The Prevalence of Secrecy in Eating Disorders

by

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ABSTRACT

Eating disorders have become widespread during the past few decades, especially amongst young adolescents. The two most common types of eating disorder are anorexia nervosa, which involves self-starvation and fears of gaining weight, and bulimia nervosa, which involves excessive eating (bingeing) and compensatory behaviors to get rid of food (purging). Many eating disordered behaviors, such as starvation and bingeing and purging are done in secret. Some studies demonstrate a correlation between eating disordered behavior and secrecy, but this relationship has not been explored thoroughly.

Research studies have found that there may be a variety of secretive thoughts and behaviors that can have an impact on the formation and maintenance of an eating disorder. These factors include a lack of self awareness (Barry, 1992; Vitousek, Watson, & Wilson, 1998), denial (Vitousek et al, 1998), secrecy (Smart & Wegner, 1999), family secrets (Imber, 1993), and a person's readiness to change (Gusella, Butler, Nichols, & Bird, 2003; Prochaska, DiClemente, & Norcross, 1992). Although these factors may play a role in the prominence of an eating disorder,

no conclusive relationships have been found between levels of secrecy and eating disordered behavior.

This research paper will review the literature regarding the possible relationship between secrecy and eating disorders. In addition, a method will be proposed for carrying out a research study that addresses whether a relationship exists between levels of secrecy and the prevalence of eating disorders.

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CHAPTER I: Introduction

The occurrence of eating disorders has increased dramatically in our society during the past few decades (Office on Women's Health [OWH], 1999). Eating disorders are defined as "severe disturbances in eating behavior," according to the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition-Text Revision, or DSM-IV-TR (American Psychiatric Association [APA], 2000, p. 583). Three main types of eating disorders exist: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified. To date, researchers have not been able to identify what causes eating disorders. Many speculate that weight gain in adolescence, low self-esteem, perfectionism, media messages of thinness, and excessive concern over body appearance all contribute to the development of an eating disorder (Phelps, Sapia, Nathanson, & Nelson, 2000). Females are much more likely to develop an eating disorder than males. Females account for 85 to 95% of people with anorexia or bulimia, and account for 65 percent of people with eating disorders not otherwise specified (National Institute of Mental Health [NIMH], 2001).

The symptoms and characteristics of anorexia, bulimia, and eating disorder not otherwise specified vary significantly from one another. As stated in the DSM-IV-TR, anorexia nervosa is "characterized by a refusal to maintain a minimally normal body weight" (APA, 2000, p. 583). People with anorexia have an intense fear of gaining weight and see themselves as overweight, even though they are dangerously thin (NIMH, 2001). The intense fear of becoming fat is not alleviated by weight loss. In fact, "concern about weight gain often increases even as actual weight continues to decrease" (APA, 2000, p. 584). Self-esteem in people with anorexia seems to be dependent on their body weight and shape. When weight is lost, they see this as an achievement. When weight is gained, they perceive this as a failure. Many persons with anorexia

deny the seriousness of their health. They do not have insight into their problem and have considerable denial of their malnourished state. Anorexia often begins in early to late adolescence. Persons with anorexia develop unusual eating habits, such as avoiding food and meals, eating only certain foods, and carefully measuring and portioning food. Other disordered behaviors include frequent weighing, measuring body parts, compulsive exercising, and, for some, purging by means of vomiting, using laxatives, enemas, or diuretics.

According to the DSM-IV-TR, bulimia nervosa is characterized by repeated episodes of binge eating followed by inappropriate compensatory methods to prevent weight gain. These compensatory behaviors include self-induced vomiting, fasting, excessive exercise, or misuse of laxatives, diuretics, or other medications (APA, 2000). Vomiting is the most common method of purging and is employed by 80 percent of people with bulimia. Binges are often triggered by negative mood states, stress, or intense hunger following dietary restriction. Persons with bulimia usually weigh within the normal range for their age group. However, like those with anorexia, people with bulimia fear gaining weight and feel dissatisfied with their bodies (NIMH, 2001).

People with bulimia are often ashamed of their eating disorder and strive to keep their symptoms, including bingeing and purging, a secret. A binge is defined as "eating in a discrete period of time an amount of food that is definitely larger than most individuals would eat under similar circumstances" (APA, 2000, p. 589). Binges are often triggered by negative mood states, stress, or intense hunger following dietary restriction. Frequent vomiting often leads to permanent loss of dental enamel and an increase of cavities. Many people with bulimia also develop calluses or scars on their hands due to repeated trauma from the teeth. Bulimia nervosa is a serious disorder and can cause many physical complications if not identified and treated.

