British Journal of Clinical Psychology (2003), 42, 367–378
© 2003 The British Psychological Society
www.bps.org.uk

The relationship between shame, eating disorders and disclosure in treatment

Sarah Swan* and Bernice Andrews
Royal Holloway, University of London, UK

Background. This study considered shame in 68 women who had received treatment for eating disorders (EDs) compared to 72 non-clinical controls, and shame in relation to disclosure in treatment.

Method. All participants completed questionnaires on ED and depressive symptoms, and bodily, behavioural and characterological shame and shame around eating. ED women also answered questions on disclosure in treatment.

Results. The ED group scored significantly higher than controls on all shame areas when depression was controlled. ED women who were currently symptomatic and those who had recovered scored higher than controls on bodily and characterological shame and shame around eating. Non-disclosure in treatment was reported by 42% of the ED group and was associated with higher shame in all areas except bodily shame.

Conclusions. The study is the first to show a relationship between shame and ED in a clinical sample. It supports existing evidence regarding the importance of bodily shame in women with EDs, and extends the literature in terms of the importance of other shame aspects for ED symptomatology and disclosure. Implications for treatment are discussed.

Although often mentioned in the eating disorders literature, there has been very little empirical investigation of shame in clinically eating disordered populations. Shame is an intense and incapacitating emotion involving feeling self-conscious, inferior and powerless, and a wish to hide oneself and one's deficiencies (Tangney, Miller, Flicker, & Barlow, 1996; Wicker, Payne, & Morgan, 1983). Evidence that women with eating disorders are likely to be unreliable informants of their personal experiences (e.g., Brown, Russell, & Thornton, 1999) supports the proposal that a tendency to feel shame may be high in this clinical group, and might be related to lack of disclosure in

* *Requests for reprints should be addressed to Sarah Swan, Lakeside Mental Health Unit, West Middlesex Hospital, Twickenham Road, Isleworth TW7 6AF, UK (e-mail.sarah.swan@wlmht.nhs.uk).*

treatment. In the current study these issues were investigated in women who had been in treatment for eating disorders.

A number of studies have considered the relationship between shame and disordered eating in predominantly female student samples. Sanftner, Barlow, Marschall, and Tangney (1995) demonstrated a significant association between general shame and two eating disorder (ED) symptom clusters, a drive for thinness and bulimia. However, the magnitude of the correlations was modest (.22 and .19). Other studies have considered shame specifically involving bodily and eating concerns. Three have found significant correlations between body shame and disordered eating (McKinley & Hyde, 1996; Noll & Fredrickson, 1998; Tiggemann & Lynch, 2001). Frank (1991) reported a significant group difference on a combined measure of shame and guilt around eating in students assigned to 'eating disordered', 'depressed' and 'normal' groups. The ED group scored higher than the depressed group, who in turn scored higher than the normal group. Shame/guilt around eating was significantly correlated with depressive symptoms in the ED group, but the question of whether ED symptoms or depression accounted for the elevated shame/guilt in the ED group was not addressed. Following Frank's study, Burney and Irwin (2000) considered the relative contributions of general and specific shame and guilt to ED symptoms in women recruited from colleges and fitness clubs. Shame and guilt around eating and bodily shame all made significant independent contributions to ED symptoms, whereas general shame and guilt did not.

These studies of disordered eating in students suggest the importance of including specific assessments of bodily shame and shame around eating in clinical ED investigations. It would also be important to include assessments of shame related to behaviour and non-physical personal characteristics, as these shame aspects have been shown to relate to other disorders such as depression and post-traumatic stress disorder (see Andrews, 1998; Andrews, Brewin, Rose, & Kirk, 2000; Andrews & Hunter, 1997).

