowship as an empirical case, including overcoming the considerable barriers to researching this population of anonymous groups in situ (Mäkelä et al. 1996). Most study of 12 step is based on respondents captured

through treatment centers or from the larger population of substance abusers and is focused on identifying the aspects of participation associated with desistance from substance abuse (see Tonigan 2008b for an excellent summary of this work). Moreover, it is unusual to capture a quasi-representative sample of an actual 12-Step fellowship. The representativeness of the resultant data can be seen in the marked similarity between OA members in the sample and in the larger OA fellowship (see Appendix D).

12-Step groups are unique in many respects, including their explicit articulation of the principle that helping others helps oneself. Borkman (2008: 23) writes that "[g]iving to other alcoholics simultaneously furthers the single purpose of AA—to stay sober and help other alcoholics achieve sobriety." Nonetheless, the insights of this study are intuitively appealing with respect to the dilemmas of voluntary associations in general and self-help and small groups in particular. Beyond serving as role models, committed believers possess certainty and confidence, both of which are powerful attractants to group members. They are also powerful signals about the benefits of investment in the group. Given a choice, individuals will generally seek to invest their time, energy, enthusiasm, and other scarce resources in contexts where committed others are already present.

CHAPTER FIVE: RECOVERY IN A 12-STEP GROUP

> Not everything that can be counted counts, and not everything that counts can be counted. -- Albert Einstein, quoted in AA meta-analysis (Kelly et al. 2009: 252)

> [T]he tradition of historical research within which I work holds it to be a fundamental ethic of scholarship that one seeks first to understand any phenomenon in and on its own terms; only then can interpretation and criticism worthy of the names result (Kurtz 1993: 18).

> Most individuals cannot recover unless there is a group. Realization dawns that he is but a small part of a great whole; that no personal sacrifice is too great for the preservation of the Fellowship. He learns that the clamor of desires and ambitions within him must be silenced whenever these could damage the group. It becomes plain that the group must survive or the individual will not (AA *12 Steps and 12 Traditions* 1952: 130, cited in Nowinski 1993).

Introduction

In this chapter I consider how recovery from an individual affliction is achieved through participation in a mutual-aid/self-help group. Specifically, I study the fellowship of Overeaters Anonymous (OA), the largest eating disorder self-help group, modeled after the 12-Step fellowship of Alcoholics Anonymous. While 12-Step fellowships are still somewhat controversial in the field of alcohol and other drug (AOD) treatment, they are much more so in the realm of eating disorders (EDs), as most professionals do not identify EDs as addictions. Moreover, despite increasing research on AOD 12-Step treatment and fellowships, we are only just beginning to understand, or at least know what we don't know, about 12-Step recovery in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Self-help groups (SHGs) represent an important supplement, alternative, or form of after-care to formal medical treatment. Moos and Timko (2008: 511) report that "individuals make more visits to SHGs for help with their own or family members' substance use and psychiatric problems than to all mental health professionals combined." Self-help groups exist for myriad conditions, including mental health concerns and chronic ailments such as fibromyalgia. Groups that are addiction-focused tend to follow the 12-Step model that originated with the founding of Alcoholics Anonymous in the 1930s. The 12-Step model was first replicated by Al-Anon in 1951, then Gamblers Anonymous and Cocaine Anonymous in 1957, then Overeaters Anonymous three years later.

Twelve Step is the dominant paradigm in the treatment of AOD addiction. About five million Americans aged 12 years or older attended a self-help group for alcohol or drugs annually for the years 2006 and 2007 (Donovan et al. 2013). Research demonstrates that AA is as or more effective and certainly cheaper than alternative treatments (Johnson, Finney, and Moos 2006; Kelly et al. 2009; Emrick et al. 1993; Moos and Moos 2006). Recent longitudinal studies have only increased confidence in the efficacy of AA (Donovan et al. 2014). Recent research reveals considerable overlap between participation in professional treatment and community-based 12-Step fellowships: about one-third of AOD self-help group attendees went to professional treatment simultaneously, and two-thirds of individuals in treatment attended self-help groups in a given period (Donovan et al. 2013). Studies have shown that AA attendance reduces members' subsequent health care costs, and recipients of twelve-step-focused therapy incur lower mental health costs (Donovan et al. 2014; Tonigan 2008b).

Unlike the case with alcohol and other drugs, most eating disorder professionals and treatment centers do not utilize 12-Step principles nor encourage 12-Step attendance. Some

eating disorder professionals criticize what they view as “black and white” thinking—specifically total abstention from certain foods (e.g., Kahn 2009). They also critique the emphasis on identifying as a compulsive eater/bulimic/anorexic and the 12-Step view that addiction cannot be cured, only arrested (Wilson 1991). Hertz, Addad, and Ronel (2012: 111) distinguish OA’s approach from that of other treatment modalities as rooted in the 12-Step understanding of compulsive eating as an addiction disease with physical, emotional, and spiritual manifestations. Nonetheless, von Ranson & Cassin (2007) report that approximately 30% of eating disorder treatment programs and clinicians across North America use addictions-based psychotherapies. Russell-Mayhew, von Ranson, and Masson (2009: 34) argue that while the addiction model is controversial, it is “important to explore because there is no efficacy research on addiction-based treatments for eating disorders.”

Additional reason to study the recovery process and individual outcomes in 12-Step fellowships for eating disorders is the increasing prevalence and societal and personal cost associated with overweight and obesity in recent years. In the context of rising healthcare costs, it is worthwhile to consider the utility of OA—an essentially free and widely available treatment method that can be largely tailored to individual needs, capacities, and preferences. Though written almost 20 years ago, it remains true that “little research had been conducted on OA in its 45-plus years of existence (Westphal and Smith 1996). There are literally just a handful of published articles on eating disorder recovery in Overeaters Anonymous, and two of these studies were located in Israel, which contains less than six percent of OA members worldwide.

The statistics on the increasing prevalence of obesity and its personal and societal costs are receiving more attention than ever before. The factsheet on overweight and obesity by the World Health Organization (WHO) illustrates that this is no longer a uniquely American

problem. Since 1980, the rate of worldwide obesity has almost doubled. In fact, 65% of the global population live in countries where more people die due to overweight and obesity than from being underweight. WHO also reports that in 2008, more than 1.4 billion (35%) adults aged 20 and older were overweight, with 200 million men and almost 300 million women (11%) being obese. Additionally, the number of children under the age of 5 who were overweight or obese in 2012 exceeded 40 million.

Nonetheless, the prevalence and increase in obesity is higher in the United States. In 2011-2012, 34.9% of adults were obese; the obesity rate for children and adolescents aged 2 to 19 is approximately 17%, or 12.5 million (Ogden et al. 2014). On June 18, 2013, the American Medical Association voted to declare obesity a disease. According to the Center for Disease Control (CDC), the following conditions are obesity-related: heart disease, stroke, type 2 diabetes, and certain types of cancer. The CDC estimates the annual medical cost of obesity at $147 billion in 2008 U.S. dollars. The average annual medical cost of an obese American exceeds that of his/her normal-weight counterpart by $1,429. Data indicates that both the health consequences of and the societal costs associated with obesity exceed those of smoking and alcohol and drug consumption (Sturm 2002). Levitan and Davis (2010) report that obesity is associated with negative mental health outcomes, and cite two distinct causes of obesity: eating to modify negative mood states ("emotional eating") and addictive eating.

It is unknown what portion of obese individuals meets the criteria for an eating disorder (ED) diagnosis, though Smith et al. (1998) reports a substantially higher prevalence of BED among obese individuals. An eating disorder is defined as "abnormal eating behaviour with either insufficient or excessive food intake, accompanied by feelings of distress or concern about weight or body shape, sometimes in combination with compensatory behaviour, to the detriment

of the person's physical health" (Al-Dakhiel Winklera et al. 2014: 1). There is a high rate of comorbidity between eating disorders and mood disorders (Stuhldreher et al. 2012). Eating disorders are associated with some of the highest levels of medical and social disability of any psychiatric disorder (Klump et al. 2009). Finally, de la Rie, Noordenbox, and van Furth (2005) have reported studies showing eating disorder patients have lower health-related quality of life (HRQoL) than patients with other psychiatric disorders, including severe depression (de la Rie et al. 2005).

While little is known about the differences between ED diagnostic groups, a recent review found that those with binge eating disorder (BED) reported the lowest HRQoL (Jenkins et al. 2011). Further clouding the picture is the fact that BED was only officially recognized in the recently released DSM-V; prior to that binge eaters were classified as Eating Disorder Not Otherwise Specified. According to the DSM-V (American Psychiatric Association 2014), BED entails:

> recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. Someone with binge eating disorder may eat too quickly, even when he or she is not hungry. The person may have feelings of guilt, embarrassment, or disgust and may binge eat alone to hide the behavior. This disorder is associated with marked distress and occurs, on average, at least once a week over three months.

Cognitive behavioral therapy is the most frequently used treatment for BED (Wilfey et al. 2002).

Given the increasing prevalence, cost (personal and societal), and attention given to overweight and obesity in recent years, it is worthwhile to consider the utility of an essentially free and widely available treatment method such as Overeaters Anonymous, which is now accepted as the most popular treatment method for AOD problems. Overeaters Anonymous follows the three-fold disease model of AA, viewing compulsive eating as both an addiction and a spiritual, physical, and emotional malady. From this perspective, the disease of compulsive

eating cannot be cured (in fact, unattended it becomes “progressively worse”), but can be effectively arrested by working a spiritual program. This understanding is expressed by the saying: “While I’m here in the meeting, my disease is out in the parking lot doing pushups.”

The idea of food addiction is controversial, but evidence for the addictive properties of food is mounting (see a review by Levitan and Davis 2010). Dr. Nora Volkow, director of the National Institute on Drug Abuse, has acknowledged addictive properties to food, and similar brain dysfunction—marked activity in brain areas associated with pleasure centers and inhibition of “control” centers) among both food and drug addicts. Davis (2013) notes a sudden and dramatic increase in new studies and evidence on the subject.

Animal studies demonstrate the addictive properties of sweets. Obese rats, unlike their normal-weight counterparts, will continue to press a lever delivering sugar even though it is paired with an electric shock. Lenoir et al. (2007) report that rats prefer sweetener (saccharin or sucrose) to cocaine. Additionally, as with AOD addictions there is increasing consensus that eating disorders often recur throughout one’s life (Wasson and Jackson 2004). Moreover, up to 50% of eating disorder patients relapse (Keel et al. 2005). It was long thought that anorexia nervosa was the most lethal of eating disorders. However, Crow et al. (2009) report crude mortality rates of 4.0% for anorexia nervosa, 3.9% for bulimia nervosa, and 5.2% for eating disorder not otherwise specified (the previous classification for binge eaters). The increasing prevalence and costs of obesity and overweight coupled with the individual suffering associated with eating disorders suggests the importance of evaluating multiple treatment modalities, not just professional services.

While critically important, research on 12-Step fellowships is complicated and challenging (Ogborne 1993). Since AA lacks formal theories of change and causation, Nowinski

(1993: 28) writes: “It will remain the task of the researcher to translate key AA concepts into operational constructs (without losing their meaning) and to posit hypotheses regarding AA involvement and its relation to sobriety and spirituality.” This task is all the more difficult with respect to the study of Overeaters Anonymous, which is an umbrella program for not just compulsive eaters, but bulimics (those who purge by vomiting and/or excessive exercise), anorexics, and individuals with multiple disorders. Since long-term sobriety is regarded as more difficult to achieve with respect to food than with AOD, simple measures such as percent days abstinent are inadequate.

Nonetheless, since abstinence—defined in OA as “refraining from compulsive eating and compulsive food behaviors while working towards or maintaining a healthy body weight”--is the common goal of all members, any study of recovery in the fellowship must assess member’s abstinence. I do this by asking whether one is currently abstinent and (conversely) how frequency one has experienced relapse in OA. The vast majority of OA members come into program overweight, desiring to weight loss. However, there are also a significant number of normal- and underweight participants. Therefore, weight change is an important indicator of recovery, with weight maintenance or gain likely representing recovery for bulimics and anorexics, and weight loss likely representing recovery for overweight individuals. Finally, a fairly universal measure of recovery, albeit one that must be considered in relation to duration of OA attendance (or “time in program”), is having achieved a healthy weight.

In addition to these measures of physical changes, we have learned from AOD research that any definition of 12-Step recovery should incorporate progress on other dimensions (e.g., social, emotional, physical) associated with quality of life. A six-item index captures improvement on multiple dimensions, and best represents the holistic nature of Twelve-Step

recovery, which entails a transformation that transcends abstinence. The additional four outcome variables address the diversity of eating disorders within program through a weight change measure, both current and long-term indicators of abstinence/relapse, and a fairly universal measure of physical health, having achieved a healthy weight.

In this chapter I investigate a model of 12-Step expectations for recovery from compulsive overeating, focusing both on a variety of measures approximating "sobriety"—abstinence, weight loss, achieving a healthy weight, and frequency of relapse—as well as a more holistic index of more recovery: improvement in emotional/mental health, spiritual life, preoccupation with food, family life, physical health, and social life. I begin by presenting a short background on 12-Step fellowships, followed by a summary of recent studies on recovery in 12-Step groups or through professional 12-Step treatment. After highlighting some of the limitations of and suggested future directions for 12-Step AOD research, I summarize the few existing scholarly articles on Overeaters Anonymous recovery. I then describe my data and methods, briefly summarize my survey findings, and present an in-depth discussion integrating interview data on recovery. I conclude with a brief discussion of data and study limitations and avenues for future research.

Background

Alcoholics Anonymous, the original 12-Step program, was founded in 1935. AA now claims over 2 million members worldwide, and it has spawned several dozen (and some estimate hundreds) of 12-Step fellowships for a variety of ailments and issues. Overeaters Anonymous (OA) is one of many resulting anonymous self-help/mutual-aid[7] societies that utilize the 12 steps and 12 traditions developed in AA (see Appendix A). The 12 steps have been called a "design

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[7] For simplicity, I use the term self-help throughout this chapter, but acknowledge the greater accuracy of the combination phrase self-help/mutual aid.

for living" that promises individuals freedom from their addiction or dysfunctional behavior through spiritual growth.

In AA, alcoholism is identified as a disease with mental, physical, and spiritual aspects, the solution to which can be found in the 12 steps, which in turn brings about a "spiritual awakening". Many other twelve-step groups, including OA, embrace AA's disease model. In terms of structural form, all fellowships eschew hierarchy and centralization and grant groups considerable autonomy, except in cases where their actions could threaten the fellowship as a whole (per tradition four, see Appendix A). In order to achieve their mission—"helping the addict who still suffers"—12-Step fellowships refuse outside donations, prohibit affiliation with external enterprises, and do not engage in "outside issues" such as political and social debates.

Founded in 1960 in Los Angeles, California, OA is among the oldest twelve-step fellowships. Overeaters Anonymous describes itself as a "fellowship of individuals who, through shared experience, strength and hope, are recovering from compulsive overeating" (Overeaters Anonymous 2014a). Over time, the fellowship has expanded to include individuals with a variety of eating disorders, primarily bulimics and anorexics. OA "membership" is informal and self-determined, based on the individual's desire to stop compulsive overeating. OA writes on its web page: "No one 'joins' OA in the usual sense of the word. There are no dues to pay or membership applications to be completed... Anyone who says he/she is a member of OA is a member."

That said, members are typically understood as those who attend meetings, though no formal records are kept. A sign-in sheet is passed at every meeting for individuals to write down their first name and telephone number, if they choose. The sheets are solely to facilitate contact between meetings and are not kept on file. Because there is so little research on OA recovery,

and because 12-Step fellowships follow the same recovery model and adopt the same organizational rules, I will discuss outcome research on AOD fellowships (primarily AA).

Literature on Twelve-Step Recovery

Any discussion of recovery should begin with an acknowledgement that there is no consensus definition of the word. The growth of self-help organizations has undoubtedly influenced the understanding and frequency of use of the term recovery, over time prompting AOD scholars and practitioners to consider a broader focus than reduction or cessation of substance abuse. The Betty Ford Institute convened a panel of AOD treatment experts to come up with a preliminary definition of the word recovery in 2007. They decided upon the following: "Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Institute Consensus Panel 2007).

Key points of agreement were that recovery should not simply be equated with sobriety, and that any definition should incorporate elements of personal health. In accordance with long-standing practice by the World Health Organization, now adopted by the National Institutes of Health, personal health incorporates physical, mental and social health. The Betty Ford Consensus Panel (2007: 225) advocated measuring "improvement in these domains, measured against a pre-recovery period of substance abuse."

White (2007: 234) advocates viewing recovery from addiction "not as a focal point but as a byproduct of larger personal and interpersonal processes." This perspective would differentiate AOD desistance as abstinence, and the achievement of physical, emotional, relational, and spiritual health as recovery. This distinction is rooted in 12-Step understandings of recovery. As AA historian Kurtz (1993: 14) writes, "failure to advert to the AA distinction between mere *dryness* and true *sobriety*, between 'putting the cork in the bottle' and attaining a degree of

‘serenity,’ signals a very poor understanding of Alcoholics Anonymous.”

Some renowned scholars of Alcoholics Anonymous have ably described the practical program of twelve-step recovery and its philosophical underpinnings (e.g., Kurtz 1993). Outcome research produced in the last two decades increasingly addresses Twelve Step. It does so, however, by operationalizing highly variable ideological systems and social organizations in ways that facilitate comparison to other treatment modalities. This risks missing the essence of 12-Step recovery. Beyond that, the singular focus on reduction or elimination of substance use omits much of value to 12-Step attendees. As White (2007: 234) argues, this ignores the reality that “addiction is often intricately bundled (concurrently and sequentially) with other problems and that the resolution of addiction is often inseparable from the resolution of problems in which it is nested.”

Outcome Research on AA and NA

The literature on treating substance abuse is extensive and broadly empirical (cf. Moos 2008). Project MATCH was the first randomized clinical trial of three treatment methods: cognitive behavioral therapy, motivational enhancement therapy, and twelve-step facilitation. While not a study of Alcoholics Anonymous, the resultant large and diverse sample has been used to study the relationship between subjects’ subsequent involvement in 12-Step fellowships (i.e., “AA in the community”) and AOD consumption and behaviors.

Greenfield and Tonigan (2013: 553) provide an up-to-date review of AOD outcome studies, noting strong support for: working with a sponsor, especially during early recovery; meeting attendance; and service. They report less support for the efficacy of step work in facilitating abstinence, which is noteworthy, as 12-Step fellowships describe the steps as the means of achieving the spiritual transformation deemed necessary to recovery. An earlier meta-

analysis by Emrick et al. (1993) reported support for the effectiveness of having an AA sponsor, working step 12 (“carrying the message to other sufferers”), leading a meeting, and to a lesser extent, for sponsoring other AA members and working steps 6 through 12.

A key question of outcome research is whether common or unique factors explain AA mechanisms of change, now that strong support has been provided for the fellowship’s efficacy (Emrick et al. 1993; Kelly et al. 2009; Donovan et al. 2013). Cognitive factors common to various forms of substance abuse treatment, such as self-efficacy, commitment to recovery, and motivation for abstinence, were found to mediate the effect of AA participation on later drinking (Kelly et al. 2009). Donovan et al. (2013) report that the best evidence exists for common mechanisms of change along with social network changes. Active coping efforts are another common element found to mediate the affect of AA attendance on sobriety (Morgenstern et al. 1997).

Yet elements—both cognitive and behavioral—unique to 12-Step fellowships also predict positive outcomes. For example, AA-specific cognitions (e.g., acceptance of powerlessness and disease attribution) predicted reduction in severity of relapse (Fiorentine and Hillhouse 2000). In addition, various AA practices such as reading literature (Johnson et al. 2006), working the steps (Tonigan and Miller 2005), having a sponsor, and greater meeting attendance (Emrick et al. 1993) ameliorate drinking behaviors. Recent studies have increasingly shown support for the primacy of *involvement* over attendance in predicting reductions in alcohol use (Kelly, Stout, and Slaymaker 2013). Despite these findings, other mechanisms deemed integral to recovery in twelve-step literature and lore are under- or inadequately examined. Extant studies use different measures and different samples and assess subjects over different time periods. For example, 12-Step fellowship is almost always operationalized in terms of

social networks (Kelly et al. 2009: 248). Essentially, social network changes—increased ties supportive of abstinence, reduced connections with substance users—have been shown to mediate the relationship between increased AA involvement and substance use outcomes (Kelly et al. 2011).

The study of spirituality has increased, but research assessing whether it mediates the effect of AA participation on recovery is rare. Kelly et al. (2009: 249) found insufficient evidence to "support or refute a central role for spirituality in recovery through AA," and called for further research. The authors note that spirituality is difficult to measure, may interact with other processes of change, and may vary in importance at different stages of recovery. However, Kelly et al. (2011) subsequently found that those who attended AA increased their spirituality, which in turn contributed to a reduction in their drinking behaviors.

Emrick et al. (1993: 54) write: "[r]elationships between AA participation variables and outcome in other life domains have been so little researched that a meta-analysis concerning such relationships is unfeasible.[8] A large proportion of the research on AOD 12 Step is actually assessing the efficacy of twelve-step facilitation (TSF), the use of 12-Step principles in a treatment center. Studies also predominantly involve samples in the very early phases of recovery, which leaves a gap of knowledge concerning both non-treatment AA samples and the mechanisms involved in longer-term maintenance of sobriety. Kelly et al. (2009: 252) suggest that research thus far "reflects an approach of feasibility rather than comprehensiveness or theoretical cohesiveness."

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[8] Nonetheless, Emrick et al. (1993) report small but positive correlations between AA involvement and the following: employment situation, improved social/family/marital and legal conditions, having a more active religious life, possessing a more internal locus of control orientation, reduced physical symptoms, and improved psychological adjustment.

The focus of outcome research has been to establish the efficacy of AA relative to other available addiction treatments. For that reason, factors unique to AA have received less attention. As DiClemente (1993: 95) writes: "Plaguing the reviewed research and thereby limiting its informativeness has been the failure of investigators to identify, understand, and apply theoretical constructs upon which AA is based." One such theoretical construct is the idea that addiction is a symptom and treatment must address root causes. As DiClemente (1993: 95) explains, "AA focuses on multiple levels of change and places great emphasis on maladaptive thinking and beliefs, interpersonal conflicts, and intrapersonal issues of values and character."

Antze (1976, summarized in Beutler, Jovanovic, and Williams 1993) identifies five core elements of twelve-step philosophy. In many ways these summarize the program and its mechanisms of change. First is understanding alcoholism as a disease over which the alcoholic is powerless. Recovery is further facilitated by the experience of "hitting bottom" and acceptance of and reliance upon a "power greater than oneself." Working the steps—particularly identifying character faults and harms done to others, confessing them, and making amends—is the action part of recovery, supplemented by carrying the message to others (based on the assumption that alcoholics can best help other alcoholics). Nowinski (1993: 29) writes: "The researcher who wishes to study AA needs to understand, then, that as a fellowship it is founded not on theory or operational constructs but on ideas, ethics, ritual, and traditions."

In many ways, Twelve Step is starkly at odds with a standardized, quality-controlled intervention. Kelly et al. (2009: 249) explain that "AA's pragmatic community approach was never designed to facilitate empirical validation and many AA constructs have eluded explicit operationalization. Consequently, what we know is colored by the research lens that observes it." Ogborne (1993) describes the challenges faced by outcome researchers in assessing AA

effectiveness. While treatment for alcoholics would ideally be standardized across cases (from a research perspective) "AA is a purposefully 'nonorganized,' nonexclusive, open-ended movement that relies on untrained, unpaid, and unsupervised individuals engaged in a loosely defined, mutual self-help process" (Ogborne 1993: 340). While many interventions purposefully exclude individuals with comorbid conditions for evaluation purposes, this is distinctly not the case with AA. As Ogborne (1993: 340) explains, in contrast to formal treatment, Alcoholics Anonymous does not filter out individuals "unsuitable due to poor motivation, legal charges, mental health problems, low social stability, or inability to pay. Those who relapse are welcome to return as are successful abstainers seeking to prevent relapse."

Moreover, there is considerable self-determination regarding the scale and scope of participation and involvement. Participants routinely hear the maxim, "Take what you like and leave the rest." Additionally, old-timers will frequently say that nothing in Twelve Step is "required," even the steps are just suggestions (as the Big Book reads). Every aspect of the program – sponsorship, meeting attendance, step work, tool usage (e.g., reading 12-Step literature, journaling), extra-meeting contact (fellowship, phone calls)—can either be done or not, and done to myriad degrees. One is a member if he or she identifies as one, irrespective of involvement. As self-help scholar Borkman (2008: 12) writes:

> Since ideal/textual AA expects each member to self-diagnose their drinking problem, to develop a relationship with a God or higher power of their understanding, to interpret their life story within AA's narrative framework, and to evolve their own recovery program in consultation with their sponsor, higher power, and friends, the individuality and lack of uniformity requires that in-depth field research or ethnography be used to study and understand the nuances and diversity.

To that end, there are some rich ethnographic accounts of Alcoholics Anonymous (e.g., Jensen 2000; Wilcox 1998; Denzin 1987; Rudy 1986) that help capture the experience of participants in

12-Step programs in ways that, while not conducive to assessing recovery outcomes, might ideally inform future quantitative research.

Finally, another source of variation comes from regional cultures. Borkman (2008: 26) writes that: "Current research is revealing much greater diversity in meetings than researchers have previously presumed and many early generalizations based on tiny samples of culturally similar meetings need to be discarded." Mäkelä et al. (1996) provide a unique cross-national perspective on Alcoholics Anonymous. A valuable contribution would be to study regional variation within the United States, the birthplace and largest membership base of 12-Step fellowships. One of my respondents, Sarah, discussed this type of variability. She reported feeling more at home in OA now than when she lived in New York, and cites local factors:

> I think every OA group is a microcosm of the world around it, and [this city] is progressive, is granola-head and Birkenstocks, everything is cool and groovy, you know? New York City is stressed and uptight and everyone wants to be out of the city and into relationships, and it's just kind of an interesting tone. … In the south when I lived in Durham, some of the meetings had a very fundamentalist Christian--Jesus was mentioned a lot, and it was accepted that that was how it was.

Thus, characterizations of 12 Step should always be tempered by reference to the local context. Based on my observations and discussions with OA members, meeting rituals common in one region (e.g., reciting the Lord's Prayer) might be deemed unacceptable in another. A final complication for research are the challenges posed by the anonymity of individuals (which may make them wary of involvement with outsider endeavors), and the reluctance of some groups to permit application of various research methods and tools (Ogborne 1993).

In addition to the fact that much study of AA is actually of TSF, even studies of community-based AA are derived from treatment samples. The Emrick et al. (1993: 47) meta-analysis of AA studies reported that over two-thirds of study samples were drawn from inpatient

samples, compared to 11.9% drawn from AA in the community. Tonigan (2008a: 359) writes that "nearly all studies investigating community-based AA processes and outcomes do so from the perspective of recruiting alcohol-dependent persons entering formal substance abuse treatment." While problematic in terms of bias toward treatment-seekers, at least in the case of AA, "naturalistic studies are beginning to document that considerable bidirectional migration occurs between twelve-step therapy and community-based AA" (Tonigan 2008a: 359). However, eating disorder treatment is not nearly as twelve-step oriented as treatment for alcohol and drug abuse. In fact, in many cases, treatment providers oppose OA as a treatment method, at least for certain clients. While this analysis is partly situated in AOD outcome research, it is important to recognize the limitation of the comparison.

<u>How Overeaters Anonymous Differs from AA</u>

While OA is directly derived from AA, it cannot simply be equated with AOD 12-Step fellowships. Many AA meeting attendees have been ordered there by judges or employers (Bower 1997). There is no equivalent practice regarding Overeaters Anonymous, making it more truly voluntary. According to OA's 2010 Membership Survey, two thirds of members are introduced to OA by a friend/family member/coworker, another twelve-step program, or a current OA member.

Though it draws explicitly and directly from Alcoholics Anonymous teachings, practices, and literature, OA recovery differs from that in AA, NA, and Gamblers Anonymous fellowships. While these 12-Step groups propose total abstinence as the means to recovery, this is not the case for OA, as food is necessary for survival. Some in OA use the analogy of having to "take the tiger out of the cage and walk it three times a day" to describe dealing with food addiction. Israeli members of Overeaters Anonymous interviewed by Ronel and Libman (2003) noted that

abstinence around food—avoiding problematic foods, or quantities of food(s) and eating behaviors—is decidedly more complicated than the complete abstinence required of alcoholics and drug users in AA and NA.

Beyond that, addiction to or problems with food can seem less serious to both those afflicted and those not. Some members reported that compulsive overeating is not always taken seriously by those in AOD fellowships. Additionally, one double winner thought that the nature of the disease of compulsive overeating permitted higher levels of denial:

> I think a lot of us in OA, there's a lesser threat of physical death than it is with AA. Because we can go on and on being very, very physically ill… but not dead. Death happens much more slowly, but it happens. And the quality of life is *shit*, but we can live. And as long as we're living, I think we can con ourselves into thinking we're not so bad, or we can still handle it, or we can still make it work.

Finally, it seems that rates of step completion are low for the AA-attending samples outcome researchers capture most often through treatment centers. It is possible that there is less pressure from others to join OA, and therefore OA participants may be more willing to do what the program prescribes.

