1998

A Connection Between Eating Disorder Symptomatology and Guild or Shame

Deborah J. Kuehnel

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Deborah J. Kuehnel, B. A., LCSW

An Abstract presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art
1998

Abstract

By their own nature Eating Disorders are very self-destructive and potentially life threatening behaviors. They are symptoms which may represent a constellation of underlying problems. This investigation explores the relation of shame-proneness and guilt-proneness to eating disorder symptomatology in a sample of 171 undergraduate women. Participants completed the Eating Disorder Inventory-2 and the Test of Self-Conscious Affect (TOSCA). Shame was significantly and positively correlated with drive for thinness, bulimia, body dissatisfaction, ineffectiveness, interpersonal distrust, lack of interoceptive awareness, asceticism, difficulties with impulse regulation, and social insecurity. Guilt was negatively or negligibly correlated with these symptoms. These two correlative findings impact clinical considerations by highlighting the necessity of therapeutic interventions to address shame in the treatment of eating disorders.

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Deborah J. Kuehnel, B. A., LCSW

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1998

Committee in Charge of Candidacy

Marilyn Patterson, Ed. D.
Associate Professor and Advisor

Edward Doerr, Ph. D.
Adjunct Professor

James Jarvis, D. Min.
Licensed Psychologist

Dedication

In part this thesis is dedicated to some of my fellow employees at St. Anthony's Medical Center who painstakingly and perhaps a little too eagerly helped this study into its final stages. This surprising enthusiasm conspired to bring an element of fun and creativity which resulted in the "birth" of future work together on a book spun from this research. Although my family may never want to hear another word uttered about eating disorders, I would like to thank them for gracefully allowing me to grow in this manner. Finally, I would like to thank all the professors at Lindenwood University for sharing their knowledge with me.

TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

The biblical myth of Adam and Eve is a story of shame. It conveys the ideas that shame is related to becoming self-aware, aware of another's security, and fear of transgression against authority with its consequent punishment. It also attests to the antiquity of shame (Gilbert, Pehl, & Allan, 1994). At the turn of the century, psychoanalytic theory developed various ideas on shame and guilt. Freud (1894, 1905, 1909) viewed shame as related to exposure to sexuality. Subsequently, he subsumed shame under the umbrella of guilt. Guilt, he suggested, was more closely related to psychopathology. Alexander (1938) saw guilt and shame as fear of punishment versus inadequacy, respectively. Piers & Singer (1958) regarded guilt as related to failure to meet demands of the superego whereas shame formed in a failure of the ego ideal. Lynd (1958) differentiated shame from guilt by noting that in shame the focus is on the self, whilst in guilt the focus is on specific acts.

Although the terms shame and guilt are well known, their discrimination has often lacked clarity and at times they have been used interchangeably (Gilbert, Pehl, & Allen, 1994). While there are numerous indications that shame and guilt are important emotions to consider in women with eating disordered behavior, empirical research in this area is

lacking (Tangney, Wagner, & Gramzow, 1992). In consideration of this, the distinction between shame and guilt must be underlined because the two terms are often used interchangeably. Even though shame and guilt are both negative emotions, the focus of each is different, and each leads to distinct affective experiences (Gilbert et al, 1994; Tangney, 1994).

For clarity purposes within this research, the most recent operational definitions of the terms guilt and shame are highlighted through the works of Gilbert, Pehl, & Allen (1994); Meehan, O'Connor, Berry, Weiss, Morrison, & Acampora (1996); Tangney (1992), Tangney, Wagner, & Gramzow (1992) as being experientially different. Shame is related to be an inner sense of being completely diminished or insufficient as a person. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being. Guilt is distinguished as being a developmentally more mature, though painful, feeling of regret one has about behavior that has violated a personal value. Guilt does not reflect directly upon one's identity nor diminish one's sense of personal worth. It emanates from an integrated conscience and set of values. It is the reflection of a developing self which promotes the possibility of repair, learning and growth (Gilbert

et al, 1994; Meehan et al, 1996; Tangney, 1992; Tangney et al, 1992).

While guilt is a painful feeling of regret and responsibility for one's actions, shame is a painful feeling about oneself as a person. The possibility for repair seems foreclosed to the shameful person because shame is a matter of identity, not a behavioral infraction. There is nothing to be learned from it and no growth is opened by the experience because it only confirms one's negative feelings about oneself (Bradshaw, 1988; Gilbert et al, 1994; Meehan et al, 1996).

Some authors mention shame and guilt as feelings that are likely to precipitate and follow episodes of binging and purging (Leitenberg & Rosen, 1988; Lingswiler, Crowther, & Stephens, 1989; Schwartz & Cohn, 1996; Zerbe, 1995). Women with eating disorders are also described as more prone to experience shame and guilt in general (Frank, 1991; Stober & Datz, 1988). Feelings of shame (e.g., feeling disgusted with oneself) or guilt following a binge are required for a diagnosis of Binge Eating Disorder as defined in the DSM IV (American Psychiatric Association, 1994). While in fact guilt and shame are both negative emotions, they are distinct emotions not necessarily interchangeable as some writing's might suggest (Frank, 1991).

Despite the lack of consistency in the literature with respect to shame and guilt in eating disorders, an important theme stands out. Rosen (1992) suggests that women whose eating behavior is disordered feel bad

about themselves (a phenomenon more consistent with shame) in relation to their bodies and their eating difficulties more so than they do about their behaviors (a guilt related phenomenon). Leitenberg (1993) proposed that instead of seeing their eating and/or body image difficulties as problematic set of behaviors and cognitions that are separate from the self, these individuals view them as reflections of their self-worth, as reflections of a bad self.

Similarly, several authors have noted that failure to differentiate feelings of self-worth from the aesthetic appearance of the body fuels disordered eating (Leitenberg, 1993; Rosen, 1992). Rosen (1992) argued that eating disordered women tend to process all information related to self-worth in terms of appearance, particularly in relation to body size and shape. Thus, women with eating disordered behavior may blur the distinction between their physical appearance, their self-worth, and their eating problems, and in doing this, succumb to a more shame-like style of thinking.

Statement of Purpose

The purpose of this research is to explore the complexity of eating disorder symptomatology illuminating the relative prevalence of shame and guilt in individuals with disordered eating. By their own nature eating disorders are very self-destructive and potentially life threatening behaviors. They are symptoms of underlying problems. Often there is so much focus

Chapter 2

Review of the Literature

Eating disorders are not new. Anorexia has its roots as far back as the 13th century. It was seen often with religious women who were actually canonized as being saints for their fasting practices. These woman are often referred to as "holy anorexics." Eating disorders probably occurred in other societies for different reasons than in our own. The cultures in which these young women lived valued spiritual health, fasting, and self-denial much as our own values thinness, self-control and athleticism. Holy anorexia provided women with a highly valued status in both church and society. When the definition of holiness was altered, so eventually was the incidence of holy anorexia. There are some hints of bulimia during these centuries also but no actual confirmed cases. Some of these women were suspected of binge-eating practices as well as their restricting (Bell, 1985; Davis & Bell, 1985; Zerbe, 1995).

However, in the time of Caesar (700 B.C.), bulimia was demonstrated significantly by the presence of vomitoriums. "Eat, drink, and be merry" included vomiting so that a person could return for additional eating, drinking and merriment (Thaddeus, 1927).

Although many eating disorders often have their origins in adolescence, a great percentage of those suffering with the disorder are not

treated at the time of onset. All three disorders, anorexia nervosa, bulimia nervosa, and binge eating tend to be secretive in nature especially initially. While anorexia and binge-eating eventually have visual side effects or indicators such as steady or dramatic weight loss or weight gain, bulimia can go undetected for years. The denial of the person suffering also plays a crucial role in the delaying of treatment for such disorders. Therefore, the percentage of adolescent-aged eating disorder clients seen in treatment is lower than the actual prevalent rate. Generally those suffering from an eating disorder will seek help when their denial drops enough to see that their lives are being disrupted by the destructive behaviors which accompany eating disorders (Bryant-Waugh & Lask, 1995; Killen, Hayward, Wilson, Taylor, Hammer, Litt, Simmonds & Haydel, 1994; Speed, 1995; Zerbe, 1995).

There is no one reason why an individual develops an eating disorder. Quite frequently cultural influences play an important role in disordered eating symptomatology and development. There appears to be no universal precipitating occurrence for an eating disorder's development. Likewise, a deep seated psychologically traumatic event is not required for the evolution of an eating disorder. A significant number of individuals with eating difficulties report after reviewing their own history with the eating disorder, that their symptoms developed during or shortly after a diet they were following (Johnson, Tosh & Varnado, 1996; Stice, Schupak-

Neuberg, Shaw & Stein, 1994; Rosen, J., Compas, B. & Tacy, B., 1993; Thornton & Russell, 1997; Yaryura, Neziroglu & Kaplan, 1995).

Of the myriad of potential contributing factors to the development of an eating disorder this research will examine a number of considerations including: Media and advertising, sociocultural influences, age and gender, comorbidities, self-mutilation, impulsivity, stealing, sexual abuse, perfectionism, and relationships.

