

Shame, Guilt and Eating Disorders: An Interpretative Phenomenological Analysis

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*I am forever engaged in a silent battle in my head over whether or not to lift the fork to
my mouth, and when I talk myself into doing so, I taste only shame
Morrow (2010 p.79)*

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LIST OF ABBREVIATIONS

ED	Eating Disorders
AN	Anorexia Nervosa
BN	Bulimia Nervosa
BED	Binge Eating Disorder
EDNOS	Eating Disorder Not Otherwise Specified
OSFED	Other Specified Feeding or Eating Disorders
OCD	Obsessive Compulsive Disorder
NHS	National Health Service
NICE	National Institute of Clinical Excellence
RCT	Randomised Controlled Trials
DSM	Diagnostic Statistical Manual
ICD	International Classification of Diseases
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
IPT	Interpersonal Therapy
IPA	Interpretative Phenomenological Analysis

Shame, Guilt and Eating Disorders: An Interpretative Phenomenological Analysis

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Abstract

Background: Eating disorders are commonly occurring illnesses that frequently cause substantial physical, emotional and psychosocial impairments (Fairburn, et al., 2008). The prevalence of this debilitating condition has led to substantial efforts by researchers and clinicians to search for different ways of understanding the illness for the sole purpose of increasing the presently poor treatment outcomes. Existing theoretical and research literature looking at the role of shame and guilt in eating disorders have put forward a convincing assertion that shame and guilt are poignant features in the psychopathology and symptomatology of the condition. However, these reports have not provided in-depth explanation into how people suffering from eating disorders experience shame and guilt and very little qualitative research has been conducted in this area. Likewise, the interwoven relationship and the differences between shame and guilt and their role in eating disorders psychopathology and symptomatology remain unclear. **Aims and Method:** The present study is an Interpretative Phenomenological Analysis (IPA) that recognises the uniqueness of an individual's experience of complex phenomenon such as eating disorder. Thus it aims to explore the understanding and sense-making of shame and guilt experiences by listening to the voices of six people who have been diagnosed and treated for eating disorders using semi-structured interviewing method. The study also explores the role of shame and guilt in treatment particularly their implication in the disclosure of information in the course of treatment. **Findings and Discussion:** The analysis identified five main themes; *the intensity of shame and guilt experience AND the pervasiveness of shame and guilt experience, Guilt and shame as integrated into all facets of the ED, Existential questioning of identity, shame and guilt lived out and developed in different context/ Locus of responsibility.* **Contribution to knowledge:** The study provides deeper understanding of participants' subjective experience of shame and guilt. The study highlights that shame and guilt are experiences that are intertwined with all facets of eating disorders as well as the individual's identity. Finally, shame and guilt were described as experiences that negatively impacted on treatment process. The implications of this for counseling psychology practice are discussed, and suggestions for future research are made.

Keywords: *Eating Disorders, Shame, Guilt, Treatment and Disclosure*

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute of learning.

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Chapter 1

The body is the vehicle of being in the world, and having a body is, for a living creature, to be involved in a definite environment, to identify oneself with certain projects, and to be continually committed to them.

Merleau-Ponty (1962, p. 82)

1.1 Background and Introduction to the study

At first glance, the determinants of eating behaviour might appear self-evident; the need for food is a biological imperative for survival. However, the historic existence of Eating Disorder (ED) pathology suggests that psychological factors strongly influence this basic behaviour (Fairburn, 2009). This makes the phenomenon of ED a perplexing topic for researchers (Park, 2007) and a challenge to clinicians and those affected (Granek, 2007). Perhaps one of the best indications of the complexity of the illness is the lack of a coherent definition of ED in most literature. Presently, there is not one single definition that captures the wide variety of the symptoms present in eating pathology. The definition below is taken from Hudson, Hiripi, Pope and Kessler (2007) and American Psychiatric Association (2014). Both define ED as severe disturbances in eating behaviours that result in insufficient or excessive dietary intake, which can cause serious physical and psychosocial impairments.

1.2 Historical context and clinical diagnosis

Clinicians first reported ED symptoms in the nineteenth century (Gull, 1873); however, clinical understanding of the nature of ED became more complex with time. This has also led to changes in the diagnostic criteria set out in the official Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD). Currently, there are four main ED categories in the DSM; Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Other Specified Feeding or Eating Disorder (OSFED). This section will give a brief description of the different diagnostic categories. A detailed presentation generated by the DSM can be found in the appendices (Appendix A, table 8-12).

AN is the longest recognised and the most severe form of eating pathology (Gull 1873; Fairburn, 2009). It is characterised by a persistent failure to maintain minimum body weight required for health. Individuals who suffer from AN typically weigh 15% or more below the

expected weight for their gender, height and age. Healthy adults have a body mass index (BMI) of 20-25 (calculated by the weight in kilograms, divided by the square of the height in metres). However, those with AN usually have a BMI of below 17.5 (Patient UK website, 2014). Individuals with AN generally report fear of weight gain and thus engage in severe and selective restriction of food intake. Those suffering with AN experience a distorted view of their bodies; even though they are extremely thin, they will still perceive themselves as too fat (Santrock, 2005). Similarly, they commonly have limited insight into their problems with food (Park & Bell, 2008). Often, their eating difficulties are recognised and brought to the professional's attention by a family member or friend (Colton & Pitstrang, 2004). It has been reported that some people may deny attempts to lose weight, and try to hide their bodies by wearing loose-fitted clothing (Kohn & Golden, 2001). Most importantly, eating is usually an anxiety-provoking endeavour, where people with AN may become obsessed with quantity of food consumed and preoccupied with the act of controlling and restricting the type and the amount of food eaten (Fairburn, 2009).

BN is an ED that is characterised by binge eating and inappropriate compensatory methods to prevent weight gain (Fairburn, Cooper, & Shafran, 2003). Most typically, these behaviours include self-induced vomiting, misuse of laxatives or diuretics, fasting or excessive exercise. The feature distinguishing BN from AN is that, the attempts to restrict food intake are interrupted by episodes of binge eating characterised by an aversive sense of loss of control (Fairburn & Harrison, 2003). The other form of ED that has only recently gained a legitimate recognition in the latest version of the DSM (DSM-V, 2013) is the BED. BED has always been recognised by clinical research community (Striegel-Moore & Franko, 2003), and described as severe episodes of binges without the use of compensatory behaviours seen in BN. Individuals with BED are often obese, though this is not a mandatory criteria for diagnosis (Johnson et al., 2001).

Although AN and BN are the most well-known forms of ED, the majority of individuals diagnosed with ED (approximately 50%) receive the OSFED diagnosis previously known as Eating Disorder Not Otherwise Specified (EDNOS) (Fairburn et al., 2007). This category is applicable to any individual with severe eating disturbances that does not meet the criteria for the aforementioned specified categories (AN, BN and BED). Researchers and clinicians in practice have suggested that this amorphous category of OSFED encompasses some forms of

ED that are as severe as those in the specified categories of AN, BN and BED (Wonderlich, Brewerton, Jolic, Dansky, & Abbott, 1997).

1.3 Prevalence and comorbidity

ED are severe, chronic mental health disorders associated with negative outcomes (Polivy & Herman, 2002). Prevalence and incidence rates are the basic measures of disease frequency (Hoek & Van Hoeken, 2003). While the terms are often used interchangeably, it is important to note that prevalence and incidence rates are not the same thing. Prevalence rates reflect the total number of cases in the population, while incidence rates reflect the number of new cases in the population over a period of time, usually one year (Hoek & Van Hoeken, 2003).

There have been few studies on the incidence rates of ED in the general population. The incidence rates reported often reflect cases that receive formal clinical recognition, rather than incidence rates for the general population (Smink, Van Hoeken & Hoek, 2012). Determining an accurate percentage of those at risk of ED has been a difficult task for researchers and clinicians. In the general population, rates reported vary greatly depending on the population studied, type of disorder assessed and methodology used (Pike, 2005; Micali, Hagberg, Petersen & Treasure, 2013). A large-scale review of the prevalence and incidence rates of ED in European countries revealed an increase in the registered incidence of cases of AN up until the 1970s, after which the incidence of AN appeared to stabilise (Hoek & Van Hoeken, 2003). For BN, a much sharper increase in incidence rate has been found over the 20th century (Keel & Klump, 2003). However, these studies are somewhat dated and are based on recorded cases. Thus, they have certain limitations i.e. they may not accurately reflect ED rates in the general population (Mond, Hay, Rodgers & Owen, 2009), in fact the UK national ED charity (BEAT) suggests that these statistics are grossly underestimated (BEAT, 2014). Likewise, not everyone that suffers from ED seek formal treatment (Hoek & Van Hoeken, 2003).

The number of people affected by ED is estimated to be 1.6 million in the United Kingdom (Lipczynska, 2005; NICE, 2014), and prevalence rates are highest amongst adolescent girls, aged fifteen (Calderon, 2007). Nonetheless, ED can affect people as young as six (Ballard, Handy, McGibben, Mohan & Silveira, 1993; National ED Association, 2006), or as old as seventy (Orbach, 1992; Mangweth-Matzek, 2006). The United Kingdom National Institute of

Health and Clinical Excellence (NICE) suggests around 11% of those affected are males (NICE, 2014). The figures reveal that 10% of the diagnosed ED population are classed as AN and 40% are classified as BN. The rest of the ED population received a diagnosis of OSFED (NICE, 2014). A report from the NHS information centre showed that up to 6.5% of adults displayed signs of an ED (Adult Psychiatric Morbidity Survey, 2007) without receiving formal ED diagnosis.

ED have high comorbidity with other mental health difficulties including Obsessive Compulsive Disorders (OCD), depression, substance abuse (Loue, Sajatovic & Armitage, 2004; Halmi, Tozzi, Thornton, et al., 2005; Cooper & Cowan, 2009; Bodell, Joiner & Keel, 2013). Additionally, the distinction between ED and self-harm behaviour is not always clear in epidemiological literature (Garner & Garfinkel, 1997; Sansone & Levitt, 2010), some researchers go as far as referring to ED as equivalent to self-harm (Favazza, 1987; Miller, 1994; Conterio and Lader 1998). In spite of the confusion in distinguishing between both behaviors, researchers have identified that both behaviors share a host of similar traits such as, low self-esteem, a perfectionist personality, anxiety, and perhaps a history of trauma, abuse, or family problems (Greenspan & Samuel, 1989; van der Kolk, Perry & Herman, 1991). Although, this present thesis recognises the overlaps between ED and self-injury behaviors, the focus is only on ED.

ED has been reported to strain the national economy due to patients' long hospital stays, long-term psychotherapy and poor treatment outcomes (Simon, Smith & Pilling, 2005; Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000). The illness is associated with high psychosocial impairments, even when compared to other mental health difficulties such as depression (Mond et al., 2004). People with ED such as AN and BN present a host of medical complications, such as cranial hair-loss, bodily hair-growth, osteoporosis, irregular heartbeat, poor circulation, fainting, coldness, kidney failure and low blood pressure, amongst numerous others (Somerset and Wessex ED Association, 2014). The impact is considerably similar among individuals who suffer from disordered eating but do not meet the criteria for a diagnosis (Mond et al., 2009). The duration of ED varies from person to person. Some may have a single, brief episode, whereas others may migrate between different ED diagnoses (Kohn & Golden, 2001; Fairburn & Harrison, 2003; Nielsen & Palmer, 2003; Milos, Spindler, Schnyder & Fairburn, 2005). Unfortunately, not everyone will experience full recovery from an ED, and people may instead experience dietary problems and body image disturbance for

the rest of their lives (Steinhausen, Rauss-Mason & Seidel, 1991). As Lamoureux and Bottorff (2005) assert, 'with treatment, an average of 40%–50% of individuals with AN completely recover, 30% improve, and the remainder are chronically affected or die' (p. 171). It has been reported that the illness has the highest fatality rate among mental health disorders (Arcelus, Mitchell, Wales & Nielson, 2011).

1.4 Treatment of ED

Some researchers have predicted that the life expectancy of people in developed countries may decline should the prevalence of ED continue to rise (Puhl & Brownell, 2001). Despite considerable improvements in clinical intervention and diagnosis, treatment outcomes are still quite poor. Treatment is plagued by dropout rate and notably the high value placed on ED behaviours by sufferers (Vitousek, Watson & Wilson, 1998).

NICE develops guidelines for a wide range of health problems, including mental health difficulties for UK clinicians. These are primarily based on randomised controlled trials (RCTs) and systematic reviews, but also include expert committee reports and clinical opinions. In 2004, NICE produced guidelines for treating ED by summarising treatment recommendations for the different ED diagnoses (NICE, 2004). These included psychological and pharmacological treatments, and methods of treatment management (e.g. outpatient or inpatient). The guidelines recommend that most people with ED should be managed on an outpatient basis, with psychological intervention lasting at least six months (NICE, 2004). The guidelines recommend a range of psychological treatments (including, cognitive behaviour therapy (CBT), interpersonal therapy (IPT), focal psychodynamic therapy, and family interventions). However, as the guidelines stress, there is limited evidence for their effectiveness. If outpatient therapy is not successful, or if the person deteriorates, then combined therapies (e.g. individual and family work), day care or inpatient treatment are recommended. Finally, the use of medication for anorexia is not recommended, unless it is for comorbid conditions such as depression or OCD. If necessary, medication should be used with caution; there may be problems with drug absorption and toxicity due to starvation, vomiting, dehydration and over hydration in this clinical group (NICE, 2004).

Within the NHS, the leading or gold standard treatments for ED are CBT and Interpersonal Therapy (NICE, 2004). A UK review of RCT for ED by Bodell & Keel (2010) compared different

pharmacological and psychological treatments, including CBT and IPT. They concluded that no definitive treatment works best for majority of people with ED and for AN, no single psychological treatment has demonstrated superiority over other psychological treatments in terms of efficacy, patient adherence, or safety (i.e., need for hospitalisation). McIntosh, Jordan, Carter, Luty et al. (2005) compared the effectiveness of 20 weeks of outpatient CBT with IPT in a group of 56 adult women with AN. The authors found no difference between the groups in terms of weight outcome.

1.5 The need for new approaches into ED

The growing epidemic of the ED coupled with limited effectiveness of clinical intervention signify the need for new approaches in the conceptualisation of the illness. There is a debate about the causes of ED (Polivy & Herman, 2002), which I will fully explore in the next chapter. NICE has advised on the need to prioritise psychological treatment for ED. Gilbert (2007) advised that improvements in psychological treatments come with greater understanding of the processes involved in the disorder and targeting therapies at this level. Psychological treatments are often designed to target core features that define ED (weight, appetite, distorted thoughts, and behaviours) as well as secondary symptoms, such as depression and anxiety. Despite this, success rates for ED treatment are low (Butler, Chapman, Forman & Beck 2006; Grave, 2010).

CBT researchers and clinicians (Fairburn, Cooper & Shafran, 2003) posit that whereas people without ED evaluate themselves on the basis of their perceived performance in a variety of life domains (e.g. the quality of their relationships, work, parenting, talents, etc.), people with ED judge themselves wholly in terms of their eating habits, shape or weight (often all three) and their ability to control them. On the other hand, IPT works on the principle that interpersonal dysfunction does not cause eating pathology, however, it may be viewed as a way of easing or solving eating pathology (Goodheart et al., 2011; Teyber, 2006). Consequently these factors that may serve to maintain the disorder are targeted in treatment (Murphy et al., 2012). As such, the main aims of IPT are to promote increased self-awareness and interpersonal effectiveness for the individual sufferer (Teyber, 2006).

Whilst these formulations and understanding sound logical, what appears to be lacking, although implicitly stated, is the role of self-conscious experiences such as shame and guilt in

the formation of these beliefs about the self. Studies looking at factors impacting recovery of ED from patients' perspectives have widely stated that one of the factors that impinge treatment and recovery is the difficulty tolerating difficult mood states and emotions (Federici & Kaplan, 2008; D'Abundo & Chally, 2004; Nilsson & Hagglof, 2006 and Pettersen & Rosenvinge, 2010).

1.6 Shame and guilt in ED psychopathology

Clinicians are increasingly noticing the significance and relevance of shame and guilt in ED psychopathology and symptomatology (Skarderud, 2007; Gilbert, 2008; Goss, 2011). Research often finds that ED symptoms are related to beliefs about guilt and shame. For example, earlier work of Bruch (1973) highlighted the case report of a client with ED named Karol. Karol held the belief that she was a failure and thus used self-starvation to manage her belief. Kaufman (1989) was among the first to explicitly recognise that shame dynamics constituted Karol's belief and that it entrenched the low self-worth and self-esteem that are core to her ED psychopathology.

Shame and guilt are rich and powerful human experiences that impact the most important aspect of our lives. Lewis (1971) defined guilt as a self-reproach over a behaviour that violates internalised standards and shame as negative self-evaluation associated with anticipated or actual scorn from others. Both shame and guilt are said to serve important individual and relational functions (Tangney and Dearing, 2003). These experiences are said to manifest from the tender age of *two* depending on various competencies such as being able to recognise the self as independent from others (Gilbert, 2002). The processes of shame and guilt are becoming increasingly recognised in ED studies. They are described as interwoven with ED feelings, cognitions and behaviours (Skarderud, 2007).

In clinical literature, shame and guilt are construed as both causal factors and consequences of ED (Goss & Gilbert, 2002; Skarderud, 2007; Burney & Irwin, 2000). Evidence suggests that people with ED report higher levels of shame and guilt than the general population. A number of case reports from patients with ED describe emotions and cognitions that fit neatly with the premise of shame and guilt. An early report from Goodsit (1985) suggests that patients with AN may feel guilty about the indulgent act of eating and this serves to increase the

negative feelings about the self. However, there is a lack of qualitative research in this area, which this study aims to address.

1.7 The close relationship between shame and Guilt

Both shame and guilt have been recognised in light of their close similarities. However, there remains a lack of consensus both about the distinctions and functions of shame and guilt. These inconsistencies have been explained in terms of how the two phenomena are often assessed. Most of the evidence base for the link between ED, shame and guilt come from quantitative research (e.g. Frank, 1991; Burney & Irwin, 2000). In this context, participants can only comment on the structured questionnaires that they are given. Quantitative measures used to assess guilt vary, with some conceptualising guilt as more adaptive than shame and some failing to provide a clear distinction from shame. Lutyen (1991) argues that assessment is both methodologically and theoretically flawed. This could account for the poor understanding of ED and poor treatment outcome reported (Elsworthy, 2007). Nevenon and Broberg (2000) have argued for crucial need of more qualitative research into ED, by echoing the limitations of quantitative research. In arguing for the need for more qualitative research in this field, particularly that which attends to both positive and negative aspects of ED, Serpell and Treasure (2002) have quoted Vitousek's (1997) call for researchers to 'spend more time listening' to the voices of individuals telling us about their authentic lived experience of the phenomena we seek to explain (p. 34). These recommendations are crucial for the profession of counselling psychology in which I practice listening to clients to determine the best way forward. Indeed, it seems remarkable that their opinions have been overlooked for so long.

1.8 Personal interest in the topic

I am trainee counselling psychologist with eighteen months experience of working with clients with ED. Although I have never had an ED, as a woman, I am aware of the modern society's emphasis on youthfulness, thinness and beauty and the pressure that this places on women (myself included) and increasingly men as I have witnessed in my own professional practice. This pressure has been largely linked to the development of ED and shame and guilt proneness (Raphael & Lacey, 1992; Striegel-Moore, Silberstein & Rodin, 1986). Despite the high societal awareness of the dangers of ED, from a personal and professional point of view,

worries relating to shape and weight are lived in private. Likewise, from working with this client group, I have learned that the pressure to achieve an ideal body image is only part of the contributing factor to this debilitating illness and that the cause and course of ED are more complex than this dominant discourse. A point Malson (2008) also recognised. This forms part of my own personal interest in the study.

I first became aware of ED when I was about seventeen years old and my sister suffered from what I now know to be disordered eating which caused a significant drop in her mood. Prior to this, I was passively aware as a teenager of the societal pressure and drive for thinness. I would not say that I viewed weight as a means of measuring success. However, I paid significant attention and focus to existing fashion trends and was driven to maintain certain shape and size that coincided with them. In addition, I became drawn to the widespread media coverage of high-profile cases including medical professionals such as doctors and dieticians who have died from these disorders. A few weeks into my doctorate degree, my curiosity in ED was spurred by the case of a highflying female doctor, Melanie Spooner, a Cambridge University alumna, who died as a result of anorexia. I had questions related to her degree of self-awareness despite being an intelligent medical professional. Surely she must have been knowledgeable about the implications of the illness, so how could she not have helped herself? Melanie's father during an interview on BBC One said that she was very uncomfortable talking about her struggles with ED leading to her rejecting their advice to seek/engage in treatment. Melanie's case resonated with me. Her struggles with engaging with treatment and subsequently losing the fight to ED made me really interested in finding out why people, knowing the severe consequences of their behaviours, find it hard to talk about their difficulties with ED.

I went into my doctorate training with the mind-set that had shifted from a naive motivation to fix people to a burning desire to better understand the illness. Once on my doctorate programme, my reading led me to focus on shame and guilt and their role in ED and treatment. There appeared to be a convincing and logical argument for how shame alongside stigma can prevent people from engaging in treatment and also maintain the illness (Rortveit, 2010). It also made sense that guilt was something associated with eating even for people without ED. However, I was surprised to see that there was little to no research inviting the voices of those affected by this issue. Similarly, there is a wide acknowledgement in the literature of the close relationship between shame and guilt and the difficulty separating the

two experiences. However no study has explored the close relationship between the two phenomena. From a personal account, I find it hard to distinguish the two and I have caught myself using both terms interchangeably. This lack of clarity spurred my interest in researching shame and guilt together in order to find out whether/how people distinguish between shame and guilt.

This study also sits within my personal experience in the professional context. As a trainee counselling psychologist with experience of working with people with ED, I have come across the phenomena of shame and guilt in clients' presentation. Although this experience did not form a precursor to this thesis, it fuelled my curiosity in developing a deeper understanding of ED including: aetiology, predisposing factors; potential correlations and treatment considerations. The more I thought about ED, consulted on it and worked with people affected, the more complex the situation appeared, perhaps more so than any other mental health difficulties that I have worked with. My curiosity and interest also geared me to systematically explore some of my thinking and experiences around shame, guilt and ED. This spurred me to systematically review and synthesise the extant literature on shame, guilt and ED (Oluyori, 2013) and explore the meaning making of other researchers and scholars. As a counselling psychologist in training, the philosophy that guides my practice is the search for depth in order to understand a lived phenomenon. I am grounded in my belief that every course of therapy is uniquely co-created between the therapist and the client, given that every person has their own way of making sense and meaning of their situation. Therefore, I am using this platform to seek the voices of those impacted by the illness in order to be able to offer a substantial contribution to existing knowledge and understanding of this complicated phenomenon.

1.9 Implications for practice

Not only is there a lack of coherent understanding of shame and guilt in the literature, these concepts are also under-investigated. The complex nature of these self-conscious experiences makes them hard to identify in therapy and this can impact on how the client engages with treatment. As stated above, the current leading treatments (e.g., CBT, IPT and family therapy) tend to be effective for only half of clients who complete a course of therapy, take a lengthy amount of time to achieve an effect, and/or find that the effects are not sustained (Fairburn et al., 2008). Like other mental illnesses, ED hold a stigma, and the process of therapy in general

can feel like a shameful experience, focusing on flawed aspects of the self (Tangney & Dearing, 2002). If therapists miss these signs, valuable opportunities to derive meaningful exploration and interpretation of the client's condition could be lost and this could have huge impact on decisions about intervention (Webb, Heisler, Call, Chickering, & Colburn, 2007). Consequently, it is important to understand the role of these self-conscious experiences as this could also impact on how client use their agency in therapy (Rennie, 1994).

1.10 Towards a richer methodology

The aforementioned presence of shame and guilt in ED and associated risks that surround the illness make it a sensitive topic, one that warrants innovative research methodology to enhance our understanding of how the phenomenon is lived (Brodsky & Faryal, 2006). The majority of the research that has explored the relationship of shame and guilt to ED has been quantitative. Although these studies have facilitated progress in the field of ED and put forward convincing evidence for the centrality of shame and guilt to the illness, they have not been able to gain sufficient understanding on how the processes of shame and guilt arise from individuals' experiences. This is because most of these studies have relied heavily on self-report data and non-clinical population to justify their claims among clinical population. These means of data sourcing fail to capture the complex experiences of people with the diagnosis of an ED and this may serve to explain the differing opinions about the aspects of ED that relate to shame and guilt. Some have even found negative correlation between guilt and ED, while others have found that both shame and guilt are core to ED phenomenon. Critical understanding of shame and guilt as well as their relationship with ED is desperately needed.

Likewise, literature often ignores people who have recovered from ED despite empirical investigations suggesting that people who have had treatment experience high levels of shame and guilt relating to eating, body shape and weight (Swan & Andrews, 2003). A review of existing qualitative literature indicates that no research study has looked at people's experiences of shame and guilt post-treatment (Oluyori, 2013). Additional understanding may be gained by adopting a methodological approach different from the dominant quantitative analysis and non-clinical methods; particularly as treatment outcomes for ED are significantly poor (Goss & Allen, 2009).

1.11 Relationship of study to professional practice

Hepsworth (1994) has highlighted the value and need for qualitative research in the field of ED. He described the lack of qualitative study in the field as 'a weakness in developing theory and practice' (p. 179). The current research is an Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flower & Larkin, 2009). The aim is to provide participants with an opportunity to discuss their overall perspectives on shame, guilt and ED, as well as the impact of these experiences on treatment and disclosures. Indeed, this corresponds with the general ethos of counselling psychology. Counselling psychology adopts a more holistic view of a problem or issue in order to better understand it. Based on the humanistic principles of empathy, congruence and unconditional positive regard (Rogers, 1961); counselling psychology places the utmost importance on a person's feelings, experiences, perceptions, values and behaviours (Woolfe, Dryden & Strawbridge, 2003). The present study reflects this philosophy, attaching great importance to subjective experiences and exploring the inherent meanings.

It is my belief that those suffering from ED should not be defined by their disorder. Hence, to respect their individuality and identity, I will not refer to them as 'eating disordered' 'Anorexics' or 'Bulimics' in this thesis. Instead, I will use the term 'person with ED' 'person with Anorexia or Bulimia Nervosa'.

To encapsulate, I believe that this research will allow me to explore what I can learn as a practitioner about the experiences of those with an ED in order to effectively support them, and hopefully contribute to improving treatment outcomes.

1.12 Overview and structure of the thesis

In writing this thesis, I hope to shed some light on what the experiences of shame and guilt mean to someone who has had treatment for an ED. Although each participant's experience is personal and unique, it is my view that their accounts will be indispensable, ultimately providing a sense of understanding and clarification about the nature of shame and guilt in ED. The second chapter provides a richer understanding of the topic by critically reviewing up to date literature and relevant research on ED, shame and guilt. This will be followed by the aims and the rationale for the present study highlighting how the present study contributes to

existing knowledge. The third chapter will outline the study's methodological approach and how it is applied at each stage of the analysis with reference to ethical considerations including standards of validity that guided the study. Thereafter, findings from the analysis will be presented in relations to the research question. The fifth chapter covers my reflection on findings in relations to existing literature. This chapter also covers recommendations emerging from the research process and findings, as well as recommendations for future research. Overall reflection on the process of conducting the study will be presented in the final chapter.

1.13 Chapter summary

Within this chapter, I have presented a broad introduction to the present thesis. I have provided the developments which not only contextualise but also justify this present study. I have defined ED and briefly explored how they relate to shame and guilt. This relationship will be expanded further in the succeeding chapter. I have outlined the need for this current study in enhancing clinical understanding of the phenomenon of ED, and the implications this has for treatment of ED. Within this chapter, I have introduced my personal interest in the topic of study and outlined the overall structure of the thesis.

Chapter 2

I need to make myself strong on the inside instead of what is on the outside. I know all of this, but why can't I put any of this into action? I guess that's why I'm in this place

***Piper Caleb, Shattered perfection: The diary of an eating disordered mind
(Pipercaleb.com, 2014)***

2 Literature Review

Within this chapter, I ground the present research in the relevant theoretical and research literature. Hart (1998) suggests that a review is a means of familiarising the reader with the research area under investigation and also helps the researcher garner a better understanding of the research study. This must involve a critical analysis of the literature (Harder & Thomas, 2005) as well as the identification of central issues, weaknesses, and gaps in literature (Randolph, 2009). McLeod (2003) makes the bold assertion that any new research question no matter how original, can 'only be constructed on the back of all the questions and techniques that have gone before it' (p. 11). Meeting the demands of McLeod could seem an endless task for an ED researcher, particularly as there exists a plethora of academic papers on ED.

Hart (1998), on the other hand, states that there is no such thing as a perfect review; he explains that a literature review is written from a particular perspective and for a specific audience. Due to the broadness of the topic of ED, shame, and guilt, I have elected to focus on the literature that is directly relevant to my research question. The starting point of the review is the immediate literature concerning the current status of the aetiology of ED. I then turn to examine literature that has linked shame and guilt to ED and look directly at the meaning of shame and guilt and their characteristics. I end the review by exploring literature on the impact of shame and guilt on treatment and disclosure. I did not always manage to structure the content as I would have liked. For instance, I found that I had to comprehensively explore the role of shame and guilt in ED before actually exploring the meaning and theoretical underpinnings of shame and guilt. This reflection demonstrates the interconnectedness between the three phenomena. It is important to note that the literature review has been an on-going process for me over the course of my three year professional doctorate in counselling psychology through to the final write up of the thesis. I found that, as some themes emerged from my analysis, this stimulated the need to widen the direction of my

search and this led to fresh ways of approaching my findings.

The literature reviewed for this research study was obtained via psychological, psychiatric, and medical search engines, such as PsycInfo; AssIA (Applied social sciences Index and Abstracts); CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature); and Medline. Key words used to attain journals and articles about the topic were 'Eating Disorder', 'Anorexia Nervosa', 'Bulimia Nervosa', 'shame experience', 'guilt experience', 'shame and guilt', 'shame in Eating Disorder', 'guilt in Eating Disorder', 'shame, guilt and Eating Disorder', 'Interpretative Phenomenological Analysis', 'qualitative research' and 'quantitative research'. Reference lists of papers identified were also examined for any related research. I tried where possible to focus on literature from within Britain, however, I explored literature written in English from elsewhere as not much research has been carried out on the topic within the British context and I found that other Literature outside the British context (for instance literature from Norway, Australia and the US) impacted on/illuminated developments here. The principal journals reviewed in this study were the 'European Eating Disorder Review', 'International Journal of Eating Disorder', and 'Eating Disorder'.

2.2 Aetiology and psychopathology of ED

The treatment of ED should not simply focus on symptoms: the aetiology behind them must be taken into consideration. ED researchers have acknowledged that the illness is determined by a combination of different predisposing, precipitating and maintenance factors which theorists have endeavoured to elucidate by formulating various models for understanding the condition (Garner & Myerholtz, 1998; Striegel-Moore & Bulik, 2007). In the following brief synopses, my aim is to convey a sense of some key contributions from the major theoretical approaches and their implications for treatment. This section of the review highlights the theoretical explanations for ED and the construction of the self because past studies have shown that the struggle for a sense of self is what links shame and guilt experiences to ED (Bruch, 1973; Kaufman, 1980; Stice, 1998). Similarly, shame and guilt have been broadly defined as experiences that are rooted in our perception of self and behaviours (Gilbert, 2007). This notion will be discussed extensively in succeeding sections.

The following section provides an overview of the relevant literature in the field of ED and their relevance to the self-concept. It is imperative to highlight that this is not an exhaustive

review of literature in this area; rather, contributions have been presented according to their relevance in informing the reader about the background and purpose of the current study.

2.2.1 The self in ED: previous research and theoretical contributions

Literature in this area comes from a number of different theoretical orientations, which I have categorised in the following ways: psychoanalytic, psychodynamic, and developmental theories, feminist theories, cognitive and behavioural perspectives. Another noteworthy point is the acknowledgement that the terms 'self', 'self-concept', 'identity,' and 'sense of self' have been referenced interchangeably in the literature (Stein & Corte, 2003). However, in order to provide some context for the theories discussed in the following sections, the following definition by Epstein (1973) of self/self-concept has been employed to guide the reader. Epstein represents the self as a structure that must be stable yet dynamic at the same time; and which assimilates and organises knowledge, yet is an object of knowledge itself, this led the author to propose that the self-concept is a 'self-theory':

It is a theory that the individual has unwittingly constructed about himself as an experiencing, functioning individual, and it is part of a broader theory which he holds with respect to his entire range of significant experience. Accordingly, there are major postulate systems for the nature of the world, for the nature of the self, and for their interaction. (p. 407).

I now turn to examine literature from psychodynamic, psychoanalytic, and developmental perspectives.

2.2.2 Psychoanalytic/Psychodynamic and developmental theories

From a psychodynamic standpoint, ED is determined by multiple factors, including avoidance of the threat of sexual maturity, the possibility of a new identity, strategies for coping with external self-criticism, the prospect of realising the true self, a defence mechanism for surviving parental conflicts or management of annihilation anxieties (e.g. Orbach, 1993; Malson, 1998; Bruch, 1973). Bruch (1982) offers a valuable understanding of certain behavioural processes (i.e. perfectionism and self-denial) that are present in AN. The author described these processes as defenses against underlying feelings of worthlessness or emptiness. She claimed that every individual with anorexia '*dreads that basically she is inadequate, low, mediocre, inferior and despised by others. All her efforts are directed towards hiding the fatal flaw of her fundamental inadequacy*' (p. 4). Bruch's explanation appears to be only focused on females and neglects accounts of males who are affected by the condition. However, fellow psychodynamic/feminist theorist Orbach (1992) acknowledged the

increasing prevalence and incidence of anorexia in male population.

Goodsit (1997) contended that people with ED are suffering from a disorder of the sense of self, with ED symptoms serving to bolster the cohesion and stability of an extremely fragile sense of self. This empathic insight into the perception of self as inadequate has resonance with Crisp's (1995) developmental conceptualisation of ED as a 'flight from growth', arising from a failure to master and integrate aspects of psychobiological maturation, including adult role and sexuality. Crisp (1995) suggests that in response to the perceived inadequacy, the adolescent adapts by adopting a 'phobic avoidance stance' towards puberty, which imbues a sense of mastery and safety. His theory holds that this strategy for maintaining control over a changing internal self also requires the person with ED to exert control over their environment, thus involving manipulation of others in the family system.

The role of relationships in the etiology of ED continues to be upheld in most recent psychodynamic thinking. Lawrence (2008) considers disturbances in relationships to underpin all ED, specifically, 'a difficulty in feeling open and receptive to the good things that relationships with others might have to offer.' (p. 17). In treatment, an important assumption is that a negative transference will develop, that the therapist will at some stage come to represent those frightening, oppressive figures in the mind of someone with AN (Lawrence, 2008). Accordingly, the therapeutic relationship is considered key to the playing out of the transference such that the person ultimately is able to internalise a nurturing, good representation of the other. One implication for treatment, in Bruch's (1985) view, is that the way the therapist interpret the meaning of anorexic behaviours may represent a re-enactment of the early empathic failures that resulted in the fragile, incoherent self-structure, threatened with disintegration that inspired the need for maintaining the sense of self via relationship with food and the body. An empathic understanding and relationship is therefore fundamental to foster therapeutic engagement and changes.