<u>Scholarly Study of Overeaters Anonymous</u>

Research on Overeaters Anonymous recovery—as on most non-AOD 12-Step fellowships—is limited. The few extant studies, with the exception of an unpublished dissertation (Kriz 2002), focus on depth rather than breadth of coverage. There is more work on Al-Anon, as well as the thematically similar fellowship Codependents Anonymous (CoDA). In their study of 88 Israeli OA members, Ronel and Libman (2003: 159) describe OA recovery as a change in worldview among participants in four domains: "experience of self, universal order/God, relationships with others, and perception of the problem." In terms of self-concept, participants came to understand their powerlessness over eating, which in turn reduced their efforts to control and compensate

and their tendencies toward self-recrimination. They also reported less judgmental attitudes toward others and better boundaries in relationships, attributable to improved self-esteem.

Ronel and Libman (2003: 164) relate a critical aspect of the OA fellowship: "A self-contained social experience is offered, and the group is experienced as a kind of 'social laboratory' where acceptance, modesty, giving, and unconditional love are the foundations." My observations support the authors' contention that this is part reality and part explicit aspiration. For example, most meeting scripts read: "If you decide you are one of us, we welcome you with open arms. Whatever your circumstances, we offer you the gift of acceptance. You are not alone any more. Welcome to Overeaters Anonymous. Welcome home!" Ronel and Libman (2003: 164) expound, "Sharing the weaknesses, the vulnerability, and the very difficult situations encountered by everyone in the group, creates an atmosphere of understanding, identification, and love, even if unspoken." Israeli OA interviewees reported an acceleration of this process through relationship with veteran members who were their sponsors, and credited OA with positively transforming their outside relations, as well. Finally, the disease attribution aspect of OA was helpful to participants, most of whom previously thought their eating difficulties stemmed from lack of willpower. "Like members of AA and NA, the women in OA view their eating disorder as an allergy or a chronic disease of addiction that worsens with time" (Ronel and Libman: 166).

Relatedly, and focusing specifically on emotional aspects of recovery among 20 Israeli female OA members, Hertz et al. (2012: 118) wrote "women members of OA reported experiencing what can be interpreted as the transformation of an insecure attachment experience into compensating and remedying experiences characterized by love and unconditional giving." Wasson and Jackson (2004) report a qualitative study of 26 bulimia-diagnosed OA participants,

addressing aspects of the program that helped them to obtain and sustain recovery. They found that all participants viewed OA meetings and use of a food plan as most important to their recovery. Respondents also utilized interaction with a sponsor, writing/journaling, and prayer and meditation. Malenbaum et al. (1988) studied a 100-member OA group in Boston using an OA member as a liaison to solicit 40 diagnosed bulimics with an average abstinence of three years from compulsive overeating. They found that most attended five meetings per week and called their sponsors daily, with 42% attending therapy concurrently.

Russel-Mayhew et al. (2009) conducted focus groups with 20 OA members to assess members' perceptions of and experience in the OA program. Similar to findings of Ronel and Libman (2003), the authors report a common theme that perceiving one's problem with food as an addiction was critical to recovery. Participants noted the utility of several program tools (see OA Tools of Recovery, Appendix B), but singled out the spiritual nature of OA as being most helpful. They identified the emphasis on emotional and spiritual aspects as the reason why OA is effective. As one of their respondents argued, members come in and stay for different reasons, attending OA first "because they had a food problem and stay[ing] because they had massive life problems" (Russell-Mayhew et al. 2009: 38). A common way this phenomenon is expressed by OA members is "I came for the vanity; I stayed for the sanity."

Westphal and Smith (1996) analyzed questionnaires completed by 34 OA participants and conducted follow-up interviews with 27 subjects. This study was unique for its utilization of an objective measure of physical recovery (weight reduction), which correlated well with self-rated measures of success (r=.6). The most useful aspects of OA identified were the 12 steps, OA meetings, and abstinence. In terms of behavior that most promoted abstinence, 91% identified prayer and mediation. Finally, in an unpublished dissertation, Kriz (2002) sought to

identify variables associated with abstinence from binge-eating disorder and bulimia nervosa. In addition to analyzing the demographics of her sample—231 OA participants in the greater DC area—she examined use of OA tools. She reported statistically significant correlations between a reduced frequency of relapse and length of OA attendance, adherence to a food plan, making phone calls to other members, and journaling.

Twelve-Step Theories of Recovery

Following Kurtz (1993), it is important to consider 12-Step explanations of how recovery is achieved. The Big Book of Alcoholics Anonymous contains a chapter called "How It Works", which essentially walks readers through the 12 steps. A more succinct version can be found in "Our Invitation to You," a script that is read at the beginning of OA meetings. I reproduce large portions since it captures key aspects of the program:

> If you will honestly face the truth about yourself and the illness; if you will keep coming back to meetings to talk and listen to other recovering compulsive overeaters; if you will read our literature and that of Alcoholics Anonymous with an open mind; and, most important, if you are willing to rely on a power greater than yourself for direction in your life, and to take the Twelve Steps to the best of your ability, we believe you can indeed join the ranks of those who recover.
>
> To remedy the emotional, physical and spiritual illness of compulsive overeating we offer several suggestions, but keep in mind that the basis of the program is spiritual, as evidenced by the Twelve Steps.
>
> We are not a "diet and calories" club. We do not endorse any particular plan of eating. We practice abstinence by staying away from eating between planned meals and from all individual binge foods.
>
> As a result of practicing the Steps, the symptom of compulsive overeating is removed on a daily basis, achieved through the process of surrendering to something greater than ourselves; the more total our surrender, the more fully realized our freedom from food obsession.

The "AA Promises" also detail the types of recovery 12-Step participants can anticipate, and are read at the closing of some OA meetings.

> If we are painstaking about this phase of our development, we will be amazed before we are half way through. We are going to know a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves (Alcoholics Anonymous: 83-84).

Using a tool to assess the degree to which the AA promises are realized for participants, Kelly and Greene (2013) found that those associated with psychological and emotional well-being were realized by members with longer durations of participation in AA.

Data and Methods

After engaging in prolonged informal observations, I collected the majority of my data from May 2010 to September 2012 from the OA fellowship located in a large Pacific Northwest city. In spring of 2010, the OA fellowship consisted of 21 groups of varying size meeting within city limits. Using attendance data from hundreds of meeting observations, I estimate total numbers of attendees at OA meetings as 270 per week. Some portion of this total attendance count reflects individuals who regularly attend more than one OA meeting each week, and of course, omits any individuals who consider themselves members but are not currently attending meetings.

I collected data by means of a participant survey, an organizational “meeting” survey, 366 structured meeting observations, a stratified random sample of survey-takers, and key informant interviews. I fielded the participant survey (in paper and online form) to more than half of the entire population of active OA participants in the city, soliciting respondents in person before and after meetings, offering an online survey and a paper version. I sought to secure participation of at least half the total participants in each meeting, and employed three different

sampling strategies to reduce bias in my selection. First, about one quarter of the time, I asked the first person who sat down next to me. Second, I made a particular effort to solicit a balance of old-timers and newcomers, as I thought this dimension might affect outcomes of interest for the larger study (e.g., identification, contribution to group goods, social capital, and individual recovery). Third, I sought participation by men and younger individuals, as middle-aged women constitute the majority of local participants, and were easier for me to approach. In other words, I sought to avoid compounding homogeneity in a group that already had limited demographic diversity. Finally, since a number of survey questions pertained to the meeting, I tried to solicit participants in a meeting they regularly attended (based on my repeated observations of each meeting and glancing at previous sign-in sheets). The response rate for the participant survey (n=151) was 86%, with only three outright refusals (see Appendix D for sample characteristics and comparison to the national fellowship).[9]

I designed the study with twelve-step traditions—group bylaws or operating procedures—in mind. For example, since tradition ten prohibits OA from taking positions on outside issues (including twelve-step research), I did not use meeting time to discuss or advertise my study, and made clear that it was not connected with the fellowship in any manner. Prior to starting fieldwork, I consulted with the World Service Office of Overeaters Anonymous, with University of Washington Human Subjects Division, and with researchers who have overseen large-scale outcome studies that included twelve-step members.

The anonymous nature of twelve-step participation necessitated special care in the design and implementation of my study. Twelve-Step fellowships express a cooperative attitude toward

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[9] It is relatively rare for AOD quantitative research to recruit from meetings. However, one study that recruited from two AA community meetings reported a response rate of 44% (Majer, Droege, and Jason 2012).

research, while specifying the importance of respecting the anonymity of their members. AA provides comprehensive guidelines to researchers, to which I adhered. This including reading all available OA program literature prior to consenting survey and interview participants, and studying OA's 12 traditions. All 21 OA meetings in the city were "open", which means that non-members can attend. While OA's 11th tradition forbids members from breaking their anonymity (i.e., identifying as an OA member) at the level of press, radio, and films, all aspects of my research were undeniably facilitated by my ability to authentically relate as a compulsive overeater. Additionally, my membership in multiple twelve-step fellowships gave me a shared language and cultural understanding that appeared to increase subjects' comfort with me, and presumably that increased their willingness to participate in the research.

While increasing access and trust, any insider status also necessitates researcher reflexivity. To mitigate potential problems, I conducted a confidential survey, read twelve-step critiques to supplement my knowledge of program literature and doctrine, and adopted the stance that most of the popular claims (both by insiders and outsiders) about Twelve Step remain open empirical questions. In terms of participant observation, I used standardized protocols oriented toward collecting primarily objective rather than impressionistic data. For interviews, I utilized knowledge gained from attending several hundred twelve-step meetings and reading program literature to intuit socially desirable responses, e.g., ones that align with twelve-step doctrine, and elaborated on questions in such a way as to normalize a variety of responses.

There are data limitations that should be taken into account when assessing the scope conditions of my statistical findings. While every attempt was made to obtain participants representative of the city's population of OA attendees, the sample is not randomly selected. A random sample, of course, was impossible to obtain given the anonymous nature of the

population, the decentralized structure and ideology of the organization, and the related absence of membership records. The high response rate (86%) reduces the problem of bias related to non-response. However, biases in complex data collection efforts are inevitable. Certainly, the less frequently someone attended meetings, the less likely they were to enter my sample. Those who arrived late and left early were also missed, as my solicitations occurred before and after meetings. If struggling members tend to reduce or stop attending meetings, the sample could be biased toward increased recovery; if members with sustained abstinence reduce or stop their attendance, the opposite could be true. The sample I drew for interviews included five individuals who had stopped attending OA meetings since taking the survey; their stated reasons were unrelated to abstinence except in one case. Two other limitations should be borne in mind. First, retrospective accounts reflect respondents' current understanding of their recovery process, which may be affected by numerous factors, including current levels of recovery and OA ideology. Second, the cross-sectional nature of my survey data does not enable determination of causal direction.

I conducted 28 interviews with subjects who took the survey, for the purpose of addressing selection effects, trying to assess the causal direction underlying correlations, and exploring ambiguous survey findings. I chose subjects by taking a random sample (using a random number generator) of survey takers, stratified to ensure sufficient respondents from meetings of different size and format. Of course, since the population of survey-takers was not randomly sampled, the interviews are not a true random sample. Instead, they reflect an attempt to increase representativeness by reducing bias. All those I asked to do an interview consented. I also conducted two key informant interviews. In terms of observation, I completed a minimum of 10 and maximum of 39 structured observations per group, using a form to record information

on variables of interest. In total, I made formal observations of 366 meetings during the study period. No notes were taken on what was said at meetings, to preserve participants' anonymity. While I could have sought permission from group members to record discussions, I believed that would interfere with the primary objective of the meeting. While no identifying or personal material from individual meeting "shares" appears in this dissertation, the authors' observation of hundreds of meetings is reflected in descriptions of 12-Step culture, such as slogans and collective understandings. The author's observations are the source of this descriptive material, unless otherwise attributed.

Variables

The survey incorporates a variety of outcome measures to try and capture the complexity of recovery from eating disorders. I begin with measures focused on more obvious indicators of recovery from compulsive overeating, essentially rough equivalents of variables used in AOD outcome research, modified to reflect differences related to eating disorders. First I asked respondents to report change in their weight since joining OA. While it is at least the principal motivation for the majority who join OA, it is important to not assume weight loss is universally indicative of recovery, as people join the fellowship at a variety of weights and for a variety of eating disorders (anorexia and bulimia nervosa, exercise bulimia, binge eating disorder, etc.). According to its 2010 membership survey, 82% of members were overweight when they first came to OA, 14% were at a healthy weight, and 4% were underweight (Overeaters Anonymous 2014c). Of the 151 respondents who answered this survey question from my study, about 20% reported their weight was the same as when they joined; 14.6% reported an increase, and 65.6% reported weight loss.

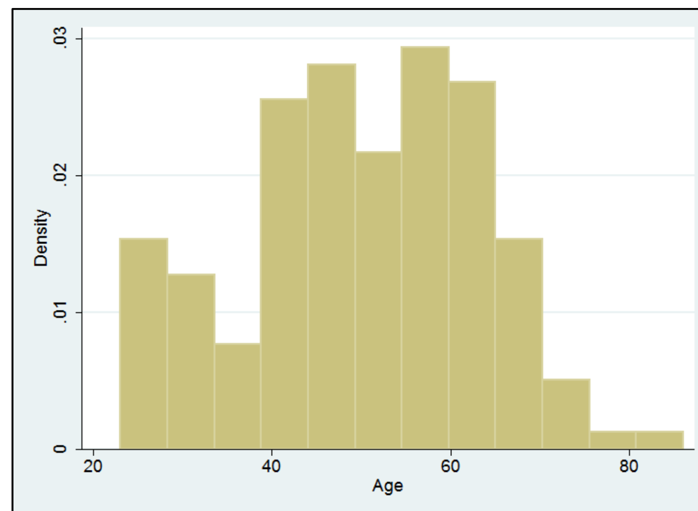
Nonetheless, since the vast majority of the sample identifies as compulsive overeaters, "pounds lost" is an important outcome. 98 respondents lost weight ranging from 4 to 200 pounds each (mean=39.6 pounds, median=30, s.d.=32.3). Another measure of recovery is whether the respondent has achieved a healthy weight: 51.4% reported no and 48.7% reported yes. The next recovery measure provides a "snapshot" of respondents' current recovery. I asked whether one is currently abstinent, which OA now defines as "the action of refraining from compulsive eating and compulsive food behaviors while working towards or maintaining a healthy body weight." It should be noted that this change in definition of abstinence—the addition of working toward a healthy body weight—was announced by the OA World Business Conference in 2011 toward the end of my data collection. I saw no evidence that the new definition influenced local OA members' practical understanding of whether or not they were abstinent. Regardless, the emphasis on achieving a healthy weight was only introduced after the majority of my surveys were distributed. The fourth outcome explicitly concerned with eating disorder behaviors and consequences, a longer-term indicator of abstinence, is the frequency with which respondents have experienced relapse in program. The breakdown of the 149 who answered the question is 10.7% never, 26.9% rarely, 36.9% somewhat frequently, and 25.5% frequently. Due to the relatively small numbers in some cells in multinomial regression analysis, I created a binary variable "frequent relapse" that collapses the responses of never with rarely and somewhat frequently with frequently.

In addition, respondents were asked to indicate whether they experienced improvement in multiple areas since joining OA—emotional/mental health, spiritual life, family life, physical health, social life, and preoccupation with food—by marking "yes" or "no". I added the six

questions together to create a recovery index variable. The recovery index variable's values range from 0 to 6, with a mean of 4.9 and standard deviation of 1.4.

Among my independent variables were a number of socio-demographic and individual characteristics that could be used as controls for predicting recovery, or alternatively, as indicators of which types of people might benefit most from Overeaters Anonymous (at least in this regional sample). OA—along with Al-Anon, another predominantly female 12-Step fellowship—has often been characterized as a fellowship of middle- to upper-middle class, middle-aged white women. This regional sample supports that characterization. Survey respondents indicated their date of birth; I subtracted this from the date they took the survey to construct the age variable (see Figure 5.1). Members' ages range from 23 to 86, with a mean of 50 years (s.d.=13.3). As with other demographic variables, the age distribution of this regional sample is quite similar to the larger OA fellowship (see Appendix D).

Figure 5.1: Age Distribution of Sample



OA members in general are well educated; the Pacific Northwest city from which the sample is drawn is also disproportionately populated by individuals with advanced degrees. For reference, see the right-hand column of Table 5.1 for some comparative educational attainment figures for

the city, using data from the American Community Survey 2008-2012. The sample is fairly similar to the OA fellowship, albeit slightly more educated.

Table 5.1: Education Levels

Pacific Northwest (PNW) OA Sample: Highest level of formal education completed			PNW city, age 25+
	Freq.	**Percent**	**Percent**
high school or GED	4	2.68	11.9%
some college	16	10.74	17.6%
vocational or technical degree	3	2.01	
associates degree	10	6.71	
bachelors degree	48	32.21	33.7%
some graduate school	14	9.4	
graduate or professional degree	54	36.24	22.8%
Total	149	100	

Table 5.2: Household Income

Total Annual Household Income			
	Freq.	Percent	Cum.
no income	1	0.7	0.7
less than $5,000	6	4.23	4.93
$5,000 to under $10,000	4	2.82	7.75
$10,000 to under $15,000	5	3.52	11.27
$15,000 to under $20,000	3	2.11	13.38
$20,000 to under $25,000	4	2.82	16.2
$25,000 to under $35,000	10	7.04	23.24
$35,000 to under $50,000	17	11.97	35.21
$50,000 to under $65,000	19	13.38	48.59
$65,000 to under $75,000	19	13.38	61.97
$75,000 to under $100,000	23	16.2	78.17
$100,000 to under $125,000	14	9.86	88.03
$125,000 to under $150,000	7	4.93	92.96
$150,000 to under $175,000	3	2.11	95.07
$200,000 and greater	7	4.93	100
Total	142	100	

I asked respondents to indicate their level of household income, choosing among 15 income categories. The average income is somewhat over $50,000 and the modal category is $75,000 to under $100,000 (see distribution above). See Appendix D for more demographic information on the sample and the OA fellowship.

Since any assessment of recovery outcomes should take into account the severity of the presenting problem (here, primarily compulsive overeating), and also because previous research has found that AA works best for those with more severe alcoholism (Moos and Timko 2008), I asked members for a baseline indication of their problem.

Table 5.3: Severity of Food Problem

Degree to which you were affected by your problems with food when you first started OA		
	Freq.	Percent
moderately affected	11	7.28
very affected	67	44.37
severely affected	73	48.34
Total	**151**	**100**

Working the Program

Twelve Step involves a multiple prescriptions, some behavioral and others cognitive. Some are contained in individual steps, some are official "tools of recovery", while others are advocated by sponsors and members, usually in meetings. In this section, I address behaviors entailed in working the program. I asked members to indicate the highest step they had completed (1-12; 0 = none). This variable is statistically significantly correlated with having a sponsor: only 10% of respondents who have worked any of the steps have done so on their own.

Table 5.4: Top Step Worked

Top Step	Frequency	Percent
none	20	13.3
1	0	0
2	6	4
3	16	10.6
4	7	4.6
5	8	5.3
6	3	2
7	4	2.6
8	5	3.3
9	11	7.3
10	0	0
11	2	1.3
12	69	45.7
Totals:	**151**	**100**

An index variable captures the frequency with which OA members use various prescribed practices of the program: prayer, meditation, making phone calls, and reading OA literature (alpha = .68).

Table 5.5: Frequency of Using Program Tools

	Pray (148)	Meditate (147)	Outreach Calls (150)	Read Literature (149)
never	3 (2%)	12 (8.2%)	11 (7.3%)	2 (1.3%)
less than once a month	6 (4%)	13 (8.8%)	16 (10.7%)	6 (4%)
1-3 times a month	7 (4.7%)	23 (15.7%)	33 (22%)	25 (16.8%)
1-3 times a week	9 (6.1%)	34 (23.1%)	38 (25.3%)	37 (24.8%)
4-6 times a week	39 (26.4%)	30 (20.4%)	31 (20.7%)	37 (24.8%)
daily or more often	84 (56.8%)	35 (23.8%)	21 (14%)	42 (28.2%)

Sponsoring is a critical part of twelve-step programs, both in terms of being guided through and then guiding others through the 12 steps. Sponsoring is a primary form of service that inculcates new members into twelve-step culture and binds them to the fellowship, but is also purported to reinforce one's own recovery, exemplified by the saying "you have to give it away to keep it".

A full 93% of respondents have had an OA sponsor at one time, with 71% of the sample currently having one. I asked respondents to indicate whether they were currently a sponsor. I

defined currently sponsoring as either having sponsees and/or raising one's hand as an available sponsor in meetings, to not miss someone who sponsors continuously but who just lost their sponsee. 66% of respondents have sponsored OA member(s) at some point; 42% were currently sponsoring. The survey also asked how many individuals the respondent is currently sponsoring. Only 5 of the 63 individuals who identified as currently sponsoring had no sponsees: 69% were sponsoring 1 or 2 members, and the remaining 31% had anywhere from 3 to 6. Because some individuals change sponsors or go periods without a sponsor for various reasons, I included measures of the frequency with which respondents have both *had* and *been* a sponsor (see Table Seven).

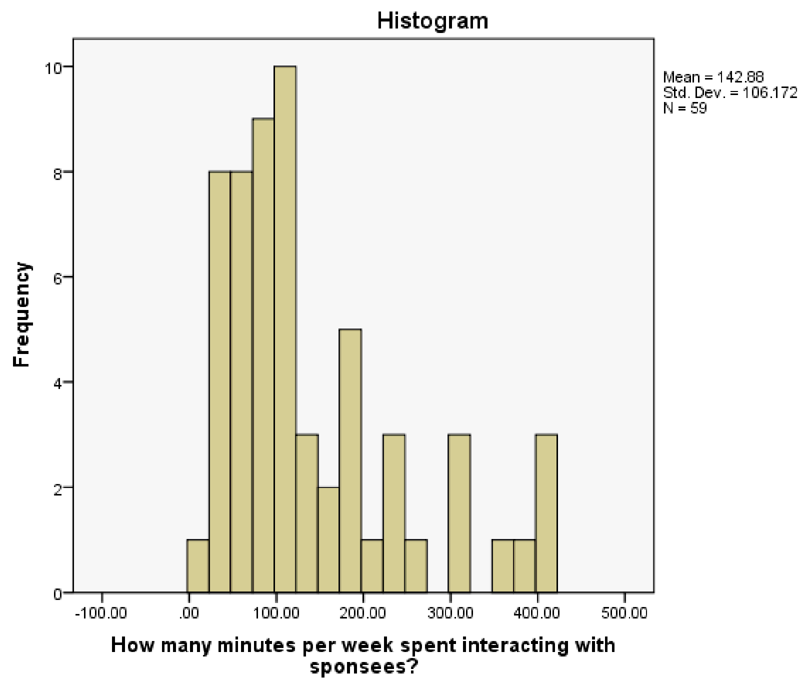
Table 5.6: Frequency of Being Sponsored and Sponsoring Others

For how much of time in program have you…				
	Had a sponsor?		***Been a sponsor?***	
	Freq.	Percent	Freq.	Percent
never	10	6.76	51	34.46
almost none of the time	4	2.7	7	4.73
little of the time	21	14.19	23	15.54
about half of the time	30	20.27	27	18.24
most of the time	37	25	12	8.11
always or almost always	46	31.08	28	18.92
Total	148	100	148	100

However, based on my observations of different twelve-step programs, there are a wide variety of sponsoring styles and intensities. For example, one sponsor may simply tell their sponsee "call me if you need me" and have very little if any contact, while another may have a daily phone call supplemented by in-person meetings. To try and capture some of this diversity, I asked respondents to indicate on average how many minutes per week they spent interacting with sponsees (see Figure 5.2).

Of the different measures of meeting attendance, the one that proved most significant in predicting recovery outcomes was attendance at 12-Step meetings (inclusive of all fellowships, not just OA) in the last year. 144 respondents answered this question, with the average number of meetings being 101.5 per year. For reference, over 42% of the sample attends Al-Anon (a program for families and friends of Alcoholics), 24% attends Alcoholics Anonymous, 7% attends Debtors Anonymous, and a handful attends still other twelve-step programs. Manning et al. (2012) reported that referral by 12-Step peers increased AA attendance rates. Similarly, referral to OA by a 12-Step member was positively correlated with 12-Step meeting attendance in this sample.

Figure 5.2: Time Spent Sponsoring



"Length of OA attendance" measures how long the participant has been in program, which in practice means how long they have been attending OA meetings. The length of attendance for the 150 respondents who answered this question ranged from 30 days to 41 years,

with a mean of 10.3 and a median of 6.8 years. Table 5.7 divides the length of attendance into categories to better show the distribution. The duration of attendance for the Pacific Northwest sample is similar to that of the larger OA fellowship (see Appendix D).

Table 5.7: Length of OA Attendance

Length of Attendance in OA		
	Frequency	**Percent**
1 to 3 months	8	5.33
> 3 to 6 months	12	8
> 6 to 12 months	15	10
> 1 to 3 years	17	11.33
> 3 to 6 years	21	14
> 6 to 10 years	21	14
> 10 to 15 years	11	7.33
> 15 to 20 years	15	10
> 20 to 30 years	24	16
30+ years	6	4
Total	**150**	**100**

<u>Cognitions, Beliefs, and Identification</u>

Asked about the importance to their personal recovery of various program tools to their personal recovery, respondents answered not at all important, somewhat important, or extremely important. These questions provide a snapshot of the relative importance of key aspects of Twelve Step, as assessed by members themselves. The program aspects are: (1) going to meetings; (2) having a sponsor; (3) working the steps; (4) phone calls and fellowship; (5) reading 12-Step literature; (6) prayer and meditation; (7) writing and journaling; (8) plan of eating; and (9) relationship with a higher power. Respondents could also indicate “I don’t know/not applicable.”

My next variable, Ideology, is intended to measure the degree to which the respondent accepts twelve-step ideology. It is adapted for OA from the AA research tool GAATOR 2.1,

which was intended to assess internalization of the steps (as a corollary to self-report of step completion). This index (alpha = .77) is composed of the following items, to which respondents could answer definitely true, true, false, or definitely false. I indicated below the corresponding step in parentheses after each tenet (these were not indicated on the survey), and have numbered the items in the order of acceptance by participants in my sample. In other words, the first tenet was the most widely accepted; the fifth tenet, the least.

1. I have realized things get worse when I compulsively overeat/engage in my eating disorder (step 1)
2. I have believed that awareness of my higher power is essential to my abstinence (step 2)
3. I have believed my recovery could only come from a power greater than myself (step 2)
4. I have recognized the amount of serenity I have is a direct result of the amount of humility I have (step 7)
5. I have been ready to let my higher power remove my shortcomings (step 6)

The five components of ideology were reverse coded and then added together, such that a higher score indicated greater acceptance of OA ideology. Creating the index variable reduced the number of cases to 144; values ranged from 10 to 20, with a mean of 17.2 (s.d. = 2.34). Recent research has noted that self-reported completion of steps does not correspond well with the GAATOR assessment tool (Greenfield and Tonigan 2013). The five items included in this analysis are indicative of "spiritual step work", as opposed to "behavioral step work"—the two underlying constructs found in a 2012 psychometric study of GAATOR (Greenfield and Tonigan 2013).

The process of identification is a prominent object of qualitative study on twelve-step fellowships (see chapter three). Identification as a compulsive overeater captures the basic criterion for OA membership. OA's third tradition states, "The only requirement for OA membership is a desire to stop eating compulsively." Respondents were asked to indicate how strongly they identified as a compulsive overeater, indicating not at all (1%), somewhat (3%),

strongly (16%), and very strongly (80%). I also included a variable indicating degree of identification as a bulimic, with responses not at all (70%), somewhat (13%), strongly (7%), and very strongly (11%). For comparison, 5% strongly or very strongly identify as anorexic.

I assessed members' spirituality using the 2006 General Social Survey question, "To what extent do you consider yourself a spiritual person?" 149 respondents answered this question as follows: not spiritual at all (1.3%); slightly spiritual (12%); moderately spiritual (43.6%); and very spiritual (43%). To try and sort out whether spiritual people participate in 12 step or 12 step increases participants' spirituality, I asked respondents whether their spirituality had changed since joining OA. 92.7% of respondents reported that their spirituality had increased since joining OA. In contrast, 74% reported their level of religiosity remained the same or decreased since joining OA.

One additional spiritual/religious questions was used in analyses. Respondents were asked how much they agreed with the idea that Higher Power is concerned with their personal well-being. Based on the idea that addicts must develop concern for others to escape the "bondage of self", I used a question from the National Altruism Study, which was administered to a random half of the respondents of the 2002 General Social Survey. Respondents had to indicate how well the following statement described them on a scale of 1 to 5, 5 being "very well": "Other people's misfortunes do not usually disturb me a great deal."

Social Activity

Three social measures were included in analyses. I asked respondents whether they took part in fellowship. This is a broad term, which can also include socializing unrelated to meetings. I was interested in a more bounded measure, so the survey asked "How frequently do you enjoy 'fellowship' after meetings?" Answer choices were never, rarely, about half the time,

most of the time, and always. Unlike other social measures in the survey, many of which require interacting outside of the meeting setting, this measure is less influenced by external constraints such as having children or long work hours. Nonetheless, fellowship is statistically significantly correlated with other measures of social interaction and embeddedness, such as the number of one's 5 closest friends who are OA members.

