Research Paper

A systematic review of qualitative studies on shame, guilt and eating disorders

Tammy Oluyori

Background: *The presence of shame and guilt in eating disorders (ED) has been widely acknowledged in existing literature. The objective of this paper is to review existing qualitative studies linking shame and guilt to ED.*

Methods: *The first three stages of the main review (literature search, applying inclusion/exclusion criteria to the studies found through the search and assessing the quality of studies which met the inclusion criteria) followed the standard methodologies used within qualitative systematic reviews (SR). The final stage of the SR involved the integration of synthesis of themes about the experiences of shame and guilt in ED population. This stage used techniques from cross case thematic analysis and meta-ethnography, one of the most well developed and frequently used methods of synthesising findings from qualitative studies. Meta-ethnography facilitates the identification of themes, which run both within and across studies.*

Results: *The search strategy found 10 studies that met inclusion criteria (i.e. clinical sample). Five of the studies met the quality criteria, and were, therefore, included in the review. Integrating findings across the five studies enabled a rich understanding of shame and guilt and their relation to ED. The synthesis generated four themes (Description of shame and guilt; Responses to shame and guilt; Shame and self-criticism; and Control). Findings suggest that guilt and shame are difficult experiences; they were described in terms of various negative feelings and cognitions such as anger, anxiety, greed, envy, condemning thoughts about self and others view of self. Shame was found to be more linked to ED severity than guilt, and similarly, shame was found to contribute to both development and maintenance of ED.*

Conclusion: *The SR points to the potential value of using well-conducted qualitative studies to facilitate phenomenological understanding and inform clinical practice. Further research is required to extend the current understanding of the role of shame and guilt in ED.*

Keywords: *Eating disorders; guilt; shame; qualitative study.*

Background

SHAME AND GUILT belong to the family of self-conscious emotions such as pride, embarrassment and humiliation. It has been identified that emotions such as shame and guilt generate power that can affect how the self is conceptualised (Burney & Irwin, 2000; Frank, 1991).

Within the field of psychology, the process of shame and guilt is said to be similar; both emotions occur in the context of self-reflection and the fear of eliciting disgust in other (Gilbert, 1992; Goss & Allan, 2009; Miller, 1997; Power & Dalgleish, 1997). Freud was a pioneer in looking at the relationship between guilt and psychopathology; he viewed guilt as retaliation of the superego in response to the Id's immediate desire for gratification and the Ego's action. Freud explained that it is this tension between the psyches that leads to psychological problems (Tangney & Dearing, 2002). Gilbert (1992, 1995) explained shame as an emotion that involves the appraisal of the self as flawed and inadequate by an imagined or real observer, or when the self fails to live up to an idealised moral standard (Tagney, 2005). The distinction here is that guilt does not affect the self as a whole or the individual's core identity, but affects a specific behaviour (Burney & Irwin, 2000).

A number of studies have found positive relationships between shame, guilt and eating pathology within clinical and non-clinical samples (Frank, 1991; Gee & Troop, 2003; Goss & Allan, 2009; Grabhorn, Stenner, Stangier & Kaufhold, 2006; Masheb & Brondolo, 1999; Murray, Waller & Legg, 2000; Sanftner et al., 1995; Swan & Andrews, 2003; Troop et al., 2008). However, the potential link between shame and eating disorders has been well documented compared to the link between guilt and ED. Nonetheless, the possibility of the significance of the two affects has been advocated by both psychoanalytic and cognitive behavioural theorists.

Goodsit (1985) identified two types of shame; internal shame (negative self-evaluation) and external shame (feelings that others evaluate the self in a negative way). This suggests that ED patients are not only self-critical but perceive others as being critical of them. In terms of eating disordered behaviours and the emotions this generates, Fairburn (1981, 1993, 2003, 2008) proposes that episodes of overeating in bulimic patients are marked by profound loss of control that elicits guilt and self-disgust. More recently, Doran and Lewis (2012) found that bodily shame was also uniquely predictive of eating pathology in a female clinical sample and a male nonclinical sample, whereas both bodily shame and characterological shame predicted eating pathology in a non-clinical female sample.

