Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. **16**, 303–316 (2009)
Published online in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/cpp.627

Shame, Pride and Eating Disorders

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This paper explores shame and shame-based responses in eating disorders. Research linking shame with eating disorders and the possible role of shame and pride in the onset and maintenance of eating disorders is reviewed. The experience of shame is likely to be complex, dynamic and variable. However, the key to identifying shame is often via the various coping strategies adopted, which in turn may form part of a maintenance cycle for eating disorder beliefs and behaviours. An outline model of shame and pride cycles in the maintenance of eating disorders is presented with clinical implications. Copyright © 2009 John Wiley & Sons, Ltd.

Key Practitioner Message:
- Shame and pride need to be addressed in the assessment and treatment of eating disorders.

Keywords: Eating Disorders, Shame, Pride, Coping Strategies

INTRODUCTION

Shame is a powerful emotion that has been associated with a number of clinical problems including depression (Allan, Gilbert, & Goss, 1994; Andrews, Qian, & Valentine, 2002; Cheung, Gilbert, & Irons, 2004; Gilbert & Irons, 2004; Harder, Cutler, & Rockart, 1992; Tangney, Wagner, Fletcher, & Gramzow, 1992); social anxiety (Gilbert, 2000a); Body Dysmorphic Disorder (Veale, 2002); Post-Traumatic Stress Disorder (Andrews, Brewin, Rose, & Kirk, 2002; Cook, 1994; Leskela, Dieperink, & Thuras, 2002); alcohol and drug misuse (Cook, 1994); and dissociation (Irwin, 1998). Feeling ashamed and being shamed by others are painful experiences that have been associated with social rejection or social put-down. Gilbert (2002) suggested a number of ways people may react (defensively) to such social threats and we focus on some of these defensive behaviours as they may present in those with an eating disorder. Pride is often viewed as the opposite of shame and is seen as a powerful social, as well as psychological, process. Goss and Gilbert (2002) suggested that pride, as well as shame, may have an important role in the onset and maintenance of some eating disorders.

This paper explores shame and shame-based responses in eating disorders. We highlight research linking shame with eating disorders and explore the possible role of shame and pride in the onset and maintenance of eating disorders. We also discuss the limitations of current research and suggest areas for further investigation. Finally, we explore the implications for clinical practice and identify potential treatment strategies.

SHAME: AN OVERVIEW

Shame is a multifaceted, self-conscious emotion that involves affective, social, cognitive, behavioural and physiological components. It blends the

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different emotions of anger, anxiety and disgust, involves social comparison and can have different foci; for example, one's physical appearance, behaviours or emotions (Gilbert, 1998, 2002; Power & Dalgleish, 1997). Shame often involves evaluations that the self is flawed or bad in some way, alongside evaluations and expectations that others are looking down on the self. Goss, Gilbert, and Allan (1994) and Gilbert (1998) suggested that these two evaluative processes ('what I think others think about me' and 'what I think about myself') involve different attentional foci and processing systems. This is in line with Cooley's definition of the 'looking glass self' in the 1920s (Scheff, 1988).

Gilbert (1998) labelled these different evaluations 'internal' and 'external' shame. Internal shame relates to inner experiences, self-evaluations and sense of self as flawed, inadequate, inferior, powerless and personally unattractive. It is often associated with intense self-criticism and even self-hatred (Gilbert, 2002). Some models of shame focus on this aspect of shame (e.g., Kaufman, 1989; Nathanson, 1994). In internal shame, the focus of attention is directed inward, processing information about or from within the self.

External shame is focused on believing that 'the other' looks down on the self in some way and is usually defined and measured in terms of the negative beliefs that one creates in the mind of 'the other'. In external shame, the person believes that others see the self as flawed, inadequate, worthless and unattractive. Often, the primary anxiety is that one will be exposed to others, leading to social diminishment, devaluation or rejection, and there can be a motivation to conceal unattractive aspects of the self from others (Gilbert, 2002; Lewis, 1992). In external shame, attention is focused outwards, processing information about what is going on in the minds of others about the self.

Significant positive correlations are commonly found between measures of internal and external shame (Allan, Gilbert & Goss, 1994; Gilbert, Allan & Goss, 1996; Goss et al. 1994). However, such findings are not inevitable and changes to the social context may lead to different outcomes. For example, it is possible that an individual may be aware that others will negatively evaluate certain behaviours (e.g., stealing) and also be aware that others may reject or introduce social sanctions if they are discovered. However, this behaviour may not be a focus of internal shame for that individual; indeed, it may be a source of pride. Thus, the individual may be concerned about the consequences of discovery but not ashamed of the behaviour in itself. Also, experiencing others as critical or hurtful to the self may trigger internal shame for some individuals in some contexts. However, in other circumstances, an alternative response might be feelings of humiliation and a desire for revenge (Gilbert, 1998, pp. 9–11).

EATING DISORDERS AND SHAME

Descriptions of eating disorder symptoms have developed to the point where there are now four official Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) eating disordered criteria: Anorexia Nervosa (AN); Bulimia Nervosa (BN); Binge Eating Disorder (BED); and Eating Disorder Not Otherwise Specified (American Psychiatric Association, 1994).