In the one study to investigate bodily shame in relation to clinically diagnosed ED, a strong association was found between an interview measure of bodily shame and bulimia in a community sample of 69 young women (Andrews, 1997). Andrews' study demonstrated the effect of bodily shame even when controlling for bodily dissatisfaction. Furthermore, the effect of bodily dissatisfaction was lost when bodily shame was included in the model. On the basis of this evidence, it was suggested that shame may be the key element in observed associations between body attitudes and bulimia. However, the study was limited by the small number of participants who met diagnostic criteria for bulimia nervosa.

Hence the research in relation to shame and EDs is mainly limited to undergraduate samples using questionnaire measures of ED symptoms. The generalizability of the findings to ED populations is problematic, as most studies have assessed ED symptoms in normal populations with low levels of actual diagnosable EDs. Furthermore, none of the existing studies have controlled for depression. There is evidence of a strong relationship between both general shame and bodily shame and depression (e.g., Andrews, 1995; Tangney, Wagner, & Gramzow, 1992), and EDs and depression (Wilson, Heffernan, & Black, 1996). This indicates the importance of controlling for depression in future research to rule out the possibility that any observed shame/ED links are due to the elevated depression levels found in eating disordered women. Further difficulties lie in the measurement of shame, as many commonly used measures make no specific mention of the word 'shame' in their items and may therefore reflect general negative affect rather than the experience of shame itself (Andrews, 1998).

There is frequent mention in the literature of the problems women with EDs seem to

experience in being able to reflect openly and honestly about their emotions and behaviours (e.g., Brown *et al.*, 1999; Vitousek, Daly, & Heiser, 1991). Disclosure of personal feelings and experiences is a necessary component of psychological treatment. As a vital aspect of shame is the wish to hide from the interpersonal realm, it seems likely that if an individual has a propensity to feel shame about aspects of his or her character, behaviour or experiences, disclosure might be difficult (Andrews & Hunter, 1997). However, there has been a lack of empirical research into this issue in clinical populations.

Given the gaps in the existing literature, the aims of the present study were:

(1) To investigate whether women with past and current EDs report higher levels of bodily, behavioural and characterological shame and shame around eating than a control group of non-eating disordered women, controlling for depressive symptoms. As a tendency to feel shame is likely to be long-lived (e.g., Andrews, 1995; Andrews, Qian, & Valentine, 2002), it was hypothesized that women with a current ED and those who had recovered would both report higher shame levels than controls.
(2) To investigate within the eating disordered group the relationship between shame and disclosure in treatment. It was hypothesized that those with higher levels of shame would be more likely not to have disclosed an important issue in their treatment.

Method

Participants

Eating disorder (ED) group

Questionnaire packs were mailed to 120 female members of the UK Eating Disorders Association (EDA). A total of 72 (60%) returned the questionnaires (four of which had insufficient information to be included in any of the following analyses). All participants reported that they had at some time received clinical treatment for their difficulties around eating, and 48% were currently receiving treatment. The mean age of the ED group was 30.76 years ($SD = 10.17$) and 98% were of white British/European origin. Their current mean Body Mass Index (BMI) was 19.82 ($SD = 5.04$).

Control group

Questionnaire packs were distributed to a total of 118 female students and non-academic staff at a London University college; 85 (72%) were completed and returned. After screening for potential EDs using the Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982), 13 women were excluded as they had scores in excess of 20 (a level above which Garner *et al.* suggest the possibility of a clinical disorder). The mean age of the 72 control group women included in the study was 26.2 years ($SD = 10.65$) and the majority (96%) were of white British/European origin. Their mean BMI was 22.8 ($SD = 4.52$).

Measures

Initially, both ED and control groups completed questions to cover height, weight and

background demographic factors. Both groups were also administered questionnaires to assess level of depressive symptoms, and different aspects of shame (characterological, behavioural, bodily shame and shame around eating). As mentioned in the previous section, the EAT–26 was administered to the control group to screen for EDs. The ED group completed additional questions to assess current and previous ED diagnoses, and questions regarding treatment and disclosure in treatment.