The category of eating disorder not otherwise specified includes eating disorders that do not meet the criteria for anorexia or bulimia. Examples of disordered eating behaviors that would qualify in this category are chewing and spitting out food, binge-eating without purging, and using compensatory behavior, such as vomiting or exercising, after eating small amounts of food (APA, 2000). Individuals who do not qualify for anorexia or bulimia may be diagnosed under this category if their behaviors are similar to someone with anorexia or bulimia, but are not as severe.

Eating disorders can be extremely difficult to assess and diagnose. Generally, medical physicians, psychologists, and psychiatrists diagnose eating disorders. Since people with eating disorders tend to be secretive about their thoughts and behaviors, the disorder will likely be first recognized by a parent, teacher, or friend (Natenshon, 2002). Early signs of eating disorders can be seen in a person's appearance, affect, thinking, learning capacity, and work ethic. The most obvious sign of an eating disorder is rapid weight loss. People with eating disorders may skip lunch, refuse to eat in front of others, and chew gum or drink water excessively. In addition, they will often seem depressed, fatigued, and withdrawn. If a friend or family member recognizes these symptoms in someone, they are encouraged to refer the person to a doctor or psychologist for evaluation and treatment.

Many treatment programs are available for persons with eating disorders. These treatment programs focus mainly on medical monitoring and psychotherapy (National Eating Disorder Association, 2004). Physicians monitor medical concerns and prescribe necessary medications, while psychotherapists and nutritionists serve as a source of support and information regarding weight, body shape, and eating. During treatment, the person with an eating disorder works on gradually changing disordered thoughts and behaviors into more healthy thoughts and behaviors

(Phelps & Bajorek, 1991). Psychotherapy and medical treatment have been found to be very successful, as they are able to produce lasting improvements in healthy eating and body attitude (Wilson, 2000).

Although eating disorders have existed for many centuries, they have only been studied during the past few decades. Research on eating disorders has begun to explore the connection between eating disorders and secrecy. Many eating disordered behaviors, such as starvation, bingeing, and purging are done in secret. Research has shown that a variety of factors contribute to the concealment of an eating disorder. These factors include the lack of self awareness (Barry, 1992; Vitousek, Watson, & Wilson, 1998), denial of an eating disorder (Vitousek et al., 1998), secretive thoughts and behaviors (Smart & Wegner, 1999), family secrets (Imber-Black, 1993), and a person's readiness to change (Gusella et al., 2003; Prochaska et al., 1992). These studies demonstrate a correlation between eating disordered behavior and secrecy levels, but this relationship has not been explored thoroughly. Currently, there is a lack of knowledge on the relation between secrecy in eating disorders and much still remains to be discovered.

Rationale

Eating disorders have become more widespread in our society, especially amongst adolescents. Because of the growing number of people affected by eating disorders, it is important for school personnel and parents to be informed about the prevalence, behaviors, and risks associated with eating disorders. Eating disorders can be dangerous and life threatening. To help prevent and treat these disorders, continued research is necessary. Much is unknown about the etiology of eating disorders and research on the topic will be beneficial to the ongoing examination of eating disorders. Research can help professionals, as well as the general population, have a more complete understanding of eating disorders and of the relationship

between secrecy and eating disorders. If a relation is found between secrecy and disordered eating, this information may provide helpful clues into the etiology, prevention, and treatment of eating disorders.

Purpose Statement

The purpose of the study is to examine the relationship between levels of secrecy and the prevalence of eating disorders. Further, the methodology of a future study regarding secrecy levels and eating disorders will be presented.

Research Questions

The following questions will guide this research paper:

1. What are the diagnostic criteria for an eating disorder?
2. Are persons with eating disorders aware of their disordered thoughts and behaviors?
3. What is the role of denial in eating disorders?
4. What is the role of secrecy in eating disorders?
5. Do families play a role in the formation or maintenance of an eating disorder?
6. What helps and hinders recovery from an eating disorder?

Definition of Terms

Amenorrhea: The absence of menstrual cycles.

Anorexia nervosa: Purposeful weight loss beyond normal range. Characteristics include fear of being fat, perfectionism, excessive exercise, ritualistic eating patterns, and disturbance of body image. Anorexia nervosa is classified into two types: (1) the restricting type and (2) the binge eating/purging type.

Binge: Rapid consumption of high-calorie foods.

