

Shame, Self-Criticism and Self-Compassion in Eating Disorders

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Statement of Originality

I confirm that this is an original piece of work.

The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

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Word Count

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Literature review (including abstract)	7,998
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Shame, Self-Criticism and Self-Compassion in Eating Disorders

Alexandra Barrow

Abstract

Literature Review

Research has suggested that shame and self-criticism are important in eating disorders. Highly shame-prone individuals are thought to have difficulty feeling warmth for the self. Self-compassion is a new construct associated with being able to self-soothe and feel kindness for the self. To date, self-compassion has not been explored clinically in people with eating disorders, however, cognitive therapies have begun to incorporate related areas such as mindfulness.

Research Report

Objectives: The aim of the study was to explore relationships between eating disorder symptoms, internal and external shame, self-criticism variables (including self-reassurance) and self-compassion in a sample of women with eating disorders attending an outpatient specialist eating disorder service.

Method: The study used a cross-sectional, correlational design. Seventy-six female participants completed a series of self-report measures assessing anorexic and bulimic cognition and behaviours, shame, self-criticism and self-compassion. Data were analysed using Pearson's Product Moment correlations.

Results: There were significant relationships between anorexic cognitions and internal and external shame, and between anorexic cognitions and behaviours and types of self-criticism. Anorexic cognitions were significantly negatively related to self-compassion. Self-compassion was significantly negatively related to all the shame and self-criticism variables, and positively related to self-reassuring. Self-compassion may protect against anorexic cognitions and associated beliefs associated with shame and self-criticism.

Conclusions: Women with eating disorders are highly shame-prone and engage in self-critical thinking. Self-compassion may be a clinically useful construct but this requires further research.

Critical Appraisal

The appraisal draws on the research diary and reflects upon how the ideas for the research were conceived and highlights some learning points from the process.

Literature Review

Shame, Self-Criticism and Self-Compassion in Eating Disorders

Article to be submitted to the British Journal of Clinical Psychology (see Appendix A for Notes for Contributors)

Abstract for Literature Review

Purpose

Recent literature has suggested that shame may play a role in eating disorders. It has been noted that it is hard to achieve change where patients are highly shame-prone and self-critical. This review aimed to explore how this aspect of eating disorder pathology has been understood in the eating disorder literature and to examine the potential of a new construct, compassion, given that compassion-focused therapies aim to target high shame and self-criticism.

Methods

A systematic search of Medline, PSYCINFO and PsycARTICLES was performed across the different domains concerning this review, using keywords including eating disorders, shame, self-criticism and compassion. The review presents newer theories relating to these fields and takes a critical narrative approach.

Results

The review highlights that there is a substantial amount of evidence to suggest that shame plays an important role in the development and maintenance of eating disorders. Shame has been seen as focusing on a number of different aspects of the self and these are presented in relation to eating disorders. Cognitive theories of eating disorders have examined the role of negative self evaluation and the content of core beliefs, which appear to reflect themes associated with shame such as worthlessness, inadequacy and failure. Evolutionary theories have understood shame in relation to processes such as attachment and through social ranking theory. Self-compassion is a new construct which has not been applied to eating disorders although it is noted that certain aspects such as mindfulness have been successfully assimilated with cognitive therapy for depression. Limitations in the studies reviewed are considered along with clinical implications and suggestions for future research.

Conclusions

Although there is much to support the importance of shame and self-critical thinking in eating disorders, self-compassion may be a clinically useful construct. However, no evidence currently exists in terms of eating disorders and this represents a new area for research opportunity.

Shame, Self-Criticism and Self-Compassion in Eating Disorders

1. Introduction

It is widely acknowledged that eating disorders are multi-determined (for example, Schmidt, 2002; Szmukler, Dare, & Treasure, 1995). Aetiological models highlight a variety of biological, cognitive, behavioural, affective and interpersonal risk factors. These include genetic vulnerability (Connan, Campbell, Katzman, Lightman, & Treasure, 2003), personality traits such as perfectionism (Fairburn, Cooper, Doll, & Welch, 1999), low self esteem (Fairburn, Cooper, & Shafran, 2003), childhood trauma including abuse (Andrews, 1997), and socio-cultural factors (Stice, 2002). Many researchers and clinicians recognise that no one factor is sufficient to explain the eating disorders and believe that only by establishing the interactions between different aetiological factors can eating disorders be better understood.

The publication in 2004 of the National Institute for Clinical Excellence (NICE) guidelines on eating disorders was significant in setting out guidance on types of treatment, and reviewed the available evidence for psychological interventions. The strength and consistency of the findings indicated that cognitive behaviour therapy (CBT) was the most effective treatment for bulimia. Despite this, the guidelines noted that up to fifty per cent of people with bulimia nervosa did not respond adequately to CBT. Furthermore, there was no single recommended treatment of choice for anorexia nervosa (National Institute for Clinical Excellence, 2004). It has been acknowledged by those in

the field that CBT should be more effective than it is (Fairburn *et al.*, 2003) and it is therefore vital that research continues to gain a better understanding of these disorders and to refine existing models in light of insights from other fields.

It has been argued that in order to isolate the fundamental roots of eating disorders, one has to look further than the classic eating disorder symptoms focused around fear of fatness. It has been noted that eating disorders are also characterised by negative self-evaluation and recently a number of researchers have drawn attention to the role of shame (Goss & Gilbert, 2002).

The recent trend toward transdiagnostic models of eating disorders has highlighted the common roots of anorexia nervosa, bulimia nervosa and other eating disorder diagnoses (Fairburn *et al.*, 2003). Self-criticism has long been acknowledged as a maintenance factor in eating disorders but in the transdiagnostic model, four further maintenance factors have been implicated. These are clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties. A number of these factors could be seen as issues associated with shame.

Recently, shame has been demonstrated to be an important concept across a wide range of phenomena and mental health diagnoses including depression (Allan, Gilbert & Goss, 1994; Tangney, Wagner & Gramzow, 1992), childhood sexual abuse (Andrews, 1995), PTSD (Cook, 1994), social anxiety (Crozier, 2002), body dysmorphic disorder (Veale, 2002) and substance misuse (Cook, 1994). A range of psychological theories

have attempted to understand shame and self-criticism as forms of self-to-self relationship. For example, psychodynamic theories see self-criticism as a form of attempting to destroy the bad 'object'. Behaviourally, self-attacking may represent a form of self-punishment. Cognitive theorists see negative self evaluations emerging from core beliefs which are formed as a result of early interaction with others and are resistant to change.

More recent literature has positioned shame and self-attacking in the context of evolutionary psychological theories (for example, Gilbert, 2002). Also emerging from this newer literature are theories about how the concept of compassion may be applied to mental health, in particular diagnoses where self-criticism is a primary aspect of the psychopathology and therefore an important target for intervention. As such it was decided to review the way shame and self-criticism have been explored in the eating disorder literature and how compassion might be represented in this literature.

2. Method

2.1 Search parameters

The search focused on eating disorders as defined by DSM-IV (APA, 1994). The search excluded studies using child and adolescent populations, although interesting new work is emerging in this field (for example, Cooper, Rose & Turner, 2005). Obesity has also been excluded from the search. The commonalities between the fields of obesity and

eating disorders are many and recent attempts have been made to bring the subjects together (for example, Fairburn & Brownell, 2002). However, the bodies of literature are predominantly separate and to include both was beyond the scope of this review.

2.2 Search strategy

The current review was not concerned with a homogenous body of literature, rather, to draw together work from the fields of shame and compassion in relation to eating disorders. As such, the following search strategy was used. Online databases Medline, PSYCINFO and PsycARTICLES were originally searched using the keywords below in June 2005. The same searches were repeated in November 2006 and a final check for any recent additions was made in May 2007. Handsearches were conducted of recent issues of relevant journals from 2000 to November 2006, including 'Behaviour, Research and Therapy', 'International Journal of Eating Disorders' and 'British Journal of Clinical Psychology'.

The following keywords (or variants of) were used for the search: anorexia nervosa, bulimia nervosa, eating disorders, core beliefs, schema, cognition, shame, self-criticism, compassion and mindfulness. This last term was included as it is a component of compassion, and there were few published studies concerning compassion and mental health. The references of the resulting papers were checked for relevant studies, certain authors were contacted for any relevant unpublished work and supervisors' recommendations were also sought out. As such, the current review of the literature was

not systematic but aims to take a critical narrative approach using systematic methods where possible to ensure quality.

3. Results

3.1 Overview of findings

The literature emerging from the current search appeared to present in a number of clusters. For example, cognitive researchers have explored negative self-evaluation in eating disorder populations, along with shame-related themes of worthlessness, inferiority, inadequacy and failure. Both the cognitive literature on eating disorders and the shame literature acknowledged the presence and role of self-directed hostility in the form of self-attacking thoughts. Some of the newer theories specifically relating to shame and eating disorders originate from an evolutionary perspective, bringing in attachment theory and perspectives concerning social ranking and associated cognitive processes and affect. The literature on compassion also has roots in cognitive, social and evolutionary theories and the concept of self-compassion has been applied to mental health in small-scale studies. Self-compassion has not been applied to eating disorders specifically and so this is mainly looked at in the clinical implications and future research sections of the current review.

It was decided from the current search to review some of the more recent conceptualisations of shame, self-attacking and compassion and as such, each section

includes some brief theoretical background prior to examining how these factors may operate in the field of eating disorders. Following from this, the clinical implications and future opportunities for research are explored.

3.2 Theories of Shame

Shame has been considered one of a group of self-conscious emotions along with embarrassment, humiliation and guilt. Shame involves internal attribution for a triggering event and the subsequent negative evaluation of the self often results in painful and paralysing feelings of worthlessness and inferiority (Lewis, 1971, cited in Tangney, 1996).

Two distinct types of shame have been identified: internal and external shame (Gilbert, 1998). It has been suggested that people with high levels of internal shame tend to see themselves as ‘undesirable, weak, inadequate or disgusting to oneself’ (Gilbert, 2002, p.20). These ideas find salience in the cognitive notion of negative self beliefs and the attribution of unpleasant interpersonal experiences to the flawed self. External shame has been seen as relating to an individual’s perception that others (especially powerful others) see them as worthless, inadequate and unattractive and involves a fear of being exposed or rejected. Internal and external shame have been found to be highly correlated with one another (Allan *et al.*, 1994; Goss, Gilbert, & Allan, 1994).

Shame as discussed in the literature is dynamic and multidimensional by nature, which may account for the breadth of mental health problems it has been associated with. Gilbert (2002) has proposed that shame can involve a social or external cognitive component, an internal self-evaluative component, an emotional component, a behavioural component, and a physiological component.

3.3 Evidence of shame in eating disorders

To date, research has suggested that eating disordered individuals have elevated levels of both internal and external shame (Goss, 2007). Shame has been significantly associated with a number of factors on the Eating Disorder Inventory including drive for thinness, body dissatisfaction, bulimia, ineffectiveness, interpersonal distrust, difficulties with impulse regulation and social insecurity in female undergraduates (Sanftner, Barlow, Marschall, & Tangney, 1995). There have existed differing opinions on the role of shame in eating disorders, whether shame proneness is a key factor in the development of eating disorders or whether shame results from eating disordered beliefs and behaviours (Burney & Irwin, 2000; Sanftner *et al.*, 1995). Sanftner *et al.* (1995) also suggested that a third factor, such as cognitive distortions, could predict both shame and vulnerability to developing an eating disorder.

It has been suggested that shame can result from or be directed at different aspects of the self and that the focus of shame can vary. Gilbert (1997) has proposed that the different shame foci may become pathological through information processing

mechanisms such as attention which reinforce the belief that this aspect of the self is flawed. These different foci provide a convenient structure to review the relationship between shame and eating disorders.

3.4 The focus of shame in eating disorders

3.4.1 Body shame

Body image shame has been seen as more than simply dissatisfaction with one's body, which does not elicit the painful negative affect associated with shame nor the subsequent behavioural means of concealing one's perceived defects (Andrews, 1995). Andrews (1997) found bodily shame acting as a mediator between childhood abuse and bulimia in a community sample of young women. Proneness to shame regarding the body has been found to predict eating disorder symptomology (Andrews, 1997; Burney & Irwin, 2000). Swan and Andrews (2003) reported elevated levels of bodily shame in current and recovered eating disorder patients, compared to a sample of non-clinical females. Masheb, Grilo, and Brondolo (1999) compared female eating disordered patients with women with vulvodynia and a control group and found the eating disorder patients' shame levels as measured by the Internalised Shame Scale were significantly higher than the other two groups. In this sample, it was body image (shape and weight) which related to shame and not the act of eating. In a study using both a student and clinical sample, shame was associated with higher levels of bulimic symptoms after controlling for guilt and depressed mood. In the clinical sample, of

women with bulimia, bulimic symptoms and levels of shame were also related but only when depression and guilt were controlled. This study highlights the possible role of negative affect in bulimia (Hayaki, Friedman *et al.*, 2002).

3.4.2 Shame associated with bodily functions or actions

Patients with eating disorders often engage in a number of behaviours as a means of changing their weight or shape, or managing distress. These behaviours may include bingeing, vomiting, taking laxatives or excessive exercise. For some, the act of eating even small amounts may cause them to experience shame. Many of these behaviours are performed in secret and can act as a source of shame for the individual. Women with a current and prior eating disorder diagnosis were found to have significantly higher levels of shame around eating than controls (Swan & Andrews, 2003). In comparing individuals with eating disorders to people diagnosed with depression and a control group, Frank (1991) found that eating disordered women displayed increased levels of shame and guilt in relation to eating, whilst depressed patients also experienced shame and guilt but not about eating. This finding was also supported by Burney and Irwin's study (2000) using self-report measures of eating disorder symptoms, self-conscious affect, shame and guilt around eating and body consciousness. They found shame associated with eating behaviours was the strongest predictor of eating disorder symptoms.

3.4.3 Shame in relation to failure

Waller (submitted) has developed a schema-based model of the aetiology and maintenance of anorexic and bulimic pathologies. This model hypothesises that different schema processes are involved in the different eating disorder behaviours. Dieting is seen as a strategy to avoid triggering negative affect or beliefs about, for example, failure to achieve, through the use of high standards and perfectionism. The cognitive behavioural transdiagnostic model also places perfectionism as key (Fairburn *et al.*, 2003). Consistent with this, Goss (2007) has noted that eating disordered patients commonly set themselves rigid goals or high standards regarding weight loss, which are often not met due to their unrealistic nature, thus they frequently experience failure. This may be an important factor in the maintenance of the disorder as it may spur patients on to try harder and take more risks with their health.

Much has been made anecdotally, in the media and through patient self-report, of the relationship between the culturally-perpetuated thin ideal and body image shame. Internalisation of this ideal size and shape has been found to predict increased vulnerability to body image shame in a group of female undergraduates (Markham, Thompson, & Bowling, 2005). Furthermore, the discrepancy between real and ideal, and the engagement in appearance-based comparison, is hypothesised to be a trigger for beliefs about failing to achieve standards or goals. Fairburn *et al.* (1998) has also highlighted the role of monitoring and checking behaviours which may be generated by shame and may also exacerbate and maintain the experiencing of shame.

3.4.4 Shame and relationships

Often, there is a narrowing of social networks as a consequence of eating disorders which can cause problems. The risk of achieving closeness with others and trusting may contribute to ambivalence about relationships in general. This may extend to include the therapeutic relationship, thus affecting disclosure (Swan & Andrews, 2003). It has been suggested that the power imbalance between client and therapist may activate feelings of inferiority and shame in the client and such feelings may serve to reinforce ambivalence about intimacy and raise fears of rejection (Goss, 2007).

3.4.5 Shame relating to thoughts and feelings

Shame associated with one's thoughts and feelings has not been investigated in people with eating disorders. However, individuals with eating disorders have been observed to experience shame regarding the amount of time spent engaged in thinking about their eating disorder, for example, the time spent body checking, mirror gazing, weighing themselves and so on. Service users are frequently aware that this time could be spent devoted to other areas of life such as family, friends or career and this often this translates into feelings of self-blame and not deserving treatment (Goss, 2007).

3.4.6 Shame of belonging to a particular group

The stigma of belonging to a particular group has been seen as a potential source

of shame, for example, those who have experienced sexual abuse. One way of understanding the relationship between stigma and abuse is using the four traumagenics model of Finkelhor and Browne (1985). Stigmatization has been named as one 'traumagenic' experienced by those subjected to sexual abuse. Finkelhor and Browne have proposed that during abuse children are often pressured into secrecy, blamed for the abuse, and from this infer that they are 'damaged goods' and 'different'. In addition, anger, seeing oneself as a victim, powerlessness, sexual difficulties or identifying with the abuser can also perpetuate a sense of shame. A number of studies have examined the relationship between reported childhood sexual abuse and eating disorders (Andrews, 1997; Murray & Waller, 2002; Murray, Waller, & Legg, 2000; Waller, Meyer, & Ohanian, 2001a), suggesting a role for shame in the pathway between abuse and bulimic symptomology.

There is evidence to suggest that receiving a psychiatric diagnosis can be a source of shame, as can accessing services (Goss & Gilbert, 2002). Avoiding being seen as belonging to a stigmatized group can be motivated by shame. This avoidance may also lead to not receiving treatment or support. Obesity is also seen as a problem in Western cultures. Goss (2007) has argued that attempts not to belong to one stigmatised group (the obese) may lead individuals to engage in behaviours which place them within another stigmatized group (the mentally ill, i.e. eating disordered). Therefore, avoiding being seen to belong to either group can be motivated by shame.

In summary, research suggests that shame can be related to cognitive, social,

affective and behavioural aspects of eating disorders. Shame-proneness has been associated with specific eating disorder symptoms and other experiences associated with having an eating disorder may also generate or be reinforced by shame. Shame-related beliefs about the self have also been explored and feature widely in cognitive models of eating disorders. This area is reviewed in the next section.

3.5 Negative self-beliefs and eating disorders

The cognitive literature on eating disorders has focused on beliefs about the importance of weight and shape that are thought to maintain the disorder (Fairburn, 2002; Vitousek, 2002). Deeper cognitive structures such as core beliefs are thought to drive the other levels of cognition. Negative core beliefs, or schemas, are long-standing, negative beliefs about the self which have been implicated in personality disorders and depression (Beck, 1995). Many studies have aimed to identify the content and role of core beliefs and the accompanying negative self-evaluation. A number of researchers have identified groups of beliefs, the content of which appears to overlap with those from the literature pertaining to shame. Although core beliefs and shame-based beliefs are not mutually exclusive, the areas have much in common. The findings of these studies are now reviewed.

Cooper, Todd and Wells (1998) identified a subset of core beliefs in eating disorder patients, which they named negative self beliefs and which reflected themes of worthlessness, inferiority, failure and abandonment. Cooper *et al.* (1998) established a

causal link between early experience and negative self beliefs. The participants in this small-scale, uncontrolled study used self-report measures and completed a semi-structured interview. Participants identified early experiences such as forms of abuse, poor understanding from parents, teachers or peers, or specific incidents of criticism about weight and shape, as the origins of their current negative self beliefs. Another study by Turner & Cooper (2002) expanded upon this by using dieters and controls as comparisons. Using a revised interview, it was found that between 72 per cent and 100 per cent of anorexic participants linked their negative self beliefs directly with negative early experiences. Similarly, Leung, Thomas and Waller (2000) reported low parental care predicted unhealthy core beliefs in anorexic women.

Sarin and Abela (2003) examined the relationship between life history, core beliefs and a history of eating disorder with a recovered eating disorder population and their work provided support for the notion that core beliefs represent a stable vulnerability factor for eating disorders. But, the researchers cautioned that future research needs to rule out the possibility that these beliefs develop as a 'scar' of past eating disorders. This is one problem associated with many studies investigating the role of early experiences in the development of eating disorders as they often rely on retrospective data.