Most of these studies have focused on female populations and therefore these explanations are unjustifiable for cases of males with ED; particularly with the speculation that the prevalence and incidence rates of males with ED are on the rise (Wonderlich, Gordon, Mitchell, Crosby & Engel, 2009). Likewise, majority of the writings from this perspective are focused on AN and therefore neglect the existence of other forms of ED presentations.

2.2.3 Feminist theory

As it might be expected, literature from the feminist perspective focuses on women. Bartky

(1990) argued that ED is culturally specific and is an indicator of the immense pressure that the society puts on females to maintain a certain body shape and size. Bartky suggests that culturally women are seen and treated via the lens of their physical appearance. This external view of the female gender is said to lead to 'self-objectification' whereby girls and women internalize these empty beliefs about the self '*self-objectification occurs whenever a person is viewed, evaluated, reduced to, and/or treated by others as merely a body*' (Cologero, Davis & Thompson, 2005, p.43). Other feminist theorists have argued that during adolescence, there is an intense conflict experienced in females about their roles within a patriarchal society (Griffin & Berry, 2003; Malson, 1999; Piran, 2001). The expectation is that women achieve in all areas, and that they can be the feminine (nurturing, family type, assertive with their own needs), as well as ambitious, and career driven. It is thought that this pressure creates stress and a fear of failure resulting in ED behaviours as a way of managing this tension.

Malson (1992) argued against the commonly held explanation of ED as a mere consequence of cultural pressure to attain thinness. She asserted that this perspective undermines the functional and significant role of the illness for those that are affected. For example, she commented that woman and girls who suffer from an ED are casually referred to 'super-dieters' that overly adhere to the omnipresent cultural ideology of 'feminine beauty equates thinness'. According to the author, this explanation omits other aspects of the ED or the woman's subjectivity such as, the cultural and the political meaning of the ED to the sufferer, and the significance of the female gender role in a patriarchal society (Malson, 2008).

Lester (1997) put forward a similar proposition by asserting that AN functions as a means of 'tailoring the self' in a culture in which thinness is viewed as more than a measure of physical attractiveness and seen as measures of self-control and intelligence. She argues that though women suffering from AN are pursuing the mastery of the pure, intellectual mind (which is symbolically masculine) over the wanton, sexual and self-indulgent body (which is symbolically feminine). Of this symbolism she writes:

Thinness comes to represent the hard-won triumph of the self over the flesh - 'proof' that the self and the body can be dislodged from one another, and that her female body can be discarded as the anchor weight harnessing her otherwise brilliant self to a mundane and restricted existence. (p. 486).

She suggests that the body, while in one sense separate from the psychological self, also becomes a metaphor for the psychological self.

Orbach (1986) and Lawrence (2008) are two other feminist psychotherapists who have written and proposed psychodynamic/feminist approaches to anorexia. Orbach (1986) argued that the media heavily influences women's relationships with their bodies and that this can be a contributing factor to the development of an ED. She views ED as an individual's response to a range of interpersonal, intrapersonal, social, and cultural tensions that is associated to the social and psychological existence of the sufferer. She also asserts that a big factor in the development of an ED is how one comes to relate to their body early on in life. She proposed that AN can become a way of rebelling against femininity and the responsibility of managing to resolve the conflict one experiences. Lawrence (1987) proposed that a woman who suffers from AN feels that she has to deny that she has needs, because she feels that her needs will be too overwhelming for others. She theorised that AN is a manifestation of a conflict between independence and autonomy (Lawrence, 1979), which stems from a social world full of conflicts about what a woman should be (Griffin & Berry, 2003; Malson, 1999; Piran, 2001).

What is clear from the different views is that ED is seen as a 'solution' (Bruch, 1978; Orbach, 1986) by the individual to help them when they feel powerless and out of control, whether that be theorised physiologically, psychologically, medically or sociologically. The difficulty is ED is socially and medically seen as a problem (Vitousek, Watson & Wilson, 1998). This psychodynamic feminist explanation of ED as a search for control, autonomy, and independence is supported by studies that have looked at ED in non-western cultures such as South Africa and Fiji (Pike & Borovoy, 2004; Nasser, 2001; Becker, 2004; Szabo and le Grange, 2001, Littlewood, 2004). These studies looked beyond the microsystem and into the macro-system by stating that the ED is a complex phenomenon relating to socio-political transformation, quest for/achievement of freedom and changes in female gender roles. Norwegian psychiatrist and professor Finn Skarderud echoes these assertions. In an interview with Nasser (2001), he commented that rapid social changes pose psychosocial threat that destroy traditional contexts, routines and learned boundaries, making people feel vulnerable and void of safe reality.

'In this vulnerable, empty and fragmented space, the body is a perfect vessel through which to express symbolic messages due to being physically concrete and directly associated with self-identity which are the most threatened construct during the period of transition' (Skarderud in Nasser, 2001 p. 37-38). I now turn to a slightly different approach that sees ED as direct consequence of maladaptive beliefs and cognitions.

2.2.4 Cognitive and behavioural perspectives

Cognitive behavioral theorists view ED psychopathology as a direct implication of cognitive abnormalities, including obsessive thoughts, inaccurate judgments, and rigid thinking patterns (Polivy & Herman, 2002). This section draws on literature concerning the role of negative self-esteem and the role of negative self-schema as explained by cognitive behavioural perspectives. Vitousek and Hollon (1990) proposed a self-schema framework for a cognitive understanding of ED, drawing on Markus' (1977) self-schema theory:

'self-schemata are cognitive generalizations about the self, derived from past experience, that organise and guide the processing of self-related information contained in the individual's social experiences' (p. 64)'

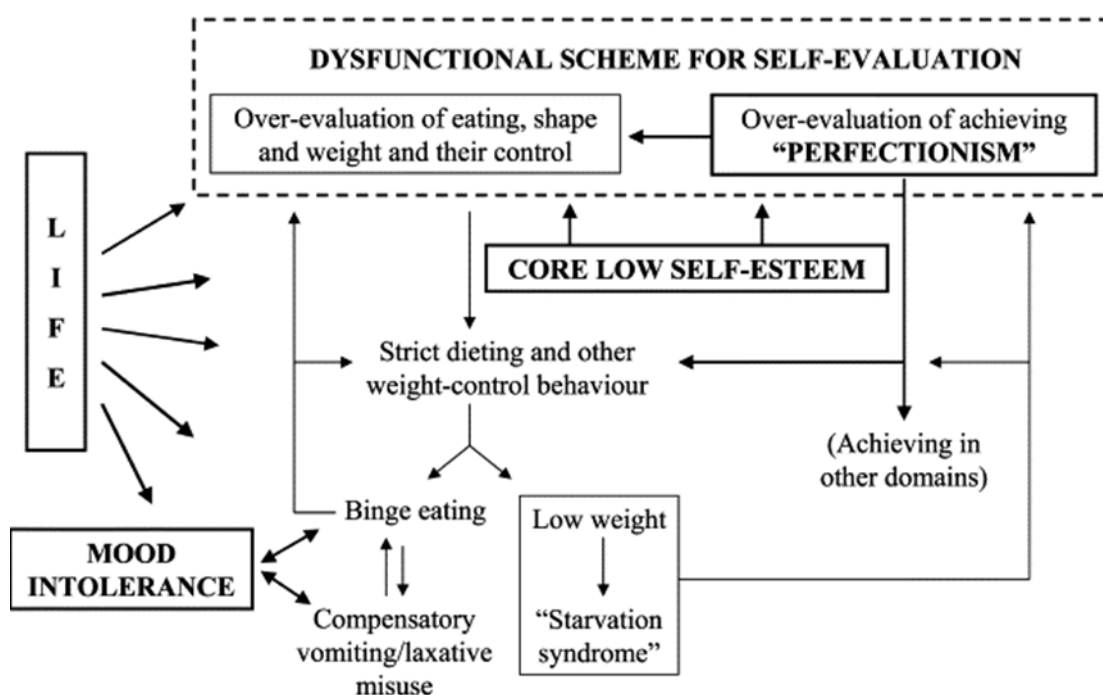
This demonstrates the identified relationship between low self-esteem and ED (Fennell, 1998; Polivy & Herman, 2002). Fennell (1998, p. 297) suggests that:

...the essence of low self-esteem lies in global ('me as a person') negative core beliefs about the self, which derive from an interaction between inborn temperamental factors and subsequent experience, for example, neglect, abuse, bereavement or an absence of sufficient warmth, affection and praise. Dysfunctional assumptions then function as 'escape clauses' which allow the person to feel more or less happy with him/ herself, so long as he or she is able to do as they require (be perfect, be loved, be in control, etc.).

Self-esteem is linked to the reactions of others; hence actual or perceived rejection may cause lower self-esteem (Polivy & Herman, 2002; Fennell, 1998; Gilbert, 2008). Heatherton and Polivy (1992) have suggested that dieting (which when disrupted results in overeating) sends self-esteem into a downward spiral that contributes specifically to ED, rather than to other disorders such as depression. An emphasis on the role of past experiences in the development of self-schema provides a link between the more here-and-now emphasis of CBT models and the interest in the early experience of the infant found in more psychoanalytic and psychodynamic theories. Vitousek and Hollon (1990) describe how schema are of particular relevance to clinical problems due to their tendency to honor stability over change, and hence their role in perpetuating negative views of the self. In the case of ED, Vitousek & Hollon suggest that people with ED develop schemata around the issues of weight and its implications for the self, which influence their perceptions, thoughts, and behaviours. They also propose that these schematic processes fulfill the valued roles of simplifying, organising and stabilising the person with ED's experience of self and the external environment.

Fairburn, Cooper and Shafran (2003) posit that whereas people without ED evaluate themselves on the basis of their perceived performance in a variety of life domains (e.g., the quality of their relationships, work, parenting, sporting ability, etc.), people with ED judge themselves wholly in terms of their eating habits, shape or weight (and often all three) and their ability to control them. The struggle to control shape and weight features leads to development of rigid rules and the difficulty adhering to these rules or their consequences lead to a negative perception of self (Fairburn, 2009). These distinctive, and highly characteristic, behavioural and attitudinal features are prominent and well recognised, as is the dysfunctional system for evaluating self-worth (e.g., Vitousek & Hollon, 1990; Goss and Allan, 2009; American Psychiatric Association, 2000). The Schematic representation of this model is represented in Fig 1 (Fairburn et al., 2003)

Figure 1: A schematic representation of the 'transdiagnostic' theory of the maintenance of ED. 'Life' is shorthand for interpersonal life. (Fairburn, Cooper and Shafran, 2003)



To encapsulate, this section has looked at some pertinent explanations for why some people develop ED. The main obstacle facing these attempts is the virtual impossibility of combining all such factors into a model that is not cumbersome or one that assumes a reductionist position for the way in which the identified processes affect the individual with ED. Whilst these theories can serve as a guide, they fail to capture the complexity of all ED presentations,

particularly in relations to guiding practice (Polivy & Herman, 2002). Clinicians working in the field have argued for focus on identifying the underlying factors that trigger and maintain ED and tailoring intervention to address these factors (Kelly & Carter, 2014). One of the processes that have been said to implicate the cause and course of ED is self-conscious affects such as shame and guilt. In-depth exploration of these experiences is somewhat lacking in ED research. The next section will explore the recognition paid to the implication of shame and guilt in psychopathology and symptomatology of ED.

2.3 The recognition of shame and guilt in ED phenomenon

The role of shame and guilt in ED has long been recognised by practitioners (Bruch, 1978), though the interest given to this line of enquiry has not been steady over time. Most ED clinicians will agree that shame and guilt are core experiences that clients report in therapy (Goss, 2011). The aforementioned theoretical accounts of aetiology of ED have also addressed implicitly the presence of shame and guilt in ED psychopathology and symptomatology. For instance, Fairburn's (2003) cognitive behavioural model recognises that shame and guilt are constitutive of the mood states that mediate some ED behaviours. However, there is a lack of consensus on how the process of shame and guilt comes about. Some suggest that shame and guilt are consequences of ED and others have argued that shame and guilt are predisposing and perpetuating factors in ED. As stated earlier, shame has attracted more attention than guilt in this respect.

Likewise Fredrickson and Roberts (1997) extends Bartky (1990) feminist perspective on ED to include the implication of shame in aetiology and maintenance of ED. They suggest that our culture socialises girls and women to internalise an objectifying observer's perspective of their own bodies making them preoccupied with their own appearance. This form of self-appraisal and self-consciousness generates heightened self-monitoring or self-surveillance of the body's outward appearance through the psychological processes of shame (Fredrickson et al., 1998). Fredrickson and Roberts did not identify guilt as a consequence of this method of self-appraisal. However, Cologero and Pina (2011) extended the theory to add that appearance monitoring as a result of self-objectification creates an increased opportunity for shame *as well as* [own emphasis] guilt. These strategies are not necessarily conscious processes or deliberate attempts but the repercussion of repeated exposures to a range of external pressures (Constantizo, 1999). Although Freud (1930) saw this unconscious process

of self-surveillance as evidence of narcissism, Fredrickson and Roberts (1997) termed it an adaptive strategy used to maintain or promote self-worth.

The authors of this theory assert that because phenomenological shame and guilt generate the desire to hide and escape from the hurtful gazes of others or make reparative attempts (Tangney, Miller, Flicker & Barlow, 1996) along with feelings of worthlessness and powerlessness (Lewis, 1992), this can lead people to actively make efforts to self-repair the aspect of the self (body and appearance) that is viewed as flawed. A range of experimental and correlational studies are consistent with the primary tenets of this account. Research data suggest that heightened self-monitoring promotes body shame which drives ED symptoms such as: the desire to control weight and shape (Forbes, Jobe, & Revak, 2006; Henderson-King & Henderson-King, 2005; Prichard & Tiggemann, 2005; Piran & Cormier, 2005; Moradi et al., 2005).

It is noteworthy to state that this hypothesis is not exhaustive for people with ED, a stance that the authors also acknowledged (Fredrickson et al., 1998). Additionally, the theory predominantly focuses on women and therefore lacks the accounts of men who present with ED symptoms, though some research points to the objectification theory for understanding men's experiences (see Hebl, King & Lin, 2004; Aubrey, 2006; Grabe & Hyde, 2005; McKinley, 2006; Hallsworth et al., 2005). Likewise, most of the studies that support this theory utilised non-clinical samples; therefore, the supposed ED symptoms could be considerably low to warrant a diagnosis; a stance that is warranted when drawing conclusions from the findings (e.g. Tiggemann & Kuring, 2004). Additionally, this theoretical explanation of ED omits personality factors and variance in the extent to which people internalise others' views as their own (Croke & Wolf, 1997), therefore providing no explanation as to why some people develop ED and others do not (Moradi & Huang, 2008). Another important point is that the theory may not apply to wider cultural contexts as participants in the study were mainly from the US, and as previously explained in sections above, there are several cultural and socio-political factors that influence the onset of ED. I will also explain later in this review the cultural tenets of shame and guilt. Nevertheless, self-objectification theory and its growing body of evidence provides a promising framework for the understanding of how sociocultural factors impact on the psychological and phenomenological experience of shame and guilt and how these processes mediate the risk in the development and maintenance of ED.

2.4 Defining shame

The phenomenon of shame is so well studied that there exists a plethora of theoretical literature from a wide range of perspectives such as psychodynamic, psychoanalytic (e.g. Freud, 1930; Jacoby, 1994) and developmental perspectives (e.g. Barrett, 1995). In some ways this has contributed to the poor understanding of the relationship of shame to ED psychopathology. Due to the complexity of shame, most of the studies investigating shame break shame experiences into different subdivisions (see section 2.4.2) and this impacts on the meaning and perhaps explains for varying reports of its relevance to ED pathology. It is only recently that psychologists began to conduct systematic empirical and phenomenological research on the nature of shame and guilt and their implications for psychological functioning (Tangney & Dearing, 2002).

2.4.1 Shame: theoretical framework

Sociologists view shame as a product of social stigma (Goffman, 1968). Goffman, who was based in America at time of his writing, defines stigma as the experience of possessing undesirable and negatively evaluated personal attributes that exclude one from social acceptance (Goffman, 1963). Similarly, social psychologists define shame in relation to social context (Crozier, 1990). Psychoanalytic theorists understand shame as resulting from a failure in childhood (Schore, 1991). Cognitive theorists recognise shame as a consequence of anxiety (Beck, Emery & Greenburg, 1985; Gilbert, 2002). Although the aforementioned definition connotes shame as something negative, across a variety of cultures, shamelessness is seen as a personality deficit (Manion, 2002). It is noteworthy that the authors cited above are based in America and UK for the purpose of the present study. Within other cultures, particularly non-Western cultures, the experience of shame varies. For example, in China, shame is regarded as a 'valued' emotional response to failure (Wong & Tsai, 2007). The full exploration of cultural conceptualisation of shame is beyond the scope of this review. This has been well presented elsewhere by Wong & Tsai (2007).

2.4.2 Psychological discourse of shame

Goss, Gilbert, and Allan (1994) distinguish between two types of shame. They suggest that some people are prone to shame in certain situation (i.e. state shame) but would not negatively evaluate themselves (i.e. trait shame). Similarly, Kaufman (1989) identified internal and external shame; this distinction was later developed by Gilbert (2002). Internal shame involves negative self-scrutiny and appraisal of self as flawed, worthless, unlikeable by

others, or weak (Gilbert & Miles, 2002). Gilbert (2002) explains that internal shame results from past experiences that involve chronic exposure to shameful situations, which are internalized (Cook, 1994; Kaufman, 1992). The failure or inability to challenge these experiences could lead to the individual internalising and attributing these experiences of rejection to a deficit on their part (Kaufman, 1989; Nathanson, 1994). This process could become enduring and a possible trigger for shame response due to the individual's internalised thoughts and beliefs about the self even without the presence of the overpowering other. Equally, this unpleasant view of self could lead to the desire to inflict self-punishment (Gilbert, Clarke, Herpel, Miles & Irons, 2004). In terms of external shame, the individual inhabits the perception that the self is viewed as flawed and unattractive by others (Gilbert, 2008) or they may fear that others will harbor this negative view of self, leading to fear of rejection (Lewis, 1992). A protection response from external shame may forcefully lead the individual to hide, withdraw, or submit (Gilbert & Miles, 2002).

2.5 Defining guilt

Most of the theoretical and empirical papers on guilt are rather dated. Elsworth (2007) explained that the neglect of research into guilt could be a result of the close similarities between shame and guilt. Guilt like shame is listed under the umbrella of self-conscious experiences that involve the evaluation of the self (Baumeister et al., 1994). However, there is less focus on guilt in the literature in comparison to shame (Baumeister et al., 1994). Generally, guilt is argued to be experienced when one violates a moral standard (Lindsey-Hartz, Rivera & Mascolo 1995; Lazarus, 1991). Guilt has been linked chiefly to private self-consciousness (Buss, 1980). Freud (1930) focused on the impact of guilt; he viewed guilt as retaliation of the superego in response to the Id's immediate desire for gratification and the ego's action. In this respect, Freud failed to recognise the social phenomenon of guilt by recognising guilt as predominantly intra-psychic conflict although the superego is the internalised father, the means by which we internalise societal standards and rules.

Likewise, Lewis (1971) asserted that guilt is a private experience that is mainly invoked from within the self, stating, 'the imagery of the self 'vis-à-vis the other is absent in guilt' (Lewis, 1971 p.111). In the same vein, behaviourist Mosher (1965) proposed that guilt may be defined as 'a generalised expectancy for self-mediated punishment for violating, anticipating the violation of, or failure to attain internalised standards of proper behaviour' (p. 162).

Baumeister et al., (1994) reviewed empirical findings that argue against guilt as a private experience. They summarised that guilt has strong social and interpersonal origins in the context of communal relationships, connoting both positive and negative consequences while also acknowledging the private context of guilt.

Researchers have distinguished between 'state guilt' and 'trait guilt' (e.g., Kugler & Jones, 1992). The former refers to experiences of guilt that arise from performance of an action that violates a moral code (Jones, Kugler & Adams, 1995). The latter is defined as a disposition to experience a state of guilt in various guilt-eliciting circumstances, all of which relate to the person's internal moral standards (Tangney, 1998). Efforts to further distinguish guilt are beleaguered because it is often mistaken for shame even though empirical literature suggests that the terms differ theoretically and phenomenologically (Ferguson & Stegge 1998; Lewis, 1971; Tangney, 1989, 1990, 1991; Wicker, Payne and Morgan, 1983). The next section will explore existing debate regarding the distinguishing features of shame and guilt phenomenon.

It is noteworthy that the classification of guilt and shame into various states and affects could assume a global and stable view of self and may not be generalisable to other cultural contexts (Wong & Tsai, 2007). For example the viewpoint that global, stable attributions lead to shame and specific temporary attributions lead to guilt assumes that there is a stable self that can be differentiated from one's temporary actions. I refer back to Epstein (1973, see section 2.2.2) who stated that the self can be stable but at the same time dynamic. Similarly, the notion that shame has external orientation (i.e., is oriented to others' standards or social norms) whereas guilt has an internal orientation (i.e. oriented to one's own standards) assumes that internal and external orientation can be easily separated and that internal orientation is more powerful than and genuine than external orientation.

2.6 The relationship between shame and guilt

Empirical studies have revealed strong correlations between shame and guilt (Ferguson & Crowley, 1997; Harder, 1995; Tangney, 1996; Tangney & Dearing, 2003). Both shame and guilt are multifaceted experiences comprising of cognitive, emotional and behavioural facets. On the one hand researchers have often recognised shame and guilt as 'twin' phenomenon (Tangney & Dearing, 2003). This is because the normative standards common to both self-conscious experiences are usually more implicit norms than explicit (Caprara et al., 2001;

Tangney et al. 2007a, 2007b; Tracy & Robins, 2007; Basil, Ridgeway & Basil, 2006; Menesini & Camodeca, 2008; and Hosser, Windzio, & Greve 2008). However, recognition has also been paid to the need to distinguish the differences and similarities of both experiences. Tangney and Dearing (2003) presented a useful review (see table 1) highlighting the differences and similarities between shame and guilt. The review identified that both shame and guilt are self-conscious and moral experiences lived out in our interpersonal relationships affecting the evaluation of the self and one's behaviour. The review posits that shame and guilt have different focus of evaluation and varying degree of intensity. Shame is recognised to be more intense than guilt and the focus is predominantly on the disablement of the self. Conversely, guilt is primarily focused on behaviour and motivates reparative actions, whereby keeping the self intact. Where the consequence of shame is the need to hide, escape or withdraw, guilt motivates the need to confess and apologise for one's identified wrongdoings.

Table 1: Similarities of and differences between guilt and shame, from Tangney and Dearing (2003, p. 25).

Similarities of guilt and shame		
FOCUS	GUILT	SHAME
Experiences	Moral	Moral
Awareness	Self-conscious experiences	Self-conscious experiences
Valance	Negative	Negative
Attribution	Internal	Internal
Context	Interpersonal	Interpersonal
Events	Negative, similar to shame	Negative, similar to guilt
Differences between guilt and shame		
FOCUS	GUILT	SHAME
Evaluation	Focus on behaviour	Focus on the self (on what I did)
Degree of distress	Less painful than shame	More painful than guilt
Self-experience	Tension, regret, remorse	Shrinking, feeling worthless, small, powerless
Operation of self	Unified self-intact	Split self: observing and observed
	Self-unimpaired by global	

Impact on self	devaluation	Self-impaired by global devaluation
Concern about the other	One's effect on others	Others' evaluation on self
Counterfactual processes	Mentally undoing some aspect of behaviour	Mentally undoing some aspect of the self
Motivational features	Desire to confess, apologise, repair	Desire to hide, escape, strike back

To support this proposed differences between shame and guilt, Tangney and Dearing (2003) examined shame and guilt response among 245 American undergraduate students. They found that participants rated shame experiences as more difficult and painful to process, resulting in feelings of inferiority, self-depletion, self-insignificance and kindling the desire to hide rather than make reparative actions. The study concluded that shame promotes concealment whilst guilt promotes reparative action. A broad tendency of this claim is the attribution of guilt to higher moral status and relevance in comparison to shame. A major criticism of this study is that it is correlational in nature and thus cannot directly address the causal links between shame-proneness and psychological maladjustment.

2.7 Challenging the assumptions of the dominant models of shame and guilt

The above report which is very dominant in the literature evidence the complexity of shame and guilt. The debates concerning the distinction between shame and guilt have influenced the field of psychology and psychiatry. These assumptions reflect a view of self that is bounded, separate from others, and defined by stable personal characteristics, or what Markus & Kitayama (1991) refer to as independent self-construct. Likewise, these dominant models of shame and guilt assume that being negatively evaluated by others or by oneself is bad and should be actively avoided. The assumption is context dependent i.e. some countries (e.g. Japan, china) pride internal and external self-evaluation than others (Markus & Kitayama, 1999).

Also, given that a significant body of research (e.g. Tangney & Dearing, 2003) comes from the United States, a context that is known to promote an independent view of self (Markus & Kitayama, 1999; Trandis, 1995), the generalisability of these models of shame and guilt will be limited. Thus the discourse of shame and guilt in relation to self-construct may differ in

other cultures that hold different views of self (i.e. collectivistic countries such as China) (Mesquita & Karasawa, 2004; Camras & Fatani, 2004; Kitayama, Markus & Matsumoto, 1995). For example, in countries like Japan where the view of self is dependent on its connection with others (Markus & Kitayama, 1999), external influences such as others' thoughts and feelings are as important and meaningful as internal ones (i.e. one's own thoughts and feelings). Notwithstanding, one must not omit the nature of individuality regardless of global culture; for example, it will be unjust to assume that everyone in England would subscribe to a self-dependent approach. The self is contextual and situational changes in the concept of self should be taken into consideration (Kondo, 1990; Madill, Jordan & Shirley, 2000). The next section will explore literature that has studied guilt and shame in relations to ED psychopathologies.

2.8 ED, guilt and shame

In recent years, more and more researchers are beginning to capitalise on the role of shame and guilt in ED. Some have speculated that shame and guilt are what distinguish ED from other mental disorders and others have argued for shame and guilt as causes and/or perpetuating factors in the course of ED. The majority of these studies are quantitative and are presented below.

An early study of shame and guilt conducted by American researcher Frank (1991) found that shame and guilt in relation to eating are distinguishing features of AN and BN. Participants with ED (student population, n=94) presented with higher shame and guilt than participants affected by depression. The study concluded that it is possible that shame and guilt differentiate ED from depression and other psychopathology.

An Australian study by Burney and Irwin (2000) found that shame associated with an ED was the strongest predictor of the severity of the ED in a non-clinical community sample of 97 females. The findings further support Frank (1991) that reported that shame and guilt focused on eating are germane to eating disturbance. They added that people with ED condemn both ED behaviour (which Frank referred to as 'guilt processes) and their own inadequacy in this regard (shame). A major criticism of both studies is the explanation by which association is justified based on a correlation design. Considering that the literature demonstrates the close similarities and the difficulty distinguishing the two phenomena, it is likely that the measures that are used in this study assume that participants understand and

are able to differentiate between shame and guilt experiences. Likewise, the audience is not provided with a sense of what aspect of self or eating constitutes shame and guilt. These methodological issues raise concerns about the validity of these findings, as they do not allow for elaboration on such statements. Similarly, as quantitative studies propose generalisability, it should be noted that these studies used samples that are predominantly females, and people with no formal diagnosis of ED. This thus restricts the wider conclusions that can be drawn from these studies.

A German study by Grabhorn et al. (2005) indicated higher internalised shame scores in people with AN in comparison to those who suffer anxiety and depression. The authors also found that shame was related to perfectionism, performance anxiety as well as low self-esteem. Unlike the studies above, this research used clinical samples and expatiated on aspects of personality that link shame to ED symptoms. Nonetheless, the correlational design and cultural context of the study limits the wider conclusions that can be drawn from the study.

In BED population, American authors Jembekar, Masheb and Grillo (2002) examined the relationship between trait shame (Cook, 1994) and depression whilst also controlling for low self-esteem. The authors found a positive correlation between shame and attitudinal features of BED. In BN, Hayaki, Friedman and Brownell (2004) carried out two studies that explored the relationship between shame and bulimic symptoms in clinical and non-clinical populations consisting of 147 American undergraduate students. The outcome of their study revealed shame as significantly and positively correlating with bulimic symptoms in the clinical population. In the non-clinical population shame also positively correlated with higher levels of bulimic symptoms when controlling for depression and guilt. However, the result was inconclusive in terms of levels of shame when controlling for guilt and depression. This result could account for methodological deficiency relating to measures that were employed to account for shame. First, the diagnostic composition of the ED sample is unclear. It is unknown what proportion of the clinical sample exhibited a full-blown manifestation of the disorder. The classification of individuals in the clinical sample as person with bulimia and someone without bulimia was based solely on questionnaire measure. As such, conclusions regarding the role of shame in symptoms of clinical BN may be inaccurate. Likewise, British researchers Waller, Ohanian and Osman (2000) carried out a comparative quantitative study among 50 individuals who reported bulimic symptoms and a control group. They found a

positive relationship between shame and bulimic symptoms: shame mediated the severity of the purging and vomiting.

Potentially more instructive for the issue of aetiology in the aforementioned studies is the possibility that shame might be implicated in people with ED's perception of their bodies. Typically, individuals with AN have such a high emotional investment in achieving a thin body that they fail to recognise the severity of their emaciation (Fairburn, 2008). In this unrelenting pursuit of thinness, a disturbance of body image is a core feature (Williamson, Barker & Norris, 1993). In observing that shame was one of the predominant affect in their clinical sample of patients with AN, Casper, Offer, and Ostrov (1981) argue that feelings of shame about the perceived shape and size of the body inspire the pursuit of a thin body. A more direct investigation of the issue was undertaken by American researchers Sanftner Barlow, Marschall, and Tangney (1995); using non-clinical sample of undergraduate women, the researchers found that shame-proneness was positively related to the severity of a wide range of eating disturbances (including body dissatisfaction), whereas guilt proneness tended to be negatively and less strongly related to the severity of such symptoms.

The finding that shame has greater predictive value than guilt confirmed the general expectation expounded earlier in this review. Perhaps less expected was the observation of eating behaviours' negative correlations with guilt. Sanftner et al. (1995) suggested the latter findings might stem from the fact that guilt tends to motivate reparation. That is, if guilt-prone people are inclined to resolve their conflicts through reparative action they will not develop psychopathology, and to this end, guilt-proneness is actually a protection against ED symptomatology.

It is important to closely examine the statistical figures and their meaning in this study. For example, the reported correlations for shame and for guilt, while statistically significant, were not high (most were below 0.3). Generally, the larger the effect size, the greater is the impact of an intervention. Jacob Cohen has written on this topic; he suggested, a little ambiguously, that a correlation of 0.5 is large and between 0.1 and 0.3 is small (Cohen, 1988; 2011). Thus one might hold that the effect sizes are not particularly encouraging for the view that self-conscious affects play a pivotal role in eating-disordered behaviour.

A potential limitation of the study by Sanftner et al. (1995) is the measure used to index proneness to shame and guilt. The Test of Self-Conscious Affect (TOSCA) (Tangney, Wagner & Gramzow, 1989) provides a global assessment of proneness to self-conscious affects in everyday life and does not focus exclusively on shame and guilt associated with eating, dieting, purging, body image, or other facets of eating disturbance. Consequently, a more recent investigation (Burney & Irwin, 2000) failed to replicate the report by Sanftner et al. (1995) of a negative relationship between guilt and ED symptomatology.

In a self-report study of female American undergraduates, Bybee, Zigler, Berliner, and Merisca (1996) found eating disturbances were positively related to guilt over eating and exercise ($r = 0.56$), but were unrelated to a global proneness to guilt. Although Bybee et al. did not assess aspects of shame; their findings also lent support to the assumption by Frank (1991) that investigation of the self-conscious affects underlying ED should take account of distinctions between proneness to these affects in a global sense and proneness to the affects specifically in eating related contexts.

Another study by Andrews (1997) signalled the potential role of yet another facet of shame. In a community sample of young women, bulimic symptoms were significantly associated with a sense of shame about one's body. A quantitative study by American authors Stice and Shaw (1994) collected reports from 236 undergraduate students on media exposure and measured whether the level of media exposure impact ED symptomatology. The authors suggested that a major source of bodily shame among women with bulimia was media's promotion of the 'thin ideal' body image in women.

2.9 The interrelationship between shame and Pride

So far, shame has been seen as a cause, consequence and maintenance of ED. Goss and Gilbert (2002) proposed a shame-shame model of binge eating. The authors stated that factors such as biology, personal and sociocultural can predispose people to experience external shame and people with BED use binge behaviours as an attempt to norm shame, especially in interpersonal contexts. The authors further noted that a sense of secrecy which characterises shame may lead to greater sense of shame particularly as bingeing attempt to escape shame is incapable of doing so or addressing underlying interpersonal difficulties. Likewise, the authors recognise that pride can serve compensatory functions for issues discussed above.

Pride is opposite to shame as it involves positive appraisal of one's attributes that are approved and admired by others (Mascolo & Fischer, 1995). Gilbert (2002) proposes that pride may serve as coping strategy for shame experience that was initiated as a result of socio-cultural factors. An indication is the widely acknowledged appreciation for dieting in modern culture, where restricting food is likened to control and success (Casper, Offer & Ostrov, 1981; Markham, Thompson & Bowling, 2005; Masheb et al., 1999; Stice & Shaw, 1994).

A shame-pride model was proposed by Goss and Gilbert (2002) as a self-perpetuating mechanism in ED. The model suggests various background factors; for example, biological, personal and socio-cultural that can lead to external shame and influence internal shame (Gilbert, 2002). The authors hypothesised that shame relating to body weight could lead to dietary control and restrictions (e.g. AN symptoms). Successful mastery of restricting and control behaviours evokes a sense of pride. Likewise, the actual attempts to control diet evoke experiences of pride. The authors believe that this process leads to a self-perpetuating cycle that may lead to shame should the individual begin to eat again especially at times of recovery, where it may be viewed that others are trying to gain control, leading to shame response. Goss and Gilbert (2002) concluded that both pride and shame play a crucial role in the maintenance of ED. In addition, individual may feel that they will lose the sense of pride and positive compliments gained via restricting and control should they begin to lose the ED behaviours. Therefore ED behaviours could serve the function of reducing shame with consequences leading to pride. Undoubtedly, this has significant implications for treatment and its cost to physical wellness. Wallace (1986) illustrated this with the tragic story of Gibbens twins whose ED served as a means to secure power by using ED behaviours as competitive tools.

