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# **Exploring positive and negative aspects of eating disorders**

**By**

**Melanie Jane Elsworth**

A thesis submitted in partial fulfilment of the requirements for  
the degree of Doctor of Clinical Psychology

Coventry University, School of Health and Social Sciences and  
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## List of abbreviations and measures

<b>SF-36</b>	36 Item Short-Form Health Survey, Ware and Sherbourne (1992).
<b>ADCQ</b>	Adapted Dimensions of Conscience Questionnaire, Gilbert, Pehl and Allan (1994).
<b>AN</b>	anorexia nervosa
<b>ASGS</b>	Adapted Shame and Guilt Scale, Harder and Zalma (1990).
<b>AGG</b>	Aggression Questionnaire – Hostility Subscale, Buss and Perry (1992).
<b>BDI</b>	Beck Depression Inventory, Beck and Steer (1987).
<b>BED</b>	binge eating disorder.
<b>BES</b>	Binge Eating Scale, Gormally, Black, Daston and Rardin (1982).
<b>BIGSS</b>	Body Image Guilt and Shame Scale, Thompson, Dinnel and Dill (2003).
<b>BSQ</b>	Body Shape Questionnaire, Cooper, Taylor, Cooper and Fairburn (1987).
<b>BN</b>	bulimia nervosa
<b>BULIT-R</b>	Revised Bulimia Test, Thelen, Farmer, Wonderlich and Smith (1991).
<b>CES-D</b>	Center for Epidemiological Studies Depression Scale.
<b>EAT</b>	Eating Attitudes Test, Garner and Garfinkel (1979).
<b>EDI-2</b>	Eating Disorder Inventory – 2, Garner (1991).

## List of abbreviations and measures

<b>EDE-Q</b>	Eating Disorder Examination Questionnaire, Fairburn and Wilson (1993).
<b>EDNOS</b>	eating disorder not otherwise specified.
<b>ESS</b>	Experience of Shame Scale, Andrews, Qian and Valentine (2002).
<b>FNE</b>	Fear of Negative Evaluation, Watson and Friend (1969).
<b>ISS</b>	Internalised Shame Scale, Cook (1994).
<b>MPI</b>	Multidimensional Pain Inventory, Kerns, Turk and Rudy (1985).
<b>OBC</b>	Objectified Body Consciousness Scale, McKinley and Hyde (1996).
<b>PBI</b>	Parental Bonding Instrument, Parker, Tupling and Brown (1979).
<b>PFQ</b>	Personal Feelings Questionnaire, Harder and Zalma (1990).
<b>PFQ2</b>	Personal Feelings Questionnaire-2, Harder, Rockart and Cutler (1991).
<b>PACS</b>	The Physical Appearance Comparison Scale, Thompson, Fabian, Moulton, Dunn and Altabe (1991).
<b>PARTS</b>	Physical Appearance-Related Teasing Scale, Thompson, Fabian, Moulton, Dunn and Altabe (1991).
<b>PANAS</b>	Positive and Negative Affect Schedule, Watson, Clark and Tellegen (1988).

## List of abbreviations and measures

<b>SDQ III</b>	Global Self-Esteem Sub-Scale of the Self-Descriptive Questionnaire III, Marsh (1990).
<b>SG</b>	New Shame and Guilt Eating Scale, Frank (1989).
<b>RS GS</b>	Revised Shame and Guilt Scale, Hoblitzelle (1982).
<b>RRS</b>	Revised Restraint Scale, Herman, Polivy, Pliner, Threlkeld and Munic (1978): Polivy, Herman and Howard (1988).
<b>SCAAIR</b>	Revised Self-Conscious Affect and Attribution Inventory, Tangney (1990).
<b>SEQ-2</b>	Sexual Events Questionnaire-2, Calam, Griffiths and Slade (1997).
<b>SGES</b>	Shame and Guilt Eating Scale, Frank (1989).
<b>SATAQ</b>	The sociocultural attitudes towards appearance questionnaire, Heinberg, Thompson and Stomer (1995).
<b>SSES</b>	State Self-Esteem Scale, Heatherton and Polivy (1991).
<b>STAI</b>	State-Trait Anxiety Inventory – Trait Subscale, Spielberger (1983).
<b>SCL-90</b>	Symptom Checklist 90, Derogatis, (1977); Derogatis, Rickels and Rock (1976).
<b>SCL-90-R</b>	Symptom Checklist 90-Revised, Derogatis (1983).
<b>TOSCA</b>	Test of Self-Conscious Affect, Tangney, Wagner and Gramzow (1989).
<b>YSQ</b>	Young Schema Questionnaire, Young (1990).



## **List of abbreviations and measures**

**Body Image Esteem Scale**, Markham, Thompson & Bowling (2005).

**Locus of Control Scale**, Rotter (1966).

**The Kaplan Self-Derogation Scale**, Kaplan & Pokorny (1969).

**Sexual Objectification Subscale**, Swim, Cohen & Hyers (1998).

**Sexual Objectification Subscale**, Swim, Cohen & Hyers (1998).

**Social Anxiety Scale**, Fenigstein, Scheier & Buss (1975).

**Social Desirability Scale**, Crowne & Marlowe (1960:1964).

**Sociocultural Attitudes Towards Appearance Questionnaire**,

Heinberg, Thompson & Stormer (1995).

**Stanford Shyness Inventory**, Harder & Lewis (1987); Zimbardo (1977).

**The Narcissistic Personality Inventory**, Raskin & Hall (1979).

**The Private Self-Consciousness Scale**, Fenigstein, Scheier & Buss (1975).

**The Submissive Behaviour Scale**, Buss & Craik (1986).

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**Declaration**

This research was carried out under the supervision of Ken Goss, who provided the initial idea for the research, helped me design the study, and provided access to participants, and Dr David Giles, who provided academic supervision.

I have conducted, transcribed and analysed all the interviews myself and apart for the aforementioned collaborations, this thesis is all my own work. Authorship of any papers that follow this thesis will be shared with Ken Goss and Dr David Giles. This thesis has not been submitted for a degree at any other university. The literature review is being prepared for submission to European Eating Disorders Review (Elsworth, Goss & Giles, in preparation), and the main paper is being prepared for submission to European Eating Disorders Review (Elsworth, Goss & Gilbert, in preparation), the brief paper is being prepared for submission to European Eating Disorders Review (Elsworth, Giles & Goss, in preparation). See appendix thirteen for instructions to authors.

**Word count (excluding tables, references and appendices)**

Literature review	7069
Brief paper	2967
Main paper	5956
Reflective paper	2964
<b>Total</b>	<b>18956</b>

## Summary

Eating disorders are notoriously difficult to treat, and anorexia nervosa has the highest mortality rate of all the psychiatric illness (Gremillion, 2003). Therefore this client group can present challenges to clinicians working with them. Those working in the area of eating disorders require research with clear clinical implications, to improve treatment and outcomes. The thesis will attempt to provide such research, with clearly stated clinical implications for treatment.

The first paper in this thesis reviews the literature on the link between shame and eating disorders. This paper defines shame, then explores studies identifying the differences or similarities between shame and other self-conscious emotions, such as guilt, embarrassment and humiliation. The paper then explores the link between shame and eating disorders. The second and main paper is an empirical paper exploring shame and pride in a clinical population with a diagnosed eating disorder. The third paper explores 'pro-anorexia' websites to assess whether such sites offer any advice or support that could be considered positive. The final paper is a reflective paper which explores my research journey.

# **Chapter 1: Literature Review**

## **The link between shame and eating disorders: A review**

## 1.1 Abstract

**Objective:** Previous research has found shame and guilt to be distinct emotions and shame related to a number of psychopathologies, including eating disorders. The objective of the current paper is to review papers linking shame to eating disorders. This paper will begin by defining shame before exploring studies identifying the differences or similarities between shame and other self-conscious emotions, such as guilt, embarrassment and humiliation. The empirical papers to date on shame and its association to eating disorders will then be reviewed. **Method:** Seventeen published, peer reviewed journal articles on shame and eating disorders were reviewed. **Results:** Out of the seventeen papers reviewed, sixteen employed published measures that had been used elsewhere and one of them used qualitative measures. The majority of the studies used female, student samples. Results show a link between shame and eating disorders and a distinction between shame and guilt. **Discussion:** The presence of shame in an eating disorder population has important clinical implications. For example, some may withhold important information about their eating disorder to clinicians. Others may find the very experience of therapy and treatment further shame provoking. These implications are discussed in detail.

## **1.2 Literature search strategies**

Three strategies were used to establish the literature to be included in this review. First, three major databases were searched for peer-reviewed published literature (PsycINFO, ProQuest and Science Direct), between August 2005 – February 2006. Specific search terms were used (shame, guilt in eating disorders). General searches were then carried out on the terms shame and guilt. Non-empirical theoretical literary reviews were excluded. The second search strategy used was to scan the identified sources from the first search for any references to other publications containing any of the search terms. These references were then collected and the process repeated until no new references were found. The third search strategy was to include references known to the author and supervisors of this thesis that were directly relevant to the research, but that had not been detected by the other two search strategies. Table one gives the details of the articles reviewed.



Table 1 – Summary of studies examining shame in eating disorders

Authors & year	Title	Gender	n	Measures	Mean age of participants	Sample
Andrews 1997	Bodily shame in relation to abuse in childhood and Bulimia: A preliminary investigation	Women	69	None used	Qualitative study	Community
Burney & Irwin 2000	Shame & Guilt in women with eating disorder symptomatology.	Women	97	EAT-40/ TOSCA/ SGES/OBC	24.9	Community
Frank 1991	Shame and Guilt in eating disorders	Women	94	EAT/PPFQ CES-D	19.9	Student
Gee & Troop 2003	Shame, depressive symptoms and eating, weight and shape concerns in a non-clinical sample		70	EDE-Q/ TOSCA/ OAS/BDI-II	27.0	Student/non clinical
Hayaki, Friedman & Brownell 2002	Shame and severity of bulimic symptoms	Women	137	BULIT/ BDI/TOSCA/ BMI	18.62	Student
Jambekar, Mashed, & Griolo 2002	Gender Differences in shame in patients with binge-eating disorder	Men & women	188	ISS/ BDI/EDE-Q BSQ	45.32 (men) 42.65 (women)	Clinical



Table 1 – Summary of studies examining shame in eating disorders

Authors & year	Title	Gender	n	Measures	Mean age of participants	Sample
Markham Thompson & Bowling 2005	Determinants of body-image shame	Women	146	BIGSS/ SATAQ/ PARTS/PACS/ PBI/Body image esteem Scale/SDS	Not provided	Student
Masheb, Grilo & Brondolo 1999	Shame and it's psychological correlates in two women's health problems: binge eating disorder and vuluodynia	Women	203	ISS/EDE-Q/ BSQ/SF-36/MPI	42.1 (BED gp) 43.9 (Vulvodynia gp) 42.1 (control gp)	Clinical and control
Moradi, Dicks & Matteson 2005	Roles of sexual objectification experiences and internalisation	Women	221	Sexual objectification Subscale/Socio-Cultural Attitudes Towards Appearance Questionnaire /Objectified Body Consciousness scale/ Objectified Body Consciousness Scale EAT	20.42 26	Student
Murray, Waller & Legg 2000	Family dysfunction and bulimic psychopathology: The mediating role of shame	Women	139	PBI/TOSCA/ ISS/BULIT	21.0	Student
Murray & Waller 2002	Reported sexual abuse and bulimic psychopathology among non-clinical women: The mediating role of shame	Women	214	SEQ-2/BULIT/ SS	21.6	Student

**Table 1 – Summary of studies examining shame and in eating disorders**

<b>Authors &amp; year</b>	<b>Title</b>	<b>Gender</b>	<b>n</b>	<b>Measures</b>	<b>Mean age of participants</b>	<b>Sample</b>
Noll & Fredrickson 1998	A mediational model linking self-objectification, body shame & disordered eating	Women	93/11	BULIT-R/EAT/The RRS/BSQ Self-objectification Questionnaire	18.8 (sample 1) 18.3 (sample 2)	Student
Sanftner & Crowther 1998	Variability in self-esteem, moods shame, and guilt in women who binge	Women	171	BULIT-R/ EDQ/BES RRS/SSES/ PANAS	21	Student
Sanftner, Barlow, Marschall & Tangney 1995	The relation of shame and guilt to eating disorder symptomatology	Women	171	TOSCA/EDI-2	21	Student
Swan & Andrews 2003	The relationship between shame, eating disorders and disclosure in treatment	Women	140	Diagnostic quest (based on DSM-IV/ SCL-90/ESS	30.76 (clinical) 26.2	Clinical and control
Troop, Allan, Serpell & Treasure 2001	Shame in women with a history of eating disorders	Women	224	OAS/Measurement of eating disorder symptoms/BDI/	31.6	Clinical
Waller, Ohanian, & Osman 2000	Cognitive content among bulimic women: The role of core beliefs	Women	100	YSQ		Clinical and control

### **1.3 Definitions of shame**

Shame belongs to the same family of self-conscious emotions as guilt, embarrassment and humiliation. It has been identified as a powerful emotion since the biblical story of Adam and Eve, where shame was associated with becoming self-aware, aware of how others view us, a fear of transgressing against others and fear of punishment. It has been conceptualised in a number of ways, for example from a social perspective or as a result of early family interactions. Cognitive therapists suggest that shame results from evaluation anxiety (Beck, Emery & Greenburg, 1985). Social psychologists also consider shame in terms of its social context (Crozier, 1990); whilst some sociologists believe that shame is a result of social stigma (Goffman, 1968). Psychoanalytic theorists view shame as a consequence of a failure in early child and parent interactions (Schoore, 1991).

Shame can be defined as either trait, an enduring characteristic of an individual, for example dislike of self, or state, a tendency to experience shame in shame provoking situations, for example, spilling a drink in public. Goss, Gilbert and Allan (1994) suggest that some people may be sensitive to experience shame in some situations (state shame) but would not rate themselves as inferior (trait shame). Shame has been further defined as either internal or external.

The concept of internal shame, also referred to as internalised shame, was originally explored by Kaufman (1989) and was later expanded by



Nathanson (1994). It involves a self-evaluation of being flawed, inadequate, powerless or personally unattractive to others (Gilbert & Miles, 2002). Some believe that this form of shame results from internalising attributions about the self from chronic exposure to shameful situations over time (Kaufman, 1992; Cook, 1994). For example, shame can occur when an individual's social need for affection, belonging and status are denied, typically by powerful others, for example, parents, teachers or other more dominant group members. Due to the difficulty in challenging these powerful people or attributing negative feelings to them (due to fear of possible rejection), the individual can internalise the reasons for the rejection, lack of affection or denial of group membership to their own attributes (Kaufman, 1989; Nathanson, 1994). Once shame is internalised, an individual's own thoughts, for example, being unworthy, ugly or flawed in some way, can elicit an involuntary shame response and they no longer have to have someone else present in order to experience shame. The individual can then experience self-persecuting statements, which can be associated with wanting to punish the self (Gilbert, Clarke, Herpel, Miles, & Irons, 2004). These punishments could be as extreme as self-mutilation.

External shame can be defined as an individual perceiving the self seen by others as flawed, inadequate, worthless, inferior in some way and unattractive to others (Lewis, 1971, 1987), or a fear that others will see them in these ways if their "true" self is revealed (Lewis, 1992). An individual may engage in concealment and submissive or appeasement

strategies to avoid the experience of external shame (Gilbert & Miles, 2002).

Shame has been linked to a number of psychopathologies, including domestic violence (Lansky, 1987,1992) schizophrenia (Morrison, 1987), depression (Allan, Gilbert & Goss, 1994; Andrews & Hunter, 1997; Chueung, Gilbert & Irons, 2004; Nathanson, 1987, 1994; Tangney, Wagner, & Gramzow, 1992), bipolar disorder (Goldberg, 1991), social anxiety (Gilbert, 2000), disassociation (Irwin, 1998), body dysmorphic disorder (Veale, 2002), post traumatic stress disorder (Andrews, Brewin, Rose & Kirk, 2000; Cook, 1994;; Leskela, Dieperink & Thuras, 2002) and alcohol and drug misuse (Cook, 1994) .

So far we have defined shame as a negative emotion, damaging for both the individual and society, and much of the literature has also defined shame negatively. However, some argue that shame does provide a useful social function. The social ranking theory of shame proposed by Gilbert, Pehl and Allan (1994) suggests that shame can help to both establish and maintain social rank. Social rank can be achieved by many factors including coercion and attractiveness (Gilbert et al., 1994). Shame can result from a perception that one is viewed as unattractive or inferior in the eyes of others, which in turn can activate a submissive or aggressive response. Thus shame can be aimed at appeasing dominant others, or hiding traits or characteristics that may not be socially valued. Gilbert (1998) proposes that part of the shame response is the active

signalling of submissive behaviour, such as concealment or avoidance. This could guarantee membership of a valued group or maintain the social status within the group. Moreover, Gilbert (1989) suggests that shame can result from any form of defeat or subordination.

Shame is a complex emotion, affecting many aspects of the individual. As with any emotion, there are a number of possible ways to cope with shame, for example, Gilbert (2002) proposes the following:

- Increased attention to perceived threat.
- Aggression.
- Help seeking behaviour (for example reassurance and protection).
- Submission.
- Concealment of any perceived faults.
- Avoidance and withdrawal (both cognitive and behavioural).
- Compensation or reparation.
- Destroy the source of shame (self-directed hostility).
- Pride and rebellion.

#### **1.4 Shame and guilt as distinct emotions**

There has been speculation on the links between shame and guilt to psychopathology since the early work of Freud, however, despite this long history, psychologists, researchers and lay people have not made a clear distinction between these two emotions (see Gilbert, 2003 for a review). Historically the term “guilt” has been used to loosely describe



both emotions Tangney (1995) resulting in Lewis (1987) describing shame as a hidden emotion. However, over the last fifteen years there has been an increase into the study of the concept of shame. With this increased interest in shame there has been a corresponding de-emphasis on the role of guilt and the differences between these two emotions. The terms guilt and shame have been used interchangeably due in part to the shared features of these emotions (Burney & Irwin, 2000).

Freud (1953) believed that shame was largely a reaction formation against sexually exhibitionist impulses and focused mainly on guilt, however, Lewis (1971) suggests that Freud's development of a primarily guilt-based theory was based on mislabelling his patients' shame experiences as guilt. The literature on shame and guilt does demonstrate that these are indeed two distinct emotions, with different implications for the individual (Tangney, 1995). Lewis (1971) argues for an integrated conceptualisation of the different roles of shame and guilt in psychopathology.

A useful way to highlight the differences between shame and guilt is that the former is more dependent on public exposure of one's faults whilst guilt is more private, remaining a secret the individual keeps from others (Gehm & Scherer, 1988). This public versus private view of shame and guilt was advanced by social scientists in the 20<sup>th</sup> century (Ausubel, 1955). From this perspective it is a disapproving audience that leads to the experience of shame. In contrast guilt was considered to be a result

of a breach of one's own conscience or personal standards and could be experienced in isolation from other people. Thus shame is an affective reaction that follows some form of public exposure, shortcoming or wrongdoing whereas guilt is thought to be a result of doing something that is considered wrong by one's own conscience and can be felt when alone. Research has found that public exposure and subsequent disapproval were not prerequisites for the experience of shame (Tangney, Marschall, Rosenberg, Barlow & Wagner, 1994), demonstrating that not all research supports this public-private distinction between shame and guilt.