Evidence suggests that negative self beliefs are more prevalent in anorexic and bulimic patients than in controls (Cooper *et al.*, 1996, reported by Cooper, 1997). A number of studies have supported this. Cooper and Turner (2000) demonstrated in a

small scale pilot that anorexics have more negative self beliefs than dieters, who themselves score more highly than normal controls. The relative absence of core beliefs in dieters is thought to account for the lack of clinical disorder. Eating disordered patients have also been shown to have higher levels of so-called ‘unhealthy core beliefs’ using the Young Schema Questionnaire (YSQ) in several studies (for example, Leung, Waller, & Thomas, 1999; Waller, Ohanian, Meyer, & Osman, 2000). Leung, Waller and Thomas (2000) found that higher levels of unhealthy core beliefs predicted less change in bulimic attitudes or behaviours in group CBT for women with bulimia nervosa.

Despite the evidence about the presence and possible importance of core beliefs, it is suggested that core beliefs alone are not sufficient for the development of an eating disorder. Literature from cognitive behavioural models and schema theory has proposed that core beliefs are linked to dysfunctional assumptions, used to evaluate the self in terms of weight and shape. Theorists have argued that both levels of cognition are required for eating disorders to develop (Vitousek & Hollon, 1990; Cooper *et al.*, 1998).

3.5.1 Specific core beliefs relating to shame and their relationship to eating disorder behaviours

In investigations using the YSQ to examine the effects of negative self beliefs on specific eating cognitions and behaviours, a cluster of beliefs have emerged as particularly important. The YSQ contains a number of subscales concerning beliefs about, for example, ‘defectiveness / shame’ and ‘failure to achieve’. Beliefs about

defectiveness / shame have been associated with rigid weight regulation (Gongora, Derksen, & van der Staak, 2004) and frequency of vomiting (Waller *et al.*, 2000). Beliefs about failure to achieve were associated with weight and eating as means of approval from others, which was important in relation to low self-esteem (Gongora *et al.*, 2004). The same beliefs predicted frequency of vomiting in bulimic anorexics (Leung *et al.*, 1999). Binge frequency has been associated with beliefs about social undesirability (Leung *et al.*, 1999) although Gongora *et al.* (2004) did not find that core beliefs were associated with severity of bingeing or purging, possibly due to retrospective data collection.

Women with disorders of the bulimic type have been differentiated in terms of their core beliefs, such that those with bulimia nervosa and anorexia nervosa (bulimic subtype) both had high defectiveness or shame beliefs and insufficient self-control beliefs compared with controls. Beliefs concerning failure to achieve also distinguished these two subgroups, with bulimics scoring low and bulimic anorexics scoring high (Waller *et al.*, 2000). These findings represent important information for understanding individualised pathways for the development of specific eating disorder diagnoses, and help to build a cognitive profile of certain bulimic-type disorders (Waller *et al.*, 2000).

3.6 Eating behaviours as a means of managing shame

There was evidence from cognitive behavioural models that eating disordered behaviours such as dieting, bingeing and purging play a role in regulating affect and, specifically, managing shame. Schema theory has suggested that cognitive structures

such as core beliefs use past experience to organise and guide cognitive processing which includes managing threats to the self (McGinn & Young, 1996; Stein, 1996). This processing means that particular cognitions may be permanently in working memory and thus constantly affecting perception and experience (Stein, 1996).

Waller (submitted) has developed a schema-based model of the aetiology and maintenance of anorexic and bulimic pathologies. This model has proposed that dieting may be a strategy designed to avoid triggering negative affect or beliefs about, for example, failure. Bulimic behaviours were seen as a secondary mechanism engaged after the negative affect such as shame has been triggered. Although this model is based on existing evidence, a study designed to test the model did not fully support its predictions (Mountford, Waller, Watson, & Scragg, 2004). Only one study has found direct evidence for higher levels of schema avoidance in bulimics (Spranger *et al.*, 2001, cited in Cooper, 2005).

3.7 Summary

Cognitive theories suggest that shame-related beliefs about worthlessness, inferiority or being flawed may drive dysfunctional assumptions concerning weight and shape and cause distressing feelings and problematic behaviours in an attempt to cope with these feelings. In particular, schema theory proposes that eating disorder behaviours are employed to regulate or avoid triggering unpleasant emotions including those related to shame. Evidence from cognitive behavioural models suggests that early experience

such as poor attachment can give rise to patterns of beliefs, particularly negative evaluations and attributions relating to the self. These are commonly found in patients with eating disorders and are thought to perpetuate the disorders. The literature derived from the current search provides support for the argument that shame is present in eating disorders and may play an important role in their development and maintenance.

Cognitive models have rapidly progressed and helped increase our understanding of some of the key features of eating disorders. The development of these models is briefly reviewed prior to moving on to more recent theories.

3.8 Historical and more recent models of eating disorders including shame and negative self beliefs

Shame and associated self-conscious emotions have featured in the early clinical literature on eating disorders, for example in the wealth of case studies collected by Bruch (1974). Reviewing examples from medieval and Victorian times, Baxter (2001) noted themes of self-starvation as a means of purification and penance for sins and she explored the similarities with some contemporary patients, who equated eating with self-indulgence and greed, and saw themselves as flawed and inferior.

Negative thoughts relating to the self have been seen as originating from core beliefs (Greenberger & Padesky, 1995). Core beliefs or schemas are thought to develop early in life and have been described as 'one's most central ideas about the self' (Beck,

1995, p.166) and are unconditional, over-generalised and absolute. These cognitive structures are thought to influence information processing systems such as perception, interpretation and memory processes such as recall (Beck, 1995). Cognitive models have seen these processing biases as generating dysfunctional assumptions which are reinforced by behaviours including avoidance and compensation. This suggests that core beliefs are self-perpetuating.

Negative self-evaluation has long been acknowledged as a primary maintaining factor in the eating disorders. In the original cognitive model of anorexia, the process of dieting was seen as a means of self-improvement and to bolster low self-esteem and manage affect such as anxiety and shame (Garner & Bemis, 1982). Early CBT approaches to bulimia nervosa (Fairburn, 1981) also placed emphasis on negative automatic thoughts and assumptions as maintenance processes. Fairburn's model bore a treatment manual for clinicians which is widely used and has led to a number of outcome studies (Wilson, Fairburn, & Agras, 1997).

Literature has emerged from cognitive behavioural models and schema theory which suggests that core beliefs are linked to dysfunctional assumptions, used to evaluate the self in terms of weight and shape. As noted earlier, theorists have argued that both levels of cognition are required for eating disorders to develop (Cooper *et al.*, 1998; Vitousek & Hollon, 1990).

In the recent transdiagnostic cognitive behavioural model of eating disorders

(Fairburn *et al.*, 2003) a number of maintenance factors can be seen as relating to shame. For example, perfectionism by its nature often generates experiences of failure, which may be attributed to a flawed, inadequate self and result in shame. Low self esteem reflects global negative evaluation of the self. Mood intolerance results in ‘dysfunctional mood modulatory behaviours,’ that is, bingeing, vomiting, exercising and so on as a means of managing negative affect which may include shame (Fairburn *et al.*, 2003).

Cognitive models suggest that early experience influences self-perception, and in particular negative self-evaluation. Ideas relating to how humans process information relating to ourselves can also be found in evolutionary perspectives. Evolutionary psychologists also acknowledge that cognitive processing develops in a social context and relate this to notions such as managing threats to ensure survival. These theories have recently been applied to understandings of shame and eating disorders and represent an emerging area of literature. The evidence for these theories in relation to shame, self-criticism and eating disorders is now examined.

3.9 Shame in the context of evolutionary psychological models

One way that shame has been understood in recent times has been from an evolutionary perspective. Briefly, attachment processes have been seen as one way that humans learn about their worth within a social system and may influence the development of a positive or negative self-image (Bowlby, 1988). Bowlby (1980) proposed that where it is too threatening for a child to attribute blame to a caregiver,

instead the child attributes bad events to the self. This internalising attribution process is linked to feeling inferior and can lead to shame and associated monitoring and avoidance (forms of safety behaviours) to help calm the negative affect (Gilbert & Irons, 2005).

Evolutionary psychologists have seen humans as having evolved to process information relating to social groups, particularly allowing us to attend to and evaluate threats in our complex social environments. Social ranking theory (Gilbert, 2005) has proposed that perception of our relative status could be advantageous in aiding us to behave in ways which manage threat. These behaviours may include shame as a display of submissiveness. Gilbert (2006) has emphasised the functional nature of shame, such that the behaviours it generates (including avoidance, anxiety, concealment) can be seen as solutions to threats to the self. This may still be the case despite shame's more recent associations with negative evaluations of the self and its links to psychological problems. This view contrasts with previously held views that suggested shame was a response to interruption in positive affect (Tomkins, cited in Sedgwick & Frank, 1995; Kaufman, 1989; Nathanson, 1994).

3.10 Evolutionary models relating to shame in eating disorders

The link between shame and eating disorders has been considered from a number of perspectives. For example, the role of poor attachment and subsequent deficits in emotional processing has been highlighted in a neurodevelopmental model for anorexia (Connan *et al.*, 2003). Shame has also been seen as a means of managing threat and

signalling submission and defeat. Dietary restriction has been seen as one such submissive behaviour (Gatward, 2007). Submissive interpersonal behaviours may be a response to shame and one way for individuals with eating disorders to regulate the negative affect associated with social threat of various kinds. Research has demonstrated that individuals with an eating disorder reported more submissive behaviours than student controls even when depression was controlled for (Troop, Allan, Treasure, & Katzman, 2003). In addition, Treasure and Owen (1996) reported some striking similarities between anorexia in humans and examples from animal studies where severe weight loss has been associated with defeat and low social ranking.

The evolutionary literature on shame highlights a number of behavioural responses, many of which have been observed in those with eating disorders. These include increased vigilance to threat, which may include comparing others' bodies with one's own, help-seeking, submissive behaviours, concealment of feelings, avoidance, low mood, self-directed hostility and rebellion (Gilbert, 2002). The evolutionary notion of 'fight or flight' has also been proposed to be operating in people with eating disorders. Dietary restriction may represent a submissive behaviour and therefore an escape from threat (Gatward, 2007), or a means of making oneself more attractive, moving up in terms of social ranking, and bolstering self-esteem (Goss & Gilbert, 2002).

The desire to avoid shame has been seen as a factor which may maintain an eating disorder. Shame may be triggered when an individual begins to return to a normal weight, as normal weight may signal that they may have to again face social threats and

competition from others. This idea may help us to understand the strong ambivalence often seen among those with anorexia regarding their own recovery and may be a factor in the chronic nature of the disorder (Gatward, 2007).

Much of the evolutionary psychological theory in relation to shame and eating disorders focuses on threats that might arise through social and interpersonal situations and relates to how competition might influence one's feelings about one's status in relation to others (for example, Gatward, 2007). Gatward (2007) states that belonging is also important to humans in a social context. It may be useful to explore this concept as distinct from competing. Theories of compassion place a sense of belonging and shared human experience as central and will be explored in the next section.

3.11 Self-compassion

Compassion is a new concept in the field of clinical psychology but has roots in both Buddhist and social psychological traditions. Neff (2003a; 2003b; 2004) has used the concept of compassion and applied it to the self to explore psychological wellbeing. In Neff's view, self-compassion is multi-faceted and involves three basic components: '1) extending kindness and understanding to oneself rather than harsh self-criticism and judgment; 2) seeing one's experiences as part of the larger human experience rather than as separating and isolating; and 3) holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them' (Neff, 2003, p.224). It has been argued that self-compassion as a construct may have advantages to the long-

established but conceptually problematic ‘self-esteem’. This is proposed because self-compassion is not based on perceived talents or competence in comparison with peers. It is therefore thought that self-compassion may have greater potential for stability, as suffering or failure can always be framed in light of shared human experience (Neff, 2003a; 2004).

Writing on the use of compassion in group therapy, Bates (2005) states ‘compassion denotes a particular response to pain that encourages an individual to disengage automatic responses to their inner mental states and be present to their pain in a different way’ (p.369). This might include disengaging from shame responses. To measure self-compassion, Neff (2003b) has developed the Self-Compassion Scale (SCS). Initial studies using this measure have suggested that self-compassion is strongly associated with adaptive coping strategies and good mental health (Neff, 2003b).

The notion of distancing oneself from automatic responses or thoughts has always been important in CBT (Beck, 1995). For example, techniques have been developed to train people to re-attend, re-evaluate and re-attribute their thoughts. Cognitive therapy has been assimilating ideas more synonymous with, or derived from compassion (Allen & Knight, 2005). Recently this has included research into ‘mindfulness’ to reduce depressive relapse (for example, Segal, Williams, & Teasdale, 2002).

It has been noted that people with eating disorders and other psychiatric diagnoses (for example depression, personality disorder) tend to have higher levels of shame and

self-critical thoughts. This has been conceptualised as a lack of compassion towards the self (Gilbert, 2005). Self attacking thoughts can be hard to treat using 'standard' cognitive tasks and behavioural experiments (Lee, 2005). For those individuals it may be that their capacity for self-compassion is underdeveloped (Gilbert & Irons, 2005).

Self-compassion has only a small body of empirical evidence to date but a series of studies involving student participants found that self-compassion buffers against the psychological impact of negative events and attenuates reactions to both positive and negative events (Leary *et al.*, 2007). This buffering effect was demonstrated even in those with low self-esteem. Self-compassion was associated with fewer negative and self-critical thoughts and was inversely related to self-blaming and over-identification. The findings also suggested that those high in self-compassion more readily accept less desirable aspects of their personality without triggering negative affect or rumination.

Compassion has been used in clinical settings in the form of Compassionate Mind Training (CMT). CMT has been designed to help patients re-evaluate distressing thoughts and develop self-acceptance. Its focus is on the positive affect system, particularly soothing, calming qualities, which are highly responsive to various cues of support, affiliation and warmth. This system is believed to provide the emotional experience of reassurance and sense of safeness (Gilbert, 2005). CMT has been successfully piloted in group settings for people with personality disorders or chronic mood disorders who were self-critical (Gilbert & Procter 2006). Participants in this small-scale, uncontrolled trial achieved encouraging and significant reductions in depression, self-criticism, shame,

inferiority, and submissive behaviour. Compassionate imagery has been used with volunteers from a depression support group, resulting in a significant improvement in the reported ability to self-soothe (Gilbert & Irons, 2004). Lee (2005) has developed the notion of the 'perfect nurturer' as a compassionate image. She has used this in the context of cognitive therapy with people suffering from PTSD and elevated shame in a series of case studies and obtained encouraging results.

3.12 Self-compassion in the eating disorders

To date, no published studies have directly explored the relationship between self-compassion and eating disorders. However, as Baer, Fischer and Huss (2005) have noted, there is growing empirical support for incorporating mindfulness into treatments for eating disorders, both of which are elements of a compassionate approach. Mindful meditation was taught in a group programme for women with binge eating disorder (Kristeller & Hallet, 1999). The trial resulted in decreased frequency and severity of binges and this was predicted by the time spent using the meditation techniques. Mindfulness, as a component of Dialectical Behaviour Therapy (DBT) has been used with those with binge-eating disorder (Wiser & Telch, 1999). Binge-eating can be seen as a method of dampening down negative affect. Mindfulness aims to allow patients to engage with their emotional experience without avoiding it, but to simultaneously achieve distance to prevent over-identification. Larger scale, controlled trials are required to determine the usefulness of such techniques.

4. Methodological Issues

4.1 Conceptual issues

One problem confounding the field of shame research to date is that the terms shame and guilt have at times been used almost interchangeably (Burney & Irwin, 2000), and according to Tangney (1996), this confusion has hindered the empirical investigation of both phenomena. The once-held view that shame requires public exposure and disapproval whereas guilt is a more private experience associated with conscience has been largely discredited as shame can be internally triggered (Tangney, 1996).

Lewis (1971, cited in Tangney, 1996) provided a clinically useful and operational definition of shame as experientially very different from guilt, involving overwhelming feelings of worthlessness and powerlessness, a debilitating sensation often serving to paralyse the self. These ideas fit with what is known about core beliefs, where the self is perceived as defective and inadequate. Although shame and guilt often co-occur, guilt is less problematic in clinical settings as it has less of an association with psychopathology (Burney & Irwin, 2000). It has been argued that shame is the more relevant to eating disorders as means of judging *the self* in terms of weight and shape (e.g. Sanftner, 1995).

4.2 Methodological issues arising from the literature reviewed

Many of the studies reviewed have used large student samples rather than clinical

groups. Whilst this is an understandable approach which provides useful exploratory and control data, there are a number of reasons why research using this group may not be generalisable. Student samples are typically from white, middle class backgrounds and by definition of at least average intellectual ability. They may also be non-representative of the wider community in terms of ethnic background. Often the control samples had not been screened for eating disorders, or for other disorders such as depression, which may confound the results about shame and self-criticism. Clinical studies also have focused predominantly on women. Whilst eating disorders are known to present more frequently in females, there is a dearth of studies examining eating disorders in males and how they may manifest differently.

Many researchers have recognised the need for longitudinal studies as well as cross-sectional designs. At present, a number of studies have demonstrated a relationship between shame, self-criticism and eating disorders but demonstrating causality requires more creative design. This is also an issue for research exploring possible links between adverse early experience and the development of eating disorders.

There are difficulties with the measures used to assess shame. In part this is associated with the conceptual distinction between shame, guilt and associated emotions described above. There are also difficulties associated with producing operational definitions for use in research. Certain measures have aimed to reflect state shame, such as the Test of Self Conscious Affect (TOSCA; Tangney, Wagner, & Gramzow, 1989). The TOSCA has been used in a number of the studies reviewed. Measures of state shame

often present the respondent with a scenario and then require them to rate their anticipated shame response. Trait shame, as used by Cook (1994) in developing the Internalised Shame Scale (ISS) may be clinically more useful as it aims to measure global negative self-evaluations and is likely to measure more stable attributions which may relate better to clinical samples.

The Young Schema Questionnaire (YSQ) has not been designed to specifically measure shame but does assess beliefs relating to defectiveness / shame schemas. It has acceptable internal consistency (Waller, Meyer, & Ohanian, 2001b) but has not been standardised against other shame measures. New scales have been developed to assess the forms and functions of self-criticism and self-attacking but have not been used with an eating disorder population to date (FSCRS and FSCS; Gilbert, Clarke, Hempel, Miles, & Irons, 2004).

Andrews (1995) moved away from fixed response questionnaires to use an interview schedule to measure shame. The advantage of this is that it can ask participants directly about memories of being shamed rather than hypothetical situations. One further methodological uncertainty is the use of the Beck Depression Inventory (BDI; Beck & Steer, 1987) to control for depression in studies relating to shame. Goss (2007) notes that the BDI is highly correlated with the ISS and a number of questions tap feelings of failure, guilt, worthlessness and self-blame. This is problematic but symptomatic of the complexity of shame and the frequent co-existence of low mood in people with eating disorders.

5. Research and Clinical Implications

5.1 Research implications

The research on eating disorders and shame remains limited and further research needs to explore the relationship between eating disorder symptoms (thoughts, beliefs, behaviours), diagnosis, positive affect (compassion) and shame. In particular, there is a need to design and conduct longitudinal trials to trace the stability of concepts such as shame and self-criticism. Better controlled trials are required, where depression is screened and clinical and community samples are recruited. With most studies focussing on women, effort should be made to examine how shame and self-criticism presents in men.

Future research questions might address the ways in which shame influences the development of eating disorders, and how eating disorders reinforce shame. The role of internal and external shame in predicting eating disorder symptomology should be investigated to clarify and add to knowledge on the specific pathways between shame and eating disorders. Self-compassion appears a useful concept but it is unknown whether helping people to develop greater self-compassion (for example using Compassionate Mind Training) and be less shame sensitive might protect against relapse of eating disorders or have a greater impact on eating disorder symptoms than standard treatment. Measures of self-compassion are only now being developed and the usefulness of such scales needs to be determined in clinical populations. There is a clear need for a robust

and well-validated measure of self-compassion to move this research agenda forward. In addition, it needs to be determined how acceptable a compassion-based treatment may be for clients with an eating disorder.