There are sporadic descriptions of the power of shame in the early eating disorder literature. For example, Bruch's (1973) case description of Karol outlined her patient's feelings of being a failure and her desire not to become a 'horrible person, a nothing', and her use of self-starvation to avoid this fate. Such descriptions fit the idea that eating disorders may take root in the context of a general sense of an unattractive self.

Shame Research in Eating Disorders

In the years since these early case descriptions, there have been a number of empirical studies directly or indirectly focused on eating disorders and shame. Studies exploring the association between shame and eating disorders have often used one or more trait shame measures. Examples of internal shame measures include the Internalised Shame Scale (ISS; Cook, 1994) and the Personal Feelings Questionnaire (PFQ; Harder, 1987). The latter also assesses feelings of guilt. An example of a trait external shame measure is the Other As Shamer Scale (OAS). The items of the OAS were designed to focus on how individuals think others see them (Allan et al., 1994; Goss et al., 1994). In addition to trait shame measures, some studies have employed situational scenarios (Andrews, 1998). In line with the trait measures, situational measures also link shame about eating to eating disordered pathology (Burney & Irwin, 2000; Hayaki, Friedman, & Brownell, 2002).

One of the earliest studies exploring shame and eating disorders was reported by Frank (1991). Frank used two measures of shame and guilt: the PFQ and her own measure called the 'Shame & Guilt Eating Scale'. The PFQ was used to assess

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general feelings of shame and guilt, and her own measure was used to explore shame and guilt in relation to normal eating and overeating. She found that both depressed and eating disorder patients experienced marked shame and guilt about eating, although the eating disorder population experienced significantly higher shame and guilt about eating compared to the depressed group. Thus, in addition to demonstrating a link between shame and eating disorders in general, this study also highlighted an important specific focus of shame for women with an eating disorder (i.e., eating behaviour).

Cook (1994) developed the ISS, a trait shame measure, and used it to assess levels of shame in different clinical populations. The items of the ISS are aimed at assessing internal shame as a global self-construct. Cook found that patients with an eating disorder scored significantly higher on this measure than other clinical groups.

Cooper, Todd, and Wells (1998) conducted an important study exploring cognitive–behavioural maintenance models of eating disorders (see also Fairburn & Cooper, 1989; Garner & Garfinkel, 1985). Based on a sample of 12 anorexic, 12 bulimic and 12 non-eating disordered women, they concluded that the eating disordered groups differed from non-eating disordered women in two major areas. First, they exhibited higher levels of negative self-belief, which were 'without exception, negative and unconditional', focusing on themes of worthlessness, uselessness, inferiority, being a failure, abandonment and being alone. Second, they exhibited greater conditional beliefs about eating and the meaning of size and shape. The focus of these beliefs was on the relationship between weight and shape and self-acceptance.

Cooper et al. (1998) hypothesized that the purpose of dieting was to manage emotional difficulties arising from aversive early experiences and to avoid abandonment or rejection. They noted that dieting helped individuals to feel more successful and in control, while bingeing appeared to provide a distraction from unpleasant thoughts, images, negative self-beliefs and emotional states. These findings have informed many of the developments in Cognitive Behaviour Therapy (CBT) in recent years (Fairburn, Cooper, & Shafran, 2003). However, the focus of these developments and new treatment models have primarily been aimed at addressing the meaning of size and shape, rather than addressing shame directly.

Gee and Troop (2003) found that shame in a non-clinical sample, measured on a situational scale—the Test of Self-Conscious Affect (Tangney, Wagner & Gramzow, 1989)—and a trait external shame scale (the OAS; Goss et al., 1994), was significantly associated with eating disordered psychopathology for women currently experiencing or having recovered from an eating disorder. This appears to be the case even when depression was controlled for.

Troop, Allan, Serpall, and Treasure (2008) used a similar methodology to explore shame in a clinical population. This study also differentiated between symptom presentations within an eating disordered population. Troop et al. used the Personal Feelings Questionnaire-2 (Harder & Zelma, 1990) as a measure of internal shame and a self-report measure of eating disordered symptoms (the Short Evaluation for Eating Disorders [Bauer, Winn, Schmidt, & Kordy, 2005]) to classify patients by anorexic or bulimic symptoms. Their 224 female sample included 151 'probably ill' and 57 'in remission'. High levels of external shame (as measured by the OAS) and internal shame were found across the sample and shame was related to eating disorder symptoms after controlling for depression. Those reporting anorexic symptoms experienced higher levels of external shame compared to those reporting bulimic symptoms. This appeared to be positively related to the degree to which they were underweight. On the other hand, internal shame was more highly associated with bulimic symptoms, primarily via an overconcern about body weight and shape. Those 'in remission' continued to struggle with elevated levels of external shame in comparison with non-clinical samples. However, their external shame levels were significantly lower than those assessed as 'probably ill'. The 'probably ill' group also reported the highest levels of internal shame, significantly above those 'in remission' or non-clinical samples. Interestingly, there was no difference on internal shame between those in remission and non-clinical samples. Thus, those in remission from an eating disorder may no longer feel personally ashamed but still hold expectations that others see them flawed or inadequate in some way, suggesting that external shame may remain problematic even when the eating disorder is successfully treated.