2.10 A review of qualitative studies linking shame and guilt to ED

Most of the evidence base for the link between ED, shame and guilt comes from quantitative research. In this context, participants can only comment on the structured questionnaires that they are asked to respond to. Likewise, the quantitative measures that are used vary in their conceptualisation of both phenomena with some representing guilt as more adaptive and some failing to provide a clear distinction between the two. Furthermore, generalisability and

strong truth claims of these studies are limited in light of the methodological limitations highlighted above.

Upon researching this area, I was only able to identify two significant qualitative studies evaluating the experience of shame and guilt in ED. None of the studies were conducted in Britain; both were conducted in Norway.

The first study was by Skarderud (2007) who interviewed women with AN (n=13). Using qualitative text analysis, the dialogue with participants led to the identification of types and sub-types of shame which related to the symptoms and meanings of AN e.g. globalized internal shame, which denote a general sense of shame of being who one is; focuses of shame, which were divided into several categories and subcategories: feelings and cognitions (greed, envy, sadness, grandiosity, rage); failure to achieve, body shame (appearance, body function), self-control and self-destructive behaviours (self-control, self-mutilation, self-destruction), shame related to sexual abuse (being made to feel inferior, shame about not resisting) and, finally, shame about having an ED (the problem of eating, the self-accusation of vanity, social stigma).

The author also explored the experiences of pride as the opposite of shame. Prideful feelings fell into the following categories: self-control, being extraordinary, appearance, rebellion and protest. A shame-shame cycle and a shame-pride cycle as proposed by Goss and Gilbert (2002) were presented and described as self-perpetuating mechanisms in AN. The author also illuminated 'silence' as a shame countenance that challenges the therapeutic relationship and health promoting dialogue; 'shame represents withdrawal, sabotages dialogue and has the potential to make the therapist feel shut out' (p. 95). An implication for clinicians is to be aware of the deeper understanding of shame and its potential influence on the therapeutic relationship with the patient (Skarderud, 2007).

The second study identified focused on the meaning of shame and guilt from the perspective of eight mothers who had ED using content analysis (Rosveit, Astrom & Severinson, 2010). The authors found that shame and guilt are powerful phenomena that originate from ED and are lived in silence, thus, they also serve as consequences of the ED. Mothers in the study described overwhelming feelings of self-disgust, humiliation and body hatred when they shared their understanding of shame in relations to their ED. They talked about feeling guilty

about the impact of their ED on their children. Both shame and guilt were found to be maladaptive and related to self-judgments. The mothers in the study talked about cognitive aspect of shame and guilt when they shared the feeling of responsibility for their illness and the impact of their illness on loved ones, particularly their children.

Undoubtedly, there is an appreciation for the few qualitative studies in the area. However, considering the complexity of shame and guilt and the complex relationship of both experiences in ED, little is known about how people suffering from ED experience these phenomena. Both studies have used exploratory means to analyse the information, therefore, a more in-depth methodological approach would be appropriate to gain a richer and nuanced picture of the individual's discourse. Additionally, Skarderud's (2007) study appeared to have focused specifically on classifying shame, although the author mentioned that participants found it difficult to differentiate between shame and guilt despite the interview being about shame and pride, this relationship was omitted in the analysis. Finally, interviews from both studies were not conducted in English and thus had gone through the process of translation making the findings susceptible to loss of meaning. Equally, considering the cultural context of self-conscious experiences, the wider application of the findings may therefore be restricted. This highlights the need for a more thorough and in-depth exploration of the topic.

Likewise, empirical research has suggested that people who have had treatment for ED still experience shame and guilt in relation to ED symptoms. However, no qualitative research has explored the role of shame and guilt in treatment and disclosure. This stance is important for the rationale of the present study. Before going into this, I will explore literature that has linked shame and guilt to treatment and recovery of ED.

2.11 The role of shame and guilt in treatment and disclosure

It is very common for people with mental health difficulties to be stigmatised (Hamre, Dahl & Malt, 1994). Cumulated with this is the active promotion of self-autonomy in the field of health (Beckett & Davison, 2005). The implicit message is that we are responsible for our health and this message is delivered through widespread health promotion advice such as those guidelines on specificity of food intake, classification of good or bad food, proliferation of exercise guidelines etc. (Frich, Malterud & Fugelli, 2007). Research suggests that diagnosis of conditions such as lung cancer and ED are socially perceived as a lack of self-management

or self-control in the individual. Such diagnosis are said to evoke shame and guilt (Richards, Reid & Watts, 2003; Chapple, Ziebland & Mcpherson, 2004). This may lead people to interpret their conditions as self-inflicted (Horton-Salway, 2004).

Specifically, many studies have found that ED population is more stigmatised than other categories of mental health (Holmes & River, 1998). Roehig, Carmen, and Mclean (2009) assessed stigma towards people with ED and depression among American participants. The study found that attitudes toward individuals with ED are significantly more stigmatising than attitudes toward individuals with depression. Additionally, individuals with ED were rated as more fragile, more responsible for their illness, and more likely to use their illness to gain attention than other individuals (ibid, 2009). Similar findings were reported by Stewart, Keel and Schivano (2006); respondents in their study commented that people with ED could 'pull themselves together' and only 'have themselves to blame. Indeed, some believe that AN is a form of attention seeking and that bulimic symptoms are 'willfully performed behaviour' (p. 104).

There is sufficient evidence in literature regarding the difficulty that people with ED face in terms of openly and honestly expressing their feelings and experiences particularly in relations to eating behaviours as well as the additional impact of shame and guilt processes (e.g. Brown et al., 1999; Vitousek, Daly & Heiser, 1991; Gilbert & Goss, 2002). From professional and personal experience, I can say that this disclosure is a necessary component of therapeutic engagement. Goffman (1990) wrote about stigma and within his work he highlighted that people with potentially discrediting conditions make active efforts to preserve their identity and dignity by controlling information about the stigmatising attributes of their illness. A vital aspect of shame and guilt is the wish to hide perceived flawed self or behavior. It seems likely that if a person has the propensity to experience shame and guilt about an aspect of themselves or action committed, they might also struggle to disclose information that elicit shame and guilt (Andrew & Hunter, 1997).

Swan and Andrews (2003) examined ED, disclosure, depression, and different aspects of shame in a group of women who have had treatment for ED (n=68) and compared them to a non-clinical group (n=72). Their result showed that the women with ED as well as those who had recovered scored higher across areas of shame than the control group. The areas of shame included in the investigation were: bodily characteristics, non-physical characteristics,

general behaviour and eating behaviour. It is also interesting to note that forty-two percent of the women with ED reported non-disclosure about themselves or their ED behaviour during treatment. These findings suggest that 'non-disclosure in treatment was most common around eating behaviours and other ED symptoms', and therapists need to directly address issues related to shame in therapy (Swan and Andrews 2003, p. 375). The findings also identified that people who have recovered from ED reported higher levels of character shame, body shame and shame around eating. People who still presented with symptoms of ED also match people who have recovered from ED on levels of shame. The findings supports Zerbe (1995) who proposed that non-disclosure could be due to participants' experience of shame. The findings therefore concluded that shame is long-lived and resistant to change post treatment from ED.

It can be argued that if people who have had treatment for ED experience higher levels of shame post treatment, these experiences may put them at risk of relapse or risks of depression (Andrews, 1997). Perhaps, this explained the aforementioned higher rates of relapse and poor treatment outcomes in ED population that has been highlighted in the literature review and why ED are often referred to as conditions that are difficult to treat (Fairburn, 2008). This notion is very crucial for designing effective treatment especially in areas of case formulations and case conceptualisations which inform individual intervention plan. None of the studies on disclosure have looked at implication of guilt despite empirical findings relating guilt to ED symptoms and behaviours.

Currently, the gold standard treatment, i.e. CBT does not primarily address shame or guilt: rather they are primarily aimed at addressing the meaning of size and shape to the ED patient (Goss & Allan, 2009). Additionally, the process of therapy itself can feel like a shameful endeavour with focus on flawed self (Tangney and Dearing, 2002). Guilt is also a main feature in therapy. Dryden (1994) talked about client feeling guilty for taking up therapist's time and feeling responsible for others who could take their place in therapy. If these experiences are not recognised or explored in therapy, this could significantly impact on therapy process. Lindsay-Hartz et al. (1995) have warned that shame is a crucial factor when considering patients' motivation to commit to making changes. The authors further suggest that if experiences of shame are not sensitively addressed in therapy, this may lead to clients withdrawing from treatment. Therefore, it is pertinent to know how shame as well as guilt impact treatment and disclosure in treatment.

The only study (Swan & Andrews, 2003) that has directly explored the impact of shame in ED treatment and disclosure is quantitatively based and thus provides a limited scope for the understanding of the ED and shame phenomenon. The aim of this project is to fill the gap in literature by gaining in-depth understanding of the phenomenon of shame, guilt and ED from perspectives of those that have had treatment for the illness and gain an understanding of how shame and guilt impact on treatment and disclosure in treatment.

2.12 Conclusion

The review has highlighted contradictions and controversies surrounding literature on shame and guilt from differing theoretical perspectives (e.g. Bybee, 1998; Tangney & Fischer, 1995; Wallbott & Scherer, 1995; Barrett, 1995; Harder, 1993; Lindsay-Hartz, DeRivera & Mascolo, 1995). Achieving a precise, agreed-upon definition and distinction of shame and guilt is an ongoing challenge for psychologists and researchers. That said, the review indicated that both shame and guilt share interpersonal affective features; shame embodies a profound concern over public disapproval accounted by negative self-judgments and guilt typically follows an appraisal of a behaviour as bad (Baumeister, Stillwell & Heatherton, 1994; Rawls, 1971). All of these suggest that shame and guilt are complex phenomena that significantly impact our psychosocial and interpersonal functioning.

Undoubtedly, the pieces of theoretical and research literature looking at the role of shame and guilt in ED have put forward a convincing assertion that shame and guilt are poignant features in the psychopathology and symptomatology of the ED. However, despite the complex relationship between the two, (Gehm & Scherer, 1988; Lewis, 1971; Tangney, 1995; Tangney et al, 1996), more studies have explored the role of shame in ED than the role of guilt. Literature focusing on treatment of ED has identified the presence of shame experiences in ED. Shame has been argued to play a role in the aetiology and maintenance of the illness. Most importantly, research has found that shame associated with ED is the strongest predictor of ED severity (Brown, Russell & Thornton, 1999; Swan & Andrew, 2003). Also, guilt has been linked to ED behaviours and negative evaluation of self (Cologero & Pina, 2011). Likewise, studies have shown that ED behaviours may be used to manage negative experiences such as shame and guilt leading to increase or severity of shame and guilt and severity of ED symptoms (DeSilva, 1995; Sanftner & Crowther, 1998; Burney & Irwin, 2000; Frank 1991).

Gender differences have also been explored and research in this area has reported similar levels of shame in both men and women (Jambekar et al., 2003).

An attempt to explain the complexity of shame and guilt in ED has led to the breaking down of different facets of the two phenomena rather than a holistic explanation of what they represent and how they are experienced. A thorough understanding of shame and guilt and how people who have eating difficulties experience these two complex phenomena will no doubt benefit clinical judgment and treatment approach (Pettersen & Rosenvinge, 2003).

Shame has been found to correlate with anger and lead to the need to hide symptoms and even withdrawal (Goss & Allan, 2009). These features have been recognised in ED literature looking at ambivalence in treatment. Participants in a study that looked at patients' experience of recovery alluded to not admitting to the illness for the first five years due to experience of shame and guilt (Federici & Kaplan, 2008). Thus unspoken or unrevealed shame and guilt may disrupt treatment progress, underscore client's resources, and limit their agency in therapy (Rennie, 2004). Tangney and Dearing (2003) expressed that shame has a toxic effect when it is not spoken about. A study exploring mothers' experience of shame and guilt in relations to ED (Rortveit et al., 2010) found that silently suffering from shame features, like self-focusing, intensify shame experience.

Furthermore, it is important that counselling psychologists and other professionals working in the field of ED have a good understanding of the intertwined relationship between shame and guilt as well as possible differences in their mutually exclusive relationships to psychological symptoms so that suitable and appropriate intervention can be tailored to meet individual client's needs (Webb et al., 2007). Shame and guilt experiences may also be present in client's verbal and non-verbal cues, it is important for therapist to be aware of this (Tangney and Fisher, 1995). This indeed has serious implications for clinical practice particularly in relation to treatment and disclosure. For example, client may withhold information about their symptoms, which may lead to inaccurate formulation and choice of intervention offered. Furthermore, shame and guilt may also lead client to disengage from accessing and/or committing to treatment.

2.13 Towards a richer methodology

One of the major problems highlighted in the study of guilt and shame relatedness to ED concern assessment tools and conflicting conceptualisation of shame and guilt as operationalised by these tools. Empirical studies have erred methodologically in attempts to conceptualise an understanding of both affective states, leading to heated debates on the nature of both phenomena. A common flaw in quantitative research studies is in the use of rating measures that comprise of adjectives associated with both shame and guilt (Lindzey-Hartz, 1984; Tangney, 1990) and the content of retrospective description of experiences of shame and guilt (Lynd, 1958; Wicker, Payne & Morgan, 1983).

Likewise, the majority of studies reviewed have relied on student populations and non-clinical samples where participants may possess low levels of diagnosable ED making it difficult to relate findings to actual ED populations. Although Flett, Vredenburg and Krames (1997) argued that psychological symptoms may be similar between these two groups, the frequency, strength and range of symptoms are likely to be higher in clinical groups, therefore invalidating conclusions drawn from such studies. Additionally, the use of self-report measure could have been confounded by factors such as memory recall and social desirability. The complex relationship between shame and guilt and their phasic role in ED, particularly the possibility that they are associated with different facets of ED suggest the need for qualitative enquiry as most quantitative studies ask participants to give global responses to standardised psychometric questionnaires (Denzin & Lincoln, 2011). Furthermore, the phenomenological experience of shame and guilt could be situational and phasic rather than continuous. Studies like Sanftner and Crowther (1998) suggest that shame and guilt experiences are not permanent affect. This indicates that shame may be more difficult to detect through the use of generalised and standardised rating scales.

2.14 Aims and rationale for the present study: originality and distinctive contribution to knowledge

From a critical perspective, a thorough understanding and appreciation of shame and guilt, their interwoven relationship, and their differences is needed. The above review is supported by the systematic review published by the researcher (Oluyori, 2013) highlighting methodological weaknesses within many studies exploring the role of shame and guilt in ED. The over-dependence on self-report data and non-clinical populations provide little depth and

understanding on this topic. Encouraging studies by Skarderud (2007) and Rortveit et al. (2010) offer some qualitative evidence. However, to date no in-depth research has been published concerning the experience of shame and guilt in ED population as well as their role in treatment and disclosure.

As a counselling psychologist in training, the ethos of my profession is that a more holistic view of a problem should be adopted in order to better understand it. This research study corresponds with this ethos in its endeavour to better understand participants' overall experiences of shame and guilt, in order to make their treatment as effective as possible.

My aspiration in carrying out this study is to explore in depth, the experience and sense making of shame and guilt in people who have had treatment for ED. It also aims to gain understanding of the implications of shame and guilt affects on treatment and disclosures in treatment. It is hoped that this study will shed more light into the mystery surrounding ED, in particular that an understanding of this will help contribute to treatment efficacy and help improve treatment outcomes.

Qualitative methodology is the most adequate choice to understand the nuances and complexity of shame and guilt experiences in ED. This type of methodology is designed to capture the individual's lived experience and meaning making in relation to this phenomenon. The following research question was captured through the use of semi-structured, one-to-one interviews that Kvale (2009) suggested as a means of eliciting critical responses that are deeply rooted in a person's lived phenomenon.

2.15 Research question

- How do people who have undergone treatment for ED describe their experience of shame and guilt?

The research methodology and rationale for the method chosen as well as the research questions will be discussed extensively in chapter three.

2.16 Chapter Summary

I have outlined above the rationale for the present study. I have provided a full background to the research project, including a critical review of relevant research that has endeavoured to explore and understand shame, guilt and ED. Literature relating shame and guilt to treatment and disclosures in treatment has also been reviewed. I presented the rationale for the present study and its relationship to my professional practice. In the following chapter, I will discuss in great depth the methodology of the study, including the rationale for the methodology chosen and the philosophical underpinnings of this research method. Thereafter, I will provide an explanation of research design and data analysis procedures. Finally, I will provide a detailed reflection on the researcher's relationship to the topic.

Chapter 3

*How much simpler to let things do only what they can do
Being uncreative about what seems dark and terrifying;
Preferring only what seems easy and effortless;
Asking about the number of a philosophy's followers;
Rather than examining the efficacy of its ideas
Okri (1999, p.59)*

3.1 Introduction

This thesis explores and interprets the experience of shame and guilt in people who have had treatment for ED, and the impact of these affects on treatment process, including disclosure in treatment. This chapter describes the methodological framework used in the study. It commences by describing methodological considerations and thereafter explains the rationale for the chosen methodology (IPA) through the lens of its philosophical underpinnings. Following this, I reflect on the research design and method of data collection. Finally, explanations of the qualitative data gathered using the chosen methodological approach and ethical considerations are presented.

3.2 Methodology

Archer (1995) defines research as a search for knowledge that involves a systematic enquiry. Cross (1995) extended this definition, highlighting that research design involves three stages; 'development, articulation and communication of the research design' (p. 5). The purpose of this section is therefore to elucidate the processes involved in the development of this research and its design and give a brief justification for the chosen methodology.

Crotty (1998) in his book *The Foundations of Social Research: Meaning and Perspective in the Research Process*, asserts that research evolves from 'a real life issue that needs to be addressed, a problem that needs to be resolved, a question that needs to be answered' (p. 13). It seems appropriate therefore to begin this section with reflexivity, by tracing the starting point of this research journey.

3.3 Reflexivity

The concept of reflexivity and the ways in which 'our subjectivity becomes entangled in the lives of others' (Denzin, 1997 p. 27) are prominent issues of concern for psychologists and researchers (McLeod, 2001; Etherington, 2004). The concept arises through the recognition of the integral relationship between the researcher and the researched (Yardley, 2008). In quantitative research, 'objective' facts are sought through the use of methodology, which attempts to keep the researcher out of the loop for the fear of contaminating the search for truth (Hayes, 1997). Gaventa and Cornwell (2001) recognise that in doing so, reality is distorted because it is impossible to exclude oneself from the field of inquiry. Giorgi (1994) stated, 'Nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather how the subject is present is what matters, and objectivity itself is an achievement of subjectivity' (p. 205).

Feminist, postmodern, post-structural, hermeneutic, interpretive, and critical discourses recognise that knowledge and understanding are contextually and historically grounded, as well as linguistically constituted. Denzin (1994, p. 503) points out that, '[r]epresentation ... is always self-presentation ... the other's presence is directly connected to the writer's self-presence in the text'. I echo these bold statements; this research has been conducted whilst fulfilling my role as a trainee counselling psychologist. Within this role, the practice of reflexivity is equally at the core of my professional practice and personal development. Part of my role as a therapist is the pursuit of depth in my therapeutic encounters by paying attention to my own subjectivity in relation to therapeutic engagement with clients. I hope to cultivate this attitude throughout the process of this research.

One way of engaging with this process is by acknowledging what Gadamer (2004) refers to as 'pre-understanding'. This notion refers to the knowledge and ideas that we bring into a new encounter. What I admire about Gadamer's contribution is the appreciation for the researcher's pre-understanding as something that gives us access to the world in order to have a better view of the world. Gadamer stated that we must look beyond it, but not look away from it. Finlay (2008) argues that the researcher needs to bring 'critical awareness of their own subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process and findings' (p.78). Colaizzi (1973) advised

that the researcher's self-reflection is one of the most important processes in separating out what beliefs belong to the researcher rather than the people researched.

It can be said that social researchers have accepted reflexivity as a way of acknowledging and looking beyond one's pre-understanding in order to achieve richer meanings from encounters. For example, researchers are increasingly becoming more accustomed to recognising the interpretation of data as a reflexive activity through which meanings are made rather than found (Mauthner et al., 1998). More so that it has become a tool to ascertain fundamental ethical standard of research validity (i.e. trustworthiness). Indeed, Ely et al. (1990) asserted that 'doing qualitative research is by nature a reflective and recursive process' (p. 179). Cresswell (2007) and Etherington (2004) write about the researcher's capacity to acknowledge how their experiences, values, and sociocultural context inform the research process and outcome.

As I write this chapter, I work as a trainee counselling psychologist at an ED service. I have been particularly inspired by the therapeutic treatment approach of compassion-focused therapy that acknowledges the presence of shame and guilt in ED. Although I had developed my research question before I started this placement, I have attempted to bear in mind that this experience could influence my interview data. It was important that I stayed open in my inquiry and contact with the data. Finlay (2006) advised on the importance of cultivating this open attitude to allow the opportunity to gain a fresh perspective in a research encounter. As such, I have kept a reflective journal throughout this process and also, my supervisor is aware of my 'insider status' with the research topic and as such questioned some of my unseen assumptions particularly at the research analysis and findings stages.

The process underlying the present study comprises a circle of mediating, searching for new knowledge and understanding and using this creatively to co-construct new meaning (Gadamer, 2004). My reflection is not only an attempt to identify my presuppositions, and my positioning within the study, but also serves to discuss how these factors might have impacted the present study and how I have attempted to manage this in the research process (Kasket, 2012). I elaborate more on this in the subsequent sections. In the words of Shacklock and Smyth (1998 p. 6-7), the failure to acknowledge the interests implicit in a critical agenda for the research, or to assume value-free position of neutrality, is to assume 'an obscene and dishonest position' (ibid). Hopefully, these factors will not be the principal bases of my

opinion and perspectives; however, I am mindful that they will no doubt have an impact on my understanding of ED. Below I insert a segment from my research journal;

23rd March 2013

I was surprised to hear xxx (placement supervisor) discuss openly with colleagues an issue about her body and weight. It freed me on the inside, and I felt more at ease with some of my own thoughts about my weight, although I was very self-conscious about joining the discussion, it felt freeing that people in the field shared some of my own thoughts and feelings.

3.4 Method

I have chosen to adopt IPA as the methodology of choice in this present study and I will extensively explore the reasons for this choice. Crotty (1998) suggests two questions that should guide a researcher at the initial phase of their research; one is about how the researcher will answer their research question in terms of proposed methodology and the other focuses on justification for the researcher's decision. Kvale and Brinkman used the metaphor of a traveller to describe the role of a researcher as thus:

'the interviewer-traveller wanders through the landscape and enters into the conversations with people he or she encounters. The traveller explores the main domains of the country, as unknown terrain or with maps, roaming freely around the territory' (Kvale & Brinkman, 2009 p. 48).

This metaphor signifies that there are a number of stories or 'truths' to be collected and retold rather than an absolute truth to be discovered. This stance mirrors my own beliefs and to some extent explains my rejection of quantitative method for the present study. I elucidate this further below.

3.4.1 Choosing between quantitative and qualitative methods

From the early nineteenth century, psychologists and researchers have associated with quantitative measurement and identification of psychological variables with statistical

research methods (Murray & Chamberlain, 1999). This empirical approach has taken credit for the successes of modern medicine because of its close association with the biomedical model (Lyons & Chamberlin, 2006). Quantitative approaches are associated with positivism which holds that a meaningful reality exists independently of consciousness and experience (Marsh & Furlong, 2002; Ponterotto, 2005), that entities carry intrinsic meaning within them as objects and that we can discover this 'objective truth' if we carefully go about it in the right way (Morrow, 2005). Positivist adopt 'foundationalism ontology' (Marsh & Furlong, 2002) that believes that there is a real world that is independent of our knowledge and life is built upon this foundation (Gergen, 1992). Epistemologically, this position seeks to explain behaviour and not meaning (McLeod, 2001). However, Crotty (1998) credits quantitative method for its unambiguity. Harts (1998) and Flyvbjerg (2001; 2006) advised that researchers need to move away from paradigm wars and that differing traditions need to be appreciated for what they are rather than their voids. The positivist movement has contributed immensely to the understanding of ED and this has served as a foundation for the present study as reflected in the literature review. Likewise, quantitative research has trail-blazed development of evidence-based treatment interventions. This approach also deserves credit for identifying and bringing to light shame and guilt as central tenets in ED.

However, my rejection of this approach for the present study stemmed in part from pragmatic reasons- the search for a new way of seeking knowledge by exploring lived experience, which readily fits with qualitative paradigm. Pragmatism focuses on what works and celebrates practice over theory (Patton, 1990). When thinking about research, pragmatism translates to the adoption of the most appropriate method of enquiry for a research question, and makes it a pertinent tactic for mixed-method researchers (Cresswell, 2007). My research interest stems from lived experiences and a desire to seek meaning and understanding within a pre-existing field of interest. I am particularly driven to 'give voice' to a phenomenon by listening to the meaning that individuals ascribe to their experiences. This impulse does not accord with quantitative methodology. My main interest was to co-construct rich pictures of people's experiences, to illuminate what currently appears to be a grey area as highlighted in my literature review and the commitment to add to existing knowledge by providing such rich pictures.

3.4.2 Rationale for methodology: The value of qualitative research

The value of qualitative research in ED has been identified by many authors (e.g. Hepworth 1994). ED are complex phenomena that have warranted an integrative epidemiological understanding from psychological, biological and social perspectives. In this way, new research calls for a different type of research question (Colton & Pitstang, 2004). There is now a need to move away from comparing groups and categorising different ED behaviours to seeking meanings associated with different facets of the illness, a task that cannot easily be accomplished via quantitative method.

The limitations of quantitative research also have implications in practice. I have highlighted in the literature review the limitations of the use of quantitative research for hypothesis testing as reflected in questionnaire research as a means to understand lived experiences of participants (Yardley, 2000). The complexity of ED is difficult to capture with methodologies that utilise structured reporting methods as participants can only comment upon what they are asked to respond to, which may impact outcome (Elliott, Fischer & Rennie, 1999). Qualitative approaches reject the use of predefined categories. This approach is useful when a topic of research is complex, novel or under-researched (Colton & Pistrang, 2004; Elliott & Timulak, 2005). The current study fulfils both of these requirements. This means that it will allow for the discovery of genuine possibility of unlimited and emergent descriptions rather than predicting an expected outcome, as is often the case in quantitative research.

With this in mind, and considering how the particular research question of this study may best be addressed, I decided to adopt a qualitative methodology. Such approaches have the advantage of allowing in-depth and detailed study of phenomena that are not easily quantifiable, for example seeking to understand experience of a phenomenon such as the present study. A further advantage was that such an approach allows for the emergence of unanticipated findings (Barker, Pistrang & Elliott, 2002).

3.4.3 Why not a different qualitative method?

Qualitative research includes a diverse range of approaches some of which have close similarities. The main purpose of all of them is to deepen our understanding of the phenomenon under investigation. However, they have each developed their own philosophical and methodological approaches (Elliot et al., 1999). Within this section, I

present a brief rationale for choosing IPA over three other types of qualitative analysis that I considered as possible alternatives: Grounded Theory, Discourse Analysis, and Narrative Analysis.

IPA was chosen over Grounded Theory because it is considered to be more of a sociological approach (Willig, 2003) that draws on convergences within a larger sample to support wider conceptual explanations. By contrast, IPA is more psychological; it is concerned with giving a more detailed and nuanced account of the personal experiences of a smaller sample (Smith et al., 2009), which was felt to be more in keep with the primary aims of the present study.

I decided against Discourse analysis due to its scepticism regarding accessibility of cognitions and increased focus on linguistic discourse particularly in terms of its function in construction of social reality. IPA instead is more psychological and concerns itself with cognitions and sense making and IPA also recognises that cognitions are not evidently available from verbal reports, there has to be a level of engagement with the analytic process in the hope of being able to say something about the sense and meaning making involved in such thinking and cognitions (Smith, Flowers & Osborn, 1997; Smith et al., 2009).

Narrative analysis was considered because it is also concerned with meaning making. However, narrative analysis only makes use of 'narrative' as the only way of making meaning whereby omitting other pathways such as discourses and metaphors. Consequently, it was felt that IPA could include consideration of narrative in making sense of participants' discourse, without being inhibited by this focus (Smith et al., 2009).

3.5 Interpretative Phenomenological Analysis (IPA)

IPA is an approach that has initially gained momentum within the field of health psychology; its utility has since been demonstrated within clinical and counselling psychology research (e.g. Rhodes & Jakes, 2000; Pearce, Clare & Pistrang, 2002). IPA has also been used to address other questions in ED research, such as Colton and Pistrang's (2004) study of experiences of inpatient treatment for anorexia nervosa, and Mulveen and Hepworth's (2006) study of participation in a pro-anorexia internet site.

The aim of this section is to explain why I believe IPA method is optimally appropriate qualitative approach in addressing the aims of the present study. The long history of IPA is deeply rooted in three philosophical and theoretical foundations, namely; phenomenology, hermeneutics and idiography. It is within these bedrocks that I aim to ground this section using each as a prism to elicit the values that IPA brings to the present study.

3.5.1 Phenomenology

Phenomenology is a philosophical discipline or movement that is concerned with the study of how experience is structured (Crotty, 1996). As a discipline, it has been central to the tradition of continental European philosophy throughout the 20th century (Ashworth, 2003). Experience within phenomenology refers to perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity (Giorgi & Giorgi, 2003). Many phenomenologists (e.g. Edmond Husserl, Martin Heidegger, Maurice Merleau-Ponty, Jean-Paul Sartre, et al.) have committed to how human consciousness and self-awareness can be studied from the perspective of the individual. Husserl (1859-1938) (sometimes referred to as the father of phenomenology) was interested in examining the 'particular' within human experience (Ashworth, 2003). The central structure of this examination is 'intentionality' (Smith et al., 2009). This refers to the directedness of experience toward things in the world, the property of consciousness that it is a consciousness of or about something. The core philosophical basis of Husserl's approach was that there is nothing more fundamental than experience. To this end, the philosopher defined experience as a 'system of interrelated meanings that are bound up in the totality of the 'life-world' (Husserl, 1901). These make up the content of a given experience, and are distinct from the things they present or mean.

In order to cultivate a phenomenological attitude, Husserl suggests that we need to 'bracket' any assumptions that we may hold in order to have a pure focus on the perception of the world that we encounter (Husserl, 1927). Bracketing will help us to free ourselves from prejudices and secure the purity of our detachment as observers, so that we can encounter 'things as they are in themselves' independently of any presuppositions (Crotty, 1996). Phenomenology was given an edge when a follower of Husserl, Heidegger, paid homage to his work in describing the many different ways in which we exist and encounter things. Heidegger studied and analysed the structures constitutive of things not only as they are encountered in the detached, theoretical attitude of consciousness, but also in day-to-day

living (Finlay, 2010). Furthermore, he identified the structures that are constitutive of the particular kind of being which he calls '*Dasein*' (Heidegger, 1962). Where Husserl was concerned primarily with psychological processes within an individual, Heidegger accounts for the full human being as one which is thrown into an already existing world and cannot be separated from people, language and culture that are external to it but integral components of it. Our inter-subjectivity and relatedness to the world forms an essential part of our being (Heidegger, 1962). For an IPA researcher, the keynote of Heidegger's concept is the importance of being immersed or thrown into a world of people, objects and relationships that are interconnected and change with time.

Another important note is that meaning making is involved as the person attempts to understand their being in relation to the world. This implies that meanings occur and are made sense of as a result of social interactions (Smith, 1996). Therefore the aim of IPA is to understand the participant's view of the world and associated cognitions in order to gain an insider's perspective of the phenomenon in question. With phenomenology as its basis, IPA explores in detail how participants have made sense of their experiences by examining the accounts of their experiences (Brocki & Warden, 2006).

3.5.2 Hermeneutics

Ricoeur (1981) defined hermeneutics as the science or art of interpretation. IPA's use of hermeneutics makes it the method of choice for the current study. Although it emerged as a distinct philosophical concept to phenomenology, Heidegger played a part in the convergence of the two concepts, therefore giving rise to 'hermeneutic phenomenology'. Smith and Osborn (2003) coined the term double hermeneutics, which refers to the researcher's attempt to make sense of the participant's attempt at making sense of his/her experience. This encounter is not limited to the data analysis phase; it is a dialogical process and method that surface during the interview phase of this research. According to IPA, the researcher is in a position to access deeper level of understanding that is beyond the author's awareness because of their theoretical knowledge (Smith et al., 2009). Schleiermacher (1998) posits that a researcher's careful analysis of a transcribed text could produce more insightful and comprehensive account than they are able to gather at the time of interview. This interpretative process (Smith et al., 2008) is due to the inter-subjective and the meta-perspectives that emerge from thorough observation and engagement with the data set. For Schleiermacher, language is

highly significant and texts are born out of the co-construction of the individual and social and cultural forces. Methodologically, IPA achieves this dynamic concept through the use of a hermeneutic circle that Schleiermacher asserts is only achievable and dependant through the interpreter's receptivity to the author's narrative (Wagstaff et al., 2014).

Heidegger's concept of *Dasein* (being in the world) places humanity in worldly context and forms the platform of this study. This simply implies that our consciousness is not separate from the world but socially constructed (Lavery, 2003). The key social construction that Heidegger postulates is the impact of our presumptions 'fore-structure or fore-conception' on the interpretation process (Heidegger, 1927; 1967). He advised that we bring our fore-understanding inevitably to the interpretive process. Likewise the hermeneutic engagement/hermeneutic circle is grounded in the idea that understanding evolves from an iterative process, which forms part of the hermeneutic circle. Smith and Osborn (2003) advised that we cannot understand the whole without looking at the part and we cannot fully understand the part without looking at the whole. IPA analysis therefore involves thorough reflection that does not follow a linear or sequential fashion, but that is iterative in nature, involving circling back and forth between presumption and new meaning.

Gadamer (2004) claimed that the researcher's pre-understanding is always taking shape throughout the research process. The hermeneutic circle described above within this study comprises of a circle of meditating, searching for new understanding and using it as a pre-understanding for the next interpretation. Ricoeur (1970) contributed to the hermeneutic concept by developing within it the ideological concept of suspicion and empathy. *Hermeneutics of suspicion* refers to interpretation of text through the use of psychological and theoretical concepts. *Hermeneutics of empathy* refers to interpretation of content as it was presented. Both are distinctively important in the art and science of meaning making. IPA advocates for both ideological standpoints. Inevitably, finding a balance between both is a difficult endeavour. Schleiermacher (1998) noted that hermeneutics of suspicion might project a power imbalance where the researcher may assume a superior understanding of what the participant conveyed.

