

Shame and Pride in Anorexia Nervosa: A Qualitative Descriptive Study

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During the last decades, there has been a rising interest in the role of shame in psychiatric disorders.

Objective: To define shame and describe types and subtypes of shame and their relations to symptoms and meaning in anorexia nervosa. The study will also describe the possible role of pride, as a contrasting emotional and cognitive experience.

Method: Thirteen female patients (age 16–39 years) with anorexia nervosa were interviewed about their general understanding of the concept of shame, what they considered shameful in themselves, past and present, and in others and shame related to eating and body.

Results: Based on statements from the patients 'globalised internal shame', different subtypes of focal shame and different subtypes of pride are categorised. Shame is described both as cause and consequence in relation to symptoms in anorexia nervosa, hence a shame–shame cycle. A shame–pride cycle is also presented.

Discussion: The use of shame, as well as pride, as concepts in regard to anorexia nervosa may improve our understanding of the nature of this disorder, as well as being a guideline for therapists.

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INTRODUCTION

Many clinicians and researchers will support the statement that shame is a central phenomenon in eating disorders (Goss & Gilbert, 2002). But what is shame? And what are the more specific roles of shame in these disorders, particularly in anorexia nervosa? The aim of this research study is to

describe types and subtypes of shame, and their interactions with symptoms and meaning in anorexia nervosa. The study will also describe the possible role of pride, as a contrasting emotional and cognitive experience.

The article is based on a phenomenological approach, and presents descriptions, concepts and categories of shame. The data bases for the analyses are verbal statements from female patients with anorexia nervosa, collected via research interviews. Hopefully, such a focus on the role of shame and pride will contribute to a further understanding of anorexia nervosa. The overall aim is to bring forth

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such understandings, so they can guide therapeutic approaches and techniques.

Shame is something we want, and something we do not want. Even if we may immediately think of shame as something negative, we probably associate shamelessness with something even worse. Shame represents a withdrawal. It has been argued that shame is an affective response which helps us in adapting (Gilbert, 1998; Tomkins, 1987). The withdrawal may be interpreted as a protection against being hurt when confronted with violations in relationships, or when there is a lack of response. The withdrawal represents an effort to terminate or change the character of the relationship. Such a reaction may protect against an invasion of the self, and will thus help to preserve relations and the sense of identity. But 'too much' shame makes this kind of protection self-destructive. Shame becomes a dysregulation of self-esteem. The shame reaction becomes a problem in itself. The shameful may withdraw, hide or be silent in such a way that he or she excludes himself/herself from nurturing and healing relationships.

Hence, it is relevant to make a distinction between positive and negative shame (Wurmser, 1981). A positive sense of shame may be described as the respect for other people and for oneself. A good sense of shame protects social bonds, and regulates intimacy. Shame defines borders for privacy. And a good sense of shame may be moderating, preventing us from loosing ourselves in ideas of our own grandiosity (Skårderud, 2003). This paper will not discuss such positive adaptive aspects, but will deal with shame as a negative experience.

In order to define shame, it can be described as a multifaceted experience with different components and mechanisms. It has been conceptualised in terms of (Gilbert, 1998, 2002; Tangney, 1996): *Emotions*, as a primary effect of its own, or as a composite of other emotions such as anxiety, anger or self-disgust. *Cognitive aspects*, cognitions and beliefs about the self: seeing oneself or being seen by others as inferior, inadequate or flawed, particularly in social comparison with others. *Bodily components*, for example blushing. *Behaviours and actions*, for example concealing, hiding, running away and withdrawing: trying to compensate shame by achieving or attacking others in an attempt to hide one's shame. *Interpersonal relationships*, as the relationship between the shamed and the shamer.

Gilbert (1998) contributes with a useful distinction between *internal* shame and *external* shame. External shame refers to 'self as seen and judged by others', and refers to negative judgement by others. We may

be an object of scorn, contempt and humiliation. Internal shame, on the other hand, refers to 'self as judged by self'. Thus one sees oneself as bad, flawed, worthless or unattractive. Another way of expressing this distinction is the difference between 'being ashamed' and 'feeling ashamed'. Internal and external shame is often highly correlated, but they need not always be. A person can have socially stigmatised traits, such as being severely obese, and experience negative comments without a sense of internal personal shame. Another person may feel intense shame even though there is great acceptance and assurance from others. Intense internal shame is an inner experience of the self as an unattractive social agent, under pressure to limit possible damage to the self via escape or appeasement (Gilbert, 1998); it is the pain of not seeing oneself as being worthy of love.

Shame Psychology

The interest in shame in psychology has changed dramatically in the last couple of decades. Relatively little has been written about shame in the early history of psychology and psychiatry. Lewis (1987) wrote about shame as the 'hidden emotion' and the 'sleeper in psychopathology'. Classical psychoanalysis has guided our interest towards guilt, with Sophocles' tragedy about King Oedipus as the core metaphor. The shameful self has stood in the shadow of the guilty self. Exceptions among the psychoanalytical classics are Adler (1958) with his descriptions of inferiority feelings and the inferiority complex, and Erik H. Erikson describing a shame phases in the child's normal psychological development (1980).

However, during the last decades, we have witnessed the rise of a psychology of shame. Among the pioneers, we find Lynd (1958), Lewis (1971, 1987), Tomkins (1962, 1963, 1963, 1963, 1992), Wurmser (1981, 1987) and Nathanson (1987). From being ignored in psychology, shame is about to be accepted as a central effect (Gilbert, 1998). Miller (1996) even argues that shame is now so commonly seen as 'the bedrock of psychopathology' and the 'gold to be mined psychotherapeutically' that there has been neglect of other emotions and their interaction with shame (p. 151).

Explanations for the recent appearance of shame in the professions of psychology and psychiatry may be sought in different areas, in terms of a development of theory, a trend in late modern culture, but not least in clinical reality (Skårderud, 2001). In recent decades, there has been an increased

awareness of so-called shame-based syndromes (Kaufman, 1989). Examples of shame-based syndromes are drug and substance abuse, addictions, reactions after violation and abuse, self-mutilation, and, to be discussed here, eating disorders. In such clinical conditions, the feeling of shame is often both origin and consequence.