Although the events that trigger shame or guilt may not differ, the role of the self in these two emotions may. In guilt the self is negatively evaluated with something that has been done, but the self is not the focus of the experience whereas in shame it is the self that is negatively evaluated as defective and unworthy (Lewis, 1971).

Some suggest that shame and guilt may also differ in terms of the degree of pain they cause to an individual. For example, Lewis (1971) states that the shame experience involves painful self-scrutiny of one's core self-concept, resulting in wanting to hide, escape or disappear whereas guilt does not involve this. Supporting research for Lewis's findings comes from Tangney (1993) who found that shame experiences were rated as significantly more difficult and painful to describe and resulted in feeling smaller, and inferior, with less control to change the situation. This study

found that shame experiences resulted in a sense of being exposed and worries about others opinions, resulting in a desire to hide rather than take reparative action. Therefore shame can promote concealment whilst guilt can promote reparative action.

Some researchers argue that shame and guilt are not distinct emotions (Smith & Ellsworth, 1987; Harris, 2003). Smith and Ellsworth, (1987) found few differences between shame and guilt in their studies, whilst Harris (2003) found no distinction between shame and guilt in research on drink drivers.

Shame and guilt have also been compared and contrasted with embarrassment and humiliation. Some state that embarrassment is a milder element of shame rather than a distinct emotion (Izard, 1977), thus they are the same affect (Kaufman, 1989). Others believe that shame and embarrassment are in fact distinct emotions (Buss, 1980; Tangney, Miller, Flicker & Barlow 1996). For example, some suggest a defining feature of shame is that it has moral implications with an enduring loss of self-esteem, whereas embarrassment does not have moral implications and results in only a temporary loss of self-esteem, rather than enduring (Buss, 1980). Other researchers have found that whilst shame is focused on a defective core, embarrassment is focused on deficiencies in one's presented self (Klass, 1990; Modigliani, 1968; Shott, 1979). A further distinction is that shame may be a result of serious failures or



transgressions whereas embarrassment results from minor social transgressions (Buss, 1980; Lewis, 1992).

Fischer (1995) suggests that humiliation is different from the other self-conscious emotions of shame, guilt and embarrassment. Fischer (1995) argues that humiliation is relational and therefore cannot exist without other people. In addition, the experience of humiliation involves being placed in a powerless position by someone with more power (Gilbert, 1999; Hartling & Luchetta, 1991; 1999; Miller, 1988; Silver, Conte, Miceli & Poggi, 1986).

### **1.5 Measures of shame and related emotions**

A central issue when reviewing the papers on the link between shame and eating disorders is the way shame is measured (Goss, Gilbert & Allan, 1994). The most widely used measures of shame and some related measures will now be briefly reviewed.

The problem of distinguishing specific emotions has understandably caused some difficulty in the design of measures (Strongman, 1987). Shame proneness is currently measured in two different ways, either by presenting a number of scenarios, for example spilling a drink in public, and then measuring the respondents' reaction to these or by listing a number of statements that the individual agrees or disagrees with.

The first of these types of measure tap into state shame (Goss et al., 1994). An example of this type of measure is the Test of Self Conscious Affect (TOSCA, Tangney, Wagner & Gramzow, 1989), which was designed to measure an individual's view of self as flawed/defective. The TOSCA (Tangney et al., 1989) is the most widely used measure of shame and was used in five of the reviewed studies. Internal consistency of the scale (Cronbach's alpha) is .77 for shame and .63 for guilt (Tangney, Wagner, Flecher & Gramzow, 1992). Tangney, Burggraf and Wagner (1995) suggest shame is a negative evaluation of the entire self. They state that 75% of the shame responses involve attributions that are both internal and stable. Some suggest the TOSCA may not be sensitive to trait shame (Andrews, Qian & Valentine, 2002).

The Internalised Shame Scale, (ISS, Cook (1994) is an example of the second type of measure that does tap into trait shame. Respondents are asked to rate a series of statements related to how they see themselves, for examples "*I see myself as inadequate*". Scores are then calculated to give an overall shame score. The ISS was designed to assess internal shame and self-esteem as trait variable, a global self-construct. The ISS (Cook, 1994) was constructed using a large clinical (n=370) and non-clinical (n=645) population. It has high internal consistency (Cronbach's alpha for the shame scale is .96 and for the self-esteem scale .95, (Goss et al., 1994). The test-retest reliability for the clinical sample at seven weeks was .84 and for the non-clinical sample it was .94 (Cook, 1994).

Goss et al. (1994) developed the Other As Shamer scale (OAS) by modifying the ISS to explore external shame and found significant correlations between these two measures. The OAS asks respondents to rate the frequency of certain experiences, for example, *"I feel other people see me as not good enough"*.

An alternative measurement of shame involves assessment by interview (Andrews, 1995; Andrews & Hunter, 1997). This form of measurement showed a high internal consistency (Cronbach's alpha of .92 and test-retest reliability over eleven weeks of .83, Andrews et al., 2002). While example the TOSCA, Tangney et al., 1989) or global self-descriptions (for example the ISS, Cook, 1994), interview assessments ask respondents direct questions about whether they have felt ashamed of specific personal characteristics or behaviour. The Experience of Shame Scale, ESS, Andrews et al. (2002) is based on the same principle. The ESS has a high internal consistency (Cronbach's alpha = .92) and test-retest reliability over eleven weeks of .83 (Andrews et al., 2002). Furthermore, Andrews et al. (2002) argue the ESS assesses specific areas of shame related to self and performance rather than general or state shame. Therefore it may be more sensitive to trait shame.

The Personal Feelings Questionnaire, PFQ, Harder and Zalma (1990) is another measure of shame used. However, it has been criticised for the small number of items it uses to measure shame and guilt, the difficulty in discriminating between shame and guilt concepts in the measure and the



difficulty of the test items making it difficult for people with a low level of intelligence to complete (Tangney, 1990).

The Beck Depression Inventory (BDI, Beck & Steer, 1987) is widely used by both clinicians and researchers to measure depression. It was used in some of the studies on shame in eating disorders. Research has found that the BDI is highly correlated with the ISS (Cook, 1994) and OAS (Goss et al., 1994). Examples of questions on the BDI that could be measuring shame rather than depression include question 3, *"I feel I am a total failure as a person"*, question 6, *"I feel I am being punished"*, question 7, *"I dislike myself"*, question 8, *"I blame myself for everything bad that happens"* and question 14, *"I feel utterly worthless"*.

One of the studies reviewed used the Young Schema Questionnaire (YSQ, Young, 1990). The YSQ was not explicitly designed to measure shame, in addition it has not been standardised against other robust measures of shame, for example, the TOSCA (Tangney et al., 1989), ISS (Cook, 1994) or OAS (Goss et al., 1994).

The analysis of the different ways of measuring shame suggests some important conclusions. Shame appears to be a primary human emotion therefore everyone will experience some shame, triggered by one situation or another. However, scales measuring situational shame can only ever assess shame in those given situations. The trait approach to

measuring shame appears to tap into more enduring and chronic shame experiences, and thus may be better at identifying shame.

## **1.6 Shame and eating disorder symptomatology**

### **1.6.1 Introduction**

Research linking shame to eating disorders is relatively recent having only really started ten to fifteen years ago. Prior to this, clinical descriptions resembling shame appeared in the literature, however these descriptions were limited. For example, Bruch (1973) published a case study of a client she called Karol, describing her client's belief that she was a failure and her use of self-starvation to avoid or control this feeling. Other research found that shame associated with an eating disorder was the strongest predictor of the severity of eating disorder symptomatology (Burney & Irwin, 2000).

### **1.6.2 Shame and binge eating disorder**

Research on eating disorder and its link to shame has tended to focus on specific eating disorders classifications, typically using DSM criteria (Diagnostic and statistical manual of mental disorders, American Psychiatric Association 1994). For example, research exploring the link between shame and binge eating disorder. Jambekar, Masheb and Grillo (2002) explored this link using a trait measure of shame, the ISS (Cook, 1994). They found that shame was significantly related to the attitudinal features of eating disorders, even after controlling for depression and low self-esteem. This study measured depression by using the BDI, (Beck &

Steer, 1987), which may be also be measuring shame (Cook, 1994; Goss et al., 1994). The participants in the study were also seeking treatment at a university based outpatient eating disorder unit, therefore it may not be possible to generalise the results to community based programs or outpatient services treating those with binge eating disorder.

### **1.6.3 Shame and bulimia nervosa**

Studies have also explored the link between shame and bulimia nervosa. Hayaki, Friedman and Brownell (2001) carried out two studies on shame and the severity of bulimic symptoms. They revealed that shame was significantly and positively related to bulimic symptoms. In a student group, shame was associated with higher levels of bulimic symptoms when controlling for depression and guilt. However, bulimic symptoms failed to differentiate between levels of shame when controlling for depression and guilt. Possible methodological problems with the study are that they used the TOSCA (Tangney et al., 1989), which may not be sensitive to trait shame. They also used the BDI (Beck & Steer, 1987) which as previously mentioned may measure shame (Cook, 1994; Goss et al., 1994) rather than just depression.

Waller, Ohanian and Osman (2000) used YSQ (Young, 1990) and found that failure to achieve, defectiveness/shame and insufficient self control schemas were all higher in a group of bulimic women compared to a control group. This research found that the schema of defectiveness and shame predicted the severity of purging (vomiting) in the bulimic group,



whilst an elevated emotional inhibition schema score predicted the severity of vomiting. As previously mentioned the YSQ as not explicitly designed to measure shame, in addition it has not been standardised against other robust measures of shame.

#### **1.6.4 State versus trait shame in eating disorders**

Shame can be either state (dependent on a given situation) or trait (underlying predisposition of experience shame). Research has explored these in relation to shame and eating disorders. Burney and Irwin (2000) used situational scenarios for measuring state shame (rather than trait measures) and found that shame about eating was related to eating disordered beliefs, with lower correlations than studies using trait measures. Further research (Gee & Troop, 2003; Troop, Allan, Serpell & Treasure, 2001) using a situational scale and a trait external scale, found that shame and low pride in self is significantly associated with eating disordered psychopathology for those currently suffering or recovering from an eating disorder, measured on the TOSCA (Tangney et al., 1989) and the OAS (Goss et al., 1994). Moreover, women with a current eating disorder had higher levels of shame whilst those in remission scored in the intermediate range and a control group consisting of non-eating disorder individuals scored the lowest in terms of shame score.

Sanftner and Crowther (1998) conducted research on a sample of 78 students and found that women who binged reported significantly greater fluctuations compared to women who did not binge on state self-esteem,

negative affect, shame and guilt. This research also found that positive affect and self-esteem increased prior to all eating episodes; however, women who binged had lower levels of self-esteem and positive affect than those who did not binge. Therefore shame may not be a permanent affective state but rather may fluctuate over time. This clearly has implications for the way shame is measured.

#### **1.6.5 The focus of shame in eating disorders**

Perhaps it is the focus of the shame experience that is important in eating disorders. For example, individuals with an eating disorder may feel increased shame about their body size or weight. This body-image shame is very different from body dissatisfaction, which is widespread among women without an eating disorder (Cash, Winstead & Janda, 1986). Andrews (1997) found that body-image shame had a significant link with bulimia, which could not be explained by body dissatisfaction. This study argues for the distinction between body dissatisfaction and body shame. Both involve not living up to one's own standards, influenced by society, but body dissatisfaction does not involve the active concealment of believed deficiencies and extreme concern about how one appears to others (Andrews, 1995).

Research supporting the link between body-image shame and eating disorders has shown that proneness to shame in eating related contexts and in connection to one's own body are the strongest predictors of the severity of eating disorder symptomatology (Andrews, 1997; Burney &



Irwin, 2000). Moreover, Burney and Irwin (2000) found that the severity of eating disorder symptomatology was related to shame and guilt in eating contexts and body-image shame rather than global shame or guilt. They suggest that the shame experienced by women with an eating disorder is likely to be a consequence rather than a cause of such behaviour.

Research linking shame to eating disorders includes the study by Sanftner, Barlow, Marschall, and Tangney (1995) which found that women with disordered eating viewed negative feelings about their bodies and eating as a reflection of a bad self rather than problematic behaviours or thoughts.

Other research on body-image shame and eating disorders comes from Swan and Andrews (2003) who found that women currently suffering from an eating disorder reported significantly higher levels of body-image shame than a control group of women who had recovered from an eating disorder. Sanftner et al. (1995) conducted research using a measure of shame on a non-clinical sample and found that shame proneness was positively related to the severity of a range of eating disturbances, including body dissatisfaction. However, the correlations in this study were modest. Other studies have found significant correlations between body-image shame and disordered eating (McKinley & Hyde, 1996; Noll & Fredrickson, 1998; Tiggemann & Lynch, 2001).

Further research on body-image shame comes from Masheb, Grilo and Brondolo (1999) who conducted research using the ISS (Cook, 1993) to explore shame based on body-image and physical attractiveness. They found that a group of women with Vulvodynia (a medical condition with psychiatric implications) and a group of women with a diagnosed eating disorder (binge eating disorder) both reported higher levels of shame than a control group of women, however, the eating disorder group scored significantly higher than both the other groups. For those in the eating disorder group, shame was related to shape and weight rather than eating.

Body-image shame may develop as a result of the internalisation of the thin ideal that provides a standard sanctioned by society to which people compare themselves to. Magazines, such as 'Hello', are full of such images, alongside hints and tips of how to achieve this "perfection". Despite the coverage given to this culturally valued and prescribed thin ideal, it is virtually impossible for the average women to achieve (Harter, 1999). Research has found a link between the pursuit of this thin ideal and body-image shame (Markham, Thompson & Bowling, 2005). Markham et al. (2005) found that the internalisation of the thin ideal indirectly predicted increases in body-image shame and lower global self-worth via social comparisons. Collectively, body-image esteem, global self-worth, appearance comparison and the internalisation of the thin ideal accounted for 62% of the variance of body image shame. Each of these factors appear to elicit feelings of inadequacy, resulting in body-

image shame. A previous history of weight related teasing was not linked to body-image shame.

One possible explanation for the link between the internalisation of the thin ideal and body-image shame is sexual objectification theory (Fredrickson & Roberts, 1997). This theory states that routine sexual objectification experiences socialise females to consider themselves as objects to be looked at and evaluated in such a way that their bodies become objects for others (Bartky, 1988; McKinley, 1998; Spitzack, 1990). Moradi, Dirks and Matteson (2005) found that body surveillance and the internalisation of the thin ideal simultaneously mediated the link of reported sexual objectification experiences to body-image shame. Noll and Fredrickson (1998) also found a direct relationship between self-objectification and disordered eating.

Body-image shame may then lead to excessive bodily monitoring and checking. Fairburn (2001) suggests that excessive bodily monitoring, excessive mirror checking or pinching the skin may exacerbate shame, which may result in further attempts to control weight. It is unclear whether such behaviours serve to increase shame by increasing focus on perceived defects or because such behaviours themselves become the focus of further shame-related appraisals. Moradi et al. (2005) found that body-image shame acts as a mediator to the link of body surveillance to eating disorder symptoms.



Those with an eating disorder may experience greater shame and guilt in response to eating. Frank (1991) conducted research to explore this hypothesis comparing a group of people with an eating disorder (diagnosis not specified), a group of people with depression and a control sample. This study found that women with an eating disorder reported significantly higher levels of shame and guilt in relation to eating. For women in all three groups, depression was associated with shame and guilt in general, however, it was only in the eating disorder group that the reported depression was associated with high levels of shame and guilt about eating. Frank (1991) suggests that the depression in those with eating disorders maybe linked to rumination about food eaten, which in turn may lead to a binge.

Supporting evidence for the link between shame and eating also comes from Burney and Irwin (2000). They conducted research using situational scenarios rather than using trait measures to measure shame and found shame about eating related to eating disorder symptomatology. Jambekar et al. (2003) found that shame was not associated with the frequency of bingeing; however, it could be that women who binge do not experience fluctuations in shame immediately prior to a binge, as supported by Saftner and Crowther (1998). This suggests that shame may be present as a trait rather than a state before or after a binge, alternatively, participants could also be under-reporting their binges due to shame. Masheb et al. (1999) found that shame was related to body shape and weight rather than eating.



Some people with an eating disorder may also be ashamed of belonging to a stigmatised group. There is evidence that clients find both mental illness and obesity stigmatising (Falkner et al., 1999), perhaps due to both of these being culturally undesirable. Research has found that women with eating disorders tend to be unreliable informants of their personal experiences (Brown, Russell & Thornton, 1999) suggesting that they may feel stigmatised. Swan and Andrews (2003) took a sample of 68 women who had received treatment for eating disorders and found that 42% did not disclose important information about their eating to professionals working with them. Perhaps individuals feel shame in relation to being a higher weight, however, Jambekar et al. (2002) in a study of those with binge eating disorder, did not find this. This again was contrary to their hypothesis, given the nature of stigma attached to obesity, perhaps suggesting that either being stigmatised does not result in feelings of shame or that once a person is above a certain weight, the degree of stigma may remain constant.

#### **1.6.6 Pathways to shame**

There are only a few papers exploring the possible pathways of shame to the development of eating disorders. Studies that have explored this important area have tended to focus on parental style/family dysfunction, reported childhood sexual abuse or the eating disorder behaviour to regulate negative affect, including shame.

There is growing evidence that suggests that early experiences with primary care givers influence a person's vulnerability to later psychopathology. Adults who experienced primary care givers providing low levels of empathy and affection, and high levels of overprotection or control when children, have lower self-concepts, bulimic symptomatology and higher levels of depression (Dunlop, Burns & Bermingham, 2001; Murray, Waller & Legg, 2000). Family dysfunction is often cited as one of the risk factors for the development of bulimia nervosa (Strober & Humphrey, 1987; Welch, Doll, & Fairburn, 1997). It has been argued that shame may mediate between family dysfunction and the development of eating disorders (Murray & Waller, 2002). Further suggestions are that internalised shame can result from chronic exposure to a "shame bound" family environment (Fossum & Mason, 1986; Kaufman, 1992).

Murray et al. (2000) suggest that certain early experiences and shame might act as predisposing factors in the aetiology of eating disorders. They found that shame played a central and complex role in the link between perceived parental style and bulimic symptoms, and overprotective fathers had a direct influence on internalised shame, if one is already predisposed to shame-proneness. However, Markham et al. (2005) found that parental care and overprotection failed to significantly predict body-image shame.

The link between body-image shame and early sexual abuse, resulting in eating disorders has also been investigated. Studies have found a link

between childhood sexual abuse and the later development of eating disorders (Andrews, 1997; Murray & Walker, 2002; Waller et al., 2001). Andrews (1997) found that self-reported childhood sexual abuse was highly associated with bulimia nervosa and suggests that body-image shame may be a mediator between childhood sex abuse and subsequent development of this disorder. This finding can be understood by Gilbert's (1989) proposal that any act of defeat or subordination can result in shame. The research used an interview script rather than self-report measures to collect data. Murray and Waller (2002) further explored the possible link between reported childhood sexual abuse and bulimia nervosa in a study using a non-clinical sample and found that internal shame (measured by the ISS, Cook, 1994) was a partial mediator between self-reported sexual abuse (non interfamilial) and bulimic attitudes, and a perfect mediator between sexual abuse (interfamilial) and bulimic attitudes. Other studies have found no relationship between childhood sexual abuse and eating disorders (Kinzl, Traweger, Guenther & Biebl, 1994; Schaaf & McCanne, 1994; Smolak, Levine & Sullins, 1990).