I have attempted to balance both ideologies throughout the process of this research with my analysis rooted in hermeneutics of empathy. Engaging in a dialogue with the participants during the interview implied that as a researcher, I listened carefully and was able to

understand the participants' words. Additionally, during the interview phase, I was aware that my presuppositions might influence the dialogue (Holm, 2009). However, I attempted to remain open in the dialogue about the topic under investigation. As a result the first question asked participants of their broad understanding of shame and guilt. At the same time, I constantly tried to validate the meaning of the individual expressions articulated by each participant by using participants' quotes. These two interpretive positions are congruent with my own philosophical stance as a trainee counselling psychologist. The profession of counselling psychology has its philosophical root in humanistic values that is born out of empathic engagement with others as they describe their experience and reflecting these through the lens of a theoretical perspective (in this instance, humanistic theory) according to Rogers (1960). What IPA draws from Ricoeur (1970) is that interpretation strives towards enabling the participant to make sense of their experience (Smith, 2004).

My findings and discussion sections illuminate how I have situated the research within these standpoints. I moved through deeper levels of interpretation with main focus on the participants' texts (hermeneutics of empathy) to hermeneutics of suspicion or questioning; which is a critical engagement aided by theoretical perspectives 'in ways which participants might be unwilling or unable to reveal themselves' (Eatough & Smith, 2008, p.189). The process of this thesis from the genesis to the end was dynamic, where parts gave meaning to the whole and the whole gave meaning to the parts, thus allowing it to be seen as part of a greater picture.

3.5.3 Idiography

IPA is an Idiographic approach that concerns itself with the particular (Smith et al., 2009), which is the premise on which the current study is based. More so, my interest in ED, shame and guilt was fuelled by my own fascination and spurred by my in-depth encounter with sufferers. I found that there was a lack of studies that looked at it from the lens of the particular. The fundamental principle within this paradigm is that collection of qualitative data permits the exploration of complexities that inevitably exist in human experiencing. Sampling within IPA is not concerned with representativeness or generalisation as with quantitative or nomothetic approaches. It is concerned with the creation of 'fine-grained accounts of a pattern of meaning for participants reflecting on a shared experience' (Smith et al., 2009, p. 38). Nonetheless, the act of communicating research findings within IPA can

allow for general statements to emerge from individual cases (Wagstaff et al., 2014). The discussion section within the present study will illuminate this concept. This concept has been applied to study of emotional experiencing; for example studies looking at experience of anger (Eatough & Smith, 2006) and pain (Smith and Osborn, 2007). It is a particular fit for this study that aims to gain an account of how participants make sense of their experience of shame and guilt in the context of their ED.

3.6 Conclusion

If the purpose of a research study is to recognise the uniqueness of an individual's experience and seek to understand these phenomena, then theoretically and practically, IPA stands out as a method of choice. Through the use of IPA, in-depth accounts of an individual's experience and gaining greater insight into the lived experience of that individual can be achieved. For example, when the focus of research surrounds the notion of meaning making of someone's experience, then the method of psychological enquiry such as IPA, which can delve into and gain access to such rich and diverse data would be necessary (Shaw, 2001). In this way, IPA provides psychological research with a rich understanding of human experience that can be used to inform clinical practice. More importantly, IPA may be able to illuminate and enrich an area previously only studied through a quantitative lens.

3.7 Personal epistemological reflexivity in the context of this research

Denzin and Lincoln (1994) purport that the field of qualitative research is 'defined by series of tensions, contradictions and hesitations' which waver between 'the broad, doubting postmodern sensibility and the more certain, more traditional positivists, post-positivists and naturalistic conception of the project' (p. 15). IPA can be said to be caught in, and articulate this debate. The relationship between truth, reality, and meaning is complicated and the overlapping nature of some of the epistemological positions is a reflection perhaps of the 'essentially ambiguous character of human knowledge' (Crotty, p. 30).

The task of trying to understand my own epistemological position has been a cumbersome but reflexive, process; the art of becoming aware of something that I had previously been immersed in, but not been explicitly conscious of or examined in detail. A note from my reflective journal captures this struggle

20th January 2014

A few months to submission and I still don't have my epistemology game together. Methodology is becoming more complex than eating disorders! I am overwhelmed by the confusion. I learnt something new about Christian ontology that I never knew existed. How it makes me see my faith differently...really interesting, but I'm still confused...Dear God I need you more than ever!

This is a process of recognition that highlights the understanding of my social and psychological worldviews and the fundamentals of how and what I understand the world, and knowledge, to consist of. My position within this debate has emerged from this process and from my perception and understanding of mental illness as a trainee counselling psychologist. I have highlighted throughout this thesis the importance of the individual and their context as the primary focus, rather than the diagnosis which the client might arrive with. In this study, I have found myself privileging the client's story, their understanding of the nature of their distress, its impact and the sense they make of it; a stance characteristic of **contextual constructionism**.

According to Madill, Jordan and Shirley's (2000) definition, the contextual aspect of contextual constructionism understands knowledge as 'local, provisional, and situation dependent' (p. 9). They argue that constructionism means that there is no one reality to be revealed by using the 'correct' methodology because human beings are conscious and constantly making meaning as well as acting on the world around them and making sense of it in unique ways. The process of my arrival at this epistemological position also mirrors this stance and my meaning making of IPA has shifted since I first encountered it. Reading more on its philosophical bases and working closely with a highly versed IPA researcher has influenced my sense making of this paradigm. Therefore, this decision making has been guided by knowledge that is provisional and context dependent (Jaeger & Rosnow, 1988; Giorgi 1995). In choosing IPA as my research method, I commit myself to exploring, describing, interpreting, and situating the means by which the participants make sense of their experiences.

This is a creation of meaning through the interaction of subject and object, an individual engagement with the world, which explains why meaning is different for everyone, even in

relation to the same phenomena (Crotty, 1998) and therefore not *prima facie*. This also accounts for how and why the meaning of objects changes over time, because the perspective of the person perceiving it influences meaning and that person will be a product of their cultural and social context (Lyons, 2007; Madill, Jordan & Shirley, 2000). For research purposes, this position acknowledges that results collected will be influenced by a number of factors. These include both participants' and the researcher's meaning making systems, their cultural backgrounds, and also the criteria by which research is judged by a wider psychological community (Henwood & Pidgeon, 1994).

Madill, Jordan and Shirley (2000) acknowledge that this position overlaps with that of critical realism where facts exist, or as Fade (2004) phrases it: 'there are stable and enduring features of reality that exist independently of human conceptualization' (p. 647). As with contextual constructionism, however, people are understood to interact with others and their world from within their own networks of cultural meaning, and will therefore have different beliefs and expectations (Madill, Jordan & Shirley, 2000). Larkin et al., (2006) echo this by saying that IPA is concerned with 'understanding the person-in-context, and exploring persons' relatedness to, or involvement in, the world' (p.54). For contextualist purposes, this position allows research results to be grounded within the social practices and norms of the participants' world. This is especially important for this research given the significance and on-going influence of social norms in ED. As a contextual constructionist, I can acknowledge that my view is just mine, but that other people's views are both different and equally individual. Madill (2000) advised that the researcher's subjectivity is important in contextual analysis. I agree with McGuire that findings should be considered as context-specific. As a result I have aimed to articulate the perspective from which I have approached this study. I have stated in my literature review the context the literature comes from in order to help the reader form their judgment. The next section will be explicit in giving the demographics of the participants in this research this includes details such as gender, age, and ethnicity, all of which conceivably inform the audience of the position from which I write. I have used reflexivity throughout this thesis to inform the reader of my position whilst also acknowledging the impossibility of achieving absolute openness and leaning on Heideggerian appreciation of the influence of my own personal and cultural perspective on the research process.

3.8 Research design

The study examined participants' understanding of shame and guilt experience in relation to ED and how the experiences of shame and guilt impact on treatment and disclosure. Qualitative design was selected for the primary purpose of capturing the uniqueness of participants' lived experience and how they made sense of their experience. The emergence of participants' experience at a deeper level is aided through in-depth discussion (Polit & Beck, 2005); therefore, this project employed one-to-one semi-structured interviews, with the use of open questioning that allows thorough reflection from the participant and as advised by Reid, Flowers and Larkin (2005).

3.8.1 Data collection and sample size

IPA is dedicated to quality exploration of participants' perceptions and meaning making of their experiences. This approach allows participants 'to think, talk and be heard' (Reid et al., 2005, p. 25). Therefore, a semi-structured interview has been suggested as the best data collection fit for IPA (Smith et al., 2009) because of its flexibility and allowance for open questioning which aid thorough reflection on the part of both researcher and participants in a way that rich descriptions of lived experiences of participants can be elicited. Unlike quantitative research design where larger sample size is advocated, this is problematic for an IPA study as it jeopardises the primary commitment of IPA to idiography and attention to richness of data. Additionally, efficacy of small sampling (between 3- 6 participants) has been attested by many studies carried out by prominent IPA researchers (Smith, flower & Larkin, 2009). The quality of data that emerges from the small sample size was described as 'poignant, emotive and interesting' in a reflective paper by several IPA researchers (Wagstaff et al., 2014 p. 4). The approach does not aim for a socially representative sample. Instead the focus is on homogeneity, with prime criteria being common experience of the phenomenon under investigation. The size of the sample employed in this present research sits inside the professional doctorate guideline suggested by Smith et al., (2009). An in-depth interview was used to seek the voices of six participants who met the sampling criteria below.

3.8.2 Sampling strategy and participants

A purposive sampling strategy was employed. The focus was directed at recruiting participants who:

- Have had a formal diagnosis of an eating disorder
- Have had treatment for an eating disorder
- Are over the age of 18

This type of strategy is compatible with IPA qualitative design on a theoretical and practical level. It is expected that participants who have had the diagnosis and had treatment for an ED would be best able to answer the research question. Hence they could share insight into their experience of shame and guilt and the impact of shame and guilt on treatment and disclosure in treatment.

As a counselling psychologist in training, I was able to reach out to participants at a local and national level through a private psychological service and via a national charity agency. A notice was placed on the agencies' website. The notice included clarification of the purpose of the study, along with the inclusion criteria and the description of the requirements of a recorded one and half hour semi-structured interview and the contact detail of the researcher (see appendix B). Responding potential participants were forwarded an information sheet (Appendix B). Once information sheet was read and understood, participants who were willing to proceed contacted the researcher via their chosen method (email or telephone) and arrangements were made to coordinate a face-to-face meeting or telephone interview. Participants that met all the inclusion criteria, and who expressed interest to proceed with the interview, were selected on a first come, first served basis.

3.8.2.1 Pen picture of participants (Pseudonyms have been used to protect the identity of participants)

Participant 1 referred to as Rose, is a white British female in her mid-twenties. She suffered with anorexia for twelve years and was in treatment for a total of five years.

Participant 2 referred to as Jane. Jane is a white British female in her mid-thirties and married with children. Jane was initially diagnosed with anorexia in her teens. Since initial diagnosis, Jane has also been diagnosed with Bulimia Nervosa. She has had two episodes of treatment.

Participant 3 referred to as Ava, was diagnosed with Anorexia Nervosa about twelve years before the study. She first commenced treatment in 2003. Ava is a single white British female in her early twenties.

Participant 4 referred to as Kim, is a white British female in her early twenties. Kim was in full time education at time of interview. Kim received a diagnosis of ED not otherwise specified about seven years before the study.

Participant 5 referred to as Phil is a British white male in his early forties. Phil suffered from anorexia as a teenager. Due to lack of awareness during this period, Phil did not have specified treatment tailored to address his ED but had inpatient treatment to address the physical ailment consequential of his ED.

Participant 6 referred to as Leah, is a white British female in her early twenties. Leah was diagnosed with anorexia five years before the study and was in treatment for a year.

3.8.3 The interview

As someone with a therapeutic background, the interview was a rapport that was empathically driven through the use of active listening and gentle probing to generate a rich source of data. Face to face semi-structured interview was carried out with participants who were local to the researcher. This is consistent with phenomenological approaches where the emphasis is on attempting to understand the psychological conception of the participant's beliefs, perceptions or account of a particular topic (Smith, 1995). For participants who lived far away from the researcher, a telephone interview was decided upon for reasons relating to risk to both researcher and participants. This was agreed and cleared by University of Manchester Ethical Committee. In total, four interviews were conducted face to face and two interviews were conducted over the telephone. Telephone interviews are the norm within quantitative research and are often extensively discussed in survey methodology literatures (Barriball, Christian, While, & Bergen, 1996; Aday, 1996; Carr & Worth, 2001). However, within the field of qualitative research, face-to face interview has been dubbed the gold standard in research literatures (Chapple, 1999). So much so that most research literature and text omit the option of telephone interviews in their plethora of interview menu or modalities. The omission of telephone interviews in qualitative research has been found to reflect implicit subjective attitudes of researchers' low expectations of telephone interviews

as a medium with the potential to generate high quality data. For example, Chapple (1999) admitted to prejudice in form of scepticism about qualitative telephone interview based on the belief that face-to-face interview was more significant in obtaining quality data than a telephone interview. Chapple (1999) later found telephone interviews surpassed her expectation when she employed this medium.

A review of English language published articles on telephone interviews for data collection in qualitative research by Novick (2008) found that telephone interviews are capable of producing rich, vivid, detailed and high quality outcomes. Novick (2008) further suggested that the negation of telephone interview modality in qualitative research stems from the legitimate concern of lack of access to non-verbal information, which could lead to data distortion or data loss. The occurrence of these losses could impinge the quality, validity and accuracy of findings. However, there is little evidence to suggest that presence of these losses in telephone qualitative interviews (Sturges & Hanrahan, 2004; Sweet, 2002). In fact, many have argued that telephone interview allow participants to divulge sensitive information more freely, and telephone conversation has been reported to contain several features that render it particularly suitable for research interviews (Hopper, 1992; Chapple; Kavanaugh & Ayres, 1998).

Situating the identified nuances of qualitative telephone interview identified by Nowick (2008) in the context of this project, I now present how these were addressed. The nuances are presented in three categories; loss of non-verbal data (e.g., facial expression and body language); loss of contextual data (e.g. physical appearance, age and race); and loss or distortion of verbal information.

First, I have two years experience of working as a telephone counsellor. I believe I was able to draw on my telephone counselling skills to attend to non-verbal information, such as noting a change in the flow of participants' communication and gently reflecting back my observations to the participants in a non-patronising way. As Hopper (1992, p. 8) noted regarding telephone conversation, 'visual cues are absent, but what those cues accomplish in face-to-face encounters does not go undone'. Opdenakker (2006) stated that a disadvantage of being unable to see participants is that the interviewer cannot see where the interviewee is situated. The value placed on contextual data may be traced to the origins of qualitative research in sociology and anthropology (Patton, 2002; Warren, 2002) in which ethnographic

methods, most notably, participant-observation, are prized. However, participant-observation is of no significance in the present study. Furthermore, semi-structured interviews were employed, which allowed for flexibility in form of probing and reflection. I also used demographic information sheet (see appendix D) to collect information on race, gender and age. As Burnard (1994) suggests, contextual data does not always have a significant hold on understanding and interpretation of words, therefore their loss may not always undermine the quality of findings.

According to Sweet (2002), telephones are deficient in building rapport. Drawing on my telephone counselling skills, I conducted the interview in a way that awareness was paid to auditory cues (Tausig & Freeman, 1988, p. 424). In my assessment, this was in no way less effective when compared to face-to-face interviews that I conducted. The first 10 minutes of the interview were used to introduce participants to the study and invite them to ask any question. This also allowed us the opportunity to gain a sense of connectedness. I was empathetically attuned to participants' emotions and used my tone of voice to communicate empathy.

Table 2: Interview venue

Participants	Face to face	Telephone interview
Rose	X	
Jane	X	
Ava	X	
Kim	X	
Phil		X
Leah		X

3.8.4 Recordings

All interviews were audio recorded and subsequently transcribed for analysis. Telephone interviews were audio recorded using a digital adapter connecting the phone to the recorder. After all interviews were transcribed, participants were offered the opportunity to participate in member check process which involved checking transcription from the initial information for accuracy of meaning (Cresswell, Hanson, Plano Clark & Morales, 2007). Transcribed interviews were sent to each individual via email. This was to ensure accuracy of transcription, and particularly, to address the potential deficits of telephone interviewing highlighted above.

3.8.5 Interview Schedule

Consistent with IPA design, semi-structured interviews benefit from having an interview schedule; but one that does not require rigid adherence to. I made use of an interview schedule which I had familiarised myself with prior to the interview (see appendix E). The schedule was used more as a guide, which in some cases became redundant as participant organically touched on questions without being prompted. I used open-ended questions to foster a conversational style interview that was organic in nature. This allowed for a rich and meaningful phenomenological enquiry to take place. The interview schedule was flexible, and allowed the interviewer to honour and respect participants' directions. Adhering to Smith and Osborn (2008), the schedule was used flexibly and acted as a guide to unfold phenomenological enquiry into the pivotal area of interest: understanding of shame and guilt, experience of shame and guilt, and its impact on treatment and disclosure. The schedule asked key questions that were in keep with the research question: how do people who have had treatment for an ED experience shame and guilt, and what impact do these experiences have on treatment?

The duration of each interview was a maximum of 70 minutes. Participants' were only interviewed once. Etherington (2004) talks about the importance of flexibility by emphasising the need to connect with participants 'wherever they are at that point in their lives and to recognise that stories are constantly being reconstructed' (p. 77). This stance resonated with my second interview, where the participant generated a new narrative regarding shame in recovery. This had not been added to the initial interview schedule, but later informed the rest of interviews. This meant that not only were the participants met at differing point in their lives, they were also meeting me at differing point of my research journey. Participant two influenced my research journey in a way that influenced my research narrative with the rest of my participants. From my understanding, the concept of standard interview questioning does not fit with the notion that the interviewer is inevitably changed by each interaction. It is important to note that thus the interview schedule presented in the appendix was an initial one and not representative of all my interviews.

During the interviews, participants' responses were checked back with them to check understanding, as recommended by Atwood and Stolorow (1984). At the end of each

interview there was a period of debriefing. The debriefing sessions lasted as long as each participant needed, ranging from five to twenty minutes and they were not recorded.

3.9 Data analysis

In regards to IPA design, there is no pre-set gold standard approach to analysing IPA data. Smith (2007) has described the process as an inductive and iterative process. The centrality of analysis is on participants' efforts at sense and meaning making of their experiences. Smith, Flower and Larkin's (2009) text offers a clear intrinsic guide to the execution of analytic process. These include immersion into text; infinitesimal, line-by-line analysis of the experience of each participant; identification of emerging themes; auditable tracking of data; and reflexive account of investigator's process. The stages I pursued were strongly influenced by Smith et al. (2009), but not absolutely defined by them. Within this section, I will describe how the data were organised, structured and given meaning. I illustrate this process in table 2 and with a diagram (see fig. 2).

3.9.1 Stages of IPA analytic process

Stage 1: Transcription

I followed the transcription guideline suggested within IPA (Smith et al., 2009). I transcribed each interviews and saved them as separate files. This includes words and notable para-verbals such as pauses, laughter and obvious hesitations. In this phase, I entered the researcher's role and abandoned pre-existing knowledge as far as I was able to. By transcribing the interviews while listening to them, I achieved an overview of, as well as distance from, the participant.

Stage 2: Immersion in the data

This second stage involved an in-depth connection with the data through listening to individual interviews. The aim was to re-live the interview in a way that I was attentive to the content and process of the interview. I would say that this stage is interlinked to transcription. As I re-listened to the recording to proofread the transcript and re-live the interview, I also used my reflective notes. I would often return to my reflective notes I made after re-living the interview. Here is an example:

Feeling very wowed after listening to my interview with (xxx). This has left me wondering more about measurements of recovery and diagnostic labels. Do people fully recover, and how do they know? I am not sure if she's saying that she does not want to recover or she's striving for recovery. I am also intrigued by her passion regarding shame relating to diagnosis. I'm intrigued that she brought it up after we had ended the interview. It was almost like the most important point for her to convey to me. This makes me question how casually practitioners (myself included) handle diagnosis and diagnostic labels during clinical assessment ...

Stage 3: Initial noting

In this phase, I engaged in a line-by-line free-flow circling and noting of striking words and phrases within the transcript. I delved deeper to grasp meaning of each text using Smith et al. (2009) guideline that suggests dividing comments into these elements; descriptive of content e.g. making notes of explanations and keywords used by participants; linguistic e.g. focus on use of language, metaphors, evident pauses and hesitations; and conceptual e.g. initial sense of participants overarching understanding of the matter that they are discussing. I addressed each element with my supervisor's advice in my mind. She advised to ask myself the question: 'What is this person trying to tell you'?

Stage 4: Identifying themes within cases

Identified themes within the individual transcript were then recorded and connections across these themes were sought out. Emergent themes were developed into super-ordinate themes that enabled related themes to be brought together into clusters. This allowed for a reduction in volume of data whilst staying close to the themes represented in the dataset. These were organised both pictorially and in spreadsheet format (see Appendix H) that allowed for the inclusion of quotes from the data. The former in particular allowed me to map patterns in the data set and represent conceptual level of analysis. This was repeated for each data set in turn.

Stage 5: Searching for connections of themes across cases

The following stage sought to identify emerging patterns across the different cases in the dataset. At this level of analysis, the individual tables allowed for shared themes to be

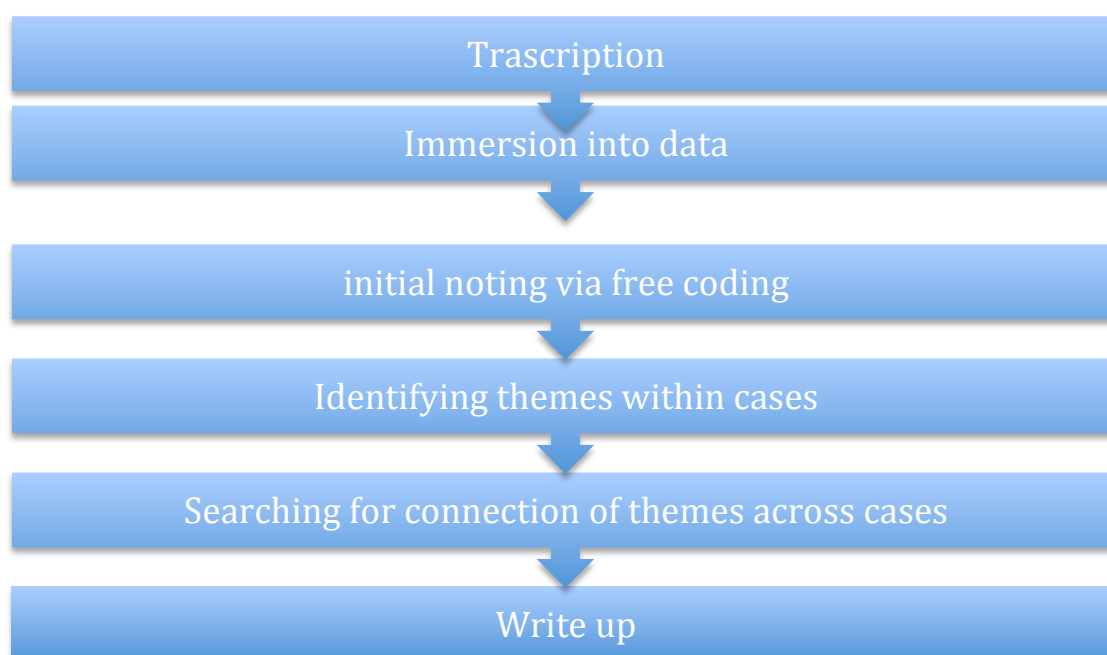
identified. However, transcripts were also examined for oppositional relationships' across themes thus allowing for conflict across transcripts on particular themes and allowing these to be organised together as a related set. These were then organised into a spreadsheet format and a checklist was produced to enable me to identify which of the superordinate themes occurred in each interview, thus allowing me to gauge recurrence (See Appendix H).

Smith et al., (2009) suggest a variety of ways in which the researcher could engage in identifying themes across cases. These include: abstraction (putting together similar themes; subsumption (classifying one theme as superordinate to the other); polarisation (searching for difference between themes); the function of a theme in participants' presentation of self; and frequency of themes. Themes were grouped under superordinate theme titles, using ***abstraction and subsumption***, in order to bring together related themes across the data. This resulted in five superordinate themes. Tables of themes were produced with text excerpts from each interview in order to ensure that the group data remained grounded in the individual voices of the participants.

Stage 6: Writing up

The analytic process continues into the writing up stage. The emphasis in IPA methodology is on the production of a narrative account that explicates the nuances of descriptions. The following diagram presents an overview of the analytic process.

Figure 2: Stages of IPA analytic process



3.10 Validity and Trustworthiness

Assessing the quality of qualitative research requires a different set of criteria than those for assessing the validity and reliability of quantitative work (Barker, Pistrang & Elliott, 2002). There are a number of available guidelines for doing this (e.g. Elliott, Fischer & Rennie, 1999; Yardley, 2000; Spencer et al. 2003). Since Smith et al. (2009) particularly recommend the Yardley (2000) guidelines, and have described how they apply to an IPA study; I have chosen to present the quality issues for this study according to Yardley's four principles: sensitivity to context, commitment and rigour; transparency and coherence; and importance.

3.10.1 Sensitivity to context

Sensitivity to context may be established through demonstrating sensitivity to the existing literature and theory, the socio-cultural setting of the study (Yardley, 1999) and the material obtained from the participants (Smith et al., 2009). I have endeavoured to demonstrate these aspects through the theory included in the introduction section; descriptions of the sample characteristics and study context and through the manner in which I collected and analysed the data. For example attention was paid to issues of power between myself and the participants, to my role in the interaction throughout the interviews, and to ethical issues during all phases of the study. This informed my approach to the interview process leaning greatly on hermeneutics of empathy described above. I have maintained a position that does not identify people by their diagnosis throughout the presentation of this study. I have aimed to identify the contexts in which the literature reviewed in chapter two were sought. I have aimed to demonstrate sensitivity to the data by conducting and describing an in-depth analysis and supporting my arguments with verbatim extracts. Smith et al. (2009) argue that this gives participants a voice in the project and allows the reader to check the interpretations being made.

3.10.2 Commitment and rigour

Yardley describes that commitment involves in-depth engagement with the topic and developing competence and skill in the method used. Smith et al. (2009) suggest that this may be demonstrated through attentiveness to participants during data collection, which I have endeavoured to do and hope will be demonstrated through my interview example and an example audit trail of an analysis in (Appendix G). Although I am new to qualitative research and IPA, I have sought to develop my skills, not only through attending lectures on these

methods as part of my doctorate training and reading on the topic, but by also using the approach in one of my second year assessment in which I received constructive feedback on my performance. I have in addition worked closely with my research supervisor who is very conversant in IPA methodology.

By rigour, Yardley refers to thorough data collection and the depth and breadth of analysis. Whilst the rigour of this study will have been affected by my status as a novice qualitative researcher, and also practical constraints in terms of time, I have at all times aimed to carry out the study in a thorough and careful way drawing on available training and supervision.

3.10.3 Transparency and coherence

Smith et al. (2009) state that transparency refers to how clearly the stages of the research process are described in the write-up and that there should be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised. I have aimed to enhance the transparency of my analysis by including an audit trail in Appendix (H). Yardley also includes consideration of reflexivity within the principle of transparency, and I have woven my reflexivity throughout the presentation of this study.

3.10.4 Impact and importance

This final principle reflects that, however well or sensitive a piece of research is conducted, the most decisive way it may be evaluated is by whether or not it tells the reader something interesting and useful. To this end I have included a consideration of the clinical relevance of this study in the discussion section.

3.11 Ethical consideration

I was informed by a number of ethical frameworks and guidelines in my decision making throughout this research process. As a trainee counselling psychologist, I adhered to the 'BPS code of ethics and support' (2009) and the Health and Care Professional Council's 'standard of conduct and performance & support' (HCPC, 2012). In addition, I was also guided by the University of Manchester's Ethical Research framework.

Prior to commencing the research process, the research proposal upon which the methodology was based was submitted to the University Research Ethics Committee for scrutiny and approval (see appendix G). The common themes and principles universal to all ethical frameworks are: awareness of confidentiality, non-maleficence or avoidance of harm to participant, beneficence or promotion of wellbeing and procedure for dealing with potential distress caused to participant (McLeod, 2003). Guillemin and Gillam (2004) postulate that the researcher owns the sole responsibility of ensuring the ethical nature of the research. As a researcher, I aspired throughout this process to embrace these principles and considerations.

Within qualitative research, Smith, Flower & Larkin (2009) were quick to stress that absolute confidentiality is an illusion, I quote: 'to say that something is confidential is to say that nobody else will see it' (p. 53). They asserted that a qualitative research design can only offer anonymity. Within this project, I have ensured anonymity by deleting any information that could remotely identify participants. Additionally, all names referenced by participants (e.g. institutions where they sought treatment and institutions where recruitment took place) were also erased or anonymised. Participants were awarded the option to review their transcript before analysis and, in addition, were offered the opportunity to have their data withdrawn from the research up to the point at which I began data analysis. Data analysis did not proceed until one month after they were given opportunity to review transcript.

To ensure informed consent, participants were given a consent form and information sheet (see Appendix B and C) to sign before they proceeded with interview. The consent form and information sheet detailed specific information about ethical issues associated with the study. Information regarding study aims, methodology, and inclusion and exclusion criteria were also included in the information sheet. These documents were informed by the ethical

frameworks detailed above. During the interview, participants were informed that they could withdraw from the interview at any time and that they were not obliged to answer any question they did not want to, without having to supply the researcher a reason for their withdrawal. Before proceeding with interview questions, I presented participants with an information sheet for the second time and verbally explained the process. I adhered to process consent (Haverkamp, 2005) by looking for cues of discomfort. When I formed the impression that participants showed signs of distress, I offered them the opportunity to withdraw or take a break. Following the interview, I offered participants the opportunity to ask questions and participants were given a debrief sheet that contained the researcher's information and contact details for organisations that offer support in case the interview triggered distress. They were also given my supervisor's contact details in case they were unwilling to speak directly with me, as the researcher.

3.11.1 Data protection

In accordance with the University of Manchester's Ethical Research framework and The HCPC Standard of Conduct, every attempt was made to secure data and information collected; all electronic information and recordings were secured on an encrypted electronic storage device only accessible by the principal researcher.

3.12 Chapter summary

Within this chapter, I have presented the design of the current study. Specifically, I described the methodological framework used in the study, including methodological considerations and rationale for the chosen methodology (IPA) through the lens of its philosophical underpinnings. Following this, I reflected on the research design and method of data collection. I then presented a description of the process involved in explicating the qualitative data. Finally, I concluded with ethical considerations that guided this study.

Chapter 4

Findings

I lift my arm out of the water. It's a log. Put it back under and it blows up even bigger. People see the log and call it a twig. They yell at me because I can't see what they see. Nobody can explain to me why my eyes work different than theirs. Nobody can make it stop.

Anderson (2010, p.84)

4.1 Introduction

The findings present participants' accounts of the phenomena of shame and guilt in relation to their ED experiences. These findings have been structured to capture themes that recurred across individual cases. However, it is noteworthy to start by acknowledging that shame, guilt and ED in the present study have a symbiotic relationship, impacting individuals in tandem. For instance, at times when people explored the intensity of shame, they were also exploring the intensity of guilt and equally, the intensity of ED because of the close relationship between them. Consequently, the findings mirror this interwovenness. Another noteworthy stance is the difference within and between each individual's narratives.

Each individual reported a complex dynamic in their guilt and shame experiences. Although this reveals the richness of the issues under investigation, these multi-layered complexities made the analysis and write up very challenging. For example, timelines were complex in each individual's discourse. As well as chronological shifts in participants' subjective sense-making; there was a sense that each individual's narrative was different and this made it difficult to identify unified themes. Identifying themes was such a heavy task that it made the analysis vulnerable to generating artificial division of themes. Significant efforts have been made to avoid this trap; this meant that some quotes that appeared to belong to different themes were used twice.

Another major consideration in theme finding was the use of on-going supervision. Having an additional person helped tremendously in structuring of the themes in a way that convergent findings were presented whilst also focusing on issue of divergence within each individual theme. The discussion section that will succeed this chapter will attempt to further present a complex and nuanced yet coherent picture of the analysis. However, it is important to demonstrate how as a researcher I managed the tensions and dilemmas (of identifying,

constructing and defining themes) described above. Finlay (2008) considers that this emphasises the role and importance of a researcher's reflexivity. Therefore, I have dedicated the next section to present reflexive accounts of this aspect of the research process. I start this section by looking at the issue of researcher's pre-suppositions and how this is managed with the interpretative process of the data analysis.

4.2 Personal reflexivity

The founding principle of phenomenological inquiry is that experience should be explored in the way that it occurred. Given the interpretative, double hermeneutic nature of IPA methodology, phenomenologists Heidegger and Husserl whose writings influenced the birth of IPA methodology recognised that our pre-conceptions or pre-understandings can easily impact the process of pursuing this type of inquiry. Husserl (1970) suggested that we must bracket our pre-conceptions and pre-understandings so as not to interfere with the actual experience of a phenomenological inquiry. Heidegger (1962) who once worked alongside Husserl presented a different opinion of working with the pre-understanding. He notes:

Our first, last, and constant task in interpreting is never to allow our fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves (Heidegger, 1962 p.195)

From the perspective of IPA methodology, Heidegger's formulation of phenomenological inquiry and its relationship with our fore-understandings evoke the need to evaluate the role of bracketing and reflexivity when interpreting qualitative data. What Heidegger lends to an IPA inquiry is that it is impossible to bracket all our pre-suppositions. Moreover, the awareness and sense making of pre-suppositions can sensitise the researcher to what might potentially be part of people's experiencing. As Gadamer suggests, the process of phenomenological interpretation is multifaceted and dynamic in a way that we are not always conscious of all our pre-conceptions and that the process of phenomenological inquiry itself can shape or bring awareness to our pre-conception (Gadamer, 1990).

Whilst I have carefully given detailed accounts of my personal experience and connection with the topic as well as my own theoretical and philosophical position in succeeding sections, I believe it is inevitable that these experiences will influence data interpretation, despite my

conscious and best efforts to put them aside in my reflective journal throughout the research process. I take comfort in Heidegger's belief that it is unrealistic as well as impossible for the researcher to rid their mind of all pre-suppositions whilst engaging with the lived experience of participants. Below, I aim to illuminate how this process of interaction and interpretation came about in the study and how I managed the process.