Table 5.8: Fellowship

Partake in Fellowship After Meeting	Frequency	Percent
Never	3	2
Rarely	27	18
About half the time	44	29.3
Most of the time	55	36.7
Always	21	14
Totals:	**150**	**100**

The next social variable measured provision and/or receipt of emotional support, using a question asked as part of the *Project on Human Development in Chicago* Neighborhoods. The survey question was: "How often have you provided or received emotional support to/from a fellow OA member in the last year?" Respondents could answer never, sometimes, or often. Of the 146 individuals who answered the question, 3.4% answered never, 45.2% sometimes, and 51.4% often. This and related questions were aimed at assessing the *qualit*y of ties among members. The third social variable assessed the quantity of ties, asking respondents how many OA members they socialize with outside the context of meetings. The 143 responses ranged from 0 to 15, with a mean of 2.13 friends (s.d.=2.42). The distribution is highly skewed, with only five individuals reporting socializing with more than six OA members. 94.4% reported 5 or less; the mode was zero at 31.5%, followed by one at 17.5%.

Having discussed the individual-level predictors of different facets of OA recovery, I turn to a group-level variable[10] I suspected would affect identification processes: the level of emotionality of the meeting. I constructed a subjective measure of this for each meeting by averaging scores of emotional intensity made during observations (minimum of 10) of each meeting. I initially designed the scores to range from 0 (“unemotional”) to 5 (“highly emotional”), but in practice found that no meetings were unemotional (all featured some expression of emotion). Thus, the scores of individual meetings ranged from 1.5 to 5. The mean emotionality of a meeting (sum of scores divided by number of observations) ranged from 2.5 to 3.4. To use this variable in analyses, I attached to each participant the mean level of emotionality observed in the meeting in which they were surveyed.

I begin the next section with discussion of the different recovery outcomes, including additional information concerning member definitions of abstinence, since that affects two of the four measures. Then I present a table reporting members’ rankings of the importance of various program elements to their personal recovery. When I report a variable as statistically significant related to weight and abstinence-related outcomes, this means in a fully populated model (see Table 5.14). Given the relatively small sample size, I report findings at the $p<.1$ level.

Findings

My first outcome and the one intended to best capture the totality of 12-Step recovery is the six-item recovery index. I present the index in Table 5.9 below with the items ranked in terms of

[10] In analyses for chapter one, being a member of the more structured “HOW” program in which members abstain from sugar and white flour and weigh and measure their food reduces the odds of more frequent relapse. The variable indicating degree of restrictiveness of each member’s abstinence has no effect on recovery outcomes, which suggests that aspects of the more structured program other than its food dictates affect individuals’ recovery.

Table 5.9: Index of Recovery

Improved since joining OA?	Yes		No		(n)	1992 OA Gallup poll results
	frequency	%	frequency	%		
Emotional/mental health	139	92.7	11	7.3	150	95%
Spiritual life	135	90	15	10	150	92%
Preoccupation with food	125	83.3	25	16.7	150	81%
Physical health	124	82.7	26	17.3	150	72%
Family life	106	70.7	44	29.3	150	79%
Social life	100	66.7	50	33.3	150	*not asked*

areas in which the most members saw improvement. In the far-right column, I provide data OA reported from its 1992 survey on the percentage of respondents who indicated improvement in those areas since joining OA.

It is noteworthy that half of all respondents indicated improvement in all six areas since they joined OA. However, this does not speak to degrees of improvement. In its 2010 membership survey, OA asked members to indicate significant, moderate, a little, or no improvement in a variety of areas. The two "life areas" in which 2010 OA respondents reported the highest levels of improvement were (1) mental/emotional health and (2) spiritual connection—the two areas in which the greatest number of members in my sample reported gains. See Table 5.12 for bivariate correlations between variables in the model predicting the 6-item recovery index; and Table 5.13 for regression analyses predicting that outcome.

Before discussing other recovery outcomes, I review descriptive statistics on the survey question asking respondents to rank the importance to their recovery of certain of the 12 steps and nine tools of recovery. Respondents (as a whole) ranked items in the following order of importance: (1) going to meetings; (2) relationship with a higher power; (3) plan of eating; (4) prayer and meditation; (5) working the steps; (6) having a sponsor; (7) reading 12-Step literature; (8) phone calls and fellowship; and (9) writing and journaling. Table 5.11 illustrates the

distribution of responses. Most of the above are program tools, with the exception of "working the steps"; "prayer and meditation" (step 11); and relationship with a higher power (steps 2 and 3). While meeting attendance has been shown less predictive of recovery than other forms of involvement such as service and sponsoring and social aspects, it is clearly viewed by respondents as critical to their recovery. I discuss the results of my analyses not by outcome (since there are five dependent variables), but by independent variables that are presumed to be causal. I start with demographic characteristics.

<u>Demographics</u>

The survey contained data on a variety of socio-demographic characteristics; the only characteristics that attained statistical significance in regression models predicting various recovery outcomes were income, age, and being in a relationship.[11] I grouped baseline severity of problem with food in with demographic variables, as it is an individual characteristic of sorts. Severity of problems with food prior to joining OA appears to enhance the odds of having achieved a healthy weight.

In models predicting the recovery index—improvement in emotional/mental health, spiritual life, preoccupation with food, family life, physical health, and social life since joining OA—age remained a statistically significant *negative* predictor across all models (see Table 5.13). Age also reduced the odds of a respondent being currently abstinent. Interestingly, higher income reduced the odds of having achieved a healthy weight, while being in a relationship increased the odds ($p<.1$). In a model using only demographics, the more hours one worked per week, the less likely they were to report improvement in the areas included in the recovery index.

[11] Being a male was significant in predicting number of pounds lost, but this was due to the fact that one of the 22 males in the sample had lost half of his body weight. Once this outlier was removed, the "male" coefficient reversed direction and became statistically insignificant.

However, once variables indicating that one is “working the program” were included, hours worked lost significance. It is likely that the more one works, the less time they have to do step work, attend meetings, work with a sponsor, etc.

I now move on to discussing behaviors that constitute the core of the Twelve-Step program. Most Twelve-Step fellowships view addiction, including compulsive overeating, as a disease that can be arrested but never cured. The remedy is daily treatment through participation in the fellowship. In this view, it is a program from which one never graduates, and newcomers and seasoned members alike are advised to “keep coming back” to recover. The longer one has attended OA, the more improvement they report in the six areas that constitute the recovery index, and the more likely they are to have achieved a healthy weight (the latter at the $p<.1$ level). In contrast, the longer one has been in program, the higher the frequency of relapse. The higher the number of total 12-Step meetings one attends, the greater their score on the 6-item recovery index, and the lower their frequency of relapse.

As the name suggests, the primary activity in twelve-step fellowships is working the steps. Progress on the steps is positively correlated with the 6-item index of recovery. Unsurprisingly, since most people work the steps with a sponsor, frequency of having a sponsor also predicts increases in the recovery index ($p<.1$). Using the tools of the program (e.g., phone calls, reading literature) increases the odds of being abstinent, but is negatively related ($p<.1$) to number of pounds lost. Twelve-Step participation often involves changes in identity, outlook, beliefs, and ideology.

While identification as an overeater—part of step one and the sole criterion for membership—predicts more frequent relapse and is negatively associated with having achieved a healthy weight, it could be that members who have experienced more recovery lose some that

initial identification. Endorsement of Twelve-Step ideology predicts greater weight loss and current abstinence (the latter at the $p<.1$ level). Increased spirituality predicts higher levels of recovery as measured by the index. Of note is the fact that increases in religiosity do not affect any measures of recovery. In this sample, increased religiosity reduces identification as an OA member, in contrast to findings that religious individuals are more likely to attend Twelve-Step groups and less likely to drop out. Religious individuals, however, do not experience better recovery outcomes than their atheist and agnostic counterparts (Moos and Timko 2008). Finally, an attitudinal variable—indifference toward others' misfortunes is negatively associated with number of pounds lost.

Another tenet of Twelve-Step philosophy is that addicts maintain and increase their own recovery by working with fellow sufferers. In OA, one often hears the adage that "service is slimming". The most critical form of service is sponsorship. As frequency of sponsorship increases, so does weight loss and the odds of achieving a healthy weight. More sponsoring also translates into less frequent relapse. Similarly, time spent sponsoring (interacting with sponsees) each week increases the odds of current abstinence.

Table 5.10: Predictors of Index of Recovery

Index of Recovery Improvement in emotional/mental health, spiritual life, preoccupation with food, family life, physical health, social life	(1)			(2)			(3)			(4)			(5)		
	β	SE	Sig.	β	SE	Sig.	β	SE	Sig.	β	SE	Sig.	β	SE	Sig.
Demographics															
Age	-0.02*	0.009	0.038	-0.034**	0.010	0	-0.036**	0.012	0.006	-0.038**	0.011	0	-0.038**	0.011	0.002
Male	0.346**	0.122	0.010	0.5*	0.199	0.02	0.552*	0.264	0.049	0.545*	0.235	0.03	0.487*	0.230	0.047
Program Prescriptions															
Twelve-Step Meetings				0.002	0.002	0.14	0.003**	0.001	0.038	0.003*	0.001	0.04	0.003*	0.001	0.020
Having Been Sponsored				0.090	0.272	0.75	0.407	0.252	0.121	0.53†	0.291	0.08	0.494	0.288	0.102
Top Step Completed				0.08**	0.027	0.01	0.05*	0.031	0.125	0.047	0.028	0.11	0.047†	0.027	0.096
Time Attended OA				0.031†	0.018	0.1	0.038**	0.011	0.003	0.032**	0.011	0.01	0.032**	0.011	0.008
Beliefs/Identity															
Endorse OA Ideology							-0.023	0.063	0.72	0.004	0.045	0.929	0.002	0.044	0.964
Spirituality							0.58***	0.168	0	0.459**	0.153	0.007	0.446**	0.147	0.007
Social															
Fellowship										0.403***	0.096	0	0.372**	0.098	0.001
Group Characteristics															
emotionality of meeting													0.711*	0.251	0.010
Constant	5.809***	0.403	0	5.194***	0.562	0	3.712**	0.993	0.001	2.323*	1.021	0.034	0.273	1.353	0.842
Pseudo R^2	0..041			0.227			0.352			0.435			0.449		
N	147			137			129			129			129		

†p < .10; *p < .05; **p < .01; ***p<.001

Notes: Regression model with clustering for robust standard errors (in parentheses); the group variable is meeting ID number.

Data: STSS, 2010-2012

Table 5.11: Importance of Program Elements

	Importance to personal recovery of:																	
	Going to meetings		**Having sponsor**		**Working the steps**		**Calls & fellowship**		**Reading literature**		**Prayer & meditation**		**Writing & journaling**		**Plan of eating**		**Relationship with HP**	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
not at all important			3	2	1	.7	2	1.3			2	1.3	11	7.3	1	.7	4	2.7
somewhat important	9	6	29	19.6	26	17.3	62	41.3	60	40	29	19.3	61	40.7	21	14	18	12
extremely important	140	94	107	72.3	119	79.3	82	54.7	89	59.3	119	79.3	73	48.7	125	83.3	127	84.7
don't know or n/a			9	6.1	4	2.7	4	2.7	1	.7			5	3.3	3	2	1	.7
N	149		148		150		150		150		150		150		150		150	

Table 5.12: Correlations: Recovery Index and Its Predictors

	Recovery index	Age	Male	12-step meetings attended	Ever had a sponsor	Top step completed	Time attended OA	Spirituality	Endorse OA ideology	Fellowship
Age	.024*									
Male	0.082	0.055								
12-step meetings attended	.193*	-.065	.004							
Ever had a sponsor	.023	.188*	.101	-0.005						
Top step completed	.353***	.143†	.085	.176*	.111					
Time attended OA	.203*	.404***	-.055	.082	.233**	.477***				
Spirituality	.258**	.192*	-.107	.034	-.082	.211**	.265**			
Endorse OA ideology	.185*	.192*	-.02	.123	-0.14	.283***	.26**	.615***		
Fellowship	.297***	.056	-.027	.012	-.062	.1	.127	.24**	.163†	
Emotionality of meeting	.216**	.033	.069	-.133	-.006	.001	-.038	.089	.026	.191*
Significance levels: †p < .10; *p < .05; **p < .01; ***p<.001										

Fellowship—interaction with other OA members after meetings—is positively correlated with the six-item recovery index. Providing and receiving emotional support and socializing with more OA members outside meetings predicts greater weight loss. Finally, in terms of group-level factors, higher levels of emotionality in meetings predict higher scores on the recovery index and lower frequency of relapse.

Finally, while one of my outcomes is "pounds lost", a continuous variable, I also ran multinomial logistic models (available on request) predicting the odds of losing, gaining, or maintaining weight relative to each other (i.e., varying the base outcome). Internalization of OA ideology, which increases the number of pounds lost, also increases the odds of maintaining one's weight relative to gaining weight. Increased spirituality increases the odds of weight loss

relative to weight maintenance. Identification as an overeater reduces the odds of gaining weight relative to staying the same weight.

Given that some compulsive overeaters experience near continuous weight gain (sometimes punctuated with short spurts of weight loss followed by still greater weight gain), remaining the same weight can represent improvement. It is also worth remembering the variation in sizes and weights of individuals who have different eating disorders. For example, identification as an anorexic makes one almost five times more likely to report maintaining versus losing weight ($p=.000$) and about 2.5 times more likely to report gaining versus losing weight ($p=.083$).

Table 5.13: Comparison of Predictors of Five Recovery Outcomes

		Recovery Index	Pounds Lost	Frequent Relapse	Currently Abstinent	Achieved Healthy Weight
Demographics	Relationship					Pos†
	Income					Neg*
	Male	Pos*				
	Age	Neg**		Neg†	Neg*	
	Baseline severity of eating problem					Pos†
"Working the program"	Time attended OA	Pos**		Pos***		Pos*
	12-Step meeting attendance	Pos*		Neg*	Pos†	
	Frequency of tool usage		Neg*		Pos**	
	Top step worked	Pos†				
Beliefs and Cognitions	Identification as overeater			Pos**		Neg*
	Identification as bulimic					Pos***
	Spirituality	Pos**				
	Religiosity				Neg*	
	Indifference to others' misfortunes		Neg†			
	Endorsement of 12-Step ideology		Pos*			
	Realize things get worse when engage in eating disorder				Pos†	
Service	Frequency of *being* a sponsor		Pos***	Neg***		Pos**
	Time spent sponsoring				Pos*	
Social	Fellowship after meetings	Pos**				
	Frequency of providing and receiving emotional support outside meetings		Pos**			
	Number of OA members socialize with outside meetings		Pos*			
Group Factors	Emotional intensity of meeting	Pos*		Neg**		

Note: significance levels: †$p < .10$; *$p < .05$; **$p < .01$; ***$p<.001$

Table 5.14: Regression Models for Four Recovery Outcomes

Pounds Lost Since Joining OA

	Coef.	Robust Std Err.	P>t
Indifferent to Others	-4.288 †	2.424	0.094
Exchange emotional support	13.240**	3.490	0.001
Frequency of tool usage	-1.518*	0.668	0.036
Internalize OA ideology	3.065*	1.119	0.013
# of OA members socialize with	2.272*	0.972	0.031
Frequency of being a sponsor	5.983***	1.312	0
constant	-22.550	26.676	0.409
N = 85 R-squared = .355			

Frequent Relapse

	Odds Ratio	Robust Std Err.	P>z
12-Step Meetings	0.992*	0.004	0.027
Frequency of tool usage	0.965	0.065	0.599
Internalize OA ideology	0.800	0.111	0.107
Identify as overeater	2.675**	0.880	0.003
Emotionality of meeting	0.032**	0.034	0.001
Length of OA attendance	1.157***	0.036	0
Frequency of being a sponsor	0.503***	0.084	0
constant	1169547**	5490838	0.003
N=129 Pseudo R2 = .341			

Currently Abstinent

	Odds Ratio	Robust Std Err.	P>z
Frequency of tool usage	1.216**	0.075	0.002
Religiosity	0.576*	0.144	0.027
Belief engaging in eating disorder makes worse	3.112 †	1.864	0.058
Baseline severity of food issues	0.861	0.331	0.698
Higher power concerned w/me	1.536	0.715	0.356
Age	0.957 †	0.024	0.074
12-Step Meetings	1.01 †	0.005	0.079
Time spent sponsoring	1.013*	0.005	0.017
constant	0.023	0.075	0.243
N=122 Pseudo R2 = 0.346			
Log pseudolikelihood = -35.576			

Achieved a Healthy Weight

	Odds Ratio	Robust Std Err.	P>z
Current service position	2.097	1.076	0.149
Identify as bulimic	1.947***	0.309	0
Severity of food issues when first joined OA	1.653 †	0.479	0.083
In relationship	2.770 †	1.664	0.09
Household income	0.801*	0.075	0.017
Frequency of being a sponsor	1.402**	0.143	0.001
Identify as overeater	0.162*	0.124	0.017
Length of OA attendance	1.08*	0.034	0.013
constant	2.593	7.792	0.751
N=132 Pseudo R2 = 0.298			
Log pseudolikelihood = -64.079			

Significance levels: †p < .10; *p < .05; **p < .01; ***p<.001

Discussion

In many ways, the disparate findings of outcome research arguably reflect more than different measures and different samples of AOD users. In some ways, Twelve-Step fellowships offer a multitude of "curative" ingredients, many of them evidence-based, all of which may be used or not, at any dose found beneficial. If spirituality does not work for one person, they may benefit from the structure and accountability of a sponsoring relationship in which they report their food daily and work through the steps and are required to use program tools such as outreach calls and writing. Others may benefit primarily from hearing the message and identifying with fellow addicts in meetings. In addition to there being something for everyone, the needs of individuals seeking recovery—perhaps particularly with food—often change over time, necessitating an individualized approach.

Before discussing the different measures of recovery and their correlates, it is important to discuss abstinence in the OA context. The issue of food plans and abstinence is controversial inside and outside OA. For its first couple decades, OA struggled to find a consensus definition of abstinence and many groups followed a very strict reduced-carbohydrate food plan made available at meetings. Eventually OA moved away from prescribed food plans and over time prohibited their overt distribution at meetings. Most importantly, based on traditions three and four, Overeater Anonymous forbid the practice of linking meeting participation to following a specific food plan. As a consequence, beginning in the late 1970s, a number of splinter groups favoring mandatory food plans left the fellowship. A number, such as Food Addicts Anonymous, eventually incorporated as new Twelve-Step fellowships.

Despite fellowship-wide policy, however, individuals within OA may choose to sponsor using prescribed food plans that are quite restrictive. As a consequence of OA's gradual

evolution and the diversity of abstinences attributable to sponsorship lineages, there is considerable confusion and misconception about OA among individuals in the public and in the eating disorders field. In their 1996 study, Westphal and Smith (1996: 167-168) wrote: "Although 'abstinence' used to imply avoiding sugar and white flour, in this study it was described by the majority as eating only three meals a day (61.8%) and refraining from binge eating (58.8%)." To learn more about current practices, I asked respondents whether they had defined an abstinence for themselves. If they answered yes, I asked them to describe that abstinence.

An important finding in and of itself is the tremendous diversity in the way people define abstinence for themselves. Although the vast majority of respondents understood the question and answered as expected, a handful instead described the duration of their abstinence. In addition, one member stated that I should technically have asked for members' "food plan", which is different than abstinence. While I was interested in food plans, some individuals define abstinence in terms of behaviors around food consumption. That said, 107 individuals described their abstinence around food, some writing a few words, others more than a paragraph.

To facilitate statistical analysis, I categorized each member's abstinence in terms of the degree of restriction entailed (see Table 5.15). Another way to think about these differences is that some abstinences are loose and others more structured; I prefer to not use the terms lenient and strict, since they can have moral undertones and evoke a dieting mentality, which is conspicuously eschewed in OA. For purposes of illustration, two abstinence definitions with fewer restrictions include: "3 meals a day, no desserts," and "my abstinence is obtained when I do not binge." An example of an abstinence with many restrictions is: "I follow a weighed and

measured food plan approved by a nutritionist which excludes sugar, refined flour, wheat in all forms, corn, rye, barley, spelt, dairy, artificial sweetener, caffeine."

Table 5.15: Restrictiveness of Abstinence

Restrictions entailed in definition of abstinence		
	Freq.	Percent
1 = fewest restrictions	3	2.8
2	40	37.4
3	32	29.9
4	19	17.8
5 = most restrictions	13	12.2
Total	**107**	**100**

Multiple participants compared their experiences with abstinence/sobriety in other fellowships to that in OA. Three years abstinent and at a healthy weight, Kim said: "I was in another program, I have been in another program for like 20 years, and I don't feel the connectedness. Because like, so what I don't drink. Anybody can not drink." "So it's harder?" I asked. She answered, "Definitely. And, it also has informed my other program of like, being less judgmental about people who can't get [sober], like being more empathetic. This is hard. This is worth working on. I had never really had sponsees in the other program, and I've found my way in [OA] to like, be able to pass it on." With this clarification concerning the complexity of abstinence (and therefore the frequency of relapse), I now discuss the multiple facets of OA recovery.

The Many Facets of Twelve-Step Recovery

In Twelve Step, addiction is seen as a consequence of a spiritual ailment, a symptom rather than a cause. One respondent relayed a telling Twelve-Step expression (modified for overeating): "'I'm not here because food was my problem, I'm here because food was my solution." In part

because eating disorders tend to be enduring parts of people's lives, many members do not expect to "graduate". Having chronologically examined her history of relapse, Sarah discovered:

> when I stopped attending meetings, when I stopped working the steps, I would start to binge. And not just binge on one little cookie, it was copious amounts of food, that I really am not only a compulsive overeater, but I am a compulsive overeater who if I really want to experience recovery, I'm in this for the long haul. And that was almost an "Oh shit" kind of moment.

While individuals enter these groups for help with addiction, members routinely report improvement in other areas. Noting AA's 2008 survey showing that almost half its attendees have been sober at least five years, Kelly et al. (2009: 251) surmise "there may be other positive quality of life factors that keep many attending AA well beyond the achievement of full sustained remission from alcohol dependence." I found similar results through direct inquiry. In response to the survey question "If you could remain abstinent without participating in OA, how likely is it that you would continue to participate?", more than three quarters of respondents in my sample reported being likely or very likely to continue attending. I have also seen multiple examples of respondents unable to get abstinent remaining in OA. Cindy, for example, is and has always been average-sized and identifies as a compulsive eater addicted to sugar. She said she doesn't have recovery, despite over two decades in OA. I probed: "So do you feel like you don't have physical, emotional, spiritual recovery?" She replied:

> I do feel that way. I don't feel like I have any of it. The thing is… so let's see, why do I come to OA? But you haven't asked me that yet. [Both laugh.] So, um, I have a friend who says I'm vastly different than I used to be, in a better way. But I don't see it. She doesn't mean physically, she means what it's like to be around me. She's known me for like 20 years. … I know I have this fear of leaving OA, because it's my last bastion or firewall between me and being just facedown in the food.

Nonetheless, she called OA (then and now) a "refuge". "That meeting, that's something I really hate to miss, even though it doesn't really change my eating that I can see. … [J]ust sitting in the room, it is like the only spiritual activity in my life really. It's a valuable thing in my life."

When asked about their recovery (i.e., without specifying type), members often addressed improvements in their relationships and emotional well-being, both incorporated in the index of recovery. I discuss social/relational changes first. I asked all interviewees about any possible effects, positive or negative, of OA on their social circle. Most reported an increase in the number of friends or greater contact with friends since joining. For some, this was due to making new OA friends; for others, as they recovered from compulsive overeating, they isolated less and were more available for social activities. Angela talked about how program has dramatically affected how she interacts with people, including her family:

> My son, we were never touchy feely people, and at meetings [OA members] always hug each other. And a couple years ago, I started hugging my son. And he's 6'4, he has to go down a step to turn around and hug me, and he's a single person, and I don't think that he is in physical contact with anybody. And he's looking now, he's always waiting for me to hug him. Always. So it changed that in our relationship. He never leaves me without hugging me now.

Melissa discussed the effect of OA on all her relationships:

> I could do a graph line of my time in program, and how my relationships were with people around me, how judgmental I am of strangers, and it fits exactly, I mean, it's exactly inversely proportional. [D]efinitely the positive ways in which I relate to people really increased as my recovery increased… the trust level, having the trust to not react, be understanding, and make myself vulnerable, that was a huge thing that really, really improved as my program improved.

Certainly spiritual change was frequently noted. Though she had lost over half her body weight and enjoyed newfound ability to participate in athletic events, Alana remarked, "I think the weight is kind of the fringe benefit to all of the emotional and spiritual recovery that I've been able to experience, and the freedom to no longer be living in bondage anymore." She clarified, "There's no food, no situation that happens to me today, or tomorrow, that is necessary for me to eat over." Similarly, long-time member Angela offered: "I think for me it's the spiritual and

emotional recovery that are more important than the physical." She puzzled about an aspect of recovery she feels is insufficiently discussed in meetings.

> We talk about recovery, we talk about the promises, and we talk about all these different things, which is fine. But why not the simple fact of "hey, I'm happy." … I haven't always been able to say that. … But to just say, I am quietly happy, and I feel serenity, I feel like life's worth living, that there's things to look forward to, and I, that's, you know, based on program. So that's what I tell people, hey, stick around. You'll get happy.

Interviewees almost *universally* identified feeling less judgmental and more accepting of others as a consequence of their Twelve-Step participation. Most also reported judging themselves less harshly and reduced perfectionism. Female respondents in particular frequently discussed improvement in boundary-setting. The qualitative study of OA respondents by Ronel and Libman (2003) similarly reported better boundary-setting, enhanced self-esteem, and reductions in judgmental feelings. Linda exemplified this improved capacity to set boundaries: "Rather than being the victim of a situation, I feel I have more choice; I've learned to say no and set limits. I find that I don't get as depleted, and I mind other people's business less and my own more."

Finally, more than one member opined that everyone can benefit from the introspective process and program of action in the 12 steps. Beth argued:

> The interesting thing is I wish more people would be open to it. It has saved me. And it's kept me clean. And I wish I would have delved into it 10 years or 20 years earlier, but, it is what it is. There's a stigmatism around AA and OA and NA and being a member that I think is unfortunate. And it's a lot of hard work, and a lot of people just don't want to work that hard for what they want to get. But, yeah, I think it's a fabulous process that I think "normies", anybody, can benefit from, because it's just good.

With respect to how Twelve Step "works", it is important to note that members frequently emphasize willingness and reliance upon a higher power. There is also an understanding, reflected in the Big Book chapter titled "Into Action", that there is a lot of footwork to be done

(e.g., work the steps, use the tools). In other words, members are taught to "trust god but row to shore."

At the same time, many members are unsure of how program works. It is sometimes remarked that it is easier to understand and see why one relapses than why one is able to be abstinent. Discussing AA's "inspirational focus", Beutler et al. (1993 pg. 12) write "the suspension of intellectual explanation is essential at certain phases of recovery; it is precisely the intellectual's wish to be able to explain what is happening or to attribute cause that impedes progressive movement into recovery." There is a 12-Step maxim that "You can't be too stupid for program, but you can be too smart for it." Essentially, individuals are asked to suspend analysis and accept certain things on faith, to not overanalyze, to be open to not knowing, and to "act as if" when all else fails. There is a prayer (with many variants) called the "Set-Aside Prayer" that reflects this need to open oneself to a new experience:

God, Please help me set aside
everything I *think* I know
about myself, my disease,
these steps, and especially you;

For an open mind
and a new experience
with myself, my disease,
these steps, and especially you.

For example, when asked to explain how being a sponsor enhanced her recovery, Kathleen replied, "It was just one of those magical higher power things." John, prior to answering any questions about recovery, said: "I think first thing I want to say is I consider recovery a mystery, to some extent, just as the fact that I am an addict is a mystery. Because I grew up in a family of 8 kids and I'm the only addict! I got the same love and everything as all my siblings. And a lot of people come to OA and don't get it, never really get abstinent, get

recovery, so to some degree I consider it a mystery." Now I return to the findings from the survey and meeting observations.

Demographics

Most of the demographic variables were included in models to control for the effects of individuals traits on recovery outcomes. Aside from severity of addiction, outcome research has not established demographic differences in recovery among AA participants. Being in a relationship is significantly correlated with having achieved a healthy weight. Without knowing the characteristics of partners, one can speculate that having achieved a healthy weight might make one more likely to be in a relationship—either because slimness is valued in our culture or because a person in stable recovery is less occupied with food and body issues. The negative relationship between income and having achieved a healthy body weight is not readily explained and merits further analysis. Age is negatively correlated with current abstinence and the 6-item recovery index. This may be due to either age-related biological changes or the difficulty of changing life-long patterns and habits.