Shame Research in Specific Eating Disorder Groups

Several studies have also explored shame in specific eating disordered patient populations, in particular those with BED. Masheb, Grilo, and Brondolo

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(1999) used the ISS to assess shame in a non-clinical female group ($n = 74$), in a group of patients with a psychiatric disorder with medical implications (i.e., BED, $n = 72$) and in a group of patients with a medical condition with psychiatric implications (vulvodynia-vulvar discomfort, $n = 57$). Masheb et al. found that both the BED and the vulvodynia groups experienced high levels of shame, with the BED group scoring significantly higher on the ISS than both the normal and vulvodynia groups. Shame in the BED group was associated with shape and weight concern but not with Body Mass Index, frequency of objective or subjective binge episodes or eating concern (as measured on the Eating Disorders Examination Questionnaire; Luce & Crowther, 1999).

Jambekar, Masheb and Grilo (2003) also investigated the relationship between shame and BED. In their study of 188 patients with BED, they used the ISS to assess levels of shame. They reported similar findings to Masheb et al. (1999), with a strong correlation between internal shame and BED psychopathology. In addition, their study indicated that there may be important gender differences in the foci of shame. They found that shame in men was related to body dissatisfaction, whilst women's shame was associated with weight concern, thus indicating potential gender differences in aetiological and maintenance pathways for BED.

Shame has also been linked to obesity. Webb (2000) investigated both internal and external shame in an obese group and found that the subset of participants with disordered eating behaviour were highly internally shame prone (as measured by the ISS) and also externally shame prone (as measured by the OAS). These participants were also found to experience marked psychological distress at levels similar to patients with an eating disorder diagnosis.

Shame appears to be an important aspect of core beliefs associated with eating disorders. Waller, Ohanian, and Osman (2000) explored the beliefs of 50 bulimic and 50 non-bulimic women using the Young Schema Questionnaire (YSQ; Young, 1999) and an eating behaviour diary. They identified three distinct beliefs: 'defectiveness/shame', 'insufficient self-control' and 'failure to achieve', which discriminated between the two groups. Emotional inhibition (the need to control or not display emotions and fear of losing control of emotions) predicted severity of bingeing, whilst defectiveness/shame beliefs predicted frequency of vomiting in the bulimic group. The YSQ was not explicitly designed to measure shame and its various subscales have yet to be compared with more commonly used shame measures. However, this research is significant in identifying potential alternative symptom pathways relating to specific cognitions for eating disordered patients.

In summary, the relationship between shame and eating disorders has been evident since the early case descriptions of eating disorder sufferers, and has been identified in general eating disordered samples and specific populations. Indeed, shame is central to the differential diagnosis of the most recently identified eating disorder (BED). More recently, there is evidence of some relationship between specific eating disorders symptoms or diagnoses and specific forms of shame (internal and external). Interestingly, the remission of eating disordered symptoms may not be associated with a reduction in feelings that others see the self as flawed and inadequate (external shame).

THE FOCUS AND SHORT TERM VARIABILITY OF SHAME IN EATING DISORDERS

Much of the research exploring the link between shame and eating disorder has viewed shame as a global construct and assessed shame as a trait. However, when working clinically, it may be more productive to focus on specific and changeable aspects of the self rather than personality traits. Gilbert (1997) noted that when working clinically with shame issues, it is preferable to concentrate on those particular aspects of the self that are actually the focus of shame. For people with an eating disorder, there may be a number of aspects of the self that may commonly become a strong focus for shame, including shame about body appearance, shame about a perceived failure to achieve control of eating behaviour and shame about purging behaviours (see Goss & Gilbert, 2002). However, the clinician needs to be alert to other strong shame concerns that may be important to the client but are less obviously linked to eating disordered cognitions and behaviours. Given that shame is an affect associated with a painful sense of the self as being flawed or undesirable in some way, then it not surprising that such important issues may be avoided or concealed in the clinic (Gilbert, 2000a).

The experience of shame can also vary over time. Using a time sampling approach, Sanftner and Crowther (1998) compared the daily fluctuations of shame, guilt and positive and negative affect in bingeing and non-bingeing women. The timescale

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of the study was 7 days with measures taken every 4 hours. Their findings suggested that women who binge experience significantly greater fluctuations in self-esteem, negative affect, shame and guilt. In particular, shame and low state self-esteem significantly differentiated women who binged from those who did not.

The experience of shame for individuals with an eating disorder would appear to be dynamic and variable. In fact, fluctuations in eating disordered behaviour have often been linked in the literature with the regulation of negative emotional experiences. Various interpersonal difficulties have often been identified in those suffering from an eating disorder or disordered eating (e.g., Eldredge, Locke, & Horowitz, 1998). The negative affect associated with such difficulties has often been thought to be a trigger for episodes of problematic eating behaviour such as bingeing, purging and compulsive eating (e.g., Fairburn & Cooper, 1989; Garner & Garfinkel, 1982). More broadly, the use of disordered eating behaviours to self-soothe and as a means of dissociating from negative affective states has been noted in those suffering from BN, BED and AN (Cooper et al., 1998; Polivy & Herman, 1993). Shame would appear to be one of the negative affects linked to these fluctuations in eating disordered behaviour. Interestingly, Sanftner and Crowther (1998) also found that positive self-esteem and positive affect increased prior to binge episodes. This may be consistent with a self-nurturance model (eating to feel better) and the hypothesis that bingeing provides a means to escape from intense negative affect (Heatherton & Baumeister, 1991). Thus, the strategies used to manage and cope with negative affect (including shame) are likely to be important for the understanding of eating disorders and disordered eating in general.