Eating Disorders and Shame Research

In the clinical literature, there are a great number of case reports of eating disordered patients describing emotions and cognitions that would fit our definitions of shame. And many of them support the idea that eating disorders take root in the context of a general sense of an unattractive self. One wants to change, to become another, and changing one's body serves as both a concrete and a symbolic tool for such ambitions (Skårderud, 2007a, 2007b). But the research literature is far more limited. In general, previous results seem to suggest that persons with eating disorders have elevated rates of both internal shame (negative self-evaluation) and external shame (feeling that others look down on them) (Goss & Gilbert, 2002).

Cook (1994, 1996) compared the scores of a number of psychiatric groups, using his own The Internalised Shame Scale (ISS), and noted that eating disordered patients scored significantly higher on the ISS than all the other clinical groups tested. The ISS views internalised shame as a global self-construct. Other studies measuring shame and guilt show similar results (Garner & Garfinkel, 1985; Sanftner & Crowther, 1998). Burney and Irwin (2000) using situational scenarios for measuring shame, found that shame associated with eating behaviour was the strongest predictor of the severity of eating-disorder symptoms.

Reviewing the literature of shame and eating disorders, one finds many references to bingeing behaviour, and to the aetiological role of sexual abuse. Andrews (1997) proposes that bodily shame plays a mediating role between childhood physical and sexual abuse and bulimia.

METHOD

This study is based on a qualitative research method. The informants were female patients with anorexia nervosa, all recruited from the author's own psychotherapeutic practice. Data was collected from research interviews with patients in active treatment for anorexia nervosa. All interviews were

carried out by the author. The interviews followed a manual for semi-structured interviewing. An additional source was medical data and process notes from their medical journals. The study was approved by the Norwegian Medical Ethical Committee.

Participants

Thirteen female patients participated in this study. They were between the ages of 16 and 39. A necessary criterion for inclusion in the study was the fulfilment of the diagnostic criteria for anorexia nervosa according to DSM-IV (American Psychiatric Association, 1994). Eight of the 13 patients had suffered from the restrictive subtype of anorexia (ANR), the main symptom being restriction of food. The remaining five corresponded to the bulimic subtype (ANB), with episodes of bingeing behaviour (DSM-IV) (American Psychiatric Association, 1994). Body Mass Index (BMI) (weight/height² × height) at the time of the interview varied in an interval from 10.8 to 17.6. WHO defines BMI less than 19.0 as underweight. Eleven had their symptom debut, and had also been diagnosed before they were 18 years old. One patient started with her anorexia at the age of 19, the last one experienced the onset of illness when she was 32, after a severe psychological trauma. The patients had the diagnosis anorexia nervosa from 1 to 19 years, median 6.4 years.

At the time of the data collection, all the informants—hereafter called patients—were in active treatment with the author. The context for the treatment was a private psychotherapeutic practice with public funding. All of the patients had been treated by the author for more than 6 months. In this context, treatment means individual psychotherapy, with session every week or every second week. The psychotherapeutic approach is mainly based on psychodynamic models, with a considerable integration of elements from cognitive and psychoeducative traditions.

Data Collection

The data collection took part over 2 years, since only a limited number of patients fulfilled the criteria for inclusion. The patients were given detailed information both verbally and written, about the aims of the study, and their therapist's dual role as a clinician and researcher. The research interview was presented as separate from the therapeutic context. The patients signed a written declaration of consent.

Great emphasis was placed, both verbally and in writing, on the voluntariness of all participation in the study, and that absence from participation would have no negative consequences for their therapy. But it is of course difficult to assess the degree of freedom actually felt by the patients. One patient declined the invitation to participate.

Interviews

The interviews were semi-structured. They covered a wide range of topics relevant to eating disorders (e.g. the history of their illness in their own words, turning points, their understanding of the functions of anorexia nervosa in their lives). Hence, shame was not the only area to be investigated. There were specific questions about their general understanding of the concept of shame, what they considered shameful in themselves, past and present, and in others and shame related to eating and body. In a semi-structured interview, the written guidelines are not used slavishly. The interviewer may follow-up different themes that appear in the dialogue. Emphasis was put on clarifying, repeating, confirming and diving deeper into the answers. Such a practice corresponds to what Kvale (1996) describes as 'communicative validity' or 'member checks' (Denzin & Lincoln, 2000). These are methods to improve the validity. The tape-recorded interviews lasted for approximately 1 hour, and were transcribed by an assistant in Winword text format.

To some of the patients, the concept of shame was little familiar. They were not used to applying this concept to themselves, to their own emotions and cognitions. Their responses were limited, and some were obviously unsure about the distinction between shame and guilt. Others presented a rich material, and seemed to speak openly about these topics. A third group found this a difficult topic to deal with, and to the researcher, it seemed that bringing up the topic of shame may have aroused feelings and reactions of shame.

Reflections on Method

In a discussion on method, it is inevitable to look into the dual role as therapist and researcher. There are certain basic differences between the roles of the clinician and the researcher. For the researcher, the goal is the generation of knowledge. For the psychotherapist, the patient and the therapeutic situation are the objectives (Fog, 2004). In combining both, one must serve two masters. This can lead to

ethical problems that must be addressed in each concrete instance.

It is the author's contention that in this particular case, there were no serious ethical objections to the dual role of researcher/therapist. The nature of the task is such that it is compatible with the therapeutic aims: the patient's self-understanding and articulation of her own situation. In fact, a change of context for the dialogue may in itself be advantageous to the therapeutic process. This research took place in a context, in an ongoing therapeutic relationship, which is basically oriented towards increased self-understanding and insight. In this way, the dual contexts may be seen as partial aspects of a common context of inquiry and introspection. It is a common context with analytic ambitions.

The fact that the therapist carries out research interviews with his own psychotherapy patients must be viewed as an intersubjective co-construction of meaning. This particular task should be seen as part of the dialogical process, in which research and therapy cannot be clearly differentiated. One must be willing to accept that the patients, in varying degrees, use assimilated terms, expressions, fragments or entire modes of reasoning that form part of the therapist's/researcher's preconceptions, and that their conceptualisations and descriptions of shame may to some extent be coloured by earlier dialogues with the therapist. The patients' responses in the research context may also be communications to the therapist. One may also critically state that anorectic patients are a 'risk group', since they are compliant with the interviewer. The group as such is described as outer-directed, sensitive to and dependent on other's needs and views (Buhl, 1990).