Baseline severity of food problems, as expected, increases the number of pounds lost and odds of achieving a healthy weight. Outcome researchers consistently find that severity of addiction predicts twelve-step participation (Tonigan 2008b). Asked about the severity of her problems with food, one average-sized respondent who had lost well over 100 pounds through following a very structured abstinence and active involvement in the fellowship replied:

> I realized I have an addiction to sugary things, things made with flour, things made with a lot of fat or a lot of grease, I have an addiction to *food in general*. So if I get all those types of foods out of my diet, I will still eat *quantity* as well. Quantity and ingredients and mental obsession: I've crossed every line in food that I know of.

Sarah, another healthy-weight respondent, has spent most of her adult life in OA. She discussed variations in the severity of eating disorders:

> I've met a number of people in OA who come for a while, they kind of get what they need and they leave and they're fine. And of course there are people who come and they leave and they're horrible. And what I've learned through just doing a lot of listening to different tapes and talking to people is a lot of people come in the rooms that just may not be as bad as I am. In AA they talk about the heavy drinker and the alcoholic, and the heavy drinker, given reason to stop drinking, can stop drinking. And I think so too with the compulsive overeater. People come because, "Oh, that's what I think I am that's what I do with food." But they've not gotten to the point where I've gotten to.

Having discussed individual characteristics, I now turn to behaviors, beginning with indicators of the degree to which participants work the program. As with any intervention, compliance matters.

Working the Program

There are many different ways to think about the length of time individuals attend a twelve-step program. One of the benefits of studying a local self-help fellowship is obtaining members with diverse lengths of attendance while reducing some variation in the local context (to the extent this is possible in a federation of autonomous groups). Meetings typically contain old-timers and newcomers, both having distinctive contributions. Old-timers often appreciate the raw testimonials of new members, which serve as reminders of where they came from, and where they could return if they stopped taking the daily "medication" of the program. Newcomers, in turn, often benefit from seeing live examples of the "solution".

The rigorously controlled studies conducted by outcome researchers typically have very short follow-ups. While these studies make an important contribution to our understanding of AOD treatment, they provide only a snapshot of very early recovery from what is increasingly considered a life-long disorder (Tonigan 2008a). This short-term focus may be particularly inappropriate for studying eating disorders. The trajectory of recovery from binge eating disorder, bulimia, and anorexia is non-linear for many, including virtually all of my interviewees.

In the few studies with longer follow-up times, duration of AA attendance has been correlated with maintenance of long-term sobriety (Moos and Moos 2006) and is more strongly related to sobriety than frequency of meeting attendance (Moos and Timko 2008). For respondents in my sample, longer lengths of OA attendance predicts greater recovery as measured by the six-item index and achieving a healthy weight. In addition, there is evidence that both the nature of recovery and what is required to create and sustain it change over time for Twelve-Step participants. Initially, the focus is on defining, achieving, and fortifying a personal abstinence. Once physical recovery is secured, the focus moves toward emotional, relational, and spiritual growth. Brown (1993) depicts early abstinence as a state of heightened dependency on external sources of support that necessitates sustained focus on alcohol and on identification with other alcoholics. In later stages of recovery, Brown (1993: 49) writes that "concrete behavioral and cognitive focus moves from a constant emphasis on alcohol and attendance at AA meetings to involvement in many other life concerns … into the world outside of AA meetings."

While time in program increased some forms of recovery, it is associated with more frequent relapse. For many members, frequency of relapse was "part of their story", reflected the reality of the long-term nature of the disease, and while tremendously painful, was not *always* viewed as antithetical to recovery. Thus, it is important to discuss and understand relapse in OA, particularly as it is perceived differently from relapsing with drugs and alcohol.[12]

Susan is in her seventies and has been attending OA for a couple years. She described her trajectory as having "ups and downs, but for the most part moving steadily ahead. And when there's a down I can recognize it and I know that there is something I can do about it, so the

[12] For this reason, one interviewee who has attended 4 different 12-Step fellowships wondered whether Al-Anon (in which people have frequent "slips" with codependent behavior) might be a better model for OA than Alcoholic Anonymous.

down isn't as disastrous as it probably would have been in the past." Similarly, Miriam related a similar perspective on setbacks: "plateaus, numbness, losing abstinence, food is calling, and not handling issues as beautifully as I really could—that's ok, I'm still growing, and I'm still in the journey."

Frequent meeting attendance has been found predictive of sobriety (Greenfield and Tonigan 2013). Accordingly, the more Twelve-Step meetings attended, the lower the likelihood of relapse in my sample. One respondent discussed what she gets from OA members at meetings: "Wisdom! Wisdom. Compassion. Modeling. How to cope." I asked if she thought that was the primary mechanism of change in the fellowship.

> That's a good question. I think it is… the word that comes to mind is expansion. My vocabulary expanded. … I don't think it's mimicking, it's expanding possibilities, horizons, options, ways of viewing, before even coping. Sometimes I would leave a meeting and I would hear the voice of someone who had said something and it was so beautiful and so authentic, and so wise, and my heart, like expanding with love to that person, with gratitude, and toward myself. And I think it's a very big thing. It's walking the talk. The books are very good, but that's actually, that makes a difference, that they're real people, not someone on a stage that I have nothing in common with.

The importance of meetings is discussed below with respect to their level of emotionality.

However, while meeting attendance is the foundation of participation, in many ways it is the "bare minimum" of Twelve-Step involvement. Outcome studies have established that, for most populations, active involvement in Twelve Step—such as working with a sponsor or using other program tools—is more strongly predictive of abstinence than is meeting attendance (Tonigan 2008b; Donovan et al. 2013). Various measures of OA meeting attendance in my study were not significant once variables reflecting greater engagement (e.g., working the steps) were entered in models; some were not significant even in minimal models. While there may be truth to the twelve-step maxim "meeting makers make it"—and this is likely the most palatable prescription for newcomers—the mechanism of change may be better reflected by another

slogan: “It works if you work it (and you’re worth it)!” At the same time, it is worth noting that of ten choices including “relationship with a higher power” and “working the steps”, the highest percentage of survey-takers marked meetings as very important to their recovery. As Tonigan (2008a: 370) writes, “AA attendance ought to be viewed as a bridge to the practice and internalization of prescribed AA-related behaviors and beliefs.” One such practice is having a sponsor.

Having a Sponsor

Frequency of having a sponsor in program was predictive of higher scores on the recovery index. Members credited sponsors with providing accountability, mentoring them through the steps, and reinforcing program ideology. John deemed having a sponsor “Absolutely essential. I needed to have a sponsor to have that one-on-one attention and accountability.” Similarly, Kim, who was over three years abstinent at the time of the interview, explained: “I have to kind of be accountable to someone, besides myself, and she also reminds me to be consistent instead of spotty in my activities, and to be less negative about myself. She points out my positive qualities.” Miriam, also maintaining her weight loss, credited her sponsor with having an “enormous effect” on her recovery: “she bridged between the program and my life”.

Julie has struggled to maintain abstinence over her decade of participation in OA. Asked whether she thought having a sponsor was helpful for her food problems, she replied, “I think it keeps me coming back. I think it helps my growth as a person, and I think if I didn’t have those relationships I might not come back, and I’m hoping that as I learn more, and grow up emotionally, I’ll be more willing...” Melissa, who was not attending meetings by the time of our interview, also thought sponsorship has a very positive effect, particularly during her early involvement:

> I think especially in the beginning it was the thing that kept me abstinent, the thing that would keep me from picking up some kind of food that was not on my plan that would lead to overeating, so I think in the very beginning it was almost 100% of the success that I had. And it kind of went down, as I was working the steps and doing all this reading and writing and other stuff, it just became kind of one component of the whole thing...

Cindy participated in OA at two different times in her life. This most recent time, she has struggled with food and not been abstinent. She attributes the difference to not working with sponsors the second time around. Cindy equated getting a sponsor with working the steps, and surrendering one's will (step 3). When asked to elaborate, she explained, "If I have a sponsor, then I am pretty much letting go of the direction that my food takes. That to me is the crux of the issue, that I still want to run the show. And it doesn't work, but I'm not willing to let go yet." Peggy had a different take on the benefits of having a sponsor, that of elucidating negative traits and patterns:

> It's about having a witness to my process, to validate my experience, and to say there's another way to do it. This has been your experience, this is what happened, this is how you react, this is how you respond, and here are some other ways to do it. … [A]lso having someone who knows me really well, who knows my patterns. And then having a chance to do something differently.

Elise, a woman in her mid-sixties who has been in program more than a decade, discussed the effects of having a sponsor: "It's affected my *life* in that … the kind of connection one has with a sponsor, and later *as* a sponsor, is unique. It is so deep." I clarified: "So what's been transformative for you is that really close relationship?" Elise replied, "In an area that has been *so* secret. I mean, I don't talk to people about this stuff." George, a man in his early thirties who lost half of his body weight in OA, described having a sponsor as:

> definitely a boost to my recovery. I mean he was just so incredibly helpful, for more than just not overeating. If I'm not overeating, what do I do? Just really, not knowing how to live life. So he helped guide me through some difficult situations and really strengthened my recovery in that way, it just really helped. Because when I wasn't

> eating I was a mess in my head. Kind of like he was a stabilizing force in my life, you know, when feelings were chaotic and thoughts were chaotic.

Step Work

As with having a sponsor, step work predicts higher scores on the 6-item recovery index. Virtually all interviewees spoke very highly about working the steps. One respondent thought the steps were more helpful than therapy in terms of working on personal issues. Jamie, a young woman who had attended a couple years, noted benefit from step work around emotional issues:

> I think I have gotten a lot better with letting go of the fact that I can't control everything and recognizing the fact that I'm not this terrible person who makes all these mistakes, I think it's allowed me to heal some of my relationships… As far as food goes, I really haven't yet seen how the steps have affected my food. I mean, I do think indirectly by fixing the emotional stuff, the less emotional and blaming, the less I'm going to binge. But because my food is still so bad, it's not like I feel like I worked the steps and I was abstinent.

In contrast, Kathleen was adamant about the critical nature of step work to recovery, including from the physical manifestations of the eating disorder.

> There is no recovery without step work. And there is no abstinence without step work. Whether or not you can adhere to a food plan is…. Well, I don't think you can without doing the emotional work. I don't think it's possible for a compulsive overeater to adhere to a food plan and not work the steps, because that's the nature of our disease. If I could, I could go to Weight Watchers, and follow a diet. And that would work to give me a healthy body and well-rounded life, but it doesn't, because of the nature of what compulsive overeating is, it's a disease, and that means I have the spiritual malady, the mental obsession, and the physical allergy, not just one or two of those, I have all three and all three need to be treated. And if I don't do the steps, I won't be abstinent, I won't get recovery, I will continue to do the addictive behavior.

I asked, "So you view [working the steps] as a continuous requirement?" She replied, "Absolutely. You can't, I don't believe you can ever stop working the steps and be OK. For me, that's not possible. Because I've tried, in a manner of speaking. My intention is never to give up working the steps, but sometimes I will, and I stall out. And the results are never good."

Beth, a bulimic who entered OA after attending treatment, singled out the 9th step: "I think having to do amends was for me, especially, some of them were just incredibly hard to do. Incredibly hard to do. But they were life-changing. You can really go forward, it really does free you. If there's one step at all, I think making amends for me is really transformative." I asked Helen, who had been in program a quarter of a century, how working the steps related to her recovery from compulsive overeating. She answered:

> I'm a good person when I work the steps. I was one of those who said, I have no amends to make. Why am I doing the fourth step, I'm the victim of all these things! So that did change me, I did have a part in it. And the first three steps of course are having your hand in God's, instead of thinking you need to have all the answers. I learned that first, I wasn't the cause of a lot of things that I was trying to cure in other people, it wasn't my business. So the first three steps are the most important to me. But it helped clean house [do the 4th step] after that.

When I prompted her about whether step work helped with her food, specifically, she replied, "Oh, right, it did, because I'm an emotional eater. So if I didn't know how to handle a situation, I would just soothe myself with food. And so, I learned not to; I'm still learning not to." Asked whether working the steps has helped with her food recovery, Kim, a middle-aged woman with three years in recovery, responded, "I don't know, I kind of almost think of it as a separate thing, that [abstinence from overeating] is a prerequisite to doing that work." Melissa, a young professional who had been in program a couple years at that time, credited the steps for her emotional transformation:

> In the beginning, doing steps 1, 2 and 3—just getting the baseline, just really intellectually understanding and connecting with my heart that I am a compulsive overeater, just totally admitting that and turning it over and understanding that there's no way that I can do this myself, that was really helpful. Doing step four was pretty intense emotionally, and in some ways that made me want to pick up [food], but it was also a positive thing because I could work through these situations where I was feeling so agonized and attacked and see what my part was. That gave me a feeling of empowerment, and I wasn't feeling quite so much like the victim. It gave me some confidence that, I'm partly creating this, and so I can choose not to create it. And so that was good.

Melissa went on to describe how she encountered emotional difficulty in the approach to step 9, the making of amends. "Even when I had positive experiences with making amends, it was just so big. And I could feel that this could actually improve my life quite a bit, and that kind of scared me, too." Three other respondents reported emotional or psychological difficulties working the steps that deal with material from the past (steps 4-9).

Linda, who at the time of the interview was attending 90 meetings in 90 days (a common prescription for anyone who is struggling), described pivotal steps for her as step eleven (prayer and meditation to achieve "conscious contact" with a higher power) and one (admitting powerlessness over one's addiction). Asked whether those steps help with her food, she was certain they do.

> If I identify that I have a problem with food, it's going to help me with food. And knowing that I'm not doing this by myself, that god is there and is part of who I am, god is within me, and in every molecule, everywhere. So I'm really never alone, though I may feel like it. So those two things help keep me in a reality that helps me deal with my life and events in my life without eating. So, knowing that I have a problem, number one, and that I'm not alone, which is number 11. Those are for me the biggies.

Sarah described in detail how working the steps brought her recovery that insight alone could not. Her explanation of how step work expanded her relationship with a higher power and her description of the inventory process of the later steps in many ways encapsulates the Twelve-Step model:

> The second step helped me to develop this deeper power that, at first I really just believed in the power of the group, because I went into that Monday meeting and I saw people that had what I wanted… [T]hey were recovering, and so they became a big corporate power, and that power just kept deepening and expanding and just going in all different directions, which then paved the way to work the rest of the steps to really see what was the core of my compulsive overeating, that it was more than just the food, it was more than I just think about eating sugar when I get stressed. I really, the steps enabled me to dig that level deeper to think you know, what drives the compulsion, what are the feelings and what is the spirit that can undergird all of that? I mean, I've read pop psychology books and I could probably put Barnes & Noble up on the stock

> exchange, but even having all that information, when I wanted to overeat, it was only a matter of time. So, having that information about emotion, and thinking, combined with the spirit, that was power. Isn't that what they say in the Big Book, lack of power was our dilemma? And I didn't have the power: I thought reading was the power or insight was the power. And the steps I think kind of reoriented where the locus of power is. … I'm learning that insight is undergirded by this power that enables me to put the insight into practical application.

George emphasized the importance of working the steps to address the root causes of addictive behavior, but also to avoid the situation of being a "dry drunk".

> I think working the steps was incredibly helpful, because it really helped me to grow. I think not to overeat is just not enough. Because we can all do that, with some level of control, periodically in our lives. And what the steps have done for me, particularly 4 and 5, just really got some old hurts out—the fears, the anger, the resentments—is why I ate. I had no other way of coping with those things. So not [over]eating and working the steps really helped me grow incredibly fast I think, because I feel like maybe I'm at the maturity level of a 25-year old now… rather than like 11 when I started, in just a few short years! (laughs) [Y]eah, that for me is integral to my program—working the steps, to really get the growth out of it. It's so easy to become a dry drunk, too. Because it's not just about the food. I can be totally in my other character defects, and still not have the urge to overeat. And just be the biggest asshole (laughing) and be abstinent. And the steps help with that, too, for me.

Multiple interview participants argued that the sole purpose of the steps was to connect members with a higher power. Step 12 reads, "Having had a spiritual awakening *as a result of these steps*…" (emphasis added). In line with this expectation, the more steps participants completed, the greater their level of spirituality, and the more likely they were to report increases in spirituality since joining OA. It is perhaps telling that increases in step work predict improvement in a multi-faceted index of recovery, which includes physical health and preoccupation with food, but not more nuanced measures of OA "sobriety". In addition to working the steps, members are advised to avail themselves of OA's tools of recovery (see Appendix B).

The Tools of the Program

This variable assessed two official "tools of recovery" along with prayer and meditation. The more frequently members in my sample used these tools over the last 90 days, the more likely they were to be abstinent at the time of the survey. Most members, when asked what about OA contributed to their recovery, listed multiple tools. Julie explained that her therapy, while helpful for personal change, did not address her compulsive overeating the way meeting attendance did, though hearing people talk in the meetings about the struggle, their histories, the changes they've made, and what their action plan [OA's 9th tool] is and what they're implementing". Multiple members focused on the importance of a food plan, of having a sponsor, and various daily practices such as reading, writing, and emailing sponsors. Melissa's answer to the question illustrated the difficulty of separating out a single largest "cause" of recovery:

> I think sponsorship and fellowship, but mostly I would have to say overall the tools. They all have a really important part, but to me the basis is sponsorship and meetings, because for me, everything comes out of that. If I'm seeing people in meetings, it's reminding me that I need to call them, people will talk about reading and writing, it reminds me that's a valuable thing. If I'm working with a sponsor they're giving me assignments for reading and writing, so it all evolves from the sponsorship and meetings.

Similarly, Elise opined: "I need the meetings, I need a sponsor, I need the service, to be doing service, I need the writing, and I need the steps, and I need the traditions [Twelve-Step rules governing how groups operate]. Oh boy do I need the traditions. And they all apply, to my whole life! I mean, recovery and my life are not different." While respondents clearly indicate that the steps improve the quality of their lives, and for some, reduced the likelihood of emotional eating, other aspects of the fellowship may be more proximal causes of abstinence and physical recovery.

Beliefs, Cognitions, and Identification

Ideology

Fiorentine and Hillhouse (2000) found that greater acceptance of twelve-step ideology predicted higher meeting attendance. They analyzed a 14-item measure of AA ideology, and found that three items explained about half of the variance: (1) "the need for abstinence in order to manage the negative life consequences of addiction" (32% of response variance); (2) "addiction is a lifelong malady and addicts need to participate in Twelve-Step programs" (10%), and (3) belief in the "need to give oneself over to a higher power" (6%) (Fiorentine and Hillhouse 2000: 378). Similarly, the two aspects of ideology most endorsed by respondents form my sample were very similar to numbers 1 and 3 above; my ideology measure did not have a close analogy of number 2. However, belief in the life-long nature of eating disorders is indicated by the fact that about 93% of my survey respondents indicated an expectation that they would attend OA indefinitely.

A key aspect of Twelve-Step ideology is the notion of addiction as a disease, which was liberating for many OA members (see Ronel and Libman 2003). For example, Alana, a young woman in program about six years, described the effects of her new perspective:

> I think before I just thought that it was all about my willpower, what I could and couldn't do, and also too, because I'm a spiritual person, kind of equating a lot of my actions to being debaucherous or all these kind of things, being bad or being sinful type of things. So I think that all kind of falls in the realm of feeling like it was all my fault, I was doing bad and I just couldn't get it together and I was to blame. So I think what OA has helped me to realize is it's not all my fault, it was never a willpower situation, that this is a disease, and that I didn't ask to have it.

Spirituality

Tonigan, Miller, and Schermer (2002) found atheists and agnostics less likely to affiliate and sustain attendance in Alcoholics Anonymous, but found no difference in percent days abstinent or drinking intensity between them and spiritual and religious participants. In a large after-care

sample consisting of more severely addicted alcoholics, Kelly et al. (2011) found that the mechanism by which AA attendance reduced drinking was spiritual and religious practices, controlling for other mediators. The authors speculate that the motivation to undertake a major shift in spiritual beliefs and world view "would have to be compelling, and we speculate that the toll that [addiction] may have had on the lives of more severe patients may be so much graver as to stimulate a new openness and motivation to embrace a new outlook" (Kelly et al. 2011: 297). In terms of survey findings, increased spirituality predicted improvement in the 6 items of the recovery index, though again, not in the more direct measures of abstinence and physical recovery. However, the OA ideology measure includes predominantly spiritual components, and was positively correlated with current abstinence and greater weight loss.

In response to a question asking what aspect of OA is most important for their recovery, the vast majority answered "higher power". For some, program introduced them to a higher power, for others it helped them access or connect to a higher power more than ever before, and still others found OA helped them to make practical use of their higher power. For almost all, spiritual growth factored prominently in their understandings of their recovery. For example, one participant explained,

> [I]nitially I focused on the physical recovery, and then it really went to social, emotional recovery. And um, the underlying one has been the spiritual recovery. That has been the biggest overall change, in that I have a more direct line with spirit. I've always had that, but I have more ways of getting there now. So it kind of sways back and forth. I'll kind of have growth in one area, and that will slow down as something else grows, and right now I seem to be having recovery slowly in all areas, it's more balanced at the moment, but there's quite a bit of variability. So it's not been linear.

Cecilia has been in program for decades and has lost significant amounts of weight on three occasions and then regained it. She was also a "cradle Catholic" and has always been extremely active in her church. She is not as active in OA at this point as she used to be, but still attends a

meeting weekly. She expresses the conviction that OA is the solution, but says she has had difficulty being willing to do the work required. When I asked her my standard interview-ending question about whether there was any other way in which OA had affected her life, she responded as follows:

> I really believe that it's helped me with my marriage and with raising my children, it's been a really big part of my life, I look sometimes at my religion … how OA and my religion are different. The same but different, because I think that OA is more personal for me. It's terrible to say, but it has opened up a much more loving concept of God … It's a real big, it has to be part of my life. And maybe because I haven't been doing it as much as I did before, is why I feel like… I don't know. There are a lot of things about my religion that I do not agree… Forget that they're a hierarchy, where we [OA] are all equal.

Identification Processes

Individuals who believe in the disease model and possess an addict identity are likely to become more involved in self-help groups and less likely to drop out (Kelly and Moos 2003). In answer to my asking what she "gets from fellow OA members, if anything," Kathleen said, "I get identification and validation. I get support, and understanding, the identification is crucial, because I need to know that what I'm doing has worked for someone else, or why the hell would I do it? That they know how I feel or have felt, that they're willing to talk to me and share themselves, just like I want that with them."

Interestingly, identification as a compulsive overeater (step one) does not predict improved recovery. Frequent relapse and identification as an overeater are positively correlated, but this is likely due to the fact that nothing so vividly demonstrates being an overeater as being in relapse. Identification as a compulsive eater is also negatively correlated with being a healthy weight. There is a Twelve-Step saying that the "ism" in alcoholism stands for "incredibly short memory". Perhaps frequent relapse and carrying extra weight keep the disease identify fresh. Additionally, the greater recovery one has, the harder it might be to remember being "in the

food". As one participant stated: "So coming back to your identification, I think working the steps really, really changed the way that I saw myself. So right now I still very much say that I'm bulimic and that's the thing that I identify with, but it's so farfetched from my… it's farfetched from who I am today, which is nice." Julie, a middle-aged woman in OA for a decade, discussed competing concerns around identification:

> Well, I felt right away when I came to the support group that I was indeed a compulsive overeater, and a food addict, which is just a little bit worse of a compulsive overeater (laughs). And I am a believer, and I had a therapist who felt that, when you identify yourself as a compulsive overeater, that's akin to negative thinking, it's a label that, you know, I would identify with it, and times I over identify with that label, and at times I am just able to place it as a realistic part of my personality.

When asked about the trajectory of his OA recovery, George discussed how understanding his powerlessness over food affected how he felt about bingeing.

> Recovery has been peaks and valleys but it trends up. The overall trend is up. And it definitely hit some pretty lows. Not the low bottom with food – and some of the binges have been pretty painful, but by comparison were not like any of the binges that I had before program. However, how painful it was, was incredibly worse, being in program.
>
> "Like OA ruined the binge?" I asked. George responded:
>
> Ruined the high. Sure. It kills the high. It just does not feel good to binge at all. And yet I'll find myself just on occasion eating something I'm not supposed to eat, and think the whole time, I'm not supposed to be eating this, I'm not hungry, why am I eating this, and just continue on doing it, and just feeling shittier and shittier with every bite. It's terrible! So, overall it trends up, but no, definitely peaks and valleys.

Service

While service is one of nine program tools in OA, it is held as a primary antidote to the self-centeredness 12 Step views as characteristic of people, but addicts in particular. Service is often thought to benefit not only the recipient, but also the giver. This dates back to the work of Reissman (1965) on the "helper therapy principle," which predicts that as a function of helping others, one's own problems diminish. Certainly the idea of transcending the "bondage of self" is

integral to AA teachings. Interestingly, Pagano et al.'s 2013 study of AA-related helping found that it increased participants' interest in others ("other-oriented-interest"). Those with less interest in others had worse alcohol-related outcomes. This accords with the finding from my survey analysis that those respondents who were more indifferent to others' troubles lost less weight, controlling for other factors.

72% of my sample has at some point held a formal service position in OA, while 58% currently held one. I asked members who had ever served to indicate the primary reason why they took on their most recent service position, giving them the following choices: my sponsor requires or suggests I hold one; I think OA service is essential to my personal recovery; I thought if I didn't do it, no one would; I was pressured to take it by fellow group members; or "other". By far the most popular answer at 57% was that service helped their recovery. Most who chose the other category (6.3%) expressed the sentiment that they wanted to contribute, help, or "give back" to the group.

A number of studies show that helping others mediates the positive effect of spirituality on physical and emotional health, and helping others within the context of self-help/mutual aid groups specifically increases satisfaction with the group and subjective well-being (Zemore and Pagano 2008). Zemore and Pagano (2008: 151) write: "It is fascinating that, despite the explicit linkages that many recovering people make between helping, recovery, and spiritual growth, there is so little quantitative research on the interplay between growth in these areas."

I asked interviewees whether they did service—and if so, why. Often I asked whether they thought it related to their recovery. A key motivation not discussed (to my knowledge) in the literature on how Twelve-Step service promotes recovery is rather simple and obvious. Essentially, members take service positions as a form of precommitment (Schelling 1978).

Respondents talked about service as a way of “getting your butt in the chair”, or obligating yourself to attend the meeting, so you are not reliant upon having motivation and desire to attend every week. Asked about whether service was related to her recovery, Beth said: “I think early on in my recovery it was, because it made me go to meetings when I didn’t want to. Now it’s more about giving back to the community. So I think it changes for me, over time.” Sarah also noted that over time the meaning of service changed for her:

> What starts to happen is that then service becomes more than just something I have to do because my sponsor told me to. It then becomes this thing of just really feeling like this is another way to become part of the group. Because we, somebody early on in that meeting gave the analogy that we’re all climbing this mountain together, we’re all tied together the way rock climbers are. I don’t know if there’s a technical term for it but they’re all tied together by a rope, and one slips, or one starts to stumble, and the rope of the others supports them. And I really started feeling that, and it wasn’t so much like geez I have to do [service], it’s almost like, great, this is another way I get to not only enhance my own recovery, but keep the group moving, keep us all moving through, and you know, kind of be an example of what this program can be.

Jill said she does service as a way of giving back to the program, “the ‘you have to give it away so you can keep it’ concept. And if I want a meeting to remain strong, I can’t leave it up to everyone else to take care of business. And, taking a service position helps anyone, and me, stay active in the meeting.” Kathleen thought service “absolutely” promoted recovery.

> Because, addicts in general, I think, this is more of a concept I learned in AA, but it’s not different, like I said, it’s the same mother program, it’s the same 12 steps, and meetings are meetings. To have self-esteem, which many if not all of us lack, we have to do estimable acts, and to act our way into feeling better about ourselves. What I end up doing ends up helping the program in general, but it’s for me, so I can be the type of person who I can like well enough to take care of well enough, to be in recovery. I want to be a person that I like. And a person that I like respects and helps others.

Martha generally holds a service position in her weekly meeting. When I asked her motivation, she replied:

> It’s good for me, and to give back. It makes me show up: it gets me there sometimes! My experience in 1975, I had three years of abstinence, I did no step work but I did so

much service I abstained for three years! So that taught me a lot. Not only did it keep me abstinent for three years, but I actually gained some self-esteem behind it. I am a firm believer in service.

I asked Melissa what motivated her to take on service positions or discrete service tasks, and she replied, "Well, partly because I know it helps my recovery." When asked to explain, she said:

> You know. Focusing, keeping my focus outside myself. Having something I'm working toward that's not just me, it automatically makes me feel I'm part of a bigger, a larger thing, that's not just my own interests, I'm doing this for other people, I can actually be of help, whether I'm struggling with my program or not, I can actually do something that is useful to a large group of people, and that is important to me, to be of use, and for people to see me as part of the group. Like when I go to [the regional service body meeting], even just participating in that way feels good because I'm helping to further the program, I'm helping to perpetuate this program that I know I need and I know that society needs… [I]t's just very energizing to be part of something positive like that. And, I don't feel so alone, being part of that group, and we're all working together towards a positive purpose, and it shows me that interaction and being part of a group and being noticed, being an important part of things does not have to be scary. It's safe to not isolate all the time.

One seven-year attendee, Cindy, considered herself to have no form of OA recovery. I asked her what motivates her service to her weekly meeting. Explaining why she does service, she said "Well, I guess I no longer believe that that's going to influence my recovery. I suppose in the beginning they would say that "this helps your recovery." Instead, she says she does service "to get more of a sense of belonging in the group." Whether or not they believed it helped with their recovery, either indirectly or directly, multiple interviewees talked about feeling a sense of belonging and connection with the group through service. Perhaps service may promote recovery by increasing identification with and attachment to the meeting.