IDENTIFYING SHAME RESPONSES IN PEOPLE WITH AN EATING DISORDER

Shame responses are multifaceted, involving affective, cognitive, behavioural and physiological components. Gilbert (1998, 2002) has argued that the affect of shame acts as an early warning sign of social rejection or put-down by others. Thus, individuals need rapid ways to detect and cope with such social threats and also to work out longer term coping strategies. Such coping strategies might be expected to reflect the internal/external shame balance and also reflect the specific focus of the shame-based problem. In the context of clinical work, these responses may deliberately or accidentally mask the difficulties that patients are trying to cope with and, we will argue later, may actually form part of a maintenance cycle for eating disordered beliefs and behaviours. Gilbert (2002) identified a number of ways in which individuals may respond to internal and external shame experiences; these include attentional bias to potential shaming stimuli, aggression and/or submission towards others who may provoke a shame response, concealment of shaming thoughts and behaviours, avoidance of potentially shaming situations or relationships and destruction of the object of shame. Gilbert also recognized that individuals can attempt to overcompensate for their sense of shame by overachieving or trying to make reparation to others. He also acknowledges that people can and do cope with shame by eliciting care and support from others. In the following section, we outline potential shame responses in people with an eating disorder. As yet there are no empirical studies exploring these issues in eating disorders. The following points and suggestions are based upon clinical observation and the various defensive behaviours outlined by Gilbert (2002).

Attentional Bias

Detection and attention to potential threats is the first element in the development of threat-coping strategies and tends to occur rapidly, automatically and outside of conscious control (see Gilbert, 2002, pp. 12–13) for an overview). Studies of anxiety disorders suggest that attention mechanisms are an important first step in the detection of threat and play a significant role in the onset and maintenance of disorders (e.g., Clark, 1999).

For eating disordered patients and disordered eaters, these may include increased sensitivity to size-, shape- and food-related information; increased attention to external social cues from others regarding size, shape and weight; or to internal feelings of bodily cues relating to shape or weight. There is also likely to be increased social comparison (Troop, Allan, Treasure, & Katzman, 2003), particularly with other people's weights. The development of catastrophic imaginal scenarios, linked with anxious arousal, may lead to further rumination, which in turn links to greater sensitivity to threat cues, forming a vicious cycle. However, it is unclear if such biases are related to state factors (i.e., hunger or chronic starvation) or trait factors (Vitousek, 1996).

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Aggression

Aggression problems have not been well-studied in eating disorders. People with eating disorders can be hostile towards others who criticize their size, shape or eating behaviour. Some may express anger if challenged. More passive forms of aggression can include resistance, sulking and non-compliance with therapy programmes aimed at changing eating and activity patterns.

Submission

Many people with an eating disorder report difficulty with assertiveness and involuntary submissive behaviour (Williams et al., 1993). Troop et al. (2003) noted that eating disorder patients have higher levels of submissive behaviour and negative social comparison than controls, even when depression and other psychopathology were accounted for.

It is also possible to see similar models of submission, or apparent submission, to therapeutic authority (for example, high levels of compliance with therapeutic inpatient programmes), which can lead to later therapeutic difficulties (e.g., high relapse rates post-inpatient admission).

Concealment

This can involve concealing what is actually eaten (or not), bingeing, vomiting and laxative use. People may conceal their hiding and hoarding of food, and this is common for AN patients on supervised re-feeding programmes. Body concealment may involve wearing excessively baggy or dark clothes. Many patients report the need to conceal their desire and need to eat from others and from themselves, and may feel deeply ashamed of their hunger.

Avoidance and Withdrawal

There are a variety of avoidance behaviours that can be used by eating disordered patients to cope with shame and other feelings and thoughts. These include avoiding triggers for eating, withdrawal from eating situations (particularly social eating) and avoidance of size- and shape-related information (e.g., avoiding looking in mirrors or being weighed). There can be avoidance of public bodily exposure (e.g., undressing in public changing areas and going swimming), and avoidance of intimate relationships that involve body observation or contact (e.g., sexual relationships).

Avoidance may also include non-attendance or disengagement from therapeutic programmes or withdrawal from friends and family who remind the individual of their difficulties.

Destruction of the Object of Shame

For individuals with an eating disorder or suffering disordered eating, shame can lead to extreme methods to rid oneself of the undesired object (e.g., body fat) by extreme food restriction, self-mutilation or suicide. Others can be co-opted into this process, for example as 'dieting buddies', or at the more extreme, using potentially hazardous surgical procedures to reduce or change body shape or remove fat (e.g., gastric stapling and jaw wiring).

Compensation/Reparation

Many eating disorder patients believe they are not entitled to eat, or must compensate for being a bad person by providing excessive care and consideration for others. They frequently talk about the need to compensate for their lack of attractiveness by submissive behaviour in relationships or over-performance in other areas of their life (e.g., at work or academically).