I found that prior to conducting this study, I came with theoretical and research knowledge of the topic under investigation. I had worked therapeutically with people with eating disorders and as expected, I was aware of the broad psychopathology and symptoms of the illness as well as their relationship with shame and guilt. Likewise my reading of shame and guilt informed me of their characteristics. This reading informed my therapeutic practice by helping me understand ways to identify shame responses in the clients I was working with before meeting with any of my research participants. During the interview stages, I believe that this foreknowledge impacted the interview as the process analysis of excerpts from my first interview depicts below:

- 1. Int: Ok, question one, what is your understanding of shame?*
- 2. Rose: ok I would say, shame is something that you're not proud of [emphasis]...that you err feelings that you're not kind of not willing to disclose.... ermm things that you feel guilty about.*
- 3. Int: so basically, from what you have said, there is an element of guilt in shame. Something that you're not...you don't feel proud of enough to disclose to someone*
- 4. Rose: uhm yeah*
- 5. Int: ok, what do consider shameful about yourself, past, present and in others. So if we start, this question has a lot of element to it, so if we start with the self,*

The brief excerpts were taken at the beginning of my interview with Rose and they provide an interaction between Rose's description of her experience and my own pre-conception. My observation was that I was more sensitised to the relationship between shame and guilt in Rose's discourse. Line 3 shows that this was the only part (the relationship between shame and guilt) of her discourse that I reflected back to her. Rather than unpacking the actual meaning of shame (Rose line 2), which the question asked (Int, line 1), I jumped to the entwined relationship between shame and guilt. In retrospect, this was due to that fact that most of the theoretical reading that I had done was around this area though, as with the use of an interview schedule, the discussion moved back naturally to guide Rose to describe in

depth, her experience of shame (Line 5). Also my reflection back to Rose was intended to allow her the opportunity to feedback if she wanted to (Line 4).

Whilst transcribing the interview and coding the transcript, I became aware of the similarities between participants' discourse and existing theoretical knowledge of the topic that I held in mind from previous reading. This process in a way opened up my pre-conceptions and made me stay alert to them. In my reflexive journal I note:

12th February 2014

My mind is dominated with the characteristics of shame and guilt that had emerged from my SR [Systematic Review] and other studies. I am finding it hard to extract and name themes from my transcripts that are not born out of the themes from my SR. I am actively trying to find newness in the discourse before me. What are they (participants) trying to tell me?

I found it helpful to remind myself of my experience as a therapist who has undergone several hours of personal therapy and supervision. These experiences have heightened my awareness of counter-transference- a phenomenon named by Freud (1923), which describes the therapist's emotional entanglement with a client. These are usually unconscious feelings that emerge for the therapist as a result of working with the client and Freud emphasised that the therapist needs to be aware of these feelings and manage them effectively within their therapeutic work with client. This process is not exclusive to therapeutic relationship; it is a phenomenon that occurs within qualitative research process between the researcher and the researched. My training in counselling psychology has sensitised me to this process and I have learnt skills of interpreting and containing it where possible. For instance, during the initial stages of the analysis, a dialogue with my supervisor made me recognise that my analysis and engagement with the research data were descriptive in a sense where I was again projecting my understanding of shame (shame as a negative emotion; shame as a similar emotion to guilt) onto the data by characterising it theoretically. This led me to return to the data with this awareness in mind. As Gadamer notes 'it necessary to keep one's gazes fixed on the things throughout all constant distractions that originate in the interpreter himself' (Gadamer, 1990 p.267).

This process of gazing on participants' narrative allowed for more depth to be gained in how shame was a negative experience for participants involved in the study. My understanding of 'shame as a negative emotion' was strengthened through this further in-depth engagement. The newness to this discourse was that shame was not just a negative emotion as my initial reading suggested. Additionally, what I heard in my participants' discourse was that it was 'an experiencing' that was beyond its emotional qualities, it was holistic in nature as it implicated all aspect of self. In this way, participants' interpretation impacted my own pre-understanding in a way that shaped the interpretative process of the research and influenced the naming and description of themes that emerged from participants' discourse.

As Smith et al (2009) suggest, our presuppositions are always present in our interpretations and we cannot always be aware of all our pre-suppositions. The authors however warned that 'priority should be given to the new object, rather than to one's preconceptions' (p.25). This stance was therefore aided through active use of journaling, regular consultation with my supervisor and going back to re-listen to interview tapes in order to make sure that the voices of the participants take centre grounding in the data analysis.

The process of constructing and defining themes was another area of significance in this research process and one that warrants an open evaluation. Wagstaff et al. (2014) quoted Nolan (2011) who described the process as akin to 'drowning in a deep bowl of spaghetti' (p.6) because of the volume of data that an IPA interview and data analysis generate. My experience of this process mirrors this description; I once described it as trying to untangle matted hair without losing any strand of hair in the process. I wanted to make sure that I presented detailed analysis of each participant's discourse. However, I found this an overwhelming experience particularly when developing general patterns to construct superordinate themes. I identified a personal reluctance against moving from the 'particular' to the shared discourse and a resistance to abandon the focus on the individual in the way that was required by IPA method. This is because the emphasis on common experience shared by research participants seemed incongruous with the idiographic focus of IPA. Although, my research participants shared their experience on a particular topic (experience of shame and guilt in relations to eating disorders), the flow of rhythm of events was different for each and every one. For example, Phil was a participant that focused his story on looking back; the regrets relating to suffering from an eating disorder and a sense of disgust for the eating disorder behaviours while Kim (another participant) discussed ongoing struggles with weight issues and appreciation for her eating disorder.

This difference in discourse really impacted the search for unified themes and narrating the analysis without losing one participants' story for another. One way in which I addressed this dilemma was by writing a short summary of each client's narrative and identifying unique superordinate theme for each of the participants. Within the tables that highlight the themes, I was transparent about the participants that contributed to each superordinate theme and each subordinate theme. I tried as much as possible to stay close to the phrases and words that were used by my participants in naming the themes. In fact, I found that my initial noting and free coding (stage 3 of analysis, see fig 2) within each transcript was a repeat of the words that participants used. It was difficult to move away from their words because of the felt sense of power that the words they used to describe their experiences generate. Unfortunately, having to put experiences under unified themes meant moving away from the actual words that they used. I found myself pushing and pulling themes into boxes in order produce a 'suitable' number of superordinate themes under 'nicely defined' and 'concise' titles. Having done this, I checked the themes against the short summary of narrative that I had penned for each participants to make sure that each of their voices were reflected in the final themes that were identified. Each theme was illustrated with a 'key word' (See tables 4-7) taken from participants' quotes.

Nonetheless, I was still left feeling that there was something artificial about the creation of superordinate themes to represent the overall experience of a group of people, particularly as I had to subsume some themes under other themes. For example, the theme '*shame and guilt of eating*' was a strong main theme for a prolonged period of time and eventually was subsumed under the theme '*shame and guilt of having an eating disorder*'. This was because it did not carry enough subthemes to be made a superordinate theme and it shared similarities with another theme. I came to appreciate why the use of single case studies might be encouraged to maximise the effectiveness of IPA as a phenomenological approach. To ensure that I was not delving away from idiographic discourse, I was conscious within the presentation of findings to pay attention to areas of divergence and convergence within participants' discourse. For instance, under the subordinate theme titled '*treatment*', shame and guilt experience had different focus for Kim in comparison to the rest of the group. Therefore, Kim's account was included using her direct quote to illustrate her narrative.

These tensions emphasise the key role of reflexivity for the phenomenological researcher particularly the issues pertaining to the process of how themes are constructed. Wagstaff et al (2014) explained that this is where the researcher can mark their identity on upon the research study. Likewise, this process was highlighted during my own viva examination; the examiners in my viva suggested that I insert more reflexive passages into the body of text to better illustrate the tensions and challenges that I encountered during the construction of my analysis and the impact of this on my study.

It is important to note that despite these challenges, the sense of being overwhelmed by participants' data was one of the defining experiences for me as a phenomenological researcher. It was enjoyable to see the complexities within and across cases. I feel that this validates the aims of IPA as the method of choice that is able to recognise the nuances of a particular phenomenon and the researchers attempt to make sense of them. My appreciation for IPA comes from its comprehensive engagement with participants' lived world by explicitly incorporating the perspectives of both the participants and the researcher.

4.3 Presentation of analysis

The analysis identified five main themes. Each of the main themes is divided into the different subthemes, presented below.

Table 3: Summary of superordinate and subordinate themes

Superordinate Themes	Contributors	Subordinate Themes	Contributors
The confusion and complexity in understanding shame and guilt AND The pervasiveness of shame and guilt experience	<i>All participants</i>	The complex and interwoven nature of shame and guilt	<i>All participants</i>
		The pervasiveness of shame and guilt	<i>All participants</i>
		The lived intensity of shame and guilt	<i>All participants</i>
		The masked nature of shame and guilt	<i>All participants</i>
		Enduring nature of shame and guilt	<i>All participants</i>
Guilt and shame as integrated into all facets of the ED	<i>All participants</i>	The shame and guilt of having an ED	<i>All apart from Kim</i>
		Relationship of shame and guilt with the cause of the ED	<i>All apart from Jane and Leah</i>
		Treatment	<i>All participants</i>
		The psychological splitting of the self during treatment and recovery from an ED	<i>All apart from Phil</i>
		The recovered sufferer	<i>Rose, Ava, Leah, Kim, Jane</i>
Existential questioning of	<i>All participants</i>	The wish to disown	<i>Phil, Leah, Ava</i>

identity		ED identity	
		Loss and grief	<i>Kim, Phil, Ava</i>
		The status of ED diagnosis	<i>Kim, Ava, Jane</i>
Lived out in different contexts	<i>All participants</i>	Social ostracization	<i>Phil, Ava, Jane</i>
		Media influence	<i>Phil, Ava, Kim</i>
		Medical discourse	<i>All</i>

Table 4: Superordinate theme: The confusion and complexity in understanding shame and guilt AND the pervasiveness of shame and guilt experience

Superordinate Theme	Subordinate Theme	Keywords
The confusion and complexity in understanding shame and guilt AND The pervasiveness of shame and guilt experience	The complex and interwoven nature of shame and guilt	<i>Well, shame is a very strong word. Guilt is tied up with the same emotions but not so powerful.</i>
	The pervasiveness of shame and guilt	<i>There was a feeling of guilt for enjoying life.</i>
	The lived intensity of shame and guilt	<i>Shame is a raw emotion.</i>
	The masked nature of shame and guilt	<i>Guilty behaviours have to be kept hidden, where nobody can see. Nobody can know.</i>
	Enduring nature of shame and guilt	<i>I kind of permanently felt quite guilty I think.</i>

The experience of shame and guilt was described by all participants as extremely complex and intense: to this effect, it appeared that participants struggled to make sense of shame and guilt experiences, particularly in their relatedness to the ED. This potential confusion also related to the entwined relationship between shame and guilt.

As a researcher, this degree of complexity also made it difficult for me to gain insight into participants' meaning-making of shame and guilt. Unsurprisingly, the superordinate theme of '*complexity and confusion in understanding and the intense experience of shame and guilt*' recurred across all interview cases. From the outset of the interview, participants struggled to give a clear description of shame. Shame was interchangeably described as 'something', a 'feeling', 'actions', 'thoughts' and 'behaviours'. Most participants gave a hesitant description of

shame and found it difficult to tell shame and guilt apart, however they recognised shame and guilt as different phenomena. I identified five subordinate themes from this superordinate theme. These were:

4.4 The complex and interwoven nature of shame and guilt

Shame and guilt were described as complex and negative experiences that have multiple facets. Both phenomena are very intertwined and participants were quick to recognise the enmeshed relationship between them from the outset of the interview process. A very close relationship between shame and guilt, and even embarrassment, started to emerge at a very early stage of the interview. The first question asked participants to give their understanding of shame. The close similarity between shame and guilt appeared to make it difficult for participants to describe shame without mentioning guilt:

***Int:** What is your understanding of shame?*

***Phil:** Something that compromises your self-worth, if you like ... I would say if you feel somewhat worthless. Shame and guilt are very similar emotions, I guess.*

***Ava:** I would say that shame is feeling ashamed and embarrassed but to a very intense degree, feeling as if you are in some way less than other people, and that it's partly your fault, maybe, but I suppose that would be more guilt really.*

The way Phil hesitates in saying, '*if you like*' followed by a long pause, could represent his grappling with the complexity of separating shame and guilt. Thereafter, both Phil and Ava recognised the complexity of shame and guilt by stating that they are similar experiences, despite only being asked to give their understanding of shame.

Complex, yet rich accounts of shame appear to vary among the individuals in the study. For Ava, shame was a 'state' of being '*that you are in some way less than other people*'. Jane talked about shame as a 'dislike for her lifestyle'. She described an ideal lifestyle which contradicts her actual lifestyle, therefore evoking shame reactions. Leah described shame as a form of self-hatred in terms of ED struggles. Although, this suggests that shame may have different focus for each person, the commonality in shame experiencing is that of a negative affect.

Although participants found it difficult to separate shame and guilt, the analysis identified distinguishing features from participants' meaning-making of shame and guilt. One identifiable distinction between shame and guilt is the notion of responsibility. This was more

poignant when participants described their definition and experiences of guilt. This is because all participants referred to guilt as action-specific. Here most participants alluded to feeling responsible for circumstances that elicit guilt. Additionally, the discourse noted the varying degrees of intensity of shame and guilt.

Shame was reported as more intense than guilt because of the powerful discomfort that its presence generates. Looking at participants' texts in a little more detail, it seems as if the intensity of shame was due to its strong association with self while guilt was mostly associated with negatively appraised behaviours that one feels responsible for. Phil articulated this very movingly when he expressed a preference for self-association with guilt rather than shame, despite saying that he found it difficult to disentangle the two, when he said, *'Shame, I think is a very strong word. Guilt is tied up with the same emotions but not so powerful. Shame has more seriously negative implications for me. I tend to use guilt rather than shame'*.

All participants in the study recognised that shame impacts condemnation of both actions and the self while guilt is about dissonance between an action committed and one's character, which Leah recognised as *'conscience'*. It is not a judgement of one's character but one that triggers or recognises that one has deviated from some standard.

A fusion of shame and guilt occurs when both shame and guilt are elicited by the same behaviours. One way that participants described the fusion of shame and guilt is in terms of relationships with others. Everyone in the study talked about how their ED-related actions affect others and how other people perceived the action. Jane articulated this when she talked about finding it difficult to separate feelings of shame and guilt when she had to leave her family at home to have treatment for her ED.

Jane: *I think that's where I get stuck between the two (guilt and shame). I felt guilty when I was in the hospital for leaving my children and husband at home. Is that massively different from saying I feel really ashamed I'm failing my family because I'm not at home?*

In the above extract the reader may be able to distinguish shame and guilt based on relatedness to action and self. However, the internal experiences appeared indistinguishable for the participant. Both shame and guilt appear as a burden that rested on the individual's conscience and sense of self.

4.5 The pervasiveness of shame and guilt

All the participants acknowledged shame and guilt as embodied experiences that riddled all aspects of being. Participants discussed the multiple components of shame as including thoughts, feelings and actions, which result in a negative perception of the self. The presence of shame was interpreted as a state of self-diminishment or a deficit in identity. Terms such as 'unworthiness', 'less' and 'worthlessness' were used to describe the experiences of shame. Memories of ED experiences also appeared to generate a shame response for Rose, Phil, Jane and Ava. Likewise, Jane was explicit about ongoing shame and guilt experiences. She described incessant shame and guilt that riddled her thoughts and beliefs about herself in different roles:

I feel guilty and ashamed about most things, like not being a good enough mum, not a good enough wife, I'm not a good enough housekeeper, that I don't work hard enough at my job, that I don't do enough voluntary work at my church: the general principle is that I'm not good enough and I'm never going to be good enough.

It appears that shame and guilt experiences created a fertile ground for self-criticism for everyone in the study. Whatever situation triggered shame and/or guilt, led to a judgement of self or action. Jane shared with me the realisation that she treats others more favourably than she treats herself, saying, '*[Guilt and shame] are obviously completely separate things because the rules for me, you know, are totally different. I would never treat anyone as meanly as I treat myself.*'

4.6 The lived intensity of shame and guilt

Participants' rich accounts of shame and guilt highlight the power of the phenomena and their deep impacts. The intensity of shame and guilt experience was captured in both the verbal and nonverbal linguistic discourse of participants. Likewise, both shame and guilt were also talked about as being constant and burdensome to carry. For example, Phil described shame as 'a raw emotion' and echoed his experience of shame as an affect lived in uncomfortable intensity, saying, '*Shame, I think, is a very strong word. Guilt is tied up with the same emotions, but not so powerful. Shame has more seriously negative implications for me. I tend to use guilt rather than shame.*'

Phil verbalised his discomfort with shame by expressing a preference for guilt. This did not mean that he denied experiencing shame. Furthermore, his preference for guilt appears to be his attempt at seeking some form of relief from his experience of shame. I formed the impression that shame manifested in other participants' non-verbal discourse i.e., body language and physiological reactions. For instance, when participants were asked to describe aspects of their ED that they found shameful, Jane, who had suffered from bulimia, verbally described intense shame in relation to purging and binge eating. She withdrew eye contact when she talked about purging and bingeing as a lifestyle that conflicted with her ideal image or what is expected of her. Leah verbalised the presence of shame during the interview when she was sharing her experience of shame.

Leah: I guess [ED] is the usual thing that would make me feel like a bad person, I guess like I let somebody down or lie or, ermm, I don't know...also feeling a lot shame now.

4.7 Masked nature of shame and guilt

Even though shame and guilt have been described as intensely relational experiences, participants explained that their response to shame is characterised by a state of secrecy and silence. All participants alluded to shame as a phenomenon that brings about the act of concealment and secrecy in relation to their ED. Kim pointed out that her shame experience at the time of interview was around weight gain. In line with this she described feeling ashamed of weight gain and she shared how she lived this experience in secret:

I guess gaining weight is completely about shame for me. I just want to keep it a secret. I feel embarrassed about it. I wouldn't want to tell anyone about that: I just want to lose that weight again and pretend that the gaining of it never happened.

In reflecting back, Phil, Leah, Rose and Ava talked about ED as a hidden lifestyle. Equally, they also talked about shame preventing them from seeking help and also not talking to people about experiences of shame and guilt. This desire to hide the ED parallels the masked nature of shame and guilt experiences. This theme was frequently coloured by significant efforts to hide perceived aspects of self or behaviour seen as flawed from others. A major aspect that all alluded to as flawed was vomiting behaviour. Jane spoke of intense guilt and shame upon eating and her response to this was to hide. She said:

I suppose I [have] hidden behaviours. A few years ago I couldn't eat at all in front of other people generally that doesn't bother me. I can sit at my desk and I can eat grapes and my very boring salad, and if I want to eat chocolate, then I do that on my way home in the car where no one can see that kind of guilty behaviour. That has to be kept hidden where nobody can see: nobody can know.

This theme also includes description of shame and guilt responses expressed as other emotions. For example, Leah shared how the shame of having an ED alongside guilt about receiving treatment she felt she did not deserve led to her disengagement in treatment. This emotional and cognitive process manifested as anger towards clinicians and people that made her seek treatment. When this was explored further, she recognised the function of her anger as resulting from the experience of shame and guilt of seeking treatment because she perceived herself as weak for needing help for something as basic as eating, and for depriving others from services that were offered to her.

I think I often pretended that everything was ok but It wasn't because I felt like I did not deserve the help that they had to offer me like I felt I shouldn't need help erm I often kind of just withdraw from treatment.

4.8 Enduring nature of shame and guilt

Shame and guilt were also revealed as phenomena resistant to change. When participants reflected on their ED experiences, Phil explained that shame and guilt were not just episodic. Shame was 'a constant emotion throughout 20-plus years' and an experience that continued 'to a lesser degree' for him post recovery from the ED.

Ava talked about how guilt was a 'permanent' experience from treatment onwards:

I always find that there would be the rules that I've sort of arrived with like there will be my ED rules and these other rules (treatment rules) and they would often be the opposite to those rules and I would be inevitably be failing one or the other. So I kind of permanently felt quite guilty.

Rose talked post-recovery about being unable to disentangle the continuous behaviours perpetuated by shame and guilt from her identity. She was unsure whether the residues of ED symptoms were just part of her self-critical nature:

So and I think in terms of what I was saying about being quite self-critical, that's something that is kind of associated with that...is that that part of my character or is that associated with the ED? I don't know, but that is something that I still struggle quite a lot with, so I can feel quite ashamed of myself if I kind of underachieve, or if I feel that I'm underachieving.

To recapitulate, shame and guilt are complex and intense experiences that have significant impacts on participants' sense of self. Both shame and guilt are recognised as different phenomena but their co-occurrence in relation to the ED made it difficult for participants to identify and distinguish them. Likewise, these experiences are long-lasting and sometimes hidden and lived out in other emotions.

Table 5: Superordinate theme: Guilt and shame as integrated into all facets of ED

Superordinate theme	Subordinate theme	Key words
Guilt and shame as integrated into all facets of ED	The shame and guilt of having an ED	<i>I feel ashamed about being ill.</i>
	Relationship of shame and guilt to cause of ED	<i>Before it happened, there were no external influence trying to get me to live up to a body image</i>
	Treatment	<i>As I said, shame was something that stopped me from seeking treatment.</i>
	The psychological splitting of the self during treatment and recovery from an ED	<i>I think the thing that I find hard about recovery is that I don't feel ashamed when I do slip back into [ED].</i>
	The recovered sufferer	<i>[Recovery] is something that I still struggle quite a lot with, and I can feel quite ashamed of myself</i>

This superordinate theme aims to capture the complex and interwoven relationship between participants' experiences of shame and guilt in relation to the ED. Participants described varying and entwined relationships between their experiences of shame and guilt and the different aspects and phases of their ED journey.

4.9 Shame and guilt of having an ED

Participants talked of how their own perception of having an ED had shifted overtime. Of all the participants, only Kim explained that 'I never really felt ashamed of most of my ED' at the time of the interview. Others looking back on the ED described an embodied experience of shame. Phil and Jane talked about co-occurring shame and guilt in this context. Phil and Ava spoke of the ED in form of losses: a 'waste of life', Phil echoed. For Rose, she felt ashamed of the function that the ED served, as she explained:

In relation to myself, I would say that I'm aware that when I get into stressful situations, the way that I often cope with them is through eating or not eating or exercise, or ED associated behaviours, and so it's kind of like a coping mechanism but obviously, it's not a coping mechanism that's is very healthy [laughs] and it's one that you know, the majority of the population [laughs] don't need to resort to. So I guess, yeah, I feel kind of ashamed that is the way that I cope

The co-occurrence of the experience of shame and guilt also became apparent when some participants discussed the issue of taking responsibility or feeling responsible for the cause and course for their ED. This was more concerned with reflection on the ED past. For example, the whole interview for Phil was about feeling both shame and guilt for the course of his ED, the negative impact of the ED on his life, and the disappointment he caused others as a result. Likewise, Leah, Rose and Ava talked about experiencing both shame and guilt in relation to feeling underserving of treatment. Sometimes participants described the ED as self-initiated and other times; they recognised and highlighted external factors as the extract from Leah below depicts:

I feel ashamed about being ill. Even though now I know that it's not my fault or that it's something that I chose to have, I feel ashamed and guilty that I take up so much services and help and stuff that people need. I feel like I can choose to put food in my mouth, I just don't because of the thoughts and feelings that I get and that make me feel bad.

In terms of the ED behaviours, participants recognised that certain ED behaviours or cognitions provoked and intensified the experience of shame and guilt for all involved in the study. All apart from Phil described vomiting as a shame-and-guilt provoking behaviour. Jane said:

'I suppose when you're making yourself sick [emphasis], however many times a day, or binge eating, and then deliberately purging or making sure you don't under-exercise so that whatever you've eaten doesn't count, that's shameful'.

Restricted eating was another behaviour that generated a varied but fascinating discourse for most in the study. Looking back on restricted eating as an ED behaviour generated shame for all apart from Kim. In spite of this however, Rose and Ava recognised that they experienced pride an opposite affect to shame and guilt in relation to this behaviour at the peak of their ED experience. Pride was described as a positive experience that reinforced the function that the illness served for each individual. Rose explained her control concept (primary function of illness) by saying, *'If I eat more, the more ashamed and conscious I am about it and also the type of food I'm eating definitely. I guess that I feel that they view me as someone 'in control' who doesn't eat anything so it contradicts that if I am eating'.*

Participants recognised pride, alongside shame and guilt, as a maintaining factor. An aspect of the illness that brought about experiences of shame and guilt was the arduous and complex process of recovery. Here, participants described how the severe physical consequences of the ED provoked shame and negative beliefs about the self, which as a result heightened the degree of self-responsibility attached to the cause and course of the illness

4.10 Relationship of shame to the cause of ED

When participants were asked whether shame impacted the development of their ED, all described a negative correlation between the onset of the ED and shame. Participants described differing causes of the illness; they described this in relation to personality traits and life experiences. In spite of this difference, there was a consensus that shame did not play a role in the development of the illness. Phil highlighted this stance by making reference to his age and shifting attitudes towards ED and treatment

***Phil:** Before it happened there was no external influence trying to get me to live up to a body image. We are talking 25-odd years ago now, and body image wasn't in the media to the same extent. It never crossed my mind to be honest.*

When asked if shame had a role in the onset of her illness, Ava echoed:

Ava: Ermmm...I don't think so. I did feel a lot of social embarrassment, I would say, sort of at school. I could be very shy, and easily embarrassed but I wouldn't have said that I was ashamed of myself. In terms of my body image, I don't think I felt at all of ashamed.

Rose and Kim talked about the possibility that their self-critical nature and drive for control and the desire to be better at something influenced them in developing ED:

The ED becomes a thing that's just for youuuuu [emphasis] if you see what I mean, you need to feel like, it sounds awful, but like you're good at something. Like you can do something better than other people because you can be critical of yourself and just like everyday thing. 'I'm not doing better at this and other people are than me'. That sounds awful but you know, comparing yourself to other people and feeling like you could do better. So eating becomes something 'I can do better'. You tell yourself 'I cannot eat' or, I don't know, 'I can eat less than other people.

(Rose)

It appeared that the ED was developed to serve a specific purpose for each individual. And although, shame and guilt may not have implicated the cause for those that took part in this present study, they certainly played a part in maintaining and propagating the illness.

4.11 Treatment

Treatment for an ED was described by some as invading them of their sense of autonomy and was seen as a sign of weakness because all participants at some point in their ED journey conceptualised the ED as a trivial illness or one that was self-inflicted. The intensity of shame and guilt was mediated by this internal locus of responsibility for the cause and recovery from the illness. In this instance, people felt ashamed and guilty, for requiring treatment, to the point where Phil, Rose and Leah compared their struggle and treatment process to those affected by cancer. Participants felt that they needed to have control over the treatment and recovery process:

Phil: When I was really ill in the hospital I felt guilty and ashamed for inflicting this on myself. When people suffer things like cancer they have very little control over it. You could say an illness like an ED is something that you have control over.

Shame in relation to treatment was also discussed in light of others' perception of the illness as self-induced. Participants felt that others saw ED treatment as a process that should be self-

facilitative, non-arduous and certainly not one that requires the help of professionals in this view, Rose said:

I had an illness, but I think that a lot of peoples' perception of it is that it was completely self-induced. It's not really like I don't know [emphasis], cancer or something where you know you can't do anything about it, this is something that you could sort out yourself you know why should you have it.

The dynamic interplay between shame and guilt was also captured in how they impacted on the course of treatment. In this context shame and guilt co-occurred and their intense internal experiencing made it difficult for participants to articulate the process. Leah, Ava, Kim and Rose talked about shame and guilt as oppositional affects i.e. they had different focus. Guilt was particularly important for Rose, as she recognised that she lived in guilt when she initially came out of treatment. She described feeling guilty when she failed to adhere to treatment strategies that she had learnt. Likewise, she experienced guilt for using these strategies and any form of positive reinforcement triggered guilt. Rose said:

I felt guilty about relaxing, or I felt guilty about eating a chocolate bar or something because, even though those were things that were encouraged and there were positive associations with them, it's more normal not to. There are things that you should be doing, there's still the ED element as well which means that you feel guilty about doing those things because if you're relaxing, you're not achieving as much as you could be. If you know what I mean like if you eat a chocolate bar or have a big dessert after dinner, then you're not as 'in control' of your eating as you should be.

For Leah, shame and guilt were described as having opposing affects during the course of treatment leading to dilemma, tension and confusion. Leah described guilt as a consequence of eating. This time it differed from shame as the goal in treatment is to be able to eat in order to recover and, added to this, Leah described active struggle towards mastering recovery. However, she explained that eating evoked guilt of breaking the rules and principles of the ED. When the feeling of guilt prevails and serves to stop participants from eating, this evokes a sense of shame; perception that the self is weak and not good enough for treatment and recovery, as the following exchange demonstrates:

Leah: *I guess guilt [grows] when you let yourself have something that you don't feel like you deserve, or something that is against the rules that you have in your head, or that you haven't challenged yourself as much as you wanted to.*

Int: *When you say 'challenge yourself', it occurred to me that you also mentioned 'challenge' in regards to shame, how you describe the role of guilt and shame in that way, like the dynamics, as it sounds as if that they are playing the same role.*

Leah: *It's a kind of 'damned if you do, and damned if you don't' type of thing because I really want to recover, and I'm trying hard to recover. I feel like I don't want to waste any opportunity to challenge my illness and fight my illness. I know if I kind of panic and cave into it, it becomes a question of 'I'm I not even good enough to recover'. It's like keeping both sides of your brain healthy at the same time it's like pulling puzzles.*

4.12 The Psychological Splitting of Self in Treatment and Recovery

Leah, like other participants, described the shame and guilt dilemma and the tension that surfaced during recovery. In the above extract, Leah talked about recovery as something that requires high levels of physical and mental strength. Her choice of words, like 'fight' and 'challenge' in reference to the illness indicates that she was not against recovery. In the extract, she referred to the 'rules' that maintain the ED such as rigid control over eating. The failure to adhere to these rules set guilt for Leah and equally Rose and Ava. Ava distinguished these rules as 'treatment rules' vs. 'ED rules':

I think I felt more guilty from the treatment point forward as opposed to before or leading up to it, because once you start planning treatment you start to feel like you are supposed to be responsible for recovering, and so when you don't meet those requirements, you tend to feel as if it's because of a lack of your effort or ability, and also treatment tends to have a whole set of rules. I always find that these would be the rules that I've sort of arrived with. There will be my ED rules, and these other rules (treatment rules) and they would often be opposite to those rules and I would be inevitably be failing one or the other. So I kind of permanently felt quite guilty.

The discourse was understood as psychological splitting of the self that wanted treatment and recovery and the self that wanted to keep the ED. Even Kim, who cherished her ED, highlighted aspects of treatment and recovery that she cherished and she also mentioned that recovery evoked a sense of weakness. The sense of power and control derived from the ED appears hard to battle:

I think the thing that I find hard about recovery is that I don't feel ashamed when I do slip back into [ED]. That's the hardest thing, to keep up with it. Recovery is positive. I am a much happier

person, but at the same time, I forget about how miserable I was, I mean I was suicidal at the time when I was really sick, and I forget that my ED purposely blocks off all the negatives that I have from it and only makes me remember the feeling of power, control, and pride, so as you said before going into recovery is the opposite of that. Pride and power and stuff, and it just makes me feel ashamed of being in recovery. The only thing that keeps me in it is the fact that I'm happier.

Kim explained that this process increased the frequency at which she relapsed from recovery. This is so because recovery leads to weight gain and weight gain invokes high level of shame. She expatiated that relapse is a difficult experience for her due to reactivation of biological mechanisms such as hunger cues and metabolism. Her resolution to this conflict was the idea that she could keep her ED at no cost:

I mean in a perfect world I would be able to not eat and be really thin which is why ED was trying to convince me that, no, it'll be different this time you can not eat and you'll be able to feel fine. I know that's not true, and I was kind of stuck between believing it and not believing it at the same time.

Another aspect of this tension is the failure to make disclosure in treatment. Most participants talked about hiding useful and important information from their clinicians due to feeling ashamed of ED behaviours. Shame and guilt served different functions in disclosure; participants explained that even though they withheld certain information from their clinicians because they felt ashamed, they also felt guilty for withholding the information. Jane described this tension of withholding information below:

It's really made it harder, particularly as there are behaviours that it would be helpful to talk about in therapy, but equally, I could never quite bring myself to talk about them ... say last year, I was getting treatment at [organisation] and I remember this as well as a seeking help as a teenager. A lovely lady whose name I can't quite remember said that it's really important that you're honest and I was like erm 'noooo' [laughs]. It's like I can't, I can't write down what I eat. I thought I couldn't even write it down for myself and there's no way I could write it down for anyone else. I could barely admit it to myself, let alone anyone else.

4.13 The Recovered sufferer

It appears hard for participants to measure their recovery levels, as they explain:

I've had treatment, and I should be better you know, yet there's still things that I think are probably associated with the ED that I still do. I still exercise, like go to the gym a lot. That's fine but it's when I get to the stage where I know that I like have to go to the gym, regardless of whether I want to or not, so it's something that I feel ashamed of because I feel that, oh, 'I should be better', kind of thing, and 'yeah, I'm fine, I don't need to have treatment', and 'I'd know if you were to go to the doctors and measure your BMI, I would be ok', and 'yeah, they'd say that you're fine'. So, if that's ok, why do I still have these thought processes or these actions? I still feel these things are associated with the ED behaviour.

Despite the hesitation regarding her recovery level, it appeared that Rose saw continued compulsive attitudes towards exercising as a continuation of ED cognition. Some participants appeared terrifically confused as to the extent of their recovery. Biologically, they recognised that they may be fine; however certain cognitions were reminiscent of ED symptoms. It also appears that some participants feared admitting these symptoms as Rose hesitated above. These ED cognitions are so complex, strong and shame-provoking that Rose questioned whether they were a part of her character. Particularly as the longevity of the ED makes it difficult to discern how the different processes of shame, guilt and other personal traits interact with the ED, as well as the reasons for this interaction. For instance, Rose recognised the dynamic between self-criticism and shame by highlighting compulsive behaviours (i.e. exercising) driven by self-criticism that serve as a driver for shame. There was an expectation that treatment should have addressed these cognitions and emotions, leading to feelings of shame, as Rose explain:

I had a course of CBT, and the focus on that was more about changing my actions, and it didn't necessarily lessen the guilt that I would feel if I was doing an ED action, if you see what I mean.

The discourse was somewhat different for Jane. She focused on body image as she talked about not being able to find a way to accept her body without feeling ashamed:

I suppose, in terms of body image, I might have gotten over most of the things to do with my ED but I don't think many people recover to think that, 'oh, look. I've got a marvellous body, now'. I suppose my body is inherently disgusting and therefore I ought to be ashamed of it. If I just tried

harder then I wouldn't be so revolting so then I'm ashamed of myself because I'm not being disciplined enough. I'm not trying hard enough to make it ok.

The use of the word 'inherent' implies that there is nothing she could do about body shame; she perceives it as a part of her identity, which could explain for the self-blame in earlier discourse.

Table 6: Superordinate theme shame and guilt in complex interplay with identity

Superordinate Theme	Subordinate Theme	Key Words
Existential questioning of identity: acknowledging losses and cost of ED	The need for an identity separate from ED	<i>I find those memories very shameful.</i>
	Loss and grief	<i>I feel like I've lost control of myself.</i>
	The different status of ED diagnosis	<i>Again, it's feeling not good enough for that diagnosis.</i>

All the participants in the study recognised the longevity of their struggles with ED. They described the ED as a lived phenomenon that has formed part of their identity and in interplay with certain character traits. However, it is an experience that most participants described as conflicting with how they perceived themselves. This makes it difficult to accept or integrate the ED with other aspects of self. Paradoxically, there are aspects of the ED that participants also cherished, especially the function that the ED served for the individual. For example, it was a means of accessing control, pride and self-esteem for Kim, Rose and Ava.