Eating disorder diagnosis

The ED group completed a diagnostic questionnaire, strictly based on DSM-IV criteria, adapted from a questionnaire used by Andrews and Brown (1999). Participants were asked to report their symptoms both currently and when at their worst in order to ensure that they had at some point met diagnostic criteria for an ED (anorexia [AN], normal weight bulimia [BN] or eating disorder not otherwise specified [EDNOS]). At their worst, all the women met ED criteria: 51 for AN, four for BN and 12 for EDNOS. Due to incomplete data we were unable to classify one participant. Currently, 11 met criteria for AN, one for BN and 17 for EDNOS. A further 12 women failed to meet ED criteria but still presented with marked difficulties on the important diagnostic criteria such as low BMI or purging behaviour. For example, in addition to other symptoms, 10 of the 12 had a current BMI of 17.5 or less. For the purposes of analysis, these 41 women were classified as current ED. Of the other women, 21 currently reported very minimal or no symptoms and were classified as currently recovered. We were unable to classify six women into either current ED or recovered groups due to incomplete data. Inter-rater agreement (between SS and BA) for assignment to the different diagnostic categories was 97% for symptoms at worst and 94% for current symptoms. Disagreements were resolved by discussion. A copy of the diagnostic questionnaire is available from either author on request.

Depressive symptoms

Level of current depression was assessed in all participants with the relevant subscale of a widely used measure, the SCL-90 (Derogatis, 1977; Derogatis, Rickels, & Rock, 1976). All 10 items were answered on a 5-point scale ranging from 1 = not at all to 5 = extremely, yielding total scores in the range 10–50.

Shame

All participants completed the Experience of Shame Scale (ESS; Andrews *et al.*, 2002). Based on an interview measure (Andrews & Hunter, 1997), the questionnaire assesses four areas of characterological shame: (1) shame of personal habits, (2) manner with others, (3) sort of person (you are), and (4) personal ability; three areas of behavioural shame: (5) shame about doing something wrong, (6) saying something stupid, and (7) failure in competitive situations; and bodily shame: (8) feeling ashamed of (your) body or any part of it. For each of the eight shame areas covered there are three related items addressing

(1) the experiential component, in the form of a direct question about feeling shame (e.g., 'Have you felt ashamed of your personal habits?');
(2) a cognitive component, in the form of a question about concern over others' opinions (e.g., 'Have you worried about what other people think of your personal habits?'), and
(3) a behavioural component, in the form of a question about concealment or

avoidance (e.g., 'Have you tried to cover up or conceal any of your personal habits?').

For bodily shame there is an extra item concerning avoidance of mirrors (in addition to concealing body parts from others). Each item is rated on a 4-point scale, ranging from 1 = not at all to 4 = very much, yielding total scores in the range 25–100, and subscale scores in the range 12–48 (characterological shame), 9–36 (behavioural shame) and 4–16 (bodily shame). The ESS has been shown to have good validity, internal reliability and test–retest reliability for the total scale and the three subscales, and factor analyses have confirmed the existence of the three separate subscales (Andrews *et al.*, 2002; Qian, Andrews, Zhu, & Wang, 2000).

For the purposes of the current study the ESS was extended to include an additional three-item scale to assess shame around eating. This subscale was developed in line with the existing ESS subscales and included an experiental item ('Have you felt ashamed of your behaviours around eating?'), a cognitive item ('Have you worried about what other people think of your behaviours around eating?') and a behavioural item ('Have you tried to hide or conceal your behaviours around eating?').

In the ESS, participants are instructed to respond to items for recent feelings (i.e., 'over the past year'). In line with the shame interview (Andrews, 1995; Andrews & Hunter, 1997), in the current study participants were also instructed to answer the same items for feelings 'at any time in your life'. This was so that shame could be considered in relation to both current ED status and the extent of disclosure in therapy, which may have been in the past.