On the other hand, there are arguments that the dual role is beneficial for scientific quality when the topic is personal shame, and actually increases the validity of the research process. There is one ethical and practical issue connected to face-to-face interviews about shame. Shame is usually connected to concealment and silence. One does not want to speak about one's own shame. The ethical dilemma in this type of face-to-face interviewing is that it may induce shame in already shame-prone individuals. The practical problem, on a methodological level, is that shame in the academic interview context with strangers decreases the likelihood of aspects of shame being divulged. There is research evidence that respondents may feel uneasy when responding to questions about shame (Andrews, 1998). Because an established patient-therapist relationship presumably represents a safer environment for the patient, being interviewed by one's

therapist may improve research validity and also reduce stress in the interview situation.

Another limitation in this study is of semantic nature. It is neither evident nor distinct what shame refers to. Individuals may use it in slightly different ways. Some use the concept very rarely and have diffuse ideas of its meaning; others may partly confuse it with guilt. Individuals cannot be expected to know the abstract difference between shame and guilt, and definitions of shame and guilt are best left to the researcher (Tangney, 1996). A related problem inherent in all assessments of dispositional shame is the possibility that much shame may not be experienced at a conscious level, so-called 'bypassed shame' (Lewis, 1971). The therapist as a researcher has a great deal of comprehensive knowledge about the patients, and that this may influence the interpretations. The patients had attended at least 30 psychotherapeutic sessions with the author. This may contribute to a wider context for the interpretations, but it may also represent a bias in the sense of oversensitivity for the topic of shame.

Analyses

In analysing the transcribed texts, a computer programme for qualitative text analysis NVivo (Gibbs, 2002) was used. The text analyses were carried out in consecutive steps corresponding to the main research questions in this article, that is to describe types and subtypes of shame in anorexia nervosa.

First, all statements involving the use of the word shame were marked. These naturally included the responses from the interviewee on shame, but for some, the topic also appeared in other contexts in the interviews. These could be from very brief statements to coherent narratives. The computer program is based on making so-called 'nodes', and in this first part of the analysis, all these selected excerpts from the text were marked by the node 'shame'. Not coded were the verbal presentations of emotions, cognitions and situations which the researcher could interpret as examples of shame, but where the patients themselves did not use this concept in the same verbal context. Therefore, the text excerpts which were coded refer exclusively to their own use of the concept, or as a response to the researcher using the word 'shame' in an immediately preceding question.

Second, the next step was a further selection of all of these statements. A new node, 'personal shame' was developed as a subcategory of 'shame'. To be

included in this category, it was a necessary qualification that the statements from the patients referred to themselves and their personal feelings. The context of this research paper is to describe the patients' own shame emotions, cognitions and relationships with reference to their eating disorder. Hence, general statements about shame, discussing the concept, other people's shame, etc. were not included.

A third step in the analysis was further categorisation, arranging the different units of meaning into categories, referring to different domains of life and psyche. Finally, these categories were organised in hierarchical order, in relation to superior common categories.

As a part of the analysing process, the research field was expanded. The patients also presented statements that could be categorised as 'opposite to shame'. In addition to negative, shameful experiences more of them also described positive experiences related to being a person with anorexia nervosa. Their anorectic symptoms and behaviour made them proud. Hence, such statements were included and organised in a main node/category called 'pride'. Coding for this category were in some situations based on the patients explicitly using the words 'pride' or 'proud', but the category does not presuppose this. It is also based on statements and descriptions which the researcher interprets as synonymous to pride about own qualities, talents or deeds. Pride was included to increase the understanding of the complexity of affective life in anorexia nervosa. Methodologically, the analysis of pride followed the same steps as the analysis of shame.

RESULTS

Concerning shame, these subcategories are organised into two main categories. They are 'Globalised internal shame' and 'Focuses of shame'. In the first category, there are no subcategories, which precisely underscore the global sense of shame. The second category is constructed of different subcategories, calling attention to the different, 'local' domains of shame. And these again have subcategories. The global sense of shame will often prove to be so persistent that the patients also report many focuses of shame, so that for these persons the global sense of shame may be considered as a higher order category than focal shame. Other patients, however, contributed to different categories and

subcategories of focal shame without contributing to globalised shame.

In the presentation of the results, there is no reference to the frequency of the different categories, which is not considered a topic in this study. Some categories will be illustrated with extracted citations from the interviews, others with references to statements without using direct quotes. The quotes and patients used in the presentation of results have been chosen because they are exemplary; they are quite explicit in illustrating the actual categories (Table 1).

GLOBALISED INTERNAL SHAME

One main category is a global sense of shame. This relates to the presented concept of internal shame, of feeling ashamed. It refers to a general sense of being unworthy: to the shame of being the person one is.

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

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

Table 1. Shame

Globalised internal shame
Focuses of shame
Feelings and cognitions
Greed
Envy
Sadness
Grandiosity
Rage
Achievement failures
Body shame
Appearance
Body function
Self-control and self-destructive behaviour
Self-control
Self-mutilation
Self-destructive behaviour
Shame related to sexual abuse
Being made inferior
Shame of not resisting
Shame of having an eating disorder
The problem of eating
The self-accusation of vanity
Social stigma

... When I eat more, then I feel that I get more energy. I am more alive.

I feel that there is a chance that I might become eager. I speak up and things like that ... I don't like that so much. I take up space, too much space; there is too much of myself. I can also notice it in the others at school. I realise that it is better to be worn out and small. Then I don't take up more room than I deserve.

These statements demonstrate the embodiment of emotions so basic in eating disorders. The feeling of shame is embodied as a physical reduction.

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

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

... I feel ashamed about everything. I feel ashamed about feeling ashamed.

The utterances of both patients express in different ways the global aspect of the feeling of shame. This kind of negative feeling of shame can contribute to a wish not only to change oneself, but also to get away from oneself: to disappear in the sense of suicide.