#### **1.6.7 Coping with negative affect**

Shame may lead to other negative emotions, for example, depression and anxiety. How individuals cope with these emotions may also be linked to further shame. For example, people may binge or purge in an attempt to control negative emotions (DeSilva, 1995; Sanftner & Crowther, 1998). Shame is undoubtedly a powerful, negative emotion and



can potentially trigger eating disordered behaviour. Eating may serve as an escape from negative affect for all women (Heatherton & Baumeister, 1991), but more so for women who binge. However, overeating may then lead to a sense of loss of control, which can lead to shame and guilt (Fairburn, 1981; Johnson & Larson, 1982).

Research has also explored the link between shame and depression.

There is evidence of a strong relationship between general shame, body-image shame and depression (Andrews, 1995; Tangney et al., 1992).

Gee and Troop (2003) found that shame was related to both depression and eating disordered concerns. This study used the OAS (Goss et al., 1994) and the TOSCA (Tangney et al., 1989) to compare which aspects of shame were important in depression. They found that the OAS predicted depression whilst the TOSCA predicted eating disorder symptomatology. Swan and Andrews (2003) found that an eating disorder group scored significantly higher than a control group on all shame areas when depression was controlled for, suggesting that shame is an important factor in eating disorders independent of depressed mood.

#### **1.6.8 Gender differences in shame and eating disorders**

The majority of the studies reviewed used a female only sample (sixteen out of the seventeen studies), perhaps due to the prevalence of women seeking treatment in eating disorder units. However, men are subject to culturally prescribed standards of appearance to an increasing degree



and thus there may be an under reporting of men with eating disorders. The shame experience may also differ for men compared to women.

Research by Jambekar et al. (2003) found men and women seeking treatment for binge eating disorder (BED) reported similar levels of shame and overall did not differ in terms of their behavioural and attitudinal eating disordered features. However, whilst shame was associated with body dissatisfaction in men, in women it was associated with weight concern (this study controlled for depression, using the BDI). In addition, shame was also associated with dietary restraint in women but not men, perhaps supporting other research that eating small amounts of food is associated with femininity (Silberstein, Striegel-Moore & Rodin, 1987).

Participants in the study by Jambekar et al. (2003) were selected from a group of individuals seeking treatment at a university-based outpatient eating disorder program, therefore results may not be generalisable to community groups or outpatient groups. The use of self-report measures may also have limitations. The low numbers of men compared to women may also limit the conclusions of gender differences in BED.

### **1.7 Methodological considerations and future research**

The majority of the studies have relied upon undergraduate samples using self-report questionnaire measures of eating disorder symptoms. Most studies have assessed eating disorder symptoms in these non-

clinical populations with low levels of actual diagnosable eating disorders, thus making it difficult to generalise findings from these studies to an eating disorder population. In addition, such groups are typically made up of young white middle class individuals and therefore may not generalise to other groups. The use of self-report measures in non-clinical populations may also assess general psychological distress rather than specific types of maladaptive functioning (Gotlib, 1984).

Studies have also focussed on single diagnostic categories, resulting in difficulty making comparisons between the different eating disordered populations. No study so far has explored shame in those with an eating disorder not otherwise specified. In addition, many of the studies used small numbers of participants making it more difficult to assess the validity of such studies.

The majority of the studies reviewed relied on published measures to assess the phenomenon they were exploring. Such measures were typically completed by the participants. The use of such self-report measures could have been affected by issues such as social desirability and memory recall. In addition, in eating disorders there is often a quite specific focus on the shame (e.g. body-image shame) and it appears that attempts to cope (e.g. checking, restricting) may be associated with an increase or maintenance of shame over time. Nonetheless it is likely that such coping strategies provide relief, distraction or increased positive affect at least for a short time. Such phasic changes in mood have not

been addressed as yet by formal qualitative methodology with most studies utilising standardised psychometrics, which require participants to give longer-term, global mood ratings. Indeed, it could be argued that the phenomenological experience of shame and negative affect in eating disorders is phasic, rather than continuous in nature and that fluctuations or cycling between positive and negative affect may occur within an episode. The study by Sanftner and Crowther (1998) supports this argument that shame can fluctuate over time and is not a permanent affect. Therefore shame may be more difficult to detect using general, global ratings from standardised psychometric measures

There is evidence of a strong relationship between general shame, body-image shame and depression (Andrews 1995; Gee & Troop 2003; Tangney et al., 1992). Despite the association between depression and eating disorders, only six of the reviewed articles controlled for depression (Frank, 1991; Gee & Troop, 2003; Hayaki et al., 2002; Jambekar et al., 2002; Swan & Andrews, 2003; Troop et al., 2001). Four of these studies used the BDI which is highly correlated with the ISS (Cook, 1994) and OAS (Goss et al., 1994).

## **1.8 Summary and clinical implications**

The research to date is convincing in highlighting an association between eating disorders and shame, indeed much has changed since Lewis (1987) described shame as a 'hidden emotion'. There has been an increase in published articles on the role of shame in a number of



psychological problems, including eating disorders. However, with this increased interest of shame there has been a corresponding de-emphasis on the role of guilt and the differences between these two emotions. The literature on shame and guilt does argue that these are indeed two distinct emotions, with different implications for the individual (Gehm & Scherer, 1988; Lewis, 1971; Tangney, 1995; Tangney et al., 1996).

Recent studies suggest that shame is an important variable to consider in the treatment of eating disorders (Frank, 1991; Gee & Troop, 2001; Masheb et al., 1999; Swan & Andrews, 2003; Troop et al., 2001). Papers finding a link between shame and bulimic symptoms have provided some important insights (Hayaki et al., 2001; Waller et al., 2000). Other research has found that shame associated with eating disorders is the strongest predictor of the severity of the disorder (Andrews, 1997; Burney & Irwin, 2000). Gender differences have also been explored and research has found similar levels of shame, but a different focus of shame between men and women (Jambekar et al., 2003).

Research has found that those with an eating disorder may also be ashamed of belonging to a stigmatised group resulting in them being unreliable informants of their personal experiences (Brown et al., 1999; Swan & Andrews, 2003). If shame is associated with belonging to a stigmatised group, then this has clinical implications. For example, clients may deny symptoms altogether or minimise their severity, leading to a



possible inaccurate formulation and resulting treatment program. In addition, clients may also find the assessment and treatment of their eating disorder shame provoking, especially when services are located within psychiatric hospitals.

In addition to exploring the shame of having an eating disorder, this review has also explored papers addressing the possible pathways of shame to the development of eating disorders, including parental style/family dysfunction, reported childhood sexual abuse or the eating to regulate negative affect. Research has found a link between parental style and the later development of eating disorders (Dunlop et al., 2001; Murray et al., 2000; Murray & Waller 2002). However, other research failed to find this link (Markham et al., 2005). A link between childhood sexual abuse and the later development of eating disorders has also been found (Andrews 1997; Murray & Walker 2002; Waller et al., 2001). However, other studies have failed to find this link (Schaaf & McCanne, 1994; Smolak et al., 1990). Therefore a definitive conclusion is yet to be reached on the link between parental style or sexual abuse experienced in childhood and the later development of an eating disorder.

Some individuals may binge or purge in an attempt to control negative emotions (DeSilva, 1995; Sanftner & Crowther, 1998). Those with an eating disorder appear to experience greater shame and guilt in response to eating than those without an eating disorder (Burney & Irwin, 2000; Frank, 1991). The functional role of an eating disorder has previously

been ignored by research (Andrews et al., 2002; Goss and Gilbert 2002). However, it is important that those working with a client group with eating disorders are aware of the possible immediate benefits of the behaviour and the resulting possible shame.

The research suggesting a link between shame and eating disorders has obvious implications for treatment. Thus a tendency to feel shame may be high in this clinical group and relate to a lack of disclosure. More problematic is that by encouraging clients to reveal information about themselves that they find shameful (e.g. via food diaries), may lead to increased shame in the short-term. It is important that those working with a client group with eating disorders are aware of possible shame issues and the ways in which this can not only effect the therapeutic relationship but also the outcome of treatment.

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## **Chapter 2: Empirical Paper 1**

### **Shame and pride in eating disorders: A qualitative investigation**

## 2.1 Abstract

**Objective:** The objective of the present study is to explore shame and pride in a clinical population with a diagnosed eating disorder. **Method:** The research involved interviewing eight participants, who attended an outpatient eating disorder service. They were diagnosed with; anorexia nervosa , bulimia nervosa or eating disorder not otherwise specified. Interpretative Phenomenological Analysis, IPA (Smith, Jarman & Osborn, 1999) was used as a framework for the analysis. **Results:** Based on interview transcripts from the participants, a number of themes were found including; shame, pride, shame responses, control and recovery. The results suggest that shame exists both as a cause and consequence of having an eating disorder. **Discussion:** Shame and responses to shame emerged as important themes in the research, along with pride, control and recovery. An understanding of shame and pride in eating disorders may improve our understanding of the disorders and may improve clinical outcomes.

## 2.2 Introduction

There are four official DSM-IV categories of eating disorder, anorexia nervosa, bulimia nervosa, binge eating disorder and eating disorder not otherwise specified (American Psychiatric Association, 1994). Despite the differences between these diagnostic categories, they all involve a negative self-view (Palmer, 2000).

Previous studies have found shame associated with eating disorder symptomatology (e.g. Andrews, 1997; Burney & Irwin, 2000; Frank, 1991; Gee & Troop, 2003; Hayaki, Friedman & Brownell, 2002; Jambekar, Masheb & Grillo, 2002; Masheb, Grilo & Brondolo, 1999; Sanftner, Barlow, Marschall & Tangney, 1995; Swan & Andrews, 2003; Troop, Allan, Serpell & Treasure, 2001; Waller, Ohanian & Osman, 2000; Waller et al., 2001). Research has also found that shame associated with eating disorders is the strongest predictor of the severity of the disorder (Andrews, 1997; Burney & Irwin, 2000), whilst Cooper, Todd and Wells (1998) found shame in both those with anorexia nervosa and bulimia nervosa.

Shame has been conceptualised in many ways. For example, someone can experience internal shame (Kaufman, 1989; Nathanson, 1994), a self-evaluation of being flawed, inadequate, inferior, powerless and personally unattractive to others. Individuals may also experience external shame, involving holding a belief that others see them as flawed, inadequate, worthless or unattractive (Lewis, 1971, 1987).

Goss and Gilbert (2002) suggest that people with an eating disorder have elevated internal shame. Research by Andrews (1997) and Burney and Irwin (2000) linked body dissatisfaction with eating disorders. Supporting research for the link between body dissatisfaction and eating disorders comes from Masheb et al. (1999) who found shame was related to shape and weight rather than eating for those with an eating disorder. Body dissatisfaction or body-image shame may result in excessive bodily monitoring (Fairburn, 2001), which in turn results in further shame and self-disgust. Indeed, Moradi, Dirks and Matteson (2005) found that body shame acts as a mediator to the link of body surveillance to eating disorder symptoms.

Shame has traditionally been conceptualised in negative terms, however, a number of researchers suggest shame can serve an important social function. Social ranking theory of shame (Gilbert, Pehl & Allan, 1994) suggests that shame may help to establish and maintain social rank. Previous generations would assess social ranking in terms of strength, however, modern day cultures use a variety of ways, including attractiveness (Gilbert et al., 1994). If a person believes they are unattractive or inferior to others, they may experience shame, aimed at appeasing dominant others, or hide traits or characteristics that may not be socially valued. This could guarantee membership of a valued group or maintain the social status within the group. Gilbert (1998) argues that part of the shame response is the active signalling of submissive behaviour, such as concealment or avoidance, to maintain social



rank/group membership. In addition to concealment and self-directed hostility, Gilbert (2003) outlines the following ways of coping with shame: increased attention to treat, aggression towards others, help seeking behaviour, submission, compensation/reparation and pride and rebellion.

Another way of coping with shame, and indeed other negative emotions is avoidance. For example, some individuals engage in bulimic behaviours in an attempt to avoid and therefore control negative affect (DeSilva, 1995; Cooper et al., 1998; Heatherton & Baumeister, 1991; Sanftner & Crowther, 1998). For some, eating food or purging may temporarily improve mood or help the individual dissociate to avoid severe affect shifts. McManus and Waller (1995) suggest that bulimic behaviours are more likely to regulate immediate affective states rather than more global states.

A contrasting emotional and cognitive experience to shame is pride, which is associated with a feeling that one's own attributes and talents are approved of or admired by others (Mascolo & Fischer, 1995). Pride may also be a way of coping with shame (Gilbert, 2003). Pride can also develop from a sense of being able to control one's own eating, despite pressure from family and professionals. In comparison to shame there has been surprisingly little evaluation of pride in eating disorders.

Restricting food can be culturally encouraged and reinforced. The media, for example, encourages competition between women and social

comparison in magazines is evident. The pursuit and internalisation of the thin ideal is linked to body image shame (Casper, Offer & Ostrov, 1981; Markham, Thompson & Bowling, 2005; Masheb et al., 1999; Stice & Shaw, 1994). In the light of this, individuals can feel a sense of pride over their food restriction. For example, Bruch (1973) described the case history of Celia noting that although she originally initiated weight loss to please her husband she soon developed a sense of glory and pride in her food restriction. Further support of the role of pride in eating disorders comes from MacLoad (1981) who reported her own eating disorder, describing a sense of energy and interpersonal power from the disorder.

Other studies have linked restriction of food in anorexia with euphoria induced from feelings of success and control (Overton, Selway, Strongman & Houston, 2005; Vitousek, 1996). Therefore the behaviour to reduce shame (restricting food) can hypothetically lead to pride and become a valued ideal, encouraged by society, which may become resistant to intervention even in the face of distress, shame and risks to physical health. Wallace (1986) reports on the tragic story of the Gibbens twins, and how their eating disorders, anorexia nervosa and bulimia nervosa, helped them to gain a sense of power by competing with each other in terms of eating disordered behaviour.

Goss and Gilbert (2002) propose a shame-shame and shame-pride model (see appendix one and two). The shame-pride model suggest various background factors, for example, biological, personal and socio-

cultural, act as background dispositions that can lead to external shame and influence internal shame. For food restrictors it is hypothesised that when an individual feels shame they will cope by body/weight/food control, resulting in a sense of pride, initially perhaps encouraged by significant others. However, this sets up a self-perpetuating cycle of shame-pride, where the individual's ability to control their body/weight/food intake becomes a reward in itself. Therefore to begin eating again could be seen as giving in to pressure from others, who now may attempt to gain control. If the person with anorexia began to eat again they may fear a return to the shamed self, of giving in and losing. In addition they may lose the sense of pride and positive social comparison gained by restricting.

For the second cycle, the shame-shame model of binge eating, a different self-perpetuating cycle is proposed. The background factors can lead to shame in the same way for restrictors, however, for those who binge such behaviour may be an attempt to control unstable and negative effects, especially in interpersonal contexts. A sense of rebellion and secrecy may be implicated in the binge episodes. Following a binge or purge, the person may feel disgusted by their behaviour, and although the behaviour may be initially a form of rebellion, it can also be isolating, leading to a fear of abnormality and consequently a greater sense of shame. The behaviour does not address the underlying emotional/interpersonal problems and a self-defeating and self-perpetuating cycle is set up and maintained.



The current study, with a focus on shame and pride within different types of eating disorder builds upon existing research and has clinical implications for the treatment of eating disorders. Previous studies on shame in those with an eating disorder have typically used non-clinical populations. The current study used a clinical sample of participants with an eating disorder as recommended by Overton et al. (2005) and Swan and Andrews (2003). Indeed, Overton et al. (2005) argue that shame and pride are experienced differently by those with an eating disorder thus drawing clinically important conclusions on shame and pride from research using a non-clinical sample may be problematic.

The present study aims to explore whether shame and pride exist in a eating disorder population. The study will attempt to find out if those with a clinically diagnosed eating disorder report any body shame, possible shame responses or pride in an existing or previous body shape.

## **2.3 Method**

### **2.3.1 Procedure**

Ethical approval was obtained for this study from Warwickshire Local Ethics Committee (appendix three) and Research and Development Department at Coventry Primary Care Trust (appendix four). The study adopted a qualitative research design and involved interviewing eight participants. Those selected as potential participants had the research explained to them and were asked if they would consent to take part. If



they agreed, they were given an information pack containing a participant information letter (appendix five); a letter, inviting them to take part in the research which included the researchers contact details (appendix six); and a written consent form (appendix seven). All those who took part in the study gave their verbal and written consent. In addition, the General Practitioner (GP) of all those involved in the study received a letter confirming their involvement (appendix eight)

### 2.3.2 Participants

Potential participants were approached from clients who attended an outpatient eating disorder service. Inclusion and exclusion criteria are shown in appendix nine. Participant details are shown in table two.

**Table two - participant details**

Number	1	2	3	4	5	6	7	8
Age	21	21	23	20	36	31	20	49
Gender	F	F	F	F	F	F	F	F
BMI	16.9 under-weight	21.8 Normal	19.8 under-weight	18.6 under-weight	35 obese	21.4 Normal	19.2 under-weight	26 over-weight
Previous diagnosis	None	Self reports of AN for 4 years	Self report of BN for 6 years	Self reports of AN for 6 years	None	None	Self reports of AN for 3 years	None
Current diagnosis	AN	BN	BN	BN	EDNO S	BN	BN	EDNO S
Length of illness from diagnosis	12 months	11 months	16 months	14 months	12 months	9 months	16 months	25 months
Ethnic origin (self determined)	White UK	English / Korean	White other	White UK	White UK	White UK	White UK	White UK

AN = anorexia nervosa

BN = bulimia nervosa

EDNOS = eating disorder not otherwise specified

### **2.3.3. Data collection**

The interviews were conducted at an eating disorder service, in a private room. Each interview was tape-recorded and began with a discussion of approximately ten minutes. This was to encourage engagement and help develop trust to help prevent superficial answers (Stiles, 1993). The discussion began with introductions, an explanation of the purpose of the research, a discussion of ethical issues (including voluntary participation), the complaint procedure and the possible publication of any data, and an opportunity to ask questions or gain further clarification. This part of the interview was not tape recorded.

A semi-structured interview schedule (appendix ten) was used to help facilitate the participants' report of their own story in their own words, as recommended by Smith, Flowers and Osborn (1997). During the interviews participants' responses were checked back with them to check understanding, as recommended by Atwood and Stolorow (1984). At the end of each interview there was a period of debriefing. The debriefing sessions lasted as long as each participant needed to explore the issues, ranging from five to twenty minutes and were not tape-recorded. Most interviews lasted approximately one hour, but this ranged from fifty minutes to one and a half hours. The interviews were transcribed by the chief investigator (see appendix eleven for a sample page of the transcript).