Disclosure in treatment

Questions were designed for the ED group which asked whether the participant was currently or had ever been in treatment for difficulties around eating. They were also asked: 'Is there anything about yourself or your behaviours around eating that you have not disclosed to professionals involved in your care?' For participants who answered in the affirmative, space was left for the woman to give details, if she wished, of what the issue was and why she had felt unable to disclose.

Data analysis

As the shame variables were significantly intercorrelated, (r(136–139), ranged from .80 to .64), for the main case/control comparisons, the data were analysed with a mixed model multivariate analysis of variance (MANOVA) with current level of depressive symptoms as a covariate. The between-subjects factor was ED status (current ED, recovered ED and controls) and the within-subjects factor was type of current shame (characterological, behavioural, bodily and eating). For the analysis of the relationship between shame and disclosure in the ED group, data were also analysed with MANOVA. The between-subjects factor was disclosure (those who had not reported an important issue in treatment vs. those who had disclosed) and the within-groups factor was type of shame ever. Univariate ANOVAs and t tests were used to interpret significant effects, adjusted, where relevant, for the covariate.

Results

Case/control analysis

Comparison of participant characteristics

The groups did not differ significantly in terms of ethnicity, $\chi^2(1,140) = 0.16$. However, participants in the ED group were significantly older than the controls, $t(136) = 2.39$, $p < .05$, and their current BMI was significantly lower, $t(130) = 3.58$, $p < .001$. Furthermore, their mean SCL-90 depression score of 34.7 ($SD = 10.82$) was significantly higher than that of the controls, which was 22.4 ($SD = 7.91$); $t(136) = 7.7$, $p <. 001$.

Participant characteristics and ESS subscales

Further analyses were conducted to determine whether any of the three identified group differences, age, BMI and depression score might be related to the ESS. Neither age nor BMI were significantly correlated with characterological, behavioural and bodily shame or shame around eating: *r*s ranged from −.08 to .04 for age (*p*s .37 − .68), and from .00 to −.16 (*p*s .07 − .98) for BMI. However, all the shame subscales had significant correlations with SCL-90 depression: *r*s ranged from .64 to .78 (all *p*s < .001). Depression was therefore confirmed as an appropriate covariate in the case/control analyses that follow.

Relationship of shame subscales to ED status

Initial univariate comparisons between the ED group as a whole and the controls, with depression entered as a covariate, indicated the ED group had significantly higher mean scores than controls on all the current shame subscales: $F(1,132) = 24.8$, $p < .001$ for characterological shame; $F(1,134) = 4.32$, $p < .05$ for behavioural shame; $F(1,135) = 17.6$, $p < .001$ for bodily shame; and $F(1,135) = 57.8$, $p < .001$ for shame around eating.

Table 1 shows the unadjusted mean shame scores for the ED women who were currently symptomatic, the recovered ED women, and the controls. As each ESS shame subscale has a different number of items, the mean score for each subscale is given in the table for ease of comparability. This reflects the mean range of the 4-point scale for each item (1 = not at all to 4 = very much).

A MANCOVA showed a significant main effect for ED status, $F(2,126) = 22.1$,

Table 1. Comparison of current and recovered eating disorder groups and controls by characterological, behavioural and bodily shame, and shame around eating, covarying for depression.

	Current ED (*N* = 41)		Recovered ED (*N* = 21)		Controls (*N* = 72)		
Shame type	*M*	*SD*	*M*	*SD*	*M*	*SD*	$F(2,126–129)^a$
Character	3.33	(0.73)	2.40	(0.78)	1.77	(0.60)	15.68***
Behaviour	3.36	(0.64)	2.80	(0.86)	2.30	(0.77)	1.84
Body	3.53	(0.56)	2.86	(0.98)	2.17	(0.87)	7.55**
Eating	3.58	(0.71)	2.63	(1.04)	1.49	(0.78)	30.96***