Influences: Media and Advertising. Society pays a significant amount of attention to body image and physical attractiveness, youthfulness, sexuality, and appearance. The covers of magazines display pictures of men and women alike, whose images are offered as near perfection in society's consensus. These photographs are often additionally computer-enhanced and taken in near perfect circumstances. The average man or woman could not possibly compete with these images. Perhaps the models themselves cannot live up to these expectations. Eating disorders are not foreign illnesses to the modeling industry. What is unfortunate but interesting is the fluidity of society and the alterations imposed due to its changeableness. The impact of these changes can be enormous to those who strive for that perfection. It guarantees they may never quite be able to reach those goals and almost ensures a sense of failure, shame, and guilt (Grub, Sellers, & Waligroski, 1993; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Wiseman, Gray, Mosimann, & Ahrens, 1992).

One of the strongest messengers of sociocultural pressures may well be the mass media (Stice, Schupak-Neuberg, Shaw, & Stein, 1994). Irving (1990) discovered a direct relation between media exposure and eating disorder symptomatology over the last several decades. The increase in eating disorders through the years has coincided with a decrease in women's ideal body weight as portrayed in the media (Wiseman, Gray, Mosimann, & Ahrens, 1992).

Paralleling the rise in eating disorders was an increase in the number of articles and advertisements promoting weight-loss diets in women's magazines (Anderson & DiDomenico, 1992). Anderson & DiDomenico (1992) established that women's magazines contained 10.5 times more advertisements and articles promoting weight loss than men's magazines, the same sex-ratio reported by Anderson (1990) for eating disorders. Irving (1990) exposed women to slides of thin, average, and heavy models which resulted in lower self-esteem and decreased weight satisfaction for these women. A similar experiment utilizing pictures of models from women's magazines found that exposure to thin models, rather than average sized models, produced increased depression, stress, guilt, shame, insecurity, and body dissatisfaction (Stice et al, 1994).

These associations support the assertion that exposure to the media-portrayed thin ideal is related to eating pathology and suggests that women may directly model disordered eating behavior presented in the media (e.g.,

fasting or purging) (Stice et al, 1994). Leon, Fulderson, Perry, & Cudeck, (1993) established strong associations between body dissatisfaction and eating disorders. The internalization of the media's thin ideal produces heightened body dissatisfaction which leads to the engagement in disordered eating behavior. Additionally, the focus on dieting in the media may promote dietary restraint which appears to increase the risk for binge eating (Polivy, 1996; Stice et al, 1994).

Body dissatisfaction is a widespread and common phenomenon among women in general (Andrews, 1997). One of the most central aspects of shame pertains to individual concerns about how one is regarded by others and self-conscious feelings about the body have been consistently noted in the shame literature (e.g., Gilbert, 1989; Mollon, 1984). There is evidence that bulimia is related to general public self-consciousness (Striegel-Moore, Silberstein, & Rodin, 1993). Bodily shame aspects include self-consciousness and embarrassment about general appearance and about exposing specific body parts, concealment of different body parts, and feelings of disgust about oneself concerning others' comments about appearance and body parts (Andrews, 1997). Stice & Shaw (1994) demonstrated that greater ideal-body stereotype internalization predicted increased body dissatisfaction, which was related to heightened eating disorder symptoms. Consistent with these findings, Leon (1993) also drew a path from body dissatisfaction to eating pathology.

Stice & Shaw (1994) indicated a strong positive relation between internalization of the thin-ideal and disordered eating. Specifically, it may be that exposure to ideal-body images results in negative affects including shame, guilt, depression, and stress, as well as a lack of confidence which also shows a strong relation to eating pathology (Stice et al, 1994). Further body dissatisfaction leads to restrained eating, which has been linked to the onset of binge eating and bulimia (Wiseman et al, 1992).

Although most women are exposed to the media portrayed thin-ideal images, only a small proportion develop eating disorders. It may be that women with perfectionistic tendencies are more inclined to feel dissatisfied with their bodies when they compare themselves to those images presented in the media. Coping skills may also moderate the relation between negative affect, binge eating and restricting, as women with better coping skills would likely ameliorate negative affect in more adaptive ways (e.g., seeking social support) (Stice & Shaw, 1994; Stice et al, 1994).

Sociocultural Influences. Fatness among women has traditionally been a greater preoccupation in western societies than in third world countries. Women living in third world countries appear much more content, comfortable, and accepted with fuller body shapes. In fact the cultural stereotype of attractiveness within these societies includes a fuller figure. Women from these societies acculturating into areas in which there

is a greater preoccupation on thinness have tendencies toward adapting the thinner viewpoint and more stringent eating attitudes of the prevailing culture (Stice, Schupak-Neuberg, Shaw & Stein, 1994; Wiseman, 1992).

In fitting the given cultural stereotype of attractiveness, women may try to overcome their natural tendency toward a fuller figure. It is apparently hard to "just say no" to society. Attempting to become a part of a new culture may encourage one to over-identify with certain aspects of it. Additionally, eating disorders may develop in different cultures at various times because of enormous changes occurring within the society itself (le Grange, Telch, & Agras, 1997; Wiseman, Gray, Mosimann, & Ahrens, 1992). One example of this type of transformation is depicted through the rise of eating disorder symptomatology and diagnosis since the massive transitional changes in what once was known as the USSR (le Grange et al, 1997).

Sociocultural factors are thought to play a central role in the promotion and maintenance of eating disorders. These sociocultural pressures include the ultra-slender ideal-body image espoused for women in Western cultures, the centrality of appearance in the female gender-role, and the importance of appearance for women's societal success (Stice et al, 1994). According to the sociocultural model of bulimia, eating disorders are a product of the increasing pressures for women in our society to achieve an ultra-slender body (Wilson & Eldredge, 1992). This societal

obsession with weight is so ubiquitous that moderate degrees of body dissatisfaction, shame, and guilt are currently normative among women. These sociocultural pressures are consistent with theories in which it is proposed that body satisfaction is a primary determinant of eating disorder symptoms (Stice, Schupak-Neuberg, Shaw, & Stein, 1994).

The widely accepted false belief that eating disorders only affect middle to upper-middle class white adolescent women often leads to incorrect diagnosis. Clinicians sometimes fail to diagnose women of color appropriately. This may be due to the fact that eating disorders have been reported much less among African Americans, Asian Americans, and American Indians. This oversight reflects a cultural bias and unintended yet prevalent bigotry. These unconscious tinges of prejudice can undermine appropriate treatment (Anderson & Holman, 1997; Grange, Telch, & Agras, 1997).

Not only can a diagnosis of an eating disorder be culturally determined but no culture appears immune to the possibility of eating disorders. Moreover, individuals from other cultures should not automatically be excluded from the potential of an eating disorder diagnosis. A point in case is how Westernization has affected Japan (Wiseman, et al, 1992). In densely populated urban areas it has been found that anorexia nervosa affects 1 in 500, but Wiseman, Gray, Mosimann, & Ahrens (1992) discovered the incidence of bulimia is

markedly higher then that of anorexia. Gandi (1991) reported anorexia has been found within the American Indian and Indian populations.

Age and Gender Considerations. Middle-aged women as well as children are not immune to the development of eating disorders. The development of these disorders again appears linked to the cultural standards (le Grange et al, 1997; Shapiro, Newcomb, & Loeb, 1997). Zerbe (1995) states that in women over the age of 62 the second greatest concern for them are changes in their body weight. The "double standard of aging" reveals how aging women in Western society consider themselves less attractive or desirable and become fixated on their bodies (Wiseman et al, 1992).

Gender and age also have their voice in the acceptableness of body dissatisfaction. Children as young as five have expressed concerns about their body image (Feldman, Feldmann, & Goodman, 1988). Historically through the decades children have also been found to have negative attitudes regarding obese individuals, dislike an obese body build, express a fear of becoming obese (Feldman et al, 1988) and do not like to play with fat children (Schapiro, Newcomb, & Leob, 1997).

A real tragedy and some of the scariest statistics of all are those surrounding eight to ten year old girls and boys and are presented by Shapiro, Newcomb, & Leob (1997). Their research indicates that children at this young age have internalized a sociocultural value regarding thinness

on a personal level. Boys as well as girls reported very similar perceived social pressures. These children have demonstrated an ability to reduce their anxiety about becoming fat by implementing early weight control behaviors. These weight control behaviors are believed linked to a sense of body dissatisfaction, guilt, and shame. Shapiro, Newcomb, & Leob (1997) found that 10% to 29% of boys and 13% to 41% of girls reported using dieting, diet foods, or exercise to lose weight. One concern expressed involves the possibility of using more extreme measures, such as vomiting or using medication if the earlier methods fail or the pressure to be thin intensifies. At tender ages children have apparently equated success and popularity with thinness, potentially planting the seeds for shame, guilt, and the development of an eating disorder (Killen, Hayward, Wilson, Taylor, Hammer, Litt, Simmonds, & Haydel, 1994; Shapiro et al, 1997).

Men typically have been excluded from eating disorder diagnosis. However, Anderson (1992) points out that about 10% of eating disorder patients in western society are men. Men and eating disorders are said to be under-studied and tend to "fall through the cracks." Anderson & Holman (1997) address the issue that advertising has begun to target men encouraging them to change their body shape. It goes on to state that "capitalism woke up and realized there is a lot of money to be made" as it has with women for decades (DeAngelis, 1997).