5.2 Clinical implications

The literature on eating disorders, particularly from cognitive researchers and clinicians, is rich with descriptions of shame-related cognitions and affect. As noted before, shame has been associated with non-disclosure in therapy and therefore shame needs to be dealt with sensitively by the therapist to avoid non-attendance and drop-out (Swan & Andrews, 2003).

Shame and self-critical thinking would appear to be a target for intervention, although it has already been noted that CBT, the most recommended treatment for bulimia, can be inadequate for people with long-standing difficulties. It is recognised that change is hard to achieve with core beliefs due to their unconditional nature. Therefore working therapeutically to develop and reinforce previously under-developed skills involved in self-compassion may be a useful area for clinicians to explore when working with people with eating disorders.

Lee, describing the rationale for developing the ‘perfect nurturer’ technique describes an experience which will be common to therapists working cognitively: the ‘heart-head lag’ (Lee, 2005). This highlights patients’ ability to process information

about the self at a rational level (for example, to assimilate evidence that they are not a worthless person) but not to have processed this new information at the automatic, affective and unconscious level. This can result in patients knowing they should feel differently but not being able to.

Compassionate Mind Training has been developed to directly target physiological systems associated with self-soothing and therefore may help to close the proposed gap between head and heart. Gilbert (2007) states that priming patients with feelings of being cared for can protect against future experiences of shame as they will be better able to access memories of another as supportive. Studies with students support this notion of protection (Leary *et al.*, 2007). Consequently CMT may be usefully applied to treatment of people with eating disorders.

In a psycho-education context it may be useful for patients to gain an understanding that systems designed to manage social threat evolved earlier than, and can override, more recently developed systems such as those used for rational thought (Gilbert, 2007). For example, it may be helpful for service users to understand that humans have evolved to evaluate their relative social status and attractiveness in order to assess and manage threats that may arise in a social context. This is the underpinning of social ranking theory (Gilbert, 1997). Applying this theory clinically would involve moving away from the 'thin ideal' and the emphasis on physical appearance to understanding issues of power and attractiveness in a broader sense. This may help to

focus the thoughts of those seeking therapy on other attributes which contribute to their sense of self-worth rather than simply physical attractiveness (Troop *et al.*, 2003).

Connan *et al.* (2003) noted that there is a tendency for those with eating disorders to feel ashamed and to engage in submissive strategies as a defence. As such, avoiding power differentials in the therapeutic relationship is important. CBT aims to engage clients in a collaborative and explorative way. Despite this, many patients will still experience the therapist as more powerful. This is particularly relevant for low weight anorexics who may feel trapped into attending therapy so as to avoid inpatient treatment. Therefore an approach focused on warmth, validation and empowerment may reduce some of these dynamics.

6. Conclusions

The literature reviewed suggests that shame may be a clinically useful concept in the treatment of eating disorders. The attention it is beginning to receive is perhaps long overdue. Shame has been highlighted in a number of studies as playing an important role in the aetiological pathway of eating disorders. Shame and its associated emotions, cognitions and behaviours may also deepen our understanding of the maintenance of eating disorders. There are a number of new treatment approaches for clinical problems that involve developing self-compassion and mindfulness. Such new models and treatments will require well-designed studies to prove their effectiveness.

In conclusion, the findings from the current review suggest that shame and self-criticism are important to the field of eating disorders. Research into the importance of shame has promising applications clinically and in particular, self-compassion opens up new areas for use in therapy. Such approaches may have potential but it is necessary to understand more about the concept of self-compassion. There is a need to develop good measures of self-compassion for clinical populations to further the area. Such ideas and measures may pave the way for greater treatment efficacy in eating disorders, particularly where traditional CBT falls short.

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Shame, Self-Criticism and Self-Compassion in Eating Disorders

Research Report

(Option 1)

**Target Journal: British Journal of Clinical Psychology (See Appendix A for Notes
for Contributors)**

Introduction

1. Overview

Eating disorders can have serious physical, psychological and social consequences. They are potentially chronic, recurrent and can exist alongside other psychiatric diagnoses. As such, the burden on the NHS and on the economy is thought to be considerable (National Institute for Clinical Excellence, 2004). The National Institute for Clinical Excellence guidelines recommended cognitive-behavioural therapy (CBT) for people with bulimia nervosa but noted that it was likely to be effective with only fifty per cent of patients¹. Therefore research is needed to explore how CBT can improve its efficacy, or look to other models to target those who do not respond to current treatments.

Eating disorders are widely acknowledged to be complex disorders and no one explanation has so far been sufficient in explaining their development and maintenance. There has been a recent trend toward transdiagnostic models of eating disorders (for example, Fairburn, Cooper, & Shafran, 2003). These aim to highlight the common roots of eating disorders rather than looking at what distinguishes the diagnostic groups. In addition to 'dysfunctional assumptions' (long thought to maintain the disorder) there are additional factors now seen as potentially important maintenance factors. These include clinical perfectionism, core low self esteem, mood intolerance and interpersonal difficulties. A number of these factors are associated with shame.

¹ There was no single recommended treatment for anorexia nervosa.

Shame has recently been identified as playing a role in the development and maintenance of eating disorders (Goss & Gilbert, 2002). Shame is a self-conscious affect, that is, an emotion that relates to the self, and which involves cognitive processes of self-evaluation. Shame also comprises affective, physiological and behavioural components (Gilbert, 2002).

Shame is associated with negative self-evaluation and self-criticism and cognitive theories have been at the forefront of investigating this phenomenon in eating disorders. CBT, however, can struggle to achieve change at an affective level when it comes to shame and self-critical thinking (Lee, 2005). One reason for this could be due to an individual's under-developed capacity to feel warmth for the self (Gilbert & Irons, 2005). A new literature on the role of compassion in mental health is emerging which aims to target shame and self-criticism. This extends the recent trend for CBT to incorporate techniques such as mindfulness when training people to re-evaluate their thoughts.

2. Shame and Eating Disorders

Shame has been seen as playing a key role in maintaining eating disorders (Burney & Irwin, 2000; Goss & Gilbert, 2002). Central to many recent definitions of shame is negative evaluation of the self, often involving a perception that one is defective or worthless (Tangney, Wagner, & Gramzow, 1992). Alongside this can often be heightened self-consciousness (Andrews, 1995) and the expectation that others also see one as inferior or inadequate (Tangney, 1996). Shame is thought to

elicit a powerful unpleasant emotional response along with cognitive and behavioural responses.

In the eating disorder literature, shame has been significantly associated with a drive for thinness, bulimia, and body dissatisfaction in female students (Sanftner, Barlow, Marschall, & Tangney, 1995). Shame has been associated with higher levels of bulimic symptomology when depressed mood and guilt were controlled for (Hayaki, Friedman, & Brownell, 2002). Bodily shame acted as a mediator between childhood sexual abuse and bulimia in a community sample (Andrews, 1997). Swan and Andrews (2003) found elevated levels of bodily shame in people with current and previous diagnoses of eating disorders compared with controls. They also found higher levels of shame around eating. However, Masheb, Grilo and Brondolo (1999) found shame was not related to eating but to weight and body shape. Shame has also been found to affect disclosure in people with eating disorders. Swan and Andrews (2003) found that 42 per cent of their sample had failed to disclose important information to their therapist and this was associated with higher levels of shame.

Two distinct types of shame have been identified: internal and external shame (Gilbert, 1998). Individuals exhibiting high levels of internal shame tend to see themselves as inadequate and inferior, leading to self-critical thoughts and the attribution of negative interpersonal experiences to their flawed self. Those with high levels of external shame experience the perception that others see them as worthless, inadequate and unattractive and with these thoughts comes the fear of being exposed or rejected. Research to date has suggested that eating disorder

patients have higher levels of both types of shame (Goss 2007; Goss & Gilbert, 2002).

It has been suggested that shame can be directed at different aspects of the self. Gilbert (2002) has explored these possibilities and many have relevance to eating disorder pathology. Shame can be focussed on body appearance such as when comparing one's own body to the culturally perpetuated 'thin ideal' (Markham, Thompson, & Bowling, 2005). Fairburn, Shafran and Cooper (1998) noted the role of body and mirror checking which may generate and reinforce shame. Bodily functions such as eating may be a source of shame for some patients (Swan & Andrews, 2003). Shame can be associated with the experience of failure and not being good enough at something valued, from academic achievement to, as may be the case in eating disorders, dieting. Shame may be present in relationships, including the therapeutic relationship (Swan & Andrews, 2003). One can be ashamed of one's own thoughts and feelings, and of belonging to a stigmatised group, such as the overweight, the mentally ill (Goss & Gilbert, 2002), or those having experienced abuse (Andrews, 1997).

In the cognitive behavioural transdiagnostic model of eating disorders proposed by Fairburn *et al.* (2003), a number of factors suggested to maintain the disorders can be seen as relating to shame. For example, perfectionism by its nature often generates experiences of failure. Failure to live up to unrealistically high standards may lead to self-critical thoughts which encourage further striving and result in further failings (Fairburn, Cooper, Doll, & Welch, 1999). Another maintenance factor is low self-esteem. This reflects a high degree of negative self-

evaluation, and beliefs that are associated with shame (Garner, Vitousek, & Pike, 1997). The relationship between negative self-beliefs, self-criticism and eating disorders is considered next.

3. Negative Self-Evaluation and Eating Disorders

The self-evaluative component said to be involved in the experience of shame can be found in the cognitive behavioural literature on eating disorders. Cognitive research has found that negative self beliefs or schemas are more prevalent in anorexic and bulimic patients than controls (Cooper & Turner, 2000; Leung, Waller, & Thomas, 1999). These beliefs have been found to reflect themes of shame, worthlessness, inferiority and failure (Cooper, Todd, & Wells, 1998; Waller, Ohanian, Meyer, & Osman, 2000). Negative core beliefs predicted less change in bulimic attitudes and behaviours in a CBT group for bulimic women (Leung, Thomas & Waller, 2000). Beliefs about defectiveness or shame have been associated with rigid weight regulation (Gongora, Derksen, & Van Der Staak, 2004) and frequency of vomiting (Waller *et al.*, 2000). Beliefs about failure to achieve have predicted frequency of vomiting in bulimic anorexics (Leung *et al.*, 1999) whilst binge frequency has been associated with beliefs about social desirability (Leung *et al.*, 1999).

Various eating disorder behaviours have been seen as mechanisms to manage psychological distress such as feelings of shame or lack of emotional regulation. Waller (submitted) has hypothesised that dieting may be a strategy to avoid triggering negative affect or beliefs about failure to achieve, whilst

compensatory behaviours may be a way of managing, or dampening down negative affect once it has been triggered.

4. Shame, Self-Criticism and Self-Compassion

Lee (2005) observed that patients experiencing feelings of shame and inadequacy (characterised by high levels of self-critical thinking) and a reduced capacity to nurture the self are less likely to achieve an emotional shift during treatment. Self-critical thinking has been seen as maintaining negative mood states and may take different forms and have different functions depending on an individual's existing relationship with the self. Thus, some individuals may employ a self-critical style to motivate or improve their performance, while others may use self-criticism to attack a part of themselves (Gilbert, Clarke, Hempel, Miles, & Irons, 2004).

Lee (2005) has described a 'head-heart lag' whereby individuals with longstanding difficulties including shame and negative self-evaluation can often be helped to understand how to think differently. However, they may fail to sustain an accompanying emotional shift, particularly where they find it hard to feel any sense of emotional warmth towards the self. This group can be hard to treat using the standard repertoire of CBT techniques, for example behavioural experiments and challenging negative thoughts (Lee, 2005).

Aiding highly shame-prone groups to develop ways of self-nurturing, including being able to access memories of being soothed and comforted, may be a

potential way of addressing self-critical thinking. Having the ability to self-reassure has been found to be inversely associated with self-criticising and it has been suggested that developing the skills to self-reassure may produce change at an affective level (Gilbert *et al.*, 2004). Focusing on rational challenges to negative thoughts could be one area where traditional CBT falls short with a certain proportion of highly self-critical people with an eating disorder.

Shame and self-critical thoughts have also been conceptualised as a lack of compassion towards the self (Gilbert & Irons, 2005). Compassion as a construct can be found in evolutionary models including attachment theory. Cognitive therapies have also focused on training individuals to monitor, explore and re-evaluate their thoughts in ways which are not self-blaming. As such, cognitive therapy has been able to assimilate techniques used in compassion-focused therapy, such as mindfulness (Allen & Knight, 2005).

Neff (2003a; 2003b; 2004) has applied the concept of self-compassion to psychological wellbeing. Neff has argued that self-compassion as a construct has advantages to self-esteem and is associated with adaptive coping strategies. Self-compassion involves three main components:

- extending kindness and understanding to oneself rather than harsh judgment and self-criticism;
- seeing one's experiences as part of the larger human experience rather than as separating and isolating; and
- holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them (Neff, 2003a).

Self-compassion has been found to provide a psychological buffering effect against negative events in student samples (Leary, Tate, Adams, Allen, & Hancock, 2007). This was the case even for those with low self-esteem and was associated with fewer negative and self-critical thoughts.

In clinical populations, Compassionate Mind Training (CMT) has been piloted alongside cognitive behavioural techniques for people with a diagnosis of personality disorders or chronic mood disorders, with encouraging reductions in shame and self-critical thoughts (Gilbert & Procter, 2006). Compassionate imagery has also been used with people with depression and PTSD (Gilbert & Irons, 2004; Lee, 2005). CMT aims to help individuals to re-evaluate distressing thoughts and develop self-acceptance (Gilbert & Irons, 2005).

The evidence base for incorporating compassion into psychological therapies is limited. However, the studies available suggest that there may be potential for compassion-focused therapy to help bridge the gap between traditional CBT and those patients high in shame and self-criticism. This may include hard-to-treat individuals with eating disorders.

5. The Current Study

There is evidence to suggest that shame and self-criticism may have important roles in the development and maintenance of eating disorders. These features are central in cognitive behavioural models. Self-compassion is a new construct and compassion-focused therapies aim to work specifically with shame

and self-attacking. As such, these could be useful in protecting against or reducing the self-critical thoughts that maintain eating disorders. However, to date, self-compassion has not been explored in an eating disorder population, and the relationships between shame, self-criticism and self-compassion have also not been examined.

Therefore, the current study aims to explore associations between the eating disorder symptoms (cognitions and behaviours), self-compassion, internal and external shame, and different types of self-criticism. The study explores these relationships by examining self-report questionnaire data collected from service users at a specialist outpatient eating disorder service. By doing this it is hoped to establish whether individuals with eating disorders have lower levels of self-compassion, and how this construct might be associated with shame and self-criticism.

6. Research Questions

The research questions and hypotheses of the current study all pertain to a sample of clients diagnosed with an eating disorder. The specific questions and hypotheses are summarised below.

1. What is the relationship between eating disorder cognitions and behaviours and shame? Previous research suggests that shame and eating disorder symptoms are related in terms of development and maintenance of the disorder (Goss & Gilbert, 2002). Therefore, it is hypothesised that there will be a

significant, positive relationship between eating disorder cognitions and behaviours and measures designed to assess internal and external shame.

2. What is the relationship between eating disorder symptoms and self-criticism? Research has suggested that self-criticism is a maintenance factor in eating disorders (for example, Cooper *et al.*, 1998; Fairburn *et al.*, 2003). Self-criticism has been seen as taking different forms and serving different functions and self-reassurance may protect against self-criticism (Gilbert *et al.*, 2004). It is hypothesised, therefore, that eating disorder cognitions and behaviours will be significantly positively related to measures of self-criticism, and negatively associated with having a self-reassuring style of relating.

3. What is the relationship between eating disorder symptomology and self-compassion? It has been proposed that those with negative thinking styles may have under-developed capacities for self-compassion (Gilbert & Irons, 2005). The levels of self-compassion in the client group will be investigated. It is hypothesised that there will be a significant negative relationship between eating disorder cognitions and beliefs and self-compassion.

4. What is the relationship between self-compassion, shame and self-criticism in this client group? The literature suggests that higher levels of shame and self-criticism are likely to be associated with lower levels of self-compassion. Therefore it is hypothesised that there will be a significant negative correlation between self-compassion and measures of shame and self-criticism. In addition,

there will be a significant positive relationship between self-compassion and self-reassuring.

5. What is the relationship between shame, self-criticism and self-reassuring in this client group? It is hypothesised that there will be a significant positive relationship between measures of internal and external shame and all forms and functions of self-criticism. There will be a significant negative relationship between shame and self-reassuring.

Method

1. Design

The current study used a cross-sectional, correlational design. Participants with an eating disorder referred to a specialist outpatient eating disorder service were asked to complete a number of quantitative self-report measures. These measures assessed eating disorder cognitions and behaviours, shame, self-criticism and self-compassion.

2. Participants

2.1. Sample characteristics

Seventy-six female participants attending for an assessment at a specialist outpatient eating disorder service consented to participate in the study. They were recruited between November 2006 and May 2007. Participants in the study were aged between 18 and 65 and were registered with a local general practitioner. Each had a primary diagnosis of anorexia nervosa, bulimia nervosa or eating disorder not otherwise specified (EDNOS). Diagnosis was determined by the eating disorder service and was based on DSM-IV criteria (APA, 1994).

The targetted service covered a catchment area of 300,000, which included approximately 10-15 per cent university students. Referrals were received from a variety of sources, including general practitioners, community mental health teams,

social work, psychiatry, psychology and counselling services, medical wards and dietetic services, and dentists.

Four males also provided data but these were not included in the analysis.

There is evidence to suggest that men presenting with an eating disorder may differ in a number of ways from women (Andersen, 2002). In addition, the small number of male participants precluded meaningful gender comparisons. The small number of men participating in the study reflected the male referral rate to the service.

Non-English speaking patients were not approached to take part in the study for two reasons. First, the pattern of eating disorder beliefs and behaviours presents differently cross-culturally (Nagi, Lee, & Lee, 2000). Second, there are no cross-cultural norms available for the questionnaires used in the study and the translation of these measures may invalidate them as they have not been standardised in other languages.

3. Measures

Certain demographic data including age, ethnicity, and diagnosis were collected from participants. The six self-report measures used in the study are described below. Copies are provided in Appendices B - G. Measures 1-3 were part of the standard assessment procedure at the eating disorder service. Measures 4-6 were added for the purpose of the current study.

3.1 Stirling Eating Disorders Scales (SEDS)

The SEDS (Williams & Power, 1995, see Appendix B) is an 80-item self-report scale designed to assess eating disorder psychopathology and can be used to screen referrals and monitor symptoms. Item scores are weighted according to level of severity and level of ambiguity. Each item requires a true or false response.

The measure comprises eight subscales but only the four subscales measuring anorexic and bulimic cognitions and behaviours were used in the study¹. On the Anorexic Dietary Cognitions scale, participants scoring equal to or above cut off (9.0) are likely to experience guilt when eating. They may feel they do not need as much food as others and experience fear or disgust if overeating occurs. Participants scoring above cut off (14.0) on the Anorexic Dietary Behaviours scale are likely to control their calorific intake and avoid high calorie foods. They may often hide food or eat slowly. Those scoring above cut off (17.0) on the Bulimic Dietary Cognitions scale are likely to feel ashamed about the amount of food they eat, and experience fear if they are unable to compensate using vomiting, exercise or laxatives. They are also likely to feel that they do not have control over their eating patterns. Those scoring above cut off (14.0) on the Bulimic Dietary Behaviours scale may eat large amounts of food when not hungry, experience binges, self-induced vomiting or take laxatives. They tend to try to restrict their intake but then lose control.

¹ The other four subscales tap into factors commonly associated with eating disorder psychopathology (low assertiveness, low self-esteem, self-directed hostility and perceived external control). These were not used in the current study as the purpose of using the SEDS was to determine specific eating disorder symptomology to relate to specific shame and self-criticism variables.

Williams *et al.* (1994) reported high internal consistency for all the subscales (Cronbach alphas range .83 - .92). Campbell, Lawrence, Serpell, Lask and Neiderman (2002) also reported subscale alphas between .70 and .90 in an adolescent population. Concurrent validity with similar scales and test-retest correlations at three weeks were acceptable ($p < .001$) (Williams *et al.*, 1994).