FOCUSES OF SHAME

Below are shown the different focuses of shame relating to different aspects of the self.

Feelings and cognitions

Clinical literature as well as research literature contains descriptions of the difficulties of anorectic patients to tolerate and regulate their feelings (Buhl, 2002). There are some main examples of feelings and thoughts which were described as shame-inducing, and they are presented here.

Greed

Elisabeth: Sometimes there is so much I want to do. I daydream both about things and about success. But then I rebuke myself, thinking that this is not for me. I have not done anything to deserve it. And then I think that I am terribly greedy. It's the same also with food. Since I am thinking about food all the time, it must be because I am really greedy—that's what I think.

Envy

Ingrid: I compare myself a lot to others. And they are so much better than me at most things. They are smarter than me in most things. And so I want to be like them. I am envious, and envy is a feeling which I think is pathetic.

Sadness

Martha: My life is a mess. I am desperate and depressed. I really believe that I am extremely sad. But then I immediately get the thought: what do I have to be sad about. After all, I should be fine. Think of all those who are much worse off than me. And then I usually feel ashamed of feeling so depressed.

The three categories cited above point to a common psychological quality which emerges in the interviews and is well-known from clinical work with anorexia: The problem of being able to feel entitled to something good, and not feeling that one deserves it. In the case with sadness, it is about feeling entitled to self-pity and self-comforting. These are feelings which can be concretely

expressed in terms of food, by not allowing oneself to have what one needs, and what one perhaps also would like to have.

Grandiosity

In clinical practice, one may experience that shame and feelings of grandiosity are complementary. They mutually feed each other. The shameful can cling to fantasies about his or hers grandiosity.

Christina: I often think of my former, and still actual, to some extent, urge to be unique and different. I needed to believe that I was a special person. A part of this was the idea that I did not need anything, and could manage without food. I was different from all the others, from the weak ones with desires and needs. Now I think: That was a bizarre idea! In fact, it was a great illusion.

... Finally, I had to realise that I needed to eat more. That was the great defeat. I became nobody, nothing.

... But worse was my sudden insight in what a person I was, who had had such great ideas about myself, about being extraordinary. And even worse, on second thoughts, was also the remembrance of how arrogant I had been in these first months and years of my anorexia, imaging being that unique. I had felt much contempt for others, for those who ate, for my parents, for ordinary people and also for my therapists. ... I remember how I had looked down on them. It is embarrassing to recall now, how I behaved towards those who wanted to help me.

Rage

Christina goes on to describe how she not only feels shame about her arrogance, but also how her defeat about having to eat again had made her furious.

Christina: It was a terrible defeat. It made me sad and depressed. But I also went into a rage. It was a rage that frightened me. It seemed like I had no control over it. And the feeling of exploding made it all even worse. I can't keep myself in order.

Christina describes a painful rage, and how she was filled with more shame about having strong and uncontrolled emotions.

To sum up, the patients describe feelings and cognitions related to their eating disorder,

and experience these as non-acceptable, hence shameful.

Achievement failures

The examples presented below illustrate experiences of non-achievement in terms of the goals one has set oneself, or the demands one believes are made on oneself by others. It is well known from the work with anorexia that some patients seek external coping, within social contexts, school, work and sports. They try to conform to current collective norms. A likely interpretation of these phenomena is an attempt to improve one's self-esteem by winning acceptance and receiving positive recognition. Another personal trait which often manifests itself in this illness and has relevance to this category, is perfectionism (Franco-Peredes, Mancilla-Díaz, Vásquez-Arévalo, López-Aguilar, & Álvarez-Rayón, 2005). A negative variant of perfectionism is rarely or never feeling adequate.

Hanna: I can't do anything well. I'm neither pretty nor am I smart in my head. That's the reason why I haven't managed to get myself a proper education. Because I am ill, I'm unable to do particularly well at my boring job. I'm not a good wife, and definitely a far too self-centred and bad friend. I'm not a success. Being thin is in fact the only thing I can manage. But actually I'm not particularly good at this either, since there are many others who are much thinner than me. And I hate to see extremely thin anorectic patients in newspapers or magazines. Then I realise what a failure I am even here.

In this brief quotation, Hanna manages to refer to a number of areas where, in her own opinion, she is inadequate: being pretty, being smart, education, work, as a partner and friend and as an anorectic.

Helena is generally submitted to the collective norms about right and wrong and achievements. She worked hard to appear as successful and hide the fact that she strived to cope in everyday life.

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

... And then I think about something else: A few days ago I got praise from my father. It was unreserved praise. He didn't praise me for a special effort, as he had often done previously. He just praised me, and said that he liked me. It gave me

a strange and unknown feeling. It was both frightening and good at the same time. The good part was that I felt good about it. The frightening part was that I wanted so very much more. So I began to wonder whether I'm a person who is too weak since I'm so dependent on others.

Helena describes the feeling of dependence and of needing others as problematic and shameful. The feeling of wanting more positive response and confirmation is experienced as illegitimate. Her statement may be seen in context with the Western cultural ideal of self-realisation, autonomy and independence. The belief that one cannot live up to them, can lead to shame.

Body shame

It is difficult to make distinctions between dissatisfaction and shame. It may to a certain degree, be a matter of using different words to describe the same phenomenon. An attempt to make a distinction is to assess shame as an intense negative feeling, a severe perception of having attributes which others will find unattractive and a cause for rejection or attack (Gilbert, 1998; Gilbert & Thompson, 2002; Kaufman, 1989). A corresponding distinction can be made between body dissatisfaction and body shame. Body shame as a concept is relatively new to the psychological literature. It can be defined as a severe perception that one has bodily attributes which others find unattractive and which are a cause for rejection or attack. According to McKinley (1998, 1999), the experience of bodily shame involves a state of self-consciousness and embarrassment evoked when individuals view their body shape or appearance as falling short of society's representation of the ideal male or female. In many of the interviews, this type of shame about one's own body refers to appearance. However, some of the responses also refer to body functions.