Theoretical Shifts. While the eating disorder field is still in its

infancy, its clinical development reaching back only 60 years, there have already been significant theoretical shifts and clinical transformations that are continuing to unfold today (Ash & Piazza, 1995; McFarland, 1995). One of these changes can be seen in diagnosis of the disorders. It is clear that the diagnosis of bulimia nervosa and atypical eating disorder have increased significantly over the last three decades (Ash et al, 1995). Ash & Piazza (1995) studied the changes in diagnosis made and reported that:

> None of the patients in 1970 received a diagnosis of pure bulimia nervosa, 3.1% and 29.0% of the cases in 1980 and 1990 were diagnosed with bulimia nervosa while 3.1% and 16% received diagnoses of both anorexia and bulimia nervosa, respectively. Similarly, while none of the cases in 1970 received a diagnosis of atypical eating disorder, 6.5% of the cases in both 1980 and 1990 received such a diagnosis. It is unclear whether such changes represent true changes in the incidence of bulimia and atypical eating disorders or merely reflect the improvements made in diagnostic practices over the last 30 years. However, it is clear that with the advent of better classification systems more eating-disordered patients are receiving secondary Axis I and Axis II diagnoses. Whereas only 9.4% of the 1970 group received secondary diagnoses, 51.6% and 54.8% of the 1980 and 1990 groups received such diagnoses. Similarly, the number of Axis II diagnoses increased from

3.1% in 1970 to 6.4% in 1980 to 12.8% in 1990. (p. 36)

Other notable changes presented by Ash & Piazza, (!995) included:

> The essential diagnostic criteria for anorexia nervosa, the somatic criterion of 15% less than expected body weight was met by significantly fewer cases in 1990 (58%) than in 1970 (88%) and 1980 (90%). The symptom of amenorrhea decreased significantly from 1970 (96%) and 1980 (93%) to 94% in 1990. Similarly, drive for extreme thinness increased significantly from 44% in 1970 to 71% in 1980 to 94% in 1990!
>
> Additionally the trends associated with the secondary symptoms of bulimia, vomiting, laxative/diuretic abuse, and excessive exercise were unmistakable. The presence of bulimia (episodes of binge eating) increased three-fold between 1970 (16%) and 1990 (52%). The presence of vomiting doubled from 25% in 1970 to 55% in 1990. Sixty percent of the vomiting was reportedly noninduced as compared to only 5% of the 1990 cases. Finally, laxative and/or diuretic abuse jumped from a mere 3% in 1970 and 6% in 1980 to 32% in 1990. Such findings suggest that the conscious symptoms associated with binging and purging have increased significantly over the last three decades. (p. 37)

Pryor, McGilley, & Roach (1990) suggest that all eating disorder patients probably will not have a similar response to the same treatment.

It has become apparent that eating disorders are multidimensional and have significant psychological components. Factors involved should not only include additional diagnoses but also personality structure, patient age, chronicity of the illness, patient weight, family history, and family structure (Speed, 1995; Zerbe, 1995).

While many questions continue to be unanswered regarding theory and treatment of eating disorders as well as the constellation of problems associated with these diagnosis, a combination of treatment modalities appears comprehensive. To date, the combining of psychotropic medications, nutritional counseling, cognitive-behavioral approaches, psychodynamic techniques, group therapy, ego-state therapy, and family therapy have been shown to be effective (Pryor, McGilley, & Roach, 1990; Schwartz & Cohn, 1996; Torem, 1992; Zerbe, 1995).

Comorbidity: Mood Disorders. It is not uncommon that clients presenting with an eating disorder also have additional diagnosis concurrently. Depression is often seen accompanying a diagnosis of an eating disorder. Grubb, Sellers, & Waligroski (1993) reported a high percentage of depressive disorders among eating-disordered women and contend that often the depressive symptoms decrease after treatment of the eating disorder. Depression has been described as a prominent, though not the exclusive form of psychopathology in these disorders (Wexler & Cicchetti, 1992). Additionally, measures of depression are often influenced

by the subject's current state or illness. It is not uncommon that depression, rather than eating disturbances, is the symptom for which women seek psychological counseling (Grubb, Sellers, & Waligroski, 1993; Schwartz & Cohn, 1996; Zerbe, 1995).

Bi-polar Disorder. Kruger, Shugar, & Cooke (1996) addressed the comorbidity of binge eating disorder, partial binge eating syndrome, and bipolar disorder. The work of Kruger, Shugar, & Cooke (1996) was the first to describe and link the consistent occurrence of night binging syndrome between 2:00 and 4:00 a.m. This behavior was thought this to be of significance in the bipolar population because the early morning hours are also the time in which mood switches are reported to occur in subjects with bipolar disorder. Kruger, Shugarr, & Cooke (1996) encouraged along with others that there is a definite need for developing useful diagnostic categories by redefining the eating disorders not otherwise specified (de Zwaan, Nutzinger, & Schoenbeck, 1993; Devlin, Walsh, Spitzer, & Hasin, 1992; Fichter, Quadflieg, & Brandl, 1993).

Eating is more than just food intake; eating plays an important role in our social interactions, and it can also be used to alter emotional states, and even to influence brain function. Serotonin, or 5-hydroxytryptamine (5-HT), is a neurotransmitter that plays an important role in the regulation of circadian and seasonal rhythms, the control of food intake, sexual behavior, pain, aggression, and the mediation of mood (Wallin & Rissanen,

1994). Dysfunction of the serotoninergic system has been found in a wide array of psychiatric disorders: Depression, anxiety, disorders of the sleep-wake cycle, obsessive-compulsive disorder, panic disorder, phobias, personality disorders, alcoholism, anorexia nervosa, bulimia nervosa, obesity, seasonal affective disorder, premenstrual syndrome, and even schizophrenia (van Praag, Asnis, & Kahn, 1990)

While the background of eating disorders is complex, the disorders probably involve dysregulation of several neurotransmitter systems. The involvement of impaired hypothalamic serotonin function in these disorders is well documented (Leibowitz, 1990; Kaye & Weltzin, 1991). There is good evidence from experimental and clinical studies to suggest that serotoninergic dysfunction creates vulnerability to recurrent episodes of large binge meals in bulimic patients (Walsh, 1991). There is also evidence that bulimic behavior has a mood-regulating function, (e.g., binging and purging are used by the patients to relieve psychic tension). However, bulimic behavior seems to have different functions for different subgroups (Steinberg, Tobin, & Johnson, 1990). Binging may be used to relieve anxiety, but it may result in an increase in guilt, shame, and depression (Elmore, De Castro, 1990).

Obsessive-Compulsive Disorder. Obsessional personality traits and symptoms have been reported in between 3% to 83% of eating-disordered cases depending on the criteria used. Up to 30% of anorexia nervosa

patients have been reported to have significant obsessional personality features at first presentation. Clinical similarities between obsessional personality and the dieting disorders have led to the contention that obsessional personality traits might predate the onset of the eating disorder (Fahy, 1991; Thornton & Russell, 1997).

Thornton & Russell (1997) discovered that 21% of the eating disorder patients were found to have comorbid Obsessive-Compulsive Disorder (OCD) but even more significant was that 37% of anorexia nervosa patients had comorbid OCD. By contrast, individuals with bulimia nervosa had much lower rates of comorbidity for OCD (3%). Thornton & Russell (1997) stressed the likelihood that the impact of starvation exaggerates an already (premorbid) obsessional personality in those with eating disorders. When individuals with a premorbid obsessional personality and symptoms focus on food, weight, and shape issues, these may become enmeshed into their series of obsessions and compulsions. These obsessions and compulsions may result in feelings of guilt, shame, and a sense of "loss of control" for the individual (Fahy, 1991; Thornton et al, 1997).

Within these obsessions and compulsions, Andrews (1997) found one explanation for the concurrent occurrence of bodily shame with bulimic and anoretic symptomatology may be that the shame itself taps directly into a central component of the disorders - undue preoccupation

with body shape and dread of getting too fat. Bodily shame was shown to have a significant association with disordered eating patterns but it was unclear whether shame was an antecedent concomitant or consequence of the eating disorder (Andrews, 1997; Thornton et al, 1997).

Self-Mutilation. Yaryura-Tobias, Neziroglu, & Kaplan (1995) presented the relationship between OCD and self harm and explored this connection with respect to anorexia. Four observations were found:

> First, there was a disturbance of the limbic system resulting in both self-mutilation and menstrual changes. Second, pain stimulation releases endogenous endorphins which produce a pleasant feeling, control dysphoria, and actively maintain the analgesia-pain-pleasure circuit. Third, 70% of their patients studied reported a history of sexual or physical abuse. Finally, the administration of fluoxetine, a selective serotonin reuptake blocker, has been successful in treating self-injurious behavior. (p. 36)

With these observations, Yaryura-Tobias, Neziroglu, & Kaplan (1995) encouraged clinicians treating OCD and eating disorders to be aware of the possibility of self-mutilation among their patients. Conversely, those treating self-mutilation may look for symptoms of OCD and eating disorders (Chu & Dill, 1990; Favazza & Conterio, 1989).