Hitherto, there is a fundamental diversity of opinion with regards to the presence of shame and guilt in the aetiology of ED. Where some authors see shame and guilt proneness as causal factors in the psychodynamics of ED, others interpret these affects as the consequence of having ED. Despite this, such conjectures have warranted limited empirical scrutiny (Burnley & Irwin, 2007; Sanftner et al., 1995).

Rationale for the present study

My doctoral thesis is a qualitative study of the experience of shame and guilt in people who have had treatment for an ED. This is driven by my own clinical experience of working with individuals struggling with ED, and my curiosity around aetiology; predisposing factors; potential correlations around shame, guilt and ED; and treatment considerations. Therefore, as a precursor to my thesis, it seems logical that I undertake a secondary research study as a means of scoping what existing literatures there are around this issue and what these studies can tell us. I hope that this piece of work will help to identify gaps in literature which will inform the planning of my doctoral thesis.

The aim of the present study is to review existing qualitative research that has sought the client's experience and understanding of shame and guilt in relation to ED. To date there have been no comprehensive reviews of the research literature looking at shame, guilt and ED. Additionally, qualitative research is not traditionally included in systematic reviews. Therefore, the aim of this paper was to elucidate what qualitative research there has been to date looking at shame, guilt, and ED. It is hoped that an in-depth understanding will be gained by adopting a different methodological approach. With this in mind, the research question was as follows:

> *What does the qualitative research evidence tell us about the experience of shame and guilt in an eating disorder population?*

Systematic review methodology

The recent proliferation of studies using qualitative methods within the fields of health and counselling psychology has led to an accumulation of a substantive body of qualitative research. However, this popularity does not extend to the synthesis of multiple qualitative studies. Furthermore, whilst there has been considerable development of methods for fusing quantitative findings, methods to do the same with qualitative research finding are still in the early stages of development (Dixon-Woods et al., 2003). In fact, many authors (e.g. Booth, 2001; Campbell et al., 2003; Murphy et al., 1998;

Popay et al., 1998) have argued that conventional systematic review methodology cannot be used as a method for reviewing qualitative research findings.

This review was conducted using a combination of conventional systematic review methods and newly evolving methodological insights from recent reviews of qualitative research (Barroso et al., 2003; Campbell et al., 2003; Dixon-Woods & Fitzpatrick, 2001; Hawker et al., 2002; McDarmott, Graham & Hamilton, 2004). There were four stages to the review: a search strategy to locate studies; the application of inclusion/exclusion criteria; quality assessment; and the integration/synthesis of study findings.

Search strategy

Literature scoping

For the review, research papers were identified by conducting searches on the following databases: PsycInfo; ASSIA (Applied Social Sciences Index and Abstracts); CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature); and Medline. The search terms used were 'shame, guilt and eating disorders' 'Shame AND 'eating disorders, 'Guilt AND eating disorders' qualitative study'. Reference lists of papers identified were also examined for any related research. As the review aimed to examine both shame and guilt, searches were carried out using either shame or guilt at any one time and also using both keywords at the same time. Much research addressed either shame, or guilt within eating disorders and not both. It should be noted that searching for qualitative studies in electronic databases poses particular problems in relation to the specificity and return of the number of records obtained. In addition, most databases have not indexed qualitative research with an explicit subject heading. While filters have been developed and verified for randomised controlled trials and other types of study, the work on filters for qualitative studies is in the developmental stages and often those developed are not practically useable. Overall, the only approach is to use free text words to identify qualitative studies but the recall/specificity problems persists.

Inclusion/Exclusion criteria

In line with conventional systematic review methodology, the inclusion/exclusion criteria (see Table 1 below) were applied to the studies located in the search strategy.

Table 1: Inclusion/Exclusion criteria.