3.2 Internalised Shame Scale (ISS)

The ISS (Cook, 1994, as shown in Appendix C) is a 30-item scale which measures negative self-cognitions. It consists of 24 shame-based items and six items designed to measure self-esteem. The self esteem scale was not used in the current study. The items in the shame scale can be summed to produce a total shame score (range 0 – 96). Individuals are required to rate statements relating to how they see themselves on a five-point Likert scale from 0 (never) to 4 (almost always), for example, ‘I would like to shrink away when I make a mistake’. Patients with an eating disorder were included in the initial standardisation study and were found to score significantly higher on the ISS than patients with other diagnoses (Cook, 1994), and other studies have produced similar findings (Garner & Garfinkel, 1985; Sanftner & Crowther, 1998).

The ISS has demonstrated high internal consistency (Cronbach alpha = .96) and acceptable test-retest reliability ($r = .84$ for shame items) and is sensitive to change over time. Cook (1994) suggested a clinical cut off of 50, indicating problematic levels of internal shame, and stated that those scoring 60 or above are likely to be experiencing ‘very high or extreme’ levels of shame.

3.3 Other as Shamer Scale (OAS)

The OAS (Goss, Gilbert, & Allan, 1994; Allan, Gilbert, & Goss, 1994), shown in Appendix D, was adapted from the ISS and was designed to measure an individual's vulnerability to feeling that others evaluate them negatively, a trait which has been linked to external shame. The OAS is an 18-item scale. Participants respond to statements such as, 'I think others are able to see my defects' on a five-point Likert scale ranging from 0 (never) to 4 (almost always). A total score can be calculated by summing all items, such that the maximum score is 72. The scale has good internal consistency with a Cronbach alpha of .92 (Goss *et al.*, 1994) and has been used in a number of studies as a measure of external shame (Gilbert, Cheung, Grandfield, Campey, & Irons, 2003; Cheung, Gilbert, & Irons, 2004).

3.4 Forms of Self-Criticising / Self-Reassuring Scale (FSCRS)

The scales in this measure, shown in Appendix E, focus on how people think and feel about themselves when things go wrong (Gilbert *et al.*, 2004). The measure consists of 22 items. Participants respond to all items on a five-point Likert scale ranging from 0 (not at all like me) to 4 (extremely like me).

The measure comprises three subscales, with two scales measuring different forms of self-criticising, and one scale measuring tendencies to be reassuring and caring of the self. Nine items form a scale referred to as 'Inadequate Self', which measures feelings of inferiority and seeing the self as flawed, for example, 'I remember and dwell on my failings'. Five items form a 'Hated Self' scale, for

example, 'I have a sense of disgust with myself'. Eight items measure capacities to focus on one's positives and be reassuring of self, forming a 'Reassured Self' scale, for example, 'When things go wrong for me I find it easy to forgive myself'.

The scales have been reported as having good internal consistency. Cronbach alphas in the original validation study were .90 for the Inadequate Self scale, .86 for the Hated Self scale, and .86 for the Reassured Self scale in a student population (Gilbert *et al.*, 2004).

3.5 Functions of Self-Criticising / Attacking Scale (FSCS)

This measure, shown in Appendix F, focuses on the perceived function of self-criticism (Gilbert *et al.*, 2004). The measure consists of 21 items, with two scales measuring different reasons for self-criticising. The Self-Correction scale measures self-criticism as a means of self-correcting, motivating or self-improving, and consists of 13 items such as 'to stop me being lazy'. The Self-Persecution scale measures the need to hurt or harm the self through aggression towards the self. This scale consists of eight items such as 'because if I punish myself I feel better'.

Participants respond on a five-point Likert scale ranging from 0 (not at all like me) to 4 (extremely like me). The scales have reported Cronbach alphas of .92 for Self-Correction and .92 for Self-Persecution in a student population (Gilbert *et al.*, 2004).

3.6 Self-Compassion Scale (SCS)

Neff (2003b) constructed the 26-item questionnaire, shown in Appendix G, to assess levels of compassion towards the self during difficult times. The theoretical underpinning for the scale is derived from Buddhist psychology, with a clear distinction between self-compassion and self-esteem.

Factor analysis of 391 students revealed six factors. Thirteen items loaded onto three factors that Neff (2003b) identified with self-compassion. These factors were labelled Self-Kindness, for example, 'I'm tolerant of my own flaws and inadequacies'; Common Humanity, for example, 'I try to see my failings as part of the human condition'; and Mindfulness, for example, 'When something upsets me I try to keep my emotions in balance'. The remaining thirteen items loaded on factors identified with a lack of self-compassion. These were labelled Self-Judgement, for example, 'When times are really difficult, I tend to be tough on myself'; Isolation, for example, 'When I fail at something that's important to me, I tend to feel alone in my failure'; and Over-Identification, for example, 'When something upsets me I get carried away with my feelings'.

Respondents indicate how often they behave in particular ways on a five-point Likert scale from 1 (almost never) to 5 (almost always). To produce a total score, the lack of self-compassion items are reverse coded and then a mean is computed from the subscale scores. The scale has demonstrated high internal reliability (Cronbach's $\alpha = .92$), and high test-retest correlation over three weeks (.93) (Neff 2003b).

The SCS is a relatively new measure and the psychometric properties have not been examined with clinical samples. Therefore it was decided to assess the factor structure within the present sample and the findings are more fully reported in Appendix H. In summary, the principal component analysis revealed six factors, however, these were not consistent with the factor structure described by Neff (2003b). Therefore it was decided to only use the total mean score for the scale and not the subscales. This is in line with other studies that have used this scale (e.g. Leary *et al.*, 2007). This analysis is very provisional given the relatively low number of cases per scale item (see Pallant, 2005).

4. Procedure

4.1. Ethical approval

The study was granted approval from the Local Research Ethics Committee on 30th November 2006. The study was also approved by the R&D department of the Primary Care Trust and by the University Ethics Committee. Copies of these documents are provided in Appendix I.

4.2. Recruitment

Prospective participants were identified in collaboration with the clinical team at the eating disorder service. Power analysis revealed that to achieve a medium effect size (0.3) at $p < 0.05$ then 70 participants were required (Clark-Carter, 2004). They were then approached (either by the researcher or the Head of Service) and

given preliminary information about the project, an introductory letter and a Participant Information Sheet to read and keep (see Appendix J and K). It was made clear to potential participants that they could ask questions about any aspect of the study and that deciding not to participate would have no impact on the care they received from the service. If a service user chose to participate they were given a Participant Consent Form to sign (see Appendix L), which was also countersigned by the researcher.

4.3. Data collection

Service users were sent the set of self-report measures with their appointment letter for their assessment. Mostly these were completed at home by the service users, however, they were able to seek assistance and clarification during the appointment if necessary. Eating disorder diagnosis was obtained by clinicians trained in the use of a semi-structured interview schedule as part of the standard assessment procedure.

Data from 53 participants were from the initial assessment and 23 participants' data were collected at a second time point prior to treatment. The two groups were compared for any significant differences in terms of age and scores on all measures using a series of independent samples *t*-tests. No significant differences were found between the two groups on the different measures (all *t*'s > 0.29; all *ps* > 0.05). Therefore the data from the two time points were combined to produce a final sample of 76.

4.4. Data screening

All questionnaire data and certain demographic data such as age, ethnicity and eating disorder diagnosis were analysed using the Statistical Package for the Social Sciences (SPSS) computer software version 14.0. Data were initially screened for missing values, invalid values, range scores, means and standard deviations. Boxplots revealed that there were no outliers.

Missing values were handled as follows. Where up to three items were missing from the ISS, OAS, FSCS, FSCRS or SCS, means were computed to fill in missing values. This was the case only if the missing items came from different subscales. Otherwise the subscale was not used in the analysis. Given that the SEDS requires a true or false response and the items are weighted, it was not possible to do the same for this measure. Therefore, missing data meant that the subscale would not be included in the analysis. Every effort was made to ensure participants completed all items. However, this did vary across the measures. The number of completed measures therefore ranged from 65 to 76. Missing cases were excluded pairwise from the analyses.

The data were checked to see if they met the assumptions required for parametric tests. Six variables were found to be significantly violating the assumptions of normality when subjected to the Kolmogorov-Smirnov test ($p < .05$). These were the four Stirling Eating Disorder Scales (SEDS) relating to eating disorder symptomology, the Self-Persecution scale and the Inadequate Self scale. Violation of the assumptions of normality is common in clinical samples (Pallant, 2005).

Given that the Kolmogorov-Smirnov is considered a conservative test, the variables were further examined using the more specific z-score method of testing for skew and kurtosis (Field, 2005). This method showed five of the variables to be within normal parameters ($z < 2.58$). This was consistent with visual inspection of the data, although the Self-Persecution scale was positively skewed and therefore a square-root transformation was required. The untransformed mean and standard deviation are presented in Table 3 in the Results section to allow comparison with previous research. However, the transformed variable is used in all subsequent parametric analyses.

Using the z-score method, the Bulimic Dietary Cognitions score from the SEDS was not normally distributed. A square-root transformation was applied to normalise a negative skew but this was not successful. Given the relatively large sample size it was decided to continue with parametric analyses but to be cautious in the interpretation of any analysis using this variable².

4.5. Data analysis

A description of the sample was produced to determine frequencies of diagnosis and ethnicity. Where possible, the means, standard deviations and internal consistencies (Cronbach's alphas) of the measures were compared to those found in previously published research.

²The pattern of results obtained using the non-parametric Spearman's rho was not different from those reported here.

A Pearson's Product Moment Correlation analysis was employed for each research question to explore the relationships between the eating disorder cognitions and behaviours, self-compassion, types of shame and self-criticism. Using the correlations as a guide, multiple regressions were then performed to establish which variables best predicted eating disorder symptomology, self-compassion and types of shame.

Results

1. Descriptive Statistics

1.1. Participant characteristics

Seventy-six female participants attending for assessment at a specialist outpatient eating disorder service consented to participate in the study. Participants' ages ranged from 18 to 60 years, with a mean age of 29.3 years ($SD = 9.18$). With regards ethnic background, 70 participants (92%) were white European, three (3.9%) described their ethnic background as Indian, one participant (1.3%) described themselves as black (other) and two participants (2.6%) indicated their ethnic background as 'other'. All participants had an eating disorder as defined by DSM-IV (APA, 1994). Table 1 presents the frequencies of the different diagnostic categories.

Table 1. Eating disorder diagnoses

Diagnosis	Frequency ($N = 76$)	Percentage (%)
Anorexia Nervosa	12	15.8
Bulimia Nervosa	26	34.2
Eating Disorder Not Otherwise Specified (EDNOS)	35	46.1
Multi-impulsive Bulimia	3	3.9

The most frequent diagnosis was bulimia nervosa or EDNOS. No analyses by major diagnostic group were conducted due to relatively low numbers of those with a diagnosis of anorexia nervosa and multi-impulsive bulimia.

1.2. Key to abbreviations

Please note that in tables where scales are referred to, a key is employed to save space. This is presented in Table 2.

Table 2. Key to abbreviations for the scales

Abbreviation	Scale
Anorexic Cognitions	Stirling Eating Disorder Scales – Anorexic Dietary Cognitions scale
Anorexic Behaviours	Stirling Eating Disorder Scales – Anorexic Dietary Behaviours scale
Bulimic Cognitions	Stirling Eating Disorder Scales – Bulimic Dietary Cognitions scale
Bulimic Behaviours	Stirling Eating Disorder Scales – Bulimic Dietary Behaviours scale
ISS	Internalised Shame Scale (Excluding Self-Esteem scale)
OAS	Other As Shamer scale
Self-Compassion	Self Compassion Scale
Self-Correction	Functions of Self-Criticising / Attacking scale – Self-Correction scale
Self-Persecution	Functions of Self-Criticising / Attacking scale – Self-Persecution scale
Inadequate Self	Forms of Self-Criticising and Self-Reassuring scale – Inadequate Self scale
Hated Self	Forms of Self-Criticising and Self-Reassuring scale – Hated Self scale
Reassured Self	Forms of Self-Criticising and Self-Reassuring scale – Reassured Self scale

1.3. Means, standard deviations and internal consistencies for the scales

Table 3. Means, standard deviations and internal consistencies for all scales

Scale	<i>N</i>	Missing	Mean	Standard Deviation	Internal Consistency (Alpha)
Anorexic Cognitions	65	11	25.76	11.50	.70
Anorexic Behaviours	64	12	28.33	14.67	.88
Bulimic Cognitions	66	10	14.01	8.58	.58
Bulimic Behaviours	69	7	22.41	14.29	.83
Internalised Shame Scale	75	1	56.97	22.08	.95
Other As Shamer	73	3	33.23	16.32	.94
Self-Compassion¹	76	0	9.59	14.91	.90
Self-Correction	75	1	23.55	12.36	.89
Self-Persecution	75	1	13.32	9.19	.90
Inadequate Self	75	1	25.35	7.47	.85
Hated Self	75	1	9.59	5.76	.83
Reassured Self	75	1	10.76	6.51	.87

¹ Published studies using the SCS have used a mean total rather than a total score. This is calculated by summing the total score and dividing by six, the number of subscales in the measure. The same procedure has been followed here to allow comparison.

The majority of the means obtained in the current study were comparable to those from other studies using clinical populations. The means on the SEDS scales were comparable with those found in specialist outpatient eating disorder services seeing a range of diagnoses (Gamble *et al.*, 2006; Goss, 2007), with the exception of the Bulimic Cognitions scale, which was considerably lower than that found in Gamble *et al.* (2006). The means were consistently higher than those from the control group used in the original validation study (Williams & Power, 1995). As expected, all of the scale means from the SEDS were above the suggested clinical cut offs (Williams & Power, 1995).

The ISS mean was above the suggested clinical cut off of 50 (Cook, 1994). This score was also comparable to scores found in another study using the measure in outpatient eating disorder services (Goss, 2007), although a little lower than the mean published in the original validation study, which was established using inpatients with a variety of eating disorder diagnoses (Cook, 1994). Non-clinical populations have consistently recorded lower levels of internal shame (e.g. Goss *et al.*, 1994; Murray, Waller, & Legg, 2000). The one previous study that has used the OAS with a similar sample reported a very similar mean score (Goss, 2007). Mean scores on the OAS in both studies were consistently higher than those found in non-clinical samples (e.g. Cheung *et al.*, 2004; Gilbert *et al.*, 2003).

The Self-Compassion Scale has only been used with mixed gender student samples and means of around 18 have been reported (Leary *et al.*, 2007; Neff, 2003b). In contrast, the mean for the current sample was much lower, indicating that

patients with eating disorders may have much lower levels of self-compassion than student samples.

On the Self-Correction scale the sample in the current study scored higher than undergraduate samples, who scored around 19 (Gilbert *et al.*, 2004; Gilbert, Durrant, & McEwan, 2006). The data suggest that patients with eating disorders do criticise themselves as a means of self-correction, motivating and improving the self. The sample in the current study also scored higher on the Self-Persecution scale than undergraduate samples, who recorded means of between 4 and 5 (Gilbert *et al.*, 2004; Gilbert *et al.*, 2006). This suggests that patients from the current sample also used self-criticism to persecute and punish the self. Studies from undergraduate samples have recorded means of around 16 on the Inadequate Self scale, means of between 3 and 4 on the Hated Self scale and means of around 19 on the Reassured Self scale (Gilbert *et al.*, 2004; Gilbert *et al.*, 2006). The current sample also demonstrated higher means on the Inadequate and Hated Self scales and a lower Reassured Self mean.

The internal consistency of all measures was tested using Cronbach's alpha reliability coefficient. Clark-Carter (2004) states that alpha should not be below 0.7. The internal consistency of all measures used was found to be acceptable, with the exception of the Bulimic Dietary Cognitions scale from the SEDS, which was below 0.7. The internal consistency of the SEDS in this study ranged from .58 to .88, lower than those reported in the original validation study, where they ranged from .83 to .92. However, the Cronbach alphas here were consistent with those reported in more

recent studies using the SEDS (e.g. Gamble *et al.*, 2006). The alphas of all the other scales in the study were very similar to those previously reported (e.g. Cook, 1994; Goss *et al.*, 2004; Gilbert *et al.*, 2004; Neff 2003b).

2. Research Questions

The overall aim of the current study was to explore the relationships between eating disorder cognitions and behaviours and shame, self-criticism and self-compassion. This was undertaken in a series of analyses.

2.1. Research question 1

What is the relationship between eating disorder cognitions and behaviours and shame?

To investigate this question a correlational analysis was conducted using each of the four eating disorder variables of the SEDS and the two measures of shame.

The results are presented in Table 4.

Table 4. Correlational analysis of Anorexic and Bulimic Cognitions and Behaviours scales and the ISS and the OAS

Scale	Anorexic Cognitions	Anorexic Behaviours	Bulimic Cognitions	Bulimic Behaviours
ISS	.48**	.33**	.25*	.18
OAS	.32*	.31*	.13	.10

Note. ** $p < 0.01$, * $p < 0.05$ (1-tailed test) ($N = 61 - 68$)

The Anorexic Cognitions and Behaviours scales were significantly positively correlated with both the ISS and the OAS. The Bulimic Cognitions scale was significantly related to the ISS only and the Bulimic Behaviours scale was not significantly related to either of the shame scales.

The associations between the ISS and the Anorexic Cognitions and the Anorexic Behaviours scales were of medium effect size, as were the relationships between the OAS and the Anorexic Cognitions and Anorexic Behaviours scales (Clark-Carter, 2004). The association between the ISS and the Bulimic Cognitions scale was of small effect size.

This analysis suggests that anorexic pathology is characterised by both internal and external shame. Bulimic cognitions were significantly associated with internal shame. However, the data indicate less of an association generally between bulimic pathology and shame.

2.2. Research question 2

What is the relationship between eating disorder symptoms and self-criticism?

To investigate this question, a correlational analysis was conducted using each of the four eating disorder variables of the SEDS and the five scales of self-criticism, including the Reassured Self scale. The results are presented in Table 5.

Table 5. Correlational analysis of Anorexic and Bulimic Cognitions and Behaviours and all self-criticism scales

Scale	Anorexic Cognitions	Anorexic Behaviours	Bulimic Cognitions	Bulimic Behaviours
Self-Correction	.36**	.28*	.12	.10
Self-Persecution	.45**	.34**	.26*	.09
Inadequate Self	.36**	.27*	.17	.05
Hated Self	.26*	.35**	.03	-.17
Reassured Self	-.16	-.23*	-.11	-.04

Note. ** $p < 0.01$, * $p < 0.05$ (1-tailed test) ($N = 63 - 68$)

Table 5 demonstrates that both the Anorexic Cognitions and Anorexic Behaviours scales were significantly positively correlated with the scales of Self-Correction, Self-Persecution, and Inadequate Self and Hated Self. This analysis suggests that in those people with eating disorders who experience the typical

anorexic pathology, these symptoms may be acting as a means of attempting to correct or improve oneself, or to persecute or punish the self. Reassured Self held a significant negative relationship with Anorexic Behaviours. This may suggest that those who exert control and avoidance around food may find it hard to self-reassure. In contrast, the self-criticism and self-reassurance scales did not correlate significantly with bulimic symptomology, except for the Self-Persecution scale and Bulimic Cognitions.

2.3. Research question 3

What is the relationship between eating disorder symptomology and self-compassion?

Evidence from previous studies and the current study suggests that people with eating disorders have high levels of shame and self-criticism and it has been proposed that those with negative thinking styles may have under-developed capacities for self-compassion. Therefore, the relationship between self-compassion and eating disorder symptoms were investigated. The results are presented in Table 6.