Impulsivity: Stealing Behavior. Closely linked to OCD is an aspect of impulsivity seen in eating disordered patients. In anorexia nervosa,

stealing behavior was first connected with the sometimes strange habit of hoarding foods or objects (Norton, 1985). The association of stealing and anorectic behavior even in non-Western countries has stimulated various interpretations, ranging from biological to psychodynamic views (Lee, 1994). In early reports on bulimia, a connection was made between compulsive eating and stealing (Ziolko, 1988). Some reports have made mention of stealing behavior as an aspect of "impulsivity" in eating disordered patients (McElroy, Hudson, Pope, & Keck, 1991; Wellbourne, 1988). However, Vandereychen & Houdenhove (1996) proposed that stealing is more likely when the eating disorder includes "Bulimia-like" behavior (binge eating, vomiting and laxative abuse).

The majority of bulimic shoplifters reported stealing something which was involved with their eating disorder (e.g., food money, laxatives, diuretics, or diet pills) and they indicated that embarrassment and shame over buying these items was the main reason to shoplift (Vandereychen, et al, 1996).

From the opposite viewpoint, in recent years studies on kleptomania paid attention to its frequent connection with eating disorders (McElroy, 1991). Stealing has been related to the new phenomenon of "compulsive buying," a lifetime diagnosis of an eating disorder was found in 17% to 20.8% of these subjects (Christenson, Faber, de Zwaan, Raymond, & Mitchell, 1994; Schlosser, Black, Repertinger, & Freet, 1994)

Substance Abuse. Impulsivity is a key feature of both bulimia and substance abuse. The self-medication hypothesis suggests that eating disordered individuals begin abusing chemical substances in an effort to treat their eating problems, as a means of coping with the worry caused by these problems. Additionally, an association between eating disorders and familial drug abuse, usually alcoholism, suggests the possibility of biological similarities or links between substance abuse and eating disorders (Holderness, Brooks-Gunn, & Warren, 1994).

Sexual Abuse. The relationship between sexual abuse and eating disordered symptoms in women from nonpsychiatric or college student populations indicate that the impact of sexual abuse on eating disordered behavior is a variable (Calam & Slade, 1989; Bulik, Sullivan, & Rorty, 1989; Smolak, Levine, & Sullinhs, 1990; Beckman & Burns, 1990). Despite the lack of definite links between sexual abuse and specific eating disordered symptoms, Root & Fallon (1989) and Root (1991) suggest that binge eating, starvation, or chronic purgative use may develop as a maladaptive attempt to cope with or escape from the negative effects of prior abuse.

Sexual abuse is associated with the development of a variety of psychiatric symptoms in women. Although eating disorder patients may be adversely affected by sexually abusive experiences, it must not be universally assumed that eating disorder symptoms are responses stemming

from these experiences (Folsom, Krahn, Nairn, Gold, Demitrack, & Silk, 1993).

. Shame-proneness may mediate the relationship between early abuse and depression because it leads to an increased sensitivity to depressogenic life-events involving hostile reactions and rejection in intimate relationships (Andrews 1995). Abused women may, in addition, be more susceptible to prevailing social attitudes about the way women should look. It has been proposed that such attitudes encourage feelings of shame in many, as they cannot ever meet society's ideal. In turn, shame influences eating habits as women strive to meet this ideal. Young women who have been abused would appear to be particularly susceptible to such feelings. As a result of their experiences they may have an especially high need for social approval and a need to avoid others' real or imagined scorn (Andrews, 1997; Schwartz & Cohn 1996; Root, 1991).

Perfectionism. Perfectionism is a personality style that has been described frequently as a central feature of eating disorders (Bauer & Anderson, 1989). Several theorists have hypothesized a pathogenic role for perfectionistic tendencies in these disorders (Hewitt, Flett, & Ediger, 1995). A strong need for perfectionistic self-presentation can influence eating behavior by not allowing the person to display imperfections, or admit to difficulties (Herwitt, Flett, & Fairle, 1993). It may be that women with perfectionistic tendencies are more inclined to feel shame and

dissatisfaction with their bodies when they compare themselves to the sociocultural expectations of the thin-ideal. These sociocultural influences may interact in a complex fashion with biological, cognitive, and personality influences to ultimately produce disordered eating behavior (Hewitt et al, 1995; Stice & Shaw, 1994) .

There is a commonly reported belief that individuals with eating disorders feel that they must do everything perfectly and that these beliefs are self-imposed. This reflects the tendency of eating disordered individuals to view achievements in black and white terms such that anything less than perfection is failure (Bauer & Anderson, 1989.) Some perfectionistic striving seen in eating disordered behavior is motivated by strong needs to conform to a model or ideal of perfection that is perceived as demanded of the self by others. The critical determinant of this motivation is the central belief that one must be acceptable to others by meeting their perceived perfectionistic requirements (Herwitt et al, 1995).

Herwitt, Flett, & Ediger (1995) have conceptualized perfectionism as a multi-dimensional construct that incorporates self-related and interpersonal trait components, and self-presentational components. This construct describes social facets of perfectionism as involving self-presentational styles that entail striving to create an image of flawlessness to others. For the perfectionist, mistakes and flaws represent failures to live up to one's own perceived expectations of perfection and may be

interpreted as evidence of personal deficiencies. Mood disorders as well as any other disorders can be painful reminders of personal inadequacies intensifying shame experiences for the perfectionist. Denial, deception, and secrecy are characteristic of individuals with eating disorders which clearly suggests unwillingness to admit problems and shortcomings, both to others and to themselves (Herwitt & Flett, 1990; Herwitt et al, 1995; Holderness et al, 1994; Rosen et al, 1993).

Intimacy: Empathy, and Relationships. When anorexia nervosa or bulimia nervosa patients are married or live together with a partner unmarried, the question arises as to what impact an eating disorder has on the relationship with a partner or, alternatively, how an intimate relationship with a partner influences the course of an eating disorder. Despite valuable implications, the marital relationships of adult eating-disordered patients have not received much attention in the form of empirical research (Van den Broucke, Vandereycken, & Vertommen, 1995). One of the major impressions emphasized in this clinical literature is that married eating disordered patients and their partners often report a significant degree of dissatisfaction with their relationships (Van den Broucke & Vandereycken, 1988). Marital intimacy is one aspect of a relationship which may be conceived both as a process which includes empathy, (e.g., a characteristic way of relating of two partners), and as a state, (e.g., a relatively stable, structural quality of a relationship which

emerges from this process) (Waring, 1988).

Van den Broucke, Vandereycken, & Vertommen (1995) see intimacy as a quality of a personal relationship at a certain point in time primarily referring to a relational phenomenon, (e.g., the degree of connectedness or interdependence between two partners). As such it includes affective, cognitive and behavioral aspects. These three types of interdependence are reflected in the couples' emotional closeness, empathy and commitment, the validation of each other's ideas and values, and the implicit or explicit consensus about the rules which guide their interactions (Van den Broucke et al, 1988).

Additionally Van den Broucke, Vandereycken, & Vertommen (1995) suggest that there are two additional levels of intimacy, individual and situational. On an individual level, intimacy implies two aspects, one being authenticity, or the ability to be oneself in the relationship with the partner, and openness, or the readiness to share ideas and feelings with the partner. The situational level entails an aspect of exclusiveness: As the partners' individual privacy decreases with the enhancement of their intimacy, the dyadic privacy is likely to increase.

Communication difficulties and the lack of openness in eating disordered patients' marriages were found and considered to be a serious relational deficiency, which may represent an important obstacle to the growth and enhancement of their marital intimacy. The intimacy deficiency

of these patients' marriages does not necessarily imply that this deficiency is the cause of the eating disorder but probably more accurately is described as a circular enigma (Van den Broucke et al, 1995).

With empathy holding a key position in the construct of intimacy, Tangney's (1991) research discovering a positive correlation between proneness to guilt and empathetic responsiveness but inversely related to the tendency to experience shame, may provide some insight into the relational difficulties described by Van den Broucke, Vandereycken, & Vertommen (1995). Bateson (1990) defined empathy as including feelings of sympathy and concern, but distinguished empathy/sympathy from personal distress, the latter representing an observer's own feelings of distress in response to a distressed other. This other-oriented empathic concern, not self-oriented personal distress, has been linked to altruistic helping behavior (Bateson, 1988). Other-oriented empathy is generally viewed as the good moral affective capacity or experience because it is presumed to foster warm, close interpersonal relationships, to facilitate altruistic and prosocial behavior, and to inhibit interpersonal aggression (Bateson, 1990).

Shame, an ugly feeling, draws the focus away from the distressed other, back to the self. This preoccupation with the self is inconsistent with the other-orientated nature of empathy. When faced with a distressed other, shame-prone individuals may be particularly likely to respond with a

personal distress reaction, in lieu of a true empathetic response. The acute pain of shame may motivate a variety of intrapersonal and interpersonal processes that are incompatible with a continued empathic connection. Shame-prone individuals have a tendency to externalize cause or blame, as a defense maneuver against the overwhelming pain of the shame experience, in addition to making internal, global shame-type responses (Tangney, 1990; Tangney, 1991; Tangney, Wagner, Fletcher, & Gramzow, 1992).

While shame involves the self's negative evaluation of the entire self, guilt involves the self's negative evaluation of specific behaviors. Guilt's consequent motivation and behavior tends to be oriented toward reparative action. Guilt seems less likely to motivate the defensive maneuvers, antithetical to empathy, that are frequently associated with shame. Guilt-prone individuals are clearly not disposed to blame external factors or other people for negative events allowing room for empathetic responsiveness (Tangney, 1990, Tangney, 1991; Tangney et al, 1992).