Like Cindy, Miriam did not connect her service to her recovery. She said she did service because she felt good "just feeling like I *do* something, because I am *getting* so much." I asked, "Do you see any connection between service and recovery?" She answered no. "That's the one thing that actually never clicked. In theory, absolutely: there's no question about it. But

somehow in my experience, no." I asked Ellen why she did service in her home (regular weekly) meeting. She said she thought it was "really important for her abstinence":

> I deeply value having a meeting to go to, of like-minded people, and it takes volunteers to put it on, for it to be there, and it takes people that have abstinence to suit up and show up so that when the new people walk in the door, they have that framework to lean on, just like I did. So it works both sides … If I'm there, I'm taking care of my own sobriety, and if I take a service position, then I'm helping provide for other people. And a lot of times, it just means that I'm going to be there.

George was less enthusiastic about service, calling it a "pain in the ass" and a "nuisance to me, for the most part." Nonetheless, following Twelve-Step prescriptions, he volunteers, and says "when I struggle, at whatever level—food, or emotionally, whatever—I hear to do service to help with your recovery. "And when I do, and I don't want to, it always helps my recovery." I asked whether he knew how it helped. His answer is in line with the predictions of Reissman (1965) and findings of Pagano and colleagues (2013):

> I think it's because if I'm having a hard time, it's all about me, my life, what I'm not getting, how my ex-wife is making me angry, how my boss is an asshole, or how my kids are not well-behaved or adjusted enough, it all becomes about that, my life, whether I'm in the food or just woefully depressed. And I'm all I think about. When I do service positions, I have to stop thinking about myself, at least for half an hour or an hour, whatever. And that is something, there is something healing about that, of giving of myself. And expecting nothing in return. Makes me get out of this self-obsessed, selfish hurt. So, I think that has something to do with it.

Sponsoring Others

Using Project MATCH data, Pagano et al. (2004) found that those who sponsored others and/or worked step 12 during treatment had much greater success staying sober in the year after treatment. They speculate that the relationship may be due to the sponsor acquiring "a sense of purpose, development of trust, a shift of focus from self to others, greater treatment involvement and increased motivation for lifestyle change" (Pagano et al. 2004: 770). They further suggest that early sponsoring might be beneficial and call for future research to develop measures of the

intensity and scope of the different service activities in Twelve Step. To that end, my study asks when sponsoring was initiated, how frequently one has sponsored, and how much time has been spent sponsoring (including a measure of face-to-face interaction).

In many ways, the form of service that is most vital to sustaining the fellowship is sponsoring. Moos (1993: 401) summarizes the sponsoring role: "Sponsors provide other members with support and direction, twelve-step instruction, tips to help promote abstinence and improve relationships, and peer counseling and crisis intervention." Outcome research has shown consistently positive (if variably sizable) correlations between sponsoring others and recovery. For respondents in my sample, sponsoring others predicts less relapse, more weight loss and greater odds of having achieved a healthy weight. Moreover, amount of time spent sponsoring others increases the odds of current abstinence. Moos (1993: 401) argues the benefits of being a sponsor are attributable to increasing one's "sense of purpose and personal responsibility, rewards for remaining sober, and commitment to recovery" and sponsoring can also augment one's self-esteem and social network. Martha explained why she thought sponsoring helped her, noting the identification aspect and the reinforcement of prescribed Twelve-Step behaviors:

> Every time I work with somebody who's in the same situation that I'm in, difficulty with living and making choices, it helps me make better choices, it helps me keep my program. I can't be telling my sponsee to be doing something I haven't done. I can see their struggles and I can identify because I've been there, or I can see maybe something that they did to help them through a struggle that might help me.

Of all the independent variables in my models, the most consistent predictor of recovery was sponsoring others. Twenty-eight of thirty interviewees save judged *being* a sponsor as vital to one's recovery. Kathleen thought it indispensable for true recovery:

> There's always exceptions, people that stay in the program that stay abstinent, whatever that is to them, without sponsoring, but I would not want what they have. I think that is

> a crucial thing, and it is one of the 12 steps, so I don't think that someone who doesn't sponsor is truly recovered… they're skating on the edge of relapse, I think: the longer they go, I mean, that's a crucial part of the program. You can't leave out step 4; why would you leave out step 12? I want to have the full experience, because I want the full recovery.

Oppenheimer's famous statement "The best way to learn is to teach" seems true of Twelve-Step recovery, as well. Peggy explained how sponsoring others kept her recovery fresh: "I think the most profound thing is that when I go back through the Big Book, things strike me differently than when they did at other times in my recovery … and it resonates in a different way." She equated working with a sponsee to working the steps again. Similarly, Sarah explained how sponsoring others reinforced her program:

> Being a sponsor *really* holds me, because I don't say to my sponsees anything that I'm not going to do myself. … It's remarkable how [my sponsees] will bring up things that I need to be looking at myself. Or they will remind me of something that I had forgotten that I just hadn't been thinking about in my program, because you know there are so many different aspects of program that we can't put it all in our head every day.

George focused on how rewarding it was to help others:

> Being a sponsor has helped in that I get out of the self-obsession and the selfishness and become of service. And like they talk about in the AA Big Book, about being rocketed into the fourth dimension of existence, how they set out to just help drunks to stay sober, but they didn't realize how rewarding it was, and I didn't realize how rewarding it could be until I was doing it. It is incredibly rewarding to give, rather than to take.

When I asked whether he thought it actually helped with his food recovery, he replied, "Yeah, it helps my recovery with food because I feel fulfilled, on an emotional and spiritual level." OA members who also attend AA are often called "double winners". Some of these double winners lament OA's less zealous twelfth-step intercession with struggling addicts and new members, relative to that seen in AA. Nonetheless, there are indications of extensive involvement among some OA members, particularly those who sponsor. For example, the frequency of sponsoring in OA is strongly correlated (.43, p=.000) with an index of "Coleman"-

type social capital composed of items such as frequency of providing and receiving emotional support, car rides, and information on opportunities, loaning and borrowing items, etc. Coleman conceived of social capital as “inher[ing] in the structure of relations between actors and among actors" (1988: 82). This formulation emphasizes informational resources, norms of trust and obligation, and dense networks that are a resource for individuals but also facilitate collective action. Closed social networks facilitate social capital.[13]

Finally, it should be noted that some interviewees consciously chose to not sponsor other members. For example, Linda found it detracted from her personal recovery:

> I have tried sponsoring a number of times and I tend to lose my abstinence when I sponsor. So I’m doing service, I am a really good partner in recovery [a more horizontal support relationship], I do a lot of phone calls. If I know somebody is having a difficult time, I focus on being in contact with them. But, sponsorship when I’ve tried it has not worked for me up to this point. So I’ve got some more work to do. When I sponsor, I tend to take on responsibility for the other person, and that’s one of my character defects. I will take care of other people to the detriment of my own program.

Social Activity

Kelly et al. (2009: 252) highlight the importance of social sources of recovery in Twelve Step, writing: “AA itself, at least it its core texts, may have ignored explicating perhaps its most potent influence on individuals’ recovery—that of social group dynamics in the AA meeting, the broader fellowship, and the expression of support that can be healing to many.” Similarly Kaskutas, Bond, and Humphreys (2002: 891) write: “The type of support specifically given by AA members, such as 24-hour availability, role modeling and experientially based advice for staying sober, may help to explain AA’s mechanism of action.” Participation in fellowship after meetings was positively correlated with the six-item recovery index, while both the number of

[13] The questions that compose this index variable were taken from the Project on Human Development in Chicago Neighborhoods.

OA friends one socializes with outside of meetings and the frequency of giving and receiving emotional support with other OA members increased weight loss.

Social factors are typically operationalized in AOD research as the sober versus using ratio of one's social network. For example, Kaskutas et al. (2002) found that an increase in the proportion of AA friends relative to using friends mediated AA involvement's effect on substance use. One of my survey findings, that the number of OA members one socializes with outside of meetings predicts weight loss, may be indicative of such network effects in OA, as well.

Given both recent evidence that obesity is affected by one's social network (Christakis and Fowler 2007) and consistent findings that a key cause of sobriety in Alcoholics Anonymous is social network change (Kelly et al. 2011), the study of social factors in Overeaters Anonymous is of critical importance. Ronel and Libman's qualitative study of OA members in Israel found loneliness to be a defining characteristic of overeaters, which led to overeating, which in turn increased individuals' sense of alienation. Their interviewees reported that the social network aspect of OA was a major component of their recovery. One of my interviewees talked about the difference between AA and OA, which illustrates perhaps the importance of joining a welcoming community to reduce the isolation that characterizes many overeaters.

> And going into OA after 12 years of sobriety in AA, it was different in many ways, in that the people in [OA] are much more isolated. Compulsive eating is not a partying thing. You know? We want connection, we want love and relationships, but mostly we cut ourselves off. … I mean, when you're drunk, you're expressive, whether or not you're lying or it's bullshit or whatever… OAers, it's all very much internalized, and we're concerned with pissing people off…

Isolation is a very common theme in OA meetings. A famous line from OA's chapter on Step One reads: "We procrastinated, we hid, and we ate" (OA 2002: 5)

The provision of community and open and accepting welcome that many newcomers experience in their initial meetings can provide a powerful antidote to the sense of aloneness and alienation with which many compulsive overeaters struggle. Linda, only a couple years in program, provided a detailed narrative of the newcomer experience, one similar to experiences related by other interviewees. She reported a surprising degree of identification with and welcome from the group. When asked if she wanted to tell me anything else about how OA had affected her, Linda related that OA surprised her: "I had almost completely given up on myself". She was considering gastric bypass surgery but was confident that she could "eat around it" and still gain weight with very densely caloric food. A friend encouraged her to try OA, and in a moment of desperation, she decided to go to a meeting:

> I sat there and cried and began to understand…and I began to talk and ask questions and feel things and go places that I was afraid to go by myself. And I could go there, and in that meeting, a person came up to me and said, Linda, we will love you until you learn to love yourself. (Pause) And I didn't know what that meant. I now know what that means. But there was hope there. And I believed that it would work. Because I was there, they had presumably the same issues that were going on with me, and there were people there who said they understood me. I didn't know if they understood me or not, but I began to trust. … And there was something different that I discovered in OA, once I allowed myself to open to it a bit more, that made me think that maybe I didn't have to hurt so much. And I didn't even know how much I hurt at that point. And so this has been a journey that I didn't ever anticipate taking, I didn't know the road that it would take me on, I didn't know what I'd encounter along the way, but it created a new beginning for me, when I felt like I could be looking at the end – just a diminishment of my life. And instead I'm flourishing.

Borkman writes, "Some AA attendees think that their sobriety is based on their friendships rather than working the steps. Others work the steps and AA members become their major friendship networks. As Maxwell described, talking to fellow members before and after meetings is as significant as the meetings per se" (2008: 28). It is this aspect of social engagement—discussions among members before and after meetings—that is predictive of recovery as measured by the six-item index. While only a couple members referenced

fellowship after meetings in their interviews, many did discuss the social aspects of their OA participation in response to certain questions. For example, I asked Melissa whether she saw her recovery as intertwined with that of other people, or entirely separate, or somewhere in the middle. Her answer indicated a connection between social contact with other members and recovery:

> I think it's definitely, if the quality of my recovery is very strong, that means I am completely connected with other people, in many different ways, doing service, phone calls, going to meetings, you know, spreading the message to people who may not understand the program, the more intertwined I am, the better my recovery is. So that's definitely the reason recovery works for me.

Referencing addiction-focused research with primates by Morgan et al. (2002), Kelly et al. (2011: 298) write "it is plausible that the rich social integration that occurs in AA may accelerate up-regulation of dopamine D2 receptors, a higher density of which has been shown to protect against relapse." Whatever the mechanism, it is very clear that most OA members are profoundly affected by co-presence with like-minded addicts.

My question—"What sorts of things, if anything, do you get from fellow OA members?"—elicited many responses that illuminate the significance of social aspects of Twelve Step. For example, George replied: "I think a sense of belonging, really being loved, like, 'cause these folks know some pretty rough things about me, and they still call me. So, you know like, fulfilling what my family of origin never fulfilled, being accepted, being loved. Just come as I am, and it's OK. That's what I get." One factor that can promote and enhance social effects is the emotional intensity of meetings.

<u>Emotional Intensity of Meetings</u>

In *Interaction Ritual Chains*, Collins (2005: 42) brings a Durkheimian focus on social density and collective effervescence to the study of how emotions affect people, arguing that:

> occasions that combine a high degree of mutual focus of attention, that is, a high degree of intersubjectivity, together with a high degree of emotional entrainment…result in feelings of membership that are attached to cognitive symbols; and result also in the emotional energy of individual participants, giving them feelings of confidence, enthusiasm, and desire for action in what they consider a morally proper path.

Identifying as a member of the group and having "feelings of confidence, enthusiasm, and desire for action" would all arguably promote abstinence. In addition, Collins' discussion may explain the effects of emotionally intense meetings: "The outcome of a successful buildup of emotional coordination within an interaction ritual [IR] is to produce feelings of solidarity. The emotions that are ingredients of the IR are transient; the outcome however is a long-term emotion, the feelings of attachment to the group that was assembled at that time" (2005: 108). The average emotional intensity of meetings is negatively correlated with relapse and positively correlated with the six-item index of recovery.

I asked interviewees to describe the level of emotional intensity of the meeting in which they were interviewed (which, for two-thirds of respondents, was their home group). I then asked them whether the level of emotion affected their experience of the meeting and their recovery, more generally. In response, Kaitlin said "Yes, because it shows me that happiness and joy is there and possible, regardless of how I might be feeling." Kathleen unequivocally favored it: "Definitely, the more the better: the more gut-level, the better the experience." Martha expressed appreciation for the full range of emotions at her home meeting: "I think people who are doing well, it's good for me to hear that, people who are having a really hard time, it's good for me to remember that I could be there having a really hard time myself." Helen said emotional expression in meetings helped her feel tied to other members, and related the following story:

> Two Saturdays ago we had… a retread, somebody who was coming back [to OA]. And he had had a heart attack, and he was very upset, he was afraid that OA would not work

> for him. So I think that emotion really set us in helping him find someone who is male and could help him. So that was very emotional. I have cried at meetings when people shared about how they have been picked on through being overweight, losing their fathers, things like that.

So the expression of emotion in meetings appears to enhance identification among group members.

Melissa, a young professional currently taking a break from attending meetings, aptly explained how the expression of emotion affected her recovery:

> It's almost, my experience is a lot stronger and more effective if another person is crying? I definitely feel the support when I am, I feel connected, but there's something about when there's a newcomer or somebody who is really struggling, and they're crying, and everybody else is just so bonded together, and I'm not totally absorbed in my own struggle, it's like we're all bonded in supporting that person. To me that's the most powerful thing. I think especially with someone who is brand new, who's never been, who is totally confused and totally just floating out in the middle of nowhere and feeling like they have no support, they're totally alone, nobody understands, that's when I feel the most emotion, and where I get the most benefit.

In contrast, Jamie commented on the frequency of laughter in her home meeting and the benefit she derived from the modeling of openly sharing emotions.

> I've heard people say, you know, "We're not a glum lot" a lot in that meeting. But I do feel like people also open up and cry …It helps me, especially the crying, because I'm a crier, so when I see other people who are able to express their emotions, it kind of acknowledges for me that that's ok to do, and honestly, most of the time, some of the shares that I find the most inspiring are when people are really just opening up their hearts, and talking about their struggles.

Three interviewees expressed some reservation about emotional shares. Two strongly preferred "positive pitches." Elise, who at the time of our interview was abstinent over a decade with a weighed-and-measured food plan, reported appreciation for emotional expression, however not without reference to the solution:

> I am very emotionally affected by when people are sharing what they are going through, and how program is helping. That can be very emotional, and especially if I've shared that experience, whatever it is they're talking about. I went to an Adult Child [of Alcoholics] meeting once, at least 18 years ago. There was no solution, everybody was

> bleeding in that room. And that is just terrifying. It's like group therapy gone wrong, and that's not what I'm looking for in a meeting. I want some hope.

There is an expression "share the message not the mess", which reminds participants to focus on their experience, but also their strength and hope in meetings.

<u>Additional Factors in Recovery</u>

Willingness

A key ingredient in Twelve-Step recovery, one that is rather difficult to inquire about by survey or in any sort of direct way, is *willingness*. Donovan et al. (2013: 319) noted the major barrier to attendance and engagement in AA may actually be motivation: "Many individuals who are substance dependent view 12-Step groups as helpful resources in the recovery process, but even following treatment, many are ambivalent, fluctuate in their readiness and commitment to change, and question their need for help." John, a long-time member, described his part in laying the foundation for recovery through his willingness:

> But I would also say that I've been able by the grace of god to put myself in a place to get some help, getting sponsorship, being willing to work a very structured program. And, I do believe in higher power, I would concede that higher power has been involved and I've been able to step out and trust in my higher power, which is wound up and combined with trust of people in program, specifically my sponsors.

John found a sponsor who required a daily 6 am phone call and was available every day for two years while they worked together. While he found the process initially uncomfortable, he thought his addiction so strong that he "needed intensive help to get out of it" and greatly appreciated the "intensive accountability and support". Interestingly, individuals I interviewed who were struggling with their food or abstinence defined the problem in terms of their lack of willingness to do the required practical and spiritual Twelve-Step work. Recognizing the difficulty of making radical changes and expending significant effort on

spiritual and moral issues that may seem tangential to abstinence, sponsors often ask their sponsees if they are "willing to be willing," and then work with that.

AA texts focus extensively on the concept of willingness. This relates to the now mainstream idea of "bottoming out". AA's chapter on the first step explains the importance of bottoming out as making one "as open-minded to conviction and as willing to listen as the dying can be" (AA 12&12: 24). The chapter illustrates the necessity of willingness:

> [F]ew people will sincerely try to practice the AA program unless they have hit bottom. For practicing A.A.'s remaining eleven Steps means the adoption of attitudes and actions that almost no alcoholic who is still drinking can dream of taking. Who wishes to be rigorously honest and tolerant? Who wants to confess his faults to another and make restitution for harm done? Who cares anything about a Higher Power, let alone meditation and prayer? Who wants to sacrifice time and energy in trying to carry A.A.'s message to the next sufferer? No, the average alcoholic, self-centered in the extreme, doesn't care for this prospect—unless he has to do these things in order to stay alive himself (AA 12&12: 23).

The simplest expression of this idea was contained in one respondent's answer to my question about what contributed most to her recovery. She answered simply: "pain."

"Exiters" and "Retreads"

For all Twelve-Step fellowships, there is a need to study who leaves and why. AA reports a very high rate of attrition through the first year of participation. The OA members I interviewed who were no longer attending meetings reported a variety of reasons for this. One was overwhelmed by participation in multiple Twelve-Step fellowships and wanted to focus on what he considered his two core programs; another had difficulty establishing abstinence and at some point no longer felt part of the group. Another had stopped working with a sponsor and drifted away in part due to tiring of the very structured abstinence she had been following. Two others simply found that they no longer benefited from attending meetings, though both kept up some of their OA practices.

However, stopping meeting attendance is not necessarily the same as disaffiliation. Tonigan (2008b: 353) reports that research using Project MATCH data showed that "a significant proportion of persons that discontinued AA meeting attendance nevertheless still practiced AA-related principles. Whereas many AA members do reduce the frequency of their attendance at AA and even stop going entirely, they do not relinquish the identity." Of the five OA members in my sample who had stopped attending meetings, all still identified as compulsive eaters (or as having an eating disorder). Three still identified as OA members, and two definitely thought they would at some point resume attendance. Miriam, for example, said:

> But in my mind, I am an OAer, and I believe I will be back. I don't know when, how, but I definitely didn't call it quits. And when one says "I work the program" it usually means there's a structured way to do that, and I don't do that, but I work the program, I apply it in my daily life, I internalized a lot of it.

I asked Jamie, a young woman who could not stop overeating in program and stopped attending, "Now that you've had some distance from it, do you regret the time in OA?" She answered:

> Definitely not. No, I definitely don't regret my time, I think it helped me a lot. One thing that I think it helped is I've been able to feel less shame around the food, I've been able, and partly through my ninth step, I've been able to open up to a lot of people [outside of OA] about the struggles that I have with food.

She also added that she thought OA increased her self-acceptance: it "made me feel a little more comfortable in my body and that people love me for me, it's not about the size of my pants." Finally, as the comments of the above "exiters" suggest, a common membership pattern is cycling in and out of OA. Numerous members in my sample reported such activity. For example, Martha explained: "I did 3 years in 75, went away for 30 years, and have been back six and a half years" (it is more typical for members to be gone no longer than a decade).

Outside Resources

It is important to remember that Twelve-Step recovery does not occur in a vacuum, that eating disorders frequently and mental health issues such as depression frequently co-occur, and that many OA members are likely to have received or be receiving what OA members refer to as "outside help" such as psychotherapy, psychiatric medication, nutritional guidance, and participation in other Twelve-Step fellowships. I asked interview respondents about non-OA things that might have contributed to their recovery. The resources that members most frequently mentioned were mental health therapy, sound knowledge of nutrition, being part of a faith community, participating in Al-Anon, and formal meditation training and practice. Another member talked about the importance of receiving professional eating disorder treatment. Beth attended a treatment center using Twelve-Step principles and upon release began attending OA, where she has remained abstinent from purging. For her, the immersion experience of treatment was essential for becoming abstinent:

> I actually look at people that come in and only do OA and my heart just goes to them, because I actually had it easier I think, because I was in a treatment center for five weeks. So I already had 5 weeks clean. If you're only going to 1 meeting, or 2 meetings, or 3 meetings a week, oh, it's got to be hard. Versus being thrown in and being told, now this is the food you eat. … [W]hile sponsors are fantastic and going through the steps is fantastic, you know, there are times when you need therapy, and you need a therapist.

Harmful Effects?

Twelve-Step programs, including OA, are not without critics. Miller (2008) reevaluated a multi-site Veterans Administration study evaluating twelve-step facilitation and concludes that Twelve Step either has no effect or possibly harms participants. He critiques Twelve-Step processes for labeling as deviant and disempowering individuals, the latter of which might be particularly

harmful for women and minorities. Relatedly, he also critiques the emphasis on culpability found in the moral inventory process of steps 4-9.

Some interviewees reported difficulty with aspects of Overeaters Anonymous. Julie, a decade-long member who vacillated between a very structured and a looser abstinence, opined that the steps can be used against oneself: "I just want to say that I also wonder if there's an abusive piece in Twelve Step, that it's very superego, you know, there's just kind of an abusive piece there. You know, with alcohol, don't drink no matter what. But food is, food is more grey, but I don't know how to be more grey with it."

A member who had left the program by the time of our interview discussed over-identification with the compulsive eater label, such that he only felt part of the group when he was losing or had lost his excess weight. Finally, many members report gaining increased awareness of their addiction, which can cause "slips" or relapse with food to be much more painful to the individual. There is an expression about the effects of no longer having denial that one is a compulsive overeater: "There is nothing worse than a head full of program and a belly full of food." And as a result, engaging in it causes more pain than before program. As a consequence, if someone is unable to get and stay abstinent in OA, they might in some ways be worse off than before.

Conclusion

The two areas in which the highest percentage of respondents in this Pacific Northwest urban sample reported improvement since joining OA are emotional/mental health and spiritual life. This alone strongly suggests the appropriateness of using quality of life measures when assessing 12-Step outcomes. OA's annual survey contained similar findings. At the same time, if OA were Weight Watchers, they might not advertise this fact! While many who attend OA report

having tried Weight Watchers and other "weigh and pay" programs, it is likely that those who end up in Overeaters Anonymous have more severe problems with food (and possibly lower quality of life). Nevertheless, improvements in preoccupation with food (in Twelve-Step language "the mental obsession") and physical health were each reported by about 83% of survey-takers, making them the next most reported areas of improvement.

Many of my findings accord with studies of AOD outcomes, including the importance of frequency of meeting attendance, duration of attendance, aspects of spirituality (including via endorsement of ideology reflecting step work), and social factors. While holding a service position did not retain significance in multivariate models, being a sponsor is undoubtedly a "curative" and protective factor, particularly for those who sponsor frequently and spend more time working with sponsees. In terms of group-level variables, only the emotionality of meetings affected recovery outcomes; the percentage of sponsors in the meeting also appears beneficial to individuals' recovery, but data was not available for the full sample of meetings due to variation in whether meeting formats ask sponsors to announce themselves.

Perhaps most encouraging are aspects of program that correlate with both the multi-faceted recovery index and a more traditional measure of eating disorder recovery. For example, the following variables predict higher scores on both the recovery index but also another outcome: (1) duration of attendance predicts having achieved a healthy weight; (2) frequency of total Twelve-Step meeting attendance predicts decreased relapse frequency; (3) spiritual variables predict greater weight loss; (4) social variables predict greater weight loss; and (5) more emotional meetings decrease the frequency of relapse. While not significant in the model presented for the recovery index due to collinearity with other variables, sponsoring other OA

members predicts greater weight loss, reduced frequency of relapse, and having achieved a healthy weight.

I began this chapter with some statistics on eating disorders and obesity and their costs, as well as the link between eating and mood disorders. There is debate about the seriousness and consequences versus social construction of the increase in overweight and obesity (Patterson and Johnston 2012) and whether one can be addicted to food (Gearhardt et al. 2011), but an arguably reasonable way to evaluate the effectiveness of a treatment modality is to assess changes in participants' quality of life along with their own opinions on the efficacy of the method. There is something about facilitating honest, vulnerable, accepting social connection for people who are profoundly isolated with and by their addiction. This can be seen in the frequency with which members who share their "stories" in meetings start by saying that they cried their way through their first (or first few) meetings.

One frequently hears participants in OA meetings discuss mood disorders and using food to numb themselves or "self-medicate." John, like others in OA, suffers off and on from depression, but with notably severe episodes. He reported:

> My current abstinence is going on seven years and there's been some ups and downs, by the grace of god I've been able to stay abstinent. And I would say my program is fairly strong. I'm not claiming credit for myself, other than enough motivation because I do remember how bad it was, and how I, seven years ago I had real fears of losing my life, either by somehow committing suicide actively or passively or being so depressed I was unable to work or carry on a normal life. And I remember it, very, very well. And so it's worth it for me to put effort into this program.

In response to my asking if there was anything else she would like to tell me about OA, Lindsey responded:

> Well, I don't think I would still be alive without OA. Staying, quote, "sober" in AA, being a food addict, that wasn't going to take me any further with my recovery, because I was an addict with *food.* And for me, the 12 steps are the same no matter what program you go to, but for me, I needed to go and identify with compulsive overeaters

> to get recovery in that area. I was suicidal. I mean, I was ready to go. There was no point in me going on the way I was, as far as I was concerned, even having 12 years of AA sobriety, I was sponsoring, I was sponsored, but the addiction was extremely active, and that makes a miserable, suicidal person.

Such accounts demonstrate the need for multi-faceted indicators of recovery when assessing not only 12-Step, but arguably all modalities of treatment for not only addictions but also a variety of conditions that affect individuals' quality of life.

In all likelihood the causes of Twelve-Step recovery are multi-faceted, vary significantly by individual (and for individuals over time), and involve many circular, reinforcing processes. As Young (2010: 221) recommends, "researchers might occasionally hypothesize relationships among variables as recursive rather than strictly linear." Moos and Timko (2008: 518) offer a well-reasoned summary of the effective ingredients of self-help groups for long-term recovery from substance use disorders:

1) bonds and social support from new relationships;
2) supervision or monitoring (e.g., by a sponsor);
3) "involvement in rewarding activities that do not involve substance use"; and
4) "affiliation with a group that provides a sustained source of hope, inspiration, and self-esteem, such as AA or a religion."

Certainly my findings support ingredients 1, 2, and 4, with the caveat that serving as a sponsor appears to involve accountability to one's sponsees. There is less data on involvement in alternative activities, and based on interview responses to questions about effects on OA members' social lives, there seems less of a need to rearrange one's social network among overeaters than among AOD users (although members who weigh and measure their food without exception report changes in social activities). Nonetheless, social variables—fellowship, number of OA friends one socializes with outside of meetings, and giving and receiving emotional support—clearly enhance recovery.

Future Research

Tonigan (2008b: 352), in his introduction to an impressive edited volume on Alcoholics Anonymous research, summarizes the findings of the chapter by Moos:

> perceived AA group cohesion and supportiveness may be strong curative factors in AA and documented differences between AA groups in cohesiveness suggests that the effectiveness of AA may vary considerably. Such variability in effectiveness is masked in most AA research and may have the net effect of attenuating relationships of interest.

While I currently just control for the fact that my sample is clustered in groups, future analyses will look specifically at group effects, using data from group ("meeting") surveys, structured meeting observations, and several interview questions about the meetings members attend.

In addition, Tonigan (2008a: 352) acknowledges that little research addresses the problem of assessing AA outcome "within the context of a chronic disorder and cyclical AA attendance patterns. He also notes the issue of "disaffiliation". While attendance at meetings generally counts as membership, stopping meeting attendance does not equate to disaffiliation. A significant proportion of Project MATCH participants who "had discontinued AA meeting attendance nevertheless still practiced AA-related principles" (Tonigan 2008b: 353). The ethnographic element of my study allows some consideration of what are termed "retreads" (returning members), as well as those who have consciously stopped attending meetings but consider themselves OA members.