Parameters	Inclusion criteria	Exclusion criteria
Location	Any country.	Any country.
Language	Language Studies written in English.	Studies not written in English.
Time frame	Studies published from 1990 (inclusive) onwards.	Studies published before 1990.
Population	Studies which focus on or include people who suffer from eating disorder.	Studies which did not focus on or include people who suffer from eating disorder.
Study type	Primary research. Studies which report on findings which use qualitative methods (data collection and analysis).	Studies which DO NOT include qualitative methods of data collection and analysis.

Quality assessment

The procedure for assessment of this current review was borrowed from the existing sets of assessment criteria develop by the EPPI-Centre (Rees et al., 2001). These criteria were selected because they were constructed on the rationale and assumptions of qualitative research rather than on a check list of dogmatic 'technical fixes' (Barbour, 2001). Studies that met the assessment criteria are listed in Table 2.

Procedure of data synthesis

As mentioned before, qualitative SR is relatively new paradigm, consequently a consensus on the most appropriate method to synthesise qualitative research findings is still evolving (Britten et al., 2002). This is exemplified by the diversity in existing methods used by researchers in the field (Hammersley, 2002; Strike & Posner, 1983). For example, existing methods include: narrative summary, thematic synthesis, grounded theory, meta-ethnography, 'aggregation of findings approach', qualitative meta-analysis, qualitative meta-synthesis, meta-study, cross-case analysis, content analysis, and case-survey (Dixon-Woods et al., 2003). All of these approaches were considered for the present study and a discernible similarity was found; at varying levels, they all attempt to draw out and integrate findings across qualitative studies in ways that generate new insights and understandings. Paterson (2001) argues that the purpose of a synthesis should be key factor in deciding the choice of method. Taking the aim of this study as a prime factor, the methods for this synthesis drew upon techniques from meta-ethnography (Noblit & Hare, 1988) and cross-case analysis, for reasons which will be discussed next.

Meta-ethnography (Noblit & Hare, 1988) is about how to interpretatively, rather than aggregately, derive understanding from multiple qualitative studies. The overall aim of meta-ethnography is to achieve greater understanding and attain a level of conceptual or theoretical development beyond that achieved in the existing individual study by carefully selecting studies to be synthesised. Selected studies are then read repeatedly and key concepts are noted. These key concepts become the raw data for the synthesis. As highlighted by McDarmott et al. (2004), one of the most challenging aspects of qualitative synthesis methodology is the tension between developing practical and communicable methods that synthesise findings, whilst also maintaining the integrity of individual studies. However, this is what sets meta-ethnography apart from other methods; the main appeal is the potential to preserve the interpretative properties of primary research. This stance is particularly important for this study as although all the included studies have eating disorders shame and (or) guilt as the common factors, they differ in the perspective at which they have looked at it. The process of this methodology is achieved in three steps:

1. Reciprocal translation analysis – this involves examining the key concepts across each study and translating the concepts into each other. Judgements about the ability of the concept of one study to capture concepts of others are based on the attributes of themes themselves.
2. Refutational synthesis – the key concepts and themes in each study are identified and contradictions between the reports are characterised. The 'refutations' are examined and an attempt made to explain them.
3. Lines of argument synthesis – involves building a general interpretation grounded in the findings of the separate studies (similar to comparative analysis of grounded theory).

One major problem of the meta-ethnography method is that it relies upon comparing concepts between studies through the process of conceptual translation and refutation. It takes for granted that the concepts are of similar interpretive levels. After reading the studies included for the synthesis on shame, guilt and eating

Table 2: Studies that met the quality assessment criteria.