Table 6. Correlational analysis of Anorexic and Bulimic Cognitions and Behaviours and the Self-Compassion Scale

Scale	Self-Compassion Scale
Anorexic Cognitions	-.28*
Anorexic Behaviours	-.15
Bulimic Cognitions	-.20
Bulimic Behaviours	-.16

Note. * $p < 0.05$ (1-tailed test) ($N = 64 - 69$)

All associations between the eating disorder symptoms scales and the Self-Compassion Scale were negative, as expected, but only the relationship between the Self-Compassion Scale and the Anorexic Cognitions scale reached statistical significance. This finding may indicate that the ability to feel compassion for the self is associated with fewer anorexic cognitions, such as feeling guilty or anxious about eating, self-disgust at overeating and feeling the need to restrict and control one's food intake. This analysis also suggests that anorexic cognitions are associated with a lack of self-warmth and other features associated with relating to the self without compassion, such as judging the self, and feeling isolated and overwhelmed by one's emotions.

2.4. Research question 4

What is the relationship between self-compassion, shame and self-criticism in the eating disorder sample?

The relationships between the Self-Compassion Scale and the shame and self-criticism variables were explored using a correlational analysis. The results are presented in Table 7.

Table 7. Correlational analysis of the Self-Compassion Scale and all shame and self-criticism scales

Scale	Self-Compassion Scale
ISS	-.67**
OAS	-.65**
Self-Correction	-.46**
Self-Persecution	-.62**
Inadequate Self	-.72**
Hated Self	-.57**
Reassured Self	.71**

Note. ** $p < 0.01$ (1-tailed test) ($N = 73 - 75$)

Table 7 demonstrates that the Self-Compassion Scale was significantly negatively correlated with all types of shame and self-criticism, with the exception of the Reassured Self scale, which as expected produced a positive correlation. All correlations in Table 7 demonstrated a large effect size, except Self-Correction and Self-Compassion, which represents a medium effect size (Clark-Carter, 2004). The

analysis suggests that where people are highly shame-prone and self-critical, that they struggle to relate compassionately towards themselves.

Table 7 above demonstrates strong negative associations between Self-Compassion and the other shame and self-criticism variables. Self-Compassion was also significantly correlated with Anorexic Cognitions. Therefore, it was decided to investigate which of the shame and self-criticism variables make significant unique contributions to the variance in Self-Compassion by conducting a multiple regression analysis using the enter method. The data met the assumptions required for such an analysis (Pallant, 2005). Results are presented in Table 8.

Table 8. Regression analysis of shame and self-criticism variables as predictors of the Self-Compassion Scale.

Model	Unstandardised coefficients		Standardised coefficients	Sig.
	B	Std. error	Beta	
Scale				
ISS	-.007	.015	-.064	.635
OAS	-.047	.019	-.307	.016
Inadequate self	-.158	.049	-.475	.002
Hated self	.140	.061	.323	.025
Reassured self	.099	.046	.260	.034
Self-Correction	.033	.022	.163	.145
Self-Persecution	-.414	.215	-.253	.058

Significance is indicated in bold ($p < 0.05$) ($N = 73 - 76$) R square = .667, Adjusted R square = .630

The results of the regression analysis revealed that certain shame and self-criticism variables are significant predictors of Self-Compassion, and this model represents a large effect size. The small difference between R square and adjusted R square suggests that one might generalise from these results despite the sample size

(Field, 2005). Inadequate Self appears to be the strongest predictor. Hated Self, OAS and Reassured Self were also significant predictors of Self-Compassion. As noted above, the ISS was significantly correlated with the Self-Compassion Scale. However, the ISS is not a significant predictor when all variables are entered. This is likely to be due to shared variance with other independent variables.

2.5. Research question 5

What is the relationship between shame, self-criticism and self-reassuring in the eating disorder sample?

The associations between the shame and self-criticism variables were explored using a correlational analysis. Results are presented in Table 9.

Table 9. Correlational analysis of the ISS and OAS and self-criticism scales

Scale	Inadequate Self	Hated Self	Reassured Self	Self-Correction	Self-Persecution
Internal shame	.72**	.64**	-.66**	.59**	.64**
External Shame	.61**	.64**	-.64**	.53**	.54**

Note. ** $p < 0.01$ (1-tailed test) ($N = 72 - 74$)

Table 9 shows that both the ISS and the OAS are highly correlated with the self-criticism scales. The negative correlations between the Reassured Self measure and both of the shame scales reflects the fact that higher scores on Reassured Self

signifies higher levels of a reassuring style of relating to the self. The ISS and OAS are also strongly correlated with self-criticism aimed at self-correction and self-persecution.

Due to the strong relationships between shame and self criticising it was decided to explore which types of self-criticism predicted shame. Two standard multiple regressions were performed using the enter method with each shame scale as the dependent variable and all self-criticism scales as independent variables.

Results are presented in Tables 10 and 11.

Table 10. Regression analysis of the self-criticism scales as predictors of the ISS

Model	Unstandardised coefficients		Standardised coefficients	Sig.
Scale	B	Std. error	Beta	
Inadequate Self	.646	.453	.219	.159
Hated Self	.351	.547	.092	.523
Reassured Self	-.983	.401	-.290	.017
Self-Correction	.401	.199	.224	.048
Self-Persecution	1.406	1.975	.097	.479

Significance is indicated in bold ($p < 0.05$) ($N = 74 - 75$). R square = .602, Adjusted R square = .573

The Reassured Self scale made the most significant unique contribution to the variance in the ISS. Self-Correction was also a significant predictor. This model represents a large effect size (Clark-Carter, 2004).

Table 11. Regression analysis of the self-criticism scales as predictors
of the OAS

Model	Unstandardised coefficients		Standardised coefficients	Sig.
Scale	B	Std. error	Beta	
Inadequate Self	-.129	.367	-.059	.726
Hated Self	1.098	.442	.387	.016
Reassured Self	-.967	.325	-.386	.004
Self-Correction	.402	.161	.304	.015
Self-Persecution	-1.614	1.598	-.150	.316

Significance is indicated in bold ($p < 0.05$) ($N = 73 - 75$) R square = .537 Adjusted R square = .502

In the regression analysis, Hated Self, Reassured Self and Self-Correction were all found to be significant predictors of the OAS. The size of the sample does not diminish the adjusted R square too much, and the results suggest a large effect size (Clark-Carter, 2004).

Discussion

The current study investigated the relationships between eating disorder symptomology and shame, self-criticism and self-compassion in an outpatient eating disorder sample. The main findings from the study are summarised and are presented in relation to the original aims and hypotheses as described in the introduction. The findings are then reviewed and interpreted in relation to existing theories of shame, self-compassion and eating disorders. The clinical implications of the findings are then considered followed by a methodological critique. In light of this appraisal, suggestions for future research are presented.

1. Summary of Findings

1.1 Eating disorders and shame

Both internal and external shame, as measured by the ISS and OAS, were found to be significantly correlated with anorexic psychopathology. There was a less clear relationship between bulimic symptomology and shame, with only internal shame and bulimic cognitions being related. Anorexic symptomology often involves guilt about eating, self-disgust and attempts to conceal eating. These findings suggest that individuals' negative evaluations of themselves (internal shame) and fears that others will evaluate them negatively (external shame) are both operating where individuals engage in cognitions and beliefs about controlling food and restricting one's intake.

1.2 Eating disorders and self-criticism

As with the shame scales, there was a clear relationship between anorexic symptomology and self-criticism. Anorexic cognitions and behaviours were significantly associated with feelings of self-correction, self-persecution, inadequacy and self-hatred. This suggests that where individuals experience anorexic cognitions and behaviours, these symptoms could be performing different functions and taking different forms. Anorexic symptoms are often seen as ways of coping with emotional distress and therefore may be seen as an individual's attempt to correct, motivate or improve the self, as demonstrated by the Self-Correction scale, but also to punish or persecute the self, as assessed by the Self-Persecution scale.

Self-reassurance as a coping style was significantly negatively associated with anorexic behaviours which typically involve control and avoidance around food. This may suggest that people who engage in anorexic behaviours are poor at self-reassuring. These types of behaviours may be attempts at avoiding negative affect in individuals who engage in them, either those with anorexia or those with other eating disorder diagnoses who at times engage in dietary restriction. This may be due to poor skills in self-soothing.

Only Self-Persecution was significantly related to bulimic symptoms. Bulimic cognitions involve feeling afraid of losing control around food and feeling ashamed about the amount that is eaten. Feeling that one deserved punishment for these behaviours appears to fit.

1.3 Eating disorders and self-compassion

Self-compassion is a new construct to be explored in relation to eating disorders. Anorexic cognitions were significantly negatively correlated with self-compassion. Anorexic cognitions typically involve guilt, fear and self-disgust. This finding suggests that anorexic cognitions may be associated with self-judgement, feeling isolated with one's feelings and being overwhelmed by one's emotional distress. It also suggests that individuals able to experience self-compassion are less likely to experience such cognitions.

Interestingly, self-compassion was significantly related to anorexic cognitions but self-reassurance was not. Self-reassurance may comprise some aspects of self-compassion. However, it may be factors specific to being able to relate to the self with compassion that are associated with fewer anorexic cognitions.

1.4 Self-compassion, shame and self-criticism

As expected, shame and self-criticism were significantly negatively associated with self-compassion. Self-compassion was positively related to a self-reassuring style. All forms and functions of self-criticism and both types of shame were strongly negatively related to self-compassion, suggesting that the particular style of relating to the self is unimportant, but that any negative self-evaluation is associated with lack of warmth for the self. This finding supports the proposal that

people who experience high levels of shame and self-criticism may have a reduced capacity for self-compassion.

Certain shame and self-criticism factors were significant predictors of self-compassion. In particular, the variance in self-compassion was best predicted by feelings of inadequacy, followed by self-hatred and external shame. Self-compassion involves tolerance of one's flaws and inadequacies and keeping one's emotions in balance. Self-reassurance also predicted self-compassion. Internal shame did not predict self-compassion. This finding was not expected as internal shame typically involves feelings such as inadequacy and failure, which were associated with a lack of self-compassion and which did significantly predict self-compassion when assessed by other measures (for example, the Inadequate Self scale). This finding may be due to the nature of the ISS, used to measure this variable, having shared variance with the other variables.

1.5 Shame, self-criticism and self-reassuring

Internal and external shame were significantly associated with all forms and functions of self-criticism. Self reassuring may protect against or reduce the experience of shame. The regression analyses demonstrated that self-criticism variables explain significant proportions of the variance in both internal and external shame.

2. How do the findings from the current study relate to previous studies?

The current results support certain findings regarding the relationships between shame and eating disorders. The relationship between shame and anorexic symptomology such as drive for thinness and rigid control of weight has been suggested by previous researchers (for example Gongora *et al.*, 2004; Sanftner *et al.*, 1995). Goss (2007) obtained significant correlations between internal and external shame and anorexic and bulimic cognitions and behaviours with a larger sample than the current study.

Previous studies using other measures of shame and eating disorders have found significant relationships between bulimic symptoms and shame (for example, Hayaki, *et al.*, 2002; Leung *et al.*, 2000; Waller *et al.*, 2000). The current study found much less of a relationship between shame and bulimic symptoms. This pattern of association can be interpreted in a number of different ways. For example, it could be a product of a smaller sample size than other studies or different methods of measuring shame. However, it must also be considered that the bulimic cognitions scale did not achieve satisfactory internal consistency and this may have affected the findings.

The findings also support the notion that people with eating disorders have high levels of self-criticism. That the sample experienced high levels of self-hatred and inadequacy supports findings from studies examining the content of core beliefs such as Cooper *et al.* (1998). Negative self evaluation has long been considered a key factor in maintaining the eating disorders and the current study suggests that

different types of self-critical thinking are in operation. The self-correcting, motivating and self-improving style of self-critical thinking may reflect the perfectionistic tendencies observed in those with anorexia (Fairburn *et al.*, 1999).

Self-compassion as a specific construct has not been researched in this population before. However, the findings followed an expected pattern, relating strongly to shame and self-criticism. However, that self-compassion was only significantly related to anorexic cognitions and not the other eating disorder symptoms was not expected. There are different ways to interpret this finding. One might be that anorexic cognitions are significantly negatively related to self-compassion as they particularly involve feelings of guilt, inadequacy, and so on. Studies using the SEDS to assess eating disorder symptoms have found no significant difference in the anorexic cognitions scores between people with a diagnosis of anorexia and those with bulimia (Gamble *et al.*, 2006). This suggests that although self-compassion was only significantly negatively related to anorexic cognitions, it does not mean that only individuals with anorexia have a lack of self-compassion, as anorexic cognitions underlie bulimia as well. This may support the notion underpinning transdiagnostic models of eating disorders in assuming that the underlying roots of the disorder (for example, the drive for thinness, evaluating one self in terms of weight and shape) are common to all eating disorder diagnostic groups. Other methodological factors influencing this result are considered in the next section.

3. Clinical Implications

The current study has demonstrated that individuals with eating disorders are highly shame-prone and are characterised by self-critical thinking styles. They tend to be poor at reassuring themselves and those experiencing anorexic cognitions in particular are likely to be low in self-compassion.

Self-compassion and self-reassuring were strongly related to one another. Self-reassuring was significantly negatively related to anorexic behaviours while self-compassion was significantly negatively correlated with anorexic cognitions. Anorexic cognitions typically involve control and rigidity around food and weight. Transdiagnostic models suggest that cognitions concerning the over-valuation of eating weight and shape, and the need to control these, underlie both anorexia and bulimia. The models also propose that most clinical features, including bulimic-type behaviours stem from this core psychopathology (for example, Fairburn *et al.*, 2003). This suggests that these cognitions are an important target for treatment. This finding from the current study suggests that developing a self-reassuring style alone is unlikely to be effective in alleviating eating disorders but developing self-compassion, which was related to the underlying cognitions, might be effective.

This finding also adds support to the idea that traditional CBT may not be effective in achieving change with feelings of shame and self-criticism (Lee, 2005) but that self-compassion, by stimulating positive affect and teaching people to feel warmth for the self, might enhance the effectiveness of such treatments.

The findings from the current study suggest that self-compassion is a useful construct to assess in this client group. It also suggests that this lack of self-compassion may need to be addressed in treatment. Allowing patients to monitor and explore their style of relating to the self may be a helpful aspect of therapy. Using compassion in the therapeutic relationship may also be helpful (Gilbert, 2007).

The strong associations between the shame and self-criticism variables may suggest that these factors form a self-reinforcing network of negative beliefs and affect. This may be one reason why it is hard to achieve long-term change in individuals who are shame-prone and self-critical. It also suggests that shame and self-criticism need to be directly targeted in treatment programmes to prevent the eating disorder being maintained.

Shame may also affect referral and attendance rates for treatments. Individuals attending for therapy often express concerns about being undeserving of treatment. It can therefore be difficult to engage such individuals. However, shame may also mean that only a small proportion of those with eating disorders ever seek help for their problems at all.

The high shame and self-criticism scores, and the poor ability of the sample in general to relate to the self with compassion may mean that treatments such as Compassionate Mind Training have potential for this client group, as has been demonstrated in small scale studies with people with depression (Gilbert *et al.*, 2004; Gilbert & Proctor, 2006).

4. Methodological Critique

The current study is the first to evaluate self-compassion in an eating disorder population and to relate this to shame and self-criticism variables. However, there are a number of methodological limitations.

4.1 Design

This study used a sample of outpatients, each with a diagnosis of an eating disorder. The heterogeneous nature of the sample may be representative of those people accessing specialist outpatient eating disorder services. The results are therefore relevant to similar services assessing a range of diagnoses. There was no attempt to group the sample by diagnosis and explore the data; instead, anorexic and bulimic cognitions and behaviours were used as indicators of eating disorder symptomology. The approach taken in the present study was in line with recent trends towards transdiagnostic models and treatments. However, analysis by diagnostic group might have been useful to explore any possible differences between diagnostic groups.

The analyses did not control for low mood or depression. Given the overlap between depression, self-criticism and shame, some of the findings may have been a product of low mood associated with depression and not unique to the eating disorder. It was not recorded whether participants had previously completed treatment for an eating disorder or any other mental health problem such as

depression. This might have been useful information to collect as treatment addressing low mood may have influenced shame and self-criticism scores.

The small proportion of participants with a diagnosis of anorexia meant that it was not possible to compare groups by diagnosis. The largest proportion of participants had a diagnosis of EDNOS. This is a difficult group to quantify in terms of particular eating disorder characteristics. In future it may be useful to group participants not by diagnosis but by specific behaviour, for example, dietary restriction, bingeing and vomiting. This might allow exploration of the pathway between the shame, self-criticism and self-compassion variables and particular behavioural responses. Given that the sample contained few participants with a diagnosis of anorexia nervosa, it is uncertain the extent to which the results generalise to this client group.

4.2 Participants

The study had a relatively small sample size. Although sufficient to achieve statistical power, it did impact upon the study in a number of ways. These are discussed in the section above.

Service users whose self-report measures contributed to the study were those who were assessed at least once by the service. The rate of non-attendance for first assessments at the service is approximately 16 per cent and therefore there may be differences between those who attend the assessment and those who do not. This

may include motivational factors but also feelings of shame and feeling undeserving of treatment.

4.3 Measures

All measures used in the study required self-reporting by the participants. Previous research has demonstrated that shame-prone individuals with eating disorders may fail to disclose information about themselves when attending services (Swan & Andrews, 2003). Participants did not complete the scales anonymously, they were aware that the assessing clinicians would be viewing their questionnaire data when they attended the service. Individuals completing the scales prior to their first appointment may have been concerned that they would not be offered a service unless they were 'severe enough'. Equally, anecdotal evidence suggests that even those service users regarded as severely unwell often voice that they feel they do not deserve treatment and this may have affected the responses of a proportion of participants. These difficulties are present whenever measures are used simultaneously for both research and clinical purposes. However, these problems are by no means unique to this study. Using anonymous questionnaires that would not be seen by clinicians involved in service users' care may have alleviated this issue.

In general, the internal consistencies of the measures were adequate. However, the internal consistency of the Bulimic Cognitions scale of the SEDS was low. Since the current study began the data collection phase, a study was published which reported a range of problems with the internal consistency of the SEDS scales

and recommended some reform to the scale to improve this (Gamble *et al.*, 2006). Certain behaviours on the SEDS scales are not explained, for example, what constitutes a 'binge' (Campbell *et al.*, 2002), unlike other measures such as the Eating Disorder Examination, which provides a context for what may be considered a binge. A range of alternative measures of eating disorder symptoms exist. These include the Eating Disorder Examination (self-report questionnaire version; Fairburn & Cooper, 1993), the Eating Attitudes Test (Garner *et al.*, 1982) or the Eating Disorder Inventory-2 (Garner, 1991).

The current study applied the Self-Compassion Scale to a clinical sample. The principal component analysis of the Self-Compassion Scale revealed six factors which were not consistent with those described by Neff (2003b). Although self-compassion may be a clinically useful concept, the scale itself requires further investigation with regards factor structure and its use with clinical populations. It is possible that a clinical, semi-structured interview may be more effective at exploring the nature of self-compassion in people with eating disorders.

5. Future Research

The findings of the current study indicate a number of future research opportunities. Firstly, replicating the study with a larger sample would allow the factor structure of the SCS to be adequately evaluated as the number of participants per item was rather low (Pallant, 2005, p.174). This would give greater indication of whether such a measure, which was not designed for clinical populations is appropriate for such use.

The current study has shown that self-compassion may be an important construct in eating disorders and in those with high shame and self-critical thinking. However, the current study only used one measure of self-compassion to investigate this. Research should find alternative, qualitative methods of adding to our understanding of self-compassion. One suggestion would be to interview a number of individuals with eating disorders and explore their experiences of shame, self-criticism and self-compassion. The interview could ask service users about whether they saw their eating disorder and degree of self-compassion as being related, and when they feel more or less compassionate towards themselves.

It would also be beneficial for clinicians to know how individuals' self-compassion might change over time, in response to traditional and compassion-focused therapies such as Compassionate Mind Training. This could be assessed using the SCS. If therapies incorporating compassion do achieve change, the long-term impact of this would also need to be evaluated in order for this to be compared with existing, well-evidenced therapies such as CBT.

Research could examine which groups (by diagnosis, or symptom) are the most responsive to compassion-focused therapy. As service user choice is an important issue in today's National Health Service, it would be useful to establish what individuals accessing services think about using self-compassion in therapy. This may include experiences of group or individual therapy.