Help Seeking

It is important to acknowledge that many people do actively seek help to change their eating disorder. However, this can be extremely difficult to obtain, and in general practice, patients with severe AN may have only a 50% chance of receiving help, whilst for BN patients, the chances are less than 1 in 100 (Hoek, 1995).

A number of patients speak about the difficulties in giving up their eating disorder, particularly AN, as they find it a way of eliciting support and care from others. The rise of pro-anorexia and self-harm web sites suggest that alternative help seeking, to de-shame behaviours that are more widely devalued, also occurs.

THE ROLE OF AVERSIVE CHILDHOOD EXPERIENCES IN SHAME AND EATING DISORDERS

Identifying shame-based pathways into eating disorders could potentially assist in prevention, early

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DOI: 10.1002/cpp

detection and treatment. Relatively few papers have explored the role of shame in the development of an eating disorder. However, some studies have suggested that adverse childhood experiences, including sexual abuse or bullying, or specific parenting styles, may be linked to both shame proneness and the subsequent development of an eating disorder.

Several studies have identified sexual trauma, and particularly childhood sexual abuse, as a route to shame and eating disorder difficulties. Andrews (1997) explored the relationship between bodily shame and childhood sexual abuse and BN in a community sample of 69 women. She used an interview rather than self-report questionnaire approach to data collection. She found that self-reported childhood sexual abuse was highly associated with BN, a relationship that was not accounted for by general body dissatisfaction. She found that bodily shame acted as a possible mediator between early abuse and BN.

Waller, Meyer, Othanian, Elliott, Dickson, and Sellings (2001) further explored the relationship between a reported history of childhood sexual abuse and women with BN. In a study of 21 bulimic women with reported sexual abuse, they used the YSQ to explore the role of core beliefs in mediating the relationship between sexual abuse and bulimic psychopathology. The authors identified two distinct pathways that mediated the relationship between reported childhood sexual abuse and bingeing/purging behaviour. Fear of abandonment and beliefs that others cannot be trusted and are likely to be abusive, in combination with beliefs regarding the need to inhibit emotional response following sexual abuse, predicted binge frequency. The frequency of vomiting was mediated by shame/defectiveness beliefs following sexual abuse. The sample size of this study significantly limits the conclusions that may be drawn. However, it represents an advance on earlier correlation studies by highlighting the possibility of different shame pathways to particular symptom patterns following aversive life experiences.

Murray and Waller (2002) applied a similar analytic model to explore the role of shame as a mediator between reported sexual abuse and bulimic attitudes in 214 non-clinical women. They found that internalized shame (as measured by the ISS) was a partial mediator between reported sexual abuse and bulimic attitudes. However, when the reported sexual abuse was interfamilial, shame was found to be a perfect mediator between this form of reported sexual abuse and bulimic attitudes.

The impact of shame in mediating childhood experiences of teasing or bullying in eating disordered patients has also been explored. Sweetingham and Waller (2007) found that being bullied or teased about appearance were a common experience for over half of their sample, with bullying by peers being more common than by family members. They also found that shame (measured by the Emotional Experiences Scale; Andrews et al., 2002), was a perfect mediator of the relationship between teasing about appearance by peers in childhood and body dissatisfaction in adult life.

Several studies have suggested that recalled parenting style in addition to, or rather than, specific traumatic experiences can also contribute to later experiences of shame and an eating disorder pathology. Leung, Thomas, and Waller (2000) explored the relationship between perceived parental bonding, measured by the Parental Bonding Instrument (Parker, Tupling, & Brown, 1979) and a range of core beliefs (measured by the YSQ) in an eating disordered population. They found that low maternal care was predictive of a range of negative core beliefs, including shame/defectiveness in their sample of anorexic patients ($n = 30$), but not in their sample of bulimic patients ($n = 27$) or their female control group. A similar pattern was found for maternal overprotection. Although there was no relationship between shame/defectiveness core beliefs for bulimic patients, there was an association for this group between maternal overprotection and social undesirability (which is a similar construct to external shame). Low paternal care was also associated with shame/defectiveness for anorexic and comparison groups, but not the bulimic group. Finally, paternal overprotection was associated with shame/defectiveness beliefs in the anorexic group only. The authors identify perceived patterns of parental care and overprotection as risk factors for the later development of unhealthy core beliefs in eating disordered patients, particularly anorexic women, including shame and social undesirability beliefs.

Murray, Waller, and Legg (2000) explored alternative pathways into eating disorders in their study of 139 non-clinical women. Their study suggested that shame proneness acted as a moderator and internalized shame was a perfect mediator in the link between recalled parental overprotection and bulimic attitudes.

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Jones, Leung, and Harris (2006) have specifically explored the father–daughter relationship in relation to core beliefs (as measured on the YSQ) and eating psychopathology. In their study of 66 eating disordered and 50 non-eating disordered women, they found significant relationships between paternal rearing behaviours (measured on the EMBU [My Memories of Upbringing Scale]; Arrindell et al., 1999) and specific eating disorder beliefs (measured on Eating Disorder Inventory; Garner, Olmsted & Polivy, 1983). They found that the effects of paternal rejection on drive for thinness were mediated by abandonment and shame/defectiveness core beliefs. These variables also mediated the effect of paternal rejection and body dissatisfaction.