Authors	Aim	Sample Size	Sample Composition	Data Collection
Shaderud (2007)	To define shame and describe types and subtypes of shame and their relations to symptoms and meaning in anorexia nervosa. The study will also describe the possible role of pride, as a contrasting emotional and cognitive experience.	13 female patients in active treatment for anorexia nervosa.	Age 16 to 39 years.	Semi-structured interviews with patients in active treatment for anorexia nervosa.
Rortveit, Astrom & Severinson (2010)	To illuminate and interpret guilt and shame expressed by mothers with eating difficulties (ED).	Eight Norwegian mothers agreed to participate. Mother and researcher.	Aged between 23 and 48 years.	A qualitative data collection method by means of individual in-depth reflections was employed.
Rortveit, Astrom & Severinson (2009)	Its aims are to explore guilt, motherhood in the context of eating difficulties.	Eight patients with eating disorders.	Mothers age 36 to 44.	A hermeneutic qualitative research.
Elsworthy (2006)	To explore shame and pride in a clinical population with a diagnosed eating disorder.	Eight patients undergoing treatments for anorexia nervosa.	Age 21 to 49.	Semi-structured interview.
Rortveit, Astrom & Severinson (2009)	The aim of this study was to explore women's bodily experiences of suffering from eating difficulties (ED). The research question was: How do women who suffer from ED experience the bodily aspects related to their condition?	The qualitative data were collected by means of seven focus group discussions.	Over 18's.	Focus group interview.

disorders, it was apparent that there were different levels of interpretations within the findings. These ranged from more 'interpretative' findings which arose from sophisticated theoretical and conceptual research frameworks, through to findings which relied less on such frameworks and were more descriptive. Popay (1998) describes these different levels of findings as 'thick' and 'thin' interpretations. For this review, it seemed inappropriate to compare (for translation or refutation) a 'thick' interpretation of, for example, 'how mothers interpret shame and guilt in relation to eating disordered behaviours' with a more descriptive account of 'contribution of shame to eating disordered behaviour'. Although the findings may be about the same subject but they are at different conceptual levels. It was for this reason that the reciprocal translation synthesis and refutational synthesis were not attempted. As a replacement, this review drew upon stages one and two of cross case analysis (Miles & Huberman, 1991) in order to address the problems of synthesising disparate research findings. The integration of two slightly different methodological approaches is not novel in qualitative synthesis. A similar creativity was achieved by McDarmott, Graham and Hamilton (2004) in their report on 'Experiences of Being a Teenage Mother in the UK: A Report of a Systematic Review of Qualitative Studies'.

The first two parts of the analysis drew on techniques from Miles and Huberman's (1991) cross case analytic method which Woods et al. (2003) noted as a very 'stylised' method that provides clear procedures to follow when working with multiple studies. For the present synthesis, each study was treated as a single case with multiple findings/data. The findings from each study were closely read a number of times to capture the meaning and content of each sentence and to sensitise the researcher to the main themes/findings of the research. Notes were made about general categories. Following this, the main themes from each study were generated, grouped and coded. After this, a mapping diagram was developed. This grouped together the main findings of all the five studies. To facilitate a proper understanding of each case (study), a summary of the context of the research (e.g. sample, aims, and methods) was inked at the top of the mapping diagram. This stage of synthesis highlighted six emerging themes as important interpretive context for understanding shame, guilt and ED.

The final stage of the synthesis employed Noblit and Hare's (1988) 'lines-of-argument' synthesis. The authors state that the 'line-of-argument' synthesis is the same as basic theorising in qualitative research. Essentially, this technique is about inference. That is, 'What can be said of the whole based on selective studies of the parts'? (Noblit & Hare, 1988, p.62). To aid the comparative analysis for this synthesis, a table for each of the identified codes in the mapping diagram (outlined in the previous section) was designed which tabulated the studies' main findings under each code. In this way, the concepts, interpretations and findings for a particular code, for example, shame of having EDs, could be compared more easily (in one table) across the four studies. Comparing concepts using code tables enabled the analysis to move away from the particular to the general, and allowed for greater abstract thinking space. In the end, four themes were generated.