#### **2.3.4 Data analysis**

IPA (Smith, Jarman & Osborn, 1999) was used as a framework for organising the data according to themes identified in the research, i.e. shame, pride and shame responses. Material not categorised this way was classified using appropriate grouped themes, for example; control, and recovery. IPA has previously been used within a pre-existing theoretical framework, for example, Green, Payne and Barnitt (2004) used IPA and the self-regulation model (Leventhal, Nerenz & Steele, 1984) as frameworks for their analysis. Whilst some suggest that IPA should not attempt to test a pre-determined hypothesis (Smith & Osborn, 2003) others argue it is unlikely that any researchers could embark on a study without having any ideas or at the very least an awareness of the literature (Brocki & Wearden, 2006).

Smith (2004) suggests that IPA has three characteristic features. Firstly it is idiographic, starting with a detailed examination of one case before moving onto other cases. Secondly it is inductive, allowing the use of flexible techniques to encourage unanticipated topics to emerge. Finally it is interrogative, using existing research to discuss findings.

IPA is an idiographic qualitative methodology and was chosen as the methodology for the study because it is focussed on understanding the participants' perspective and recognises that this can be achieved by the interpretative analytic efforts of the researcher. The researcher using this method is attempting to get close to the personal world of the



participants. For this study, the use of IPA allowed us to explore participants' subjective experiences, helping us to understand what shame and pride meant to them. Published research on shame and pride in an eating disordered population is limited, thus it was felt important to gain participants perspectives of these emotions. The idiographic nature of the methodology was important, to fully understand one case before moving on. It was also important that any methodology was inductive and interrogative, linking the findings to existing research. The stages recommended by Smith et al. (1999) were followed for the analysis of the data (appendix twelve).

During any qualitative research, it is important that researchers are aware of their own views on the subject under investigation, and the possible impact these views have on the research process. The chief investigator in the research was on placement in a different eating disorders service than the research site at the time of the research. The experience of working in an eating disorders unit made the researcher very aware of possible shame issues in eating disorders and their impact upon the therapeutic relationship. Using IPA within a pre-existing theoretical framework did impact on the themes found, however, other themes outside this framework still appeared (for example, control and themes of recovery).



### **2.3.5 Validity**

One view of qualitative research argues that adhering to guidelines is against the nature of this approach (Feyerabend, 1975). During this research, however, guidelines were used to improve validity and reliability. In particular, Elliott, Fisher and Rennie's (1999) and Yardley's (2000) broad principles for the completion of robust qualitative research were followed. For example, the researcher sent each participant a copy of their transcript and followed up approximately ten days later with a phone call in order to check that the transcripts were an accurate reflection of the interview (testimonial validity). A second check for validity was to send the first participant a list of the superordinate and subordinate themes, again these were checked for accuracy via a phone call. No changes were made by any of the participants (testimonial validity).

In addition, the validity and credibility of the research was checked on a regular basis with a second researcher, experienced and taught in the use of IPA. This second researcher also read the first transcript, using the first three stages of the analysis. The chief investigator and the second researcher then met and discussed any differences and similarities in the emerging themes. Agreement was reached on approximately 98% of the themes. The themes were also checked with the two co-authors.

## 2.4 Results

The eight participants' experiences of having an eating disorder were analysed. Five superordinate themes emerged, which were pride, shame, shame responses, control and recovery and twenty one subordinate themes were found. The use of linguistic data does not prevent the use of numerical data, and some suggest they can be combined (Stiles, 1993). Thus simple numeric data is also provided to support the linguistic data.

The superordinate and subordinate themes are presented in table three along with the number of participants' transcripts, the theme appeared in, and the total number of times each theme occurred within the transcripts.

The figures at the end of each quotation in the following results section indicate it's location in the transcript and transcript number.

**Table three – master themes**

<b>Superordinate theme</b>	<b>Subordinate theme</b>	<b>Number of transcripts</b>	<b>Total frequency</b>
<b>1. Shame</b>	1a. External shame	8	76
	1b. Body weight/shape	8	67
	1c. Internal shame	8	41
<b>2. Pride</b>	2a. Body weight/shape	7	24
	2b. In restriction/self control	5	17
	2c. In others compliments of weight loss	4	7
<b>3. Shame responses</b>	3a. Negative social comparisons - other women	8	67
	3b. Self directed hostility – punishment	7	24
	3c. Avoiding social comparisons & checking behaviour	6	23
	3d. Negative affect control	6	23
	3e. Negative social comparisons –media	6	22
	3f. Body/weight checking behaviour	7	21
	3g. Identification with slim ideal	6	17
<b>4. Control</b>	4a. Fear of losing control/putting on weight	8	71
	4b. Loss of control	6	29
	4c. Control attempts by others	6	28
	4d. Anger at control attempts by others	4	21
	4e. Resisting control attempts	5	12
<b>5. Recovery themes</b>	5a. Ambivalence	6	48
	5b. Quest for wellness	7	27
	5c. Searching for explanation	6	24

### **Superordinate theme 1 - shame**

Subordinate themes of external shame, body weight or shape shame, and internal shame appeared in every transcript.

### **1a. Subordinate theme – external shame**

Participant six talked about what she believes people think about her:

*“I think they are looking at me and thinking I am fat or something”. (4: 42-43).*

Participant five reported what she thinks others think of her if they see her eat:

*“I think they will be thinking that I eat too much and that I am fat and greedy and ‘look at the size of her, does she really need to eat that? Wouldn’t she be better with a cracker or a bit of bread? Why does she have to eat all that for?” (12: 41-45).*

### **1b. Subordinate theme – shame of body weight or shape**

Participant six talked about the shame she feels about her body shape:

*“If I am feeling fat I just hate it, hate it, just want it gone, hate the way it looks, hate the way it feels, just feel I would be better if it wasn’t there”. (1: 30-32).*

Participant eight when asked about her body shape reported:

*“It’s awful, bloody awful. I have to control myself or I just wouldn’t go out, I could quite easily stay at home in jogging bottoms and not face anyone”. (10: 30-31).*

### **1c. Internal shame**

Participant number five summed up the pain of internal shame:



*“The best thing that could happen to me is to be locked up in a room with nothing to eat, because I am no good to anyone. I am no good to myself, so what I am putting out to the world is just crap because that’s all that’s inside me”. (18: 7-11).*

## **Superordinate theme 2: Pride**

This superordinate theme is divided up into three subordinate themes; pride in body weight/shape, pride in restriction/self control and pride in others compliments of weight loss.

### **2a. Subordinate theme – pride in body shape/weight**

Participant seven talked about this in relation to her previous anorexia:

*“I miss other people thinking I am better, just body wise, that my body is better than other peoples and me believing that it is better than other peoples”. (12: 25-27).*

### **2b. Subordinate theme – pride in restriction or self-control**

Participant four described her feelings of pride in restriction when she was anorexic:

*“I remember when I was restricting quite badly and sitting having a meal with my family and thinking how pathetic are they? Look at them and all the food they are eating and I can just manage to eat this little amount of calories and still exist, I am still alive. How can they not know how to control their eating? I did feel sorry for them”. (7: 12-16).*

## **2c. Subordinate theme – pride in others compliments of weight loss**

Participant one described her experience:

*“When I started to restrict they said to me how amazing I looked, and the compliments seemed really sincere and heart felt and I remember one night in particular when one of my friends said ‘oh my God you’ve lost weight, you look absolutely gorgeous’. I remember her words. I can even remember the bar we were in and I was like, I was on cloud nine and if I would have got ID at every bar that night and had a really crap night, it would not have taken away the fact that she noticed. It was just indescribable. It was great”. (25: 1-8).*

Participant four also talked about her feelings of pride in the compliments given by others when she first lost weight, before she was anorexic:

*“At the beginning, when I just slimmed down a bit, people would make comments like ‘oh you look good, you have lost weight, you are so skinny how do you manage to eat so much and stay slim?’. That was really good and people making comments about wanting a figure like mine. But it is hard to distinguish when that stopped and people started worrying”. (3: 21-25).*

## **Superordinate theme 3 – shame responses**

Participants outlined a number of ways they responded to their shame. All of the participants compared themselves negatively with other women.

Self-directed hostility in the form of punishment also appeared. Some avoided social comparisons and checking on their body shape or weight,

others increased their checking behaviour. The majority of the participants also identified with the slim ideal and compared themselves to media images.

### **3a. Subordinate theme – negative social comparisons – other women**

Participant one discussed the pain of these comparisons:

*“But every time I see my friends I body check them, you know, waist, hips. I wonder what size they are, then I try to imagine how other people see them, how maybe lads would see them and then if we were walking out together would I look like the obviously bigger one”. (23: 21-25).*

### **3b. Subordinate theme – self directed hostility - punishment**

Descriptions under this theme include self-punishment and feeling punished by the illness. Participant three reported using laxatives and described taking these as a form of punishment:

*“Laxatives, because they are so awful they make me feel better, because I am kind of punishing myself, I guess”. (4: 18-19).*

### **3c. Subordinate theme – avoiding social comparisons and checking behaviour**

Another form of behaviour reported by some of the participants was avoiding checking behaviour and social comparisons. Participant eight talked about avoiding her reflection due to shame:



*"I have got a wardrobe at home with a mirror in it, which is directly opposite my bed and because you could see the whole thing, I always have a nice skirt that I love hanging there". (9: 37-39).*

Participant four described how seeing another person at her local gym affected her:

*"I walked in and there was this real slim girl on the treadmill, so I said to the instructor 'I am not going on there while she is there' and so I had to go into this dance studio, just me and the instructor, and do my stretching there and wait until the girl had gone. I wouldn't stand there next to her. I have terrible trouble like that. I don't like going out with skinny people". (4: 30-35).*

### **3d. Subordinate theme – negative affect control**

A number of participants talked about using food to manage difficult emotions. Typically the statements made implied a sense of being overwhelmed by negative emotions. Participant two described eating to manage negative affect and the results of this behaviour:

*"I suppose you just forget about all that or put it to one side and then afterward it all comes back again and you think 'why did you do that again, you know it makes you feel crap, it doesn't make you feel any better'. You think it will, it's like a momentary release but it does not last very long. I heard someone else describe it has this, and I can relate to it. It's like you try and fill your face to fill the hole inside you that is never*

going to go, well not like that anyway, so yea a kind of emptiness feeling as well". (4:22-28).

Participant five also reported using food to manage emotions:

*"I don't know if relief is the right word, (pause) it just kind of dulls the fact that I feel like shit and wish I was dead I suppose". (8: 40-42).*

### **3e. Subordinate theme – negative social comparisons – media images**

Participant two described how looking at magazines made her feel:

*"Well most of it was just rubbish anyway that I didn't agree with, but I just know it was unhealthy for me, spending loads of time looking at these perfect looking people who are either starving themselves or are naturally like that, their bone structure and genetics have made them like that, well I suppose that's not what I think when I am actually looking at them, in the moment I think ' I want to be like that, I just wonder how they do it". (9: 12-18).*

### **3f. Subordinate theme – body or weight checking behaviour**

The checking behaviour reported was either; mirror checking, weighing self, weighing out food or/and skin pinching. Participant two described her mirror checking behaviour:

*"I do quite a lot of mirror checking, like constantly just catching myself, reflections and things and grabbing bits (points to stomach) and being unhappy". (1: 2-3).*

### **3g. Subordinate theme – identification with a slim ideal**

Participant seven described how she thinks of slim individuals':

*"I just think people look really elegant when they are skinnier". (3: 16-17).*

### **Superordinate theme 4 - control**

Control emerged as a theme consistently across the interview transcripts.

The most frequently mentioned aspect of control was a fear of losing control and putting on weight. This was often not a fear of putting on a few pounds, but a fear that their weight would increase to clinically obese proportions overnight. Six of the participants also reported at times being out of control of their eating or purging behaviours. The theme of others controlling them also appeared, along with some resistance and anger towards these control attempts. The control attempts by others were control of body weight or shape.

### **4a. Subordinate theme – fear of losing control or putting on weight**

Participant eight talked about her fear of weight gain:

*"For years I have avoided certain foods, bad foods, which we try not to do here (eating disorders service) like fish and chips, well anything from a chip shop. I wouldn't even go into a chip shop, I would send my daughter if she wanted some chips because I couldn't go in there". (2: 19-22).*



#### **4b. Subordinate theme – loss of control**

Participant six described how she felt unable to control her bingeing behaviour:

*“It’s like yesterday, I just had a day again, and it’s just, it comes from nowhere”. (3: 30-31).*

#### **4c. Subordinate theme – control attempts by others**

Participant six reported how she feels her father still continues to try and control her weight:

*“I felt I wouldn’t be loved by him unless I was slim, because he does say, sorry (participant became upset) because he does sort of, it’s a really big thing for him. I will see him and he will say ‘oh you look fit’ which means I look slim, and then when I was ill before Christmas last year, he would say ‘oh you are too bloody thin’ and I was just, I can’t win, it’s really difficult”. (6: 21-28).*

#### **4d. Subordinate theme – anger at control attempts by others**

This anger resulted from a perception of the participants of others trying to control weight gain. In some cases from significant others trying to encourage initial weight loss, but more commonly, at others trying to encourage weight gain. Participant one described how a friend had recently commented on how good it was to see her eat. The participant reported mixed feelings about her friends comment, initially positive, but then concerned:

*“But now my anorexia would manipulate it in such a way that I would think ‘look at the size 6 bitch trying to fatten you up’”. (22: 14-15).*

#### **4e. Subordinate theme – resisting control attempts**

Participant four described about how compliments turned into control attempts which she resisted:

*“I got very defensive, hmm, at the beginning I thought they were jealous, because they went from ‘oh you are so perfect’ to ‘Oh you are looking a bit skinny now’, but then I think I got to the point where I stopped caring, because the focus was on my weight, on losing my weight, so the social context had gone”. (4: 30-34).*

#### **Superordinate theme 5 – recovery themes**

This included participants' struggling with ambivalence, a quest for wellness and searching for meaning.

#### **5a. Subordinate theme – ambivalence**

Participant one reported some continued ambivalence towards the treatment of her anorexia:

*“I don't really like to think about the fact that I maybe have to go further, you see I even said maybe (laughs), trying to convince myself that I don't”. (6: 12-14).*

### **5b. Subordinate theme – quest for wellness**

Participant two summed up this theme when she described what she hopes for in a cure:

*“So I guess that would be it, not to have to think about it. Not to be scared of going to parties, where food is around”. (3: 9-10).*

### **5c. Subordinate theme – searching for meaning**

Participant one searched for an explanation and meaning for her anorexia:

*“It’s changed my perspective in that respect, in that I suppose it’s made me re-address values in life, so maybe that’s one good thing to come out of it. It’s a pretty hefty price to pay (laughs) to come to that realisation”. (27: 12-15).*

## **2.5 Discussion**

The study involved interviewing a clinical sample of participants with diagnosed eating disorders. Five superordinate themes emerged from the data; shame, pride, shame responses, control and recovery and twenty one subordinate themes emerged, which are listed in table three.

Shame is described in the results as both a contributing factor in the development of the eating disorders and a consequence. Shame in body shape was reported by all of the participants in the study, thus supporting earlier work on the link between shame and eating disorders (Andrews, 1997; Burney & Irwin, 2000; Frank, 1991; Gee & Troop, 2003; Hayaki et



al., 2002; Jambekar et al., 2002; Masheb et al., 1999; Sanftner et al., 1995; Swan & Andrews, 2003; Troop et al., 2001; Waller et al., 2000; Waller et al., 2001).

The participants also reported elevated levels of both internal and external shame. One of the most central aspects to the shame experience is external shame (Gilbert, 1989). Participants in the study reported being concerned others would consider them greedy or fat if they observed them eating. The findings support the shame–shame model proposed by Goss and Gilbert (2002).

The shame responses reported by the participants include aspects of avoidance, for example, avoiding social comparisons and body checking due to shame. This adds further support for the theory of internal shame resulting in avoidance due to a belief that the self is flawed. The study also found that participants used social comparisons, however, the comparisons mentioned were all negative. These social comparisons involved media images, for example, magazines and resulted in increased body-image shame for the participants. This supports research by Stice & Shaw (1994), who found that media images of the thin ideal increase body dissatisfaction among women with bulimia nervosa. Participants appeared to identify and internalise the thin ideal. This supports findings by Casper et al. (1981), Markham et al. (2005) and Masheb et al. (1999) that the pursuit and internalisation of the thin ideal is linked to body-image shame.

A number of facets of pride were described by the participants in the study. For example, pride in low body weight and shape, pride in ability to restrict and pride in the compliments from others. The finding of pride associated with restriction supports previous research by Bruch (1973), Wallace (1986) and Vitousek (1996). The findings of pride in restriction and in others' compliments at initial weight loss also support the shame-pride model proposed by Goss and Gilbert (2002). For the participants the behaviour to reduce their shame, for some, became a valued ideal, resulting in reluctance to seek treatment. Some of the participants with bulimia nervosa described not seeking treatment for previous self-reported anorexia, due to their pride, and only being prepared to consider treatment following weight gain due to a change to more bulimic behaviours.

Body and weight checking was also used, typically resulting in further shame. This supports findings by Fairburn (2001). The participants reported how this checking resulted in negative appraisals rather than positive in the majority of occasions.

Self-directed hostility was also evident in the data with the majority of the participants using some form of self-punishment, typically in the form of extreme misuse of laxatives, or in some cases eating unpleasant food to punish the self. Again this is consistent with a sense of being internally flawed in some way and therefore deserving punishment. This theme

supports the research by Gilbert, Clarke, Herpel, Miles, and Irons (2004) who found that those with internal shame made self-punishing statements associated with wanting to punish a 'flawed' self, and Gilbert (2003) who suggest self-directed hostility as a means of coping with shame.

Control was also a consistent and important theme across all the transcripts. Not surprisingly given that the participants had diagnosed eating disorders, all reported a fear of weight gain. Themes of loss of control and resisting others control attempts appeared. Loss of control could be linked to shame, a sense of being inadequate to control food intake or the impulse to purge. Resisting control attempts and anger at others attempts to control could be a source of pride to some with an eating disorder. A few of the participants reported pride in the others' compliments at the initial weight loss followed by resistance of control attempts. What began as a means of gaining social approval and maybe improve social rank, led to increased pride in ability to resist not only internal cues to eat but also to resist the influence of others, including close family members. This is consistent with Littlewood's (1995) suggestion that control over the body may provide personal resistance to those who otherwise experience low levels of control over other aspects of their life. In addition, the findings on control also support the shame-pride model proposed by Goss and Gilbert (2002).

Some of the participants reported using food to manage negative affect. This supports findings by Cooper et al. (1998); DeSilva (1995); Goss and



Gilbert (2002); Heatherton and Baumeister (1991) and Sanftner and Crowther (1998). Participants' described being unable to tolerate the degree of their negative feelings, and many described food helping them to dissociate from these perceived overwhelming feelings.

A number of recovery themes also emerged from the data, including; searching for an explanation, quest for wellness and a struggle with ambivalence. The participants had recently completed the recovery programme at the eating disorders service and therefore these themes emerged as salient to them.