4.14 The need for identity separate from ED

The first subtheme that emerged from the superordinate theme is the shame ridden aspects of the ED which activates shame memories in recovery. Phil was explicit to say in his reflections that he found all aspect of the ED shameful. Particularly, there were some feelings, thoughts, behaviours and situations that all participants found uncomfortable and very difficult resonate with. Ava and Kim explained this difficulty:

Ava: I still feel ashamed of many of the ED behaviours and think that they will always be something that I will want to keep secret. Even though they have been part of my life for many years, I still have trouble integrating them with who I think of myself as being. Things to do with purging methods and stuff, and maybe not at the time so much, but definitely when I think back on them, I find those memories very shameful.

Kim: one of my ex partners – we recently ended – he was with me through the whole time of me being the most sick I've ever been last year and I spoke to him recently about it and said thank you so much because I was horrible to him. I was emotionally cold and distant to him. I couldn't show any affection even if I felt it inside. I was just like so mean and so angry all the time, it affected my mood so I just wasn't me at all. I feel really guilty that I put him through that and also the fact that he literally thought that I was going to die, I mean he said that that was the most horrifying thing that ever happened to him. I guess I feel really guilty for putting him through that.

4.15 Loss and grief

This theme connotes experiences of loss and grief on two levels. First, the earlier themes have identified the functional role of ED for each individual. It was clear that participants held positive as well as negative sentiments towards ED and recovery. It appeared that recovery from an ED induced a sense of loss and grief or the possibility of experiencing these affects. Participants talked about it as a loss of power and control. For instance, Kim movingly described missing her ED during recovery, saying, *'I feel really ashamed about gaining weight. I feel like I've lost control of myself. I've let myself go. I sort of feel ashamed that I've recovered, especially when I see other people who haven't recovered. I kind of start missing being sick again'.*

Conversely, reflecting back on the ED evoked unpleasant memories, and for some, reflection served as a reminder of losses consequential of the negative implication of the ED behaviours. All participants developed the ED in their teenage years; a time when their identity was evolving. Like the majority of the participants, Phil talked about loss and grief of a potential he associated with his identity as a teenager due to the significant negative impact of the ED.

Phil: *The only shame that I would say I experienced was the fact that I wasted the potential that I had at 16 years of age. I should put it that I consider myself recovered now. I've got huge amount of my self-respect and self-esteem back, which is fantastic, so the shame has lessened to some degree. I do still feel ashamed about what I did to myself having so much going for me. I'm ashamed of what I had and what I wasted possibly: my potential at 16 years old and then the outcome by 38 years of age.*

Int: *Can you elaborate on that, please, if you don't mind?*

Phil: *Basically, like, a shameful feeling that you've let people down, you've let yourself down and you've let the society down, you know, because you had everything going at one stage and you made nothing of your potential.*

Int: *Okay, what do you mean by 'everything'?*

Phil: *At 16, I had a lot going for me. Good looks, a sporting talent - the sort of makeup that we assume means you will go places. The world was my oyster type of thing.*

Phil's use of the idiom 'the world was my oyster' captures the immensity of his loss. Unfortunately, the incapacitating feature of the ED obtrudes these possibilities, despite his explicit statement that he has recovered from his ED and recovered a 'huge amount' of his self-esteem and self-respect. There was an acknowledgement of losses as a result of having an ED. For example, there appears to have been a loss of self-esteem and self-respect that Phil suffered along with his eating difficulties. He clearly stated that, although he has recovered a lot of these back, there are aspects of these yet to be recovered. The inevitable reminder of this is the root of Phil's shame and guilt and disappointment.

Although Phil did not compare himself to others, Ava's loss was based on comparing her achievements to those of her peers:

Even though I feel like I'm sort of getting back on the right track, I'm still I see myself as being far behind, sort of, with my friends of the same age

4.16 The different status of ED diagnosis

Diagnostic status was a subtheme that emerged from this category and this discourse was particularly relevant to shame. The theme captures the way participants viewed their ED diagnosis and symptoms. Participants have talked about the complexity of the ED and its relatedness to their identity in terms of the functions and benefits of the illness. For example, Kim, Ava, Jane and Rose appraised the behavioural process of the ED as something that gives a sense of 'power and control' and increases self-esteem. Weight loss for Kim appeared to equate success and an increase in self-esteem. Therefore the diagnostic labels which connote different meanings are not taken frivolously. Participants talked about the ED diagnosis in a hierarchical form with AN diagnosis discursively placed at the top of the hierarchy.

This is due to AN characteristics of restricting and control, that are positively conceptualised by society. Participants that were not diagnosed with AN described the shame of their diagnosis. Jane, who had migrated between differing diagnosis over time, with the most recent diagnosis of bulimia, expressed a preference for talking about her past AN diagnosis because she was ashamed of her bulimia diagnosis, when she said, *'I was anorexic as a teenager so I will stick with that rather than the bulimia and binge eating'*.

The participants who were diagnosed with AN also spoke about shame relating to certain ED behaviours prevalent to bulimia and BED due to negative societal discourse, as Ava said:

Ava: *Well, the sort of the part of my ED that I hated the most was sort of my purging, bingeing and purging and stuff, and the restriction bothered me a lot less, so yeah, I kind of preferred to be labelled anorexic to being labelled bulimic, mainly just sort of as a social conception and because throwing up is not at all pleasant. People just think of it as really disgusting, whereas losing weight and being thin is seen as actually quite attractive, up to a point, anyway. But the actual behaviour [of dieting] is not considered that strange.*

Kim, who was diagnosed with the ED Not Otherwise Specified (EDNOS), described dissatisfaction with this diagnosis. She expressed that her diagnosis of EDNOS meant that she felt that her illness was not severe enough. She describes her diagnosis in this exchange with the interviewer:

Kim: *I think everybody who fits into the diagnosis of EDNOS is just very ashamed about that diagnosis. I think it's a really bad way of diagnosing people, because you've anorexia and you've*

got bulimia and then you've got loads of people that are shoved into this one category and there are people who are pretty much anorexic but don't quite fit it, and there are people who have only mildly disordered eating, and they are all fitted into this one category, and I think it's really unfair. I always felt very ashamed of being labelled that because if somebody asked me what ED I had had I would say anorexia and when people ask what I'd been diagnosed with, I would obviously say EDNOS.

Int: *So there is an element of shame and comparison in diagnosis.*

Kim: *Again, it's feeling not good enough for that diagnosis. It's saying, 'you're not sick enough really to be anorexic'.*

In the above, Kim explicitly expressed preference for an anorexia diagnosis. Her diagnosis of EDNOS as an unspecified category led to a sense of unworthiness because she did not fit into specified categories such as AN and BN. There was also a sense that being classed as EDNOS undermines the severity of her illness and her efforts at dietary control and discipline.

Table 7: Superordinate theme lived out and developed in different context/ Locus of responsibility

Superordinate Themes	Subordinate Themes	Key Words
Lived out and developed in different context/ Locus of responsibility	Social and psychological alienation	<i>I had an illness, but I think that a lot of people's perception of it is that it was completely self-induced.</i>
	Media influence	<i>...stereotype that you see in so many magazines, on the TV and in films.</i>
	Medical treatment	<i>I think some have been better than others.</i>

Participants' discourse about their experiences of shame and guilt in relation to ED varied depending on the context of the discussion. The analysis has presented participants' descriptions of shame and guilt in relation to their ED as experiences that negatively implicate the view of self. This theme extends the discussion to social identity for example, participants' views of how others perceive them i.e. the media and the medical sphere.

4.17 Social and psychological alienation

The theme of social and psychological alienation refers to the way participants described society's perception of their ED lifestyle and how this implicates their experiences of shame and guilt. The general discourse among all involved in the study was that society conceptualises ED in a negative way. First, participants themselves have discussed how their own early conception of ED was negative; Ava, Leah and Phil talked about how they kept their

eating difficulties secret before medical intervention because of their own perception of the illness being related to vanity. Ava explained:

Before I sort of had issues with food before the proper ED, and I never mentioned them because I associated not eating to lose weight with a sort of thing that girls did who are a bit vain to look pretty. I think that is quite a common misconception in general that an ED diagnosis can cause people to feel ashamed because people perceive it as sort of trivial thing that's linked to vanity, and if were that simple then it's quite shameful that you can't sort of overcome that, if it were to be so trivial.

Participants talked of responsibility in terms of both self-responsibility and external factors. Particularly Phil, in earlier responses, located the responsibility for the development and recovery from the illness in the individual sufferer. However, in the quote below, he talked about the individual taking responsibility as a misconception by the society, which, Ava added, brings about shame. As Phil explained, *'The general feeling that you get is that you're 'damaged goods' and you do believe that people think that it's your fault, and that you've done this to yourself, almost deliberately. You must be mentally unstable'.*

Rose and Leah echoed this further, and added that shame intensity rose due to eating being construed as something intrinsically within one's control. Within this context, four participants linked ED to cancer in terms of control; cancer being something that was out of one's control and ED being something that was within one's control and hence shouldn't be a struggle to get rid of. Not only did participants' perceptions impact on how they viewed their illness or how they felt society perceived their illness, Ava and Phil also talked about feeling ostracised by the society particularly in relation to the physical emaciation aspect of the illness.

Phil: *It makes you feel awful, you feel like an alien. You're not worthy or no good. Almost like an infected kid. It's like you have a contagious disease like leprosy. It distances you from the rest of society, really.*

Phil's choice of words captures this degree of alienation. His description was of someone who does not belong in society, or one that was a danger to society. Ava described an actual experience that made her feel intense shame, saying, *'On one occasion, a woman covered her daughter's eyes and glared at me when I walked past in my swimming costume. This made me feel very ashamed'.*

It was not just the physicality of the illness that caused participants to feel alienated from the society. Rose, Leah and Kim shared how their ED resulted in the psychological alienation of the self from the social world and impacted on immediate social relationships.

4.18 Media influence

Participants talked about the contribution of the media attitude to their ED experiences and the impact on the lived experience of shame and guilt. For example, participants shared feeling less ashamed about certain behaviour such as restricting and weight loss because these behaviours are seen as ideals and glamorised by the media. Following on from the above quote in the preceding subordinate theme, Ava talked about '*a narrow range*' that exists in terms of body image for women and the difficulty fitting within this. Although she suffered low weight as a result of her anorexia diagnosis, she recognised that she could have had a similar encounter of shame when she went swimming had she been overweight, saying, '*I think (shame) could easily have happened if I'd been very overweight, so I think that in terms of body image, there is only a very narrow range of what is considered acceptable, and it is now normal to feel ashamed of your body if it is not within that*'.

Jane, who has a past history of anorexia, described her body image struggles as a teen although she did not state any media influence. Despite having gone through series of treatments, she described outright body hatred '*I suppose my body is inherently disgusting and therefore I ought to be ashamed of it*'. Even when she was anorexic, Jane explained that she never celebrated her body; instead, she strived for thinness further. She continues to blame herself for not trying hard enough to fit within her own unidentified standard body weight. Equally, Kim explained that her pride in her ED resides in how restricting helps her to achieve a stereotypical figure portrayed by the media.

Ava encapsulates the toxic influence of the media on ED and body image by appraising body image as a great source of shame due to the values and meanings that the society invests in it leading people to become hyperaware of their body image regardless of their shape and size. In turn Ava reports that this makes it difficult to cope with feelings of shame.

Media influence is not gender-specific i.e. it does not only impact women, as Phil accounts:

Body image does have a massive impact on men and women. I mean, it's not just women. I see guys every day in the gym trying to live up to this hunk-of-a-male stereotype that you see in so many magazines, on the TV and in films. I think it's a dangerous thing and can influence people.

4.19 Medical discourse

While all individuals in the study owned personal responsibility for the development and recovery from the ED, all participants alluded to a degree of negligence by some medical and non-medical practitioners. Some of the discussions that recurred across all cases were the lack of awareness of and sensitivity to the person's ED experience. As a result, this implicitly provoked negative affects that impacted attitudes towards treatment and recovery. In relation to specific experiences of shame and guilt, three participants explicitly discussed that treatment procedures did not address these experiences and their complex dynamic in treatment while they were engaged in treatment. Rose talked about how her CBT treatment was all about reinforcing non-ED behaviours without addressing elements of shame and guilt. She said that, despite working hard in recovery and using all the reinforcement strategies, her ED mind-set was reactivated and that this intensified her experience of guilt. These cognitive and emotional facets of shame and guilt were not recognised by clinicians. The inevitable relapses during treatment/recovery where the ED mind-set prevails over the recovery mind-set resulted in shame and guilt of failing at recovery. Participants explained that shame and guilt made it difficult to relate these processes to their clinicians. Rose explained this in relation to her CBT treatment in the exchange below:

Rose: *I think that CBT tries to encourage the actions that I was doing that were more normal. So it encourages going out to eat with friends, encourages the eating more normally or eating more, exercising less and building positive things to do so when you do them you feel good about yourself and you try and build yourself up. The way of recovery was to build up the positive emotion and the things that you were getting out of being better.*

Int: *How does that relate to guilt?*

Rose: *I think that if I didn't come out of the treatment. These are the things you need to do. I felt more guilty and didn't achieve them and probably more guilty about the opposite actions associated with the ED. I don't think that, but then I suppose there's also an element of feeling guilty – this is going to sound really weird – feeling guilty about treating yourself well. So feeling*

guilty about relaxing or feeling guilty about eating a chocolate bar or something, because even though those were things that were encouraged and there were positive associations with, and it's more normal and that 'these are things that you should be doing' [emphasis], there's still the ED element as well, which means that you feel guilty about doing those things because if you're relaxing by doing those things, you're not achieving as much as you could be. If you eat a chocolate bar or have a big dessert after dinner then you're not as 'in control' of your eating as you should be.

The previous themes capture how for some people, recovery from an ED is an arduous process that is mediated by shame and guilt. Guilt serves double functions; one is that it is activated both in favour and against the ED, as Rose and Leah discussed. This serves to create setbacks in recovery. Although participants have taken responsibility for this struggle, a huge amount of responsibility was also situated within treatment approach and professionals' attitudes. Kim, Rose, Jane and Ava talked about treatment being centred on symptom reduction and biological recovery (i.e. weight gain) and not psychological recovery or both. Ava, Kim and Rose participants recalled that, times when they have relapsed or struggled with their ED recovery, the clinician's account of their difficulties was based on their physical health as measured by their Body Mass index (BMI). The BMI is a metric measure that ranges between 18-30+, where measures under 18 are classed as underweight. Normal weight is 18-25, over 25-30 is classed as overweight and 30+ is classed as obesity. Participants described feeling ashamed and shared their frustrations when their psychological symptoms were dismissed because their BMI fell within the healthy body range.

Rose described the difficulty she encountered when BMI was used to assess her candidacy for re-diagnosis:

I went back to the GP and I spoke to them about this, yet they just measured your BMI and if you are ok on the BMI scale then that's it, like get on with it, you're fine. So now I will feel like quite ashamed of speaking to a clinician about that because I can appreciate that they need some metric to measure, so if you fall above the line then you're fine, if you're below it then it's a problem and you need help.

Five out of six participants also talked about clinicians, particularly medical doctors, not having adequate understanding of the ED pathology which fosters the feelings of shame, especially when participants have to talk about behaviours that are difficult to verbalise due to shame. Leah demonstrates this reserve in the following exchange:

Leah : *I think some GPs have been better than others. You know it's always harder when you've had to see people that don't understand the illness. I've been in general hospitals and you see doctors who deal with critical cases and they ask you why you're there and so do you just not eat or just have no appetite, but that's really difficult, obviously you feel that you're a waste of space, like you're wasting a bed.*

Int: *And does that trigger emotion shame.*

Leah: *Yeah, that feeling of shame and, sort of, self-hatred, really.*

4.20 Chapter summary

This chapter has reported the findings of the current research project. I have aimed to stay as far possible with the descriptive, while in part acknowledging the co-construction of the narrative that I have presented. The next chapter will address the findings using existing theoretical knowledge to move through a deeper level of interpretation, loosely speaking from a broadly 'hermeneutics of empathy' to 'hermeneutics of suspicion' (Ricouer, 1970).

Chapter 5

How do you define a word without concrete meaning? To each his own the saying goes

Hopkins (2011, p.29)

Discussion

5.1 Introduction

5.1.1 Study aims

The overall aim of the present study was to gain a deeper understanding of the phenomena of shame and guilt in eating disorders (ED). The study sought to find out how people who have had treatment for ED make sense of their experiences of shame and guilt. The study further explored the impact of their shame and guilt experiences on treatment process, including disclosure in treatment.

5.1.2 Summary of findings

The main findings revealed a complex and entwined relationship between shame, guilt and ED. Shame and guilt were described as powerful and intense experiences that brought about daily challenges for the person living with/recovering from an ED. Experiences of shame and guilt contributed significantly to the maintenance of the condition. These experiences also impinged on treatment and disclosure in treatment. Furthermore, the analysis revealed that shame and guilt were not regarded as predisposing factors in the aetiology of ED for those that participated in this study though some people in the study questioned whether certain self-conscious experiences such as self-criticism and awareness of 'feeling average' made them susceptible to developing the illness.

Another main finding was the role of pride, as an opposing phenomenon to shame and guilt, in the maintenance of ED. These accounts point to the potential complexity of ED; the fact that pride (an opposite affect to shame and guilt) can interact with shame and guilt adds further complexity to the phenomenon of ED. The analysis suggests that ED can have great impact on guilt and shame experiences within a person's identity and this has serious implications for ED patients. Furthermore, this points to the possible significance of the functional role of the ED particularly in relation to the sufferer's identity. The analysis revealed that guilt may have

significant negative impact on perpetuating and propagating ED symptoms during treatment by mediating the tension between relapse and motivation for recovery.

Finally, shame and guilt experiences vary to some degree among participants. Although common themes were identified in participants' narratives, it was also evident that shame and guilt had a different focus for each individual in the study. This made it difficult to bring together participants' accounts under unified themes without losing some of the individual's subjective account. For example, the experience of shame and guilt for some participants was predominantly about current eating habits, and for others, the experience was talked about in relations to past difficulties with ED. Another dynamic was that shame and guilt varied in the degree of intensity with which they were experienced. For instance, some participants described guilt as more intense during the recovery phase of ED in comparison to pre-treatment of ED stages.

5.1.3 Chapter Overview

The complexities of each of the phenomena (shame, guilt and ED) under investigation and their symbiotic interaction has made it difficult to gain a unified understanding of the data, thus, a significant amount of time was spent structuring the findings in order to capture and build a rich, nuanced picture. For these reasons, the discussion of the analysis will be structured under three main headings to address the convergent threads that run through the analysis whilst also including areas of divergence.

The first heading aims to interpret participants' accounts of shame and guilt experience in relation to the course of ED. This section will start by exploring participants' understanding of shame and guilt experiences in light of existing literature. The second section will then focus on the impact of shame and guilt on treatment and recovery from ED with extra attention paid to participants' discourse on relapses. It is important to note here that, although the study interviewed people who have had treatment for ED, most participants in the study still described on-going ED symptoms (i.e. related thoughts, behaviours and emotions) at the time of interview. Some shared with me that they were in treatment or considering entering treatment to address these issues. The final section within the discussion of findings relates to the theoretical conceptualisation of shame and guilt in light of existing empirical literature. This section was presented last because of the lack of coherency that exists in terms of the present understanding of shame and guilt, the diverse differences and similarities and their role in the psychopathology of ED, all of which I have highlighted in the literature review. It

was apparent that some of the theoretical accounts of shame and guilt featured in the literature contradict the accounts of individuals in the present study.

It is the aim of this section to shed some light into why this might be the case, in line with the findings from this present study. The broad understanding of shame and guilt formed a prominent theme in the analysis. As well as this, shame and guilt have been identified within this study and others as core features in the presentation of ED. Likewise, they have been found to be prominent in their cognitive and emotive capacity to mediate treatment and recovery from an ED. Therefore, in order to improve the presently poor prognosis of ED, a sufficient understanding of these core features of ED is highly warranted. Although efforts have been made to divide this chapter into three main headings, the aforementioned headings are interlinked in terms of participant's narrative and therefore it was not always possible to keep the discussion separate under three headings. For instance, in the section that looks at shame and guilt in relation to ED, discussions relating to a later section on recovery were sometimes touched on, and vice versa.

Finally, the chapter will conclude by presenting innovative recommendations for clinical practice, future research and limitations of the study.

5.2 Shame and guilt in ED psychopathology

5.2.1 Features of shame and guilt: a multifaceted and pervasive experience

Shame and guilt experiences were described as powerful phenomena with intense impact on perception of self. One recurring theme in the study is that both shame and guilt are difficult experiences to process, a major reason seemed to be that shame and guilt are comprised of multiple facets that riddle through all aspects of being (i.e. thoughts, behaviours, and emotions) and they co-occur in a lot of situational contexts. For example, participants gave examples of cognitive aspects of shame by sharing that shame experience mirrors a physical and mental reduction of self; a sense of 'unworthiness' and 'failure' of self, in Phil's words. This perception of self was also sometimes conceived to equate others' opinions of self. Some participants, e.g. Ava, spoke about experiencing shame as a result of negative evaluation of herself by others. For Leah, this was the other way round: she described a negative self-evaluation that resulted in feeling like others perceived her in a negative way.

Guilt was triggered by negative appraisal of a behaviour, action or situation that would sometimes impact upon perception of the self. Sometimes these experiences were motivated by the society's attitude towards ED behaviours; they were not always directly a violation of one's own personal standard but also the societal standard that influences one's own judgement.

Both shame and guilt also manifested in other emotional responses. For instance some talked about their entwined relationship with anger and embarrassment, which sometimes led to urges to withdraw or hide. Many of the descriptions correspond with existing theoretical literature (Tangney & Dearing, 2003; Lewis, 1971) and empirical research on shame and guilt. Gilbert (2002) ascribed the overpowering presence of shame in ED to its composition of multiple mechanisms such as, emotive, cognitive and behavioural, all of which simultaneously interact with a person's internal and external experience. The relevant literature often inaccurately refers to shame and guilt as emotions. This study identified that the experiences are much deeper and more powerful than that; the impacts are visceral and holistic in nature. This casual description almost invalidates the depth, power and significance of the experiences of shame and guilt.

5.2.2 Similarities and differences between shame and guilt: an intertwined dynamic

The similarities between shame and guilt were poignant within all participants' narratives; one important similarity is the visceral and holistic response discussed above. Both experiences had negative implications for the view of self and likewise are guided by behaviours that mirror social attitudes. I will address in the last main section how, in literature, guilt is often said to be less self-implicating and unguided by societal norms in comparison to shame (Sanftner et al., 1995; Lewis, 1971). Participants' reported experiencing was at variance from such findings.

Despite the identification of similarities between shame and guilt responses, participants also noted differences between these experiences and although, these differences were discernable, participants struggled to delineate shame responses from guilt responses. This is because both were often experienced concomitantly and in an enmeshed manner with the ED. The intensity of shame was one way in which participants implicitly drew parallels between the two phenomena. Shame was described as the stronger experience of the two because it was more associated with the self as Ava captured below:

I would say that shame is feeling ashamed and embarrassed but to a very intense degree, feeling as if you are in some way less than other people, and that it's partly your fault, maybe, but I suppose that would be more guilt really.

Guilt was described as relevant to a behaviour that was appraised negatively. As a researcher I found this part of the analysis the most difficult. I found I was often asking myself “are the participants talking about shame or guilt”? Another complexity was related to their enmeshment with the ED. At points, participants would be talking about the intensity and chronicity of the ED, which made it difficult to identify how that particular experience was related to shame and guilt. Below, I captured this complexity whilst analysing Ava’s transcript:

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She keeps mentioning the negative implications of the ED, of having to be looked after like a child, yet she talked about the drive to lose weight. I can’t quite tell what it felt like for her to be looked after... is she ashamed of this or embarrassed by this?

I have heard Kim talk about feeling content about the severity of her ED almost like it was an achieved goal; enjoying eliciting care from others. These are differing narratives, yet with great similarities on some levels ...

5.2.4 Shame and guilt in the aetiology of ED: the functional role of ED

The most persuasive argument for the aetiology of ED is the social media’s promotion of slimness, which influences people’s self-perception of their weight and shape (Martinez-Gonzalez Gual, Lahortiga, Alonso, Irala-Estevez, & Cervera, 2003; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Wolf, 1991; Bruch, 1973; Crisp, 1980; Goodsit, 1997; Vitousek & Ewald, 1993; Goss & Gilbert, 2002). Although, as explained in the previous chapter, participants described social attitude as in part leading to shame and guilt (and societal conceptualisation of a behaviour), however, social and media attitude towards weight and shape were not described as the main cause of the ED in the present study. Similarly, these social factors were not the only influencing factors in shame and guilt experiences.

It is noteworthy here that although shame and guilt had different focus for each individual, they were described as experiences that maintained and propagated the ED behaviours. It appears that existing studies that have linked the attainment of attractiveness to ED may have made a simplistic link between the struggle to achieve thinness and ED. For instance, feminist theorist Bartky (1991) posited that ED are influenced by proliferation of thin and sexualised images in the media, which influences women's perception of their weight and gender roles. The accounts of participants in this study fail to support this A-B-C explanation.

Throughout this research, participants consistently highlighted the very 'functional' role of their ED. For many (e.g. Rose, Kim, Ava, Jane and Leah), ED was a means of survival when faced with limited options for (re)-gaining a sense of self-worth, security and control. The ED became an individualised mechanism for people, as Rose noted, *'It's almost that the ED becomes a thing that's just for **you** [emphasis].'*

Rose echoed clearly that she experienced the ED as a means of achieving control. Many studies have looked at the issue of control in relation to the onset and maintenance of the ED. D'Abundo and Chally (1998) stated that it is the need for control that starts the obsession with weight, although the ED does little to give control. Likewise, Lamoureux and Botorff (2005) associated power and security to a sense of control derived from anorexic behaviours and cognitions. The accounts of the participants in this study can be said to support Lamoureux and Botorff's position. Some participants in the study explicitly stated that their ED behaviours such as restricting and exercising were a means of achieving control as Rose explained below.

'If I eat more, the more ashamed and conscious I am about it and also the type of food I'm eating definitely. I guess that I feel that they view me as someone 'in control' who doesn't eat anything so it contradicts that if I am eating'.

The search for control appeared to have a significant impact on self-definition and how one is seen in the eyes of others for those in the study. Frankl (1994) explained that the will to find meaning is the central motivation in human beings. The author's assertion draws parallel to self-actualisation theory (Maslow, 1968), which holds that human beings have to commit to a particular task in order to achieve the highest levels of growth. This can explain the cases of high profile figures that develop ED, such as in the case of Melanie Spooner that I discussed in chapter one.

ED studies that have looked at the role of pride have talked about patients describing their ED as a quest for individuality, autonomy and independence. This was expressed in relation to eating and not eating, where not eating led to positive feelings of being good and 'in control' and eating led to feeling bad, fat, out of control and feelings of self-hatred (Skarderud, 2007; Goss & Gilbert, 2002). According to Mascolo and Fischer (1995), experiences of pride are associated with a feeling that one's own attributes and talent are approved of or admired by others. In describing her own journey through anorexia, MacLeod (1981) reported a sense of energy and interpersonal power from her ED. Therefore, ED can hypothetically be a search for achievement. Wallace (1986) report on the tragic death of the Gibbens twins suggests that their ED (AN and BN) helped them gain a sense of power via competition with each other in terms of ED behaviours. This highlights that ED are not always driven by a victim mind-set that reflects the cliché active pursuit of beauty as illustrated by social identity theory (Tajfel et al., 1990), some feminists' view of ED and the self-objectification theory of ED (Bartky, 1991; Fredrickson, 1997).

On the other hand, the search and quest for control via ED processes meet obstacles in form of the bio-psychosocial consequences of the ED. Some of the struggles that participants talked about were the physical and social limitations of the ED, which made them feel ashamed and guilty. As stated in other studies, ED are characterised by their biological and psychological chronicity. One such biological consequence of anorexia stated by Stice (2002) is severe emaciation. For people with bulimia, this can be uncontrollable binge eating and vomiting that can cause severe dental problems (Polivy & Herman, 2002). Some of these physical defects can compromise any attempt to use ED as a long-term sense of gaining control, autonomy and independence. Ava talked about feeling ashamed of the physical consequences of AN that left her feeling helpless and dependant on others for physical support.

When the sort of ED gets really bad or out of control that can be quite a shameful situation because if you are weak, basic task can become difficult, you just feel really pathetic. That can be shameful because you feel as an adult, 'I can't even feed myself'.

5.2.5 ED: the accusation of vanity

Although participants themselves were not aware of the academic theories that ascribe ED to pursuit of beauty (Bartky, 1991; Fredrickson, 1997), they were cognizant of this explanation. They described feeling ashamed and guilty due to the societal perception that ED is purely motivated by drive to achieve thinness. As Ava accounts, this perception negatively impacted her motivation to seek help:

I sort of had issues with food before the proper ED, I never mentioned them because I associated not eating to lose weight with a sort of thing that girls who are a bit vain did, to look pretty. I think that is quite a common misconception in general: that an ED diagnosis can cause people to feel ashamed because people perceive it as sort of trivial thing that's linked to vanity, and if it were that simple then it's quite shameful that you can't overcome that, if it were to be so trivial.

Participants at various points in the interview shifted the tone of sole responsibility from internal to external looking at personal factors, social attitudes in propagating the illness and also attitude situated within health care realms. Regardless, there was degree of emphasis that the conceptualisation of the illness as 'self-inflicted' was nurtured internally and this impacts experiences of shame and guilt. This point could be linked to the Heidegger's notion of 'dasein' (see Chapter 3)- the embedded-ness of individuals within their social context.

5.2.6 Shame, guilt and eating

Participants' accounts also focused specifically on intricacies of how shame and guilt come about in relation to ED behaviours. The report found that both shame and guilt were evoked specifically during mealtimes for five out of the six participants in the study. One of the participants that did not feature in this theme focused his experiences of shame and guilt predominantly on the occupational cost of the ED. I turn to discuss participants' account of eating shame and guilt as a simultaneous occurrence.

The participants in this present study talked about eating as an act of transgression that was against the ED mind-set, resulting in a negative evaluation of eating and negative evaluation of the self. It was revealed that eating generated emotions such as sadness, greed, anger that provoked guilt and shame. It appeared that the functional role of ED for Rose, Leah, Kim and Jane was the desire to achieve relentless control of their eating behaviour. Any deviation from this goal such as, the 'mere' act of eating provoked intense shame and guilt – connoting wrongdoing. Rose and Leah, for example, viewed eating as a relaxing activity which they felt undeserving of and one which evokes self-critical thoughts-*'You're not achieving as much as you could be doing or, if you know if you eat a chocolate bar or have a big dessert after dinner, then you're not as 'in control' of your eating as you should be'* as Rose described. The findings support widespread anecdotal accounts of the significance of shame and guilt specifically on attitudes towards eating (e.g. Bruch, 1978; Frank, 1991; Burney & Irwin, 2000; Troop et al., 2004; Skarderud, 2007; Rortveit et al., 2010; Cook, 1994; Jembekar et al., 2002; Waller et al., 2000).

Goss and Gilbert's (2002) shame-shame theory postulates that people with ED can become stuck in shame due to feeling inadequate about the self and loss of control over eating behaviour such as restrictive eating, excessive exercising, bingeing, and purging which in turn intensify ED symptoms. A close account of shame and guilt processes in ED suggests that they are mediated by internalised rules about eating that inform daily living. It is surprising that cognitive behavioural models of ED (e.g. Fairburn, 2008) did not explicitly highlight guilt as a psychological process in psychopathology of ED; however, the model (See Figure 1) implicitly stated the impact of mood affects on the ability to control shape and weight.

It is important to acknowledge here that eating provoked shame and guilt for different reasons for each individual with ED. Rose, who considered herself recovered but acknowledged residual symptoms during the interview, explained that at the time when her ED was severe, not eating was a main goal and eating provoked shame and guilt of not trying hard enough. Conversely, during and post-recovery, eating only triggered guilt and fasting triggered guilt and shame concomitantly. It appeared that commitment to treatment changes the dynamic of shame and guilt, a point I will discuss in the next section.

5.3 Role of shame and guilt in recovery

ED as described by participants connote a pursuit of achievement therefore, the level of difficulty participants experience in recovery appears logical. The recognition that recovery processes are complex has been captured qualitatively by studies looking at patient perspectives of treatment and recovery (Garrett, 1997; Jacobson, 2001; Jarman & Walsh, 1999; Young & Ensing, 1999). Five out of six participants from the present study talked about the dilemma that they face during recovery. Guilt in particular was a salient phenomenon during this phase of ED. Leah described guilt as a 'backlash' from the ED during treatment and in recovery. It appeared that for most participants in the study deviating from the ED rules evoked guilt- a sense of wrongdoing. However, participants also described their motivation to commit to treatment and recovery in order to get better. Unfortunately, the cognitive effect of guilt made this a difficult process, and the struggle and tension of succeeding at recovery elicit shame where some participants described feeling like a failure for not succeeding at recovery.

Leah: It's a kind of 'damned if you do, and damned if you don't' type of thing because I really want to recover, and I'm trying hard to recover. I feel like I don't want to waste any opportunity to challenge my illness and fight my illness. I know if I kind of panic and cave in to it, it becomes a

question of 'I'm I not even good enough to recover'. It's like keeping both sides of your brain healthy at the same time it's like pulling puzzles.

5.3.1 Impact of shame and guilt on treatment/health clinicians' attitude

The findings also revealed that shame and guilt were implicitly induced within the health care system. Some participants talked about treatment primary focus on addressing biological recovery of weight restorations and eradication of weight control measures without considering the dynamics of shame and guilt and their functions. As participants strongly recognised and described the prominent role of shame and guilt in perpetuating the illness and interceding in recovery from the illness, they also felt these strong cognitive and emotive affects /conditions were neglected in treatment. The majority of participants in the study have had treatment such as CBT, and they reported the implication of treatment focus on reinforcement of non-ED behaviours and lifestyle. Rose said:

I had a course of CBT and the focus on that was more about my actions, and I don't know if it necessarily lessened the guilt. I would feel guilty if I was doing the ED action, if you see what I mean. Like, it didn't make the association between not eating and feeling guilty and feeling ashamed of it. It didn't solve the triangle kind of thing.

Participants in other studies have reported this line of findings on ED (see Bell, 2003). Simply addressing physical status can mean patients eat their way out of treatment by conforming to treatment advice but quickly relapsing which invariably makes them feel more out of control; a point made by several interviewees and also by individuals treated for anorexia who participated in a qualitative study by Hsu, Crisp, and Callender (1992). This finding could explain the report from studies that have emphasised that people with ED are at greatest risk of relapse (Herzog et al, 1997; Carter et al., 2004). Equal consideration of patients' psychosocial and physical functioning during treatment could help to provide them with a more stable state of being with which to face future problems and prospects.