Bulimia nervosa: An emotionally based disorder in which bingeing and purging is a response to distress in an individual's life.

Eating disorder: Anorexia nervosa or bulimia nervosa.

Purge: Act of getting rid of consumed food by vomiting, using laxatives, or diuretics.

Methodology and Limitations of the Study

This paper will consist of a literature review on the relationship between secrecy and eating disorders and propose a methodology which will be used to explore the relationship between levels of secrecy and eating disordered thoughts and behaviors. The proposed study will be correlational in design. Correlational studies are unable to determine causation of any factor. Since the topics of study are sensitive subjects (eating disorders symptoms and secrecy), honest responses may not be elicited. Even though these limitations exist, the research is intended to help practitioners, educators, and parents better understand the prominence of secrecy in eating disorders. This information will hopefully contribute to a more complete understanding of the role of secrecy in eating disorders.

CHAPTER II: Literature Review

Little research has been conducted on the role of secrecy in eating disorders. Eating disorders are a relatively new research topic. Although eating disorders have existed for many centuries, they have only been identified and studied during the past few decades. The DSM-IV-TR (APA, 2000) currently lists specific criteria that individuals must meet in order to be diagnosed with an eating disorder. The diagnostic criteria will be addressed, as well as research findings on eating disorders. Of the research that has been conducted, several major themes have emerged. These themes include the lack of self-awareness in persons with eating disorders, the presence of denial, the presence of secrecy, the occurrence of family secrets, and varying levels of readiness to change behavior patterns of an eating disorder. Through these studies, the topic of eating disorders and secrecy has begun to be explored.

Diagnosing Eating Disorders

Eating disorders are generally diagnosed by a medical professional, including physicians, psychologists, and psychiatrists. In order to diagnose an eating disorder, certain criteria must be met using the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition-Text Revision (DSM-IV-TR). There are separate diagnoses for anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified.

Anorexia nervosa. The essential features of anorexia nervosa are the refusal to maintain a normal body weight, the fear of gaining weight, and a disturbance in the perception of body shape and size. Another common feature is amenorrhea, the absence of menses. The diagnostic criteria for anorexia nervosa outline these essential features:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that

expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration) (APA, 2000, p. 544-545).

As outlined in the DSM-IV-TR diagnostic criteria, there are two subtypes of anorexia nervosa: the restricting type and the binge eating/purging type. The restricting subtype of anorexia is defined by the absence of binge eating and purging behavior. An individual's weight loss is accomplished mainly by dieting, fasting, or excessive exercise. The second subtype, binge-eating/purging type, is defined by the presence of binge eating or purging (or both).

Bulimia nervosa. According to the DSM-IV-TR, "the essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain" (APA, 2000, p. 545). The diagnostic criteria for bulimia nervosa outline these essential features:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa (APA, 2000, p. 549-550).

As outlined in the DSM-IV-TR diagnostic criteria, there are two subtypes of bulimia nervosa: the purging type and the nonpurging type. The purging subtype of bulimia is defined by "regularly engaging in self-induced vomiting or the misuse of laxatives, diuretics, or enemas" (APA, 2000, p. 550). The nonpurging subtype is defined by using "other inappropriate compensatory behaviors, such as fasting or excessive exercise," but not engaging in vomiting or the misuse of laxatives, diuretics, or enemas (p.550).

Eating disorder not otherwise specified. The category of eating disorder not otherwise specified is for eating disorders that do not meet the criteria for anorexia or bulimia. There are no specific criteria in this category, but examples of disordered eating patterns are given to aid in the identification of persons with this disorder. The examples of disordered eating patterns are as follows:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.

2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge Eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual normal body weight after eating small amounts of food (e.g. self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa (APA, 2000, p. 550).

The diagnostic criteria for anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified are quite specific in order to properly identify and diagnose individuals with eating disorders. The identification of persons with eating disorders can often be difficult, as people with eating disorders tend to be secretive about their thoughts and behaviors. Many even deny they have a problem or may not be aware of the seriousness of their disorder.

Self-Awareness

Often, people with eating disorders have little awareness of their disorder. Many deny that there is any problem. One of the diagnostic symptoms of anorexia nervosa is the presence of denial (Barry, 1992; Vitousek, Watson, & Wilson, 1998). Patients with anorexia often believe there is nothing wrong with their eating. They claim not to experience hunger. Bruch (1978) stated that anorexic patients may have such chronic levels of malnutrition that their bodies

undergo biochemical changes which influences their ability to think and feel. According to Bruch, persons with eating disorders are unable to recognize their true feelings of hunger because they are in a nearly toxic state. Starvation makes it nearly impossible for anorexic patients to accurately appraise their condition (Vitousek et al., 1998). People with anorexia often refuse to acknowledge their illness, thinness, fatigue, and disordered eating behaviors. In fact, they take pride in their ability to maintain unhealthy thinness and feel superior to persons of natural weight.

