

Shame on You: Shame-Reduction Exercises in Treatment of Eating Disorders

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Nam ego illum periisse duco, cui quidem perit pudor

- Plautus

(translation: I count him lost, who is lost to shame).

Shame has been defined as “the intensely painful feeling or experience of believing we are flawed and therefore, unworthy of acceptance and belonging” (Brown, 2007).

Shame weakens resolve, dampens the spirit, and empties the soul. Shame is a bacteria that infects past life wounds to hinder their healing and to prevent recovery. Many clients with eating disorders have been taught that shame is adaptive and can affect change. In fact, many clients have been “shamed into trying to recover.” In turn, many of them “self-shame” to try to change their behaviors. However, shame is never constructive. Some therapists disagree with this premise and distinguish between “good shame” and “bad shame.”

Unfortunately, shame is never good. Guilt can be good, but not shame. Shame is the feeling that “I am bad” and guilt is the feeling that “I did something bad.” Guilt can be adaptive and motivate us toward pro-social behavior. However, shame paralyzes us and keeps us from moving forward.

What Causes Shame? Various theories on the causes of shame have been proposed. One theory is that negative messages from others become internalized in some way. Repeated shaming messages (e.g. “What is wrong with you?” “Don’t embarrass me!”) may develop into negative core beliefs (e.g. “I am defective” “I am bad” [Potter-Efron & Potter-Efron, 1999]). It has also been proposed that individuals who experienced the withdrawal of love as a punishment, or who lacked unconditional positive regard as children, are at higher risk for experiencing shame as adults (Potter-Efron & Potter-Efron, 1999). Love withdrawal and conditions of worth for misbehavior directly teach children that “they are bad” instead of teaching them that they did something bad. Also, individuals with low self-esteem may be at risk for developing shame. There is

some evidence that a foundation of poor self-worth creates a breeding ground for shame. For instance, individuals with low self-esteem may interpret experiences through a “shame lens,” which predisposes them toward shaming experiences.

Alternatively, individuals with poor self-worth may be drawn toward relationships that confirm their negative views of themselves, which perpetuates shame. Finally, parents who are ashamed of themselves may model feelings of shame for their children. Children emulate these feelings, which makes them likely to grow into adults who are prone to shame.

Shame and Eating Disorders. Women with eating disorders may be particularly susceptible to experience shame. First, shame is inextricably linked to body image, trauma, and aspects of appearance (Brown, 2007). For instance, in Western culture women are often taught that the female body in its natural form is “disgusting” and needs to be slimmed, tweezed, toned, tightened, or exfoliated. Women often feel that their bodies caused or contributed to the traumas they have experienced and may try to change their bodies to protect themselves from future abuse.

Secondly, individuals may use eating disordered behaviors to cope with shame feelings. They learn that they can temporarily numb shame by bingeing or purging, or that they can counteract or atone for their shame by restricting. The disorder is maintained through a cycle of eating disordered behaviors used in the avoidance of or protection from shame. Unfortunately, the avoidance of shame prevents processing of the emotion, which paradoxically results in heightened feelings of shame based on negative reinforcement. A similar process is observed in phobias when avoidance of the feared stimulus actually results in increased fear of that object.

Third, women with eating disorders often struggle with emotional intimacy and concerns about abandonment (Schwartz & Cohn, 1996). As such, they may go to great lengths to keep their attachments to others. This tendency may be related to the experience of shame. They may fear that

others will leave them, which will confirm their belief that they are “bad” and invoke feelings of shame. As the disorder escalates and they become more shame-avoidant, they may engage in more drastic behaviors (e.g., suicidal gestures) to avoid the shame secondary to possible abandonment. Finally, patients with eating disorders have often been silenced. They learn that it is safer to “stay quiet,” or that when they speak they are not heard. Often the eating disorder becomes their voice, but the eating disorder cannot speak of their shame. Locked in the behavior, these women lose the opportunity for shame-reduction through the sharing of the shameful event with a caring listener.

Experiential Exercises in Shame Reduction. Several exercises may be helpful in the treatment of shame and eating disorders. Most of these interventions are experiential, based on the idea that clients need to actually experience emotional activation and resolution to heal shame.