Like most other studies, these analyses have not used measures adequate to capture the complexity and significance of social and spiritual factors in Twelve-Step fellowships. Nonetheless, there were significant findings in support of the role of spirituality in Twelve-Step recovery. For example, the level of spirituality predicted higher scores on the index of recovery. Because the needs of members and the particular aspects of program that work best for them change over time, future analyses will break down the sample by the amount of time one has attended program, and look for differences in which factors work best at which stages.

CHAPTER SIX: CONCLUSION

Addictions and their treatment have not typically been considered in the purview of sociology. This should not be the case with 12 Step, as it involves many foundational issues in the discipline. For example, these voluntary associations involve central issues in political sociology and social movement research such as the opposition versus alignment of group and individual interests and the production of collective goods, along with the formation, maintenance, growth, decline, and dissolution of groups. The management of shame and stigma along with the process and consequences of identification are written about in symbolic interactionism and social psychology. Finally, medical sociologists and network scholars are examining the effects of service and social support on health. In short, 12 Step involves eminently sociological questions.

The sociological relevance of 12-Step fellowships can be seen in the introduction to a volume populated by contributions from leading AOD outcome scholars. Tonigan (2008b: 350) describes the importance of "understanding the active ingredients of AA such as group social dynamics and interpersonal relationships." Similarly, the call by Kurtz (1993) to study 12 Step on its own terms implies the utility of expanding the question of recovery beyond identifying ingredients common to multiple treatment modalities such as self-efficacy, commitment to recovery, and motivation for abstinence.

Key Findings from Each Analysis

Identification as a group member has been shown to predict involvement in and service to the group (Grube and Piliavin 2000; Sturmer et al. 2006). In the 12-Step context, identification has also been shown to increase sobriety (Moos and Timko 2008). In chapter three I examined the antecedents of identification as an OA member. I find that participants with the highest level of OA identification are distinguished by their Twelve-Step cognitions and behaviors. Those who

very strongly identify as an OA member more strongly identify as compulsive overeaters, have internalized OA ideology, have worked more of the 12 steps, and have a sponsor. They attend more emotionally intense meetings and participate in fellowship afterwards.

Concerned with OA as a voluntary association, chapter four exploited a key dimension of difference—the existence of a subset of groups that exact more sacrifices of their members, particularly in terms of abstinence requirements—to explore how costliness affects service to the group. Theories of strictness from sociology of religion (Iannaccone 1992, 1994; Stark and Finke 2000) predict greater participation from members of strict (costly) groups. Accordingly, in multivariate models controlling for demographic characteristics, endorsement of OA ideology, and identification as an OA member, being a current HOW member is associated with a 3-fold increase in the likelihood of holding a service position. HOW members also spend more time sponsoring, controlling for other factors.

Costliness, however, is not only predictive of greater service, it is associated with greater internalization of OA ideology and identification as a compulsive overeater, the single criterion for membership. OA ideology is composed primarily of agreement with statements such as "I have believed my recovery could only come from a power greater than myself." These both are equivalents of belief in 12 Step, and belief is deemed integral to recovery. HOW members, do, in fact, fare better than traditional OA members in terms of reduced relapse and greater weight loss, controlling for having a sponsor, duration of attendance, and step work completed. While costliness may be a deterrent to some, the example of commitment, belief, and recovery (i.e., illustration of the long-term payoff) seen in meetings can mitigate the up-front costs.

In chapter five I explored recovery in Overeaters Anonymous, using a range of operationalizations. The index of recovery reflecting 12-Step expectations indicated

improvement in the following areas: preoccupation with food, physical health, emotional/mental health, spiritual life, family life, and social life. This index was correlated with both frequency of all Twelve-Step meeting attendance, duration of OA attendance, spirituality, internalization of OA ideology, and participation in both more emotional meetings and post-meeting fellowship. Having been sponsored, though marginally significant, also predicted improvement in more areas of recovery.

Many of the variables that predicted improvement in the recovery index also predicted another measure of recovery, whether it was current abstinence, frequency of relapse, amount and direction of weight change, or having achieved a healthy weight. To my knowledge not assessed before, the emotionality of meetings predicted higher scores on the recovery index and less frequent relapse. Some measure of sponsoring other OA members—frequency of being a sponsor or time spent interacting with sponsees per week—predicted all four outcomes. A final interesting finding is that greater indifference to others' troubles is negatively associated with weight loss (though of marginal statistical significance). This accords with one of AA's recovery promises, "We will lose interest in selfish things and gain interest in our fellows," and also with the finding from AOD research that lower levels of interest in others is negatively associated with sobriety (Pagano et al. 2013).

The centrality of sponsoring others to establishing and maintaining physical recovery (regardless of how measured) is an interesting finding not only from a health perspective, but also from an organizational standpoint. Essentially, it provides direct evidence reinforcing a key tenet of 12-Step philosophy, that you have to give it away to keep it, just as Bill Wilson kept his early abstinence by working with Dr. Bob and other early AA members. As Zemore and Pagano (2008: 143) write:

> [T]he encouragement of helping may contribute to AA's continued proliferation not only by sustaining its functionality but by keeping both recipients and helpers sober. … AA's emphasis on helping may have promoted the group's survival as a network and institution over the long passage of time since its inception.

There is precedent for several of this study's findings in AOD outcome research. At the same time, there are certain variables that do not predict recovery as expected. For example, while the frequency of using program tools (doing prescribed program behaviors such as prayer, journaling, and making phone calls) is associated with being currently abstinent, it is *negatively* associated with the number of pounds lost. This finding highlights the difficulty of interpreting the causal direction underlying certain relationships in the quantitative analyses. For example, if someone is not progressing as expected with weight loss, their sponsor will likely tell him or her to pray more, make more phone calls, do more journaling, etc.

While social variables matter, this study did not have the measures to capture the ratio of pro-sobriety versus AOD-using friends in one's network. However, a variable indicating how many of one's five closest friends were OA members was not significant in any models. Three other social variables—the number of OA members one socializes with outside meetings, the exchange of emotional support with OA members, and participation in fellowship after meetings—all improved recovery outcomes. Based on my interview data, while some members developed social relationships with program members, others did not. Very few found that OA limited their social circle due to constricting association with non-12-Step friends. Perhaps large-scale social network change is less necessary for overeaters than AOD users.

In general, there are findings that require additional analysis. For example, identification as a compulsive overeater is clearly an important predictor of identification as an OA member, but also of feeling connected to the group. Identification as an OA member, in turn, is a

predictor of holding a service position and time spent sponsoring. However, the positive correlation between identification as an OA member and both weight loss and the six-item recovery index loses significance in full models. Finally, identification as a compulsive overeater is negatively correlated with having achieved a healthy weight and positively correlated with frequent relapse.

I do not interpret the above findings as identification as a compulsive eater decreasing the odds of recovery, but rather as recovery weakening the overeater identification. Some interview evidence supports this notion, with members with established recovery having difficulty relating to their former level of eating-disordered behavior. Consequently, I expect that the effects of identification as an overeater vary over time. Furthermore, the greater the severity of a respondent's problems with food prior to OA, the higher the likelihood of retaining the overeater identity. Regardless of identification as a compulsive overeater waning with recovery, interview respondents appreciated reminders from newcomers and struggling members about the severity and consequences of the disease, and identified with the emotional shares of individuals still struggling. There is something powerful about making the source of one's shame the source of one's belonging. Even individuals with long-term recovery will refer to people in the rooms as "my tribe" or "my people".

Insights Across Analyses

The functionality of 12-Step ideology merits attention. These fellowships emphasize service (as do many churches), except the focus is first and foremost on helping other addicts. This service ethic, while important for keeping meetings running and attracting and retaining new members, also improves individuals' recovery, as sponsoring keeps members abstinent, losing pounds, and achieving a healthy weight. As such, this is an important instance of a voluntary association

where group and individual interests can align quite well. Under these conditions, it is expected that the individual will increasingly define their interests as one and the same with those of the group.

While it is clear from previous research and the current study that identification is important in 12 Step, it is easier to explain identification processes than identification outcomes. For example, identification as an overeater is OA's membership criterion, and the basis for both relating to others (for newcomers through old-timers) and for identifying as an OA member. While identification as an OA member does not predict holding a service position in this study, it does correlate with more frequent sponsoring over the duration of one's participation. As much as identification as an addict is central to 12-Step ideology, the addict identity appears to fade with recovery. It is likely that the effects of identification as an addict are time variant. Finally, given the importance of emotionality of meetings to both identification processes and recovery outcomes, the factors that are conducive to emotional expression in meetings merit further study.

Given the limitations of cross-sectional data, I have tried to present plausible causal models, those in which there is some reason for confidence that the independent variables are predicting the outcome. However, based on years of observation and this project's interview data, I suspect the relationships between dependent and independent variables are in many instances circular and reinforcing. Specifically, I posit recursive relationships between the following: (1) emotionality of meeting and identification; (2) identification and service; (3) internalization of OA ideology and recovery; and (4) social factors and recovery.

For example, authentic, vulnerable shares help participants in the room relate, and increase identification as an addict. At the same time, greater identification as an addict increases the emotionality of individual shares, and hence the meeting. Identification predicts sponsorship,

but the act of sponsoring makes one feel like an ambassador for the program, and therefore more of a member. In the analyses, internalization of OA ideology predicts recovery. However, based on my own observations, I also think that recovery reinforces the internalization of ideology: the act of recovery provides proof of the validity of 12-Step ideas. Finally, social factors such as participation in fellowship increase recovery. At the same time, this relationship may be partially attributable to the fact that when some members are struggling (not abstinent), they isolate themselves: by making and returning fewer program phone calls, darting out of meetings in order to avoid fellowship, etc.

Finally, in some cases the interviews seemed to align more completely with the 12-Step model than did the survey results. For example, while interviewees almost invariably indicated that working the steps was pivotal to their recovery, survey analyses showed that more steps worked and 9th-step amends made had no bearing on any standard recovery outcomes (though more step work was marginally significantly related to the index of recovery). Similarly, the most frequent source of recovery reported by interviewees was some variant of having a relationship with a higher power, whereas few higher power measures were significant predictors of physical recovery in survey analyses. However, internalization of OA ideology, much of which is about reliance upon a higher power, was significantly correlated with greater weight loss.

It is hard to discern whether this is a reflection of the need for different survey measures, or whether it is simply due to the free-form nature of an interview, which does not restrict respondents to certain answers and allows them to both ask questions and elaborate their responses. Nonetheless, choosing between nine aspects of the OA program, survey respondents

chose a relationship with a higher power as very important to their recovery, second only to meeting attendance.

Study Limitations

As should be expected with 12 Step, regional variations matter. For example, religiosity does not perform in this sample as it does in AOD outcome research, which finds religious individuals more likely to attend and remain in 12-Step fellowships. In this Pacific Northwest sample, religiosity decreases identification as an OA member and is negatively associated with being abstinent. Either this is somehow related to demographic differences between OA and AA/NA, or more likely, it has to do with the relatively low levels of religiosity in this region. According to the 2010 US Religious Census, the Pacific Northwest has two of the three least religious cities in the country, and only 34.6% of Washington state's population are religious adherents, compared to about half of the national population.

While comparability is enhanced due to the similarity between this Pacific Northwest urban OA sample and the larger OA fellowship (see Appendix D), the data collected for this project is not a random sample, as would be preferable. Organizational features of OA, 12-Step traditions, and human subject and ethical considerations make obtaining a random sample impossible. Those who arrived late to meetings and left early were also missed, as my solicitations occurred before and after meetings. Accordingly, it is plausible that my survey may miss the least committed individuals. Additionally, the cross-sectional nature of the data limits my ability to make causal claims. While the interviews help mitigate this problem, it is also important to bear in mind that interviews are retrospective accounts that reflect respondents' current understandings of phenomena. As is well documented, part of the process of 12-Step participation is identifying with fellow addicts both in meetings and in the literature, and

constructing a recovery narrative. Finally, there are a number of questions I would have included in the survey, in hindsight, and will address those now in the section on areas for future research.

Directions for Future Research

While I believe frequency of relapse is a more useful measure, length of current abstinence is a question asked in the OA membership survey and would have provided useful data for comparison. In addition, more data is required on attendance gaps, both in terms of their length and why the member left and returned. To contextualize the measure of current abstinence, I would ask respondents about the presence of current life stressors, since these are frequent precipitants of relapse. Through attendance at several hundred Twelve-Step meetings, I have come to realize the contribution of individual factors to relapse. Accordingly, future research should include questions about the presence of a trauma background, history of family addiction, and mental health issues.

In future analyses, I plan to examine 12-Step-predicted character changes using questions from the National Altruism Survey. For example, many interviewees reported becoming more accepting and less judgmental over time, and I plan to see if this shows up in the survey. Completion of the inventory process through making amends (steps 4-9) should increase both participants' acceptance of and "selfless caring" for others. While the negative relationship between age and recovery outcomes needs to be investigated by examining age-group categories, the positive effect of being male and the negative effect of having higher income also merit further analysis.

In future work, I plan to thoroughly investigate group effects, looking at rates of abstinence, weight loss, sponsorship, and meeting emotionality at the group level and how these

group level averages relate to individual outcomes for attendees. I also plan to analyze organizational characteristics of meetings, such as the degree to which service positions are filled, monthly expenses are met, and contributions are made to the World Service Office, to see how they relate to the characteristics of participants. I also have extensive survey questions to assess members' participation in outside organizations, including the Social Capital Benchmark Survey. Finally, I plan in-depth study of members' higher power constructs and their import for service, identification as a group member, and recovery.

Study Contributions

The current study is noteworthy in several respects. First, I have multi-faceted measures of recovery that together present a fuller picture of improvement in respondents' quality of life, as called for by a consensus panel on AOD treatment (Betty Ford Consensus Panel 2007). The survey also included better measures of social aspects of 12 Step than typically seen in outcome research, including having a partner in recovery, the number of one's 5 closest friends who are OA members, number of OA members one spends time with socially, time spent in such social activity, and of course, participation in fellowship after meetings (Young 2010).

Beyond that, there is a paucity of research on OA. The few published studies of recovery in the fellowship typically involve small numbers of respondents recruited either through snowball sampling or study advertisements, and tend to over-represent the more successful, long-term participants. This is less likely the case in my study, given the variation in time of attendance. In contrast, in AOD outcome research, it has been charged that "long-term recovery has been of little research interest" (Borkman 2008: 22). The range of lengths of OA participation in my study is substantial, hopefully allowing some leverage on both shorter- and longer-term outcomes.

I intended this research to speak to both quantitative AOD outcome research and ethnographic studies of 12 Step, the latter of which frequently emphasize identification processes. The aim was to examine the antecedents and consequences of identification (see chapters three and five, in particular). The interview data collected helps explain some of the survey findings and adds factors omitted in the survey.

Outcome researchers are beginning to note the diversity of individual groups. This study has at least begun to assess this through the case study of the costlier subgroup of HOW meetings relative to traditional OA meetings, as well as through assessing the emotionality of meetings and its effect on participants through different types of data.

In addition to providing analysis of an understudied and frequently misunderstood group, I created a comprehensive and unique data set that reveals some of the inner workings of solidaristic groups that profoundly affect their members. The self-help/mutual aid "movement," of which 12 Step is the largest part, is certainly unique. Many note its emphasis on non-reliance upon professionals, its democratic and anti-bureaucratic nature, and focus on self-empowerment.

Final Thoughts

In conclusion, I return to the questions posed by small-group scholar Robert Wuthnow (1994, 1998). First, are Twelve-Step groups not fostering community? I do not have data to support this claim, instead finding high levels of commitment, intention to participate indefinitely, high levels of service, and social engagement among members outside of meetings. The five individuals I interviewed who had stopped attending meetings did not mention a lack of community or cohesiveness.

It is true that nothing is required in 12 Step, and so the claim that these groups exert only the "weakest of obligations" on members is technically accurate. However, my data contradict

the idea that members' involvement levels are affected by the optional nature of 12-Step activities. And as to the last claim, that 12-Step groups perpetuate self-obsession, my interview data is replete with references to the satisfaction members derive from doing service for others, from giving to the group, and from being part of something larger than oneself. The survey shows high levels of service, and I plan to analyze data on altruism and on involvement in outside (non-12-Step) associations.

In short, study of these groups is important in that they represent a counter-trend to associational decline, arguably due to their democratic, federated structure that grants considerable autonomy to individual groups, to their inclusivity (self-defined membership that is free to all who need it), and to their ideology that promotes service by connecting it to individual recovery. These groups appear rather solidaristic, with variations, of course. Additional study of survey and interview questions on individual meetings is necessary to understand the degree of meeting-level variation.

In OA, it is often said that "we were never meant to do this alone." It is fortuitous for 12-Step fellowships that individual and group interests align in that what helps the individual—service, working with others, and social engagement—helps sustain both new members and the group. This study establishes some truth to that element of OA ideology, and is in line with social science research on health, social networks, and volunteering (Wilson 2000; Smith and Christakis 2008).

Works Cited

2010 U.S. Religion Census: Religious Congregations & Membership Study. Collected by the Association of Statisticians of American Religious Bodies (ASARB) and distributed by the Association of Religion Data Archives (www.theARDA.com).

Abrams, Dominic and Michael A. Hogg. 2004. "Collective Identity: Group Membership and Self-conception." Pp. 147-181 in *Self and Social Identity* edited by M. B. Brewer and M. Hewstone. Malden, MA: Blackwell Publishing, Ltd.

Al-Dakhiel Winklera, Laura, Erik Christiansen, Mia Beck Lichtenstein, Nina Beck Hansen, Niels Bilenberg, and René Klinkby Støvinga. 2014. "Quality of life in eating disorders: A meta-analysis." *Psychiatry Research* 219(1):1–9.

Alcoholic Anonymous. *Memo On Participation Of A.A. Members In Research And Other Non-A.A. Surveys* (Retrieved November 29, 2012 http://www.aa.org/subpage.cfm?page=332)

Alcoholics Anonymous World Services, Inc. 2001. *Alcoholics Anonymous Big Book 4th Edition*.

Alcoholics Anonymous World Services, Inc. 2005. *Twelve Steps and Twelve Traditions.*

American Psychiatric Association. 2014. Retrieved August 18, 2014. (http://www.dsm5.org).

Antze, P. 1976. "The Role of Ideologies in Peer Psychotherapy Organizations: Some Theoretical Considerations and Three Case Studies." *Journal of Applied Behavioral Science* 12:323-346.

Baker, Joseph O. 2010. "Social Sources of the Spirit: Connecting Rational Choice and Interactive Ritual Theories in the Study of Religion." *Sociology of Religion* 71(4):432-456.

Betty Ford Institute Consensus Panel. 2007. "What is Recovery? A Working Definition from the Betty Ford Institute." *Journal of Substance Abuse Treatment* 33:221-228.

Beutler, Larry E., Jasna Jovanovic, and Rebecca E. Williams. 1993. "Process Research Perspectives in Alcoholics Anonymous: Measurement of Process Variables." Pp. 357-377 in *Research on Alcoholics Anonymous: Opportunities and Alternatives* edited by B.S. McCrady and W.R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Borkman, Thomasina. 1999. *Understanding Self-Help/Mutual Aid: Experiential Learning in the Commons.* Rutgers, NJ: Rutgers University Press.

Borkman, Thomasina. 2008. "The Twelve-Step Recovery Model of AA: A Voluntary Mutual Help Association." Pp. 9-35 in *Recent Developments in Alcoholism: Volume 18: Research on Alcoholics Anonymous and Spirituality in Addiction Recovery* edited by M. Galanter and L. A. Kaskutas. New York: Springer.

Bower, Bruce. 1997. "Alcoholics Synonymous," *Science News* 151(4):62-63.

Brown, J. David. 1991. The Professional Ex-: An Alternative for Exiting the Deviant Career," *Sociological Quarterly* 32(2):219-230.

Brown, S. D. 1993. "Therapeutic Processes in Alcoholics Anonymous." Pp. 137-152. In *Research on Alcoholics Anonymous: Opportunities and Alternatives* edited by B.S. McCrady and W.R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Burke, Peter J. 2004. "Identities and Social Structure: the 2003 Cooley-Mead Award Address." *Social Psychology Quarterly* 67:5-15.

Burke, Peter J. and Michael M. Harrod. 2005. "Too Much of a Good Thing?" *Social Psychology Quarterly* 68:359-74.

Cain, Carole. 1991. "Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous." *Ethos* 19(2):210-253.

Center for Disease Control and Prevention. "Overweight and Obesity." Retrieved August 18, 2014. (http://www.cdc.gov/obesity/data/adult.html).

Christakis, N. A. and J. H. Fowler. 2007. "The Spread of Obesity in a Large Social Network Over 32 Years." *New England Journal of Medicine* 357:370-379.

Cloud, Richard N., Craig H. Ziegler, and Richard D. Blondell. 2004. "What is Alcoholics Anonymous Affiliation?" *Substance Use & Misuse* 39(7):1117–1136.

Coleman. 1988. "Social Capital in the Creation of Human Capital," *American Journal of Sociology*, *Supplement* 94: S95–S120.

Collins, Randall. 2005. *Interaction Ritual Chains*. Princeton: Princeton University Press.

Cooper, Zafra and Christopher G. Fairburn. 2009. "Management of Bulimia Nervosa and Other Binge Eating Problems." *Advances in Psychiatric Treatment* 15**:**129-136.

Corporation for National and Community Service 2014. Retrieved August 18, 2014. (www.volunteeringinamerica.gov)

Crow, Scott J., Carol B. Peterson, Sonja A. Swanson, Nancy C. Raymond, Sheila Specker, Elke D. Eckert, and James E. Mitchell. 2009. "Increased Mortality in Bulimia Nervosa and Other Eating Disorders." *American Journal of Psychiatry* 166:1342-1346.

Davis, Caroline. 2013. "Compulsive Overeating as an Addictive Behavior: Overlap Between Food Addiction and Binge Eating Disorder." *Current Obesity Reports* 2(2):171-178.

de la Rie, S. M., Noordenbox, G., & van Furth, E. F. (2005). Quality of Life and Eating Disorders. *Quality of Life Research* 14(6):1511-1522.

Deaux, Kay and Daniela Martin. 2003. “Interpersonal Networks and Social Categories: Specifying Levels of Context in Identity Processes.” *Social Psychology Quarterly* 66(2):101-117.

Denzin, Norman K. 1987. *Treating Alcoholism: An Alcoholics Anonymous Approach*. Thousand Oaks, CA: Sage.

DiClemente, Carlo C. 1993. “Alcoholics Anonymous and the Structure of Change.” Pp. 79-97 in *Research on Alcoholics Anonymous: Opportunities and alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Donovan, Dennis M., Michelle H. Ingalsbe, James Benbow, and Dennis C. Daley. 2013. “12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview.” *Social Work in Public Health* 28(3-4):313-332.

Donovan, Marjorie E. 1984. “A Sociological Analysis of Commitment Generation in Alcoholics Anonymous.” *British Journal of Addiction* 79(4): 411-418.

Durkheim, Emile. 1912. *Elementary forms of the Religious Life.* New York: Free Press.

Eating Disorders Anonymous. 2014. Retrieved on August 18, 2014. (www.eatingdisordersanonymous.org/about.html).

Ellison, Christopher. 1993. “Religion, the Life Stress Paradigm, and the Study of Depression.” Pp. 78-121 in *Religion and Aging and Mental Health: Theoretical Foundations and Methodological Frontiers* edited by J.S. Levin. Thousand Oaks, CA: Sage.

Emrick, Chad D., J. Scott Tonigan, Henry Montgomery, and Laura Little. 1993. “Alcoholics Anonymous: What Is Currently Known?” Pp. 41-76 in *Research on Alcoholics Anonymous: Opportunities and alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Fiorentine, R. and M.P. Hillhouse. 2000. “Exploring the Additive Effects of Drug Misuse Treatment and Twelve-Step Involvement: Does Twelve-Step Ideology Matter?” *Substance Use and Misuse* 35:367-397.

Gearhardt, A. N., S. Yokum, P. T. Orr, E. Stice, W. R. Corbin, and K. D. Brownell. 2011. “Neural Correlates of Food Addiction.” Archive of General Psychiatry. 68(8):808-816.

Greenfield, Brenna L. and J. Scott Tonigan. 2013. “The General Alcoholics Anonymous Tools of Recovery: The Adoption of 12-Step Practices and Beliefs.” *Psychology of Addictive Behaviors* 27(3):553-561.

Greil, Arthur L. and David R. Rudy. 1984. “Social Cocoons: Encapsulation and Identity Transformation Organizations.” *Sociological Inquiry* 54(3):260-278.

Grube, Jean, and Piliavin, Jane A. 2000. “Role-identity, Organizational Experiences, and Volunteer Performance.” *Personality and Social Psychology Bulletin* 26: 1108-1119.

Hertz, Pnina, Moshe Addad, and Natti Ronel. 2012. “Attachment Styles and Changes among Women Members of Overeaters Anonymous Who Have Recovered from Binge-Eating Disorder.” *Health & Social Work* 37(2):110-122.

Hogg, Michael A. 2006. “Social Identity Theory.” in Peter J. Burke, ed., *Contemporary Social Psychological Theories*. Stanford: Stanford University Press.

Howard, Jenna. 2006. “Expecting and Accepting: The Temporal Ambiguity of Recovery Identities.” *Social Psychological Quarterly* 69(4):307-324.

Iannaccone, Laurence R. 1992. “Sacrifice and Stigma: Reducing Free-Riding in Cults, Communes, and Other Collectives.” *The Journal of Political Economy* 100(2):271-291.

Iannaccone, Laurence R. 1994. “Why Strict Churches Are Strong.” *American Journal of Sociology* 99(5):1180-1211.

Irvine, Leslie. 1999. *Codependent Forevermore: The Invention of Self in a Twelve Step Group.* Chicago: University of Chicago Press.

Jensen, George H. 2000. *Storytelling in Alcoholics Anonymous: A Rhetorical Analysis*. Carbondale: Southern Illinois University Press.

Johnson, Jennifer E., John W. Finney, Rudolf H. Moos. 2006. “End-of-Treatment Outcomes in Cognitive-Behavioral Treatment and 12-Step Substance Use Treatment Programs: Do They Differ and Do They Predict 1-Year Outcomes?” *Journal of Substance Abuse Treatment* 31:42-50.

Kahn, Sheira. 2009. “Why Overeater's Anonymous Doesn't Work.” *The Therapist*. Nov/Dec:71.

Kanter, Rosebeth Moss. 1972. *Commitment and Community*. Cambridge, MA: Harvard University Press.

Kaskutas, Lee Ann, Jason Bond, and Keith Humphreys. 2002. “Social Networks as Mediators of the Effect of Alcoholics Anonymous.” *Addiction* 97: 891-900.

Keel, Pamela K., David J. Dorer, Debra L. Franko, Safia C. Jackson, and David B. Herzog. 2005. “Postremission Predictors of Relapse in Women With Eating Disorders.” *The American Journal of Psychiatry* 162(12):2263-2268.

Kelly, John and R. Moos. 2003. “Dropout from 12-Step Self-Help Groups: Prevalence, Predictors, and Counteracting Treatment-Related Effects.” *Journal of Substance Abuse Treatment* 24:241-250.

Kelly, John F. and M. Claire Greene. 2013. “The Twelve Promises of Alcoholics Anonymous: Psychometric Measure Validation and Mediational Testing as a 12-Step Specific Mechanism of Behavior Change.” *Drug and Alcohol Dependence* 133:633-640.

Kelly, John F., Bettina Hoeppner, Robert L. Stout, and Maria Pagano. 2011. “Determining the

Relative Importance of the Mechanisms of Behavior Change Within Alcoholics Anonymous: A Multiple Mediator Analysis." *Addiction* 107:289-299.

Kelly, John F., Robert L. Stout, and Valerie Slaymaker. 2013. "Emerging Adults' Treatment Outcomes in Relation to 12-Step Mutual-Help Attendance and Active Involvement." *Drug and Alcohol Dependence* 129(1/2):151-157.

Kelly, John F., Robert L. Stout, Molly Magill, J. Scott Tonigan, and Maria E. Pagano. 2011. "Spirituality in Recovery: A Lagged Mediational Analysis of Alcoholics Anonymous' Principal Theoretical Mechanism of Behavior Change." *Alcoholism: Clinical and Experimental Research* 35(3):454-463.

Kelly, John Francis, Molly Magill, and Robert Lauren Stout. 2009. "How do People Recover from Alcohol Dependence? A Systematic Review of the Research on Mechanisms of Behavior Change in Alcoholics Anonymous." *Addiction Research and Theory* 17(3):236–259.

Klump, Kelly L., Cynthia M. Bulik, Walter H. Kaye, Janet Treasure, and Edward Tyson. 2009. "Academy for Eating Disorders Position Paper: Eating Disorders Are Serious Mental Illnesses." *International Journal of Eating Disorders* 42(2):97-103.

Knoke, David. 1990. *Organizing for Collective Action: The Political Economies of Associations*. New York: Aldine de Gruyter.