**$p < .01$; ***$p < .001$.
[a] Missing values for characterological shame (*N* = 3) and behavioural shame (*N* = 1).

$p < .001$, with 26% of the variance in the shame variables accounting for group differences ($\eta^2 = .26$) indicating a moderate effect size. The main effect for shame-type was significant but weak, $F(3,378) = 2.69$, $p < .05$, $\eta^2 = .02$. There was also a significant interaction between ED status and shame-type, $F(6,378) = 6.23$, $p < .001$, $\eta^2 = .09$, indicating that the difference between groups varied as a function of type of shame. Accordingly, univariate ANCOVAs were conducted for each shame subscale, covarying for depression in each case. Table 1 shows significant group differences for characterological and bodily shame and shame around eating, but no group difference for behavioural shame. Paired comparisons were conducted for the significant shame subscales, with depression entered as a covariate.

For characterological shame, all groups were significantly different from each other. Both the current and recovered ED groups scored significantly higher than the controls, $F(1,108) = 33.04$, $p < .001$ and $F(1,86) = 5.39$, $p < .05$, respectively, and the current ED group scored significantly higher than the recovered group, $F(1,57) = 5.38$, $p < .05$.

Significant differences between current, recovered and control groups were also apparent for shame around eating. Both current and recovered ED women had significantly higher scores than controls, $F(1,109) = 64.92$, $p < .001$ and $F(1,89) = 19.08$, $p < .001$, respectively, and current ED women had significantly higher scores than recovered ED women, $F(1,59) = 4.2$, $p < .05$.

For bodily shame, the current and recovered ED groups did not differ significantly from each other, $F(1,59) = 1.82$, but both reported higher bodily shame than the controls, although the difference did not quite reach significance at the .05 level for the recovered/control group comparison, $F(1,109) = 17.35$, $p < .001$ and $F(1,89) = 3.49$, $p < .07$, respectively.

Disclosure in treatment and its relationship to shame

Of the 65 ED women who responded to the item on disclosure, 42% answered that they had not disclosed certain information about themselves or their behaviours around eating in their treatment. Table 2 displays the means on the shame ever subscales for the two groups: those who had not disclosed and those who had disclosed. A MANOVA showed a significant group effect with a small to moderate effect size, $F(1,61) = 7.1$, $p < .01$, $\eta^2 = .10$, and a significant within-subjects effect for type of shame, $F(3,183) = 10.9$, $p < .001$, but no significant interaction, $F(3,183) = 0.43$, $p > .05$. *T* tests were conducted for each shame scale and Table 2 shows significant group differences on characterological shame and shame around eating. Behavioural and bodily shame were not significantly related to disclosure, although behavioural shame just missed significance ($p = .052$).

A significant part of the ESS is concerned with avoidance (i.e., for each component a question is asked about whether the individual has tried to hide or conceal this shame aspect). To control for the possibility that the avoidance/concealment items were accounting for the results, the analyses were repeated, excluding these items. However, their exclusion did not change the results; the overall significant group effect was still apparent, $F(1,61) = 6.3$. $p < .02$,, $\eta^2 = .09$, and both characterological shame and shame around eating were still both related to lack of disclosure, $t(61) = 2.64$, $p < .01$, and $t(63) = 2.22$, $p < .05$ respectively. Once more, behavioural shame just missed significance, $t(62) = 1.93$, $p = .06$.