The findings of the study support earlier studies that found that shame is an important variable to consider in the treatment of eating disorders. The themes of shame demonstrate that the participants were not living up to their own standards (which reflect cultural standards, including the thin ideal) and also involve some concealment of perceived deficiencies due to concern about how they appear to others and to self. The findings suggest that clients' do take pride in restriction, low body weight and others compliments at their weight loss (shame-pride model, Goss & Gilbert, 2002), whilst a loss of control over eating may be linked to increased shame (shame-shame model, Goss & Gilbert, 2002).

## **2.6 Limitations of study and recommendations for future research**

The study used only female participants who were attending as outpatients at an eating disorders service. Only women were used due to

the recruitment time-scale of the research coinciding with an all female group at the service where participants were recruited from. Those presenting to services only represent a small population of those with an eating disorder in the general population (Hoek, 1995). Those seeking treatment may experience different levels of shame and pride than those not currently seeking treatment.

Participants were recruited from a pre-therapy group. This may have affected the responses from the participants, particularly in terms of reported pride and recovery themes. For example, participants reported recovery themes throughout their interviews, and many appeared to be struggling with ambivalence. Prior to treatment one may have seen higher pride themes and lower recovery themes. The research is qualitative in design and thus it is difficult to generalise the results to other eating disordered populations. There is also a possibility that this retrospective nature of questioning could have resulted in memory bias. However, the participants recalled recent feelings of intense shame about their body shapes with no obvious difficulty.

Clinicians working in the field of eating disorders may benefit from future research exploring the role of shame and pride in eating disorders. Such studies would benefit from including gender comparisons amongst clinical and non-clinical sample, taking into account ethnicity and culture, age and body mass index. Few studies have explored the role of pride in eating disorders. Our understanding of the factors reinforcing any eating

disorder would be enhanced by further research exploring positive as well as negative consequences of eating disordered behaviour (Goss & Gilbert, 2002; Overton et al., 2005).

## **2.7 Clinical implications**

There are various clinical implications arising from the association of shame with eating disorders. Any therapeutic relationship may be shame provoking by its very nature, however, for shame based syndromes this may be particularly relevant (Kaufman, 1989). In eating disorders asking clients' about bingeing and purging behaviour may be shame provoking. This can then result in clients denying symptoms altogether or the severity of symptoms thus resulting in a possible inaccurate formulation and resulting treatment program. Alternatively, clients may fall silent due to shame. Kaufman, (1989) also found that clients used food to manage negative affect. Clinical intervention could offer affect management or tolerance to clients thus helping to possibly prevent bingeing, restricting or purging.

The shame-pride cycle provides clinicians with an understanding of the conditions under which anorexia nervosa is maintained. Pride in a thin body can result in lack of motivation on a client's part to become well. It is important that any pride in a thin body shape be highlighted in therapy, with the clinician exploring both positive and negative aspects of the illness (Serpell, Treasure, Teasdale & Sullivan 1999). Motivational interviewing could also be used with clients with anorexia nervosa, to



address any possible pride (Overton et al., 2005). It is argued that a greater understanding of the emotional phenomenology of eating disorders and the potential interactions between eating behaviours, shame and pride is of immense clinical value in improving current theoretical models and treatment interventions.

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## **Chapter 3: Empirical Paper 2**

**An interpretative phenomenological study of  
pro-anorexia websites**



### **3.1 Abstract**

**Objective:** This paper explores 'pro-anorexia' websites. The objective of the present study is to explore whether such sites offer any advice or support that could be considered positive. **Method:** The research involved exploring a message board on a pro-anorexia website. **Results:** The important theme of companionship and emotional support was found as well as the more controversial theme of encouraging the continuation of weight loss. The themes of pride and shame were also found. In addition, sharing advice on how to overcome an eating disorder and control attempts were also found to be important. **Discussion:** The study found the pro-ana internet site researched did promote and encourage weight loss. However, the site also appeared to provide a sense of belonging and mutual support.

### **3.2 Introduction**

Humans have a basic need to feel connected and belong to a group of similar others (Brewer, 1991), however, some may find achieving this need difficult due to concealable and potentially embarrassing identities (Frable, 1993; Jones et al., 1984), resulting in possible isolation. One way to help people feel connected is the use of the internet (Rheingold, 1993). Indeed the internet is a powerful communication tool and online communities, provide a 'virtual' meeting of individuals with common needs. Individuals can interact in an anonymous way, allowing those with a stigmatised identity a place to belong that may not be available elsewhere (McKenna & Bargh, 1998). Such communities reflect the changing way human relations are formed (Thomsen, Straubhaar & Bolyard, 1998). Relationships formed on these sites can be emotionally rewarding, with much of the interaction reflecting the intimate quality of relationships achieved (Cerulo, 1997).

Pro-anorexia websites, (henceforth referred to as 'pro-ana') are an example of an online community, constructed by and for those with an eating disorder. Estimates suggest there are now over 400 pro-ana sites, although such estimates are difficult due to the transient nature of these sites (Giles, 2005; Reaves, 2006). Adolescents increasingly use the Internet as a primary source for health information and advice (Eric, Chesley, Alberts, Klein & Kreipe, 2002), and this includes advice on eating disorders. The young age of those using these pro-ana sites coupled with their anti-medical model messages has raised concern from

some. Indeed, the existence of pro-ana sites has caused uproar in the media, in the medical arena and amongst family and friends of those experiencing or recovering from anorexia (Dias, 2003). In July 2001 an eating disorder advocacy group in America, Anorexia Nervosa and Associated Disorders, wrote to servers to request that they close down pro-ana sites. This resulted in 21 of Yahoo's sites being closed within days (Reaves, 2006), however, new sites developed to replace those closed down.

It has been suggested that pro-ana sites encourage women with a healthy body weight to develop anorexia (Doward & Reilly, 2003), or promote anorexia as a 'life style' choice (Doward & Reilly, 2003; Reaves, 2006). Others suggest these websites validate restriction, increasing motivation to continue, with potentially life threatening results (Paquette, 2002). Some media coverage of pro-ana sites has however, acknowledged the ambivalence of those using such sites (Song, 2005). Others argue that pro-ana sites provide their users with a space to escape the scrutiny of others, preventing secrecy and isolation (Dias, 2003). Research has found those with an eating disorder are less reliable informants of their eating disorder (Swan & Andrews, 2003) perhaps due to stigma and shame. Therefore perhaps these websites provide a form of sanctuary for their users (Dias, 2003; Fox, Ward & O'Rourke, 2005).

The critiques of pro-ana sites often use the voice of concerned family members of those with anorexia or those who have recovered from an



eating disorder (for example, 'the websites that encourage anorexia', Neustatter 2006, You Magazines) but often lack the voice of the people currently using the websites. This paper will attempt to explore pro-ana sites, using verbatim extracts from message boards, where material is posted by users', to enable the often unheard opinion of the users' of such websites to be heard. The purpose of the research is to explore whether the pro-ana site in the study served any positive social function. It has been suggested that observing actual interaction in a real community produces more legitimate analysis (Thomsen et al., 1998) than artificial experiments.

### **3.3 Method**

#### **3.3.1 Data collection**

Data was collected over four consecutive days, 4<sup>th</sup> – 7<sup>th</sup> April 2006. During this time 80 different people posted messages onto the website, on several occasions. People posting messages reported being female or had female names except one male. In total 423 messages were posted and analysed during this time. The name of the website is not given to protect the identity of those using it and prevent possible publicity for the site. Although many internet service providers delete websites when they are aware of them, by using a standard search engine many links were found within minutes.

As with most qualitative approaches the website chosen is not considered to be a representative sample, however, it is believed to be typical of



such sites in terms of structure. For example, the website chosen contained information on eating disorders such as tips and tricks; emotional support; poetry and song lyrics; message board; trigger pictures or 'thinspirations' (pictures of thin celebrities and pictures of the users' own bodies to inspire weight loss) and links to other pro-ana sites. This content is typical of pro-ana sites. Other published studies exploring pro-ana sites have also used only one website (Fox, Ward, O'Rourke, 2005).

### **3.3.2 Data analysis**

The data was analysed using Interpretative Phenomenological Analysis IPA (Smith, Jarman & Osborn, 1999) as a framework. IPA was considered to be a suitable research method given the research question, which was to explore in-depth verbatim scripts on a pro-ana site, whilst attempting to get close to the personal world of the participants' (Conrad, 1987).

Smith (2004) suggests that IPA has three characteristic features. Firstly it is idiographic, starting with a detailed examination of one case before moving onto other cases. Secondly it is inductive, allowing the use of flexible techniques to encourage unanticipated topics to emerge. Finally it is interrogative, using existing research to discuss findings.

IPA was chosen as the methodology for the study because it allowed us to explore participants' subjective experiences, helping us to understand why people use the message boards on pro-ana sites and what these sites provide to their users. There is very limited research on pro-anorexia websites, and most of the published studies have focussed on the harm these sites can cause. It was considered important to explore in detail the postings on the message board of the pro-ana site chosen. The idiographic nature of the methodology was important, to fully understand one case before moving on. It was also important that any methodology was inductive and interrogative, linking the findings to existing research. The stages recommended by Smith et al. (1999) were followed for the analysis of the data (appendix twelve).

The chief investigator in the research was on placement in an eating disorders unit at the time of the current study. The experience of working in an eating disorders unit made the researcher initially feel negatively towards pro-ana sites, which may have resulted in more negative themes appearing. In addition, the chief investigator also has an interest in shame and pride in eating disorders, which may have increased the likelihood of these themes emerging.

### **3.3.3 Validity**

In addition, the validity and credibility of the research was checked on a regular basis with a second researcher, experienced and taught in the

use of IPA. The themes were also checked with the two co-authors. The chief investigator also kept a diary throughout the research process.

#### **3.3.4 Ethical considerations**

The data collected for the research is in the public domain. Eysenbach and Till (2001) caution against using internet sites to research, however, such an argument could be extended to preclude using any naturally occurring data (Giles, 2005). King (1996) argues that posts made in public spaces may be considered open to public observation and scrutiny. It was decided that the ethical validity of such research needs to be decided with its clinical importance, and researching such websites is crucial when working with a client group with potentially life-threatening conditions (Pollack, 2003). Anorexia has the highest mortality rate of any mental illness (Gremillion, 2003). Clinicians working in the area of eating disorders may gain further understanding of their clients' unhelpful thoughts, distressing feelings and dysfunctional behaviours by understanding the content of such websites (Davies & Lipsey, 2003; Paquette, 2002).

### **3.4 Results**

Six superordinate and twelve subordinate themes emerged. Simple numeric data is also provided to support the linguistic data by providing detail of the frequency of the occurring themes, and thus its relevance to the group studied (Stiles, 1993). The superordinate and subordinate themes are presented in table four along with the number of times each



theme occurred. Thomsen et al., (1998) suggests that a simple form of content analysis is useful when studying online communities; supported by narrative analysis.

**Table four - Emerging themes**

<b>Superordinate theme</b>	<b>Subordinate theme</b>	<b>Total frequency</b>
<b>1. General social themes</b>	1a. Companionship and emotional support	106
	1a. Shared understanding	28
	1c. General advice (non eating disorder related)	27
<b>2. Supporting anorexia</b>	2a. Advice on how to restrict/ lose weight	78
	2b. Comparing statistics and weight loss histories and sharing media images	36
	2c. Encouragement to restrict/lose weight	35
<b>3. Food obsessions</b>	3a. Fantasies about food	23
<b>4. Recovery</b>	4a. Advice giving on how to overcome an eating disorder	18
<b>5. Pride and shame</b>	5a. Pride in thin body shape/weight loss/restriction	18
	5b. Internal shame	14
<b>6. Control</b>	6a. Resisting control attempts by others	11
	6b. Control attempts by others	10

**1. Superordinate theme: general social**

The subordinate themes of companionship and emotional support, shared understanding and general advice emerged.



### **1a. Subordinate theme – companionship**

The theme of companionship and emotional support was particularly important. Visitors to the chat room talked about a range of issues, for example; boys they liked, movies, music, jobs and career goals. One of the users summed up her message which, talked about where she lives and said:

*“I find that my friends near where I live aren’t real friends anymore, and I get more support and friendships here....so yeah, you can come and visit me when you get lonely”.*

Another person posted a message reporting being upset and wanting someone to talk to and received the following reply from another visitor:

*“If there is anything I can do let me know. Sending love your way”*

### **1b. Subordinate theme – shared understanding**

Visitors to the website reported a sense of shared understanding, typically in relation to eating disorder issues. One of the visitors to the site reported being unable to eat in front of other people, she summed up the posting with:

*“Is anyone else this way, or am I indeed a freak of nature?”*

When others replied they talked about their own shame when eating in public. Other postings referred to the physical side effects of restricting and purging, again offering a shared understanding between users.

### **1c. Subordinate theme - General advice (non eating disorder related)**

The advice given ranged from how to test for pregnancy, what the expected side effects are to an ear infection and how to apply to universities.

## **2. Superordinate theme: supporting anorexia**

Many of the messages posted were supporting the continuation of anorexia or bulimia, for example advice and encouragement on how to restrict and lose weight. Users also compared statistics and weight loss histories and sent each other media images, which they then discussed for 'thinspiration'.

### **2a. Subordinate theme - advice on how to restrict/ lose weight**

This also emerged as an important theme. The advice ranged from discussions about the calorie content of various foods and drinks, the duration a fast should be in order to achieve weight loss, and advice on purging. One of the users posted the following message in reply to a question about how to avoid feeling dizzy when fasting:

*"Sometimes I eat baby spinach (raw, no dressing) for the iron to give me energy, it's only 20 cals for about 2 cups, or take iron supplements".*

### **2b. Subordinate theme - comparing statistics and weight loss histories and using media images for 'thinspiration'**

This included details of current weight, lowest weight and goal weight. In addition, pictures of famous, underweight celebrities were posted to aid

motivation. After the posting of some pictures of Nicole Richie, the following replies were posted:

*"I can't believe she is so thin now!! It's really remarkable".*

*"I am totally obsessed with how thin she looks and how she achieves it".*

### **2c. Subordinate theme - encouragement to restrict/lose weight**

This typically took the form of people posting messages to seek encouragement to continue with restriction followed by messages of support. The following reply followed a message by a user who reported being on the first day of her fast:

*"Good luck, you can get down to what ever size you want to be".*

## **3. Superordinate theme - food obsessions**

### **3a. Subordinate theme – fantasies about food**

People posted pictures of fantasy food along with written descriptions. Food discussed tended to be considered 'forbidden', for example; chocolate, cake, chips and pizza. These discussions did not involve advice about how to avoid such food, but seemed to provide the users' the opportunity to share their food fantasies with each other.



#### **4. Superordinate theme – recovery**

##### **4a. Subordinate theme - advice on how to overcome an eating disorder**

One of the postings for this theme was a page long story of someone struggling with guilt following eating and wanting to restrict more. She received the following reply:

*“Avoid the mirror, avoid thinking of anything you just wrote about, take a hot shower, grab a book and take a nap”.*

Other advice received included suggestions of going to the General Practitioner to gain more support. Some postings, in response to requests for advice from people wanting to lose weight that did not report having anorexia, advised against weight loss and reported how awful the disorder really was.

#### **5. Superordinate theme – pride and shame**

##### **5a. Subordinate theme – pride in thin body shape/weight loss**

Some of the messages contained the theme of pride, either pride in a thin body shape, pride in weight loss or in restriction. One posting described how she felt after fasting for four days. She reported many physical symptoms and mood changes but also reported:

*“I can’t take my mind off food; even though when it comes down to eating some chilli cheese fries or keep on fasting I’m proud of myself for choosing fasting”.*



## **5b. Subordinate theme – internal shame**

Internal shame was described by some of the users in their postings. For example one person described using laxatives to 'punish' herself:

*"I feel like I am a trash can and that's my only way of emptying it"*

Another user also described feeling shame resulting in wanting to punish herself:

*"It keeps you feeling like shit. You think you are worthless and you deserve to be doing this".*

## **6. Superordinate theme – control**

Some of the postings contained the theme of control. These consisted of control attempts by others, typically parents or boyfriends and resisting these attempts.

### **6a. Subordinate theme - resisting control attempts by others**

The following posting followed someone asking for advice on how to prevent her boyfriend 'forcing' her to eat:

*"I know how you feel, my friends are so annoying with the 'you're going to eat tonight', it kind of sucks that none of my friends understand. I would never tell any of them. All I can say is try to avoid any outing involving food, and if you're dragged out to a restaurant, order water or a salad to pick at".*

## **6b. Subordinate theme - control attempts by others**

Control attempts reported typically involved encouraging the person posting the message to eat or stories of how parents were discouraging the use of pro-ana websites. One of the users reported how her father had blocked the pro-ana website from the home computer, resulting in her using the computer at school to visit the site:

*“Aaah, my dad has blocked this site from our computer....help”.*

Messages followed on how to overcome this block.

## **3.5 Discussion**

The most important emerging theme from the research was companionship and emotional support. Shared understanding and general advice also appeared as subordinate themes. Some of the postings described the internet site as the only place they felt comfortable to discuss their eating disorder, and feeling a sense of being understood. This supports the work of Dias (2003) who suggests that pro-ana sites provide their users with a sanctuary where they feel safe to reveal aspects of their eating disorder they may not reveal in other settings. The pro-ana site researched appeared to allow those with a possible stigmatised identity a place to belong that may not have been available elsewhere, supporting the argument of McKenna and Bargh (1998). Some of the postings also gave advice on how to overcome eating disorders. This supports the point made by Song (2005) that some media coverage of pro-ana sites show the ambivalence of those using such websites on overcoming their eating disorders.

Many of the postings on the website were supporting the continuation of anorexia. The subordinate theme of giving advice on how to restrict and lose weight was the second most frequently occurring theme, second only to companionship and emotional support. Some of the postings went beyond advice and actively encouraged people to lose weight. This supports the argument of Paquette (2002) that the use of pro-ana sites can provide its visitors with validation of their restriction increasing motivation to continue. An added element of motivation to restrict came with visitors posing their statistics and photos of thin celebrities.

Some of the visitors to the site described feelings of pride. The finding of pride associated with restriction support research by Bruch (1973), Wallace (1986) and Vitousek (1996). This also supports the shame-pride model proposed by Goss and Gilbert (2002). Internal shame and a resulting wish to punish the self also appeared in some of the postings. This supports the research by Gilbert, Clarke, Herpel, Miles and Irons (2004) who found that those with internal shame made self-punishing statements associated with wanting to punish a 'flawed' self and Gilbert (2003) who suggests self-directed hostility as a means of coping with shame.

Control also appeared in some of the postings; control attempts by others and resisting these attempts. This is consistent with Littlewood's (1995) suggestion that control over the body may provide personal resistance to



those who otherwise experience low levels of control over other aspects of their life. In addition, the findings on control also support the shame-pride model proposed by Goss and Gilbert (2002).

### **3.6 Conclusions**

The pro-ana site explored did promote and encourage weight loss amongst its members; however, it also appears to serve an important social need for companionship and support amongst a group of people with a possible stigmatised identity. Some of the postings also described a sense of pride over their body shapes and at other times feelings of shame. Moreover, postings described ambivalence often found in those with eating disorders, with many postings giving advice on how to overcome an eating disorder. The present study demonstrates the complexity of pro-ana sites. They appear to serve a useful function in addition to their more commonly reported controversial and at times dangerous use. The internet by its very nature is unregulated and therefore more sites appear as old ones are closed down. The nomadic nature of pro-ana sites perhaps demonstrates the importance of these websites to the people that use them.