Kriz, Kerri-Lynn Murphy. 2002. "The Efficacy of Overeaters Anonymous in Fostering Abstinence in Binge-Eating Disorder and Bulimia Nervosa." PhD dissertation, Virginia Polytechnic Institute and State University, Falls Church, Virginia.

Kurtz, Ernest. 1993. "Research on Alcoholics Anonymous: The Historical Context." Pp. 13-26 in *Research on Alcoholics Anonymous: Opportunities and alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Kurtz, Linda Farris. 1993. *Self-Help and Support Groups: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications.

Lenoir, Magalie, Fuschia Serre, Lauriane Cantin, and Serge H. Ahmed. 2007. "Intense Sweetness Surpasses Cocaine Reward." *PLoS ONE* 2(8):e698.

Levitan, Robert D. and Caroline Davis. 2010. "Emotions and Eating Behaviour: Implications for the Current Obesity Epidemic." *University of Toronto Quarterly* 79(2):783-799.

Magura, Stephen, Alexandre B. Laudet, Daneyal Mahmood, Andre Rosenblum, Howard S. Vogel, and Edward L. Knight. 2003. "Role of self-help processes in achieving abstinence among dually diagnosed persons." *Addictive Behaviors* 28(3):399-414.

Majer, J. M., Droege, J. R., and Jason, L. A. 2012. "Coping Strategies in 12-Step Recovery: More Evidence for Categorical Involvement." *Journal Of Groups In Addiction & Recovery* 7(1):3-14.

Mäkelä, Klaus, Ilkka Arminen, Kim Bloomfield, Irmgard Eisenbach-Bergmark, Noriko Kurube, Nicoletta Mariolini, Hildigunnur Ólafsdóttir, John H. Peterson, Mary Phillips, Jürgen Rehm, Robin Room, Pia Rosenqvist, Haydée Rosovsky, Kerstin Stenius, Grazyna Swiatkiewicz, Bohdan Woronowicz, Antoni Zielínski. 1996. *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*. Madison, WI: University of Wisconsin Press.

Malenbaum, R., Herzog, D., Eisenthal, S., and Wyshak, G. 1988. "Overeaters Anonymous: Impact on Bulimia." *International Journal of Eating Disorders* 7(1):139-143.

Manning, Victoria, David Best, Nathan Faulkner, Emily Titherington, Alun Morinan, Francis Keaney, Michael Gossop, and John Strang. 2012. "Does Active Referral by a Doctor or 12-Step Peer Improve 12-Step Meeting Attendance? Results from a Pilot Randomised Control Trial." *Drug and Alcohol Dependence* 126:131-137.

Marshall, Douglas A. 2002. "Behavior, Belonging, and Belief: A Theory of Ritual Practice." *Sociological Theory* 20(3):360-380.

McBride, Michael. 2007. "Why Churches Need Free-riders: Religious Capital Formation and Religious Group Survival." *University of California Irvine Department of Economics Working Paper* 06-07-22.

McIntosh, J. and N. McKeganey. 2000. "Addicts Narratives of Recovery from Drug Use: Constructing a Non-Addict Identity." *Social Science and Medicine* 50:1501-1510.

Miller, John Clark. 2008. "12-Step Treatment for Alcohol and Substance Abuse Revisited: Best Available Evidence Suggests Lack of Effectiveness or Harm." *International Journal of Mental Health Addiction* 6:568-576.

Minnick, A. M. 1997. *Twelve Step Programs: A Contemporary American Quest for Meaning and Spiritual Renewal*. Westport, CN: Praeger Publishers.

Montgomery, Henry A. 1994. "General AA Tools of Recovery (GAATOR 2.1)." Retrieved October 6, 2013 (http://www.helpingotherslivesober.org/documents/studymeasures/GAATOR_final.pdf)

Moos, Rudolf H. and Bernice S. Moos. 2006. "Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals." *Journal of Clinical Psychology.* 62(6):735-750.

Moos, Rudolf, and Christine Timko. 2008. "Outcome Research on twelve-step and Other Self-Help Programs." Pp. 511-521 in *Textbook of Substance Abuse Treatment* 4th Ed. Edited by M. Galanter and H. D. Kleber. Washington, D.C.: American Psychiatric Press.

Morgenstern, Jon, Erich Labouvie, Barbara S. McCrady, Christopher W. Kahler, and Ronni M. Frey. 1997. "Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action." *Journal of Consulting and Clinical Psychology* 65(5):768-777.

Musick, Marc A. and John Wilson. 2008. *Volunteers: A Social Profile*. Bloomington: Indiana University Press.

Nowinski, Joseph. 1993. "Questioning the Answers: Research and the AA Traditions." Pp. 27-40 in *Research on Alcoholics Anonymous: Opportunities and alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

OA H.O.W. 2014. Retrieved on August 18, 2014. (oahow.org).

OA Mid-Peninsula 2014. *The HOW Concept*. Retrieved on August 18, 2014. (http://www.oamidpeninsula.org/about/sponsoring/how-concept/)

Ogborne, Alan C. 1993. “Assessing the Effectiveness of Alcoholics Anonymous in the Community: Meeting the Challenges.” Pp. 339-355 in *Research on Alcoholics Anonymous: Opportunities and alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Ogden C. L., M. D. Carroll, B. K. Kit, and K. M. Flegal. 2014. “Prevalence of Childhood and Adult Obesity in the United States, 2011-2012.” *Journal of the American Medical Association* 311(8): 806-814.

O’Reilly, Edmund B. 1997. *Sobering Tales: Narratives of Alcoholism and Recovery*. University of Massachusetts Press.

Overeaters Anonymous. 2014a. Retrieved on August 18, 2014. (www.oa.org).

Overeaters Anonymous. 2014b. Retrieved on August 18, 2014. (http://www.oa.org/newcomers/what-you-can-expect-at-an-oa-meeting).

Overeaters Anonymous. 2014c. Retrieved on August 18, 2014.(http://www.oa.org/pdfs/member_survey.pdf)

Overeaters Anonymous, Inc. 2002. *The Twelve Steps and Twelve Traditions of Overeaters Anonymous.* Rio Rancho, New Mexico: Overeaters Anonymous.

Pagano, Maria E., Karen B. Friend, J. Scott Tonigan, and Robert L. Stout. 2004. “Helping Other Alcoholics in Alcoholics Anonymous and Drinking Outcomes: Findings from Project MATCH.” *Journal of Studies on Alcohol* 65:766–773.

Pagano, Maria E., Stephen G. Post, and Shannon M. Johnson. 2010. “Alcoholics Anonymous-Related Helping and the Helper Therapy Principle.” *Alcoholism Treatment Quarterly* 29(1):23-34.

Pagano, Maria E., William L. White, John F. Kelly, Robert L. Stout, and J. Scott Tonigan. 2013. “The 10-Year Course of Alcoholics Anonymous Participation and Long-Term Outcomes: A Follow-Up Study of Outpatient Subjects in Project MATCH.” *Substance Abuse* 34(1):51-59.

Patterson, Matt, and Josée Johnston. 2012. “Theorizing the Obesity Epidemic: Health Crisis, Moral Panic and Emerging Hybrids.” *Social Theory & Health* 10:265–291.

Penner, Louis A. 2002. “Dispositional and Organizational Influences on Sustained Volunteerism: An Interactionist Perspective.” *Journal of Social Issues* 58(3):447-467.

Penner, Louis A., and Marcia A. Finkelstein. 1998. “Dispositional and Structural Determinants of Volunteerism.” *Journal of Personality and Social Psychology* 74:525-537.

Putnam, Robert D. 1995. “Bowling Alone: America’s Declining Social Capital.” *Journal of Democracy* 6(1):65-78.

Putnam, Robert D. 2000. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

Rappaport, Julian. 1993. “Narrative Studies, Personal Stories, and Identity Transformation in the Mutual Help Context.” *Journal of Applied Behavioral Science* 29(2):239-56.

Rapping, Elayne. 1996. *The Culture of Recovery: Making Sense of the Self-Help Movement in Women's Lives*. Boston: Beacon Press.

Reissman, Frank. 1965. “The ‘Helper Therapy’ Principle.” *Social Work* 10:27-32.

Reissman, Frank and David Carroll. 1995. *Redefining Self-Help: Policy and Practice*. San Francisco, CA: Jossey-Bass Publishers.

Reith, Gerda and Fiona Dobbie. 2012. “Lost in the Game: Narratives of Addiction and Identity in Recovery from Problem Gambling.” *Addiction Research and Theory* 20(6):511-521.

Ronel, Natti and Galit Libman. 2003. “Eating Disorders and Recovery: Lessons from Overeaters Anonymous.” *Clinical Social Work Journal* 31(2):155-171.

Room, Robin. 1993. “Alcoholics Anonymous as a Social Movement.” Pp. 167-187 in *Research on Alcoholics Anonymous: Opportunities and Alternatives* edited by B. S. McCrady and W. R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Rorty, Marcia, Joel Yager, and Elizabeth Rossotto. 1993. “Why and How Do Women Recover from Bulimia Nervosa? The Subjective Appraisals of Forty Women Recovered for a Year or More.” *International Journal of Eating Disorders* 14(3):249-260.

Rudy, David R. 1986. *Becoming Alcoholic: Alcoholics Anonymous and the Reality of Alcoholism*. Carbondale, IL: Southern Illinois University Press.

Rudy, David R. and Arthur L. Greil. 1987. "Taking the Pledge: The Commitment Process in Alcoholics Anonymous." *Sociological Focus* 20:45-59.

Russell-Mayhew, Shelly, Kristin M. von Ranson, and Philip Masson. 2010. “How does overeaters anonymous help its members? A qualitative analysis.” *European Eating*

Disorders Review 18(1):33-42.

Scheitle, Christopher P. and Amy Adamczyk. 2010. "High-Cost Religion, Religious Switching, and Health." *Journal of Health and Social Behavior* 51(3):325-342.

Schelling, Thomas C. 1978. "Egonomics, or the Art of Self-Management." *American Economic Review* 68(2):290-294.

Skocpol, Theda. 2003. *Diminished Democracy: From Membership to Management in American Civic Life*. Norman, OK: University of Oklahoma Press.

Smith, Christian, Michael Emerson, Sally Gallagher, Paul Kennedy, and David Sikkink. 1998. *American Evangelicalism: Embattled and Thriving*. Chicago: University of Chicago Press.

Smith, Kirsten P. and Nicholas A. Christakis. 2008. "Social Networks and Health." *Annual Review of Sociology* 34:405-429.

Smith, Delia E. Marsha D. Marcus, Cora E. Lewis, Marian Fitzgibbon, and Pamela Schreiner. 1998. "Prevalence of Binge Eating Disorder, Obesity, and Depression in a Biracial Cohort of Young Adults." *Annals of Behavioral Medicine* 20(3):227-232.

Stark, Rodney and Roger Finke. 2000. *Acts of Faith: Explaining the Human Side of Religion*. Berkeley: University of California Press.

Stuhldreher, Nina, Alexander Konnopka, Beate Wild, Wolfgang Herzog, Stephan Zipfel, Bernd Löwe, Hans-Helmut König. 2012. "Cost-of-Illness Studies and Cost-Effectiveness Analyses in Eating Disorders: A Systematic Review." *International Journal of Eating Disorders* 45(4):476-491.

Sturm, R. 2002. "The Effects of Obesity, Smoking, and Problem Drinking on Chronic Medical Problems and Health Care Costs." *Health Affairs* 21(2):245-253.

Stürmer, Stefan, Bernd Simon, and Michael I. Loewy. 2008. "Intraorganizational Respect and Organizational Participation: The Mediating Role of Collective Identity." *Group Processes and Intergroup Relations* 11(1):5–20.

Swora, Maria Gabrielle. 2001. "Narrating Community: The Creation of Social Structure in Alcoholics Anonymous Through the Performance of Autobiography." *Narrative Inquiry* 11(2):363–384.

The H.O.W. Concept. Retrieved March 2, 2013 (http://www.scn.org/oahow/howcon.txt)

Tocqueville, Alexis de. 2000. *Democracy in America*, translated by Harvey Mansfield and Delba Winthrop. Chicago: University of Chicago Press.

Tonigan, J. Scott. 2008a. "Alcoholics Anonymous Outcomes and Benefits." Pp. 357-372 in *Recent Developments in Alcoholism. Vol. 18, Research on Alcoholics Anonymous and*

Spirituality in Addiction Recovery edited by M. Galanter and L.A. Kaskutas. Totowa, NJ: Springer.

Tonigan, J. Scott. 2008b. “Introduction.” Pp. 349-355 in *Recent Developments in Alcoholism: Research on Alcoholics Anonymous and Spirituality in Addiction Recovery* edited by M. Galanter and L. A. Kaskutas. Totowa, NJ: Springer.

Tonigan, J. Scott, and W. R. Miller. 2005. “AA Practicing Subtypes: Are There Multiple AA Fellowships?” *Alcoholism: Clinical and Experimental Research* 29:384.

Tonigan, J. Scott, W. R. Miller, and Carol Schermer. 2002. “Atheists, Agnostics and Alcoholics Anonymous.” *Journal of Studies on Alcohol* 63:534-541.

van Deth, Jan W., and Sonja Zmerli. 2010. "Introduction: Civicness, Equality, and Democracy--A "Dark Side" of Social Capital?" *American Behavioral Scientist* 53(5):631-639.

von Ranson, Kristin M. and Stephanie E. Cassin. 2007. “Eating Disorders and Addiction: Theory and Evidence.” Pp. 1-37 in *Eating Disorders and Weight Loss Research, edited by J. S. Rubin.*

Wasson, Diane H., and Mary Jackson. 2004. “An Analysis of the Role of Overeaters Anonymous in Women’s Recovery from Bulimia Nervosa.” *Eating Disorders* 12(4):337-356.

Westphal, Vernon K. and Jane Ellen Smith. 1996. “Overeaters Anonymous: Who Goes and Who Succeeds?” *Eating Disorders: The Journal of Treatment and Prevention* 4(2):160-170.

White, William L. 2007. “Addiction Recovery: Its Definition and Conceptual Boundaries.” *Journal of Substance Abuse Treatment* 33(3):229-241.

Wilcox, Danny M. 1998. *Alcoholic Thinking: Language, Culture, and Belief in Alcoholics*

Wilfley, D. E., R. R. Welch, R. I. Stein, E. B. Spurrell, L. R. Cohen, B. E. Saelens. 2002. “A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy For The Treatment of Overweight Individuals with Bingeeating Disorder.” *Archives of General Psychiatry* 59:713–721.

Wilson, G.T. 1991. “The Addiction Model of Eating Disorders: A Critical Analysis.” *Advances in Behavior Research and Therapy* 13:27-72.

Wilson, John. 2000. “Volunteering.” *Annual Review of Sociology* 26:215-240.

Witbrodt, Jane and Lee Ann Kaskutas. 2005. “Does Diagnosis Matter? Differential Effects of 12-Step Participation and Social Networks on Abstinence.” *The American Journal of Drug and Alcohol Abuse* 31(4):685-707.

World Health Organization. 2014. “Obesity and Overweight.” Fact Sheet Number 311. Reviewed May 2014. Retrieved on July 20, 2014. (http://www.who.int/mediacentre/factsheets/fs311/en/)

Wuthnow, Robert. 1994. *Sharing the Journey: Support Groups and America's New Quest for Community.* New York, NY: The Free Press.

Wuthnow, Robert. 1998. *Loose Connections: Joining Together in America's Fragmented Communities*. Cambridge, MA: Harvard University Press.

Young, Lance Brendan. 2011. "Alcoholism and Identity: How an Alternative Framing of Identity Can Facilitate Alcoholics Anonymous Research." *Addiction Research and Theory* 19(3):213-223.

Zemore, Sarah E., L. A. Kaskutas, and L. N. Ammon. 2004. "In 12-Step Groups, Helping Helps the Helper." *Addiction 99*:1015-1023.

Zemore, Sarah E., Meenakshi Subbaraman, and J. Scott Tonigan. 2013. "Involvement in 12-Step Activities and Treatment Outcomes." *Substance Abuse* 34(1):60-69.

APPENDICES

Appendix A: The 12 Steps & 12 Traditions of Overeaters Anonymous

The 12 Steps
1. We admitted we were powerless over food—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to overeaters, and to practice these principles in all our affairs.

The 12 Traditions
1. Our common welfare should come first; personal recovery depends upon O.A. 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 O.A. membership is a desire to stop overeating.
4. Each group should be autonomous except in matters affecting other groups or O.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An O.A. group ought never endorse, finance, or lend the O.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every O.A. 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. O.A., 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 O.A. 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, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Appendix B: Overeaters Anonymous Tools of Recovery

In working Overeaters Anonymous' twelve-step program of recovery from compulsive overeating, we have found a number of tools to assist us. We use these tools regularly to help us achieve and maintain abstinence and recover from our disease.

A Plan of Eating
Sponsorship
Meetings
Telephone
Writing
Literature
Action Plan
Anonymity
Service

In Overeaters Anonymous (OA), the Statement on Abstinence and Recovery is "Abstinence is the action of refraining from compulsive eating and compulsive food behaviors while working towards or maintaining a healthy body weight. Spiritual, emotional and physical recovery is the result of living the Overeaters Anonymous twelve-step program." Many of us have found we cannot abstain from compulsive eating unless we use some or all of OA's nine tools of recovery to help us practice the Twelve Steps and Twelve Traditions.

(Retrieved on August 20, 2014 from: http://www.oa.org/newcomers/tools-of-recovery/)

Appendix C: Memo on Participation of Alcoholics Anonymous Members in Research and Other Non-A.A. Surveys

Since the early days of our fellowship, the participation of A.A. members in research and surveys has been sought and has occurred. In recent years there has been an escalation of concerns about alcoholism in all parts of our society. As a result, A.A. can expect that requests for participation in research may increase.

In general, within A.A. there is a favorable attitude toward research. As Bill W. wrote, "Today the vast majority of us welcome any new light that can be thrown on the alcoholic's mysterious and baffling malady. We welcome new and valuable knowledge, whether it be issues from a test tube, from a psychiatrist's coach or from revealing social studies." Historically, participation has been worked out on a case by base basis.

Some of the attempts to cooperate have led to strained relationships while more have been successful, mutually satisfying, and produced new insights.

How A.A. members might cooperate with research has been discussed by the trustees' Committee on Cooperation with the Professional Community. At the suggestion of the committee, we offer this memo both to those who would solicit the participation of A.A. members in research and to those A.A. members who will be approached about such requests.

1. The best research between A.A. members and researchers have been those in which the researcher has become thoroughly familiar with the fellowship before making inquiry about participation. At the same time, the A.A. members would be involved have gotten to know the researcher so that they trusted him or her, and have been convinced of the researcher's commitment, competence, integrity, and respect for the Traditions of A.A. The investigator has been forthright in giving the A.A. members all the information about his or her research which they needed in order to make an informed decision about it.

2. For A.A. members, cooperating with a researcher and being part of a research program raises most of the same problems as cooperating with any other non-A.A. profession; or engaging in any other non-A.A. undertaking. The problems are amenable to the same kind of solutions. See "How A.A. Members Cooperate With Other Community Efforts to Help Alcoholics" and the C.P.C. Workbook. As long as there is frank communication and attitudes of openmindedness and flexibility, it has proved possible to work out ways of participating in research which does not require A.A. members to compromise A.A.'s Traditions and which permit the researcher to arrive at valid findings.

3. The researcher should be aware that central offices in A.A. cannot offer the kinds of assistance he or she may be used to from the headquarters of other organizations, e.g. access to records, endorsements, etc. However, the researcher may receive some help from the General Service Office, intergroup offices, and local office of other kinds.
(1) Individuals in these offices may be willing to give the researcher their opinion about the project and about its feasibility.

(2) Literature can be provided which will prove helpful to the researcher in understanding A.A. members, what it is, what it can and cannot do, as well as on how A.A. members cooperate with non-A.A. undertakings.
(3) A copy of this memo can be provided.

4. Decisions about whether or not to cooperate in research are always made at the local level where the research will occur. Almost always the request for participation has been made to individual A.A. members who have then sought the cooperation of other members. In rare instances the request has been made to a group. When A.A. members have decided to cooperate, it has been in their capacity as private citizens.

5. Those individuals approached about cooperation will want to make an informed judgment about whether to participate and about whether to seek the participation of others. Indeed, with the increased requests for research cooperation, it is necessary that selection take place. Some of the questions the individual might have are: what is being studies, by whom, why and how; who will carry out the research at the local level; what will cooperation involve, e.g. interviews, questionnaires, amount of time; who will evaluate the findings; who will use the findings for what purpose; in light of A.A. traditions, is cooperation possible; what arrangements are made to ensure anonymity, etc.

6. A.A. is concerned solely with the personal recovery and continued sobriety of alcoholics who turn to the Fellowship for help. Meetings are devoted exclusively to the A.A. program. No research which could interfere with this goal could be tolerated. Some groups have permitted questionnaires or interviews to occur after meetings provided that participation is on a purely, voluntary basis. Some members look upon research participation as one way of pursuing the above mentioned goal, as using their experience to contribute to log-term solutions for alcoholism. Many more will define it as a distraction from Twelfth Step work, which they define in immediate personal terms.

7. A.A. and its members are particularly concerned with anonymity. While most researchers are skilled at ensuring anonymity to subjects, A.A.'s concerns may raise some unique issues. For example, as no one A.A. can break the anonymity of another, there may be some ticklish issues in soliciting cooperation from others. Some research procedures may also require extra precautions to be taken, e.g. when data are stored in computers, when granting agencies require consent to participate forms, etc.

And, a final note from Bill W. about cooperation with non-Alcoholics working to resolve the problems of alcoholism, "So let us work alongside all these projects of promise to hasten the recovery of those millions who have not yet found their way out. These varied labors do not need our special endorsement, they need only a helping hand when, as individuals, we can possible give it."

We welcome additional information from researchers and from members of A.A. who have our experience to share or comments to make.

(Retrieved on July 30, 2014 from: http://www.aa.org/assets/en_US/smf-143_en.pdf)

Appendix D: Comparison of Sample with OA Fellowship

	Pacific NW City OA Sample (2011-2012)	**2010 OA Fellowship Sample**[14]
Race/ethnicity	90% white; 4% Hispanic; 3% Asian; 3% black	[*US only*:] 93% white; 3% black; 1% Hispanic; .5% Asian
Sex	85% female; 15% male	87% female; 13% male
Age	18 or under = 0% 19-25= 4% 26-35 = 12% 36-45 = 23.5% 46-55 = 20% 56-65 = 30.2% Over 65 = 10%	18 or under = 0.4% 19-25= 2% 26-35 = 10% 36-45 =17% 46-55 =25.6% 56-65 = 29% Over 65 = 16%
Relationship Status	married/domestic partner 44%; divorced/separated 21%; single 31%	married 48%; divorced/separated 16%; single 22%; other 14%
Length of OA attendance	< 1 year 23.3% 1-2 years 11.3% 3-5 years 14% 6-10 years 14% 10+ years 37.3%	< 1 year 15.6% 1-2 years 12.9% 3-5 years 12.4% 6-10 years 16.1% 10+ years 43%
Problem with food	96% strongly or very strongly identify as compulsive overeater; 18% strongly or very strongly identify as bulimic; 5% strongly or very strongly identify as anorexic	compulsive (over)eater 95%; bulimic 16%; anorexic 9%
Education (highest level)	high school 3%; college 32%; grad/professional degree 36%	high school 10%; college 27%; grad/ professional degree 32%
Have lost weight since joining OA	69%	66%
Pounds lost since joining OA	40 pounds	45 pounds
Currently maintaining a healthy weight	49%	51%

[14] OA reports the following concerning its survey methodology: "2,400 surveys were mailed to 700 randomly selected groups for random distribution to group members in the following countries: United States, Canada, Mexico, Argentina, Colombia, Costa Rica, Guatemala, Venezuela, Spain, France, Germany, Austria, England, Ireland, Scotland, Australia, New Zealand and Israel. Average return rate was 36 percent. Margin of error is 4.09 percent" (2010 Membership Survey Report, Overeaters Anonymous).

Appendix E: Interviewee Characteristics

Respondent	Age	Time attended OA	Degree affected by food problems before OA	Have a sponsor	Sex	Income	Relationship Status	Education	Top Step Completed
Abigail	25	2 years	very	now	female	$50 to < $75k	relationship	associate’s	12
Alana	37	5.75 years	very	now	female	$25 to < $50k	single	graduate or professional	12
Angela	68	16 years	severely	now	female	$100 to < $150k	single	bachelor's	6
Arlene	51	19.5 years	very	now	female	$25 to < $50k	relationship	graduate or professional	12
Beth	56	4.5 years	severely	in the past	female	more than $200k	single	graduate or professional	12
Bill	46	12 years	severely	now	male	$75 to < $100k	single	some graduate school	12
Cecilia	65	41 years	very	in the past	female	less than $25k	single	some college	12
Chloe	41	19.5 years	severely	in the past	female	less than $25k	no response	graduate or professional	12
Cindy	63	7 years	moderately	in the past	female	less than $25k	single	bachelor's	0
Elaine	60	21 years	very	now	female	$100 to < $150k	relationship	graduate or professional	5
Elise	65	16.17 years	severely	now	female	$25 to < $50k	single	some graduate school	12
Ellen	57	3 months	very	now	female	$50 to < $75k	single	graduate or professional	3
George	35	2.17 years	severely	now	male	$50 to < $75k	single	vocational or technical	5
Helen	66	24 years	very	now	female	$50 to < $75k	single	graduate or professional	9
Jamie	30	2 years	very	now	female	$50 to < $75k	single	bachelor’s	9
Jill	57	17 years	moderately	now	female	$50 to < $75k	relationship	graduate or professional	11
John	62	13 years	severely	now	male	$25 to < $50k	single	bachelor’s	12
Julie	57	10 years	moderately	in the past	female	$100 to < $150k	relationship	some college	5
Kathleen	42	10 years	severely	now	female	less than $25k	single	bachelors	12
Kim	57	3 years	very	now	female	less than $25k	single	bachelor's	3
Linda	56	1.1 years	severely	now	female	$50 to < $75k	single	graduate or professional	8
Lindsey	41	7.5 years	severely	now	female	$75 to < $100k	relationship	bachelor’s	12
Martha	64	4.5 years	moderately	now	female	$50 to < $75k	relationship	bachelor’s	12
Maureen	64	22.5 years	severely	now	female	$25 to < $50k	single	graduate or professional	12
Melissa	37	1.67 years	severely	in the past	female	$75 to < $100k	single	bachelor’s	7
Miriam	65	6.5 years	very	in the past	female	$50 to < $75k	relationship	graduate or professional	8
Peggy	39	5 years	severely	now	female	$75 to < $100k	single	graduate or professional	12
Sarah	58	36.67 years	severely	now	female	less than $25k	relationship	bachelor’s	12
Susan	75	6 months	severely	now	female	$50 to < $75k	relationship	graduate or professional	0
Tina	62	32 years	severely	in the past	female	$75 to < $100k	relationship	graduate or professional	12

Appendix F: Participant Survey

Questions about Your Involvement with OA

The following questions relate to your participation in OA, how you work your program, etc. The questions are not intended to indicate how you should or should not work your program. If you have questions about that, please ask your sponsor or a program member.