Leung and Price (2007) found significant differences between those with an eating disorder, those dieting and a comparison group of women in their core beliefs including shame/defectiveness (as measured by the YSQ). Results suggested that there are fundamental differences between these groups, and that dieting alone is unlikely to be a causal factor in eating disorders.

Clinical experience suggests that shame may play an important part in the aetiology, maintenance and recovery from eating disordered psychopathology. The evidence base for the impact of aversive childhood experiences being related to subsequent high levels of shame and eating disordered pathology is promising, but remains relatively small. It may be that other childhood aversive life experiences, such as experiencing parental verbal aggression, physical aggression or witnessing domestic violence linked to the development of other forms of adult psychopathology, may also play a role in the development of eating disorders (Teicher, Samson, Polcari, & McGreenery, 2006).

It is only recently that researchers and clinicians have begun to explore gender differences, shame foci and the functional role of eating disordered thoughts and behaviour in moderating affective states (Goss & Gilbert, 2002). Studies using clinical populations are rare, often with small sample sizes, and have tended to explore single diagnostic categories (e.g., BN), making comparisons between eating disordered populations difficult. Furthermore, the impact of aversive experiences in late adolescence or adulthood has yet to be explored. Clearly, these are areas for future research; however, at this stage, there does appear to be a link between aversive childhood experiences and subsequent shame and eating disorder pathology.

THE ROLE OF SHAME AND PRIDE IN THE MAINTENANCE OF EATING DISORDERS

Pride, like shame, is a self-conscious emotion. It is the affect associated with social success and feeling approved of or admired by others. Pride often involves a social comparison and competitive element, of feeling that one is outperforming others or winning in some kind of competition (Gilbert, 1998). We would label this *external pride*, as it is reliant on beliefs about others view of the self. *Internal pride* is feeling the same for one's own attributes and talents (Mascolo & Fischer, 1995). Goss and Gilbert (2002) hypothesized that pride, as well as shame, may play a crucial role in the maintenance of eating disordered behaviour; they identified two aspects of pride (in eating behaviour and in resistance to authority) as being likely maintenance factors.

PRIDE IN EATING DISORDERED BEHAVIOURS

Restriction, both of foods and other desires/impulses, is often culturally encouraged and associated with positive self-esteem and pride in the self. Fasting has long been used in attempts to induce religious experiences. Success at these forms of control can be linked to pride and self-esteem, whereas losing control can be associated with shame and guilt.

Similar feelings of pride have also been linked to eating disordered behaviour. Pride in eating disordered behaviours, and the ability to control size, shape and affect is central to some of earliest accounts of eating disorder psychopathology. Bruch (1973) presents the case of Celia who initially began to lose weight to please her husband but '. . . it now became her own project. There was a sense of glory and pride in the self-denial and feeling hungry' (p. 268). Macleod (1981), writing about her own AN, comments on the increasing sense of energy and interpersonal power that her eating disorder helped her to achieve.

There have been many studies linking restriction and control to increased self-esteem (see Vitousek, 1996). There is also a competitive element to pride, linking social success and achievement to positive feelings about the self. This form of pride competition can sometimes be observed in in/day patient settings, and may complicate the treatment of patients who are related to or cohabit with

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an eating disordered person. It may also work to produce a counterculture of esteem-giving signals by sufferers that can protect individuals against the interventions of others designed to alter their eating behaviours (for example, pro-anorexia web sites). There are also various anecdotal reports of how some people with AN compete with siblings or parents with an eating disorder.

In eating disorders, it is possible that behaviours that have served the function of managing shame (such as food restriction) can in turn become a valued (and often overvalued) ideal. This may result in the denial of any problem with eating disordered behaviours if acknowledging the problem requires the individual to give up behaviours that are imbued with strong feeling of pride.

PRIDE IN THE ABILITY TO RESIST OR REBEL

Refusing to 'give in' to external authority and change behaviour can also be seen as a source of pride to some eating disordered patients. The functional nature of these behaviours (the ability to resist both internal impulses and external directives) appears linked to self-esteem and identity—a process clearly outlined by Wallace (1986). It is paradoxical that although the function of controlled eating behaviour may first have been to elicit approval or avoid rejection, subsequently people will become so focused on their own need for control and ability to resist others' control that now they will risk severe social sanction and even death. 'You can't make me' will be a familiar sentiment to many that work in this area. As Littlewood (1995) notes, the control over the body may represent personal resistance when one experiences a limited degree of personal agency.

Patients often express anger with carers or treatment services for attempting to take away a coping mechanism that also provides them with a sense of pride. In this case, rebellion may also serve the function of provoking a sense of impotence and powerlessness in others. This may intentionally or unintentionally lead to others giving up attempts to change the patients' eating behaviours.

Clearly, resistance and rebellion are not necessarily unhealthy and dysfunctional. Indeed, they have been regarded as an essential part of personality development to enable children to develop an individual identity and sense of self. Nonetheless, it obviously matters greatly what values people adopt in this regard. Several systemic therapists have attempted to channel this resistance into a personal and political force to challenge eating disordered beliefs and behaviour. 'Externalising' the eating disorder is seen as providing the individual a way of 'fighting back' against their difficulties. This may occur at an individual level during therapy (Kayrooz, 2001) or at a more political level (e.g., The Anti-Bulimic League; Madigan, 1994).