The Shame Game

This is an exercise to be used in a group therapy setting. The instructions to the group are for each participant to write down a shameful secret on a piece of paper. It is critical that everyone in the group uses the same type of paper and same color of pen to protect confidentiality. Ask group members to note the level of shame (on a scale of 1-10) associated with their secret. Participants are then instructed to ball up their paper and have a “snowball fight” with other group members. Let them throw the “snowballs” around for a minute or two, and then tell everyone to pick up the paper nearest to themselves. (It may be helpful to have some “extra secrets” included in the snowballs so that group members’ confidentiality is well-protected.) Make sure that group members do not have their own secret, and if they do, instruct everyone to throw them again until everyone has someone else’s secret. Have everyone in the circle go around, one at a time, and read the secret on the piece of paper, exactly as it is written with no feedback or comments. Have each group member then state how it felt to read that particular secret out loud. Make the guidelines specific, so there is no

commentary or judgment. For example, “When I read the secret, I felt (*feeling words only*) and in my body I noticed (e.g. *Tension in my neck, tightness in my jaw*). Have each participant then use the same criteria to referencing how it felt to have their secret read out loud. Then, have participants rate (on scale of 1-10) the level of shame they feel with the secret they read as compared to the secret they wrote down. Interestingly, most participants tend to rate their own secret as “more shameful,” than the secrets of others. It is usually helpful for group members to hear others also rate their personal secrets as more shameful, and to hear that their personal secrets are not as shameful to others.

Other questions to process as a group include:

- *How do secrets affect us internally and externally?*
- *Why do we carry them?*
- *Who told us to carry them?*
- *How does carrying them contribute to shame in each person and in the culture as a whole?*
- *How did they feel when they made the decision to get rid of it or to keep it? To own it or to continue to keep it a secret?*
- *What has the family rule been on secret keeping and why?*
- *What boundaries around secrets will be important in future relationships?*

To close the group you can ask anyone who would like to “own their secret” to retrieve it from whomever read it out loud. Once their secret is reclaimed, participants read it aloud to the group. Ask them to repeat the above criteria after reading it, and to also rate it on the 1-10 scale, processing any differences in the numbers. At this point, have a ceremony to symbolize bringing the secrets to the light. This could be anything from a burning, to a shame container where past residents’ secrets are left behind, to a burial of the past. It is best to allow each individual to decide how she wants to symbolize the event. Ask for another “shame rating” after the ceremony, processing any changes.

The exercise can be further processed by discussing the meaning of the AA phrase

“We are only as sick as our secrets” and how it relates to this exercise.

Shame Assessment - Negative Cognition Questionnaire, Initial Form (Sine & Vogelmann-Sine, 1995)

This tool can be used to assess clients’ shame levels and categories of their shame. Based on the assessment, a top five “shame categories” can be identified. Most women fall into one of several different shame categories, which can be helpful in formulation and treatment planning:

1. “I am a bad person. I am powerless.” These clients often have trauma histories. It is often helpful to assist these patients in a shift from viewing their eating disorder as empowering to viewing recovery as empowering. This can often be accomplished by processing the consequences of the eating disorder and its “broken promises,” while reinforcing small successes in the recovery process to increase self-efficacy.
2. “I am unworthy of love. I am undeserving. I am only loveable if I am perfect.” (These clients often have abandonment issues, more severe body image disturbance, relationship problems, increased anxiety, low self-worth, and perfectionism. These issues may need to be addressed early in therapy for a more positive treatment outcome.
3. “I am incapable of making good choices. I should have. If I would have. If only.” In our experience, these clients have not been allowed to make their own choices. These patients really struggle with believing that they can recover. It is often more shaming to tell these individuals early in recovery, “You have a choice to recover.” The thought of a lifetime of choices often feels like a death sentence in early recovery to this group.

After shame categories are identified, the therapist can complete a body scan to determine where these core beliefs exist in the client’s body and how it relates to her specific eating disorder symptoms.

Example:

Patient: I feel like a brick is in my chest.

Therapist: What do you want to do with that brick?

Patient: I want to get it out.

Therapist: Do you ever feel similar feelings in relation to your bingeing and purging?

Awareness of types of shame and the relationship between eating disorder symptoms and shame can assist clients in recognizing the origin of their symptoms and triggers for their symptoms.