In contrast to people with anorexia, people with bulimia are more willing to admit they have an eating problem (Vitousek et al., 1998). Bulimic individuals are aware of their disordered eating and are often distressed and ashamed by their behavior. They are often reluctant to talk about their behaviors with others. Hornbacher (1998) wrote an autobiography which describes the shame and embarrassment that bulimic individuals experience. In Hornbacher's words, "their self-torture is private, far more secret and guilty than is the visible statement of anoretics..." (p. 153). Although people with bulimia are aware of their eating disordered patterns, they are often unable to explain what triggers a binge. They are also unable to describe their internal state before, during, and after binging and purging (Roberto, 1993). As a result, bulimic individuals may have no self-awareness during their bulimic behaviors. Cultural knowledge about bulimia has become widespread in the past few decades and bulimia has become more recognized as an illness. Bulimic patients today, when compared to bulimic individuals of the past, are more willing to talk openly about their behavior with others (Habermas, 1992). However, they often remain ashamed about their behavior. Both anorexic and bulimic persons are often hesitant to talk about their eating disorders and sometimes even deny there is any problem.

Denial of an Eating Disorder

Even though some people with eating disorders are willing to admit they have a problem, many still deny the severity of the disorder. Little research has been conducted on the prominence rates of denial in eating disorders. Reported rates of denial range from 15 to 80% (Vitousek et al., 1998). Meyer (2001) reported that of 238 surveyed high school females, most females with moderate to severe eating disorders stated that their behaviors were "not problematic enough to merit counseling" (p. 23). When participants with moderate eating disorders were asked why they avoided counseling, 50% answered that the problem was not worrisome to them, 35% believed they did not have a problem, and 21% did not want anyone to know about their problem. When females with severe eating disorders were asked why they avoided counseling, 40% responded "I don't want anyone to know." When the moderate and severe eating disordered groups were compared, the women in the severe group were much more secretive about their problem. After analyzing the data, it was found that women with severe eating disorders were more reluctant to let others know about their problem.

Denial is often used as a mechanism to preserve the symptoms of an eating disorder. By denying the problem, attention is not called to their behavior. "Individuals [with eating disorders] may never come to the attention of treatment personnel if their denial is sufficiently persuasive, their opposition sufficiently forceful, or their lives sufficiently isolated that significant others fail to intervene on their behalf" (Vitousek et al., 1998, p. 394). Although denial plays a large role in the early stages of an eating disorder, levels of denial may decrease once treatment is undertaken. Vitousek, Watson, and Wilson (1998) interviewed former anorexic females and found that 72% denied anything was wrong in the early months or years of their eating disorder. This percentage

is most likely an underestimate of the occurrence of denial, since the women all volunteered to discuss their symptoms and may represent "an unusually candid subset" (p. 395).

Many people who deny having an eating disorder believe, on some level, that their behavior is normal. Besides their abnormal eating behaviors, most people with eating disorders lead otherwise normal lives. Hornbacher (1998), who wrote an autobiography of her experiences with anorexia and bulimia, stated that she often felt normal growing up despite having an eating disorder. During her adolescent years, she had friends, crushes, and a normal school life. When comparing these aspects of her life to others, she believed she led a fairly "normal" life. After years of disordered eating, Hornbacher states that she essentially forgot what "normal" was. To her, having an eating disorder was normal because it was such an integral part of her life for many years. Due to her feeling of normalness, Hornbacher felt that her eating disorder was not a huge threat to her identity and she maintained the behaviors during much of her childhood and adolescence. Hornbacher, like many people with eating disorders, maintained denial throughout the course of her eating disorder. Denial has been found to be a common phenomenon in persons with eating disorders.

Secrecy in Eating Disorders

Secrecy seems to play a large role in the lives of people with eating disorders. People are often able to keep their eating disordered behaviors a secret from others. According to Smart and Wegner (1999), eating disorders are "concealable stigmas" because they can be kept hidden. In their 1999 study, Smart and Wegner asked a random sample of female college students to role-play a person either with or without an eating disorder. Participants with an eating disorder who role-played not having an eating disorder reported feeling more secrecy and thought suppression. Results showed that people who are secretive tended to think about their eating disorder more

often than people who did not conceal their eating disorder. Smart and Wegner believe that by keeping their eating disorder a secret, people trigger further thoughts about the disorder, and it becomes a prominent area of mental focus.