Tangney (1991) discovered that individuals who are generally empathic are also prone to feelings of guilt, exclusive of shame. The perspective-taking component of mature empathy requires the ability to make a clear differentiation between self and other. Guilt requires making a clear distinction between self and behavior, an ability to see behaviors as related but somewhat distinct from the self. Both guilt and empathy hinge

on a capacity for differentiation, a more mature level of psychological development similar to such constructs as psychological differentiation, ego development, and cognitive complexity (Bateson, 1990; Tangney, 1991; Tangney et al, 1992).

Shame-prone individuals may have difficulty maintaining an other-oriented empathic response, and instead may drift into a more self-focused personal distress reaction. They are likely to experience the resonant pain of personal distress as well as the pain of shame for "being the kind of person who would inflict such harm" (Bateson, 1990; Tangney, 1991). This wash of negative affect may be problematic as Berkowitz (1989) has demonstrated, negative affect in general can foster angry, hostile feelings and subsequent aggressive responses.

Consistent links have been found between proneness to shame and anger (Berkowitz, 1989; Tangney et al, 1992). Such anger may be fueled not only by the pain of shame itself, but also by the discomfort inherent in personal distress reaction to distressed others. The unpleasant interpersonal exchange may be so overwhelming that it may motivate a variety of defensive maneuvers that are fostered and reinforced by such anger. Finally, in the midst of a personal distress reaction the shamed individual may subsequently blame the distressed or injured party as a means of reducing their own pain. Thus shame-prone persons bring to their relationships a number of liabilities that may be particularly

exacerbated during unpleasant interpersonal exchanges (Berkowitz, 1989; Tangney, 1991; Tangney et al, 1992).

Summary. The literature on disordered eating behavior and the constellation of potential contributors to the exacerbation or development of these serious disorders, consistently reflects the constructs of shame and guilt without differentiating these emotions. The studies reviewed here represent only a small portion of the research on eating disorders. However, these studies which include: Media and advertising influences, sociocultural influences, age and gender considerations, comorbidities such as mood disorders, obsessive-compulsive personality traits, self-mutilation, stealing behavior, substance abuse, sexual abuse, perfectionism, and marital relational difficulties all illuminate the repetitiveness with which the terms shame and guilt are characteristically woven into the literature without a clear interpretation of their respective meanings. It might be valuable for an increased understanding of these potentially life-threatening disorders to see the latent relation each may have to eating disorder symptomatology.

Chapter 3

Method

Participants

A total of 259 students attending a large mid-western university participated in this research. However, all responses were not useable in this aspect of the study, primarily since its focus is solely on female students. Hence, 85 male students or (32.8%) were eliminated, another 4 students or (1.5%) were excluded due to absence, leaving 171 or (66%) female respondents. The female subjects ranged in age from 17 to 54,(M = 21, SD = 4.37). The sample had a mode of 21 (see Table 1). The height ranged from 58 to 79 inches, (M = 64.5 inches, SD = 2.96), and in weight from 80 to 275 lbs., (M = 128 lbs., SD = 27.89).

TABLE 1. Stem and Leaf Plot of Participants Age

Frequency	Stem	Leaf
2	17	00
21	18	000000000000000000
30	19	000000000000000000000000000000
21	20	000000000000000000
58	21	00000000000000000000000000000000000000000000000000000000000000
16	22	0000000000000000
7	23	0000000
2	24	00
2	25	00
2	26	00
2	28	00
1	29	0
1	30	0
2	31	00
1	35	0
1	42	0
1	45	0
1	54	0

While this university serves a culturally diverse population, a tally of demographic data obtained through this research revealed that approximately two thirds (60%) of the 171 participants were Caucasian. The classification percentages for this sample are similar to those of the U.S. population; however there is one potentially relevant variation. For example, U. S. Census data (1990) indicates that this country is slightly over 80% Caucasian and the percentage for this sample was approximately 60%. This would need to be considered before any results from this study were to be generalized for a larger sample of U. S. residents. This sample is not accurately representative of the American population; however, the data obtained can be valuable in examining eating disorder symptomatology in a more culturally diverse sample of women. The total frequency figures of cultural groups represented in this study are furnished in Table 2.

TABLE 2. Frequency Table of Participants' Cultural Background

Value Label	Frequency	Percent
African American	35	20.00%
Asian	15	9.00%
Caucasian	102	60.00%
Hispanic	10	6.00%
Other	09	5.00%
Total	171	100.00%

Instrumentation

The Eating Disorder Inventory - 2 (EDI-2) (Garner, 1984). The EDI - 2 was utilized to operationalize eating disorder symptomatology with the

subjects in this study. This instrument is a 91 item self-report measure that assesses psychological and behavioral traits common to anorexia nervosa and bulimia nervosa on 11 subscales. The students were also asked to complete the Eating Disorder Inventory Symptom Checklist, a structured self-report form, which is separate from the EDI - 2. It provides detailed information regarding the frequency of specific eating symptoms such as binge eating, self-induced vomiting, use of laxatives, diet pills, diuretics, and exercise patterns as well as data regarding weight, weight history, and menstrual history. The EDI - 2 and the EDI symptom checklist take approximately 25 minutes to complete.

Internal consistency reports for the EDI - 2 from four independent samples of non-eating disordered college females on the 11 subscales are reported as follows: Drive for Thinness, .81 to .91, Bulimia .69 to .83, Body Dissatisfaction .91 to .93, Interoceptive Awareness .78 to .81, Ineffectiveness .82 to .90, Maturity Fears .65 to .72, Perfectionism .69 to .79, Interpersonal Distrust .77 to .86, Asceticism .44 to .70, Impulse Regulation .77 to .79, and Social Insecurity .80. Forty seven percent of the coefficient alpha's were above .80 and 80% fell above .70. The combined scale had a coefficient alpha of .78 (Garner, 1984).

There have been three studies of the test-retest reliability of the EDI. Welch (1988) reported retest reliability for EDIs administered one week apart to 70 student and staff nurses. The coefficients were .79 to .95

for all subscales except Interoceptive Awareness (.67). The retest reliabilities after three weeks for 70 nonpatient university undergraduates (53 females and 17 males) reported by Wear and Pratz (1987) were higher with all except Maturity Fears above .80. Crowther, Lilly, Crawford, Shepherd, & Oliver (1990) reported retest reliabilities ranging from .41 to .75 for 282 of 401 women. The results of these studies are presented in Table 3. The lower reliabilities for the Interoceptive Awareness subscales may relate to eating behaviors and affective content which probably fluctuate over time. The lack of stability for the Maturity Fears subscale may be attributable to its relatively low internal consistency (which influences retest coefficients) and the fact that it taps maturational issues that may shift over a long interval (Garner, 1984).

TABLE 3. Test-Retest Reliability for Nonpatient Samples

EDI Subscale	Welch (1988)[a] One Week (N = 70)	Wear & Pratz (1987)[b] Three Weeks (N = 70)	Crowther et al. (1990)[b] One Year (N = 282)
Drive for Thinness	0.85	0.92	0.72
Bulimia	0.79	0.90	0.44
Body Dissatisfaction	0.95	0.97	0.75
Ineffectiveness	0.92	0.85	0.55
Perfectionism	0.86	0.88	0.65
Interpersonal Distrust	0.80	0.81	0.60
Interoceptive Awareness	0.67	0.85	0.41
Maturity Fears	0.84	0.65	0.48

[a] Student and staff nurses

[b] College students

(Garner, 1984)

Internal consistency alphas on the EDI - 2 range from .83 to .92 with the combined Anorexia Nervosa Restrictors, Anorexia Nervosa Bulimics, and Bulimia Nervosa Groups (N=889) (Garner, 1984).

The norms reported for the female college sample are based on 770 nonpatient female college students who participated in the original EDI validation study (Garner, Olmsted, & Polivy, 1983a; for Interoceptive Awareness and Maturity Fears subscales, the norms are based on only 273 women who completed the final version of the EDI that included all of the final items for these subscales). These women were reported to be from first and second year psychology classes at the University of Toronto. The current norms for eating disorder patients relies on a large sample (N=889). The total eating disorder group consists of 129 Anorexia Nervosa Restrictors (AN-R), 103 Anorexia Nervosa Bulimics (AN-B), and 657 Bulimia Nervosa (BN) patients. There is little variability seen in the SE_ms across the subscales for the patient (1.9 to 2.8) and comparison (0.9 to 3.0) samples (Garner, 1984).

Garner (1984) reports that the 11 subscales of the EDI - 2 meet Content validity requirements and that 8 items have a high degree of face validity in that the items relate to the domains of interest in a straightforward manner.

Concurrent validity was established in the original validation of the EDI by comparing patient self-report profiles with the judgements of

experienced consultants or therapists familiar with the patients' clinical presentation (Garner, 1984).

Convergent validity correlations between the EDI Subscales, the Eating Attitudes Test - 26, and the Restraint Scale are shown with 33 (82%) of the subscales having $p < .001$ for each comparison, for a family of 40 comparisons (Garner, 1984).