Several of the patients refer to negative experiences in terms of having damaged their bodies via their anorexia, that is osteoporosis and damaged bowel functions on account of their abuse of laxatives. These responses were, however, categorised as guilt and not shame, and are, therefore, not included.

Appearance

Hanna suffers from an extremely disturbed body image. In spite of the fact that she is underweight, she often experiences herself as big and fat.

Hanna: *I have to admit that I'm not particularly interested in sex. But he (her husband) does put pressure on me. And often it's quite alright. But when I feel that big and disgusting, then I refuse all contact like that. Then I don't let him touch me at all. Because I think I'm so awful.*

Martha spoke of the curse of the mirror. She couldn't bear to see herself. She had kept away from the shops in town for several days so that she would not see her reflection in the big windows.

Martha: *I don't like taking a bus or a tram in town either. Because the windows there often function as mirrors. I don't like seeing myself; I think it's so revolting.*

Both of these patients refer to strong negative feelings linked to their appearance, here categorised as body shame. For Hanna, it is mostly about feeling herself to be fat, and this is, therefore, linked to her body image disturbance. For Martha, it is more about her general dissatisfaction with her appearance, her face, hair, skin, body form and not with her size and weight only.

Body function

Else is one who in the interview expresses strong and generalised feelings of shame. She describes everything about her body as revolting. When, in the research interview, she was asked about shame in relation to her body, she did not refer to her appearance but rather that she felt uncomfortable knowing herself to be a sexual being.

Else: *And the thought of the close intimacy of sexual intercourse is most unpleasant. The very idea of being penetrated is disgusting. I think that sounds awful. This I don't think I would tolerate . . . I am being sullied.*

. . . My own sexuality is something strongly negative and frightening, and something that I feel ashamed of, and which is connected to being unclean.

It is worth mentioning that body shame is a category not relevant to all the patients who were interviewed. As shown later, in accordance with the category 'Appearance' in relation to 'Pride', some patients did report being satisfied with their own thin bodies.

Self-control and self-destructive behaviour

This category is mainly based on statements from patients practicing binge eating, and three of them have also repeatedly carried out self-mutilation. At the time of the interviews they did not do this, and they spoke about it in the past tense.

Self-control

The term self-control is here used in terms of an emotional experience: not only being able to cope with regulation of feelings, lust and desire, but it also indicates that it results in actions. A central action in eating disorders, and also in the bingeing type of anorexia, is overeating. Overeating has often strong characteristics of being a behaviour one has lost control over.

Sol: *I am really a weak person. I make plans that today I shall try to eat almost nothing. But then I may start thinking about something sad, or I get a phone call from my father, and then I completely lose control. So I go shopping and buy food. I do that because when I eat, I forget. It is even more effective than being knocked out by hunger. But it is so awful afterwards. The self-contempt is huge, I can tell you.*

. . . It is either-or with me. I seem to lack a regulation switch.

In this quotation, Sol does not only express her feelings of defeat by losing control over her food intake, but she also shows how this behaviour can be a reaction to effective experiences. She says something about the function of the behaviour in terms of avoiding feelings, in order to forget.

Self-mutilation

Self-mutilation is here defined as self-destructive non-suicidal behaviour (Favazza, 1996). It can imply cutting oneself with sharp objects, burning oneself or beating one's own body.

Rachel: *I don't do it any more now . . . I have read about self-mutilation since I have been doing it myself, and I think that some of what I have read applies to me. Other things don't apply. I know that I cut myself because I wanted to get away, deflect extremely painful feelings. I felt so awful, and had to get out. I couldn't come up with other ways of*

doing it. And it did actually work every time. That's why I found it difficult to stop doing it.

... I had to get it out in a way. I liked seeing the blood that came. It felt somehow real. But it only lasted for a short while. And it worked less and less. And when the effect was over, I sat there with my wounds. Then my only thought was that no one must see them and understand what I was doing. That would have been terrible.

Rachel gives clear expression to her feeling of shame about having indulged in a self-destructive and partly tabooed practice.

Self-destructive behaviour

When one has had eating disorders for several years, it is known that many individuals also start misusing alcohol and medications (Cantwell, Sturjenberger, Burroughs, Salkin, & Green, 1977; Mitchell, Pyle, Specker, & Hanson, 1991). Sol had a problem with both uncontrolled intake of alcohol and anxiolytics.

Sol: *Sometimes I drink too much. At first it feels good, the first glass, because then the painful thoughts let go of me. But then I sometimes feel like drinking more, and a lot, in order to humiliate myself. I want to drag myself down. For that is where I belong, far down there. I want to show myself how awful I am. Because there are rarely others who can see this. And when I am drinking, I also overeat. I do it thoroughly. But then comes the moment of awakening. Then I feel even worse ... and in this way I have supplied myself with new reasons for feeling miserable. You are asking me about shame—that makes my shame go through the roof, really.*

Sol does not only describe her feelings of shame following her self-destructive behaviour, but she also describes the reason for this behaviour as being partly based on an option to humiliate herself. This subcategory, presented by the two patients Sol and Rachel, illustrates a possible relation between shame and shamelessness. The first two, 'self-control' and 'self-mutilation' refer first and foremost to the loss of control, to shame about doing something that is experienced as shameful. The last example, 'self-destructive behaviour' does not only point to loss of control, but also to active self-abasement and to what is often described as shameless behaviour. This category can contribute

to an understanding of the fact that where we find shameless behaviour, the psychological basis does not necessarily have to be absence of shame, but it can also be too much shame. Shameless behaviour can be an acting-out of shame, one of the 'masks of shame' (Skårderud, 2001; Wurmser, 1981).

Shame related to sexual abuse

In the analyses of the patients' statements about shame, it emerges that most of the references point to what has previously been defined as internalised shame, a feeling of shame. However, in connection with this subcategory, 'shame related to sexual abuse', it is relevant to keep in mind the concept of external shame, of being shamed (Gilbert, 1998). Sexual abuse can be described in terms of the abuser inflicting shame on others by his shameless behaviour. The responses in this category come from two patients with histories of sexual abuse. They feel inferior, but they have also been treated as inferior. Abusive relationships are an extreme version of interpersonal relationships and need to be treated as an exception, although as overdistinct examples, they may contribute to a general awareness that relationships can be mortifying.