Table 2. Subscales of shame at any time in the respondent's life by disclosure in treatment

	Anything not disclosed?				
	Yes (N = 27)		No (N = 38)		
Shame type	*M*	*SD*	*M*	*SD*	$t(61–63)$
Character	3.72	(0.42)	3.38	(0.62)	2.65**
Behaviour	3.64	(0.41)	3.38	(0.65)	1.98
Body	3.81	(0.29)	3.63	(0.52)	1.80
Eating	3.96	(0.11)	3.72	(0.59)	2.40*

**$p < .01$; *$p < .05$.

Content analysis of non-disclosure responses

Participants were also invited to put further information if they so wished about what the issue was and why they had not felt able to disclose. Of the 27 participants who said they had not disclosed in treatment, 14 did not give further details. This may have reflected the extent of their shame around the issues in question, although this cannot be concluded solely from this evidence. The remaining 13 responses were analysed for emerging themes. Two main themes were evident in the responses, with around a quarter of the respondents (3/13) giving more than one answer and therefore providing more than one theme. First, five respondents (39%) detailed why they had not disclosed with all identifying general therapeutic issues in their responses. Examples included not trusting the therapist sufficiently, wanting to maintain some control within the therapeutic relationship, and fear of being judged by the therapist. The second and most common theme included details of what had not been disclosed and mainly related to issues involving eating and to the ED, highlighted by nine (69%) of the respondents. Examples within this category included not revealing the extent of ED symptoms and not sticking to eating plans. In addition to these nine, a further respondent stated that she had not disclosed that she had engaged in stealing and self-harm. Another woman explained that she had not disclosed what she saw as the real reason for her problems, which was previous sexual abuse and rape.

Discussion

To our knowledge, this study is the first to show that women who have been in treatment for EDs have higher levels of shame than comparable controls. Moreover, it is the first to demonstrate a significant association between shame and reports of lack of disclosure in therapy. Even after controlling for depressive symptomatology (which has been shown to be strongly related to questionnaire assessments of shame and to EDs), the ED group overall scored significantly higher than controls on all the assessed aspects of shame including bodily characteristics, non-physical characteristics, general behaviour and behaviour around eating. These findings are consistent with other studies that have demonstrated a link between shame and disordered eating in student samples (Burney & Irwin, 2000; Frank, 1991; McKinley & Hyde, 1996; Noll & Fredrickson, 1998; Sanftner *et al.*, 1995; Tiggemann & Lynch, 2001). However, the current study goes further than the existing research by considering potentially

confounding factors in the link. It also extends Andrews' (1997) finding of an association between bodily shame and bulimia by including other forms of shame (i.e., behavioural, characterological and shame around eating) and other ED subtypes.

Higher levels of characterological and bodily shame and shame around eating were also apparent for the women who had recovered from their ED, compared to the controls. Levels of bodily shame did not differ between the recovered and symptomatic women, although characterological shame and shame around eating were significantly lower in recovered women compared with those still symptomatic. These findings suggest that shame may be long-lived and resistant to change. As bodily shame has been shown to predict chronic and recurrent depression in community women (Andrews, 1995), it is also possible that feelings of shame may increase the risk in asymptomatic women of both ED relapse and subsequent episodes of clinical depression.

In the current study, a substantial proportion (42%) of the eating disordered respondents indicated that they had not disclosed an important issue during their contact with professionals. A content analysis of the responses given by those who had provided further information suggested that non-disclosure in treatment was most common around eating behaviour and other ED symptoms. This issue is raised by Zerbe (1995), who proposed that women with EDs tend to minimize their symptoms and other behaviours due to feelings of shame. If replicated it has obvious therapeutic implications, including the problem of making a correct diagnosis, as well as the problem of adequately formulating clients' difficulties in order to offer effective interventions.

When non-disclosure in treatment was considered in relation to shame, it was associated with significantly higher levels of characterological shame and shame around eating, and marginally higher levels of behavioural shame. However, bodily shame was not related to non-disclosure and it is possible that feelings about the body are elicited more explicitly in treatment. Yet the high bodily shame scores for both disclosure groups suggests that, even if this is the case, a focus on weight and shape does not necessarily alleviate feelings of bodily shame.