### **3.7 Further research**

The present study is qualitative in design and thus it is difficult to generalise the results to other pro-ana sites. Clinicians working in the field of eating disorders may benefit from future research exploring a number of pro-ana sites. Future research would benefit from including qualitative



interviews as well as observation, and perhaps becoming involved in the dialog of such sites, achieving an effective means of triangulation (Thomsen et al. 1998).

### **3.8 Clinical implications**

It is important that clinicians working in the area of eating disorders have knowledge of the content of pro-ana sites. Such knowledge would aid discussion with clients using these websites. This would perhaps help clinicians to put a counter argument forward and also offer alternative website addresses which provide the support without the dangerous encouragement (Davies & Lipsey, 2003; Paquette, 2002). Eric et al. (2002) suggest that it is essential for professionals working with adolescents with an eating disorder to make themselves aware of the content of such websites. Moreover, it is important when treating someone with anorexia to be aware that they may have a strong community supporting the continuation of the disorder you are attempting to treat (Davies & Lipsey, 2003).

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## **Chapter 4: Reflective paper**

## **4.1 Introduction**

This paper contains my reflections about my research experience. In total my doctoral thesis contains the following papers: a literature review exploring shame in eating disorders; an empirical paper on shame and pride in a clinical population of clients with a diagnosed eating disorder, and an empirical paper exploring pro-anorexia websites. In this paper I will reflect on the experience of researching all the aforementioned papers, including: choice of research topic, methodological considerations; clinical implications; directions for future research; ethical issues and personal reflections and learning.

During my research I used a research diary to help me reflect the process of my research and also provide an audit trail of the research process. This is recommended by Giles (2002) and Henwood and Pidgeon (1992) for qualitative research.

## **4.2 Choice of research topic**

I developed an interest in health compromising behaviours during my Masters degree in health psychology. During the aforementioned degree I studied General Practitioner (GP) exercise referral schemes (exercise on prescription) for those who were depressed, overweight, anxious or recovering from illness. In addition to findings that the GP referral scheme encouraged people to exercise who had not previously done so, the research also showed that participants were very concerned about their body image. This concern resulted in some participants reporting that

body shame made it more difficult for them to engage in the program. For example, the majority of those studied reported concerns about what other gym members would think about their body shape when they visited the gym. Others reported wanting to avoid being compared to other 'thinner' gym members, perhaps avoiding social comparison due to body shame. At the time of the research I was surprised by these findings on body image as this was not something I asked about or expected to find.

In addition to my master's research I was also influenced by my placement as a trainee clinical psychologist. My first supervisor worked across two services; an eating disorders service and an adult mental health service. During this placement I was fortunate to be introduced to those working in the eating disorders service and spent time discussing their service with them. During one of these discussions I was introduced to the work of Goss and Gilbert (2002) on shame and pride in eating disorders by Ken Goss, Consultant Clinical Psychologist and Head of Coventry Eating Disorders Service. This sparked off my interest in both eating disorders and shame and pride issues.

## **4.3 Methodological considerations**

### **4.3.1 Planning and design**

I initially designed a quantitative study for the main paper. The study involved validating a new scale of shame and pride, specifically for an eating disorder population and using this scale to explore shame and pride in a clinical population with a diagnosed eating disorder. This took



considerable time and involved working with my clinical supervisor to re-design a previously un-validated scale to measure shame and pride in eating disorders. Unfortunately this study did not received ethical approval from Coventry Ethics Committee so I reconsidered the research.

During conversations with both my academic and clinical supervisors it was decided that qualitative research would fit the research questions of whether shame and pride are associated with eating disorders better than quantitative methods. I was also aware that previous studies have found those with an eating disorder and high in shame are less reliable informants of their experience (Brown, Russell & Thornton, 1999; Swan & Andrews, 2003). In addition I was aware that there was limited previous research on pride in eating disorders, and shame studies were based mainly on non-clinical samples. Thus my own research needed to be exploratory and qualitative methods suited this. I felt that this approach would allow the participants to tell their own story, in their own time.

I re-submitted a new ethical proposal to Coventry Local Ethics Committee, but due to an administrative error on their part, it did not go forward to the planned meeting. I was very frustrated to learn that they would not be meeting for two months due to the holidays so because of time constraints I submitted the new ethical proposal to Warwickshire Local Ethics Committee, who granted ethical approval (appendix four).

#### **4.3.2 Validity and reliability**

During the initial stages of analysis I found myself wondering about my own biases and how these would affect the results. I reminded myself that any qualitative research is biased because the researchers own values and assumptions impact on the research at every stage (Hertz, 1997). Such biases cannot be eliminated but having an awareness of them can help increase insight and awareness (Finlay, 2002). I have attempted to remain aware of my own biases throughout the research process and followed Elliott, Fisher and Rennie's (1999) and Yardley's (2000) guidelines for the completion of robust qualitative research in psychology.

I ensured I liaised with my supervisors throughout the process. In addition, I sent each participant a copy of their transcript, which was followed up by a telephone call in order to check that the transcripts were an accurate reflection of the interview, testimonial validity. A second check for validity was to send the first participant a list of the superordinate and subordinate themes, again these were checked for accuracy via a phone call. No changes were made by any of the participants. In addition, the validity and credibility of the research was checked on a regular basis with a second researcher.

#### **4.3.3 Data analysis**

I found the area of data analysis quite challenging and I am aware of using avoidance before conducting this task. On reflection, this avoidance

was due to the task appearing too great and time-consuming. This avoidance only increased my anxiety! I found during this time the support and encouragement of other trainees invaluable. The initial coding of the data revealed a vast amount of information, more than could be covered with any credit in a 6000 word paper. It was difficult to decide what to include in the final paper. To help in this I designed a table listing the number of transcripts a theme appeared in and the number of times. This allowed me to see the frequency that themes emerged. I decided to include themes that appeared in at least 50% of the transcripts. I am aware that such a decision would exclude some interesting data that appeared in only limited transcripts, in many cases only one transcript, but felt this was the only way to ensure I did not end up writing a book! I also found supervision crucial at this stage, to help me in this process.

I found using IPA as a framework for the analysis on my main paper and for the analysis of my brief paper good for any anxiety about having too much data and not knowing what to do with it. Having a structured process of analysis helped me not to feel to swamped by the data

#### **4.4 Clinical implications**

The review of the literature showed a link between shame and eating disorders, whilst the main empirical paper showed an association between shame and pride in eating disorders (in the clinical sample used). This has several important clinical implications. Firstly, any therapeutic relationship itself may be shame provoking by its very nature.



For shame based syndromes this may be particularly relevant (Kaufman, 1989). The location of eating disorder services within psychiatric hospitals adds to the stigma of eating disorders. Equally some of the stigma of using mental health services could be reduced by locating eating disorders services away from main psychiatric hospitals.

The brief paper found that the pro-anorexia website explored did contain advice and encouragement to continue with an eating disorder. However, it also demonstrated the important social support these sites can provide to a group of individuals who can find it difficult to disclose information to the professionals working with them (Brown, Russell & Thornton, 1999; Swan & Andrews, 2003). It is important that clinicians working with those with an eating disorder are aware of the content of these sites (Pollack, 2003), especially given the potentially life threatening nature of eating disorders. This allows clinicians to put counterarguments forward against some of the more disturbing advice and encouragement. In addition, perhaps it demonstrates a need that this client has that is not currently being met by services.

Overall, a greater understanding of the emotional phenomenology of eating disorders and the potential interactions between eating behaviours, shame and pride is of immense clinical value in improving current theoretical models and treatment interventions.

#### **4.5 Directions for future research**

Clinicians working in the field of eating disorders may benefit from future research exploring the role of shame and pride in eating disorders. Such studies would benefit from including a gender balanced clinical and non-clinical sample, taking into account ethnicity and culture, age and body mass index. The use of clinical samples in research on eating disorders is important if we are to learn more about this client group (Overton, Selway, Strongman & Houston, 2005). Previous studies on shame and eating disorders have tended to use largely student samples.

Few studies have explored the role of pride in eating disorders. Our understanding of the factors reinforcing any eating disorder would be greatly enhanced by further research exploring the positive as well as negative consequences of eating disordered behaviour (Goss & Gilbert 2002; Overton et al. 2005).

#### **4.6 Ethical issues**

From the initial proposal stage and throughout the research process I have been aware of the possible vulnerability of clients with an eating disorder who were involved in the research. I considered several ethical issues in detail and consulted with those working in the area of eating disorders and experienced researchers before conducting any interviews.

All participants for the main paper were recruited by the head of the eating disorder service where they were attending for treatment. This

allowed informed consent to be obtained, as well as a clinical assessment of their ability to be involved in the study without compromising their treatment. Choosing participants' who were currently in treatment rather than clients on the waiting list for treatment, or those post-treatment clients, allowed the participants an additional point of support in case the research caused them any negative effects.

To ensure informed consent was obtained and participants were aware of their rights, time was allowed at the start of the interview, which was not tape-recorded. During this time, I introduced myself and the research, discussed confidentiality and the right to withdraw, discussed the consent procedure, explained the complaints procedure and allowed time for any questions. Full written consent was obtained before the interviews took place.

At the end of each interview a debriefing period was given, again this was not tape-recorded. The purpose of this debriefing period was to ensure participants were emotionally ready to leave the research environment. An added precaution was to provide all participants with my contact information and details of the other researchers if they required further support or had any further questions. On reflection the time at the end of the interview was needed by both participants and myself. It allowed participants to talk about anything that upset or surprised them during the interview. In addition, it also allowed me the opportunity to assess the



participants at the end of each interview, in order to allay any of my anxieties about possible harm the research could have caused.

The main study received ethical approval from Warwickshire Local Ethics Committee (appendix four) and approval from the Research and Development Department at Coventry Primary Care Trust (appendix five).

For the brief paper I consulted with senior members of teaching staff before deciding that ethical approval was not required. The data was collected from an internet site constructed by and for people with an eating disorder, commonly known as pro-ana sites. Such data is in the public domain and thus copyright was also not required. Before deciding to research this area I read articles by Eysenbach and Till (2001) which cautions against using internet sites to research, however, such an argument could be extended to preclude using any naturally occurring data (Giles, 2005). It was decided that the ethical validity of such research needs to be decided with its clinical importance (Pollack, 2003). Indeed, Pollack (2003) makes the point that researching such websites is crucial when working with a client group with potentially life threatening conditions.

#### **4.7 Personal reflections and learning**

I found the interview process for the main paper itself quite difficult. My research was in the same area as my placement during the period of data collection and analysis. Being a researcher in the context was very

different, for example, having to remember the purpose of the interaction was research rather than therapy. This did however, have some advantages. For example, my knowledge and experience as a therapist allowed me to judge when participants were in danger of revealing more than would be in their best interests to me. I ended two interviews prematurely on this basis, ensuring that I put the best interests of the participants' first rather than my research interests.

As a result of my training in clinical psychology I consider that I was more able to encourage participants to discuss very sensitive issues, know when to end an interview and manage any distress. These skills are important when undertaking research in a sensitive area and I believe it is potentially more difficult for a researcher with no training in clinical psychology. The dual role of researcher and therapist is now something I believe is very useful, particularly for conducting research on sensitive issues.

I did find it difficult to listen to people's experiences of shame. This is something I did not anticipate prior to the interviews. Fortunately my clinical supervisor provided supervision to allow me to process some of the issues raised by participants, however, this was not planned on my part. In retrospect I now realise this was an oversight and I would always ensure in the future that such clinical supervision is contracted into the research process rather than relying on a supervisor's good will.

I also found it strange and difficult when participants referred to my body shape. I had never encountered this before, but had witnessed clients at the eating disorders unit where I was on placement talking about clinicians' body shapes. This left me wondering what effect being female had on the research process and how different the experience would have been for a male researcher. However, I do think being female provided me some advantages, for example, the participants all appeared to talk very openly to me about very sensitive issues regarding body shape and weight shame.

The pro-ana sites explored for my brief paper did contain images of severely emaciated females, advice on how to achieve further weight loss, along with support and discussions. I initially found looking at these sites both disgusting and anger provoking. At the time of collecting the data on these sites I was working with clients with anorexia nervosa, most of whom were of a very low weight to the point their lives were in danger. I think the disgust and anger probably came from working with people with anorexia nervosa and their families and seeing the very real cost of this disorder whilst websites in the public domain were supporting disorder. I do, however, feel my understanding of anorexia nervosa improved following the data collection, especially my understanding of the very real pride some felt in their low body weight.

On reflection, I consider it important when working with a client group to be aware of the influences on both the development and maintenance of



their disorder. In the case of working with people with anorexia nervosa, such a maintenance factor could be pro-ana websites. In addition, although fairly negative about these sites initially, I did want to explore any positive social and psychological support these sites provide. As a result of the research I am now aware such sites can provide companionship and a shared understanding. This will affect any future work I undertake with any client group with a stigmatised illness using internet sites as a form of support.

Prior to the research I made the decision to transcribe all the tapes myself, to allow me to 'get to know' each transcript fully. However, I was also aware that during this stage of the research process my motivation might wane. I was surprised that this did not happen and I enjoyed listening to the tapes and transcribing them. This was no doubt helped by being a touch typist, but also by the interesting and open stories of the participants. I thank them for this.

#### **4.8 Conclusions**

Whilst reflecting on my research experience I found it useful to consider each paper as a piece of work rather than the anxiety provoking task of writing a whole thesis. This perhaps says something about my own style of breaking down tasks into meaningful chunks and also reflects the way I have approached clinical training.

Elements of the research process were frustrating, particularly gaining ethical approval. I started the research in my first year of training by identifying suitable topic areas and meeting with potential supervisors. In retrospect this was crucial given the time lost in applying for ethical approval and contacting participants.

My original intention was to produce four papers that 'hang' together well to form a body of knowledge that is useful for clinical practice. I am pleased that the results have helped forward our knowledge of shame and pride in eating disorders. In particular I know that the research process and the results have affected my clinical practice and have made me much more aware of potential shame and pride issues in any client group.

## 4.9 References

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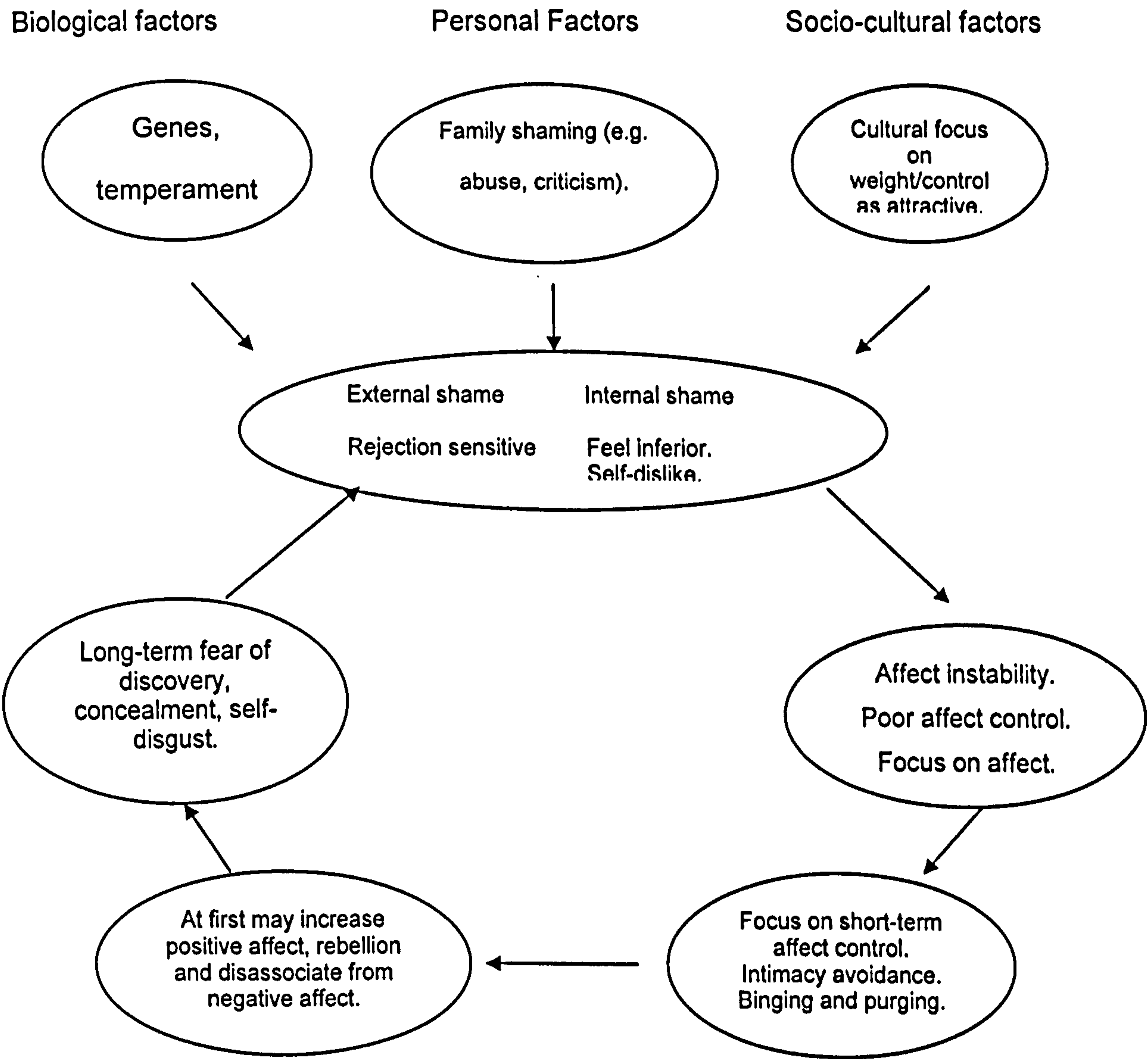
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# Appendices

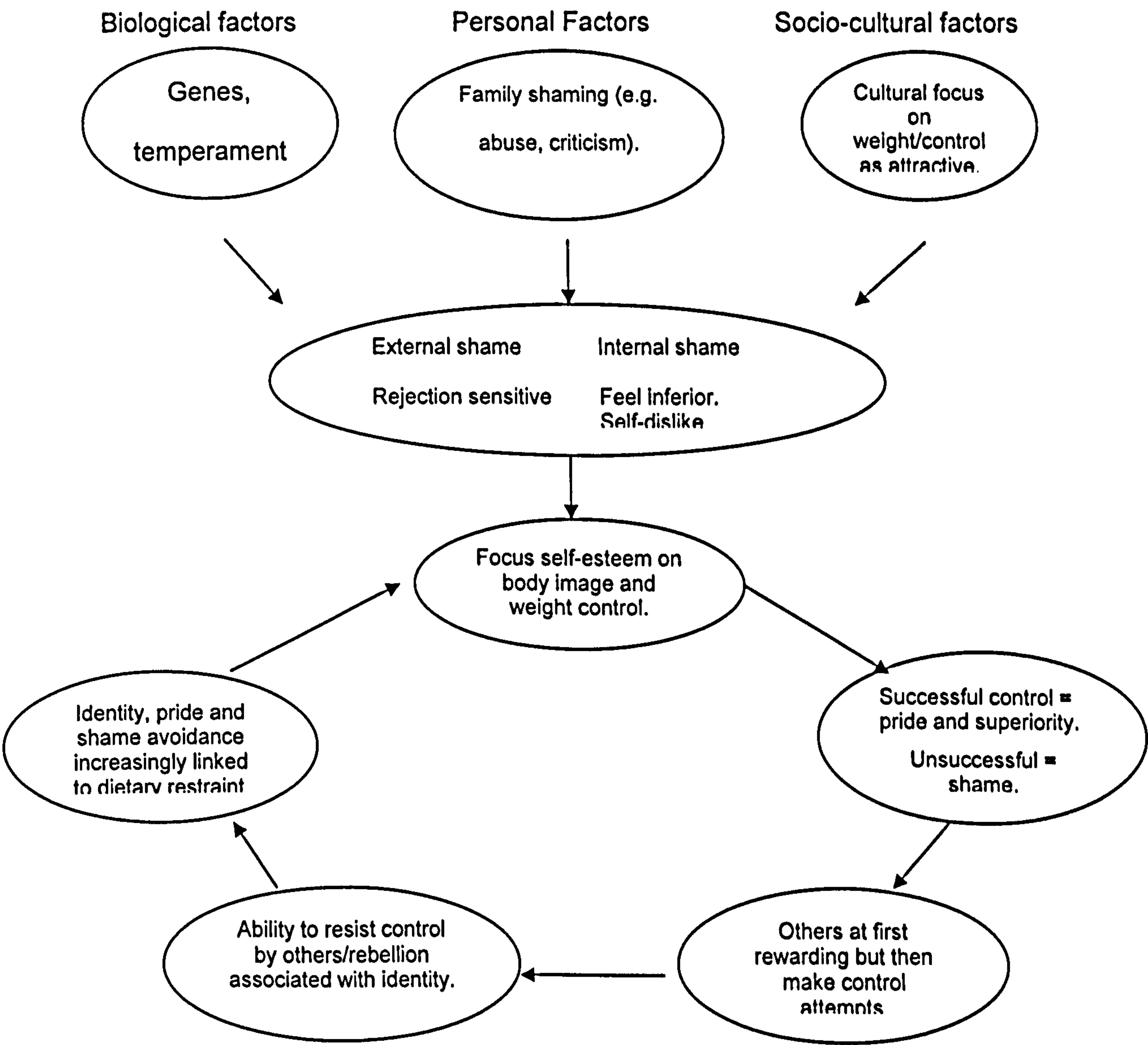
Appendix one

Shame-shame cycles in those who binge/purge (Goss & Gilbert, 2002)



Appendix two

Shame-pride cycle in those who restrict (Goss & Gilbert, 2002)





**Appendix three**

.