Being made inferior

Martha has a history of sexual abuse over a 3 years period in early adolescence. As a teenager, she showed various signs of maladjustment, and at the age of 16, she started with anorexia, the bingeing subtype. Towards the end of her teens, she began a life of acting-out. She abused alcohol and narcotic substances, and showed eroticised behaviour. This leads several times to new abuses, or to unpleasant experiences in the borderland between voluntary and forced sex. She made marks on her body with scissors, pieces of broken glass and razor blades. She says that she wanted to show that she was marked in a manner that others found repulsive. After such spells, she felt even more ashamed of herself: '... and I who am actually so shy'.

Martha's history is used here to illustrate the feelings of shame which can be experienced after one has been exposed to offending behaviour. However, this case is also relevant to the category of 'self-destructive behaviour', see above.

Shame of not resisting

This category has a fluid transition to guilt, and the distinctions are undefined. However, the point

of including this subcategory here is not with reference to the guilt feeling about the abused not doing enough to resist the abuses. On the contrary, it is the feeling of shame one refers to, which does not refer to lacking action, but to qualities in oneself; it is about being someone who is too weak to set clear limits.

Rachel also has a history of sexual abuses.

Rachel: I often think that it is my fault. It should have been possible for me to say no at the time . . . I have always had difficulties setting limits, and I still do. It causes many problems. It is actually tragic to think what I have put up with where men are concerned, especially married men.

Rachel's statements can be interpreted to the effect that she connects the abuses to her own character, her own lacking ability to set limits and to be clear. She explains the abuse with qualities in herself, and not in the abuser.

This category covering relations between shame and sexual abuse covers different areas: The feeling connected to have been ashamed by an abuser, the shame of experiencing oneself as too weak to represent oneself in a proper way and resist harassment and finally, the shame connected to one's violated body. Body shame was prominent for both Rachel and Martha.

Shame of having an eating disorder

This category is divided in three subcategories. The two first deal with the problems of how to have a normal and relaxed attitude to food. The last subcategory is about having a psychiatric illness, about having been given a psychiatric diagnosis, and thus thinking of oneself as belonging to a stigmatised group.

The problem of eating

Eating is an essential part of people's everyday life. The eating disordered is reminded of his or her problem several times a day.

Emily: There are 5 billion people on this earth, maybe even 6 now? Many of them don't have enough food, so they have their own eating problem. But for the others, for those who have enough food, eating is rarely a problem. And very many eat with great pleasure. Just eating should be very simple. Everyone manages it,

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

Emily's words express her feelings of defeat in connection with her inability to cope with something that is essential and a daily precondition for relatively normal psychosocial functioning.

The self-accusation of vanity

'Nervosa' in anorexia nervosa has been described as an over-concern for body weight and shape. The patient often feels she is emotionally and cognitively concerned with food and body in an obsessional way. This was the case for several of the patients in this study, for example Maria.

Maria: This is embarrassing. There is a war on in the world, and our country is also at war. People are dying while, when I look at myself in the mirror, my sole concern is the folds of skin on my stomach, and the gap between my upper thighs. And so I stand in the bathroom 1 hour every morning, looking at myself in the mirror. I examine my skin for spots. I realise how crazy this is, it is morbid vanity. But I can't manage to stop it.

Maria's statement can be described as an insight into how her uncontrolled overfocus on food and body also represents a strong self-centredness which she finds morally questionable. This subcategory could also be a subcategory under 'Shame of feelings and cognitions'. See also the main category 'Globalised internal shame', the case of Maria.

Social stigma

A very common experience for clinicians working with people with an eating disorder is the denial/under-reporting of severity that patients respond with, particularly in the early phases of an eating disorder. Many of them say: 'I don't have an eating disorder'. This may partly be a lack of insight into their illness, or it may be a resistance to having to change their behaviour. Another possible reason for this type of denial is related to the stigma and shame associated with having a psychiatric diagnosis.

Helena: I'm glad that you have a separate entrance and exit here at your office. So I don't have to meet other people in the waiting room. I wouldn't have come then. Nobody must know that I'm seeing a psychiatrist. I know that I am sick, probably a bit mad too, but I can't stand the thought of being a part of the

group which is referred to as being so helpless, hopeless and needy. That would be beneath my dignity.

With these words, Helena links negative self-evaluations both to being identified with a group which is defined as mentally ill, but also to the phenomenon that this group—according to her—is considered helpless and dependent on the help of others. See also Helena's statement about shame connected to feeling dependent and needing treatment, under 'Achievement failures'.

Based on the statements of the patients, seven different categories of negatively experienced shame are described. These are not meant to be complete, but a ground for further mapping. A main division is made between global and focal shame. Within focal shame, the different categories cover different areas of social and psychic life, that is shame over feelings and cognitions, achievement failures, the shameful body, shame connected to self-destructive behaviour and sexual abuse and finally, the shame over being a patient with anorexia nervosa. Within these categories, there are subcategories. In spite of the limited number of interviewees, this demonstrates a richness and complexity in shame experiences in anorexia nervosa.

Pride

Pride can be looked upon as an opposite to shame. Pride is the effect associated with social success and feeling approved of or admired by others. Internal pride is feeling the same for one's own attributes and talents (Mascolo & Fischer, 1995). There is also a competitive element to pride which links success to pride. Pride, like shame, guilt and embarrassment, is considered to be man's self-conscious feelings (Tangney, 1995).

Pride related to anorexia nervosa is described both by patients (MacLeod, 1989) and clinicians (Bruch, 1973). But in the scientific literature, based on an extensive literature search, there were no systematic research studies on the role of pride in anorexia nervosa. The interview guide did not have explicit questions about pride, but responses from the interviews indicate that this category should be included in order to supplement the picture. Pride is the effect associated with social success and with feeling approved of or admired by others. Internal pride is feeling the same for one's own attributes and talents (Mascolo & Fischer, 1995). There is also a competitive element to it which links success to pride.