Some clinicians have attempted to address this dilemma. For example Duker and Slade (1998) suggest how slow approaches to weight-gain that address psychological and physical change in parallel can help to maintain some sense of personal autonomy. Treasure et al. (1995) also stressed the importance of helping young people with AN receive inpatient care in a way that progresses their self-development and in ways that help them feel more 'in control' of their treatment. Such approaches should be collaborative in nature (Duker & Slade, 1988). This is why Federici and Kaplan (2008) advised that weight maintenance may not always signify

recovery, based on a comparison of views of people who have fully recovered and people who relapsed following treatment of ED. One major difference in the views gathered by the authors among the two groups was the way that they processed negative affects, which impacted self-validation and maintenance of personal worth and value. The study concluded by advising that the ability to tolerate and interpret negative effects was central to the recovery process. Therapeutic approaches that place greater emphasis on emotional regulation and exploration of self-conscious affects such as shame and guilt may have important implications for treatment. Whilst the aim of treatment is to help the sufferer, treatment attempts could potentially re-invoke feelings of powerlessness and hence, may inadvertently contribute to the maintenance of the behaviour they ostensibly wish to change (Warner, 2001).

5.3.2 Shame and guilt of seeking further treatment post recovery: relapse vs. recovery

To my knowledge, the function and role that shame and guilt serve in ED in the context of recovery has never been qualitatively explored in clinical literature to date despite significant recognition of shame and guilt as core to the disease. Recovery from the ED comes as a perceived cost because the ED brings perceived benefits to the sufferer, a point I have highlighted above. Eivour et al., (2002) suggests that the functional nature of the disorder is not always lost after initial treatment interventions and that for people with anorexia, starvation may serve as a coping strategy throughout various stages of the disorder.

The study revealed that people fail to seek further help for experiences of ED symptoms that surface post-recovery due to feeling ashamed and guilty and the perception that they will be negatively judged or misunderstood by clinicians. This could also explain the migration of people from one ED diagnosis to another (Fairburn, 2003). An example of this migration is one of the participants in this study who as a teenager was anorexic but developed bulimia nervosa as an adult. This could account for why individuals become stuck and confused with why they are unable to overcome their ED, leading to overpowering presence of shame and guilt for using/ requiring psychiatric services as relayed by most in the study. Although recovery may be seen as a healing process, it appears to evoke a sense of grief and loss for certain individuals, which I turn to explain next.

5.3.3 Grief and loss of ED identity

Considering the functional and purposive nature of the ED for majority of the participants in this study, it appeared that recovery from ED served as a major loss for some which evoked grief responses. Kim's fascinating quote movingly captures this:

I guess because it's part of my identity, I feel really ashamed about gaining weight. I guess I feel like I've lost control of myself and I'd let myself go. I sort of feel ashamed that I've recovered, especially when I see other people who haven't recovered I kind of start missing being sick again.

Lamoureux and Botorff, (2005) cited the sense of control and power that ED offer, along with the association of ED to identity and perception of self as not good enough as three crucial factors that make recovery from ED difficult. Granek (2007) found that for most women, thinness and the ability to control body weight through restrictive dietary intake and resisting eating urges were thought to be among their greatest possible achievements. For participants like Kim, diet restriction had been a big part of her identity from an early age of fourteen. It was felt that relationship with food at the early stage of life development provided that immediate need for security. Hence recovery from this would come as such a huge cost, which explains the immensity of anxiety, loss and grief that people like Kim report experiencing during recovery phases of ED.

Lamoureux and Botorff, (2005) explained that people find it difficult to tolerate and manage a sense of vulnerability that becomes apparent during the process of recovery posing intense fear of being exposed, heightened sense of insecurity, powerlessness and loss of sense of self. These psychological explanations are corroborated by the descriptions of Kim and others. It is no wonder that recovery from an ED is such an arduous process, particularly as it becomes engrained with the individual's identity. The majority of studies looking at factors that enhance recovery have supported this claim by reporting that the ability to develop an identity independent of the ED is one of the most crucial factors in recovery (Offord, Turner & Cooper, 2006; Federici & Kaplan, 2008). Likewise, memories of the ED as well as the residual cognitive and emotive symptoms that participants experience post-recovery act as constant reminder of the ED and hence result in the enduring nature of shame and guilt experiences. Ava talked specifically about finding it difficult to integrate her ED past with her current view of self. Within this discourse, she was able to recognise her strengths and conceptualise a positive view of self from the perspective of others.

Rose and Leah emphasised this tension. They described recovery as a stage filled with dilemmas and tensions where the ED mind-set 'grows' and 'shuts out' the self that is independent of the ED and vice versa. Rose explained this mind-set:

There are two sides and I always feel like my mind is a circle. Like Rose, I don't know 80% of the circle and then there's the ED bit around the edge of the circle and sometimes that half of the circle grows and pushes Rose out and that, as you were saying, the guilt that is associated with eating and relaxing, sometimes this part of Rose grows and that makes the guilt associated with the ED behaviour and it's a bit like a balance between the two halves.

It was obvious that participants were beginning to discover aspects of the self that are independent of this ED. Treatment can focus on helping them enhance these aspects. This could be achieved by teaching self-development strategies especially post-recovery from ED. This would hopefully integrate the two split selves by way of acceptance, leading to a change in ED cognitions and beliefs (Lamoureux & Bottorff, 2005).

In the present study, it appears that shame and guilt experiences collude negatively with participants' sense of self during the course of the ED in a way that could initiate and intensify self-blame. For instance, Leah described herself as someone 'independent,' 'proud' and 'stubborn' prior to her ED. She saw these qualities as her strengths. She echoed that she disliked being perceived as 'weak'. This impacted significantly on her appraisal of ED and the arduous recovery process that is inevitably dependent on receiving professional help. She stated that this intensified her experience of shame and guilt. Garner and Bemis (1985) have long advised that treatment needs to help people recognise the serious limitations of viewing themselves as unidimensional beings and progress toward expanding their perceptions of self as complex, multi-dimensional being.

In addition to this, some participants were deeply saddened about the losses that the ED caused them. Some of these losses are immense such as enthusiasm about life goals. Some are irrecoverable and thus evoke shame and guilt post-recovery, with the added perception and belief by the participants that the illness was self-initiated and that they did not make enough effort to achieve recovery on time. Shame and guilt in ED are therefore not solely related to current psychiatric status. Feeling ashamed was described as a daily occurrence relating to navigating through life, reflection on past and future.

5.3.4 Impact of shame and guilt on disclosure in treatment

The consequences of shame and guilt were also noted in relation to disclosure of information in treatment. During treatment, participants talked about feeling ashamed about discussing shameful ED behaviours. It is generally noted that non-disclosure in psychotherapy is higher because of actual or anticipated shame experience in general population (Macdonald & Morley, 2001) and specifically in ED patients (Swan & Andrew, 2003). In the present study, the most common issues sensitive to disclosure were severity of ED difficulties and failure to adhere to eating plan, weight, relapse symptoms and purging behaviours. Goffman (1990) highlights pertinent reasons linking shame to lack of disclosure in treatment. The author explained that shame resulting from discrediting conditions results in the need to preserve one's identity and dignity by controlling information about the stigmatising attribute of their condition. Within the present study, participants revealed excruciating shame experiences resulting from certain treatment strategies, which led them to conceal information. Participants reported that they concealed information about behaviours that provoked shame. All alluded to difficulties talking about purging methods for reasons relating to the perception that these behaviours are socially unacceptable. Fasting and restriction were among behaviours that participants reported were easy to disclose because these behaviours are socially accepted. The shame response to socially unacceptable behaviours could be an attempt at preserving dignity and personal identity as described by Goffman. However, in similar tone, participants reported feeling guilty for withholding information from their clinicians. Therefore, the study points to the idea that protection of identity is a motivator of failure to make disclosure in treatment and not a mere result of ambivalence, as it is often referred to in literature (Hsu et al., 1992).

Knowing reasons for non-disclosure will help identify ways in which treatment can help people overcome these challenges and cultivate an open attitude and at the same time demystify patients' feelings of shame in treatment. The majority of studies looking at what works in the treatment of ED have echoed feeling understood by the therapist as healing factors (Beresin, Gordon & Herzog, 1989; Hsu et al., 1992; Nilsson & Hagglof, 2006; Rosenvinge & Klusmeier, 2000; Tozzi, Sullivan, Fear, McKenzi, & Bulik, 2003; Tierney, 2007).

5.4 Theoretical conceptualisation of shame and guilt in relation to ED pathology

The findings pay witness to the presence of shame and guilt in the psychological and physiological processes that underlie ED as reported in the wider literature. Despite this evidence, there remains an empirical question regarding the characteristics of shame and guilt. The study potentially highlights the difficulty exploring shame and guilt based on self-report, given the way the participants in the study struggled to disentangle the internal experiences of shame and guilt due to their intensity and powerful dynamic.

Even with the difficulty encountered in distinguishing shame and guilt by participants in the present study, the present findings go some way against other studies that have reported negative correlations between guilt and ED (e.g. Sanftner et al., 1995). This perhaps explains why guilt has received terrifically minimal attention generally. Likewise, a few researchers that have explored both shame and guilt explicitly state that the role of guilt in ED pathology is not as substantial as the role of shame (Burney & Irwin, 2000). These findings and attitude towards guilt presence in ED significantly contradicts the findings of the present study. The accounts of participants in the present study suggest that the experience of guilt in ED may be more significant than what has been reported in other studies particularly as some participants explicitly stated guilt as an affect that hindered recovery from the ED.

5.4.1 Theoretical conceptualisation of shame: Positive vs. negative shame-implications for ED

Shame has been described theoretically in terms of its moral and psychological nature. Within this, there are two arguments; one looks at the positive characteristics of shame (Fedewa, Burns & Gomez, 2005) and the other looks at shame as a result of negative appraisal of self (Kaufman, 1989; Nathanson, 1994; Gilbert & Miles, 2002; Cook, 1994; Gilbert et al., 2004). Positive description of shame invites the belief that shame is a social protection mechanism that motivates us to conduct ourselves positively in social contexts. The psychological role of shame response is that it automatically involves negative scrutiny of self and fosters the perception that others do not perceive us the way that we perceive ourselves. Those that have subscribed to the negative views have presented that shame tends to lead to a withdrawal from our social affairs (Gilbert et al., 2004). In the present study, the conceptualisation of shame is one which sees it as perpetuating the ED via all the aforementioned shame responses (i.e. need to hide the flawed self from others).

Indeed, the present analysis found that shame hampers treatment as participants describe feeling ashamed to share useful information in treatment. Although it may be that shame response serves as a protection mechanism for people, in this case it fosters negative beliefs about the self, hampers ways in which people are able to disconfirm these beliefs and impinge on ways to build a more rich and accurate perception of themselves. Therefore, experiences of shame within this study as described by participants align predominantly with the negative features of shame.

5.4.2 Theoretical conceptualisation of guilt: implications for ED psychopathology

Theoretically, guilt has been found to be an adaptive emotion that is more relevant to behaviours than the self (Lewis, 1971). Guilt has also been characterised in terms of its moral and psychological nature. Indeed, most of the evidence on guilt makes poignant references to its moral nature. It is widely believed that we experience guilt when we violate moral standards (Lindsey-Hartz et al., 1994). While in the case of shame, we tend to focus on the self as the origin of any form of violation. With guilt, researchers have claimed that the focus is on the behaviour (Lewis, 1971; Tangney, 1998). One popular argument that extends from this concept of guilt as behaviour-specific is that it motivates us to make amends, which is why guilt is found by some to correlate negatively with psychopathology such as ED (Tangney, 1998; Sanftner et al., 1995). The present findings could support the view that guilt drives reparation; however it fails to support the view that guilt is an adaptive affect. For instance, participants talked about their ED as an attempt to achieve control and power via restricting and weight loss. Guilt in this context motivated participants to restrict their eating even when they considered letting go of their ED in treatment.

It is important to identify ways in which guilt shares features with shame in the present analysis. Both shame and guilt are driven by internalised standards such as rules for living within individual stories. For example, Jane recognised that, *'I have an image of how life should be'*. In talking about her perception of life, she discussed how her career in the health care field influences the standards that she sets herself. Therefore, her shame was predominantly about violating these standards of how she should live life e.g. mirroring the role of 'Mary Poppins' in her 'mummy duties':

I've got children, and the idea is that you're always you are a real life Mary Poppins. Seeing as I'm actually a miserable git and scream at my children when I'm in a bad mood, I then feel ashamed and wouldn't ever want anyone to see me in kind of full on 'I have told you 300 times not to do that' mode.

Similarly her guilt experiences were based on violations of standards. For example, she described feeling ashamed about binge eating and vomiting, and also described feeling guilty about leaving her children and husband to seek treatment.

5.4.2 Individual difference in theoretical constructs of shame and guilt: classification of shame & guilt

While this study has demonstrated commonalities between shame and guilt, it has also highlighted how individualised and contextualised people's experiences of shame and guilt are. In light of the above, the contradictory findings in literature about shame and guilt could be that these experiences carry different meanings for each individual. For instance Kim highlighted that shame was predominantly about weight gain and thus reported less experience of guilt in relations to ED behaviours, recovery and treatment. Leah, Ava, Rose and Jane recognised that they sometimes experienced guilt in relations to eating however, they also shared experiences of shame in relation to not eating particularly during the period of treatment.

Classifying shame and guilt as the result of violating specific morals may be too vague, as people have different concepts of morality. Jane affirmed that, *'I tend not to think of shame in relation to moral standard, it's just about lifestyles.'* Therefore, shame and guilt should not always be viewed through the lenses with which they have been viewed in some literature. Elsworth (2007) said that much of the research exploring the link between shame, guilt and ED has tended to view shame and guilt as global constructs and assess shame and guilt as traits due to the measures utilised. Therefore specific situational contexts that could account for variance in shame and guilt experiences are omitted. Gilbert (2007) noted that when working with shame issues, it is preferable to concentrate on those particular aspects of self that are actually the focus of shame (Skarderud, 2007). Due to the close similarities between shame and guilt, it can be argued that this investigation of aspects of self and behaviours that are found or hypothesised to be relevant to shame and guilt should be closely investigated rather than exploring the affects from a global lens. Specifically, in people with ED, there are a few of aspects of self and facets of the ED that frequently cause shame and guilt, including shame and guilt about body, appearance, perceived failure to achieve control (Skarderud, 2007; Goss & Gilbert, 2002).

Similarly, within this present study, it would be artificial to omit individual differences in the accounts of shame and guilt experiences. The study has taken a holistic approach to finding out what these experiences are and what they mean to ED sufferers. This means that

recognition was paid to the fact that people in the present study are at different stages in life, which would automatically impact on this study's ability to interpret the meaning of the phenomena under investigation. Additionally, the study invited people to take a journey down memory lane in order to articulate their reasoning of core experiences. Although some can view this as a limitation, I would argue that it accounts for the richness in construction of meaning and adds value to the principle of idiography that underpins the methodological approach used in the present study.

5.5 Significance of the study

The present study provides a contribution to the understanding of the phenomenon of shame and guilt in ED. The study appears to be the first to have conducted qualitative exploration of shame and guilt conjointly and to include their impact on treatment and disclosure in treatment. In exploring the impact of guilt, the findings indicate that guilt is an important affect that warrants focus on having a holistic understanding of ED and one that warrants significant focus in treatment. After reflecting on the findings from the present study, it is puzzling that the phenomenon of guilt has been neglected in ED studies. I am indeed surprised by the insistence of some researchers on the adaptive nature of guilt in psychopathology and the negative correlations with ED psychopathology and symptomatology.

It can be argued that the difficulty separating shame and guilt by individuals in the present study could account for the misunderstanding in literature. A major finding in this study is the symbiotic relationship between shame, guilt and ED. These experiences were found to vary among individual participants, and to interact in a complex way. This thus also gives credence to the current findings that shame and guilt are powerful phenomena.

Although the focus of the study was not on aetiology of ED, the analysis found that participants generally did not talk in terms of shame as a cause of the ED though some participant made passing comments at possibility of embarrassment, poor self-esteem as impacting the onset of the illness which could be argued to fit with the profile of shame. The accounts of individuals in the study point to the impact of motivational drives for survival (common to all human beings) in the development of ED. This stance raises questions over the dominant role of socio-cultural attitudes in the aetiology of ED which participants did acknowledge. As a result of this research, I hope that clinicians and researchers can begin to

take a different perspective in understanding of causes of ED. This can be achieved by shifting our perception that ED is driven by victim mind-set to one motivated by drive to better one's life; an endeavour common to all human-beings. Nonetheless, the study points to the impact of social cultural attitudes towards weight and shape in influencing individuals' attitude towards the different ED behaviours.

The findings have elucidated how the identity of an individual with ED is impacted by shame and guilt experiences particularly during recovery stages. Studies looking at recovery from ED have not addressed the phenomenon of identity shift at the onset of the illness as well as recovery from the illness. In terms of gender differences in relations to the experience of shame and guilt, the study did not identify any difference among female and male participants. This could however relate to the fact that only one male participant took part in the study and the aim of the study was not focused on gender differences.

This study highlights that there remains a significant gap in knowledge and understanding of ED. It points to the need for research to pay attention to these processes as more understanding poses a chance of improving long-term treatment outcomes. Particularly, the findings on loss and grief processes experienced during the recovery phase and the confusion that this poses for the individual.

This study also appears to have been the first to focus on shame and guilt to include the diagnosis of EDNOS; other qualitative studies seem to specifically include anorexia or bulimia. Searches of literature indicate that there is a lack of qualitative research into EDNOS category. Therefore, although this present study included mixed diagnoses, the findings do provide some contribution to the understanding of EDNOS, as the idiographic nature of IPA allows voices of individual participants to be heard.

5.6 Implications for practice

5.6.1 Implications for clinical research

The results of the present findings have potential significant clinical and research implications particularly in further exploring the role of shame and guilt in the treatment of ED. These findings and others (Burney & Irwin, 2000; Rortveit et al, 2010; Grabhorn, Stenner, Kaufbold, Overbeck, & Stangier, 2005; Swan & Andrews, 2003; Troop et al., 2008; Skarderud, 2007; Goss & Allan, 2011) that have highlighted shame and guilt as salient processes in ED

psychopathology and symptomatology evidence the need to directly address these experiences in treatment. Particularly as it is common knowledge that shame and guilt responses motivate the desire to hide, withdraw or escape (Goss & Allan, 2009). However, to accomplish such a task, it is obvious that we need more understanding of both phenomena. By collecting the views of people who have been diagnosed and had treatment for ED, the study adds to the existing body of research on shame and guilt affect in ED experience.

5.6.2 Implication for counselling psychology

The findings of the present study have significant implication for the practice of counselling psychology and equally for the variety of clinicians working with people suffering from ED. The study highlights that the phenomenon of ED is one that is rife with complexity in relations to its etiology. The dominant understanding of ED pathology comes mainly from a medical discourse, such as the classification of ED under the DSM. There is no doubt that this method of conceptualisation and classification has forwarded our understanding of ED. However, its laxity comes in terms of the classification of ED as an individualised pathology with objective diagnostic categories that exist independently of an individual's psychosocial discourse.

The findings highlight that for the participants in the study there are varying factors that implicated their development of ED and varying ways in which they experience shame and guilt within this context. Equally, the function of the ED differed for each individual. This stance is important for the ethos of counselling psychology that attach great importance to seeking an holistic understanding of individual's subjective experience by exploring the meaning that are inherent within a particular phenomenon. The thesis highlights the need to utilise a multidimensional approach in the understanding and treatment of a complex illness such as ED.

Counselling psychology identifies with a pluralistic philosophy, which means 'any substantial question admits a variety of plausible but mutually conflicting responses' (Rescher, 1993, p.79; Cooper & McLeod 2011) particularly in relations to phenomenological inter-subjective experience of those involved in the therapeutic process. Currently in terms of the understanding of ED and its relationship with the phenomenon of shame and guilt, many socio-cultural explanations of the processes involved in cause and course are limited to the documentation of increased appreciation for an unattainable slim body type which could sometimes mean that people with ED are seen as those that over-adhere to this pressure. This casual explanation could be said to omit the subjectivity of the person affected by failing to explore the significance and meaning attached to their relationship with eating and other ED

behaviours. The succeeding sections will pay attention to a specific thread of discussion and suggestions for clinicians (including counselling psychologists) working with ED that emerged from hearing the subjective experiences of people with ED.

5.6.3 Implications for treatment

The identification of maladaptive experiences of shame and guilt that perpetuate clinical distress among ED patients and people in recovery may help recognise targets for clinical intervention. Tangney and Dearing (2003) advised on the positive impact of addressing shame in treatment:

Simply verbalising the events and associated experiences often serves to ameliorate the feeling of shame. As clients translate into words their preverbal global shame reaction, they bring to bear a more logical, differentiated thought process that may compel them to spontaneously re-evaluate the global shame nature of the shame-electing episode (p. 175).

This signifies the need to specifically address the phenomena of shame and guilt directly in therapy. It is therefore important for both clinical and non-clinical practitioners to be able to identify shame and guilt and provide an environment that will encourage people to verbalise their experiences of shame and guilt. This may mean that services provide training for clinical and non-clinical staff on the role of shame and guilt and ways in which they can identify shame and guilt in client's presentations. It is also important that clinical and non-clinical staff pay attention to their own attitudes that may evoke shame and guilt responses in people with ED. I place emphasis on non-clinical staff because from my own professional awareness, they have such a significant role to play in the treatment experiences of people with ED. This includes administrative staff that may only communicate with patients over the phone. Their awareness of the powerful impact of shame and guilt in people with ED may help foster a more warm attitude when they engage with them in a way that will promote engagement in treatment and invalidate the prominent negative beliefs about self in the eyes of others. Studies have also shown that insensitivity of support worker staffs to the suffering of AN patients impacted significantly on their experiences of inpatient treatment (Bell, 2003; Treasure et al., 2007). This included ways in which staff addressed people with AN and the insensitive comments made about eating and weight in a way that trivialised the struggles that people with AN were enduring during treatment and recovery.

Communicative strategies that diminish experiences of shame and guilt may be particularly crucial for non-clinical staff in the treatment of ED. This has been talked about in health

literature (Piechart & Elam, 1986; Lazare, 1987; Malterud & Hollinagel, 2007). For example, Frich et al (2007) suggest that the health professional may diminish guilt by emphasising uncertainties with self-management conditions such as ED. The authors further recommended recognition and validation of shame and guilt and they suggest that responsibility for wellbeing should be cautiously encouraged to avoid the impression that recovery is dependent on the patient's ability to manage the treatment programme.

5.6.4 Tailoring intervention to address emotional regulation during recovery

The findings from this present study highlight the importance of emotional processing and affect regulation during recovery from an ED. Based on participants' responses, the ability to tolerate experiences of guilt described as '*backlash from the ED*' and shame experiences in relation to self and ED could have made a difference in how they deal with relapse symptoms. Although, the research findings are too limited in scope and methodology to prescribe specific therapies, the findings support therapeutic approaches that place greater emphasis on self-conscious experiences and how emotional regulation may be integrated into treatment.

The findings also highlight that ED treatment alone may not be enough to address shame and guilt responses. I believe that it will be necessary to address shame and guilt responses prior to and after treatment. I echo the findings of Colton & Pitstrang (2004); they suggest intervention that incorporates social support skills post therapy from ED. The current findings reveal that shame and guilt may remain unresolved after treatment, these may mean that individuals require further support to prevent relapse, as these states coincide with the ED symptoms.

5.6.5 Integrating techniques into existing treatment models that will specifically address shame and guilt

It may be that current empirical treatment for ED needs to be delivered in a way that gives particular focus to individual's subjective experiences of shame and guilt. Currently the two empirically supported approaches to treatment of AN and BN (according to NICE guidelines) focus on negative affects. CBT for BN (CBT-BN) (Wilson, Fairburn & Agras, 1997) focuses on identifying and modifying maladaptive cognitions and emotive states that trigger bingeing episodes. The persistent focus on changing ED cognitions and behaviours may evoke shame and guilt responses as identified by some of the individuals in the present study. One goal of CBT may thus be to identify and address these shame and guilt affects and responses in a way that will shape the client's beliefs. Similarly, in interpersonal therapy for BN, it is believed that the client's focus on interpersonal dysfunction and binge eating is used to manage or soothe

negative affects that result as a consequence of interpersonal defects (Fairburn, 1997). Shame and guilt may occur within this process. However, further clarification of the role of shame and guilt in ED symptoms are suggested.

The relatively new compassionate-focused therapy (Goss, 2011) for ED, which is a group-based programme, includes explicit strategies that address shame and guilt. The treatment is an extension of existing CBT approaches that includes incorporation of self-compassion and self-soothing strategies to manage self-directed hostility (Goss & Allan, 2009) and it has been found by patients to be more beneficial than traditional CBT on the basis of it alleviating loneliness and isolation and promoting acceptance of self.

5.6.6 Taking an idiographic approach to treatment

An empathic and empowering stance is crucial in treatment as shame and guilt may be influenced by their perceived functional role in different ED behaviours for each individual. Likewise, the analysis identified variance in shame and guilt experiencing for those in the present study. This stance points to the need for practitioners to be empathically attuned to each individual's presentation by taking an idiographic approach. For example Kim's experience of shame in recovery appeared to have a different focus to the rest of the participants. Whilst others acknowledge the presence of shame and guilt during treatment and recovery, Kim explicitly stated that treatment and recovery is predominantly about shame and not guilt due to the values she invested in weight-loss. Therapists are encouraged to explore the meaning and function of different aspects of ED and deeply explore the function and role of the affects that they elicit. The use of individual case-conceptualisation in treatment has been suggested as a good practice (Johnstone & Dollos, 2013).

5.6.7 The need to develop psycho-education on ED for a wider, non- clinical context

Services could benefit from providing psycho-education for parents and carers on the impacts of shame and guilt on ED and overall education on ED and its manifestations. Goss & Allan (2009) advised of the importance of designing psychotherapeutic strategies that target both explicit and implicit aspects of shame and guilt in treatment. The failure to recognise shame within the patient-therapist relationship and the central role of shame in the patient's inner experience jeopardizes the success of any therapy, whatever its theoretical background.

Social identity issues are not often considered in treatment. However, understanding the breadth of psychological factors that can influence a person's response to mental health

problems is important in developing an individual formulation and treatment intervention to improve clinical outcome (Petrice & Winman, 1997). Participants in the present study described extensively the impact of social attitudes on their ED. Furthermore, stigmatisation of ED diagnosis has been reported to impact people's attitudes towards seeking treatment and levels of engagement in treatment (Skarderud, 2007). Research involving members of the public has shown that people regard anorexia as a slimming illness that is easy to overcome (Holliday, Wall, Treasure, & Weinman, 2005) or as self-inflicted (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000) and blame sufferers for attention seeking (Mond, Robertson-Smith & Vetere, 2006). These findings suggest the need for interventions to increase knowledge of ED in the general public. It is believed that this may help raise awareness regarding the nature of ED and enhance early detection by family members and friends. These interventions need to address public beliefs regarding causes and treatment of ED as well as the significant role of shame and guilt experiences.

More importantly, general practitioners (GP) who act as the gatekeepers of specialized treatment will benefit from knowledge about the influence of shame and guilt in ED. If practitioners such as GPs cultivate an empathic and compassionate understanding at this early stage of consultation, this may serve to nurture a more positive perception of self. This may increase individuals' readiness for treatment and change. Tierney (2007) also highlighted instances where GPs have failed to detect early signs of ED due to what the participants in the study referred to as 'insensitivity and a lack of understanding' (p. 371).

5.6.8 Focusing on identity formation and re-formation in treatment: paying attention to processes of grief and loss

As previously stated, the ED forms part of people's identity however, recovery from the illness (although positive) has the potential to destabilise the individuals' identity. It is therefore important that changes in the individual's identity formation are not neglected due to focus on weight restoration and physical recovery. Although weight restoration or healing from other ED behaviours may be beneficial for the individual, if these are the only factors by which we judge recovery of individuals, then we run a risk of ignoring internal experiencing of the person whose ED may have been experienced as a loss or lead to identity crisis. This could make such individuals vulnerable to relapse or even susceptible to other psychological difficulties. An unequal focus on the physical recovery compared to the psychosocial recovery during treatment was a concern among those interviewed in Tierney's (2007) study that explored the views of young people about being treated for anorexia. It has been over two

decades ago that Bereslin et al. (1989) suggested the need for self-understanding, self-development and self-discovery during recovery for ED. Elsewhere, these themes continue to feature in patient's perspectives of what made recovery work (Garrett, 1997; Hsu et al., 1992; Tierney, 2007; Federici & Kaplan, 2008).

5.6.9 Re-evaluating measures of recovery

These findings may help us understand why people struggle to recover, and help challenge the dominant view that people with ED do not want to give up their ED (Pettersen & Rosenvinge, 2010). Particularly, as the findings highlight that the arduous process of recovery initiated internal blame on the part of the suffering individual due to the emphasis on responsibility that people ascribe to developing and maintaining illness. Rosenvinge and Pettersen's (2010) study found that people with ED reported an internal locus of control, which means that they took responsibility for the illness and subsequent recovery from the illness.

A worthy suggestion by Rosenvinge and Pettersen (2010) is that high levels of personal responsibility or control demonstrated or experienced by sufferers may not be enough for recovery. These might indicate the power of the presence of negative experiences of shame and guilt even after people have had treatment. Therefore, reduction of symptoms, particularly in aspects of physical recovery, should not be the overall treatment goal but rather as a means to achieve more functional interpersonal relations, thinking and problem solving strategies. Although the participants in the study have had treatment for ED, all of them reported current experiences of shame and guilt that relate to ED psychopathology and symptomatology. Some also reported feeling ashamed of these current experiences and talked about how shame prevented them from seeking further treatment. This suggests that people with ED may need further support to address residual negative affects after treatment, as physical recovery may not account for full psychological recovery.

Assumptions about responsibility of conditions related to self-management and self-control are implicit in treatment. This poses the risk of inducing shame and guilt when using strategies of positive reinforcement without acknowledging cognitive and emotional experiencing of shame and guilt in relation to ED. The client may feel guilty and ashamed to talk about relapse in treatment. It will be beneficial if clinicians could take time towards the end of treatment to educate clients about the likelihood of shame and guilt experiences after treatment and teach strategies they can use to address these affects.

5.7 Suggestions for future research

The findings of the present study strongly demonstrate the link between shame, guilt and ED and have illuminated the lived experiences of these for six individuals. The variance in experiences of shame and guilt among the individuals in this study points to the need for it to be repeated with other individuals; potentially using a more homogenous pool of participants with one type of diagnosis. Also, a way to work with the nuances of shame and guilt experiences could be through the use of a different qualitative methodology. I wondered what result would be achieved from using a narrative approach where stories of each individual are given significant focus.

The current study has highlighted the need for more qualitative study on the phenomenology of shame and more emphasis on guilt in ED population. Participants in this present study gave multifaceted accounts of all the phenomena under investigation, which was at times contradictory, but was movingly fascinating. It would be interesting to see case study accounts of people's experiences of shame and guilt in ED in order to see differences in experiences at an individual level. Flyvbjerg (2006) argues that the field of social sciences has failed in '*its relentless efforts to produce general context-independent theory and therefore can only offer concrete-dependent knowledge*' (p. 223). The author favoured case studies as a valuable means to provide such knowledge, which is viewed as core to the development of professional practice. It would also be beneficial for future studies to look at homogenous samples in relation to gender, age and diagnosis as the narrative of shame and guilt may vary in these different contexts.

Further research suggested by this study would be the investigation of humanistic and self-motivational drives in the development of ED due to the intriguing finding that shame was widely identified by participants as a negative correlation to the onset of ED in this study. The findings point to the need for practitioners working in the field of ED to recognise and acknowledge that ED may be viewed as allied to a drive to self-actualise, albeit in a potentially damaging form. This is particularly important for the counselling psychology sector that is founded on humanistic principles. The humanistic root emphasises the search for meaning and understanding where the focus is on clients' subjective experiences, values and beliefs. This clearly identifies an opportunity for the contribution of counselling psychology to the understanding of ED.

5.8 Limitations

The study was exploratory and preliminary in nature, and the findings should be considered in the context of the following limitations. First looking at 'twin' phenomena such as shame and guilt together in light of their close similarities has potential implication for the analysis and findings. However, this study has allowed for an opportunity to explore the intertwined relationship and also highlighted the difficulty in discerning between the two phenomena.

In terms of sampling, all participants were White-British and mostly females. Duration of illness and treatment were heterogeneous, which may relate to the chronicity of each individual's ED, shame and guilt experiences. There are potential limitations in having a small sample size, however, it is not the intention of qualitative research to produce a generalisable result (Giles, 2002). It is acknowledged that this may limit the findings and the clinical implications derived in the study.

Additionally, there might have been other baseline factors such as age, gender, or history of ED that could have impacted on the individual's narrative of shame and guilt experiences. However, it is believed that the idiographic approach that was taken within this study pays particular attention to each individual's subjective experience. The study did not set out to search for specific truth but it set out to gain an understanding of how participants construct their own truth at a particular point in time. It is therefore believed that the study achieved its aims by staying closely to participants' interpretations throughout the process of analysis and discussion. Nonetheless, both shame and guilt emerged as significant experiences in ED population and thus support existing empirical research that have reported the same findings.

It has been discussed in literature that the experiences of shame and guilt vary in terms of cultural context of the individual (Crystal, Parrott, Okazaki, & Wantanbe, 2001; Fischer, Manstead, & Mosquera, 1999; Kitayama, Markus, & Masumoto, 1995; Li, Wang & Fisher, 2004; Mennon & Scweder, 1994; Romney, Mooore, & Rusch, 1997; Stipek, 1998). Although all participants in the study are white British, it could be the case that age dynamism played a part in the subjective meaning attached to shame and guilt discourse, which this study did not account for. Nonetheless, definitions of shame and guilt were generally similar among all participants. It is recommended that incorporating cross-cultural research findings on shame and guilt would enable a comprehensive understanding of these two phenomena. Wong & Tsai (2007) suggested that the value, trigger and behavioural consequences of shame and

guilt may differ across different individualistic and collective cultures. The authors identified that western societies that promote self-independence devalue shame and value guilt over shame. They concluded that in these societies, guilt is viewed as adaptive within the shame and guilt model. On the other hand, other cultures (e.g. Chinese and African cultures) that promote interdependence self tend to value both shame and guilt and often distinctions between the two phenomena are impossible with both shame and guilt responses being valued as adaptive.

Additionally, as shame and guilt are entwined with the ED and as the discourse of the ED have seen a significant change, these changes may influence experiences reported in the study. This may serve to influence participants' responses to shame or experiences of shame and guilt. Thus the result may not be applicable to other cultures and variance in shame experience may exist among participants based on age range, which may impact on individual valuation of shame although this was not derived from the findings. The next section provides a reflection of my own 'lived experience' of engaging with the lived world of my participants, the impact that hearing and interpreting their stories has and continue to have on me as a person, as a researcher and as a soon to be qualified counselling psychologist.