The relationship between characterological shame and disclosure indicates that a propensity to feel ashamed of the self may affect the general ability to disclose. Furthermore, the relationship between shame around eating and disclosure, coupled with evidence from the content analysis, suggests failure to disclose in therapy may largely be focused on the symptoms surrounding eating psychopathology in eating disordered women. However, a sizeable proportion who failed to disclose did not provide any further details. It is also the case that our item inviting details of non-disclosure may not have been sufficiently specific to elicit other feelings and experiences. In addition, respondents were not asked to distinguish what they had not disclosed from why.

In this preliminary investigation, our assessment of non-disclosure was also limited to one item, and our findings are based on the assumption that women were reporting reliably on this sensitive issue. However, given what appears to be a high frequency of non-disclosure, and, consistent with findings from other patient groups (Andrews, 1998), high levels of reporting shame, we have no reason to believe their responses were unreliable. Nevertheless, our limited methods of assessment point to the need for a more detailed and systematic investigation to confirm the degree and nature of non-disclosed material in ED patients. Such research could also assess the type and duration of treatment to gain a fuller picture of the factors involved in non-disclosure.

Another limitation of the study involves the disappointing response rate (60%) for

the ED group, although the EDA, through which the sample was recruited, conveyed that this was relatively high compared with other studies they have assisted with. This suggests that the specific issue of shame in the research may not have unduly affected the response rate. Nevertheless, caution is needed in generalizing the results beyond the present sample and points to the need for replication in a different clinical sample.

The current study indicates that shame is a common experience for women with EDs, which is felt not just around the body and eating, but about general behaviour and non-physical personal characteristics. If replicated, the present findings therefore have implications for working clinically with women with EDs. Lewis (1987) identified a number of benefits from focusing on shame in therapy, such as the cathartic experience for the client of identifying and labelling their experiences of shame in a safe and accepting environment. Lindsay-Hartz and colleagues have also identified the importance of shame in the motivation to change (Lindsay-Hartz, De Rivera, & Mascolo, 1995). Furthermore, they suggest that if experiences of shame emerge in therapy and are not dealt with in a sensitive manner the individual may wish to escape the therapist and not return. Regarding the issue of non-disclosure in treatment, disclosing personal feelings and experiences may be encouraged by two means—first, by ensuring that direct questions are asked in a sensitive manner about important symptoms, and secondly, as has been suggested in previous writing (Gilbert, 1998; Nathanson, 1989), by making the individual feel comfortable with the idea of shame in order to aid disclosure of shameful experiences or feelings.

The exploratory nature of the current study has resulted in the identification of areas for future research. First, it would be of interest to investigate whether the relatively high levels of shame found among the recovered ED group are associated with a higher risk of relapse. There is also the question of whether disclosure presents particular difficulties for ED clients or for clinical populations in general. Evidence that shame appears to be strongly related to depression (e.g., Andrews, 1995; Tangney *et al.*, 1992), post-traumatic stress disorder (Andrews *et al.*, 2000) and other symptom clusters (e.g., Tangney, Burggraf, & Wagner, 1995) and is associated with a chronic or recurrent course in depressed patients (Andrews & Hunter, 1997) suggests that disclosure may well be an issue for other patient groups. Further research is also warranted to identify individual and contextual factors that might facilitate or hinder disclosure in therapy

In conclusion, the current study has provided an exploration of issues related to shame and disclosure in treatment in women with EDs. It has provided some preliminary answers to the research questions outlined which point to further potentially fruitful avenues of enquiry. The results suggest the importance of shame in EDs and support the need for clinicians to address directly issues related to shame in therapy.

References

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology, 104*, 277–285.

Andrews, B. (1997). Bodily shame in relation to abuse in childhood and bulimia: A preliminary investigation. *British Journal of Clinical Psychology, 36*, 41–49.

Andrews, B. (1998). Methodological and definitional issues in shame research. In B. Andrews & P. Gilbert (Eds.), *Shame; interpersonal behaviour, psychopathology and culture* (pp. 39–54). Oxford: Oxford University Press.

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger and childhood abuse. *Journal of Abnormal Psychology, 109*, 69–73.