Table 2. Pride

Self-control
Being extraordinary
Appearance
Rebellion and protest

So how does pride possibly relate to anorexia nervosa, illustrated by the statements of patients interviewed for this study? Four categories were drawn up in the analyses which in their various ways, connect a life with anorexia nervosa to feelings and cognitions here described as pride. These are 'self-control', 'being extraordinary', 'appearance' and 'rebellion and protest'. There are fluid transitions between these categories and—to a certain extent—they are each other's mutual elaborations (Table 2).

Self-control

Contemporary clinical and research literature describes the anorectic behaviour as a battle and as psychological control. The anorectic way of restricting can be interpreted as a symbolic attempt for control, like binge behaviour is a symbolic representation of lack of sufficient psychological control (Bruch, 1973; Crisp, 1997; Fairburn, Shafran, & Cooper, 1999b; Nasser & Di Nicola, 2001; Orbach, 1978; Surgenor, Horn, Plumridge, & Hudson, 2002). Sol speaks about the very first years of her disorder, in her adolescence, when she felt proud satisfaction in her self-control.

Sol: My anorexia and I, together we had full control. It made me almost invulnerable. Other people? Who were they? Ignorant, superficial, boring people who understood absolutely nothing. For us their way of living was worthless, we had something much bigger, better and truer... And I can still be in contact with this triumphant feeling when I don't eat, although strictly speaking, I should have seen through this as an illusion.

Sol describes how her symptomatic behaviour actually functioned: It contributed to a proud experience of coping with something, and also coping with something better than others.

Being extraordinary

The sense of self-esteem and of identity is to a certain degree based on comparisons with others, how one belongs or stands out. Elisabeth

speaks about her satisfaction about being different, about being able to cope with what few others can cope with and about being extraordinary.

Elisabeth: I don't think I despise the ordinary, no, I certainly don't, but I am very keen to be extraordinary. It has to do with my identity. It's about not being like the others, and therefore being myself.

In the interview, Elisabeth links this positive feeling of being extraordinary, of being 'oneself', specifically to being extremely thin, demonstrating in this way that she is not like others.

Appearance

Anorexia nervosa represents for most patients a drive for thinness, where thinness is considered attractive: by many as an esthetical ideal. Living up to such an ideal gives satisfaction.

Hanna: I am often told that I am so thin, mostly it is said as a compliment. And sometimes I can see envy in their eyes. That makes me feel proud. But it also confuses me. Surely, I am ill and I actually want to get well. But when I am given such encouragements, it makes me doubt whether I am really ill. Because the others want to be like me.

This example from Hanna illustrates—similar to the previous example—the satisfaction of succeeding to reach an aim.

Rebellion and protest

Rachel: My body sends signals to the whole world that something is fundamentally wrong. And so it is, and that is what I want to show. I refuse to let myself be controlled by others, to submit and only do what they tell me. I am very sick, and I have destroyed myself. But I am also proud because, in my own way, I keep going and don't give in.

By maintaining her thinness, Rachel demonstrates her individuality, autonomy and protest.

To sum up, all four subcategories of pride correspond with statements made by the interviewees about how positive it is to make a stand in relation to others. All four quotations deal with relationships, with an emphasis on comparing oneself to others, either rating oneself above others or demonstrating one's independence in relation to others.

It is worth mentioning that none of the interviews provide grounds for a category which could be termed 'globalised internal pride', being generally proud about being the person one is, in the same way as the analysis operates with the category of 'globalised internal shame'. This is as anticipated. In contemporary clinical literature and in research literature, anorexia nervosa is described as an expression of and an attempted compensation for low self-esteem (Bruch, 1973; Crisp, 1980; Goodsitt, 1997; Vitousek & Ewald, 1993). In all the cases in the study, the different aspects of the category pride as shown in this study, were connected to situations, time-limited experiences or aspects of behaviour. All of the patients who contributed to pride as a category, also contributed to different categories of shame.

Dynamics Between Shame and Pride in Anorexia Nervosa

This part of the analysis deals with chronological aspects of shame in the patients with anorexia nervosa. Therefore, the analysis deals with statements which indicate attributions of what comes first and what comes afterwards, the shame and the eating disorder. Based on these patients' statements, the following simple models can be designed. Like most models of this type, they are designed to be illustrative rather than comprehensive. The intention is to illuminate aspects of shame management in anorexia.

Dynamics between shame and shame

Shame as risk factor of anorexia nervosa

Shame, the feeling of inferiority and self-dislike constitute an emotional and cognitive point of departure for a change in conduct. Individuals with negative or low self-esteem will seek ways to self-repair and to compensate such feelings. For the anorectic-to-be, the focus of coping is on body, weight and dietary control. Emotional conditions are controlled via the concrete body. A clinical description of anorexia nervosa emphasises the way in which the patient has lost control over thoughts, feelings and behaviour in terms of food, body shape and weight.

Shame as consequence of anorexia nervosa

Anorexia nervosa as a condition represents thoughts, feelings and behaviour which contribute to shame, cf. the great number of possible categories which are described here: 'global internalised shame', 'shame of feelings and cognitions', 'achieve-

ment failures', 'body shame', 'self-control and self-destructive behaviour', 'shame related to sexual abuse' and 'shame of having an eating disorder'.

The statements by the patients give grounds for describing a mutual interaction where shame as a risk factor and shame as consequence can reinforce each other, in a shame–shame cycle (Goss & Gilbert, 2002).

Dynamics between shame and pride

Shame as risk factor for anorexia nervosa

See description above.

Pride as consequence

The behaviour connected to the anorectic condition leads to a proud experience of reaching the goals one has set oneself. To achieve, the ability to resist others and not to give up on their strategies becomes a part of the self-identity (Littlewood, 1995). On the basis of the interviews, the following categories are here defined: 'self-control', 'appearance', 'being extraordinary' and 'rebellion and protest'.

The patients' statements give grounds for describing a mutual interaction between shame as a risk factor and pride connected to the anorectic behaviour, a shame–pride cycle (Goss & Gilbert, 2002).