The Test of Self Conscious Affect (TOSCA) (Tangney, Warner, & Gramzow, 1989). The TOSCA is a scenario-based measure that yields indices of proneness to shame, proneness to guilt, externalization of blame, detachment-unconcern, alpha pride (pride in self), and beta pride (pride in behavior). Respondents are presented with a series of 15 situations, of the kind that they are likely to encounter in daily life, and asked to rate on semantic differential scales of 1 to 5 how likely they would be to respond to each situation in various ways. The TOSCA yields internal consistency estimates (Chronbach's Alpha) of .74 and .69 for the shame and guilt scales respectively (Tangney et al, 1995) In addition, test-retest reliabilities of .85 for the shame scale and .74 for the guilt scale have been reported (Tangney et al, 1992).

Validity studies have indicated that the shame scale is associated with "theoretically relevant constructs such as depression, proneness to anger arousal, low self-esteem, and private and public self-consciousness" (Tangney, 1994; Tangney et al, 1994; Tangney et al, 1992)

Convergent and discriminant validity have also been demonstrated for the guilt scale. Guilt is significantly correlated with empathic concern for others (Tangney, 1991). Additionally studies show that guilt is uncorrelated with attributional indices of internality, stability, and globality for negative events (Tangney et al, 1992).

Because shame and guilt share certain features (e.g., they both involve negative affect and internal attributions), the TOSCA subscales are moderately related (r = .45) (Tangney et al, 1992). Studies have shown, that the shame and guilt scales each account for unique variance and are functionally distinct. When the shared variance is partialled out of these variables, shame is positively and guilt is negatively or negligibly associated with all nine Symptom Checklist - 90 indices of psychopathology, with depression, and with proneness to maladaptive responses to anger, such as verbal, physical, and displaced aggression (Tangney et al, 1994; Tangney et al 1995).

Procedure

Permission was granted by various department chairpersons to conduct this study. Approval for this researcher to utilize specific results from this study was given by university administration. These data were collected as part of a larger investigation on eating disorder symptomatology focussing on correlations of disordered eating patterns and various constructs in addition to shame-proneness and guilt-proneness.

In an attempt to attain a representative sample, classes from four different departments were chosen. In all 10 classes (2 evening classes, 8 day classes) from the Nursing School, English Department, Sociology Department and Business Administration Department participated. These participants completed paper-and-pencil questionnaires in four 30-60 minute sessions, each occurring on a separate day. In order to maintain consistency, two individuals were chosen to administer the questionnaires to all classes participating in the study. Participants were informed of the nature of this study in accordance with ethical standards set forth by the American Counseling Association (Herlihy & Golden, 1990) and they were informed that participation was strictly voluntary and that their responses to the questionnaires would remain anonymous.

Upon completion of the session I packet, each participant was given a post-it and asked to write on it his or her first name and middle and last initials. To insure anonymity these Post-its were subsequently affixed to session II, III, and IV packets according to ID number. After completing session IV, participants were given their Post-its to destroy, leaving all questionnaires indexed by ID number only.

Chapter IV

Results

This research sought to examine the directional hypothesis that shame was significantly and positively correlated to disordered eating symptomatology while guilt was negatively or negligibly correlated with these symptoms. The researcher in this project hoped to consider the differences between shame-proneness and guilt-proneness in relation to their specific connection to disordered eating symptomatology.

Table 4 presents correlations of shame and guilt with the EDI - 2 subscales. In general, shame was positively associated with a range of eating disorder symptoms, with more than half of the correlations reaching statistical significance. Specifically, shame was significantly positively correlated with drive for thinness, bulimia, body dissatisfaction, feelings of ineffectiveness, lack of interoceptive awareness, asceticism, and social insecurity. In contrast, guilt was negligibly correlated with these symptoms, and was negatively correlated with interpersonal distrust.

In order to account for the shared variance between shame and guilt, part (semi-partial) correlations were conducted, where shame was factored out of guilt and guilt factored out of shame. As shown in Table 4, shame residuals remained substantially correlated with eating disorder symptoms, including drive for thinness, bulimia, body dissatisfaction, feelings of ineffectiveness, interpersonal distrust, lack of interoceptive

awareness, asceticism, difficulties with impulse regulation, and social insecurity. Proneness to shame-free guilt, on the other hand, was negligible, and in some cases negatively, correlated with such symptoms. Specifically, the unique variance in guilt was significantly negatively correlated with body dissatisfaction, feelings of ineffectiveness, interpersonal distrust, difficulties with impulse regulation, and social insecurity.

TABLE 4. Correlations of TOSCA Shame-Proneness and Guilt-Proneness with the Eating Disorder Inventory - 2 Subscales

	Bivariate Correlations		Part Correlations	
EDI-2 Subscales	Shame	Guilt	Shame Residuals	Guilt Residuals
Drive for Thinness	0.22**	0.05	0.21**	-0.07
Bulimia	0.19*	-0.01	0.22**	-0.12
Body Dissatisfaction	0.21**	0.08	0.27***	-0.20**
Ineffectiveness	0.31**	0.09	0.39***	-0.26**
Perfectionism	0.07	0.12	0.01	0.09
Interpersonal Distrust	0.10	0.16*	0.20**	-0.24**
(lack of) Interoceptive Awareness	0.24**	0.03	0.25***	-0.10
Maturity Fears	0.10	0.03	0.13	-0.09
Asceticism	0.25**	0.01	0.28***	-0.15
Impulse Regulation	0.15	0.11	0.22**	-0.20**
Social Insecurity	0.30***	0.13	0.40***	-0.31***

Note. N = 171; $p < .05$*, $p < .01$**, $p < .001$***

The subscales of the EDI - 2 can be divided into two categories: Those that are fundamental to eating disorders and are likely to be experienced only by women with clinical eating disorders, and those that

are central to eating disorders but are also likely to be experienced by women with subclinical, more normative eating difficulties and concerns (Polivy & Herman, 1987; Pike & Rodin, 1991). The first group, eating psychopathology, corresponds with the features that Bruch (1973) and Selvini-Palazzoli (1978) discussed as being fundamental to the psychopathology of eating disorders, and is composed of the subscales Ineffectiveness, Interpersonal Distrust, and Lack of Interoceptive Awareness. The second group, weight preoccupation, is composed of the subscales Drive for Thinness, Bulimia, and Body Dissatisfaction.

In order to examine the possible interaction between shame and guilt in predicting each of these composite variables, weight preoccupation and eating psychopathology hierarchical regressions were conducted. For each equation, shame and guilt were entered on the first block, followed by the interaction between shame and guilt. As was expected, shame and guilt predicted significant portions of variance, accounting for 7% of the weight preoccupation variance (Beta shame = .29, $p < .001$; Beta guilt = -.15, $p < .10$), and 12% of the eating psychopathology variance (Beta shame = .38, $p < .001$; Beta guilt = -.25, $p < .01$). The interaction terms were not significant for either composite variable, however, R^2 change = .006 for weight preoccupation and .003 for eating psychopathology.

Chapter V

Discussion

The directional hypothesis for this project was that shame would have a significantly higher correlation with a greater proportion of the variance in women's eating symptomatology relative to guilt. As predicted although shame correlated positively with eating disorder symptoms, guilt was negatively related to such symptoms. A relationship between shame and disordered eating patterns is likely a complex relation. The results from this study are correlational in nature, and cannot pretentiously address the question of causality.

Women who are shame-prone to begin with may be more vulnerable to symptoms of eating disorders. Shame-prone individuals are predisposed to feel ashamed about many aspect of themselves and for women, this may manifest in feelings of shame about physical characteristics, including body size and shape. A second possibility is that shame-proneness emerges as a result of eating disordered behavior. Shame, for these women, may result from failed dieting attempts, or in response to binging, purging, or other behaviors associated with eating disorders.

Another possibility is that a third factor affects both one's tendency to respond with shame and one's likelihood of developing an eating disorder. For example, cognitive distortion, such as dichotomous thinking (e.g., "If a gain one pound, I'll go on and gain a hundred pounds"), and

over-generalization (e.g., "When I used to eat carbohydrates, I was fat, therefore, I must avoid them now so I won't become obese"), are prominent among anorexics (Grub, Sellers, & Waligroski, 1993, p. 1008) and bulimics, and are also characteristic of a shame-prone style of thinking (e.g., "I did a bad thing, therefore I am a bad person", or "I failed once before, therefore I am a failure").

Herwitt, Flett, & Ediger (1995) also discuss the tendency of anorexics to interpret impersonal events as relating directly to the self and to over interpret the significance of the self in daily events. These distortions are quite consistent with shame where the focus for negative events is on the self rather than on behavior. For some women, these distorted thinking styles may lead to shame-proneness as well as to disordered eating behavior. Shame is most likely one of a number of variables involved in complex cause and effect relationships that are important in both etiology and phenomenology of eating disorders.

These findings may at first seem to contradict the literature, which has highlighted guilt as an important emotion in eating disorders. However, as mentioned earlier, many authors fail to make a clear distinction between shame and guilt, often referencing guilt when describing a shame-like phenomenon. Other researchers (Wiseman et al, 1992; Shapiro et al, 1997; & Elmore et al, 1990) have cited both shame and guilt without distinguishing between them, perhaps leading others to

presume that guilt is a key emotion in relation to eating disorders. This research suggests that this may not be the case.