Andrews, B., & Brown, C. (1999). The role of infant characteristics and maternal behaviour in the development of later eating disorders. *European Eating Disorders Review, 7*, 279–285.

Andrews, B., & Hunter, E. (1997). Shame, early abuse, and course of depression in a clinical sample: A preliminary study. *Cognition and Emotion, 11*, 373–381.

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41*, 29–42.

Brown, L. V., Russell, J., & Thornton, C. (1999). The process of disclosure in abused eating disordered patients: A preliminary survey of hospital experiences. *European Eating Disorders Review, 7*, 179–192.

Burney, J., & Irwin, H. J. (2000). Shame and guilt in women with eating disorder symptomatology. *Journal of Clinical Psychology, 56*, 51–61.

Derogatis, L. R. (1977). *The SCL-90 Manual: I. Scoring, administration and procedures for the SCL-90*. Baltimore: Clinical Psychometric Research.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Psychiatry, 128*, 280–289.

Frank, E. S. (1991). Shame and guilt in eating disorders. *American Journal of Orthopsychiatry, 61*, 303–306.

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: Psychometric features and clinical correlates. *Psychological Medicine, 12*, 871–878.

Gilbert, P. (1998). Shame and humiliation in the treatment of complex cases. In N. Tarrier, A. Wells, & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioural therapy approach* (pp. 241–271). London: Wiley.

Lewis, H. B. (1987). Introduction: Shame—the 'sleeper' in psychopathology. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 1–27). Hillsdale, NJ: Erlbaum.

Lindsay-Hartz, J., De Rivera, J., & Mascolo, M. F. (1995). Differentiating guilt and shame and their effects on motivation. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 368–392). New York: Guilford Press.

McKinley, N. M., & Hyde, J. S. (1996). The objectified body consciousness scale: Development and validation. *Psychology of Women Quarterly, 20*, 181–285.

Nathanson, D. L. (1989). Understanding what is hidden: Shame in sexual abuse. *Psychiatric Clinics of North America, 12*, 381–388.

Noll, S. M., & Fredrickson, B. L. (1998). A mediational model linking self-objectification, body shame and disordered eating. *Psychology of Women Quarterly, 22*, 623–636.

Qian, M., Andrews, B., Zhu, R., & Wang, A. (2000). The development of a Shame Scale in Chinese college students. *Chinese Mental Health Journal, 14*, 217–221.

Sanftner, J. L., Barlow, D. H., Marschall, D. E., & Tangney, J. P. (1995). The relation of shame and guilt to eating disorder symptomatology. *Journal of Social and Clinical Psychology, 14*, 315–324.

Tangney, J. P., Burggraf, S. A., & Wagner, P. E. (1995). Shame-proneness, guilt-proneness, and psychological symptoms. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 343–367). New York: Guilford Press.

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*, 1256–1269.

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt and psychopathology. *Journal of Abnormal Psychology, 101*, 469–478.

Tiggemann, M., & Lynch, J. E. (2001). Body image across the life span in adult women: The role of

self-objectification. *Developmental Psychology, 37*, 243–253.
Vitousek, K. B., Daly, J., & Heiser, C. (1991). Reconstructing the internal world of the eating-disordered individual: Overcoming denial and distortion in self-report. *International Journal of Eating Disorders, 10*, 647–666.
Wicker, F. W., Payne, G. C., & Morgan, R. D. (1983). Participant descriptions of guilt and shame. *Motivation and Emotion, 7*, 25–39.
Wilson, G. T., Heffernan, K., & Black, C. M. D. (1996). Eating disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 541–571). New York: Guilford Press.
Zerbe, K. J. (1995). The emerging sexual self of the patient with an eating disorder: Implications for treatment. *Eating Disorders, 3*, 197–215.

Received 9 October 2001; revised version received 7 August 2002

Copyright of British Journal of Clinical Psychology is the property of British Psychological Society and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.