**Warwickshire Local Research Ethics Committee***Recognised by UKECA to review Type 3 MREC Applications*

Lewes House  
George Eliot Hospital  
College Street  
Nuneaton  
Warwickshire  
CV10 7L

29 September 2005

Mrs Melanie Elsworth  
Clinical Psychologist in Training  
Coventry University  
School of Health & Social Sciences  
Priory Street  
Coventry  
CV1 1FB

Tel: 02476 86524  
Fax: 02476 86526  
pat.horwell@geh.nhs.uk

Dear Mrs Elsworth

**Full title of study:** Shame and Pride In Eating Disorders: An Interpretative Phenomenological Analysis.  
**REC reference number:** 05/Q2803/77

The REC gave a favourable ethical opinion to this study on 22 September 2005.

Further notification has been received from local site assessor following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site. I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research.

**Research governance approval**

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until research governance approval from the relevant NHS care organisation has been confirmed.

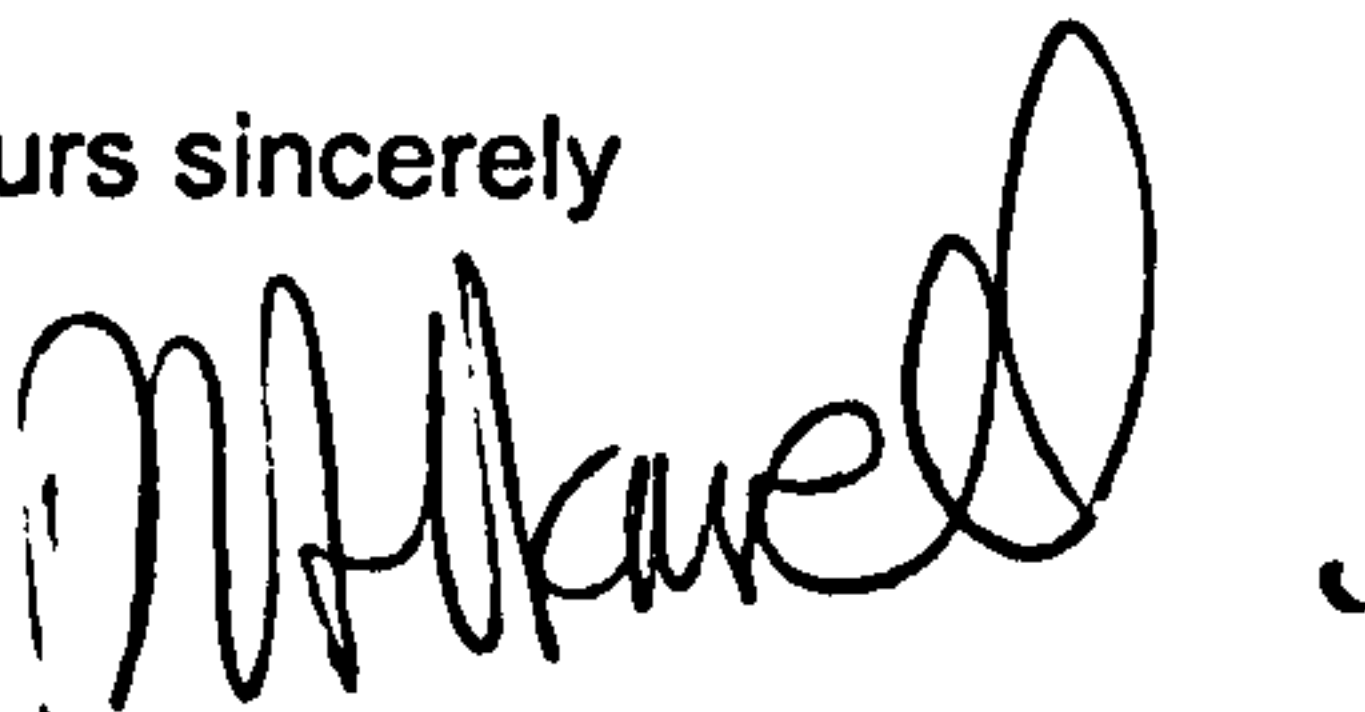
**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**05/Q2803/77**

**Please quote this number on all correspondence**

Yours sincerely



**Ms Pat Horwell**  
**Committee Co-ordinator**

**Enclosure:** Site approval form

## Appendix four



Our Ref: R&amp;D/Coventry Teaching Primary Care Trust/

Date: 29<sup>th</sup> September 2005Research & Development Dept  
The Caludon Centre  
Clifford Bridge Road  
Walsgrave  
Coventry  
CV2 2TE

email: Carmen.Brady@coventrypct.nhs.uk

☎ D/L 02476 96 7881

Fax: 02476 968101

**TO: CHIEF INVESTIGATOR**Clinical Psychologist in Training,  
Universities of Coventry and Warwick  
School of Health & Social Sciences  
Priory Street  
COVENTRY CV1 1FBFor the attention of Mrs Melanie Elsworthy**OTHER RESEARCH COLLABORATORS**Dr Ken Goss,  
Consultant Clinical  
Psychologist, Head of  
Coventry Eating Disorders Service.Dr David Giles, Senior Lecturer in Psychology,  
Coventry University.

Dear Mrs Elsworthy

**RESEARCH & DEVELOPMENT****REC Ref 05/Q2803/77 - Please quote at all times.****RESEARCH STUDY:**

Research Title:		
<b>Shame and Pride in Eating Disorders: An Interpretative Phenomenological Analysis.</b>		
Chief Investigator:	Mrs Melanie Elsworthy, Clinical Psychologist in Training	
Research Team:	Dr Ken Goss –	Consultant Clinical Psychologist Head of Coventry Eating Disorders Service
	Dr David Giles -	Senior Lecturer in Psychology Coventry University

Thank you for the above research study, the R&D Dept of Coventry Teaching Primary Care Trust considered the locality issues relating to the above application and has no objection to the research being conducted within this locality.

**RESEARCH & DEVELOPMENT**

**REC Ref 05/Q2803/77 - Please quote at all times.**

- The above study has been granted approval by Coventry Teaching Primary Care Trust and is registered with the R&D Dept of Coventry Teaching Primary Care Trust. In due course, the study will be submitted to the Dept of Health's National Research Register.
- Warwickshire Research Ethics Committee received the application for ethical review and confirmed approval for the above research study on 23<sup>rd</sup> September 2005.

I confirm that Coventry Teaching Primary Care Trust is organised and operates according to the Research Governance Framework.

- This approval is granted for 3 years from commencement of the research. If you wish to continue beyond this date it is your responsibility to contact (COREC) for further approval.
- The study must be started within twelve months of the date on which the MREC approval is given. If for any reason you do not meet this deadline you must resubmit your study to the COREC.

**The R&D Department of Coventry Teaching Primary Care Trust must be notified of:**

- a. all protocol amendments or unexpected events.
- b. any new authoritative guidance or persuasive scientific evidence that may cause Coventry Teaching Primary Care Trust to reconsider approval or rejection of the protocol.
- c. the patient must be informed if there are any new findings regarding a drug.
- d. As part of the Research Governance Framework, ALL patient Informed Consent Forms, to be signed & dated by the patient/participant and the lead research investigator.

*Completed copies of the Consent Form(s) to be retained by:*

1 copy to the Patient/Participant

1 copy the Principal Research Investigator

1 copy Medical Notes/Case Notes

- e. The Standard Progress Report form to be submitted to Coventry Teaching Primary Care Trust one year from the date of the MREC approval letter, and thereafter on an annual basis.

The standard Patient Information Sheet recommended for use by researchers informs the patient about Consumers for Ethics in Research (CERES) who publish a leaflet entitled 'Medical Research & You', which gives information about medical research and gives advice on the sort of questions patients, may wish to have answered.

- *It is recommended that the researcher hold a stock of the leaflet to hand to the patients.*

We look forward to receiving progress reports as appropriate and a final report within three months of completion.

**RESEARCH & DEVELOPMENT**

**REC Ref 05/Q2803/77 - Please quote at all times.**

We propose that in future, unless we hear to the contrary, the title of all research trials approved by Coventry Teaching Primary Care Trust will be made available to bona fide interested parties.

We thank you for your co-operation in these matters.

Yours sincerely,

*C. Brady*  
*Carmen Brady*

R&D Co-ordinator  
Coventry Teaching Primary Care Trust  
Research & Development Dept  
The Caludon Centre  
Clifford Bridge Road  
Walsgrave  
Coventry CV2 2TE

email: Camen.Brady@coventrypct.nhs.uk

☎ D/L 02476 96 7881

Fax: 02476 968101



**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Professor Delia Cushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

**School of Health and Social Sciences**  
Coventry University  
Priory Street Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8300



**C O V E N T R Y**  
**U N I V E R S I T Y**

Our ref

Your ref

Date

## **Appendix five - participant Information Letter**

**Study title:** Research into feelings about eating and weight

### **Invitation to take part in the study**

You are being invited to take part in a research study. Before you decide to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

### **What is the purpose of the study?**

My name is Melanie Elsworth, and I am studying for a Doctorate in Clinical Psychology at the Universities of Coventry and Warwick. I am interested in finding out how people feel about themselves and their eating patterns, weight and bodies. The information from the study will help psychologists and other professionals, working in eating disorders, to understand how an eating disorder can develop and ways that might help treat people with an eating disorder. It is anticipated that this study will be completed by May 2006.

### **Why have I been chosen?**

You have been identified as someone who may be interested in taking part in this study. You are currently receiving treatment at Coventry Eating Disorders Service and because of this we think you might be able to help us understand more about your eating problems. In total twelve people who receive treatment at Coventry Eating Disorders Service will take part in the study.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason, taking all information you have given to us with you. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive or your relationship with anyone working in the NHS.



**What will happen to me if I take part?**

If you agree to take part in the study, you will be asked to attend a one-to-one interview with myself at Coventry Eating Disorders Service. This interview will be audio-taped and later typed up by myself. This interview will last about one hour and will be in a private room at Coventry Eating Disorders Service.

You will be paid for any travel expenses to attend the interview at local transport rates.

**What do I have to do?**

Your involvement in the research will consist of a one-hour interview. Two weeks later you will be sent a written transcript of your interview, which you will be given the opportunity to change in a thirty-minute phone call.

You will not have to make any changes to your life-style or treatment as a result of your participation in the research.

**What are the possible disadvantages and risks in taking part?**

It is possible that you could become upset during or after the interview. At the end of the interview you will have an opportunity to talk to myself to help you understand your feelings in a debriefing session. In addition, if you wish, I can also inform the clinical team working with you that you are upset.

**What are the possible benefits of taking part?**

We hope that you find the interview itself helpful, however, this cannot be guaranteed. The information we get from this study may help us to treat future patients with eating disorders better.

**What if something goes wrong?**

The universities of Coventry and Warwick are providing indemnity cover for this research in case taking part in this research harms you. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms will be available to you.

**Will by taking part in this study be kept confidential?**

All the information you give will be strictly confidential. I will not have access to your medical records and the information you give me will not be passed on

to anyone. It will not be possible to individually identify participants in any report or publication relating to this study.

The audio-tapes and written transcripts will be stored at Coventry Eating Disorders Service, in a locked filing cabinet for a total of seven years (to comply with the Data Protection Act). Any information about you, which leaves Coventry Eating Disorders Service, will have your name and address removed so that you cannot be recognised from it.

Your GP will have no involvement in this study but will be informed of your participation.

### **What will happen to the results of the research study?**

The study forms the research component of a Doctorate in Clinical Psychology, and thus a copy of the research will be kept at both Coventry and Warwick University. In addition, it is anticipated that the findings of the research will be published in relevant journals. All those taking part in the research will receive a complimentary summary of the research and copies of any published journal articles.

### **Who is organising and funding the research?**

The research is being partly funded by the universities of Coventry and Warwick. This funding is to cover the costs of printing and inter library loans. None of the research team will receive any monetary payment in addition to their regular salary for taking part in the research. The study forms the research component of a Doctorate in Clinical Psychology for myself.

### **Who has reviewed the study?**

The study has received ethics approval from the Research Subcommittee of the Doctoral Course in Clinical Psychology at Coventry University and Warwick Research Ethics Committee. In addition, Dr Stephen Joseph, Research Tutor for the Doctorate in Clinical Psychology at the universities of Coventry and Warwick and Dr David Hacker, Clinical Psychologist, have both reviewed the research.

### **Contact for further information**

The Chief Investigator for the research is myself. Ken Goss, Consultant Clinical Psychologist and Head of Coventry Eating Disorders Service, is providing clinical supervision for the research and Dr David Giles, Senior Lecturer at Coventry University is providing academic supervision.

You will be given a copy of this information sheet. If you have any questions or require any additional information, please do not hesitate to contact me at the address or phone number below.

Melanie Elsworthy  
Clinical Psychologist in Training  
Clinical Psychology Doctorate Course  
School of Health and Social Sciences  
Coventry University  
Priory Street  
Coventry

Tel: 02476 888 328

Thank you for reading this.

Melanie Elsworthy  
Clinical Psychologist in Training



**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Professor Delia Cushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
Coventry University  
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Telephone 024 7688 8328  
Fax 024 7688 8300



**C O V E N T R Y**  
**U N I V E R S I T Y**

## **Appendix six – letter inviting the participants to take part** **Participants' details**

Our ref

Dear.....

Your ref

### **Research Study: An exploration of shame and pride in eating disorders**

I am writing to you to let you know about the research I am undertaking as part of my clinical training and seek your help with this. My name is Melanie Elsworthy and I am studying for a Doctorate in Clinical Psychology at the universities of Coventry and Warwick. I am interested in finding out how people feel about themselves and their eating, weight and body shape.

The following people are involved in this research:

**Melanie Elsworthy**

Clinical Psychologist in Training at the universities of Coventry and Warwick.  
Telephone number: 02476 888 356

**Ken Goss**

Consultant Clinical Psychologist and Head of Coventry Eating Disorders Service.  
Telephone number: 02476 521130

**Dr David Giles**

Senior Lecturer at Coventry University.  
Telephone number: 02476 888 356

Please find enclosed a participant information letter and a consent form. Please ensure you read the participant information letter and consent form fully before deciding whether or not to take part in this study.

If you decide to take part in this study then please sign and return the consent form in the stamp-addressed envelope provided. I would be happy to answer any questions you may have regarding the study so if you do have any questions then please call me on the phone number listed above.

I would like to take this opportunity to thank you for reading this letter.

Yours sincerely

**Melanie Elsworthy**  
Clinical Psychologist in Training





**C O V E N T R Y**  
U N I V E R S I T Y

## Appendix seven – written consent form

Our ref

**Study Number:** 05/Q2803/77

Your ref

**Patient Identification Number:**

Date

### CONSENT FORM

**Title of Project:** Shame and Pride in Eating Disorders: An Interpretative Phenomenological Analysis.

**Name of Researchers:** Melanie Elsworthy, (Clinical Psychologist in Training)  
Ken Goss (Consultant Clinical Psychologist)  
David Giles (Senior Lecturer)

**Please initial box**

1. I confirm I have read and understood and information sheet dated 16.09.05 (version 3) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being Affected. ☐
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from Coventry Primary Care Trust or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐
4. I understand that my General Practitioner (GP) will be informed of my participation in this study. ☐
5. I understand that my interview for the study will be audio-taped.



6. I understand that the audio-tapes and interview transcripts will have all information identifying me removed. They will then be stored in a locked cabinet at Coventry Eating Disorders Service and will only be available to those directly involved in the study.

☐
7. I understand that the analysis of the audio-tapes will take place at Coventry Eating Disorders Service. The audio-tapes and all data will be stored for a total of seven years, to comply with the Data Protection Act.

☐
8. I agree to take part in the above study.

☐

<div>Name of patient</div>	<div>Date</div>	<div>Signature</div>
<div>Name of person Taking consent (if different from researcher)</div>	<div>Date</div>	<div>Signature</div>
<div>Researcher</div>	<div>Date</div>	<div>Signature</div>

**Copies:**

1 for patient, 1 for researcher, 1 to be kept with hospital notes



**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Professor Delia Cushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
Coventry University  
Priory Street Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8300



**C O V E N T R Y**  
**U N I V E R S I T Y**

## **Appendix eight – GP letter**

**General Practitioner**  
**Address**

**Dear Dr**

Our ref

Your ref

Date

This letter is sent to inform you that:

**Name:**

**Date of birth:**

The above has agreed to take part in research exploring shame and pride in eating disorders. The participants for this research have been approached from a client group, who are currently receiving treating for their eating disorder at Coventry Eating Disorders Service.