Related to secrecy, a lack of openness in relationships has been found to correlate with eating disorders. Evans and Wertheim (1998) found that women with greater eating problems had more difficulties in intimate relationships. This included "less satisfaction, less closeness, and less comfort in close intimate relationships, and less positive descriptions of friend and mother" (p. 355). The study indicated that persons with eating disorders experienced difficulties relating to friends, romantic partners, and parents. Intimacy difficulties were most prevalent in bulimic women. Women with eating disorders scored low on scales of closeness and dependence, indicating that they avoid closeness and mistrust others. Even when a person recovers from an eating disorder, secrecy may still abound. Some may share their story with others, but many keep their experiences a secret. Hornbacher (1998), a recovered eating disorder patient, wrote an autobiography about her experiences with both anorexia and bulimia. In her book, she states:

> I have not enjoyed writing this book. Making public what I have kept private from those closest to me, and often enough from myself, all my life, is not exactly my idea of a good time.... After a lifetime of silence, it is difficult then to speak. (p. 275)

Due to the fact that people with eating disorders remain secretive and ashamed for so long, it is difficult for them to speak about their experiences, even once they have recovered.

If a person's eating disorder remains a secret, the symptoms of the disorder are likely to worsen. "When symptoms are kept secret, most often it is because shame and stigma are attached

to the particular symptom. Such shame engenders secrecy, which, in turn, engenders a deepening sense of shame" (Imber-Black, 1993, p. 14). When a person with an eating disorder maintains secrecy, he/she disconnects and isolates from others, which helps to maintain eating disordered symptoms (Tantillo, Nappa Bitter, & Adams, 2001). When patients enter therapy for an eating disorder, they are encouraged to disclose information about their eating disorder. Through self-disclosure, the secretiveness of an eating disorder becomes less prevalent (Imber-Black, 1993). However, the secrecy of an eating disorder does not seem to completely end once the behavior has been disclosed. People with eating disorders are often unwilling to talk about their problem, thus upholding the secrecy.

Family Secrets

Familial factors are somewhat related to the presence of an eating disorder. Most anorexics come from small families in stable, upper class homes (Bruch, 1978). The parents of an anorexic person often expect great things from him/her, leading the anorexic person to also expect greatness from him/herself. When a child in the family develops an eating disorder, family members typically report that this is the "only flaw" in their family. They seek to maintain a good image of the family, which leads to secrecy regarding the eating disorder. Once family members begin to keep secrets, both related and unrelated to the eating disorder, trust erodes within the family (Imber-Black, 1993). If a person with an eating disorder is not able to confide in family members, then he/she will most likely continue to remain secretive and absorbed by the eating disorder. Lieberman (1989) conducted a case study on a family with four bulimic children. Of the four children, three of them were very secretive about their behavior and did not confide in their parents. Lieberman found that the son who chose to confide in his parents was the only child who no longer displayed bulimic symptoms. Persons with eating disorders

often do not confide in family members and uphold secrecy, which often seems to maintain eating disordered behaviors.

Stages of Change

In any mental illness, there are thought to be five stages of recovery. Each stage represents a different motivational level (Gusella, Butler, Nichols, & Bird, 2003). The five stages include the precontemplation stage, in which the behavior is not recognized as a problem; the contemplation stage, in which the problem is recognized but no action is taken to resolve the problem; the preparation stage, when the person intends to take action within the next month; the action stage, in which the person begins to change his/her behavior; and the maintenance stage, when the person maintains his/her changed behavior and works on preventing relapse. These stages of change are collectively known as the trans-theoretical model. Although the model was originally used to explain motivation change in people with substance abuse problems, it has been widely used to describe people with eating disorders.

A key issue in the successful treatment of persons with eating disorders is whether an individual is ready and willing to change (Gusella et al., 2003). Associated with readiness to change is a person's motivation to recover from an eating disorder. In the trans-theoretical model, people are thought to move through a series of stages in which their readiness and motivation to change increases.

In the first stage of the trans-theoretical model, people with eating disorders have no intentions of changing and are not motivated to make improvements in their eating behaviors. Many are unaware of their disordered eating, or may even be proud of their eating patterns (Prochaska, DiClemente, & Norcross, 1992). This beginning stage is called the precontemplation

stage. Individuals in this stage do not voluntarily enter treatment, for they have no internal desire to change their behavior.