Ethical considerations

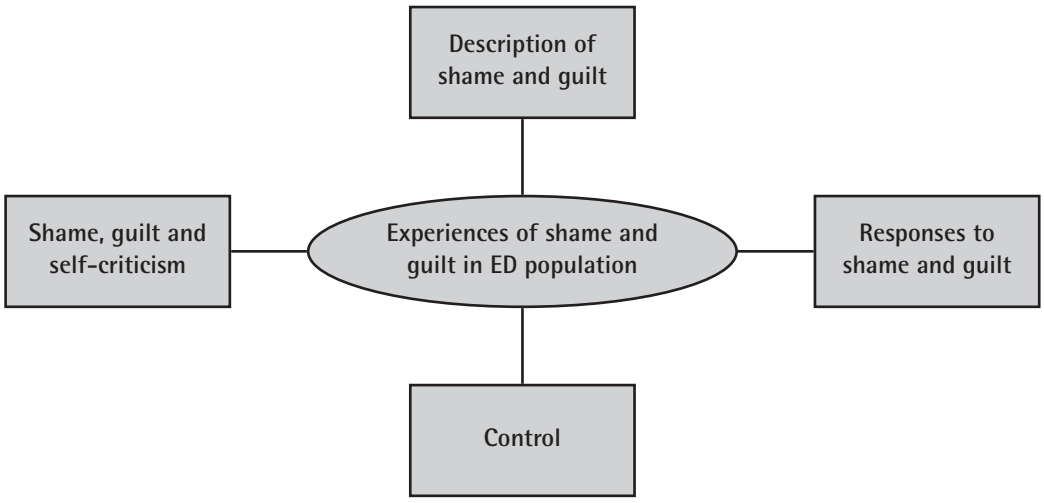
The review went through a process of ethical clearance at the University of Manchester, confirming that the research only involved secondary data synthesis. The study only utilised studies in the public domain.

Results

Study flow

The combined search strategies yielded 80 citations. The abstracts and titles of the citations were read and 70 studies were initially rejected because the majority were not qualitative research and they were carried out

Figure 1: A mapping diagram showing the final themes generated from the synthesis.



with non-clinical samples. The remaining 10 citations were read through a second time, and a further six citations were rejected for similar reasons. The final number of citations was four.

Data synthesis

This section explores the experience of shame and guilt in ED population through the four strongest themes that emerged from the synthesis. It is important to note that these are not meant to be complete, but form a ground for further discussion. In spite of this limitation, this synthesis demonstrates a richness and complexity in shame and guilt experiences in ED population.

Description of shame and guilt

Shame was described as:

> *'it is the life nerve… it is somehow one of the two or three motivating or constantly present moods I have or have had in my life, as long as I can remember and for everything… I have always been a super ambitious person. But I am ashamed of not being able to live up to them, not being able to take hold of them, not being able to be, not to have this masculine strength for just going for it and accomplishing it. But then I also feel ashamed of having these ambitions.'*
>
> (Maria in Sharderud, 2007, p.86)

Guilt was described more in terms of the consequence of ED. This was particularly prominent in the studies that focused on mothers. Within this population, guilt, like shame was described as an intense emotion which mainly had to do with the inability or deficit in carrying out maternal roles and responsibilities as well as the influence it may have on the children and worries about children developing the ED. One mother in the Rorveit et al. (2010) study reflected on her experiences of guilt in relations to her maternal role:

> *'[I] always have a pain in my stomach and a guilty conscience about them, and I'm terrified that they will develop the illness as well.'*
>
> '*When you cannot even manage to eat and get out of this situation for the sake of your own kids, it is my responsibility. I have never wanted to give them… nor have given them the feeling of having a mother who is ill.'* (p.236)

The synthesis suggests that all participants in the five studies assessed shame and guilt as an intense negative emotion. This contrasts Sanftner et al.'s (1995) study that appraised guilt positively; as a protection against eating disorder symptomatology.