The desires to hide, escape, or disappear frequently associated with shame-based reactions may lead people to be silent about their experiences of shame. If one does not ask, one does not find out about such experiences. As reported by Herwitt & Flett (1990), Herwitt, Flett, & Ediger (1995) & Holderness, Brooks-Gunn, & Warren (1994) denial, deception, and secrecy are characteristic of individuals with eating disorders which clearly suggest unwillingness to admit problems and shortcomings, both to others and to themselves. This unwillingness to admit difficulties could potentially alert mental health providers to the possibility of an individual's shame-prone point of reference. To overlook these painful affective experiences may result in unnecessary and additionally shaming relapses for the eating disordered client.

When ashamed, the individual is helplessly stuck with their negative identity. People can change what they do, but they cannot instantly change who they are. The focus of shame is on the entire self. This often excruciating feeling is experienced as a reflection of a bad self which often produces defense mechanisms to fight the overwhelming pain of shame. An eating disorder can be a mechanism which aids the shame-prone individual to cope with their own distorted self evaluations.

From the opposite yet relevant perspective, some eating disordered

behavior may justify the unconscious impact of shame by providing rationalizations for the painful shame experiences. This often is depicted through the "internal war" or "split self" described frequently by individuals with eating disorders, where the "addict" side of the self acts out while the "other" side of the self judges and criticizes it. This cyclical response to shame provides the shame experience justification. Ignored the cycle can only continue spinning out of control for the individual. It may very well be imperative to address the salient relation shame may have to eating disorder symptomatology.

The data from this study does not suggest that women with eating disorder symptomatology do not ever feel bad about their behaviors. They may indeed feel guilt about things they have done, but in reflecting on these behaviors, this research proposes they may quickly focus on the self and experience shame.

Some limitations of this study need to be highlighted. First, although these results suggest that women with eating disordered behavior and symptomatology are shame-prone rather than guilt-prone, they do not describe what role shame plays in the phenomenology of eating disorders. Second, the TOSCA assesses peoples' proneness to respond with shame and guilt across a range of day-to-day situations, but not to specific situations involving food, eating, dieting, or other pertinent issues related to eating disorders. Finally, the sample from this study when compared to

the U. S. Census data (1990) is not accurately representative of the U. S. Population with respect to culture and may not be generalized to that population. However, the study does reflect a more culturally diverse sample which provides some additional validation disputing the myth that eating disorders only affect Caucasian middle to upper middle-class adolescent females.

The findings from this research suggest that shame is an important emotion to consider in working with women who have eating difficulties. While the literature emphasizes both shame and guilt as catalysts to binging and purging and as primary affective consequences of disordered eating behavior, this data indicates that shame may be the more important emotion. Particular attention to feelings of shame (as distinct from guilt) might be helpful when working with women experiencing eating disorders. These feelings of shame could be fueling disordered eating behaviors. A prominent issue may be the global shame-like reactions these women experience about the self in relation to eating as opposed to guilt about specific behaviors that surround their eating.

Appendix A

Eating Disorder Inventory Symptom Checklist

David M. Garner, Ph.D.

Directions

Enter your name, the date, your age, sex, marital status, and occupation. Complete the questions in this booklet as accurately as you can.

Name_____ Date_____

Age _____ Sex _____ Marital status _____ Occupation_____

_____

A. DIETING

*Have you *ever* restricted your food intake due to concerns about your body size or weight? ____ Yes ____ No

How old were you *the very first time* that you began to seriously restrict your food intake due to concern about your body size or weight? _____ years old

B. EXERCISE

On average, over *the last three months*, how often have you exercised (including going on walks, riding a bicycle, etc.)? If you exercise more than once a day, please count the *total number of times* that you exercise in a typical week. _____times a week

On average, how long do you exercise each time? _____ minutes

*What percentage of your exercise is aimed at controlling your weight?

____ 0% ____less than 25% ____ 25-50% ____ 50-70% ____ 100%

C. BINGE EATING

Please remember in answering the following questions that an eating binge *only* refers to eating an amount of food that others of your age and sex regard as *unusually large*. It does not include times when you may have eaten a normal quantity of food which you would have preferred not to have eaten.
*Have you *ever* had an episode of eating an amount of food that others would regard as *unusually large*? ____ Yes ____ No
If no, please skip to Question D.

How old were you when you *first* had an eating binge? ____ years old

How old were you when you began binge eating on a *regular* basis?
_____ years old

*During the *last three months*, how often have you typically had an eating binge?

____ I have not binged in the last three months.

____ Monthly - I usually binge _____ time(s) a month.

*____ Weekly - I usually binge _____ time(s) a week.

____ Daily - I usually binge _____ time(s) a day.

*At the *worst of times*, what was your average number of binges per week? _____ binges per week

How long ago was that? ____ months ago ____ at its worst right now

If you have not binged in the last three months, please skip to Question D.

*Do you feel out of control when you binge?

___ Never ___Rarely ___Sometimes ___ Often ___ Usually ___ Always

Do you feel that you can stop once a binge has started?

___ Never ___Rarely ___ Sometimes ___ Often ___ Usually ___Always

Do you feel that you can prevent a binge from starting in the first place?

___ Never ___ Rarely ___ Sometimes ___ Often ___ Usually ___ Always

Do you feel you can control your *urges* to eat large quantities of food?

___ Never ___ Rarely ___ Sometimes ___ Often ___ Usually ___ Always

Do you feel distressed by your binging?

___ Never ___ Rarely ___ Sometimes ___ Often ___ Usually ___ Always

Do you find binging pleasurable?

___ Never ___ Rarely ___ Sometimes ___ Often ___ Usually ___ Always

D. PURGING

*Have you ever tried to vomit after eating in order to get rid of the food eaten? ____ Yes ____ No
If no, please skip to Question E.

How old wee you when you induced vomiting for the first time? _____ years

old

*During the *last three months*, how often have you typically induced vomiting?

___ I have not vomited in the last three months.

___ Monthly - I usually vomit _____ time(s) a month.

___ Weekly - I usually vomit _____ time(s) a week.

___ Daily - I usually vomit _____ time(s) a day.

*At the *worst* of times, what was your average number of vomiting episodes per week? _____ vomiting episodes per week

How long ago was that? _____ months

E. LAXATIVES

*Have you ever used laxatives to control your weight or "get rid of food?"
____ Yes ____ No
If no, please skip to Question F.

How old were you when you *first* took laxatives for weight control? _____ years old

How old were you when you began taking laxatives for weight control on a *regular basis*?
_____ years old

*During the *last three months*, how often have you been taking laxatives for weight control?

____ I have not taken laxatives in the last three months.

____ Monthly - I usually take laxatives ____ time(s) a month.

____ Weekly - I usually take laxatives ____ time(s) a week.

____ Daily - I usually take laxatives ____ time(s) a day.

How many laxatives do you usually take each time? _____ laxatives

What kind of laxatives do you take? _____

*At the *worst* of times, what was the average number of laxatives that you were taking per week? _____ laxatives per week

How long ago was that? _____ months

F. DIET PILLS

*Have you *ever* taken diet pills? ____ Yes ____ No
If no, please skip to Question G.

*During the *last three months*, how often have you typically taken diet pills?

____ I have not taken diet pills in the last three months.

____ Monthly - I usually take diet pills _____ times a month.

____ Weekly - I usually take diet pills _____ times a week.

____ Daily - I usually take _____ diet pills a day.

*At the *worst* of times, what was the average number of diet pills that you were taking per week? _____ diet pills per week

How long ago was that? _____ months

G. DIURETICS

*Have you *ever* taken diuretics (water pills) to control your weight?
____ Yes ____ No
If no, please skip to Question H.

*During the *last three months*, how often have you typically taken diuretics?

____ I have not taken diuretics in the last three months.

____ Monthly - I usually take diuretics _____times a month

____ Weekly - I usually take diuretics _____ times a week.

____ Daily - I usually take _____ diuretics a day.

*At the *worst* of times, what was the average number of diuretics that you were taking per week? _____diuretics per week

How long ago was that? _____months

H. MENSTRUAL HISTORY
(For Females only)

*Have you ever had a menstrual period? ____ Yes ____ No
If no, please skip to Question I.

How old were you when you first started menstruating? _____ years old

Do you have menstrual periods now? (Check one)

____ Yes, regularly every month

____ Yes, but I skip a month once in a while

____ Yes, but not very often (for example, once in six months)

____ No I have not had a period in at least six months

____ No, I am post-menopausal, have had a hysterectomy, or am pregnant

*How long has it been since your last period? _____ months

*Have you ever had a period of time when you did not menstruate for three months or more (excluding pregnancy)? ____ Yes ____ No

If yes, how old were you when you first missed your period for three months or more? _____ years old

For how many months did you miss your period? _____ Months

How much did you weigh when you stopped menstruating? _____ pounds

Are you currently taking birth control pills? ____ Yes ____ No

If yes, how old were you when you first started using the pill? _____ years old

I. CURRENT MEDICATION

Are you currently taking any medication prescribed by a physician? ____ Yes ____ No

If Yes, please list the medications you are taking.

_____

_____

_____

Appendix B

EATING DISORDER INVENTORY - 2

David M. Garner, Ph.D.

DIRECTIONS

Enter your name, the date, your age, sex, marital status, and occupation. Complete the questions on the rest of this page. Then turn to the inside of the booklet and carefully follow the instructions.