The stage which follows the precontemplation stage is the contemplation stage. During this phase, people are aware that a problem exists and are considering changing their disordered eating behaviors. However, they have not yet made any commitments to take action. People in this stage appear to struggle with the pros and cons of keeping an eating disorder. Eating disorders can become addictive, and a great amount of effort and energy is needed to overcome the problem. People in the contemplation stage want to overcome their eating disorder, but have not yet committed to taking action. People can remain in this stage for many years.

The next stage that people pass through on the road to recovery is the preparation stage. Individuals in this stage have true intentions to take action against their eating disorder. They are able to make small behavioral changes, but are unable to completely conquer their disordered eating patterns. However, they fully intend to continue taking action and are motivated to overcome their eating disorder.

The next stage is the action stage, in which individuals significantly modify their behaviors. This stage requires considerable commitment and energy. People are considered to be in the action stage if they have altered their behavior during a period of from one day to six months. According to Prochaska, DiClemente, and Norcross (1992), "successfully altering the addictive behavior means reaching a particular criterion, such as abstinence [from eating disordered behavior]" (p. 3). In order to be classified in the action stage, people must make overt behavioral changes and be fully successful in altering their behavior.

The fifth and final stage in the trans-theoretical model is the maintenance stage. During this stage of recovery, individuals continue to take action against their eating disorder and

consistently remain free of eating disordered behaviors. They work to prevent relapse into their eating disordered thoughts and behaviors. In order to be classified in the maintenance stage, an individual must remain free of the eating disorder for at least six months. During this time, they continue to work on strengthening new eating behaviors and avoiding relapse.

Although people with eating disorders move through these five stages of recovery, they often do not move through the stages in a perfect linear sequence (Prochaska et al., 1992). People often make gains, then relapse into eating disordered behaviors and recycle through the stages. "...Most people taking action to modify addictions do not successfully maintain their gains on their first attempt" (Prochaska et al., 1992, p. 3). Each time people recycle through the stages, they are able to learn from their past mistakes and try something different in the future. Even with relapses and setbacks, people with eating disorders can successfully move through the five trans-theoretical recovery stages and begin the road to recovery.

The stage that an individual is currently in can affect the effectiveness of treatment attempts. In the early stages of an eating disorder, people often deny any problems and resist any change in eating patterns. They maintain secrecy about their eating disorder and also disconnect and isolate from others (Tantillo et al., 2001). This behavior helps to maintain eating disordered symptoms. If people are treated during these early stages, success in treatment is minimal. When people enter treatment at a higher stage, they are more likely to make significant changes in their behaviors (Prochaska et al., 1992). They are more motivated to change their eating disordered behaviors and are willing to put forth commitment and effort. Individuals in a higher stage are often more open in their disclosures with others. They are willing to evaluate themselves and experience their emotions and feelings (Prochaska et al., 1992). When people enter therapy for an eating disorder, they are often encouraged to disclose information about their eating disorder.

Through therapeutic sessions and self-disclosure, the secretiveness of an eating disorder becomes less prevalent (Imber, 1993).

Gusella et al. (2003) arranged for 34 adolescent girls to meet weekly in a group setting for nine weeks. The purpose of the group was to encourage the girls to disclose information about their eating disorders in order to obtain support from other group members. Before the group began and after the group ended, the girls took questionnaires which assessed their readiness to change their eating disorder. Gusella found that girls who entered the group at a more advanced stage reported greater gains. Those who began in the precontemplation stage were least likely to change their attitudes, whereas those who began in the action stage reported greater changed attitudes in body satisfaction and motivation to change. Although all participants reported benefits from the group therapy, those in higher stages reported a greater change in motivation and readiness.

People with substance abuse problems and people with eating disorders are often compared because each group has a high resistance to treatment and are often unmotivated to change (Feld, Woodside, Kaplan, Olmsted, & Carter, 2000; Vitousek et al., 1998). Prochaska et al. (1992) studied smokers in different stages of change who were placed in self-help treatment programs over two years. Prochaska et al. reported that an individual's initial stage was related to the amount of success that he/she made in treatment. When people began therapy in the action stage, 94% were not smoking in a six month follow up. In contrast, no significant behavioral changes were made in people who began the program in the precontemplation and contemplation stages. People's stage of change was a good predictor of their success in the program; it was a better predictor than age, socioeconomic status, problem severity, and goals and expectations (Prochaska, 1992).