Regarding the role of shame in the etiology of ED, the synthesis suggests that shame precedes as well as maintains ED. In talking about experiences of shame, one participant attempted to distinguish whether shame precedes ED or whether it is what comes after ED:

> *'I feel as if the shame is a consequence [of the ED]. Or that it originates from… the ED; the ED is such a shameful thing! You are so ashamed about not being able… – yes ashamed. […]. And you need food in order to be able to function. It is not either/or. But if you are in the 'or-phase', when you don't eat anything, you feel ashamed about that as well. And I am ashamed at the idea of thinking about food all the time.'*
>
> (One mother in Rortveit et al., p.235)

In this participant's narrative, shame is explained as a causal and effect factor of ED. Also within this narrative, ED itself is referred to as shameful. The participant also linked shame to the severity of ED behaviours (restricting and thinking about food).

The synthesis illustrates the dynamics between shame and guilt. The accounts of the studies demonstrate the intertwined nature of both emotions. What was very explicit from the synthesis is that guilt unlike shame is a consequence of ED. It is particularly a negatively intense emotion where a moral behaviour is compromised or where a person is feeling that they have failed in to deliver an important role. For example, mothers who had ED felt intense guilt because of worries about the effect it may have on their children. In this sense, shame also goes hand in hand with guilt. On the other hand shame was described as both a preceding factor and as a consequence of ED.

Shame and guilt response to ED

The majority of the participants in all five studies referred to their diagnosis of ED as shameful. Traditionally, there is a stigma attached with mental illness in our society. Consequently, people attempt to keep their difficulties a secret from others.

> *'I'm glad that you have a separate entrance and exit here at your office. So I don't have to meet other people in the waiting room. I wouldn't have come then. Nobody must know that I'm seeing a psychiatrist. I know that I am sick, probably a bit mad too, but I can't stand the thought of being a part of the group, which is referred to as being so helpless, hopeless and needy. That would be beneath my dignity.'*
>
> (Helena from Skarderud, p.91)

Being overly concerned with body shape and weight has been highlighted in ED literature as the core psychopathology of the illness. Within this synthesis, shame in relation to weight or body shape was also present across all the five studies. Below, one participant 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 I wasn't here.'*
>
> (One participant from Elsworthy, 2007, p.30)

The response to shame in this way led this participant to make negative social comparisons:

> *'But every time I see my friends I body check them, you know hips.'*

Although eating is an essential part of people's everyday life, engaging in this basic everyday act triggered guilt, which reminded ED patients of their problem several times a day. A participant summarised this stance below:

> *'There are five billion people on this earth, maybe even six now? Many of them don't have enough food, so they have their own eating problem. But for the others, for those who have enough food, eating is rarely a problem. And very many eat with great pleasure. Just eating should be very simple. Everyone manages it,*

except for some others and me. I don't cope with something as elementary as eating every day.'

(Emily in Sharderud, 2007, p.97)

Emily's words express her feelings of defeat in connection with her inability to cope with something that is so basic and essential and a daily precondition for relatively normal psychosocial functioning. This resulted in feeling of guilt and seeing ED condition as self-centered, which is morally questionable when compared to other conditions like starvation as a result of lack of food.

Self-criticism guilt and shame

Shame within all five studies was described as an intense negative perception of self, and a perception of having what others will find unattractive.

'I am a hopeless person, not worth loving. Everything I do is stupid. I should not have been born, and very often I do think that I do not deserve to live. I cannot stand myself.'

'…I think that perhaps I am ashamed, like you are asking, but I don't think I have the right to feel ashamed. I am not worth it.

(Two participants from Shaderud, 2007, p.87)

These narratives demonstrate the embodiment of emotions and cognitions that are fundamental to eating disorders. The feeling of shame is embodied as a physical reduction, not being worthy or not deserving to live. Similarly, engaging in ED behaviours was described and shameful and guilt, consequently involved self-criticism.

'…I am ashamed of playing the hypocrite; using vomit to be thin is not strong and firm self-control, but it is cheating… I am preoccupied with being thin, but then I am also preoccupied with the fact that this is stupid vanity… I want to have pure thoughts in my head, but whether I am reading, or am about to go jogging, or almost constantly, I don't manage to keep them pure but start thinking trivial thoughts, and this makes me feel ashamed. But why do I need to be so special, why do I have to take myself so seriously?'