1. **How long have you been attending OA? _____________**

2. **Please describe the degree to which you were affected by your problems with food when you first started OA.**
   - ❑ severely affected
   - ❑ very affected
   - ❑ moderately affected
   - ❑ only a little affected
   - ❑ not affected at all

3. **Please indicate if you were encouraged to attend OA by any of the following.** *Check all that apply.*
   - ❑ friend/family member/coworker
   - ❑ doctor/nurse/counselor/clergy
   - ❑ current OA member
   - ❑ member of another 12-Step program
   - ❑ none of the above

4. **Have you ever followed the OA "HOW" program?**
   - ❑ yes
   - ❑ no ☞ **SKIP to 6**
   - ❑ don't know ☞ **SKIP to 6**

5. **Do you currently follow the HOW program?**
   - ❑ yes
   - ❑ no

6. **Please describe your current or most recent abstinence.** If you have not defined an abstinence, write "None" and ☞ **SKIP to 8** ________________________________

7. **Are you currently abstinent?**
   - ❑ yes
   - ❑ no

8. **Since beginning OA, have you experienced relapse?**
   - ❑ frequently
   - ❑ somewhat frequently
   - ❑ rarely
   - ❑ never

9. **Indicate which, if any, of the following areas have seen improvement since you joined OA.** *Check all that apply.*
   - ❑ emotional/mental health
   - ❑ spiritual life
   - ❑ preoccupation with food
   - ❑ family life
   - ❑ physical health
   - ❑ social life

10. **Please indicate how your <u>current</u> weight compares to your weight when you <u>first joined</u> OA.**
   - ❑ my weight is about the same as when I first joined ☞ **SKIP to 12**
   - ❑ my weight has decreased
   - ❑ my weight has increased

11. **Approximately <u>how many pounds</u> does your current weight differ from when you joined? ___________**

12. **Have you achieved what you would consider a healthy body weight?**
   - ❑ yes
   - ❑ no

13. **How strongly do you identify as a compulsive overeater?**
   - ❑ very strongly
   - ❑ strongly
   - ❑ somewhat
   - ❑ not at all

14. **Thinking of the last 90 days, indicate approximately how many OA meetings you have attended <u>per month</u>. _______**

15. **How strongly do you identify as a bulimic?**
   - ❑ very strongly
   - ❑ strongly
   - ❑ somewhat
   - ❑ not at all

16. **How strongly do you identify as an anorexic?**
   - ❑ very strongly
   - ❑ strongly
   - ❑ somewhat
   - ❑ not at all

17. **Do you have an OA "home group?"**
   - ❑ yes
   - ❑ no

- ❑ I don't know what a home group is

18. Do you have an OA partner in recovery?

- ❑ yes
- ❑ no
- ❑ I don't know what a partner in recovery is

19. On average, how much money do you contribute per OA meeting (for 7th tradition)?
____

20. Do you currently or have you ever had an OA sponsor?

- ❑ I currently have a sponsor
- ❑ I do not currently have a sponsor, but have in the past
- ❑ I have never had an OA sponsor ☞ **SKIP to 25**

21. Approximately how long were you in program before you <u>got</u> your first sponsor?

- ❑ one month or less
- ❑ two to six months
- ❑ seven months to a year
- ❑ one to two years
- ❑ more than two years

22. What was your <u>primary</u> motivation for getting your first sponsor?

- ❑ I wanted help to work the steps
- ❑ I thought I was supposed to
- ❑ I was desperate for help for my eating problems
- ❑ I strongly identified as an OA member and compulsive overeater
- ❑ other ____________________________

23. For how much of your time in program have you had a sponsor?

- ❑ always or almost always
- ❑ most of the time
- ❑ about half of the time
- ❑ little of the time
- ❑ almost none of the time

24. How much total time per week do you spend interacting with your OA sponsor outside of meetings (in person, by phone, and by email)? ________________ If none, ☞ **SKIP to 25**

25. How much of this interaction time is face-to-face? _____________

26. Have you ever <u>been</u> a sponsor in OA?

- ❑ yes
- ❑ no ☞ **SKIP to 3**

27. Approximately how long were you in program before you first became a sponsor?
- ❑ one month or less
- ❑ two to six months
- ❑ seven months to a year
- ❑ one to two years
- ❑ more than two years

28. Since you began sponsoring, how much of your time in program have you been a sponsor (either working with someone or raising your hand as available)?
- ❑ always or almost always
- ❑ most of the time
- ❑ about half of the time
- ❑ little of the time
- ❑ almost none of the time

29. Typically, what is the maximum number of sponsees you will work with at one time?
____

30. Are you currently a sponsor (either working with someone or raising your hand as available)?
- ❑ yes
- ❑ no ☞ **SKIP to 31**

31. With how many sponsees are you currently actively working? _________

32. When sponsoring, how much total time per week do you spend interacting with all your OA sponsees outside of meetings (in person, by phone, and by email)? _______________
If none, ☞ **SKIP to 33**

33. How much of this interaction is face-to-face? ____________

34. How do you decide who to sponsor?
- ❑ I sponsor anyone who asks
- ❑ I sponsor anyone of my own gender who asks
- ❑ I am somewhat selective
- ❑ I am very selective

35. Are you required to sponsor by your sponsor?
- ❑ yes
- ❑ no
- ❑ it is suggested but not required

36. Have you ever gone to any of the following? *Check all that apply.*
- ❑ OA retreat
- ❑ 2-hour holiday event (e.g., [event names omitted])
- ❑ day-long workshop or marathon (e.g., IDEA Day)

- ❑ Greater [city omitted] Intergroup monthly meeting

37. Have you ever held a formal service position in Overeaters Anonymous (e.g., treasurer)?

- ❑ yes
- ❑ no ☞ **SKIP to 39**

38. Do you currently hold a formal service position in Overeaters Anonymous?

- ❑ yes
- ❑ no

39. Please indicate the primary reason why you took on your most recent service position:

- ❑ my sponsor requires or suggests I hold a service position
- ❑ I think OA service is essential to my personal recovery
- ❑ I thought if I didn't do it, no one would
- ❑ I was pressured to take it by fellow group members
- ❑ other ___________________________

40. Which of the following best describes your concept of a "Higher Power"?

- ❑ I do not have a higher power
- ❑ I have not defined a higher power but believe in a power greater than myself
- ❑ the God of my religious upbringing
- ❑ a concept, holy figure, or god derived from another religious tradition
- ❑ a unique creation not derived from any particular religion
- ❑ the OA program, meetings, and/or membership

41. Please indicate the maximum amount of time into the future you anticipate attending OA:

- ❑ one week
- ❑ one month
- ❑ six months
- ❑ a year
- ❑ 2-5 years
- ❑ 6-10 years
- ❑ indefinitely

42. How strongly do you identify as an OA member?

- ❑ very strongly
- ❑ strongly
- ❑ somewhat
- ❑ not at all

43. To what degree do you think your recovery is connected with that of your fellow OA members? Would you say it is:

- ❑ strongly connected
- ❑ somewhat connected

- ❑ not connected at all

44. Thinking of the last 90 days, please indicate approximately how often you did each of the following activities per month.

Activity	Daily or more often	4-6 times a week	1-3 times a week	1-3 times a month	Less than once a month	Never
Pray						
Meditate						
Make outreach calls						
Read OA or other 12-Step literature						

45. Please evaluate the statements below. Indicate how true they have been of you during the past 90 days.

	Definitely true	True	False	Definitely false
I have been ready to let my Higher Power remove my shortcomings				
I have recognized that the amount of serenity I have is a direct result of the amount of humility I have				
I have believed that my recovery could only come from a power greater than myself				
I have realized that no matter what I do, things get worse when I compulsively overeat/engage in my eating disorder				
I have believed that awareness of my higher power is essential to my abstinence				

46. Please rank the following aspects of your 12-Step involvement according to how important they are to your personal recovery.

	Not at all important	Somewhat important	Extremely important	Don't know or not applicable
Going to meetings				
Having a sponsor				
Working the steps				
Outreach phone calls/fellowship				
Reading literature				
Prayer/meditation				
Writing/journaling				
Plan of eating				
Relationship with a higher power				

47. Have you worked any steps in OA?

- ❑ no ☞ **SKIP to 49**
- ❑ yes, on my own
- ❑ yes, with a sponsor or trusted adviser

48. What is the highest step you have gone through? ____________ If you have not worked step 9 ☞ **SKIP to 49**

49. How much progress have you made on formal ninth-step amends?
- ❑ I have made at least one
- ❑ I have made a few
- ❑ I have completed all/nearly all of them

50. How frequently do you enjoy "fellowship" after meetings?
- ❑ never
- ❑ rarely
- ❑ about half the time
- ❑ most of the time
- ❑ always

51. How much do you enjoy your involvement in OA?
- ❑ very much
- ❑ somewhat
- ❑ not much
- ❑ not at all

52. How would you characterize your general opinion of OA?
- ❑ very favorable
- ❑ favorable
- ❑ neutral
- ❑ unfavorable
- ❑ very unfavorable

53. If you could remain abstinent without participating in OA, how likely is it that you would continue to participate?
- ❑ very unlikely
- ❑ unlikely
- ❑ likely
- ❑ very likely

Questions about the OA Meeting

We are now going to ask you about the [Insert group name] OA meeting.
Please answer the following questions about that meeting.

54. Which OA meeting do you attend the most regularly?
- ❑ this meeting

- ❑ other meeting: ________________

55. What is the most important factor in why you attend this particular meeting?
- ❑ location
- ❑ format/special focus
- ❑ day and time
- ❑ other: ________________________

56. Over the last 90 days, how frequently did you attend this meeting?
- ❑ once per month
- ❑ twice per month
- ❑ three times per month
- ❑ every week
- ❑ this is my first time

57. Is this meeting your home group?
- ❑ yes
- ❑ no
- ❑ I don't know what a home group is

58. If you have a sponsor, does s/he generally attend this meeting?
- ❑ yes
- ❑ no

59. Considering the format, the people who attend, the shares, etc., how similar is this particular OA meeting relative to other OA meetings you have attended?
- ❑ very similar
- ❑ somewhat similar
- ❑ very different
- ❑ I have only ever attended this meeting

60. Describe the average emotional intensity of this meeting.
- ❑ meeting is very emotional
- ❑ meeting is somewhat emotional
- ❑ meeting is not emotional

61. About how much, on average, do you give to this group per meeting for 7th tradition?

____

62. Do you have a greater sense of belonging in this group than other OA groups?
- ❑ yes ☞ **SKIP to 63**
- ❑ no

63. Do you have a greater sense of belonging in any other OA meeting?
- ❑ no, I feel the same in all of them
- ❑ yes, another meeting:

____

64. To what degree do you think your recovery is linked to the health of this particular meeting? Would you say they are:

- ❑ strongly linked
- ❑ somewhat linked
- ❑ not linked at all

65. If you only attend one meeting per week, how important is it for you to attend this meeting?

- ❑ very important
- ❑ somewhat important
- ❑ not important at all

66. In the last 3 months, has your attendance at this meeting:

- ❑ increased
- ❑ decreased ☞ **SKIP to 65**
- ❑ remained unchanged ☞ **SKIP to 66**

67. If your meeting attendance has <u>increased</u>, to which of the following do you attribute this? *Check all that apply.*

- ❑ commitment to abstinence evident
- ❑ focus on solution and abstinence
- ❑ strong meeting structure
- ❑ public informed about the meeting
- ❑ working Steps/Steps stressed
- ❑ meets scheduling needs
- ❑ newcomers welcomed
- ❑ literature studied at meetings
- ❑ service evident and encouraged
- ❑ physical recovery evident
- ❑ sponsors available
- ❑ open and honest sharing
- ❑ strong fellowship/happy meeting/socializing

☞ **Now SKIP to 66**

68. If your meeting attendance has <u>decreased</u>, to which of the following do you attribute this? *Check all that apply.*

- ❑ physical recovery not evident
- ❑ not ready, not committed
- ❑ no food plan offered
- ❑ schedule conflict
- ❑ lack of available sponsors
- ❑ cross talk
- ❑ no outreach to members
- ❑ personality conflicts

- ❑ meeting focuses on problem rather than solution
- ❑ requirements for sharing, food plan, sponsoring, etc.
- ❑ conflict with other food-related 12-Step program
- ❑ message unclear, non-OA issues discussed

Outside Issues and Activities

Now we want to ask you questions about you, your household, and your views and activities outside of your formal participation in the OA program. Many of these questions have been asked of residents of [city] and other cities, allowing us to see how representative [city] OA members are of local and national trends.

69. Please indicate whether you participate in any other 12-Step programs. Check all that apply.

- ❑ Alcoholics Anonymous
- ❑ Al-Anon
- ❑ Debtors Anonymous
- ❑ Eating Disorders Anonymous
- ❑ Gamblers Anonymous
- ❑ Narcotics Anonymous
- ❑ Sex and Love Addicts Anonymous
- ❑ Food Addicts Anonymous
- ❑ Other ______________________________
- ❑ Other ______________________________

70. In the last 90 days, approximately how many 12-Step meetings (<u>not including OA</u>) did you attend per month? ______________________

71. About how many <u>times in the past year</u> have you done the following activities?

Activity in last 12 months	**Number of times**
Worked on a community project	
Donated blood	
Attended any public meeting in which there was discussion of town or school affairs	
Attended a political meeting or rally	
Attended any club or organizational meeting (not including meetings for work) <u>not including 12-Step meetings</u>	
Attended 12-Step meetings	
Had friends over to your home	
Been in the home of a friend of a different race or had them in your home	
Been in the home of someone of a different neighborhood or had them in your home	
Been in the home of someone you consider to be a community leader or had one in your home	
Volunteered	

72. On average, how would you characterize your involvement in <u>non-12 step organizations</u> since joining OA?
- ❑ my involvement has increased
- ❑ my involvement has decreased
- ❑ my involvement has remained the same

73. Do you think your OA involvement has had or will have any effect on your <u>volunteering outside program</u>?
- ❑ it makes me more likely to volunteer
- ❑ it makes me less likely to volunteer
- ❑ it has no effect on my volunteering

74. Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?
- ❑ people can be trusted
- ❑ you can't be too careful
- ❑ don't know

75. How many OA members do you spend time with socially (i.e., outside meetings and outside the sponsoring relationship) __________ If none ☞ **SKIP to 79**

76. Approximately how many hours do you spend per month in such social activity? ________

77. Generally speaking, how much would you say that you can trust each of the following groups?

	Trust them a lot	Trust them some	Trust them only a little	Trust them not at all	Don't know
Whites or Caucasians					
African Americans or Blacks					
Hispanics or Latinos					
People in 12-Step programs					

78. Please indicate your current level of involvement with the following organizations. <u>Do not include 12-Step participation in your answers</u>. *Check all that apply.*

	I belong	I contribute	I volunteer	I hold a leadership position
Arts or cultural organization				
An elementary, middle, or high school				
Charitable organization or group				
Church or other religious organization				
Civic or service group				
Ethnic or racial organization				

Internet-based club, group, or chat-room				
Neighborhood group or association				
Political party, club, or association				
School fraternities, sororities, or alumni association				
Sports, hobby, or leisure club/group				
Therapeutic or counseling group				
Trade union or professional association				
Youth groups or organizations				
Other group/organization				

79. How much of the time do you think you can trust the national government to do what is right?

- ❑ just about always
- ❑ most of the time
- ❑ only some of the time
- ❑ hardly ever

80. How much of the time do you think you can trust the local government to do what is right?

- ❑ just about always
- ❑ most of the time
- ❑ only some of the time
- ❑ hardly ever

81. Thinking politically and socially, how would you describe your own general outlook?

- ❑ very conservative
- ❑ moderately conservative
- ❑ middle-of-the-road
- ❑ moderately liberal
- ❑ very liberal

82. Think about your five closest personal friends. How many of them are OA members?

____

83. Thinking of the last 12 months, approximately how often have you done the following activities with or for an OA member outside the context of an OA meeting or sponsor-sponsee relationship? Check one box (often, sometimes, or never) for each.

	Often	**Sometimes**	**Never**
Said hello to each other or stopped to chat			
Had dinner or lunch			
Carpooled or given/received a ride			
Provided or received emotional support			
Provided (for free) more time-consuming assistance such as			

house- or pet-sitting, childcare, help with moving			
Received (for free) more time-consuming assistance such as house- or pet-sitting, childcare, help with moving			
Provided paid assistance (hourly or otherwise)			
Received paid assistance (hourly or otherwise)			
Provided information on opportunities such as jobs, housing, service providers, etc.			
Received information on opportunities such as jobs, housing, service providers, etc.			
Borrowed a personal item			
Loaned a personal item			

84. During the past 12 months, approximately how much money did you and the other family members in your household contribute to all secular (non-religious) causes and all religious causes, including your local religious congregation?

- ❑ none
- ❑ less than $100
- ❑ $100 to less than $500
- ❑ $500 to less than $1000
- ❑ $1000 to less than $5000
- ❑ more than $5000
- ❑ don't know

85. In the past twelve months, have you served as an officer or served on a committee of any local club or organization?

- ❑ yes
- ❑ no

86. How interested are you in politics and national affairs?

- ❑ very interested
- ❑ somewhat interested
- ❑ only slightly interested
- ❑ not at all interested

87. Are you currently registered to vote?

- ❑ yes
- ❑ no
- ❑ don't know
- ❑ not eligible

88. How would you describe your overall state of health these days? Would you say it is:

- ❑ excellent
- ❑ very good
- ❑ good
- ❑ fair
- ❑ poor

89. All things considered, would you say you are

- ❑ very happy
- ❑ happy
- ❑ not very happy
- ❑ not happy at all

90. Please tell me how much you agree with the statement "Television is my primary form of entertainment."

- ❑ agree strongly
- ❑ agree somewhat
- ❑ disagree somewhat
- ❑ disagree strongly

91. What year were you born? 19______

92. What is your gender?

- ❑ male
- ❑ female
- ❑ other

93. Which of the following describes your race/ethnicity? *Check all that apply.*

- ❑ White or Caucasian
- ❑ Black or African-American
- ❑ Asian
- ❑ Hispanic or Latino
- ❑ other ________________

94. What is your total annual household income, before taxes and other deductions, during the past 12 months?

- ❑ Less than $5,000
- ❑ $5,000 to under $10,000
- ❑ $10,000 to under $15,000
- ❑ $15,000 to under $20,000
- ❑ $20,000 to under $25,000
- ❑ $25,000 to under $35,000
- ❑ $35,000 to under $50,000
- ❑ $50,000 to under $65,000
- ❑ $65,000 to under $75,000
- ❑ $75,000 to under $100,000
- ❑ $100,000 to under $125,000
- ❑ $125,000 to under $150,000
- ❑ $150,000 to under $175,000
- ❑ $175,000 to under $200,000
- ❑ $200,000 and greater

95. Are you currently single or in a relationship?
- ❑ single
- ❑ in a relationship

96. What is your current marital or domestic status?
- ❑ married or same-sex domestic partnership
- ❑ divorced
- ❑ separated
- ❑ widowed
- ❑ never married

97. How many children do you have currently living in your household? ___________

98. How many hours per week do you spend on average caring for dependents (e.g., children, disabled)? __________

99. Where do you live?
- ❑ [city deleted]
- ❑ other city or town in [county deleted] County ☞ **SKIP to 101**
- ❑ city or town in a different [state deleted] county ☞ **SKIP to 101**

100. Please indicate where in [city] you live:
[Neighborhood choices deleted]

101. Check the box next to the highest level of formal education you have completed.
- ❑ high school or GED
- ❑ some college
- ❑ vocational or technical degree
- ❑ associate's degree
- ❑ bachelor's degree
- ❑ some graduate school
- ❑ graduate or professional degree

102. Are you currently a student?
- ❑ yes, part-time
- ❑ yes, full-time
- ❑ no

103. Are you currently employed?
- ❑ yes ☞ **SKIP to 104**
- ❑ no
- ❑ retired

104. When was the last time you were employed? _______________ If more than a month ago ☞ **SKIP to 105**

105. Over the last month, approximately how many hours did you work per week?

______

106. What is or was your occupation (e.g., auto mechanic, accountant)?

____

107. To what extent do you consider yourself a spiritual person?

- ❑ very spiritual
- ❑ moderately spiritual
- ❑ slightly spiritual
- ❑ not spiritual at all

108. Since you entered program, has your spirituality:

- ❑ increased
- ❑ decreased
- ❑ remained the same

109. To what extent do you consider yourself a religious person?

- ❑ very religious
- ❑ moderately religious
- ❑ slightly religious
- ❑ not religious at all

110. Since you entered program, has your participation in an organized religion

- ❑ increased
- ❑ decreased
- ❑ remained the same

111. Not including weddings and funerals, how often do you attend religious services?

- ❑ every week (or more often)
- ❑ almost every week
- ❑ once or twice a month
- ❑ a few times per year
- ❑ less often than that

112. Which best describes your current religious affiliation?

- ❑ Catholic
- ❑ Protestant
- ❑ Jewish
- ❑ Muslim
- ❑ Buddhist
- ❑ None
- ❑ Other _______________________

113. Even if you might not believe in God or a "Higher Power", based on your personal understanding, what do you think God or Higher Power is like?

	Strongly agree	Agree	Disagree	Strongly disagree	Undecided
A cosmic force in the universe					
Removed from worldly affairs					
Removed from my personal affairs					
Concerned with the well-being of the world					
Concerned with my personal well-being					
Angered by human sin					
Angered by my sins					
Directly involved in worldly affairs					
Directly involved in my affairs					
A "He"					

114. How well do you feel that each of the following words describe Higher Power or God?

	Very well	Somewhat well	Not very well	Not at all	Undecided
Absolute					
Critical					
Distant					
Ever-present					
Fatherly					
Forgiving					
Friendly					
Just					
Kind					
Kingly					
Loving					
Motherly					
Punishing					
Severe					
Wrathful					
Yielding					

115. During the past 12 months, how often have you done each of the following things:

	More than once a week	Once a week	Once a month	At least 2 or 3 times in the past year	Once in the past year	Not at all in the past year
Donated blood						
Given food or money to a homeless person						
Returned money to a cashier after						

getting too much change						
Allowed a stranger to go ahead of you in line						
Done volunteer work for a charity						
Given money to a charity						
Offered your seat on a bus or in a public place to a stranger who was standing						
Looked after a person's plants, mail, or pets while they were away						
Carried a stranger's belongings, like groceries, a suitcase, or shopping bag						
Given directions to a stranger						
Let someone you didn't know well borrow an item of some value like dishes or tools						

116. The following are things that you may experience in your daily life. Please tell us how often these occur.

	Many times a day	Every day	Most days	Some days	Once in a while	Never or almost never
I feel a selfless caring for others						
I accept others even when they do things I think are wrong						

117. The following statements ask about your thoughts and feelings in various situations. For each item indicate how well it describes you by choosing a number from 1 to 5.

	1 (does not describe me very well)	**2**	**3**	**4**	**5** (describes me very well)
I often have tender, concerned feelings for people less fortunate than me					
Sometimes I don't feel very sorry for other people when they are having problems					
When I see someone being taken advantage of, I feel kind of protective toward them					
Other people's misfortunes do not usually disturb me a great deal					
When I see someone treated unfairly, I sometimes don't feel very much pity for them					
I am often quite touched by things that I see happen					
I would describe myself as a pretty soft-hearted person					

Appendix G: Meeting Observation Form

Date of Observation: ____________ Group ID Number: ___________________________

1. Number of participants (w/me): ________ Number of males: _______
2. Number of sponsors: ______ newcomers: ______ visitors from other area: ______
3. Note restrictions or guidelines on lengths of shares: ___________
4. Timer used? [Yes/No]

5. Physical configuration of the participants:
   - ❑ sitting in circle/rectangle (single circle or concentric?)
   - ❑ around a table(s)
   - ❑ auditorium style
   - ❑ other (describe): ____

6. How many "pitched" or shared (not including 1st step story): _______

7. Check all that describe the meeting format:
   - ❑ Step/Tradition: 1 2 3 4 5 6 7 8 9 10 11 12
   - ❑ Speaker meeting
   - ❑ Topic meeting: ________________________________
   - ❑ Other literature: ________________________________
   - ❑ Deviation from standard script: ____

8. Anything unusual happen during this meeting? (e.g., locked out/other location/very late start):
   ____

9. Indicate rituals above and beyond saying serenity prayer holding hands at end:
   - ❑ introductions by everyone
   - ❑ candlelight
   - ❑ meditation period (length: _______)
   - ❑ writing period (length: _________)
   - ❑ formal coin ceremony (coins passed for blessings [yes/no])
   - ❑ solicitation of abstinence dates or program birthdays
   - ❑ greeter at door
   - ❑ elements of script repeated in unison
   - ❑ sponsors qualify as to weight loss, etc.
   - ❑ sponsors asked to hold up their hands
   - ❑ newcomers and/or visitors asked to introduce themselves
   - ❑ old-timers asked to be available to newcomers after meeting
   - ❑ separate newcomer meeting held
   - ❑ individual asked to share first-step story
   - ❑ closing prayer variation ____________________________________
   - ❑ other: ____

10. Assess emotional intensity of meeting: ___ 0 = unemotional; 2.5 = average; 5 = highly emotional

11. Previous attendance numbers: 2 weeks ago: ________; last week _______

12. Additional Observations: ____

____

____

____

Appendix H: Semi-Structured Stratified Random Sample Interview Protocol

1. How long have you been a member of *OA*?

2. Let's talk about your participation in the *OA* meeting you most frequently attend. Which group is that? ______________________.

   a. How long have you attended this meeting?
   b. Can you tell me some of the reasons why you attend this particular meeting? [*Prompt if they have trouble answering*:] Is it related to the time? …the location? …the structure or format? Does it have to do with the meeting's participants?
   c. I'm interested in whether meetings vary in the type and amount of emotions expressed by their participants. Can you describe the level of emotion in this meeting, for instance is there crying, laughing?
      a. In general, does the expression of emotion affect your experience of the meeting? Your recovery? How?
   d. Is this meeting distinctive in any way, or is it fairly typical of *OA* meetings you've attended? How would you describe it to me—what sort of "vibe" or "feel" does it have? Do these characteristics matter much for your recovery? Please explain.
   e. Does this meeting have any particular weaknesses? Does it have any particular strengths?
   f. Do you do service (now or in the past) in this group? Why or why not?

3. I would like you to think about your level of identification as a *compulsive overeater* over the course of your *OA* participation.
   a. Do you think it has remained constant, or has it changed at times?
      i. Can you characterize the trajectory for me? Like did it change with various stages of the program, like becoming a sponsee, a sponsor, working the steps, service?
   b. Do you think your level of identification as an *OA member* has remained constant, or has it changed at times?
      i. Can you characterize the trajectory for me? Like did it change with various stages of the program, like becoming a sponsee, a sponsor, working the steps, service?

4. Have you ever been part of an *OA* sponsoring relationship, as a sponsor or sponsee?
   A. <u>Being a sponsee</u>
      - How has being a sponsee affected your recovery?
   B. <u>Being a sponsor</u>
      - How has being a sponsor affected your recovery?

5. Have you worked the steps? How has working the steps affected your recovery? Can you give me specific examples?

6. More specifically, I want to ask you about the relationship between sponsoring and identification as a *compulsive overeater* and *OA* member. Think back to the reasons you got or became a sponsor. Do you think that your increased level of identification was what led you to get or be a sponsor? Please explain.

7. Please think about the racial, gender, age, and socio-economic (profession, income, level of education) make-up of the [city] *OA* fellowship.
    - How frequently do you encounter individuals who differ from you on these characteristics? Is it more or less than in your daily work or social life?
    - Does your sponsor or partner in recovery differ from you on any of these characteristics?

8. Can you tell me about any involvement you have in service in OA?
    - What motivates you to take on any positions or particular service tasks?
    - What, if anything, do you get out of it?
    - how has doing service (in your meeting and outside of it) affected you
    - can you tell me how much time you spend on service.
    - can you talk to me about service in the meeting you attend most—is it spread out evenly among members, do new people get involved, or is it the usual suspects.

9. We relate to people – feel like we understand them and they understand us – to different degrees in life. Can you tell me about how much you relate to the people in OA in general? And do you relate more or less to the people in the meeting you attend most?

10. Do you view your recovery as intertwined with that of other program members? Entirely separate from others? Please explain.

11. Do you think your participation in OA has affected how you see other people? The degree to which you trust others?

12. Has OA changed the way you see yourself? If so, how?

13. Were you involved in voluntary associations (like neighborhood groups, clubs) prior to joining *OA*?

    a. As you know, participation in 12-Step can be time-consuming. Would you say your involvement in outside groups *since* participating in *OA* is the same, or has it decreased, or increased?
    b. Why is this? Can you give me some specific examples?

14. What sorts of things, if anything, do you get from your fellow OA members?

15. Can you characterize the path of your recovery? Have things steadily improved over the course of your involvement in program? Have they gotten worse, or has it been up and down? Please explain.

16. To what do you attribute whatever recovery you have? What matters most (program or not)?

17. What program-prescribed practices seem to be or have been particularly helpful? Any particular non-program activities or things that have helped you a lot?

18. Please describe your conception of your HP. How has this changed during the course of your 12-Step involvement? How is it related to your recovery?

19. Has your involvement in OA affected your social life or your social circle? How so?

Subset of Questions for Traditional and HOW members

For "Traditional OA" members:

1. Have you heard of HOW? [If no, skip to end]
2. What are your impressions of the HOW program, and of people who work the HOW program, compared to regular OA?
3. Have you ever attended a HOW meeting or followed the HOW program? Please describe.
4. If you made a conscious choice to not attend HOW meetings or follow the HOW program (either ever or after having participated), please describe the reasons behind your decision.
5. If you were previously in HOW, describe the differences between how you worked your program now, and how you work it in HOW. [*If interviewee needs prompting*:]
    a. Abstinence
    b. Being sponsored
    c. Sponsoring others
    d. Use of tools (telephone, meetings, plan of eating, literature, anonymity, service, writing, prayer/meditation)
    e. Working steps
    f. Frequency of contact with sponsor and with sponsees

For HOW Members

1. How long have you followed the HOW program/been a member of HOW?
2. How strongly do you identify as a HOW member?
3. How would you characterize your problem with food?
4. Many individuals switch back and forth between HOW and "regular OA." Has this been the case for you? Please describe.
5. Why have you decided to participate in HOW as opposed to regular OA? Please explain in detail.
6. If you were previously in "regular" OA, describe the differences between how you worked your program then, and how you work it in HOW. [*If needs prompting*:]
    a. Abstinence
    b. Being sponsored
    c. Sponsoring others

d. Use of tools (telephone, meetings, plan of eating, literature, anonymity, service, writing, prayer/meditation)
e. Working steps
f. Frequency of contact with sponsor and with sponsees

7. How many meetings do you typically attend per week?
8. Of these, how many are usually HOW meetings?
   In your experience, are there many differences between HOW and regular OA meetings? If so, how would you characterize these differences?
9. In your experience, are there many differences between HOW and regular OA members? If so, how would you characterize these differences?
10. Do you think being in HOW is related to the degree you identify as a compulsive overeater and OA member? How strongly did you identify before versus after you started working HOW?

<u>Last General Question:</u>

1. Is there anything else you would like to tell me about the way OA has affected your life?