From these previous studies on readiness and motivation to change, it was concluded that treatment interventions were most successful when a person has a high level of motivation and readiness to change (Prochaska et al., 1992). Although treatment can help all persons to progress through the five stages of change, treatment was most successful when the person entered treatment with some level of motivation to change. Persons with eating disorders are able to recover, but it takes a tremendous amount of time, energy, and effort. The process of recovery is difficult, but attainable.

Critical Analysis

The literature on secrecy in eating disorders provides insight into the commonness of secretive thoughts and behaviors in eating disorders. A number of factors associated with secrecy are often found in persons with eating disorders. These include lack of self awareness, denial of the problem, secrecy regarding eating patterns, family secrets, and the lack of motivation to change. These secretive patterns seem to maintain eating disordered patterns and hinder the recovery process. People with eating disorders are able to recover from the disorder, but it takes genuine motivation and willingness to change. Secretive conduct interferes with the process of recovery by cognitively and emotionally disconnecting the person from treatment.

The research on eating disorders and secrecy raises counseling and clinical issues. Several themes seem to emerge from the collective data, including the underlying presence of denial and shame, the effects of secrecy on relationships, interference of secrecy in recovery, and changes in secrecy through recovery. These themes have implications for treating persons with eating disorders. Secrecy seems to plays a large role in eating disorders and persons with eating disorders often maintain secrecy throughout the course of the disorder. Using this knowledge,

professional health care providers may be able to create effective treatment plans to confront these issues.

Often, people with eating disorders (specifically anorexia nervosa) have little awareness of the severity of the disorder and may even deny that they have an eating disorder. This denial seems to interfere with recovery. People may believe there is nothing wrong with their eating and deny their eating disorder to their therapist or psychologist. Without insight into their eating disorder, people are unlikely to fully benefit from treatment. Therapists can strive to help the person understand the abnormality of their behavior. With time, therapists may be able to increase awareness and encourage positive change in disordered behaviors.

Along with denial, shame seems to be an underlying issue in eating disorders. People are often embarrassed and scared to tell others about their eating disordered behaviors. Specifically, persons with bulimia seem to be most ashamed of their eating patterns of bingeing and purging (Vitousek et al., 1998). People with eating disorders seem to recognize that their behaviors appear illogical, or even vulgar, to others. To avoid feeling shame and embarrassment, they strive to keep their eating patterns a secret. When treating a person with an eating disorder, therapists should be aware of the shame that underlies eating disorders. People may be unwilling to divulge information to the therapist because their behavior embarrasses them. If the therapist approaches therapy with a non-judgmental attitude, this could foster more open and honest communication between therapist and client. If therapists recognize that people often feel shameful about their behavior, they can address this in therapy and strive to help clients overcome their shame and their disordered eating patterns.

People with eating disorders seem to go to great lengths in order to keep their behaviors a secret from their friends and family. Perhaps because they are ashamed by their behaviors, they

avoid conversations and contact with others. This isolation most likely impairs relationships with both family and friends. Open communication seems absent in a person with an eating disorder. Relationships with family and friends become distant because of the great amount of secrecy. As a result of their high levels of secrecy, people with eating disorders seem to lack closeness with others (Evans and Wertheim, 1998; Tantillo et al., 2001). They are unwilling to divulge information about their personal lives, thus leading to distanced relationships. The eating disorder seems to be a higher priority than relationships with family members and friends. When people remain secretive and isolated from others, they fail to maintain healthy relationships.

If relationships are strained, then friends and family are most likely not aware of the severity of the disorder and are unable to provide adequate support. Friends and family may not think there is a problem and, therefore, will not interfere with the person's lifestyle. People with eating disorders seem to isolate themselves from others in order to maintain eating disordered patterns. If no one is aware of the presence or the severity of the disorder, then the person with the disorder is able to continue engaging in eating disordered behaviors. By upholding secrecy in the eating disorder and avoiding close relationships with others, the person seems to be protecting his or her eating disorder.

Disclosing information about an eating disorder seems uncomfortable for most people. It is difficult for people to talk openly about their eating disorder, as they are often ashamed of their behavior. However, this disclosure seems to help people fight their eating disorders. By letting others know about the eating disorder, a support system is created. Family and friends can help by challenging disordered thoughts and behaviors. If therapists recognize the importance of disclosure, they can encourage clients to talk openly with others about their disorder. This will enable the person to create close relationships with others and allow friends and family to help

them in their fight against the eating disorder. People may initially be reluctant to share their thoughts and feelings with family or friends. However, if the therapist highlights the positive aspects of self-disclosure, the client will hopefully become more willing to disclose to others and begin to build healthy relationships.