'…I feel ashamed about everything. I feel ashamed about feeling ashamed.'

(Two partipants from Rortveit et al., 2010, p.238)

The expressions of both participants denote in different ways the global aspect of the feeling of shame and guilt, and the difficulties to manage such affects and cognition. These kinds of negative thoughts and feelings can contribute to a wish not only to change oneself, but also to get away from oneself: to disappear in the sense of suicide. The synthesis highlights here that shame is more closely related to the severity of ED than guilt.

Furthermore, the synthesis illustrates self-criticism in terms of feelings of failure associated with goal settings and achievement. The failure to achieve certain goals and standards results in intense criticism of self and perception that others will perceive the self this way. This stance is well documented in research and has been described by (Gilbert, 2007) an external coping strategy.

'Being thin is in fact the only thing I can manage. But actually I'm not particularly good at this either, since there are many others who are much thinner than me. And I hate to see extremely thin anorectic patients in newspapers or magazines. Then I realise what a failure I am even here.'

(A participant from Elsworthy, 2007, p.89)

Seeking treatment and help from others was also described as failure and shame inducing:

'First of all I felt very shameful about having to start in therapy. It hurt my pride. I like to manage on my own. And I don't like to ask for help.'

The expressions above depict help seeking as problematic and shameful.

It was also evident that people with ED criticised themselves for developing the illness, which also contributed to self-criticism, shame and also guilty feelings about the impact that the illness has on the people around them. This stance was very evident in the study of mothers with ED (Rosveit et al., 2010). The mothers in the studies described feelings of failure because of the threat to their maternal role. The overwhelmingly

strong desire to be a good mum led to devalued sense of self and other emotions such as anxiety, fear and shame. In this context, these emotions and thoughts are maintained by guilt.

> *'There may be many reasons why I developed the ED. But it is of course my own fault. For not addressing the problem earlier […]. I should have done so. But then it started, sort of… I forbid myself to take food, and then it really began.'*
>
> (Mothers in Rosveit et al., 2010, study pp.235–238)

Control

Contemporary research literature describes the ED behaviours as a battle and as psychological control. Dietary restricting and binging can be interpreted as a symbolic attempt for control. Conversely, binge behaviour can also be seen as a symbolic representation of lack of sufficient psychological control (Bruch, 1973; Crisp, 1997; Fairburn, Shafran & Cooper, 1999b; Nasser & Di Nicola, 2001; Orbach, 1978; Surgenor et al., 2002). Whether the ED behaviour was as a means of control or the lack of it emerged as a consistent theme across all five studies.

> *'I am really a weak person. I make plans that today I shall try to eat almost nothing. But then I may start thinking about something sad, or I get a phone call from my father, and then I completely lose control. So I go shopping and buy food. I do that because when I eat, I forget. It is even more effective than being knocked out by hunger. But it is so awful afterwards. The self-contempt is huge, I can tell you.'*
>
> *'…It is either or with me. I seem to lack a regulation switch.'*
>
> (Two participants from Elsworthy, 2007, p.90)

The above quotes exemplify feelings of defeat by losing control over food intake, and also show how this behaviour can be a reaction to effective experiences. The function of the ED behaviour was explicated in terms of attempts to use food to avoid or ease negative feelings.

> *'I suppose you just forget about all that or put it to one side and afterwards, it all comes back again and then you think, why did you do that again, you know it makes you feel crap.'*
>
> (A participant from Sharderud, 2007, p.237)

Discussion

The review aimed to illuminate and interpret what qualitative research literature tells us about shame and guilt in ED population. The synthesis suggested that guilt and shame were difficult experiences which varied, and appeared to be described by ED sufferers in terms of various negative feelings and cognition such as anger, anxiety, greed and envy. This is in accordance with Gilbert (2007), who argued that shame is a multifaceted experience expressed through a complexity of feelings, cognitions.