Shame Spiral

A shame spiral occurs when a person moves from believing that she made a mistake to believing that she is a mistake. Basically, a shame spiral is the progression from guilt into shame. Diagramming the spiral can assist clients in identifying the process of shame. Start with the action (e.g. “I walked into the office and my boss and her boss were talking in whispers, but when they saw me, they quit talking.”). First belief: “I must have done something wrong.” Then the somatic shame symptoms hit (e.g. flushed face, racing heart, stomach is queasy, eyes cast downward). This is a key part of the empowerment process for clients, because identifying their somatic symptoms can help them identify that they are in a shame spiral. At this point, the client can learn to stop the spiral before it progresses to the next belief. Toxic Shame Belief: “I am bad, worthless, powerless. I am about to get fired because they stopped talking when I walked in. They finally figured out I am a fraud. I better go and clear out my desk.” The diagram of the shame spiral helps clients differentiate between guilt and shame and distinguish between situations and identity.

Sharing the Story of the Eating Disorder

This exercise can be particularly effective during multi-family groups or can be used in a general group therapy session. Clients share with other group members and/or family members the behaviors of their eating disorder associated with shame. Although the exercise of sharing the eating disorder story with families and other group members may appear “shaming” on the surface, it tends to be freeing, cathartic, and empowering for clients. We use this group to begin the work of separating the person from her disorder, and one of the first steps is to betray the disorder’s secrets. We begin the group with words from *The Invitation* (Dreamer, 1999): “Shame relaxes its paralyzing grip on us when we take responsibility for our mistakes and the sometimes serious consequences those mistakes can have for ourselves and others.” Clients read their stories and may ask for feedback from

a group member other than their family member. This exercise creates unity among clients, allows families to obtain a better understanding of the impact of the disorder, and empowers clients to take the next step in the recovery process.

Shame is a debilitating emotion that is often at the core of eating disorders. The interventions shared in this article can assist therapists in treating shame issues associated with eating disorders and allow clients to gain a better understanding of shame and its development and consequences. With these tools, clients can begin to cleanse shame-related wounds to promote complete healing and recovery.

References

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Sexuality and Eating Disorders

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The purpose of this article is to explain and describe the clinical techniques useful in helping patients give an accurate account of the sexual dimensions of their lives. With regard to eating disorders, working to understand patients' sexual dimensions can be particularly useful. This is not a topic that must be addressed in every treatment or for every patient, nor should it necessarily be addressed early in treatment. Sexuality can be a controversial topic, lying, as it does, at the intersection of body, power, sex and gender roles, and vulnerability. That many of our patients have endured sexual coercion or abuse also makes the topic somewhat risky. But this topic has been little explored in our literature and this aspect of our patients' emotional and physical lives deserves more attention and discussion. Much research has been offered regarding early childhood sexual trauma and whether that trauma may be a contributing factor to the development of an eating disorder. While I appreciate the value and integrity of this research, this article will have an entirely different focus. I believe sexuality

and eating disorders share important links and some common themes. With attention given to clinical considerations and age appropriateness, the integration of sexuality issues with the treatment of a presenting eating disorder can enhance the quality and content of therapy.

From puberty forward, sex is an influential part of life. No one can ignore the hormonal impact of sexual maturity, nor can anyone escape the cultural invasion ushered in by the media and peers. Sexuality is a powerful part of our identity. How one feels about his/her sexuality, and how one expresses sexuality through behavior, is the result of a complex integration of genetics, biological drive, and cultural influences.

Sex and eating are fundamental aspects of our humanity and both are critical for survival. Personal appetites and interest with both sexuality and food are things which are "discovered" rather than purposely planned. Individuals develop food preferences and aversions which just seem to emerge into one's awareness. Such appetites and

aversions can be described but one can almost never give precise cause and effect explanations as to their roots.

Food-related behaviors and sex-related behaviors are frequently used to help manage emotional distress. When excesses occur in either arena, the result may be compulsive sexual activity or an eating disorder. This is not to suggest that food-related behaviors and sex-related behaviors are inevitably connected or dependent on one another, but sex and eating do share an important feature: they both often exist in a realm of secrecy. Personal secrets are kept to avoid consequences and/or ridicule from others, usually significant others. And, whenever personal secrets are present, so is the emotion of shame.

Another powerful link between eating disorders and sexuality is body image. By applying the principles of cognitive therapy and the concept of self-spectating as described by Masters and Johnson, we can define three terms:

Body Image – what one thinks the size and form of their body is.