The Chief Investigator of this research is myself. The other researchers are Ken Goss, Consultant Clinical Psychologist and Head of Coventry Eating Disorders Service and Dr David Giles, Senior Lecturer at Coventry University. The study will form the final research for a Doctorate in Clinical Psychology for myself. During the research I will receive clinical supervision from Ken Goss and academic supervision from Dr David Giles.

Your patient's involvement in the study will consist of a one-hour interview (which will be tape-recorded and later transcribed) and a thirty-minute follow up telephone conversation. The follow up telephone conversation will be to discuss the researchers interpretation of the data and will give your patient the opportunity to make any changes or additions, thus helping prevent researcher bias.

If you have any questions regarding the research then please contact me on the phone number at the top of this letter.

**Yours sincerely**

**Melanie Elsworthy**  
**Clinical Psychologist in Training**



## **Appendix nine - inclusion and exclusion criteria for the study**

Inclusion criteria is a clinician assessed primary problem of the following eating disorders:

- Anorexia Nervosa.
- Bulimia Nervosa.
- Eating Disorder Not Otherwise Specified

The following exclusion criteria applied:

- Body mass index of 15 or less.
- Recent history of self-harm.
- Suicidal ideation, planning or intent.
- Illegal drug use.
- Alcohol misuse.
- Diagnosis of psychosis.
- History of aggressive behaviour.
- Intellectual disability.

The aforementioned are the exclusion criteria for Coventry Eating Disorders Service.



## **Appendix ten – semi-structured interview schedule**

### **Introduction:**

- Myself
- Purpose of study
- What will happen to study
- Validity phone checks
- Check contact details and if okay to phone
- Voluntary consent – can withdraw at any time
- Breaks/ending interview early if appropriate
- Complaints procedure
- Confidentiality
- Consent form

**1. Describe how you feel about your:**

- body shape
- weight
- eating

**2. Would you change your:**

- body shape
- weight
- eating

Probe: if so, how?

**3. Do you think you are slimmer or larger than average?**

Probe: if so in what way?

**4. How do you feel in terms of mood (e.g. depressed, anxious, happy)?**

Probe: How does eating/restricting/purging change this?

**5. Do you ever eat as a result of feeling low/anxious/depressed?**

6. Do you ever feel helpless to control your:
  - body shape
  - weight
  - eating
7. Do you ever control your eating?  
Probe: if so how, when, what leads to this?
8. Do other people try and control your:
  - body shape
  - weight
  - eatingProbe: if so how does this make you feel?
9. Describe how you feel after a large meal or eating high calorie food?
10. Describe how you feel eating in front of others (example, restaurant)?
11. Do you think other people are disgusted with you because of your:
  - body shape
  - weight
  - eating
12. Do you ever feel disgusted with your:
  - body shape
  - weight
  - eating
13. How do you feel compared to others in terms of your:
  - body shape
  - weight
  - eatingProbe: better, worse the same?

14. How do you think others feel about your:

- body shape
- weight
- eating

15. How you feel when you see your body in a mirror?

16. Do you ever avoid:

- looking in mirrors
- communal changing rooms
- others seeing you undressed

17. Do you ever visit a gym?

Probe: how does this make you feel?

18. Describe the last time you felt unhappy about your:

- body shape
- weight
- eating

19. Describe the last time you felt happy about your:

- body shape
- weight
- eating

**Ending:**

- debriefing
- Access if okay to leave
- Explain what will happen next
- Thank for time
- Offer expenses

## **Appendix eleven – example of interview transcript**

**Researcher:** How do you feel about your body shape?

**Participant:** Hmm, It depends on day really, but generally it is not a very good image. I do quite a lot of mirror checking, like constantly just catching myself, reflections and things and grabbing bits (points to stomach) and being unhappy. Always striving for perfection, or what I think perfection is I suppose. It is worse when my eating disorder is worse, if I have had a few good days then I start to feel better about myself altogether and my mood lifts, and then I feel better about my shape as well. But generally speaking there is always stuff you want to change (looks down at body).

**Researcher:** So what would you think when you see your reflection?

**Participant:** I need to get rid of that, need to get rid of that, need to pull that in (nervous laugh), yea I am generally bigger than I want to be.

**Researcher:** So what would you want to be? If you could describe the perfect figure what would it be?

**Participant:** I don't want to be a complete stick either, because I still want to be womanly, have some kind of shape to me, I don't know, probably about a stone, a stone and a half lighter, a couple of dress sizes down.

**Researcher:** What size would be your ideal dress size?

**Participant:** A small 8.

**Researcher:** How do you feel about your weight?

**Participant:** I get really annoyed. I used to, (pause), I just find it really frustrating, yea, I think it's too much. I try and tell myself that it depends on how much muscle mass you have got, and things like that, depending on how much exercise you do, but (pause), but yea again I would quite like to lose a fair bit there (nervous laugh).

**Researcher:** What is a fair bit?

**Participant:** About a stone and a half, yea.

**Researcher:** How do you feel about your eating?

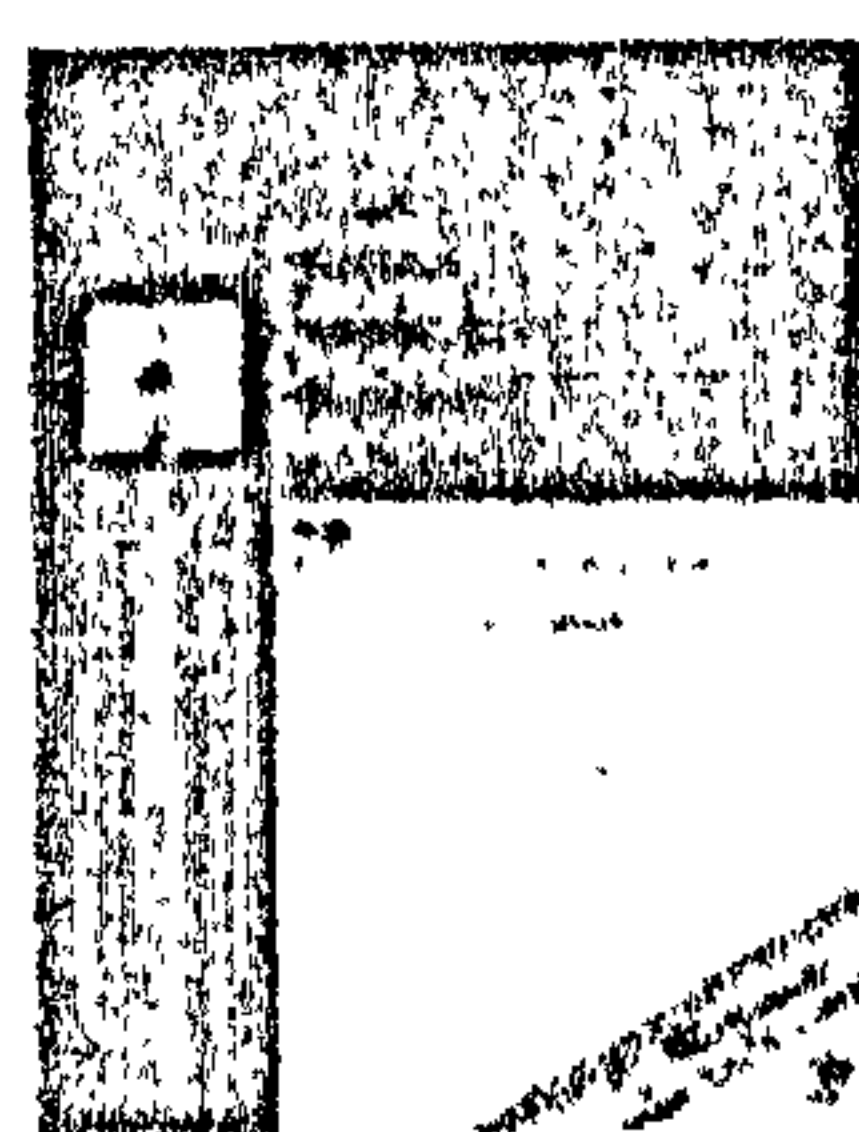
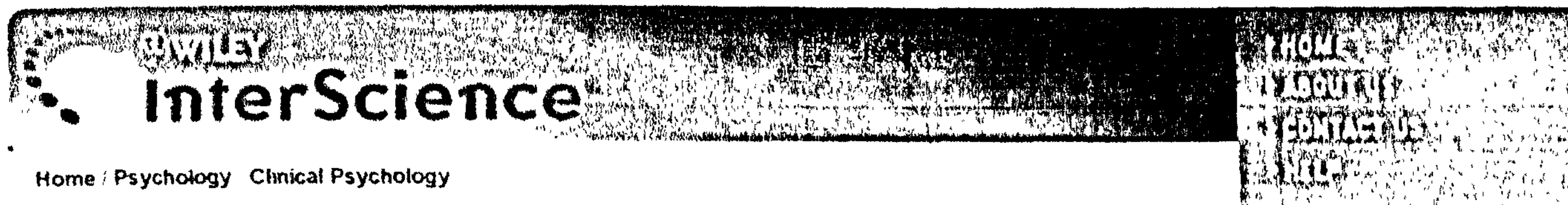
**Participant:** My eating is totally out of control really, hmm. Sometimes I think it is better than it is, I am so used to it being like it is now I just get on with it, but when I take a step back it is a real struggle. It's just really annoying, it's something that



## Appendix twelve – stages of data analysis

<b>Stages of data analysis in IPA (Smith, Jarman &amp; Osborn, 1999)</b>	
<b>Stage 1, submergence in the data</b>	During this stage the first transcript was read a number of times, to allow the Chief Investigator to become intimate with the account. At the same time, the left hand margin was used to note down anything interesting and significant to the Chief Investigator.
<b>Stage 2, Looking for themes</b>	The right hand margin of the transcript was then used to record emerging themes. New themes were checked against earlier sections of the transcript.
<b>Stage 3, Looking for connections and organising the themes</b>	Each theme was recorded, giving the reference of the page and line numbers. From this the themes were organised into a table of related themes (master theme list).
<b>Stage 4, continuing the analysis with other cases</b>	The master theme list from the first interview was then used to analyse the second transcript. During this stage the master theme list was used to look for more instances of the themes in the second transcript. The remaining transcripts were then analysed in the same way.
<b>Stage 5, distilling the themes</b>	A table of themes was then organised and distilled. This was based on their richness and frequency of occurrence. Each transcript was then re-read to check that these themes were an accurate reflection of the participants' experiences.
<b>Stage 6, Writing up the analysis</b>	The final stage involved writing up a list of superordinate and subordinate themes. This included giving a percentage of the transcripts the theme appeared in and the frequency.
<b>Stage 7, supporting the themes with narrative accounts</b>	A narrative account, using verbatim extracts, was then written. The narrative accounts were chosen by the Chief Investigator on the basis of those best reflecting or communicating the theme clearly to other readers.

## Appendix thirteen

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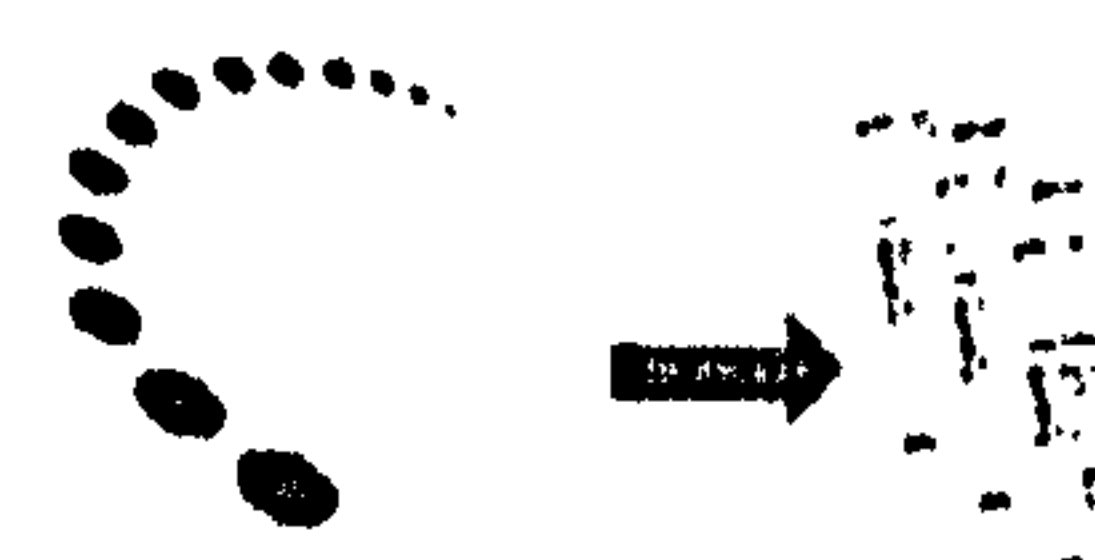
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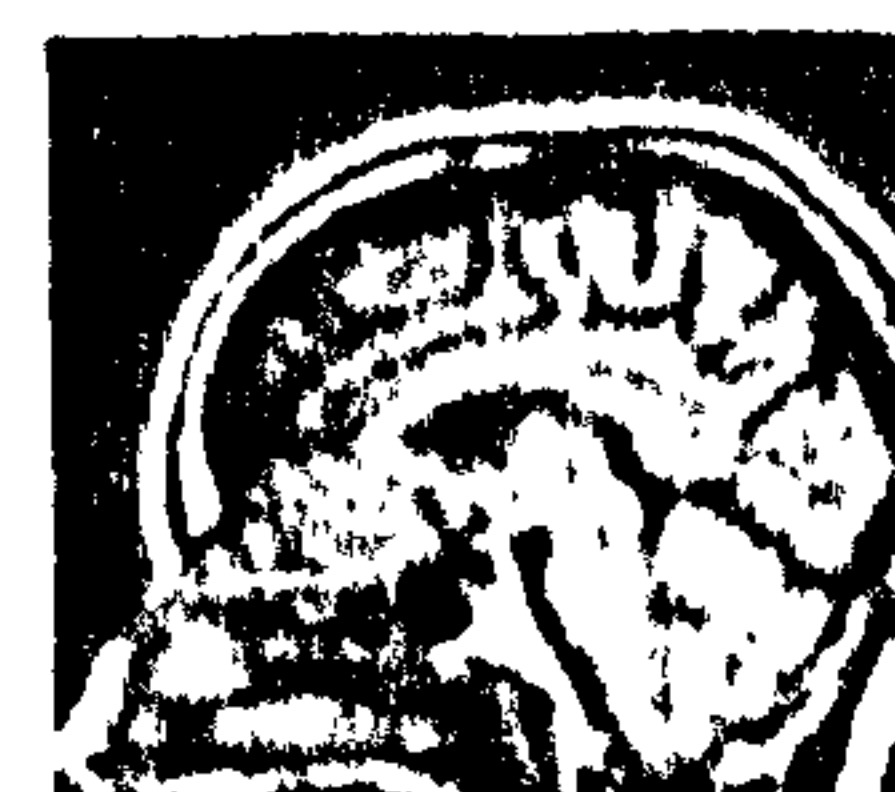
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**A. A typical citation of an entire work consists of the author's name and the year of publication**

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

**B. If the author is named in the text, only the year is cited.**

Example: According to Irene Taylor (1990), the personalities of Charlotte

**C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary**

Example: In a 1989 article, Gould explains Darwin's most successful

**D. Specific citations of pages or chapters follow the year**

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11)

**E. When the reference is to a work by two authors, cite both names each time the reference appears**

Example: Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983). . . Alcock and Thornhill (1983) also demonstrate. . .

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Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997). When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

**G. When the reference is to a work by a corporate author, use the name of the organization as the author**

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

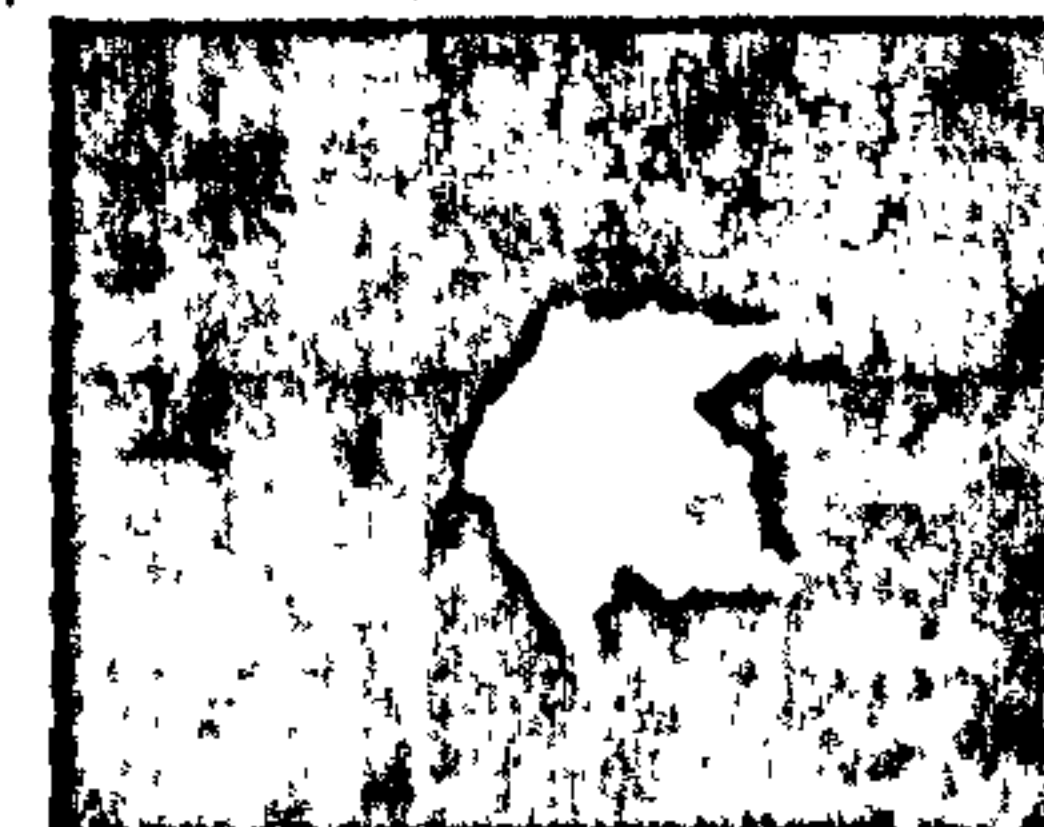
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Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas.



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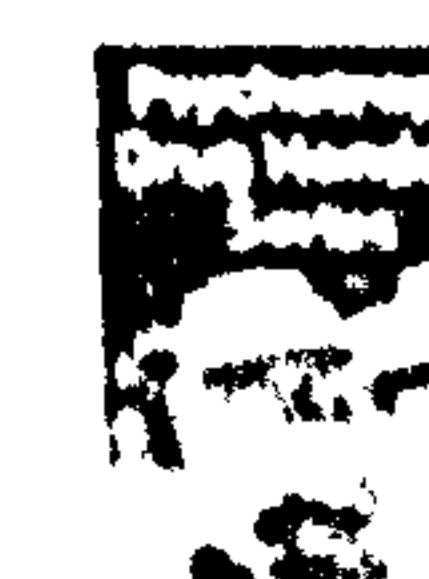
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