SHAME AND PRIDE CYCLES IN THE MAINTENANCE OF EATING DISORDERS

Goss and Gilbert (2002) offered a model based on the functional role of eating disordered beliefs and behaviours in the management of shame. They outlined a process model based on risk factors that may predispose an individual to developing both shame proneness and eating disorder proneness. They suggested that different patterns of eating disordered behaviour may be differentially associated with internal shame and external shame.

Goss and Gilbert (2002) identified a number of background factors that may set the stage for an eating disorder. These include genetic predispositions, personality (e.g., neuroticism and interpersonal sensitivity), early attachment history and experiences of rejection or abuse, as well as cultural factors that intensify competition for certain body shapes and appearances. They argued that these factors give rise to various forms of external shame cognitions, accentuate interpersonal sensitivities and also influence internal shame, self-perception and identity. Thus, individuals who feel vulnerable to negative social outcomes (e.g., rejection) seek ways to defend themselves against these threats by attempting to change body weight and shape towards an actual or perceived culturally desirable body weight or shape. In turn, they may take pride in their ability to manage their weight, but when they are not able to do so, they experience further shame. This leads to a shame–pride cycle that maintains the disorder. They argued that this pattern is particularly important in eating disorder patients with restrictive, rather than purging, eating disorders. This model predicts that patients with a more restrictive behavioural pattern are likely to be both internally and externally shame prone.

Goss and Gilbert (2002) argued that the main problems in bulimic disorders are the needs to

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DOI: 10.1002/cpp

control affect and cope with unstable and negative affects, especially in interpersonal contexts. Thus the main cycle in bulimic populations is a fear of discovery by others of their behaviours used to manage difficult affects (a shame–shame cycle). They believed that internal rather than external shame might be the main problem for this group. In line with this, Troop et al. (2008) found that those reporting anorexic symptoms experienced higher levels of external shame compared to those reporting bulimic symptoms and that internal shame was more highly associated with bulimic symptoms.

Sanftner and Crowther (1998) found that planning a binge is associated with positive affect and sense of control. Moreover, the very fact that these behaviours are going to be conducted in private ('I can do things others can't know about or stop me') may increase a sense of a separate self-identity outside the gaze of others. This may include feelings of rebellion, in that one is doing something one knows others would disapprove of. In these cases, the ability to deceive others and hide things (and get away with it) seems to strengthen a sense of self-identity and power. In the longer term, a person may also feel disgusted by their behaviour, fearful of discovery and needing to conceal and worry about harm they may be doing to themselves. While deceiving others and keeping binges/vomiting secret can at first feel empowering, it can also be isolating. The person may come to feel their behaviour is abnormal, which may compound internal shame (Goss & Gilbert, 2002).

It is possible that those who manage their weight/shape and/or affect in ways that are not obvious to others (e.g., purging or exercise) may experience less external shame as they do not expect to receive, or actually experience, direct negative feedback on their potentially socially unacceptable behaviour from others. In fact, they may well get more positive comments about their appearance or psychosocial functioning compared to those who restrict, where eating behaviour or compromised psychosocial functioning may be more obvious to others. In addition, it is likely that those who binge/purge may manage their negative affect, including shame affect, more effectively, and thus experience lower overall levels of internal and external shame compared to those with predominantly restrictive eating disorders.

Thus far, two studies have directly explored aspects of the Goss and Gilbert (2002) model. Skårerud's (2007) qualitative study of 13 female anorexic patients highlighted specific shame foci in this group and broadly supported the model. He also noted that shame of losing self-control was important for those who also binged, self-mutilated or engaged in other self-destructive behaviours. In addition to the categories identified by Goss and Gilbert, and in line with previous research, Skårerud (2007) also identified shame specifically related to sexually abusive experiences.

Skårerud (2007) found that pride in self-control, pride in being extraordinary (e.g., being able to restrict when others cannot), pride in appearance and in the use of thinness to signal rebellion and protest were common themes in his sample. He also found that both shame–shame and shame–pride cycles acted as aetiological and maintenance factors in eating disorder beliefs and behaviours, and argued that these should be a prime focus of treatment for patients with anorexia nervosa.

In a similar study of eight eating disordered patients, Elsworthy (2006) found that shame was both an aetiological and maintenance factor for eating disorders, and again, pride in eating disordered behaviour was also implicated in the maintenance of the disorder.

Clearly, further research in this area is warranted, ideally exploring large enough clinical populations to allow for comparisons between diagnostic groups (e.g., AN versus BN) or patterns of symptom presentation (e.g., restrictors who also purge compared to those who only restrict their eating).

CLINICAL IMPLICATIONS

We have highlighted the associations between shame and eating disorders, the impact that shame is likely to have on disclosure during therapy and the likelihood that eating disorder treatment alone will not resolve shame-based responses. We believe that it would be helpful to assess shame prior to and during eating disorder treatment. We suggest that it would be beneficial for eating disorder clinicians to be trained in the recognition and management of shame and pride responses. If shame, particularly external shame, is unresolved during treatment, it may require additional intervention, as it does not appear to necessarily remit once eating disorder symptoms are successfully treated.