5.9 Lived experience of engaging with the study

As I immersed myself into the lived experience of the participants in the study, I became aware and sensitised to my own thought processes and the dynamics of shame and guilt that unfolded within me. One aspect of impact was my hyperawareness and sensitivity towards my own eating behaviours, although I had been 'more' sensitive to my eating behaviours since starting a placement at the eating disorder service. This line of treatment and support meant that I educated clients on the biological implications of normal eating. I also worked alongside a dietician who had expertise in the area of normal eating practices (i.e. the number of calories to be taken, food portions, the intervals recommended between each meals, the psychobiological dangers of skipping meals etc.). Most of the participants in my research study talked about the difficulties of practicing 'normal eating' despite having had treatment. As a result, most described feeling guilty and/or ashamed for failing to adhere or practice normal eating. Indeed during the research, I became aware that I was equally not always practising 'normal' eating, and at times, my pattern of eating could be classed as chaotic especially during the final year of my doctorate and writing up of this thesis due to the demands associated with these commitments. Prior to joining the doctorate I was somewhat

conscious of healthy eating and unhealthy eating and although, I did not always commit to a healthy pattern of eating, I did not experience guilt or shame in relations to my eating pattern. However, since working at an eating disorder service and doing this research, I had started to notice fleeting feelings of guilt relating to overeating or skipping meals (i.e. breakfast or lunch).

'Eating guilt' was a profound area of discussion that research participants in this study commented on. I noticed that there were points during the interview where I was inwardly validating participants' experiences as this matched my own experience. I was equally aware of this inward experiencing during the stages of analysing participants' data. In my own reflective journal, I questioned the notion of 'normal eating' practices. How achievable is this? I also questioned my authenticity as a person and as a researcher knowing what I know about eating disorders when at times my eating behaviour was akin to what has been dubbed 'disordered eating'. Since listening to, and interpreting my research participants' experiences of 'eating guilt', I questioned what this means for me. It became obvious that my profession as a counselling psychologist with experience of working with eating disorder sufferers impacted on my relationship with food. I felt more pressured to practice 'normal' eating than I had ever felt in my life. At times, I could not always tell whether I felt guilty or ashamed. I would often think to myself that I was not setting good examples as an eating disorder researcher and practitioner. The fact that eating guilt is one of the core symptoms of eating disorders, and this was an experience that I shared made me question whether it was 'ok' for me to be an eating disorder therapist and to also have this experience. However, I soon realised that the phenomenon of eating guilt is one that is common to most people including therapists. A discussion with colleagues at the eating disorder placement validated my feelings. In recent years, eating has become a behaviour that elicits self-consciousness for most people. This is partly due to the guidelines about quantity and quality of food that is healthy and not healthy that we all are exposed to. Beckett and Davison (2005) have also talked about the negative implication of self-autonomy within the field of health particularly in relations to food and nutrition. The proliferation of healthy eating and healthy living guidelines somewhat put pressure on people and this has the potential to induce negative affects such as shame and guilt. Life demands also have significant impact on how well a person can commit to normal eating. However, the nature of 'eating guilt' is one that people are shy of talking about because of the phenomenon of 'eating disorders', its problematic nature and possibly the stigma attached to mental illness in general. I realised that amongst my other counselling psychology trainee counterparts, the issue of food and weight was also a

frequent topic of discussion. Within some of this discussion, guilt associated with eating was implicit alongside struggles of keeping up with healthy lifestyles that involve eating the 'right' food. This lifestyle was one that was difficult for most (myself included) to achieve whilst striving to meet the demands of the doctorate.

Whilst embroiled in this dilemma and ocean of conflicting and complex experiencing, the case of Melanie Spooner that I cited in chapter one resonated once again with me and in some way provided comfort. Melanie was an intellectual medical practitioner who died of complications resulting from starvation. Though it was obvious that my eating pattern/behaviours were not as severe or debilitating as that of Melanie and some of the voices in my study, it was perplexing at times that their experiences resonated with me. The question I asked (Chapter one) relating to Melanie's professional identity and her health struggles suddenly had a lot more clarity. I have come to understand that just because someone has an professional knowledge and awareness of a problem does not make him or her immune to it. Finding myself visible in my participants' lived experiences is akin to the counter-transference processes in therapy (see section 4.1). Working with clients' stories of shame and guilt in relations to eating made me more aware of my own relationship with food and the impact of these self-conscious experiences. I was able to see some newness in my own lived experience and overall, this research process has allowed me to learn how to stay open to the newness of this experience without inferring judgement (Which I did initially when I started to notice these feelings). I found the concept of mindfulness useful at these times, it has allowed me to see my thought processes for what they are and accept them rather than engage in a battle with them. This information is certainly important with this level of engagement in the data analysis and interpretation. I believe it serves to provide richer and empathic insight into participants' phenomenological experiences and meaning making of shame and guilt in relations to their eating difficulties. As a researcher, I am left questioning the notion of 'eating guilt' and 'normal eating' practices for people in general. I take away with me the awareness that this experience may not be exclusive to people who suffer from eating disorders (as my own personal experience suggests), it could be seen as a wider social phenomenon that may warrant more investigation.

To conclude, the intense personal nature of IPA has changed me as a person outside the context of eating and eating disorders. The art of closely investigating someone's lived experience has influenced the way that I make sense of my own day-to-day experiences. Since embarking on this research process and getting grasp of IPA as a method, I have noticed that I

engage in deeper processing of my own experiences. Although, this is a concept that most psychologists report that they become accustomed to as a result of the profession, I feel that doing IPA has somewhat increased this level of introspection for me as a person. It is a method that has enabled my own lived experiences to be explored and highlighted especially the overall experience of embarking on a doctorate. I have come to respect the challenges and struggles that I encountered along the way just in the way that I respect my participants' experiences. I have become an 'active listener' to my own thoughts.

5.10 Chapter summary

Within this chapter, I have attempted to pull together the findings from the present research that in some way described participants' experiences of shame and guilt in relations to ED. A particular and in-depth focus has been held around participants' meaning making of the processes of shame and guilt and how these phenomena impact on their ED lived experiences with special focus on treatment and recovery. Much of the focus in the initial sections of this chapter has centred on the content of participants narrative by which I have tried to lean unto Ricoeur's (1970) hermeneutics of empathy. However, the presentation has also been informed by hermeneutics of suspicion where the findings have been considered in light of existing psychological theories and literature. I take with me to the concluding chapter the overall, tentatively constructed findings in light of methodological approach utilised and my own involvement in the research process.

Chapter 6

Reasoning draws a conclusion and makes us grant the conclusion, but does not make the conclusion certain, nor does it remove doubt so that the mind may rest on the intuition of truth, unless the mind discovers it by path of experience

Bacon (1266, p.890)

Final discussion, summary and conclusion

6.1 Chapter overview

In this final chapter, I summarise the findings of the present research in light of methodological issues identified before, during and after this study including the limitations of the method utilised. I contribute some additional discussion regarding my role in the research process. I end this chapter and this thesis on a reflexive note sharing my own lived experience of producing this thesis.

6.1.1 Conclusion

The present study has explored experiences of shame and guilt in people who have had treatment for ED. The study has also investigated how shame and guilt processes implicate treatment and recovery from ED. The findings demonstrate that experiences of shame and guilt in relation to the ED include powerful feelings and cognitions about the self. Additionally, shame and guilt experiences are very similar and they are often elicited by the same situations.

This finding adds to the small but growing evidence base that highlights shame and guilt as salient features in the course and maintenance of ED psychopathology. These affects produce negative internal experiencing that makes it difficult for the sufferer to distinguish them independently. Often shame is related to the perception of a worthless self and guilt is related to the dissonance between an action and one's own values or wider sociocultural values. The thoughts and feelings of guilt include self-scrutiny leading to self-blame which often heighten self-criticism. The meaning of shame and guilt at a cognitive level is characterised by condemning thoughts about one's own sense of self and responsibility. At an emotional level they are characterised by the sense of responsibility for the cause of the ED and the recovery from the ED.

The self-critical thoughts that devalue the self are a part of the internal component of shame recognised by Gilbert (2002). Although shame and guilt are evaluative components that could have the potential to promote positive changes, the overall experience of shame or guilt reported by those in the study was completely negative, and did not prevent the propagation of harmful ED behaviours (Tangney and Dearing, 2003; Gilbert, 2002).

The findings also revealed that individual experiences of shame and guilt varied in relation to the ED. This highlights the complex interaction between shame and guilt and ED as well as other self-conscious emotions such as pride. This study has revealed that Shame and guilt take on different nuances in a person's daily life and negatively impact on ED and other types of mental suffering. The phenomena of shame and guilt possess such strength that they result in physical sensations, emotional and cognitive reactions such as silence, withdrawal, self-hate and self-disgust. All these responses have significant psychosocial implications for a person's wellbeing (Tangney & Dearing, 2003).

The study reveals that further investigation is needed to further unravel specific ways in which shame and guilt are entwined with the ED. Although this study did not find correlation between shame and guilt and the cause of ED, a number of studies suggest that childhood trauma provokes shame that could result in eating pathology. This may be an area for further investigation. The thesis has outlined some of the clinical implications of shame and guilt in ED and suggested possible approaches that may help clinicians improve detections, engagements and treatment outcomes of ED.

It is argued that further research into the nature of shame and guilt may lead to the development of a theoretical construct of these phenomena that may provide enriched understandings of ED. Furthermore, the present study highlights the importance of using in-depth qualitative approach to facilitate richer understanding of shame and guilt and their entwined relationship with ED processes that may be difficult to access when using quantitative methodology. Clearly, there is a great deal to be learned from clients themselves about the illness. Further research could contribute to the advancement of a relapse prevention programme that will be directed at managing negative affects that motivate relapse.

Overall, it is hoped that the study has achieved its initial aim of gaining an in-depth and idiographic understanding of shame and guilt in ED in an attempt to illuminate the processes involved in a clinically useful way. As there is a scarcity in the volume of qualitative

publication in this area, it is hoped that this study has contributed something novel to the current evidence-base. I am pleased that this study has helped advance my understanding of shame and guilt and how they affect ED processes. In particular, I know that this research process and the results have positively affected my clinical practice as a trainee counselling psychologist. They have made me much more aware of the potential of shame and guilt issues in any client group.

6.2 Methodological consideration

The strength of the present methodology was the use of an approach that allowed in-depth exploration of individual participants' experiences. Each interview was analysed in a lot of detail. It was considered that this would improve the rigour of the study, and would help ensure that participants' experiences were captured in a way that facilitated a good level of interpretive engagement with the texts. The small sample size which may be seen by some as a weakness, was actually a strength in allowing time to garner depth of analysis so as to ensure that the voices of all participants were heard, thus meeting the commitment of IPA (Smith et al., 2009).

Although I was new to IPA methodological approach, I endeavoured to ensure the quality of the research by reading a lot on IPA. Additionally, I attended a conference and workshop on IPA prior to starting the research process. This was in addition to the teaching on qualitative methods that I received as part of the doctorate training. Finally, research supervision has supported me immensely in attaining quality and maintaining transparency throughout the course of analysis and writing up. I also sent participants copies of the transcript to ensure my reflections of the interviews were accurate. Although this is not mandated for an IPA study, I found it was necessary as some of the interviews were conducted over the telephone, which poses the risk of mishearing information. One participant whose interview was conducted over the telephone made a minor change on their transcripts.

One criticism of methodology could be the heterogeneous sample size in terms of using participants with different ED diagnosis, although this occurrence is defensible in terms of the trans-diagnostic conceptualisations of ED (Fairburn, 2009). The study allowed some attempt at identifying similarities and differences across diagnoses, e.g. the sense of a hierarchy of status among different ED symptoms and behaviours. The findings that there are several consistent themes between the accounts of participants provide support for this process.

However, more divergent theme emerged within the overall discourse. For instance, Jane's experience of body shame differed to other participants' accounts of body shame because of the difference in diagnosis. Shame for Jane was intense due to being overweight. This is a parallel reflection to the limitations of IPA as analytic tool. First, IPA generates an abundance of data that, without a doubt, is overwhelming. The contradiction that I lived out on many occasion was trying to focus on the individual participants and also looking for a pattern across a plethora of experiences. This brought about the dangers of losing out individual experiences within this process. I think that this is a tension that is inherent in IPA and one that pervades the process of research analysis. In retrospect, I wonder if another choice of methodology such as narrative would have generated different findings. Nonetheless, the current study has produced a rich data that has been predominantly based on individual's account of their lived phenomenon. A future study could look at shame and guilt in a homogenous diagnostic sample.

Another improvement to methodology may have been to conduct a pilot interview to further develop my interview schedule. The question "how would you describe the experience of shame and guilt in relation to your ED" in retrospect appears too broad. There are very different facets to the ED that bring about experiences of shame and different focus to these shame experiences. Although participants did not experience difficulty answering this question, they may have varied in aspect of the ED symptoms that they responded to. The question could have been better worded to allow specificity to explore the different aspects of ED. This point could have been achieved through a pilot interview.

Notwithstanding, the interview schedule was used flexibly and sincere efforts were made not to use it as leading questions. Additional questions were formulated in response to participants' answer to previous questions. Furthermore all participants were given the opportunity at the end of the interviews to comment on things that were not asked in the interview. This led to Kim explicitly stating that she was ashamed of receiving EDNOS diagnosis instead of a preferable diagnosis of anorexia; a stance that had been implicit in previous interview responses but was explicitly expressed in following interviews. Also any questions asked by me that did not elicit participants' experiences would not have had an influence on the analysis, because although an interpretative method was used, the themes were rooted in the words of the participants themselves.

In terms of validity of the findings, it should be noted that all participants' had finished therapy at different times and had received varied forms of treatment interventions.

Additionally, one of the participants expressed that they had returned to treatment to address ED related issues. It is expected that this variance of recovery and treatment experiences could have had an impact on participants' accounting in relation to comment about treatment and disclosure in treatments.

6.3 Final study reflections

During the process of carrying out this study, I was mindful of any issues that could arise through the confusion about my clinical role versus my research role. I found the interview process quite difficult as, at that time, I was on placement at an ED service where I had experienced shame and guilt presentations in client population. I did not recruit from the service in which I had my placement; however, it was necessary to be mindful of these differing roles and my closeness to the topic. I had to put a lot of effort into making sure that I asked questions with a research focus and didn't begin to act like a therapist.

Nonetheless, the differing roles were advantageous in some ways. For instance, my knowledge and experience as a therapist allowed me to judge when participants were in danger of revealing more than would be in their best interest to me and to handle the distress that arose as a result of talking about shameful experiences. I felt that my counselling psychology training helped me to encourage participants to discuss very sensitive issues, know when to end an interview and manage any distress. These skills are important when undertaking research on very sensitive topic and I believe that this poses potential danger for someone without therapeutic training. I did find it difficult to listen to people's experiences of shame and guilt. This is something that I did not anticipate prior to interviews. Fortunately, clinical supervision allowed me to process some of the issues raised by participants. In retrospect, I now realise that this was an oversight and I would always ensure in the future that such clinical supervision is contracted into the research process rather than relying on my supervisor's goodwill.

I also found it strange when a client at my placement referred to my body shape. I had never encountered this before, but had witnessed clinicians in the same setting sharing their experiences of clients' making reference to their own weight in treatment. This left me wondering if assumptions based on my gender, colour, appearance, and status as a doctoral student may have influenced how participants responded to my questions, and what they may have chosen to tell me or keep to themselves. This may have evolved as much through our

similarities as our differences. I was aware that I was very similar in age to two of the participants, and that also some of them were employed in health care professions and some of them were also students. However, I do think being a female and a trainee therapist allowed participants to talk openly to me about very sensitive issues regarding their body weight and shape. I feel that my trainee status infer my genuine curiosity in wanting to understand a very complex phenomenon in which I had interest and one which is/was lived by the individuals. Also, I was aware of the ethnic difference between myself and my participants. I questioned what the impact of being a black female interviewing people from white British background on an issue that is widely conceptualised as a western problem. Although, there was nothing to suggest that the ethnic difference had a bearing on the interview dynamic, my questioning came from my experience of working at an ED placement for 15months where the issue of colour came up for me in my client work. In spite of the colour difference between my participants and myself there was richness to the data that emerged from the interview.

In terms of data analysis, I found this process quite challenging because of the complex interaction between shame, guilt and ED; I found that participants' narratives shifted invariably between each topic. For example, a participant can move from talking about shame to talking about the chronicity of the ED. I was often taken off topic by the discussion. Therefore, I had to always question how this relates to the research question. The actual phenomenon of shame, guilt and ED under investigation appeared complex. From the point of analysis to write up, I experienced confusion in grasping an understanding of my intriguing findings. I was consumed by the thoughts and feelings that the participants shared with me. Even though I had only caught snippets of their world, their words rang in my ears, these alarms echoed sometimes during practice and contact with other ED clients. To illustrate this, I present below an extract from my journal relating to Leah's analysis following a day at placement:

30th December 2013

I heard the guilt that she experienced during recovery from the group session today. The difficulties resisting the urges not to revert back to the ED behaviours when Y (patient) mentioned that she felt guilty about the changes that she had made so far, making it difficult to keep up with changes. I was hesitant to interject the discussion; I wasn't sure whether I

heard what I heard. The conversation also moved on quickly. I did not want to project my thoughts and feelings and I also felt embarrassed to speak in front of my supervisor. I may need to discuss this with X (supervisor) at some point about the possibility of validating these thoughts and emotions during therapy...

This reciprocated in having difficulties to ensure I carried their voices throughout the thesis and also to accurately present the complex interaction between their voices and practice experience. I found my journaling a useful tool at this point to keep my thoughts as separate as possible. I would often refer back to the initial transcript even till the point of writing the discussion chapter. The complexity of participants' shame and guilt was reflected not only in my difficulty with understanding this experience but also in the sense of difficulty I encountered in containing them within a manageable framework in the research. I felt the need to accurately capture each individual's voice effectively. I was overwhelmed particularly during the discussion phase. The feedback I got from my first draft was that I had the content but not the structure that captured the complexity that I experienced. Not only did I have the responsibility of carrying my participants' voices through, I also needed to present them in a way that would help the reader make sense of it. This took several attempts of reading and re-reading. I found perseverance and my passion for this topic as well as supervision to helpful in managing this process.

I am aware also that the difficulty completing this research has been partly due to using avoidance before conducting the task, which only serves to increase my anxiety. On reflection avoidance and anxiety was due to me having self-doubt about completing this doctorate and equally the task appearing greatly time-consuming. I found the support of my family and colleagues very useful at this time. My supervisor was also very encouraging and she always seemed to have the right words that lifted my motivation and made me believe in myself.

In conclusion, this has been the most rewarding period of my life personally and professionally. I feel a great sense of achievement to have starved the 'internal fear and doubt gremlin' by completing this study. In particular, I have immensely benefitted from my expanded knowledge of shame and guilt. I have become more aware of my own processing of these affects. As a practitioner, this experience has influenced my practice. I feel particularly more attuned to shame and guilt within my therapeutic practice and I have improved my

knowledge on their implicit and explicit responses in this context. I feel that I have effectively challenged the status quo in the manner that I set out to at the start of this study. This study has no doubt made significant contribution to the growing body of research of shame and guilt, which has seen up and down interest over the last twenty years.

I hope to disseminate this research as far and wide as possible. As I write, I am in the process of writing a short article based on the findings of this study for a national ED charity. This organisation has tremendously supported my research by warmly accepting my request to use their medium as a means to recruit participants. This will guarantee that the research is available to practitioners and individuals suffering from ED. It is hoped that the findings will enhance the healing journey by validating some of their on-going struggles and motivating them to seek support.

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Appendices

Appendix A

TABLE 8: Diagnostic criteria for AN

Diagnostic criteria for anorexia nervosa according to DSM-V	
<ul style="list-style-type: none">• Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).• Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).• Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	
Subtypes: Restricting type	Binge-eating/purging type

TABLE 9: Diagnostic criteria for BN

According to the DSM-5 criteria, to be diagnosed as having Bulimia Nervosa a person must display:

<ul style="list-style-type: none"> • Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: <p>Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.</p> <p>A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).</p> • Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise. • The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months. • Self-evaluation is unduly influenced by body shape and weight. • The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
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Table 10: Diagnostic Criteria for BED

According to the DSM-5 criteria, to be diagnosed as having BED a person must display:
<ul style="list-style-type: none"> • Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: <ul style="list-style-type: none"> ◦ Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. ◦ A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating). • The binge eating episodes are associated with three or more of the following: <ul style="list-style-type: none"> ◦ eating much more rapidly than normal ◦ eating until feeling uncomfortably full ◦ eating large amounts of food when not feeling physically hungry ◦ eating alone because of feeling embarrassed by how much one is eating ◦ feeling disgusted with oneself, depressed or very guilty afterward

- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for three months
- Binge eating not associated with the recurrent use of inappropriate compensatory behaviors as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa, or Anorexia Nervosa methods to compensate for overeating, such as self-induced vomiting.

Table 11: Diagnostic Criteria for OSFED

<p>According to the DSM-5 criteria, to be diagnosed as having OSFED a person must present with a feeding or eating behaviors that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders.</p>
<p>A diagnosis might then be allocated that specifies a specific reason why the presentation does not meet the specifics of another disorder (e.g. Bulimia Nervosa- low frequency). The following are further examples for OSFED:</p> <ul style="list-style-type: none"> • Atypical Anorexia Nervosa: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range. • Binge Eating Disorder (of low frequency and/or limited duration): All of the criteria for BED are met, except at a lower frequency and/or for less than three months. • Bulimia Nervosa (of low frequency and/or limited duration): All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behavior occurs at a lower frequency and/or for less than three months. • Purging Disorder: Recurrent purging behavior to influence weight or shape in the absence of binge eating • Night Eating Syndrome: Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).

Table 12: Diagnostic Criteria for UFED

Unspecified Feeding or Eating Disorder (UFED)
According to the DSM-5 criteria this category applies to where behaviours cause clinically significant distress/impairment of functioning, but do not meet the full criteria of any of the Feeding or Eating Disorder criteria. This category may be used by clinicians where a clinician chooses not to specify why criteria are not met, including presentations where there may be insufficient information to make a more specific diagnosis (e.g. in emergency room settings).

Appendix B: Information sheet

Shame, Guilt and Eating disorders: An Interpretative Phenomenological Analysis

Information Sheet

You have been invited to take part in a piece of research exploring how people who have undergone treatment for eating disorders experience shame and guilt and the impact of these two self conscious emotions had on disclosure in therapy and on the therapeutic treatment as a whole. Before you decide whether you would like to participate in this study, please take your time to read the following information which I have written in order to help you understand the purpose of this research and what it will involve.

The Researcher

My name is Tammy Oluyori. I am a trainee counselling Psychologist at the University of Manchester. I am carrying out this research study as part of a Doctoral qualification in counselling psychology. This research is being carried out under the supervision of Dr Terry Hanley (who is a lecturer at the University of Manchester).

What is the purpose of the research?

The research aims to gain an in-depth understanding of how people who have had treatment for eating disorders experience shame and guilt in their day to day lives; what the experiences of these emotions is like for them; whether these emotions had any impact on overall treatment, what they disclosed to the health professionals that supported them during treatment particularly, whether it affected what they told their therapists in treatment sessions.

Whilst existing research has established a link between eating disorders and these emotions (shame and guilt), there has been little investigation of how the process comes about and how the impact on treatment. It is hoped that this study will enhance the understanding of health professionals and thereby contribute to promoting recovery.

Why have I been invited to take part in this study?

All clients who have had treatment at the North West Centre for Eating Disorders (NWCED) and Beacon counselling have been invited to participate in this study.

Do I have to take part?

You are under no obligation to take part, and even after agreeing to do so you may change your mind **at any time**, without having to give a reason. Participation is entirely voluntary. In making your decision you may wish to seek advice from somebody independent e.g., a friend, family member, or trusted professional.

What is involved?

If you decide that you would like to take part, please contact me using the details below. You can ask me some more about the research study if you would like, after which you can take some more time to think about it, or we can arrange a time and place to meet. This can be either at one of the clinical rooms at NWCED or Beacon or in your own home if that is a more convenient option for you.

During this meeting I will first check to see if you have any further questions, or if you have changed your mind. If you are still happy to go ahead I will ask you to sign a consent form to say that you have agreed to take part in this research. I will then carry out an interview with you, which will last for 1 hour or less. The interview will be audio-recorded.

After the interview you will have an opportunity to ask any questions and raise any concerns you may have.

What will happen to the information collected?

The recording of the interview will be typed out so that the information can be looked at in detail. The aim of this is to find out common themes that are important in understanding the experiences we have discussed. Both the recordings and the typed out transcripts will be made anonymous and kept in a locked storage facility. In addition to the information collected from the interview, I will also ask consent to collect some background information from your records (e.g. your age, previous eating disorders you have experienced and what treatment you have had, length of treatment).

Anonymised sections of the information collected from the interview will be looked at by my supervisors, and may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project.

As part of the doctoral programme, I will write up a report of the research. Within this report I may include anonymous extracts of the interview to illustrate themes that have been discussed. These extracts will not include any information that could identify participants. I may also write a shorter article for publication in an academic journal, this may also include brief anonymous extracts of the interview. There is the potential that the research findings may be presented at conferences in the future, but again this would not include any information that could identify participants.

I will also ask if you would like me to send you a summary of the research findings when the study is complete.

What are the possible disadvantages and risks of taking part?

You will be asked to discuss how you experience shame and guilt, and how you think this affected your eating and the impact shame and guilt had on treatment and disclosure during treatment. This could be potentially distressing, and every measure will be taken to minimise the risk of distress. If during the interview you are asked a question that you are not happy to answer you can skip it, and if you do become upset, you will be given the option to take a break or stop the interview altogether. Following the interview, I will be available if you feel you need some time to talk about any issues raised. I will be able to advise you of who you can talk to if you need further support, and will give you an information sheet with details of sources of support.

What are the potential benefits of taking part?

I cannot promise that the study will help you, but the information I get from this study will help improve understandings of eating disorder and may therefore help improve treatment in the future. You may also appreciate having the opportunity to talk openly about your experiences.

What will happen if I don't want to carry on with the study?

If you decide you want to withdraw from the study please let me know by contacting me on the email address or phone number given at the end of this information sheet. If you have completed the interview you will be asked what you would like to happen to the data. It can either be included in the study, or destroyed. Either option is perfectly acceptable.

What if there is a problem?

If you have a concern about any aspect of this study, you can contact me and I will do my best to answer your questions. Alternatively you can contact my research supervisor, Terry Hanley, through the University of Manchester (see contact details below).

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Practice and Governance Co-coordinator by either writing to 'The Research Practice and Governance Co-coordinator, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research-Governance@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. All electronic data will be kept in password protected files and there will be no identifiable information contained within the write-up of the study. Any hard copies of the transcript will be kept in locked storage. As mentioned earlier, you will be referred to by a pseudonym in any written reports and any quotes used will be non-identifiable. These safeguards are in agreement with the University of Manchester regulations on data protection. All data will be erased by the university after 5 years.

Who has reviewed this study?

This research has been reviewed and approved by the University of Manchester Research Ethics Committee, to protect your safety, rights, wellbeing and dignity.

Contact Details:

Researcher:

Tammy Oluyori, (trainee counselling psychologist)

Email: Tammyitunuoluwa.oluyori@postgrad.manchester.ac.uk; temmietools@yahoo.com

Phone : 07809700336

Supervisor:

Terry Hanley, Lecturer in Counselling Psychology, at the University of Manchester

Email : terry.hanley@manchester.ac.uk Phone : 01612758627

Appendix C: Participant Consent Form

Please tick box

.

Researcher: Tammy Oluyori, Trainee Counselling Psychologist

1) I confirm that I have read the attached information sheet for the above study. I have had the opportunity to consider the information provided and if needed asked questions that were satisfactorily answered.

☐

2) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

3) I understand that my information will be filed in a locked cabinet and the information I provide will be made anonymous for the use of the study.

☐☐

4) I give consent to the audio taping and transcription of the interview, and the use of direct quotes in the write-up of the study (which I understand will be anonymised).

5) I agree that any information collected may be published in anonymous form in academic books or journals

☐

.....
Name of participant Date Signature

Appendix D: Demographic Questionnaire

Instructions: Please respond to the following questions by circling the appropriate response.

1) **I was diagnosed with:**

- a) Anorexia Nervosa
- b) Bullimia Nervosa
- c) Binge eating Disorder
- d) Eating disorder not otherwise specified

1b: Number of years since initial diagnosis

2) Please state when you started and ended treatment for eating disorder

3) Please state your ethnic origin.....

4) Are you male or female? (Please circle the appropriate response)

Male

Female

5) Relationship Status

Married

☐

Single

☐

Couple

☐

7) What age are you? _____

Appendix E: Interview guide

Exploratory Semi-Structured Interview Questions

Opening Statement

Ok, so it's the 16th of February and this is [interviewer] speaking to [P1].

The aim of this interview is to gain an understanding of how you experience shame and guilt both in the present and your past lives and in relation to Eating disorders that you have had treatment for. Also, this interview aims to gain an understanding of how shame and guilt impacted on treatment and disclosing information during treatment

Part of this interview will be exploratory in nature and some part of it will ask you few specific questions. I'll mostly just listen to your responses, however, sometimes I may need to ask for clarification or check I've heard what you've said correctly. It should last somewhere between 45 minutes and an hour.

Ok, [P1] you can take your time with these and remember, if there's one that you don't want to answer just let me know. Ok, question one: How would you describe yourself?

Shame related question

What is your understanding of shame?

What do you consider shameful in yourself, both in the past, present and in others?

What do you consider shameful in relations to ED and body image?

Please reflect on the feeling of shame and how they are related to your ED

Please describe some personal experiences of shame

What effect did this emotion have on treatments for the ED?

How did experiencing this emotion impact on what you disclosed to your clinicians during treatment?

Guilt related question

What is your understanding of guilt?

Please reflect on the feeling of guilt and how they are related to your ED

Please describe some personal experiences of guilt

Please describe the effect this had on treatment

How did experiencing this emotion impact on what you disclosed to your clinicians during treatment?

Appendix F: Debriefing Information Sheet

Thank you very much for making this study possible.

Talking about your experiences may have left you feeling low or upset. If after a while, these feelings persist, below are local sources of support and comfort which may already be familiar to you.

Sources of comfort and help

1. The most immediate sources of comfort and help your GP, friends and family.
2. There are also a number of national organisations who can also offer you support. For example:

Beat (tel. 0845 634 1414; www.b-eat.co.uk; help@b-eat.co.uk). *Beat* (the working name of the Eating Disorders Association) is the leading UK charity for people with eating disorders and their families, providing information, help and support. Their helpline staffs have received a comprehensive training programme, and are there to listen. They will offer information about treatment and other sources of help available, encouraging callers to make their own decisions about a way forward. They will also be able to give information about beat resources, books, leaflets etc., and can post out a basic information pack. The helpline is open from 10.30am to 8.30pm Mon-Fri; 1pm to 4.30pm on Sat, closed on Sun and open 11.30am to 2.30pm on Bank Holidays.

3. The Samaritans (tel. 08457 909090; www.samaritans.org). The Samaritans is a helpline which is open **24 hours a day** for anyone in need. It is staffed by trained volunteers who will listen sympathetically.

4. You are welcome to contact me again to discuss any aspect of your participation in this study, to share any concerns you might have or to ask questions.

Contact Details

Tammy Oluyori, (trainee counselling psychologist)

Email: Tammyitunuoluwa.oluyori@postgrad.manchester.ac.uk; temmietools@yahoo.com

Phone : 07809700336

Thank you again for taking part in my study

Appendix G: Ethical approval



The University of Manchester

Ethics Education

To MeTerry HanleyShelley Darlington

6 Jun 2012

Dear Tammy

Ref: PGR-8139187-A1

I am pleased to confirm that your ethics application has now been approved by the School Research Integrity Committee (RIC) against a pre-approved UREC template.

If anything untoward happens during your research then please ensure you make your supervisor aware who can then raise it with the RIC on your behalf

Regards

Gail Divall

PGT & Quality Assurance Administrator

School of Education

Tel: +44(0)161 275 3390

Working Week: Tues - Fri

<http://www.education.manchester.ac.uk>

<http://www.education.manchester.ac.uk/intranet/>

Appendix H: Working with a Transcript

An Illustration of some of the stages: Phil

Stage 3b of analysis: Making initial notes free coding

Transcript	Descriptive	Linguistic	Conceptual
<p>Int: the first part is going to be about shame and the first question is what your general understanding of shame is?</p> <p>P3: erm something that I guess compromises your self-worth If you like....I would say if you feel somewhat worthless shame and guilt are very similar emotions I guess</p>	<p>Something that compromises self worth</p> <p>Feeling worthless</p> <p>Similarities between shame and guilt</p> <p>Shame described a feeling</p>	<p>Use of 'erm' and pause...showing the underlying difficulty to express something emotive and complex feelings</p> <p>Repetitive use of 'you'</p>	<p>Does this show that he's uncomfortable talking about the emotion</p>
<p>Int: so you're saying that they are similar. In what way?</p> <p>P3: guilt I suppose is a bit the end emotion that you feel when you've done something you shouldn't have done or you could have prevented from happening' I also presume it links to other people because it's how you feel you have</p>	<p>Shame and guilt on a spectrum-guilt as end emotion</p> <p>Guilt in relations to action compared to shame related to self and self worth</p> <p>Disappointment in one's action</p> <p>Guilt links to others-perception that you've disappointed others</p> <p>Relationship with</p>	<p>Repetitive use of 'you'</p>	<p>Shame question, guilt response</p> <p>Questioning- "have you let them down" does this show how significant others opinion about one's action. Could this lead to continual rumination?</p>

affected them. – have you let them down?	other people Value ascribed to how others perceive one's action		
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Sample of Stage 4 of analysis process: Identifying initial themes

Shame understood inform of self-worth/identity:	P3: erm something that I guess compromises your self-worth If you like....I would say if you feel somewhat worthless shame and guilt are very similar emotions I guess	Understanding of shame
Something that compromises self-worth		Shame and Identity
Feeling worthless		Dynamics between shame and guilt
Shame is a raw emotion	no I think it's fine it's like a raw emotion I guess	Intensity of shame-associated with self
Shame is a strong word	and everyone experiences it to a greater or lesser degree	Raw emotion- unprocessed- difficult to hold
Shame has more 'seriously negative implications' for me	erm erm I'm ashamed of what I had and what I wasted possibly ... oh yeah my potential at 16 years old and then the outcome by 38 years of age.	Loss, grief and shame
	Int: can you elaborate on that please if you don't mind?	Loss of achievement
	P3: basically like shameful feeling that you've let people down, you've let yourself down and you've let the society down you know because you had everything at one stage and you made	Shame in the context of time

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