Furthermore, the synthesis highlighted shame, not guilt as both contributing factor to the development of ED and as a consequence of the illness. Guilt was solely described as a consequence of ED, especially when a person has failed to live up to an ideal. In this respect the study's findings did not provide support for any assumptions such as those made by Burney and Irwin, (2007); Sanftner et al. (2005) that eating disorders spring fundamentally from shame and guilt. The reason for this disparate finding could be because the studies above explored the role of both emotions from a non-clinical sample. A strength of this synthesis is that clinical sample was made an inclusion criteria.

Additionally, findings suggest that ED behaviours such as restricting and overeating were used as an attempt to control negative affect and thoughts, which in some cases led to more shame and guilt. The report simply highlights the difficulties that can occur in distinguishing between shame and guilt. It has been established in literatures that the process of shame and guilt are similar, both emotions occur in the context of self-reflection and the fear of eliciting disgust in other (Gilbert, 1992; Goss & Allan, 2009; Miller,

1997; Power & Dalgleish, 1997). The responses by some participants in the studies give ground for describing a mutual interaction where shame as a risk factor and shame as consequence can reinforce each other, in a shame-shame cycle proposed by Goss and Gilbert (2002).

The synthesis indicates that feelings of shame focused specifically on eating can lead to feelings of guilt. That is shame responses can trigger guilt. Also feelings of shame focused on body weight and shape are clearly germane to the development and maintenance of ED. People with ED appeared to both to condemn their disturbed eating behaviour (shame) and to condemn their own inadequacy in this regard (shame). This finding contradicts Burney and Irwin's (2007) speculations that eating-associated shame and eating-associated guilt are consequences rather than causes of ED behaviour. However, the synthesis supports their finding on the notion that shame may be closely related to the severity of eating disorders than is guilt in eating. Although this may be as a result of limited studies solely looking at guilt and ED compared to shame and ED. This suggests the need for further empirical research in this area.

Implication for research and practice

The synthesis above described the experience of shame and guilt on two levels: cognitive and emotional. Both levels conveyed the role of shame and guilt in ED as well as the individual's response to guilt and shame. The use of shame and guilt as theoretical constructs in regard to ED may provide an enriched understanding of the nature of this disorder. Therefore, it is argued that a greater understanding of the emotional phenomenology of eating disorders and the potential interactions between eating behaviours, shame and guilt is of immense clinical value in improving current theoretical models and treatment interventions. Clinicians working in the field of eating disorders may benefit from future research exploring the role of shame and guilt in eating disorders. This is partly because the behavioural expression of shame and guilt is silence. As therapy sometimes focus on shameful experiences, for example enquiry about bingeing behaviour, sexual abuse, etc., this may provoke shame or guilt. Furthermore, reflections on shame and guilt highlight that ED sufferers are ashamed of belonging to a stigmatised group. This can then result in clients denying symptoms altogether or the severity of symptoms thus resulting in a possible inaccurate formulation and altering treatment plan. Profound shame and guilt can therefore complicate the therapeutic process by challenging the very foundation of the therapeutic relationship. This has the potential to impair discussions between client and therapist on many levels. Understanding the role of shame and guilt in the therapeutic relationship can therefore enable the therapist to persevere, by gaining an understanding of the behaviour that may be experienced as a rejection or avoidance.

Conclusion and limitations

There are several potential methodological limitations to this report, which are important to consider. First, the review was conducted by one researcher due to the nature of the project. According to Dempster (2011), it is a good practice to have more than one reviewer in order to reduce potential bias. Secondly, as mentioned earlier, the SR of qualitative research is still in its infancy, and the methods appropriate to it are still under development. Therefore caution should be taken when interpreting results. That said, the methodology allows for deep phenomenological understanding of people's narratives, which are likely to be missed by quantitative methods. As such, it provides an important source of information and understanding to practitioners.

About the Author

Tammy Oluyori is a third-year trainee on the Doctorate in Counselling Psychology at the University of Manchester.

Correspondence

Email: tammy.oluyori@yahoo.com

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