Name _____ Date _____

*Age _____ Sex _____ Marital status _____

Occupation _____

A. *Current weight: _____ pounds

B. *Height: _____ feet _____ inches

C. Highest past weight excluding pregnancy: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

D. *Lowest weight as an adult: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

E. What weight have you been at for the longest period of time?

_____ pounds

F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting?

_____ Yes _____ No

If yes, what is this weight? _____ pounds

At what age did you first reach this weight? _____ years old

G. What is the most weight you have ever lost? _____ pounds

Did you lose this weight on purpose? _____ Yes _____ No

What weight did you lose to? _____ pounds

At what age did you reach this weight? _____ years old

H. What do you think your weight would be if you did not consciously try to control your weight? _____ pounds

I. How much would you like to weigh? _____ pounds

J. Age at which weight problems began (if any): _____ years old

K. Father's occupation: _____

L. Mother's occupation: _____

INSTRUCTIONS

First, write your name and the date on your EDI - 2 Answer Sheet. Your ratings on the items below will be make on the EDI - 2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI 2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

---

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.

18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
38. I think about binging (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.

44. I worry that my feelings will get out of control.

45. I think my hips are too big.

46. I eat moderately in front of others and stuff myself when they're gone.

47. I feel bloated after eating a normal meal.

48. I feel that people are happiest when they are children.

49. If I gain a pound, I worry that I will keep gaining.

50. I feel that I am a worthwhile person.

51. When I am upset, I don't know if I am sad, frightened, or angry.

52. I feel that I must do things perfectly or not do them at all.

53. I have the thought of trying to vomit in order to lose weight.

54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).

55. I think that my thighs are just the right size.

56. I feel empty inside (emotionally).

57. I can talk about personal thoughts or feelings.

58. The best years of you life are when you become an adult.

59. I think my buttocks are too large.

60. I have feelings I can't quite identify.

61. I eat or drink in secrecy.

62. I think that my hips are just the right size.

63. I have extremely high goals.

64. When I am upset, I worry that I will start eating.

65. People I really like end up disappointing me.

66. I am ashamed of my human weaknesses.

67. Other people would say that I am emotionally unstable.

68. I would like to be in total control of my bodily urges.

69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.
85. I experience marked moods shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

Appendix C

THE TEST OF SELF-CONSCIOUS AFFECT (TOSCA)

June Tangney, Patricia Wagner, & Richard Gramzow, 1989

DIRECTIONS

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate *all* responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. **You wake up early one Saturday morning. It is cold and rainy outside**.

a) You would telephone a friend to catch up on news.

1---2---3---4---5
not likely very likely

b) You would take the extra time to read the paper.

1---2---3---4---5
not likely very likely

c) You would feel disappointed that its raining.

1---2---3---4---5
not likely very likely

d) You would wonder why you woke up so early.

1---2---3---4---5
not likely very likely

In the above example, I've rated all of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circles a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

PLEASE DO NOT SKIP ANY ITEMS -- RATE ALL RESPONSES.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

a) You would think: "I'm inconsiderate."

1---2---3---4---5
not likely very likely

b) You would think: Well, they'll understand."

1---2---3---4---5
not likely very likely

c) You would try to make it up to him as soon as possible.

1---2---3---4---5
not likely very likely

d) You would think: "My boss distracted me just before lunch."

1---2---3---4---5
not likely very likely

2. You break something at work and then hide it.

a) You would think: "This is making me anxious. I need to either fix it or get someone else to."

1---2---3---4---5
not likely very likely

b) You would think about quitting.

1---2---3---4---5
not likely very likely

c) You would think: "A lot of things aren't made very well these days.

1---2---3---4---5
not likely very likely

d) You would think: "It was only an accident."

1---2---3---4---5
not likely very likely

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

a) You would think: "I should have been aware of what my best friend is feeling."

1---2---3---4---5
not likely very likely

b) You would feel happy with your appearance and personality.

1---2---3---4---5
not likely very likely

c) You would feel pleased to have make such a good impression.

1---2---3---4---5
not likely very likely

d) You would think your best friend should pay attention to his/her spouse.

1---2---3---4---5
not likely very likely

e) You would probably avoid eye-contact for a long time.

1---2---3---4---5
not likely very likely

4. At work, you wait until the last minute to plan a project, and it turns out badly.

a) You would feel incompetent.

1---2---3---4---5
not likely very likely

b) You would think: "There are never enough hours in the day."

1---2---3---4---5
not likely very likely

c) You would feel: "I deserve to be reprimanded."

1---2---3---4---5
not likely very likely

d) You would think: "What's done is done."

1---2---3---4---5
not likely very likely

5. You make a mistake at work and find out a co-worker is blamed for the error.

a) You would think the company did not like the co-worker.

1---2---3---4---5

not likely very likely

b) You would think: "Life is not fair."

1---2---3---4---5
not likely very likely

c) You would keep quiet and avoid the co-worker.

1---2---3---4---5
not likely very likely

d) You would feel unhappy and eager to correct the situation.

1---2---3---4---5
not likely very likely

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

a) You would think: "I guess I'm more persuasive than I thought."

1---2---3---4---5
not likely very likely

b) You would regret that you put it off.

1---2---3---4---5
not likely very likely

c) You would feel like a coward.

1---2---3---4---5
not likely very likely

d) You would think: "I did a good job."

1---2---3---4---5
not likely very likely

e) You would think you shouldn't have to make calls you feel pressured into.

1---2---3---4---5
not likely very likely

7. You make a commitment to diet, but when you pass the bakery you buy a dozen donuts.

a) Next meal, you would eat celery to make up for it.

1---2---3---4---5
not likely very likely

b) You would think: "They looked too good to pass by."

1---2---3---4---5
not likely very likely

c) You would feel disgusted with you lack of will power and self-control.

1---2---3---4---5
not likely very likely

d) You would think: "Once won't matter."

1---2---3---4---5
not likely very likely

8. While playing around, you throw a ball and it hits your friend in the face.

a) You would feel inadequate that you can't even throw a ball.

1---2---3---4---5
not likely very likely

b) You would think maybe your friend needs more practice at catching.

1---2---3---4---5
not likely very likely

c) You would think: "It was just an accident."

1---2---3---4---5
not likely very likely

d) You would apologize and make sure your friend feels better.

1---2---3---4---5
not likely very likely

9. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

a) You would feel immature.

1---2---3---4---5
not likely very likely

b) You would think: "I sure ran into some bad luck."

1---2---3---4---5
not likely very likely

c) You would return the favor as quickly as you could.

1---2---3---4--5
not likely very likely

d) You would think: "I am a trustworthy person."

1---2---3---4---5
not likely very likely

e) You would be proud that you repaid your debts.

1---2---3---4---5
not likely very likely

10. You are driving down the road, and you hit a small animal.

a) You would think the animal shouldn't have been on the road.

1---2---3---4---5
not likely very likely

b) You would think: "I'm terrible."

1---2---3---4---5
not likely very likely

c) You would feel: "Well, it was an accident."

1---2---3---4---5
not likely very likely

d) You would probably think it over several times wondering if you could have avoided it.

1---2---3---4---5
not likely very likely

11. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

a) You would think: "Well, it's just a test."

1---2---3---4---5
not likely very likely

b) You would think: "The instructor doesn't like me."

1---2---3---4---5
not likely very likely

c) You would think: "I should have studied harder."

1---2---3---4---5
not likely very likely

d) You would feel stupid.

1---2---3---4---5
not likely very likely

12. You and a group of co-workers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

a) You would feel the boss is rather short-sighted.

1---2---3---4---5
not likely very likely

b) You would feel alone and apart for your colleagues.

1---2---3---4---5
not likely very likely

c) You would feel your hard work had paid off.

1---2---3---4---5
not likely very likely

d) You would feel competent and proud of yourself.

1---2---3---4---5
not likely very likely

13. While out with a group of friends, you make fun of a friend who's not there.

a) You would think: "It was all in fun; it's harmless."

1---2---3---4---5
not likely very likely

b) You would feel small....like a rat."

1---2---3---4---5
not likely very likely

c) You would think that perhaps that friend should have been there to defend himself/herself.

1---2---3---4---5
not likely very likely

d) You would apologize and talk about that person's good points.

1---2---3---4---5
not likely very likely

14. You make a big mistake on an important project at work. People were depending on you, and you boss criticizes you.

a) You would think your boss should have been more clear about what was expected of you.

1---2---3---4---5
not likely very likely

b) You would feel like you wanted to hide.

1---2---3---4---5
not likely very likely

c) You would think: "I should have recognized the problem and done a better job."

1---2---3---4---5
not likely very likely

d) You would think: "Well nobody's perfect."

1---2---3---4---5
not likely very likely

15. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

a) You would feel selfish and you'd think you are basically lazy.

1---2---3---4---5
not likely very likely

b) You would feel you were forced into doing something you did not want to do.

1---2---3---4---5
not likely very likely

c) You would think: "I should be more concerned about people who are less fortunate.

1---2---3---4---5
not likely very likely

d) You would feel great that you had helped others.

1---2---3---4---5
not likely very likely

e) You would feel very satisfied with yourself.

1---2---3---4---5
not likely very likely

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