It is important to call attention to the fact that these two mechanisms, the shame–shame cycle and the shame–pride cycle, respectively, are not mutually exclusive. The models are prototypical and are likely to overlap over time. The same patients, who contributed to the category 'pride' in the wake of their eating disorder, have also contributed to different shame categories as a consequence of being persons with anorexia nervosa. It is worth paying attention to the fact that three of the four patients cited in terms of the category 'pride', are persons with anorexia nervosa of the restrictive subtype, while the fourth is diagnosed as anorexia nervosa of the binge subtype. Binge eating as behaviour represents loss of control, and is thus closely connected to feelings of shame. The fact that shame and pride can be experienced as relatively simultaneous feelings connected to the eating disorder, contributes to the complexity and contradictory nature of these disorders.

DISCUSSION

Shame is described here both as a contributing factor to the development of anorexia nervosa disorders and as a consequence of anorexia nervosa.

Another finding is the way in which symptoms and eating-disordered behaviour can contribute to pride. In spite of a limited scope with only few informants, and its objective being primarily descriptive and hence far from comprehensive, this study provides a rich and complex picture, with a series of different part-aspects of shame and pride in these patients.

The research work of the future needs to further develop descriptions, as well as to elaborate understandings of the interactions between anorexia nervosa and shame and pride. This should be accomplished in studies with both a qualitative and quantitative research design. One of the limitations of this study is that the data basis for the analyses relies on questions and responses where the word shame is actively used in the linguistic context. Shame as a feeling and cognition can of course also occur outside of such semantic links. Other linguistic forms can express what is here defined as shame. And the feeling of shame is often connected to silence, to refraining from putting into words these feelings and thoughts or to other forms of avoidant, camouflaging or compensatory behaviour. Operational methods of facilitating a definition of shame in reliable ways represent a scientific challenge.

The rationale for the expediency of using shame as a theoretical construct on the basis of studies is given below:

Although 'low self-esteem' is usually seen as the common denominator across disordered eating and eating disordered patients (Fairburn et al., 1997, 1998, 1999a), the concept itself has been criticised for being too vague and disorder non-specific (Robson, 1998). The concept of internalised shame has been proposed as a more powerful concept both in its association with psychopathology and as a theoretical construct (Cook, 1996). Shame has been previously defined as 'a more severe perception that one has attributes that others will find unattractive and be a cause for rejection and attack' (Gilbert, 1998; Gilbert & Thompson, 2002; Kaufman, 1989). The greater the severity with which these feelings are experienced, the more one can anticipate that they will have behavioural consequences. In this study, the patients' statements regarding a number of specific relations between their eating disorder and aspects of shame feelings are a strong indication for that shame is a relevant concept to understand the psychopathology of anorexia nervosa.

On the basis of the results in this study, it is claimed that 'body shame' is a better concept than

'body dissatisfaction' in the work with eating disorders, especially as a disposing and releasing factor for behaviour in terms of food and change of body form. 'Body dissatisfaction' is about to become a problematic and disorder non-specific concept, since it is so widespread among Western women that it has become a norm (Rodin, Silberstein & Striegel-Moore, 1984).

Descriptions of interactions between eating disorder and feelings of shame, described as a shame-shame cycle, are a contribution to the understanding of factors maintaining and possibly aggravating the illness, a self-perpetuating cycle. Shame can lead to more shame. These understandings have a clinical relevance.

Descriptions of interactions between eating disorders and positive feelings, which in this study are limited to being defined as a sense of pride, and described as a shame-pride cycle, will promote an understanding of the conditions under which the illness is maintained and which lead to insufficient, weak or unstable motivations of patients to become well. This lack of motivation is crucial in anorexia nervosa and should be highlighted in the therapy. Descriptions of the type presented here will be conducive to a widening of the scope of functional analyses of anorexia nervosa. These are analyses emphasising the negative and positive functions of the symptoms in the lives of patients (Serpell, Treasure, Teasdale & Sullivan, 1999).

Describing the role of shame and pride in these functional analyses also contributes to more disorder-specific descriptions, in order to understand the more specific aspects in anorexia nervosa. There are few psychiatric illnesses where destructive symptoms can to such an extent give positive experiences. Other forms of illness where this may be the case, are self-mutilation and variants of substance abuse. Comparative studies should be encouraged.

For many patients, dietary restriction, controlling appetites, changing body shape and resisting the influence/control of others will possibly be connected to a sense of pride, while bingeing behaviour and a more general loss of control may be experienced as a defeat and as shameful. The concept of shame should, therefore, be greatly relevant to studies of other forms of eating disorders, bulimia nervosa and binge eating disorder (BED), where precisely bingeing behaviour has a central place. Comparative studies between the diagnostic categories should be undertaken.

CONCLUSION

The use of shame, as well as pride, as theoretical constructs in regard to anorexia nervosa may provide an enriched understanding of the nature of this disorder. The shame-shame cycles and shame-pride cycles described in this study further the comprehension of self-perpetuating mechanisms in anorexia nervosa.

Shame is also a very relevant concept for understanding therapeutic processes. This applies to therapy in general, and to psychotherapy in particular. One of the central behavioural expressions of shame is silence. Profound shame can complicate the therapeutic process by challenging its very foundation: Dialogue and the therapeutic relationship itself as health promoting. Shame represents withdrawal in a context where aim and method are candour and intimacy. Shame sabotages dialogue, and it may make the therapist feel shut out. Understanding the role of shame in the therapeutic relationship can be useful for enabling therapists to persevere, by gaining an understanding of the behaviour which may be experienced as a rejection.

Therapeutic relationships can be shame-provoking. Awareness of a potential re-traumatisation in the therapeutic situation should be crucial. This applies in general, but particularly in cases of so-called shame-based syndromes (Kaufman, 1989). This may refer to not only the very nature of the therapeutic relationship, but also to the fact that thematically, therapy will be about shameful experiences, for example bingeing behaviour, sexual abuse or other areas described in this study. The fact that shame is activated by virtue of the therapeutic context itself also means that this can be a suitable room for providing it with a language in the dialogue. However, this calls for strict demands on therapeutic technique and ethics, on tactfulness, good manners and patience. As therapists, an enriched understanding of the role of shame and pride in anorexia nervosa may activate our awareness of our own feeling of shame, in the sense of 'a good sense of shame'.

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