Self-compassion has been said to be a more useful measure than self-esteem with regards general self-evaluation and general adaptive functioning (Neff, 2003b).

This could be investigated in clinical populations, including eating disorders, by using self-compassion and self-esteem measures. The aim here would be to explore whether self-compassion does have a protective function against negative events and negative self-evaluation as has been found in non-clinical samples (Leary *et al.*, 2007). A future researcher may also wish to investigate what aspects of self-compassion specifically help to protect against shame and self-critical thinking.

6. Conclusion

Despite methodological limitations this study has generated a number of interesting findings. In summary, the current study has supported the findings of previous studies which have found that individuals with anorexic-type beliefs are highly shame-prone, and this includes both internal and external shame. The study has shown that this client group engages in self-critical thinking such that they are likely to see themselves as inadequate, and experience self-hatred and self-persecutory-type self-criticism. They may also engage in self-criticism as a means of motivating or improving themselves. They tend to be poor at self-reassuring, particularly those engaging in anorexic behaviours. The study also found that individuals with eating disorders have relatively low levels of self-compassion.

The current study found that shame, self-criticism and self-compassion are strongly related. Those with anorexic beliefs, which typically underlie all eating disorder diagnoses, are particularly low in self-compassion. The findings from the study suggested that self-compassion may protect against anorexic beliefs, shame and self-criticism. However, further research is needed to explore the role of self-

compassion in individuals with eating disorders and its relationship with shame and self-criticism.

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Critical Appraisal

This critical appraisal draws on the research diary and notes made as the study was being planned and carried out. It examines decision-making throughout the process. It is also based on reflections made at the end of the process and highlights learning points.

1. Conceptualisation of Research Ideas

My interest in eating disorders began when I completed a clinical audit in a previous job looking at the services provided to people with eating disorders in community mental health teams. There, after speaking with clinicians about the complexities of eating disorders and the difficulties in delivering effective treatment, I became interested in pursuing these areas in future. As a result of this work I became involved in a local eating disorders self-help group who were campaigning for better access to psychological therapies and advising on service provision. Consequently I wanted to use the opportunity of the D.Clin.Psy. thesis to complete research in the eating disorder field, and combine this with a clinical placement in a specialist eating disorder service.

I was aware of the richness of the area for research and whilst this presented opportunities it was also hard to focus on a specific topic or research question. By speaking to NHS professionals working with people with eating disorders I was able to explore factors that clinicians were interested in from a therapeutic perspective. At one outpatient eating disorder service I discovered that there was a longstanding

research interest in the roles of shame and pride, following clinical observations that shame and self-directed hostility were hard to shift during therapy. In an early meeting with my field supervisor I was informed about a new, emerging literature on compassion and that local clinicians were using compassion-focussed therapy to help treat people with depression. This presented an ideal opportunity to see clinical models of eating disorders in action whilst on placement and conduct research using new ideas that were gaining evidence in other areas. It was this aspect that excited me about undertaking the research.

Research had already suggested that patients with eating disorders are high in shame and self-criticism. Although it was anticipated that eating disorder patients would be low in self-compassion, it was important to explore this new construct and test such a hypothesis. A scale had recently been published by a social psychologist which aimed to measure self-compassion. The Self-Compassion Scale had not been used in clinical populations and the opportunity was therefore present to establish the degree of self-compassion in individuals with eating disorders.

2. Designing the Study

The initial research ideas presented with such rich opportunities for investigation that quickly my field supervisor and I had generated a list of related studies we wished to see completed. These were as follows:

1. To conduct a correlational study to explore the relationships between eating disorder symptoms, shame, self criticism and self compassion.

2. To investigate the stability of these variables throughout the first stage of treatment at the service – a four-session psycho-education programme.

3. To evaluate change in scores on eating disorder, shame, self-criticism and self-compassion measures after a 20-session compassion-focussed cognitive-behavioural recovery group (CBT) designed to target shame and self-critical thinking and enhance self-compassion.

4. To conduct a qualitative study exploring participants' experiences of self-compassion and perhaps their experiences of using techniques designed to enhance self-compassion.

5. To validate the Self-Compassion Scale (SCS) on an eating disorder population. This idea emerged somewhat later than the other four potential studies.

I had initially been interested in conducting the qualitative study as I had limited experience of this type of methodology and wished to learn more. I was particularly drawn to this as it would have provided an opportunity to gain a richer, deeper understanding of service users' experiences. However, I was also keen to use a quantitative methodology as I felt less than confident as using statistical tests and envisaged that if I did not undertake this during my doctorate then I might shy away from such methodologies in my future career as a clinical psychologist. I knew that while undertaking the doctorate I would have ample opportunity to seek the guidance of tutors and statisticians, and so rejected a qualitative study in favour of using self-report measures.

Early on it was clear that in the time available to complete the research there might not be sufficient individuals completing the CBT group treatment to allow for appropriate statistical tests to be performed. There is often a somewhat unpredictable rate of attrition at the service and so taking into account potential drop-out it was decided that it was too risky to take this idea forward as part of the D.Clin.Psy. thesis. This was slightly disappointing as I was keen to evaluate a new treatment, however, study three was dropped quite early on in the process.

3. Decision-Making at Key Points

I therefore took studies one and two forward and developed them more fully. In mid-2006 I presented my research proposal to peers and tutors. The ideas, although still somewhat underdeveloped at that stage, received positive feedback, particularly as my colleagues could see the potential clinical implications of the study. It was suggested, however, that the two parts of the study might be too much for the thesis and it may be better to focus on one study rather than two. Both studies were approved by the Local Research Ethics Committee.

Studies one and two ran concurrently until May 2007. It was decided not to include study two as part of the thesis after a discussion with my field supervisor. There were a number of reasons for this. Firstly, there had been a higher than usual number of service users not attending their assessment sessions and so I was struggling to obtain sufficient participants for study one. This meant that data analysis and writing up were delayed. There had also been a significant number of service users dropping out of one of the psycho-education programmes and to wait for the

current programme to finish in order to test for any changes would have set back the analysis and write-up even further.

It was therefore decided to put all my effort into study one. It was acknowledged that study one was sufficient for the thesis. In addition, my field supervisor and I realised that only a few weeks later we would have sufficient individuals through the treatment programmes to evaluate the entire treatment (psycho-education and the CBT group). This realisation also made study two feel somewhat redundant. Psycho-education does not target shame or aim to enhance self-compassion and therefore we would not have expected any significant change. The purpose of this study had been to juxtapose it with study three, which we hoped would reduce shame scores and enhance compassionate thinking.

This produced one of the main learning points about conducting the research and writing it up. I found that it is important to present a cohesive story, and a good rationale behind each aspect of the work. Although in some ways it was disappointing to drop study two, it enabled me to focus more on study one. There were simply not enough participants for study four to be viable (validating the Self-Compassion Scale) although preliminary data are reported as an Appendix.

With hindsight it might have been that designing four potential studies was over-ambitious but having a group of studies did mean that if there were any significant problems with data collection for one study, that there would still be others to choose to write up. It also means that there are ways of continuing working in the

research field beyond the D.Clin.Psy. as my supervisors and I are keen to continue with the projects in this area.

Key decision-making took place in the context of supervision. It was helpful to be able to draw on the advice of my supervisors as although I had done small-scale research before, the scale of this project was new to me.

4. The Importance of the Research 'Team'

I was aware that in order for the research to go smoothly it would be advantageous to secure field and academic supervisors who were knowledgeable about the specific area. It was important to me to have clinicians interested in the findings of the research and to be able to see from the beginning what the potential benefits to clinical practice were. It would have been disheartening to have an initial research idea and find no-one wished to invest time or effort in supporting it. However, by embedding my study in a programme of research taking place at the service, I could guarantee continuous support and enthusiasm throughout.

Completing a clinical placement at the location of my research was an enormous advantage. This meant that I was in close contact with interested clinicians, I was able to keep a record of data coming in, liaise with admin staff and supervise data entry. The biggest advantage, however, was to be able to work clinically with the very patient group and models that I was investigating. Each aspect complimented the other and enhanced my learning as a whole.

5. The Impact of the Research

The study opened up a new range of theories that I had not used clinically before. These included evolutionary perspectives such as social rank theory and the concept of compassion. Primarily I had experienced cognitive models in my training to date and so the opportunity to learn about very different theories which worked alongside cognitive models was very rewarding and enhanced my interest in the research right the way through.

Conducting and writing the literature review enabled me to understand more thoroughly the background to the clinical work I was undertaking. I have found that in busy clinical settings there is rarely ample time to read and reflect on theoretical matter to that extent.

However, despite the advantages of working clinically and conducting research in the same setting, there were some aspects that I feel I could have approached differently. For example, dedicating specific time to the research was not easy due to the pressure of having a caseload of individual clients, running groups and screening new service users. Later on in the placement this became more apparent and having to withdraw from clinical work to concentrate on the research was necessary. This was a difficult balancing act in ensuring I was keeping up with my clinical duties and adhering to a deadline, however, this appears to be the nature of conducting research in a busy NHS.

Despite planning the research and reading around the area prior to beginning the study, I was nevertheless still struck by the amount of shame and self-loathing often expressed by the clients. This was an issue that I took to clinical supervision as it often left me with feelings of sadness and occasionally helplessness and frustration.

This study was the first time I had undertaken a research project of this scale and at times I found it overwhelming. I was learning how to do certain things for the first time, for example, using multiple regression. I found it difficult to reconcile the idea that despite the years of training and experience there were some skills that I was a complete novice at and this inexperience contributed to the prevailing level of stress surrounding the project in the latter stages. However, during my placement I was able to understand more about the notion of self-compassion and discovered that it was a useful coping strategy for myself as well as the clients. I also was able to approach my supervisors and say when I felt I was out of my depth and needed assistance. However, at the end of the project I do feel more competent at all aspects of research but in particular less afraid of statistics and I hope that this learning will serve me well in my career.

6. Ethical Issues

The process of applying for approval from the Local Research Ethics Committee was fascinating and I learned a great deal not just about the potential ethical issues in my own study but much more widely the issues facing psychologists and researchers when designing studies. I appreciated the detail with which the Committee examined the information that I intended to present to service users as

they were able to highlight small changes in the language to ensure no-one felt coerced or compelled to participate.

I was very aware that I was asking participants to complete a large number of questionnaires that tapped into some painful emotions. However, I also heard from some participants that these questionnaires had helped them to clarify their thoughts about their problems and what they needed help with. It also helped them to know that as a service we understood the difficulties they had were not purely about food and weight but were about their style of relating to themselves.

7. Main Learning Points

This was the first full research project that I have completed and it gave ample opportunity for me to learn about the process of conducting research, from start to finish. One of the main learning points was that what can be achieved in terms of research is often limited by externally imposed timescales. This means that it is better to scale down one's goals and make the timescale realistic.

I also learned that despite being principally responsible for the project, there were a number of individuals with far greater experience than I who were happy to advise on issues from the design to various practical matters. This also acted as a support network and helped me to feel contained during times where I was feeling under pressure. However, I also learned that it was vital that I communicated to others in the clinical team information about the aims and practicalities of my research in order to maximise the number of participants and ensure things ran

smoothly. For example, asking staff to assist service users in completing the questionnaires to minimise missing data was an important step.

It had been six years since my undergraduate psychology degree and I had no post-graduate training in research, unlike some of my fellow trainees. This meant that on commencement of the research, despite course guidelines, my confidence to complete work of doctoral standard was not high. However, one of the main benefits of conducting the project has been that I feel more confident and able than at any point in the past and reflecting on the process, I feel more enthused about research and am hoping to incorporate it into my career once qualified.

Appendix

- A. Notes for Contributors (British Journal of Clinical Psychology)**
- B. Stirling Eating Disorders Scales**
- C. Internalised Shame Scale**
- D. Other As Shamer Scale**
- E. Forms of Self-Criticising / Attacking and Self-Reassuring Scale**
- F. Functions of Self-Criticising / Attacking Scale**
- G. Self-Compassion Scale**
- H. Factor Structure of the Self-Compassion Scale**
- I. Letters of Ethical Approval**
 - 1. Local Research Ethics Committee**
 - 2. Local R&D department approval**
 - 3. University of Leicester ethical approval**
- J. Introductory letter to Participants**
- K. Participant Information Sheet**
- L. Consent form**



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Notes for Contributors

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- Tables, figures, captions placed at the end of the article or attached as separate files



STIRLING EATING DISORDER SCALES

PAGE
1

NAME

INSTRUCTIONS

This questionnaire contains 80 statements about thoughts and feelings. Read each statement carefully and decide if it applies to you or not. If the statement applies to you usually or all the time tick ✓ the True circle O. If the statement rarely or never applies to you tick ✓ the False circle O. If you make a mistake cross it out ✕ and give your correct answer. Do not spend a long time thinking about each statement – just give your first reaction. There are no right or wrong answers. There are two pages of statements – please be sure to answer all of them. Complete Page 1 first and then Page 2.

	TRUE	FALSE
I tend to bottle up my emotions rather than make a scene	<input type="radio"/>	<input type="radio"/>
At times I think I am no good at all	<input type="radio"/>	<input type="radio"/>
I often want to injure myself	<input type="radio"/>	<input type="radio"/>
I can pretty much decide what happens in my life	<input type="radio"/>	<input type="radio"/>
I find myself preoccupied with food	<input type="radio"/>	<input type="radio"/>
I eat the same food day after day	<input type="radio"/>	<input type="radio"/>
I feel satisfied with my eating patterns	<input type="radio"/>	<input type="radio"/>
I eat a lot of food even when I'm not hungry	<input type="radio"/>	<input type="radio"/>
I find it difficult to ask personal questions	<input type="radio"/>	<input type="radio"/>
I have a positive attitude towards myself	<input type="radio"/>	<input type="radio"/>
I believe I am a bad person	<input type="radio"/>	<input type="radio"/>
My life is determined by my own actions	<input type="radio"/>	<input type="radio"/>
When I eat anything I feel guilty	<input type="radio"/>	<input type="radio"/>
I eat low calorie foods all the time	<input type="radio"/>	<input type="radio"/>
When I binge I have a sense of unreality	<input type="radio"/>	<input type="radio"/>
I never eat uncontrollably	<input type="radio"/>	<input type="radio"/>
I feel I can ask my parents/friends not to nag me	<input type="radio"/>	<input type="radio"/>
I feel I am not as popular as other people of my age	<input type="radio"/>	<input type="radio"/>
I often feel angry with myself	<input type="radio"/>	<input type="radio"/>
Little in this world controls me – I usually do what I decide to do	<input type="radio"/>	<input type="radio"/>
High carbohydrate foods make me feel nervous	<input type="radio"/>	<input type="radio"/>
I often hide food rather than eat it	<input type="radio"/>	<input type="radio"/>
When I binge I feel disgusted with myself	<input type="radio"/>	<input type="radio"/>
I hide the evidence of my binges (eg food wrappers)	<input type="radio"/>	<input type="radio"/>
I feel confident going into a social gathering	<input type="radio"/>	<input type="radio"/>
I believe my parents are proud of me	<input type="radio"/>	<input type="radio"/>
I feel ashamed of myself	<input type="radio"/>	<input type="radio"/>
I feel I live according to other people's rules	<input type="radio"/>	<input type="radio"/>
I believe I am allergic to many foods	<input type="radio"/>	<input type="radio"/>
I cut my food into very small pieces in order to eat more slowly	<input type="radio"/>	<input type="radio"/>
I am not worried about my bingeing	<input type="radio"/>	<input type="radio"/>
I take laxatives in order to get rid of the food I have eaten	<input type="radio"/>	<input type="radio"/>
I am afraid of people being angry with me	<input type="radio"/>	<input type="radio"/>
I have a strong sense of self-worth	<input type="radio"/>	<input type="radio"/>
I do not behave the way I should	<input type="radio"/>	<input type="radio"/>
I feel I am in control of my body	<input type="radio"/>	<input type="radio"/>
I can eat sweets without feeling anxious	<input type="radio"/>	<input type="radio"/>
I weigh myself after meals	<input type="radio"/>	<input type="radio"/>
I feel ashamed of the amount of food I can eat	<input type="radio"/>	<input type="radio"/>
I try to diet but always lose control	<input type="radio"/>	<input type="radio"/>



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SPECIAL NOTE

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and while every effort has
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in damage.**



STIRLING EATING DISORDER SCALES

PAGE
2

NAME

INSTRUCTIONS

As you did for Page One, read each statement carefully and decide if it applies to you or not. If the statement applies to you usually or all the time tick ✓ the True circle O. If the statement rarely or never applies to you tick ✓ the False circle O. If you make a mistake cross it out ✕ and give your correct answer. Do not spend a long time thinking about each statement – just give your first reaction. There are no right or wrong answers. When you have completed this page go back and check that you have answered all the statements on both pages.

	TRUE	FALSE
If someone is unfair to me, I feel I can tell him/her	<input type="radio"/>	<input type="radio"/>
I have little respect for myself	<input type="radio"/>	<input type="radio"/>
I have very hostile feelings towards myself	<input type="radio"/>	<input type="radio"/>
I feel my family have control over me	<input type="radio"/>	<input type="radio"/>
I must be very controlled in my eating habits	<input type="radio"/>	<input type="radio"/>
I count the calories of everything I eat	<input type="radio"/>	<input type="radio"/>
I hate myself after bingeing	<input type="radio"/>	<input type="radio"/>
I intentionally vomit after eating	<input type="radio"/>	<input type="radio"/>
I am an assertive person	<input type="radio"/>	<input type="radio"/>
I feel proud of my achievements	<input type="radio"/>	<input type="radio"/>
I have very little to feel guilty about	<input type="radio"/>	<input type="radio"/>
I often feel I am controlled by something outside of myself	<input type="radio"/>	<input type="radio"/>
If I overeat a little I feel frightened	<input type="radio"/>	<input type="radio"/>
I eat rich, high calorie foods	<input type="radio"/>	<input type="radio"/>
I feel frightened if I cannot get rid of the food I have eaten either by vomiting, laxatives or fasting	<input type="radio"/>	<input type="radio"/>
I always eat a lot in secret	<input type="radio"/>	<input type="radio"/>
I feel I cannot tell people when they have hurt me	<input type="radio"/>	<input type="radio"/>
I do not feel very clever	<input type="radio"/>	<input type="radio"/>
I should be a better person	<input type="radio"/>	<input type="radio"/>
I feel my boyfriend/girlfriend/spouse/parent has a lot of control over me	<input type="radio"/>	<input type="radio"/>
I can overeat a little and not feel nervous	<input type="radio"/>	<input type="radio"/>
I keep to a very strict diet regime	<input type="radio"/>	<input type="radio"/>
I feel my eating patterns control my life	<input type="radio"/>	<input type="radio"/>
I often eat so much my stomach hurts	<input type="radio"/>	<input type="radio"/>
I feel I can assert myself with people in authority	<input type="radio"/>	<input type="radio"/>
I feel I am not as attractive as other people my age	<input type="radio"/>	<input type="radio"/>
I deserve to be punished	<input type="radio"/>	<input type="radio"/>
My health is not under control	<input type="radio"/>	<input type="radio"/>
I believe I do not need as much food as other people	<input type="radio"/>	<input type="radio"/>
I often eat in front of others	<input type="radio"/>	<input type="radio"/>
I believe I can stop eating when I want to	<input type="radio"/>	<input type="radio"/>
I lie about the large amount of food I eat	<input type="radio"/>	<input type="radio"/>
I tend to sulk rather than have an argument	<input type="radio"/>	<input type="radio"/>
I have a nice personality	<input type="radio"/>	<input type="radio"/>
I have very little to be self-critical about	<input type="radio"/>	<input type="radio"/>
Other people control my life	<input type="radio"/>	<input type="radio"/>
I feel disgusted with myself when I eat anything	<input type="radio"/>	<input type="radio"/>
I cook for others but avoid eating with them	<input type="radio"/>	<input type="radio"/>
I feel that my eating patterns are out of control	<input type="radio"/>	<input type="radio"/>
I rarely binge	<input type="radio"/>	<input type="radio"/>

I.S.S. SCALE

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had them for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way that you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.
DO NOT OMIT ANY ITEM.