An empathic, collaborative and empowering stance is likely to be crucial in treatment, as shame is likely to be triggered relatively easily, particu-

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DOI: 10.1002/cpp

larly at the beginning of therapy. In general, safety behaviours (i.e., behaviours that help patients manage difficult affect) are functional and clients resist giving them up. However, for most other disorders, safety behaviours are not a source of internal or external pride. In eating disorders, safety behaviours (such as weight control) are sometimes an initial source of external pride and frequently a source of internal pride; indeed, they may be the sole source of self-esteem and central to self-identity. Therapists will need to explore this and be empathic to the intense fear of change and the painful dilemmas this involves. Services should provide psychoeducation for patients and carers on the functional nature of eating disorder symptoms. This should be a precursor to engaging in treatments that may leave patients feeling less in control (e.g., giving up restricting behaviours) and more vulnerable to increased self-directed hostility and feelings of internal and external shame.

It may also be important to work with the individual's wider social network and provide them with specific skills for managing interpersonal relationships as shame often develops from negative interpersonal interactions. Group-based approaches may be particularly helpful in addressing shame for eating disordered patients.

Our group-based treatment programmes use CBT (Fairburn & Wilson, 1993) and Compassion Focused Therapy approach (CFT; Gilbert & Irons, 2004). Many of our patients have reported that one of the most important factors in their recovery was no longer feeling alone, isolated and 'weird', and that the social support and acceptance they found within the group was a key motivating factor in helping them engage in the difficult process of recovery. It may be that the group experience helps to provide a more validating social role. For example, that of being able to support and help others, rather than being a sufferer in need of care. In turn, this may promote self-efficacy and make it easier for the person to engage in more reciprocal care giving and self-nurturing. Issues of rejection based on appearance/weight or eating disordered behaviours are often a core theme in the groups, and patients appear to be able to move forward in overcoming eating disordered behaviours once they become more integrated into the group.

Recent developments in CBT aimed at developing self-compassion (e.g., CFT), managing self-directed hostility and developing self-soothing (Gilbert, 2000b; Gilbert & Irons, 2004) may be particularly helpful for eating disordered patients. Indeed, our treatment has included this model for several years, and patients report they have found it more useful than traditional CBT methods of challenging eating disordered thoughts or as a useful precursor to helping them generate coping thoughts and behaviours. Research is currently being undertaken to assess the effect of this modification of CBT, and early results are promising.

At present, we offer a group-based programme, which appears to have helped patients explore some shame-/pride-based issues in the context of changing their eating disordered beliefs and behaviours. This does not require them to divulge a great deal of personal history, although they often find the group a safe place to do this. Some patients prefer to work on such issues either in subsequent individual therapy with other services, or in our (smaller) post-recovery body image group. It may also be possible that patients with very severe social anxiety, complex trauma or difficult attachment histories may find it easier to work with an individual therapist instead of, or as a step towards, group-based treatment. This model is often used in therapeutic communities or inpatient eating disorder services. As yet the optimal matching of patients to group and/or individual treatment remains an issue for further research.

Of course, any modifications to treatment should not take place in lieu of existing evidence-based treatments. However, further research should be undertaken to see if tackling issues of shame and shame–pride cycles alongside these treatments increases their efficacy and/or reduces longer term risk of relapses.

Perhaps more controversial is the development of therapies to treat shame and develop alternate foci for pride without also directly addressing eating disorder behaviours. To an extent, this would mirror the model offered in Interpersonal Therapy (Fairburn, Jones, Peveler, & Hope, 1993). These treatment models have yet to be developed for eating disordered patients, but have been piloted for other group (Bates, 2005; Gilbert and Irons, 2005; Hackmann, 2005). Such an approach may provide an additional framework for treating eating disordered patients, particularly for patients who struggle to give up restricting or bulimic behaviour early in treatment. These patients often have a higher dropout rate and a poorer response in CBT programmes (Fairburn et al., 2003). It would be useful to develop this as a treatment protocol to compare with existing evidence-based programmes.

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CONCLUSION

This paper has explored the role that shame and pride may play in the development and maintenance of eating disordered psychopathology. There is a small but growing evidence base suggesting that shame and pride may be salient factors that need to be addressed during the course of treatment. As yet the specific ways in which shame and pride and eating disorders become entwined are not completely clear. A number of studies suggest that aversive childhood experience, such as sexual abuse, bullying and teasing, and some parenting styles may play an important role. However, little is known about the role of adverse experiences that occur in adulthood, such as domestic violence, sexual trauma, becoming a refugee or academic failure. How these experiences may effect the development of shame and eating disorders is unclear, although clinical experience suggests that they may be important. Clearly, these are areas for further empirical investigation.

This paper has outlined some of the clinical implications of shame and pride in eating disorders and suggested possible approaches that may help clinicians improve detection, engagement and treatment outcome. We have also highlighted new enhancements to CBT for eating disorders using CFT. Although this is in a relatively early stage of development, it does appear to be useful in addressing shame-based problems and may provide an alternative (and at times more acceptable) approach for patients who find it difficult to engage in current evidence-based treatments. Research is underway exploring the efficacy of these new approaches.

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