SCALE

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

SCALE

- | | |
|-----------|--|
| 0 1 2 3 4 | 1. I feel like I am never quite good enough |
| 0 1 2 3 4 | 2. I feel somehow left out |
| 0 1 2 3 4 | 3. I think other people look down on me |
| 0 1 2 3 4 | 4. All in all, I am inclined to feel that I am a success |
| 0 1 2 3 4 | 5. I scold myself and put myself down |
| 0 1 2 3 4 | 6. I feel insecure about others opinions of me |
| 0 1 2 3 4 | 7. Compared to other people, I feel like I somehow never measure up |
| 0 1 2 3 4 | 8. I see myself as being very small and insignificant |
| 0 1 2 3 4 | 9. I feel I have much to be proud of |
| 0 1 2 3 4 | 10. I feel intensely inadequate and full of self-doubt |
| 0 1 2 3 4 | 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me |
| 0 1 2 3 4 | 12. When I compare myself to others I am just not as important |
| 0 1 2 3 4 | 13. I have an overpowering dread that my faults will be revealed in front of others |

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

Scale

- | | |
|-----------|---|
| 0 1 2 3 4 | 14. I have a number of good qualities |
| 0 1 2 3 4 | 15. I see myself striving for perfection only to continually fall short |
| 0 1 2 3 4 | 16. I think others are able to see my defects |
| 0 1 2 3 4 | 17. I could beat myself over the head with a club when I make a mistake |
| 0 1 2 3 4 | 18. On the whole, I am satisfied with myself |
| 0 1 2 3 4 | 19. I would like to shrink away when I make a mistake |
| 0 1 2 3 4 | 20. I replay painful events over and over in my mind until I am overwhelmed |
| 0 1 2 3 4 | 21. I feel I am a person of worth at least on an equal plane with others |
| 0 1 2 3 4 | 22. At times I feel like I will break into a thousand pieces |
| 0 1 2 3 4 | 23. I feel as if I have lost control over my body functions and feelings |
| 0 1 2 3 4 | 24. Sometimes I feel no bigger than a pea |
| 0 1 2 3 4 | 25. At times I feel so exposed that I wish the earth would open up and swallow me |
| 0 1 2 3 4 | 26. I have this painful gap within me that I have not been able to fill |
| 0 1 2 3 4 | 27. I feel empty and unfulfilled |
| 0 1 2 3 4 | 28. I take a positive attitude toward myself |
| 0 1 2 3 4 | 29. My loneliness is more like emptiness |
| 0 1 2 3 4 | 30. I always feel there is something missing |

OAS SCALE

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had them for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way that you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.
DO NOT OMIT ANY ITEM.

SCALE

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

SCALE

- | | |
|-----------|---|
| 0 1 2 3 4 | 1. I feel other people see me as not good enough |
| 0 1 2 3 4 | 2. I think that other people look down on me |
| 0 1 2 3 4 | 3. Other people put me down a lot |
| 0 1 2 3 4 | 4. I feel insecure about others opinions of me |
| 0 1 2 3 4 | 5. Other people see me as not measuring up to them |
| 0 1 2 3 4 | 6. Other people see me as small and insignificant |
| 0 1 2 3 4 | 7. Other people see me as somehow defective as a person |
| 0 1 2 3 4 | 8. People see me as unimportant compared to others |
| 0 1 2 3 4 | 9. Other people look for my faults |
| 0 1 2 3 4 | 10. People see me as striving for perfection but being unable to reach my own standards |
| 0 1 2 3 4 | 11. I think others are able to see my defects |
| 0 1 2 3 4 | 12. Others are critical or punishing when I make a mistake |
| 0 1 2 3 4 | 13. People distance themselves from me when I make mistakes |

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

- | | |
|-----------|---|
| 0 1 2 3 4 | 14. Other people always remember my mistakes |
| 0 1 2 3 4 | 15. Others see me as fragile |
| 0 1 2 3 4 | 16. Others see me as empty and unfulfilled |
| 0 1 2 3 4 | 17. Others think there is something missing in me |
| 0 1 2 3 4 | 18. Other people think I have lost control over my body
and feelings |

THE FORMS OF SELF-CRITICISING/ATTACKING & SELF-REASSURING SCALE (FSCRS)

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of themselves. Below are series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Please use the scale below.

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

When things go wrong for me:

- | | | | | | | |
|-----|--|---|---|---|---|---|
| 1. | I am easily disappointed with myself. | 0 | 1 | 2 | 3 | 4 |
| 2. | There is a part of me that puts me down. | 0 | 1 | 2 | 3 | 4 |
| 3. | I am able to remind myself of positive things about myself. | 0 | 1 | 2 | 3 | 4 |
| 4. | I find it difficult to control my anger and frustration at myself. | 0 | 1 | 2 | 3 | 4 |
| 5. | I find it easy to forgive myself. | 0 | 1 | 2 | 3 | 4 |
| 6. | There is a part of me that feels I am not good enough. | 0 | 1 | 2 | 3 | 4 |
| 7. | I feel beaten down by my own self-critical thoughts. | 0 | 1 | 2 | 3 | 4 |
| 8. | I still like being me. | 0 | 1 | 2 | 3 | 4 |
| 9. | I have become so angry with myself that I want to hurt or injure myself. | 0 | 1 | 2 | 3 | 4 |
| 10. | I have a sense of disgust with myself. | 0 | 1 | 2 | 3 | 4 |
| 11. | I can still feel lovable and acceptable. | 0 | 1 | 2 | 3 | 4 |
| 12. | I stop caring about myself. | 0 | 1 | 2 | 3 | 4 |
| 13. | I find it easy to like myself. | 0 | 1 | 2 | 3 | 4 |
| 14. | I remember and dwell on my failings. | 0 | 1 | 2 | 3 | 4 |
| 15. | I call myself names. | 0 | 1 | 2 | 3 | 4 |
| 16. | I am gentle and supportive with myself. | 0 | 1 | 2 | 3 | 4 |
| 17. | I can't accept failures and setbacks without feeling inadequate. | 0 | 1 | 2 | 3 | 4 |
| 18. | I think I deserve my self-criticism. | 0 | 1 | 2 | 3 | 4 |
| 19. | I am able to care and look after myself. | 0 | 1 | 2 | 3 | 4 |
| 20. | There is a part of me that wants to get rid of the bits I don't like. | 0 | 1 | 2 | 3 | 4 |
| 21. | I encourage myself for the future. | 0 | 1 | 2 | 3 | 4 |
| 22. | I do not like being me. | 0 | 1 | 2 | 3 | 4 |

THE FUNCTIONS OF SELF-CRITICIZING/ATTACKING SCALE (FSCS)

There can be many reasons why people become critical and angry with themselves. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Use the scale below.

Not at all like me 0	A little bit like me 1	Moderately like me 2	Quite a bit like me 3	Extremely like me 4
----------------------------	------------------------------	----------------------------	-----------------------------	---------------------------

I get critical and angry with myself:

1. to make sure I keep up my standards.	0	1	2	3	4
2. to stop myself being happy.	0	1	2	3	4
3. to show I care about my mistakes.	0	1	2	3	4
4. because if I punish myself I feel better.	0	1	2	3	4
5. to stop me being lazy.	0	1	2	3	4
6. to harm part of myself.	0	1	2	3	4
7. to keep myself in check.	0	1	2	3	4
8. to punish myself for my mistakes.	0	1	2	3	4
9. to cope with feelings of disgust with myself.	0	1	2	3	4
10. to take revenge on part of myself.	0	1	2	3	4
11. to stop me getting overconfident.	0	1	2	3	4
12. to stop me being angry with others	0	1	2	3	4
13. to destroy a part of me.	0	1	2	3	4
14. to make me concentrate.	0	1	2	3	4
15. to gain reassurance from others.	0	1	2	3	4
16. to stop me becoming arrogant.	0	1	2	3	4
17. to prevent future embarrassments.	0	1	2	3	4
18. to remind me of my past failures	0	1	2	3	4
19. to keep me from making minor mistakes.	0	1	2	3	4
20. to remind me of my responsibilities.	0	1	2	3	4
21. to get at the things I hate in myself.	0	1	2	3	4

If you can think of any other reasons why you become self-critical please write them in the space below:

.....
.....

SCS

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the right of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never **Seldom** **Sometimes** **Often** **Almost Always**

1 **2** **3** **4** **5**

1.	I'm disapproving and judgemental about my own flaws and inadequacies.	1	2	3	4	5
2.	When I'm feeling down I tend to obsess and fixate on everything that's wrong.	1	2	3	4	5
3.	When things are going badly for me, I see the difficulties as part of life that everyone goes through.	1	2	3	4	5
4.	When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	1	2	3	4	5
5.	I try to be loving towards myself when I'm feeling emotional pain.	1	2	3	4	5
6.	When I fail at something important to me I become consumed by feelings of inadequacy.	1	2	3	4	5
7.	When I'm down, I remind myself that there are lots of other people in the world feeling like I am.	1	2	3	4	5
8.	When times are really difficult, I tend to be tough on myself.	1	2	3	4	5
9.	When something upsets me I try to keep my emotions in balance.	1	2	3	4	5
10.	When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	1	2	3	4	5
11.	I'm intolerant and impatient towards those aspects of my personality I don't like.	1	2	3	4	5
12.	When I'm going through a very hard time, I give myself the caring and tenderness I need.	1	2	3	4	5
13.	When I'm feeling down, I tend to feel like most other people are probably happier than I am.	1	2	3	4	5
14.	When something painful happens I try to take a balanced view of the situation.	1	2	3	4	5
15.	I try to see my failings as part of the human condition.	1	2	3	4	5
16.	When I see aspects of myself that I don't like, I get down on myself.	1	2	3	4	5
17.	When I fail at something important to me I try to keep things in perspective.	1	2	3	4	5

18.	When I'm really struggling, I tend to feel like other people must be having an easier time of it.	1	2	3	4	5
19.	I'm kind to myself when I'm experiencing suffering.	1	2	3	4	5
20.	When something upsets me I get carried away with my feelings.	1	2	3	4	5
21.	I can be cold-hearted towards myself when I'm experiencing suffering.	1	2	3	4	5
22.	When I'm feeling down I try to approach my feelings with curiosity and openness.	1	2	3	4	5
23.	I'm tolerant of my own flaws and inadequacies.	1	2	3	4	5
24.	When something painful happens I tend to blow the incident out of proportion.	1	2	3	4	5
25.	When I fail at something that's important to me, I tend to feel alone in my failure.	1	2	3	4	5
26.	I try to be understanding and patient towards those aspects of my personality I don't like.	1	2	3	4	5

Appendix H

Factor Structure of the Self-Compassion Scale

The structure of the Self-Compassion Scale (Neff, 2003b) was explored as follows. Prior to completing the analysis the data were inspected for their suitability. The sample size was lower than is desirable, with researchers suggesting at least five cases per item to be analysed (Pallant, 2005), therefore this analysis represents only preliminary findings and must be interpreted with caution. Most inter-item correlations were positive and significant at the 0.05 level. The correlation matrix showed a number of correlations at greater than $r = .3$. The Kaiser-Meyer-Olkin value was .73, exceeding the recommended value of .6 (Pallant, 2005). Bartlett's Test of Sphericity demonstrated significance at $p < .001$, suggesting that the data met the criteria for factorability and most of the assumptions.

A principal components analysis with varimax rotation was carried out with a cut of 0.4 for the inclusion of a variable in the interpretation of a factor. This analysis produced a solution with six factors having eigenvalues greater than one. These six factors accounted for 66.5% of the variance in the factor space (See Table 1).

Table 1. Factor loadings on the Self-Compassion Scale

Item	Description	Factor					
		1	2	3	4	5	6
21	I can be coldhearted towards myself when I'm experiencing suffering	.786					
1	I am disapproving and judgmental about my own flaws and inadequacies	.772					
4	When I think about my inadequacies it tends to make me feel more separate and cut off	.721					
2	When I am feeling down I tend to obsess and fixate on everything that's wrong	.688					
8	When times are really difficult I tend to be tough on myself	.675					
11	I'm intolerant and impatient towards those aspects of my personality I don't like	.667					
25	When I fail at something that is important to me I tend to feel alone in my failure	.632					
6	When I fail at something important to me I become consumed by feelings of inadequacy	.627				.520	
16	When I see aspects of myself that I don't like, I get down on myself	.626					
17	When I fail at something important to me I try to keep things in perspective		.763				
14	When something painful happens I try to take a balanced view of the situation		.688				
22	When I'm feeling down I try to approach my feelings with curiosity and openness		.633				
23	I'm tolerant of my own flaws and inadequacies		.625				
15	I try to see my failings as part of the human condition		.615				
7	When I am down I remind myself that there are lots of other people feeling like I am			.816			
10	When I feel inadequate I try to remind myself that feelings of inadequacy are shared by most			.790			
5	I try to be loving towards myself when I am feeling emotional pain				.763		
12	When I'm going through a hard time I give myself the caring and tenderness I need				.699		
19	I'm kind to myself when I'm experiencing suffering				.594	.410	
26	I try to be understanding and patient towards those aspects of my personality I don't like			.441	.454		
18	When I'm really struggling I tend to feel other people must be having an easier time of it					.745	
13	When I'm feeling down I tend to feel most other people are happier than I am					.709	
3	When things are going badly I see the difficulties as part of life everyone goes through			.540		.614	
24	When something painful happens I tend to blow the incident out of proportion						.808
20	When something upsets me I get carried away with my feelings						.718
9	When something upsets me I try to keep my emotions in balance						.438
	Eigenvalue	8.12	3.34	1.76	1.57	1.34	1.17
	Variance (%)	19.5	11.5	9.7	9.6	9.4	6.9

The factor loadings differed from those in Neff's original validation of the SCS (Neff, 2003b). However, in the current study the solution was interpretable as follows. Factor 1 (items 1, 2, 4, 6, 8, 11, 21 & 25) appeared to be related to being judgemental about oneself and also feeling separate and isolated about one's inadequacies. Factor one showed a similar factor structure to Neff's 'self-judgment' subscale. Factor 2 (items 14, 15, 17, 23 & 23) relates to seeing one's flaws and painful emotions in balance and with perspective. This factor shows a similar factor loading to Neff's 'mindfulness' subscale. Factor 3 (items 3, 7, 10 & 26) appeared to contain items relating to seeing one's suffering as part of the human condition and is similar to Neff's 'common humanity' subscale. Factor 4 (items 5, 12, 19 & 26) suggested caring for the self and relating to the self with kindness. There were similar factors loadings for Neff's 'self-kindness' subscale. Factor 5 (items 3, 6, 13, 18 & 19) related to feelings of separation when feeling down. This factor has some items in common with Neff's 'isolation' subscale. Factor 6 (items 9, 20 & 24) related to feeling overwhelmed by negative feelings and events. This factor had some items in common with Neff's 'over-identification' subscale.

NB. Items 3, 6, 19 and 26 each loaded onto two factors.

30 November 2006

Warwickshire Local Research Ethics Committee
Accredited by UKECA to review Type 3 MREC Applications

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pat.horwell@geh.nhs.uk

Dear Ms Barrow

Full title of study: The relationship between compassion, shame, symptoms and diagnosis in the eating disorders and the impact of a psycho-education programme

REC reference number: 06/Q2803/128

Thank you for your letter of 13 November 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 29 November 2006. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	1	27 September 2006
Investigator CV		17 September 2006
Protocol	1	27 September 2006
Covering Letter		27 September 2006
Letter from Sponsor		28 September 2006
Peer Review		16 September 2006
Questionnaire: Validated/ Stirling disorder scales		
Letter of invitation to participant	1	27 September 2006
Participant Information Sheet: Patient	2	13 November 2006

Participant Consent Form: Patient	1	27 September 2006
Response to Request for Further Information		13 November 2006
Consent to be contacted	1	27 September 2006
Checklist		
CV Ken Goss		19 February 2005

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

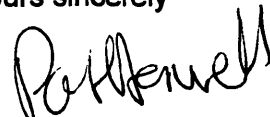
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2803/128	Please quote this number on all correspondence
---------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely


Paul Hamilton
Chair

Enclosures:

Standard approval conditions
Site approval form

Copy to: University of Leicester
 Clinical Psychology Section
 104 Regent Road
 Leicester
 R&D Department for Coventry PCT

Warwickshire Local Research Ethics Committee
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	06/Q2803/128	Issue number:	1	Date of issue:	30 November 2006
Chief Investigator:	Ms Alexandra Barrow				
Full title of study:	The relationship between compassion, shame, symptoms and diagnosis in the eating disorders and the impact of a psycho-education programme				
<p><i>This study was given a favourable ethical opinion by Warwickshire Local Research Ethics Committee on 29 November 2006. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.</i></p>					
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes ⁽¹⁾
Ms A H J Barrow	Trainee Clinical Psychologist	Coventry Eating Disorders Service, Coventry PCT	Coventry Research Ethics Committee	30/11/2006	
<p>Approved by the Chair on behalf of the REC:</p> <p>..... (Signature of Chair/Co-ordinator) (delete as applicable)</p> <p>..... (Name)</p>					

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension or termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.



Central Office for Research Ethics Committees (COREC)

RESEARCH IN HUMAN SUBJECTS OTHER THAN CLINICAL TRIALS OF INVESTIGATIONAL MEDICINAL PRODUCTS

Standard conditions of approval by Research Ethics Committees

1. Further communications with the Research Ethics Committee
 - 1.1 Further communications during the research with the Research Ethics Committee that gave the favourable ethical opinion (hereafter referred to in this document as "the Committee") are the personal responsibility of the Chief Investigator.
2. Commencement of the research
 - 2.1 It is assumed that the research will commence within 12 months of the date of the favourable ethical opinion.
 - 2.2 In the case of research requiring site-specific assessment (SSA) the research may not commence at any site until the Committee has notified the Chief Investigator that the favourable ethical opinion is extended to the site.
 - 2.3 The research may not commence at any NHS site until the local Principal Investigator (PI) or research collaborator has obtained research governance approval from the relevant NHS care organisation.
 - 2.4 Should the research not commence within 12 months, the Chief Investigator should give a written explanation for the delay. It is open to the Committee to allow a further period of 12 months within which the research must commence.
 - 2.5 Should the research not commence within 24 months, the favourable opinion will be suspended and the application would need to be re-submitted for ethical review.
3. Duration of ethical approval
 - 3.1 The favourable opinion for the research generally applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Committee should be notified.
4. Progress reports
 - 4.1 Research Ethics Committees are required to keep a favourable opinion under review in the light of progress reports and any developments in the study. The Chief

Investigator should submit a progress report to the Committee 12 months after the date on which the favourable opinion was given. Annual progress reports should be submitted thereafter.

4.2 Progress reports should be in the format prescribed by COREC and published on the website (see <http://www.corec.org.uk/applicants/apply/progress.htm>).

4.3 The Chief Investigator may be requested to attend a meeting of the Committee or Sub-Committee to discuss the progress of the research.

5. Amendments

5.1 If it is proposed to make a substantial amendment to the research, the Chief Investigator should submit a notice of amendment to the Committee.

5.2 A substantial amendment is any amendment to the terms of the application for ethical review, or to the protocol or other supporting documentation approved by the Committee, that is likely to affect to a significant degree:

(a) the safety or physical or mental integrity of the trial participants

(b) the scientific value of the trial

(c) the conduct or management of the trial.

5.3 Notices of amendment should be in the format prescribed by COREC and published on the website, and should be personally signed by the Chief Investigator.

5.4 A substantial amendment should not be implemented until a favourable ethical opinion has been given by the Committee, unless the changes to the research are urgent safety measures (see section 7). The Committee is required to give an opinion within 35 days of the date of receiving a valid notice of amendment.

5.5 Amendments that are not substantial amendments ("minor amendments") may be made at any time and do not need to be notified to the Committee.

6. Changes to sites (*studies requiring site-specific assessment only*)

6.1 Where it is proposed to include a new site in the research, there is no requirement to submit a notice of amendment form to the Committee. Part C of the application form together with the local Principal Investigator's CV should be submitted to the relevant LREC for site-specific assessment (SSA).

6.2 Similarly, where it is proposed to make important changes in the management of a site (in particular, the appointment of a new PI), a notice of amendment form is not required. A revised Part C for the site (together with the CV for the new PI if applicable) should be submitted to the relevant LREC for SSA.

6.3 The relevant LREC will notify the Committee whether there is any objection to the new site or Principal Investigator. The Committee will notify the Chief Investigator of its opinion within 35 days of receipt of the valid application for SSA.

6.4 For studies designated by the Committee as exempt from SSA, there is no requirement to notify the Committee of the inclusion of new sites.

7. Urgent safety measures

7.1 The sponsor or the Chief Investigator, or the local Principal Investigator at a trial site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

7.2 The Committee must be notified within three days that such measures have been taken, the reasons why and the plan for further action.

8. Serious Adverse Events

8.1 A Serious Adverse Event (SAE) is an untoward occurrence that:

- (a) results in death
- (b) is life-threatening
- (c) requires hospitalisation or prolongation of existing hospitalisation
- (d) results in persistent or significant disability or incapacity
- (e) consists of a congenital anomaly or birth defect
- (f) is otherwise considered medically significant by the investigator.

8.2 A SAE occurring to a research participant should be reported to the Committee where in the opinion of the Chief Investigator the event was related to administration of any of the research procedures, and was an unexpected occurrence.

8.3 Reports of SAEs should be provided to the Committee within 15 days of the Chief Investigator becoming aware of the event, in the format prescribed by COREC and published on the website.

8.4 The Chief Investigator may be requested to attend a meeting of the Committee or Sub-Committee to discuss any concerns about the health or safety of research subjects.

8.5 Reports should not be sent to other RECs in the case of multi-site studies.

9. Conclusion or early termination of the research

9.1 The Chief Investigator should notify the Committee in writing that the research has ended within 90 days of its conclusion. The conclusion of the research is defined as the final date or event specified in the protocol, not the completion of data analysis or publication of the results.

9.2 If the research is terminated early, the Chief Investigator should notify the Committee within 15 days of the date of termination. An explanation of the reasons for early termination should be given.

9.3 Reports of conclusion or early termination should be submitted in the form prescribed by COREC and published on the website.

10. Final report

- 10.1 A summary of the final report on the research should be provided to the Committee within 12 months of the conclusion of the study. This should include information on whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research including any feedback to participants.

11. Review of ethical opinion

- 11.1 The Committee may review its opinion at any time in the light of any relevant information it receives.
- 11.2 The Chief Investigator may at any time request that the Committee reviews its opinion, or seek advice from the Committee on any ethical issue relating to the research.

12. Breach of approval conditions

- 12.1 Failure to comply with these conditions may lead to suspension or termination of the favourable ethical opinion by the Committee.

Confidential

Coventry **NHS**
Primary Care Trust

Our Ref: R&D/Coventry Teaching Primary Care Trust/

Research & Development Dept
The Caludon Centre
Clifford Bridge Road
Walsgrave
Coventry
CV2 2TE

Date: 22nd February 2007

☎ 02476 96 7881

TO: CHIEF INVESTIGATOR:

Trainee Clinical Psychologist
Coventry Eating Disorder Service
James Brindley House
Coventry Canal Basin
St. Nicholas Street
COVENTRY CV1 4LY

For the attention of Ms Alexandra Barrow

COPY TO: Research Supervisor

Consultant Psychologist
Coventry Eating Disorder Service
James Brindley House
Coventry Canal Basin
St. Nicholas Street
COVENTRY CV1 4LY

For the attention of Dr Ken Goss

Dear Ms Barrow

RESEARCH & DEVELOPMENT

REC Ref 06/Q2803/128 Warwickshire LREC. – Please quote at all times.

Full study title: The relationship between compassion, shame, symptoms and diagnosis in the eating disorders and the impact of a Psycho-education programme.

REC reference number: 06/Q2803/128 Protocol number: N/A
EudraCT number: NA

Chief Investigator(s)	Principal Investigator(s)
Ms Alexandra Barrow Trainee Clinical Psychologist Coventry Eating Disorder Service James Brindley House Coventry Canal Basin St. Nicholas Street COVENTRY CV1 4LY	Dr Ken Goss Consultant Psychologist Coventry Eating Disorder Service James Brindley House Coventry Canal Basin St. Nicholas Street COVENTRY CV1 4LY

Thank you for the above research study, the R&D Dept of Coventry Teaching Primary Care Trust considered the locality issues relating to the above application and has no objection to the research being conducted within this locality.

The above study has been granted approval by Coventry Teaching Primary Care Trust and is registered with the R&D Dept of Coventry Teaching Primary Care Trust.

SERVICE SUPPORT COSTS/TREATMENT COSTS

The R&D Dept of Coventry Teaching PCT. confirms there are no associated Service Support Costs, Treatment Costs or research costs involved in the above study.

RESEARCH & DEVELOPMENT

REC Ref 06/Q2803/128 Warwickshire LREC. – Please quote at all times.

BACKGROUND

The Warwickshire Research Ethics Committee reviewed the application for ethical review. Further information was considered at the meeting held on 29 November 2006.

Confirmation of Ethical Opinion.

The Warwickshire Research Ethics Committee confirmed a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised on 30th November 2006.

Site Specific Assessment (1) – Ms Alexandra Barrow

Site Specific Assessment has been reviewed and approved by Coventry Research Ethics Committee on 30/11/2006.

I confirm that Coventry Teaching Primary Care Trust is organised and operates according to the Research Governance Framework.

- This approval is granted for 3 years from commencement of the research. If you wish to continue beyond this date it is your responsibility to contact (COREC) for further approval.
- The study must be started within twelve months of the date on which the main REC approval is given. If for any reason you do not meet this deadline you must resubmit your study to the COREC.

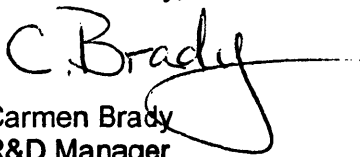
The R&D Department of Coventry Teaching Primary Care Trust must be notified of:

- a. all protocol amendments or unexpected events.
- b. any new authoritative guidance or persuasive scientific evidence that may cause Coventry Teaching Primary Care Trust to reconsider approval or rejection of the protocol.

The R&D Dept looks forward to receiving progress reports as appropriate and a final report within three months of completion; and propose that in future, unless we hear to the contrary, the title of all research trials approved by Coventry Teaching Primary Care Trust will be made available to bona fide interested parties.

The R&D Dept thanks you for your co-operation in these matters.

Yours sincerely,


Carmen Brady
R&D Manager

RESEARCH INFORMATION SHEET

Your Research study has been granted NHS R&D approval by Coventry Teaching PCT. All those involved in research with human participants, their organs, tissue or data must be aware of and implement the law, and the basic principles relating to ethics, science, information, health and safety, and finance set out in the Research Governance Framework.

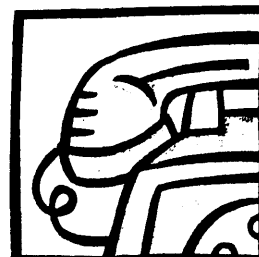
Doctors and consultants must also comply with the GMC guidance 'Good Practice in Research' – a copy of this can be obtained from the R&D Dept

As a Researcher these are YOUR responsibilities under the Research Governance Framework:

- ◆ Follow the agreed protocol as approved by relevant ethics committee and Sponsor and ensure any proposed changes or amendments to the protocol are submitted for approval to the ethics committee, Sponsor and the R&D Department
- ◆ Ensure you are aware of and follow appropriate guidelines for Data Protection, The Caldicott Principles and Health and safety, including relevant Trust policies
- ◆ Ensure the study complies with all relevant legal and ethical requirements including ensuring Ethics approval dates to check approval is still valid
- ◆ Anonymise participant data where possible and hold it in accordance with the Data Protection Act. Consent must be sought before using the information for any purpose other than that stated when it was obtained
- ◆ Report adverse events or suspected research fraud or misconduct to both the LREC and the PCT R&D Department
- ◆ Involve consumers in the research where possible
- ◆ Ensure that only researchers with a contractual relationship with the PCT hosting the research make contact with patients. There are procedures in place for issuing honorary contracts, please seek clarification if required
- ◆ Discuss any Intellectual Property issues with the R&D Department
- ◆ Update the R&D Department as necessary regarding NRR submissions and DOH R&D Annual Reporting requirements
- ◆ Ensure all data and documentation associated with the study are available for audit at the request of the appropriate auditing authority
- ◆ Supply an annual report to the LREC and copy this to the R&D office
- ◆ Disseminate results as widely as possible, both locally and nationally and always ensure all participants are kept up-to-date on the progress of the research and given feedback at the end of the study

CONTACT THE RESEARCH & DEVELOPMENT DEPARTMENT

Carmen Brady
R&D Manager
Coventry Teaching Primary Care Trust
Research & Development Dept
Email: Carmen.brady@coventrypct.nhs.uk
☎ 02476 96 7881



Barrow, A.H.J.

From: Colman, Prof A.M. [amc@leicester.ac.uk]
To: ahjb1@leicester.ac.uk
Cc:
Subject: RE: PC_ethics2006 - Ms Alexandra Barrow
Attachments:

Sent: Wed 25/04/2007 15:22

Dear Alexandra

Your project (Eating Disorders, Shame and Compassion) has been approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be printed out and kept for your records or attached to the research report if required - this includes all undergraduate and postgraduate research.

We wish you every success with your study.

Andrew M. Colman
Psychology Research Ethics Committee Chair

-----Original Message-----

From: www-data [mailto:webserver-admin@leicester.ac.uk]
Sent: 25 April 2007 12:39
To: amc@leicester.ac.uk
Subject: PC_ethics2006 - Ms Alexandra Barrow

Proposer: PC_ethics2006 - Ms Alexandra Barrow
email: ahjb1@le.ac.uk
status: 04-07 Doctorate in clinical psychology
supervisor: Dr Steve Allan
title: Eating Disorders, Shame and Compassion
date: 05.10.06
preapproval: LMRC
describe:
tellvoluntary:
obtainwrittenconsent:
observe:
maywithdraw:
allowomit:
tellconfidential:
debrief:

mislead:
distress:
animals:
kids:
sen:
patients:
custody:
criminals:

route:

routeAdesc:

The Relationship Between Compassion, Shame, Symptoms and Diagnosis in the Eating Disorders, and the Impact of a Psycho-education Programme

Appendix 2

Date:

INTRODUCTORY LETTER TO PARTICIPANTS
To be accompanied by 'Consent to be Contacted' Form

To: [The Research Participant].

The Relationship Between Compassion, Shame, Symptoms and Diagnosis in the Eating Disorders, and the Impact of a Psycho-education Programme

Dear.....

My name is Alex Barrow and I am the Chief Investigator conducting the above research study.

I am carrying out research to investigate feelings of compassion and shame in people who have eating disorders. Through this research, I hope to understand more about how these feelings relate to eating disorder diagnoses and symptoms, and so help design more effective treatments in future.

At Coventry Eating Disorders Service, we routinely collect relevant clinical information regarding your symptoms and feelings via questionnaires. This helps us to assess your difficulties and monitor your progress. I would be grateful if you would consider taking part in this research, which would involve permitting us to use the information from your questionnaires for our research.

Your participation would not require you to do anything in addition to the normal completion of questionnaires, as part of your treatment here at the service.

Further details regarding the purpose of the study and what it would entail are provided in the attached information sheet.

If you wish to participate in this study, please inform a member of staff at the service.

The Relationship Between Compassion, Shame, Symptoms and Diagnosis in the Eating Disorders, and the Impact of a Psycho-education Programme

Appendix 2

All information about participants gathered during the course of the research will be kept strictly confidential. All information will be anonymised, so that you cannot be recognised from it. Taking part in this research project is completely voluntary.

The Researchers will adhere at all times to the Data Protection Act 1998. This study will be guided and conform to NHS Research Governance Framework and COREC guidelines.

I should be pleased to answer any questions you may have currently or throughout the duration of the study. If you wish I will provide you with a summary study report.

I can be contacted on ☎ 02476 521130

Thank you for reading this.

Yours sincerely,

Ms Alex Barrow
Chief Investigator
Coventry Eating Disorders Service
James Brindley House
Coventry Canal Basin
St Nicholas Street
Coventry CV1 4LY

COVENTRY EATING DISORDER SERVICE
JAMES BRINDLEY HOUSE

COVENTRY CANAL BASIN
ST. NICHOLAS STREET
COVENTRY
CV1 4LY
☎ (024) 76521 130

Fax: (024) 76521 133

Coventry and Warwickshire Partnership Trust

139 Earls Road
Nuneaton
CV11 5HP
Tel: 0845 8770500

Email: enquiries@cowarkpt.nhs.uk

PARTICIPANT INFORMATION SHEET

The Relationship Between Compassion, Shame, Symptoms and Diagnosis in the Eating Disorders, and the Impact of a Psycho-education Programme
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As someone who uses Coventry Eating Disorder Service, you are being invited to participate in a research study. Before deciding, it is important for you, as a user of the service, to understand the study's purpose and what it will involve. Please take the time to read the information below carefully, and to discuss it with others if you wish. Ask questions about anything that is not clear, or about which you would like more information. Take time to decide whether or not you would like to take part.

1. What is the purpose of the study?

The purpose of this research is to find out more about two types of emotion in people with a diagnosis of an eating disorder: feelings of shame and feelings of self-compassion (accepting of one's mistakes and flaws and thinking kindly towards oneself). The aim is to explore how feelings of shame and self-compassion relate to thoughts, beliefs and behaviours associated with eating disorders.

It is anticipated that the findings of the study will be available for dissemination by September 2007.

2. Why have I been chosen?

You have been chosen because you have sought help from Coventry Eating Disorder Service, for treatment for an eating disorder. You may have participated in the four-week pre-treatment psycho-education programme, or you might access this group in future. This study will look

at any changes in the scores on your questionnaires between when you are first seen and when you complete the group. In total, the study aims to recruit approximately 100 users of Coventry Eating Disorder Service.

3. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

4. If I decide to take part what will I have to do?

Coventry Eating Disorder Service uses questionnaires to help assess and monitor your symptoms during your treatment. If you agree to take part in this study, you will not be required to complete any additional self-report questionnaires other than those we routinely administer.

If you choose to take part in the study then you will be asked to read and understand the information provided. If you agree to take part, you will be asked to sign a consent form. If you sign the consent form, then you are giving us permission to use the data obtained from these questionnaires.

Your participation in the study will be kept strictly confidential at all times; an anonymous identification number will be used to identify you.

5. What is being studied?

The research study is designed to explore and understand feelings of shame and feelings of self-compassion (accepting of one's mistakes and flaws and thinking kindly towards oneself) in people who have an eating disorder. We want to look at the relationships between shame, compassion, eating disorder symptoms and diagnosis. We also want to see whether these things change at all during the first part of your treatment, so we will compare your questionnaire responses over time.

6. What are the possible benefits of taking part?

As the study is to provide information about the psychological aspects of eating disorders, those taking part in the study will receive feedback regarding its findings.

7. What are the possible effects or disadvantages of taking part?

This study uses information from a series of questionnaires that are part of the usual assessment procedure. While every effort would be made to put you at ease, we are aware that questionnaires may discuss information that is potentially upsetting or embarrassing to you. We always discuss the results of your questionnaires with you at your initial assessment and follow-up appointment.

If you find completing the questionnaires difficult or distressing, a member of the clinical team will be able to discuss this with you and help you.

You are free to withdraw from the study at any time without your access to current or future treatment being affected in any way.

8. Will my participation in the study be kept confidential?

Your participation in the study and all the information you provide will be kept strictly confidential at all times; your completed questionnaires will be given an anonymous identification number, responses will be coded and information will be securely locked and stored. Information from your Coventry Eating Disorder Service records will be used only for the purpose of this study and subsequent publications of its results. In any case your identity will be protected. Only the researcher and study supervisor will have access to the study data.

If you withdraw from the study, we will no longer collect your personal information and will remove any previous information collected from you from our study.

9. What if new information becomes available during the research study?

If any additional information becomes available during the course of the research, you would be informed in writing by the Chief Investigator.

10. What happens when the research study stops?

You would continue to receive treatment from Coventry Eating Disorder Service, if that is part of your care plan.

11. Data Protection

Personal data, which may be sensitive (such as date of birth) will be collected and processed, but only for research purposes in connection

with this study. The data processed will not include any names or anything that would enable you to be identified in any report or publication, nor could the data be traced back to you.

Coventry and Warwickshire Partnership Trust (who will control the use of the data) will take steps to ensure your personal data is protected. The researchers will adhere at all times to the Data Protection Act 1998. This study will be guided by and conform to NHS Research Governance Framework and COREC guidelines.

Your rights under any applicable data protection laws are not affected.

12. What will happen to the results of the study?

The findings of this research study will be used to inform other professionals treating patients with eating disorders. The findings of the study will be made available in September 2007. The results of the study will be published in clinically relevant journals. Details and findings of the study will also be placed on the Coventry and Warwickshire Partnership Trust's public web-site and the Department of Health's National Research Register. In all of these cases, information provided by participants will remain completely anonymous.

13. Who is involved in this research?

The research has been designed by the Head of Coventry Eating Disorders Service, Ken Goss (Consultant Clinical Psychologist), and the Chief Investigator, Alex Barrow (Trainee Clinical Psychologist from the University of Leicester).

14. Who has reviewed the study?

The study has been peer reviewed by an independent researcher from the Clinical Psychology Department at the University of Leicester and Warwickshire Research Ethics Committee.

15. Complaints

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, Coventry and Warwickshire Partnership Trust has the following Services open to you:

1. For the Trust Complaints Service contact:

Ms Daryl Raiwa
Complaints Officer
Complaints Department,
Christchurch House,
Greyfriars Lane,
COVENTRY

02476 602020 Ext: 6125

2. The Independent Complaints Advocacy (ICAS) is open to you:

The Independent Complaints Advocacy delivers a free, independent and professional advocacy support service to clients wishing to pursue a complaint about the NHS. It is not tied to or controlled by the NHS, enabling ICAS to work solely on behalf of its clients to get the resolution they want from the NHS complaints procedure. ICAS supports the aspirations of the NHS in improving the patient experience and works with NHS colleagues to promote positive change in the NHS, whilst maintaining the independence of the service.

Independent Complaints Advocacy Service (ICAS)
Coventry Citizens Advice Bureau
4th Floor, Coventry Point
Market Way
Coventry
CV1 1EA
Telephone: - 0845 1203748

16. **If you have any questions or queries, or would like to know more, about the study, please contact:**

Ms Alex Barrow
Chief Investigator
Coventry Eating Disorders Service
James Brindley House
Coventry Canal Basin
St Nicholas Street
COVENTRY CV1 4LY
02476 521130

THANK YOU FOR READING THIS.

PARTICIPANT CONSENT FORM VERSION 1 – September 2006

COREC Number	Patient Identification Number for this study:
Ethics Committee Approval Date:	
<p>Research Study Title: The Relationship Between Compassion, Shame, Symptoms and Diagnosis in the Eating Disorders, and the Impact of a Psycho-education Programme</p> <p>Name of Chief Investigator: Ms Alex Barrow ☎ 02476 521130</p>	

Please Initial

1. I confirm that I have read and understand the information sheet dated .../09/06 (Version No 1) for the above study and have had the opportunity to ask questions. _____
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care, mental health care, or legal rights being affected. _____
3. I agree and give consent to a copy of this Consent Form being place with my Medical records. _____
4. I understand that the information I give will remain confidential and that I will be given anonymity in any publication or reports that arise from the research. _____
5. I agree for my questionnaires, clinical and demographical information to be used in the above research study _____

Name of Participant

Date Signature

Name of Person taking consent
(if different from researcher)

Date Signature

Researcher

Date Signature