People seem to be in different stages in regard to their motivation to change their eating disordered behaviors. Often, when an eating disorder begins, people are not willing to seek treatment. However, after time, many are able to see that their behaviors are problematic and are more willing to put forth effort into their recovery. It seems that when people are in a higher stage, they are more willing to accept help and to disclose information to their secrets to family, friends, and professional health care providers. Their secrecy levels seem to decrease. Perhaps they have an understanding that others can help them and hold them accountable for their actions. People who are highly motivated to recover seem more willing to surrender their secrecy in order to help themselves break out of the eating disorder.

Although secrecy itself most likely does not cause or prevent eating disorders, it has been shown that secrecy has an affect on people with eating disorders. People often remain secretive about their eating disorder, especially in the early stages, in attempt to maintain the eating disorder. Secrecy seems to uphold a person's eating disorder, and when the secrecy is lessened, people seem to improve in behavior and may even fully recover. Even though secrecy is not the only factor that contributes to the maintenance of an eating disorder, it does seem to play a role. Research suggests that secrecy may contribute to both the maintenance and progression of an eating disorder. When the secrecy surrounding an eating disorder is lessened, people can begin to gain support and guidance from others and begin their journey to recovery.

Limitations of Literature Review

Although this literature review seeks to provide a comprehensive examination of secrecy in eating disorders, it is certainly not an exhaustive investigation of the literature. Rather, it is an overview of the issues surrounding eating disorders and secrecy. Because the researcher has potential biases, the literature review may contain bias. Since the subject of study was sensitive in nature, it is possible that results of presented studies may not fully reveal the truth about secrecy and eating disorders. Participants may be secretive in their responses, thus leading to possible insufficient data and results.

Implications for Future Research

Because few studies have been conducted on the topic of secrecy in eating disorders, future research needs to be carried out in order to learn more about the topic. Eating disorders are flourishing in our society and it remains unknown how eating disorders begin and why they progress to dangerous levels. By studying secrecy within eating disorders, researchers can enhance the knowledge on the topic. More research is needed to further understand the progression of secrecy within eating disorders. Eating disorders are currently a widespread phenomenon in our society and any future research on the experience of eating disorders will be helpful in understanding and treating the disorder.

Conclusion

From previous research, it has been shown that a variety of secretive thoughts and behaviors can have an impact on the formation and maintenance of an eating disorder. Lack of self awareness (Barry, 1992; Vitousek et al., 1998), denial (Vitousek et al., 1998), secrecy (Smart & Wegner, 1999), family secrets (Imber-Black, 1993), and a person's readiness to change (Gusella et al., 2003; Prochaska et al., 1992) can all play a role in the maintenance of an eating

disorder. These studies show that there is a correlation between eating disorders and secrecy levels. However, there is a lack of complete understanding of this relationship. The purpose of the present study is to determine whether a relationship exists between levels of secrecy and the prevalence of eating disorders.

CHAPTER III: Methodology

The study of eating disorders is typically examined through self-report by persons with an eating disorder. The following methodology is a self-report design, which will measure people's reported levels of disordered eating and levels of secrecy. Therefore, this study will explore the relationship between disordered eating and levels of secrecy. This chapter will discuss specific methods used to carry out a self-report study. Selection of participants, instrumentation, data collection procedures, and data analysis procedures will be provided. Limitations in regard to the method, sample, and procedures will also be addressed.

Participant Description and Selection

The subjects will consist of undergraduate General Psychology students at University of Wisconsin-Stout. To obtain a representative sample of undergraduate students, a number of sections of the General Psychology course will be randomly selected. The professors for each General Psychology course will be approached and informed of the study. The professors who wish to participate will set aside one class period in which their students can participate in the study. Participants in these courses will be given the questionnaires during class. They will be given an overview of the study and will be told what their involvement entails. Participation in this study will be voluntary and consent from each participant will be obtained.

Design

Participants will complete two questionnaires, the Eating Disorder Inventory-2 and an inventory on secrecy created by the researcher. Each of these questionnaires asks the participants to self-report their eating thoughts and behaviors as well as their current levels of secrecy with friends and family. Participants' responses on both questionnaires will be compared to determine if any relationship exists between eating disordered thoughts and/or behaviors and secrecy.

Instrumentation

Eating Disorder Inventory-2. The Eating Disorder Inventory-2 (Gardner, 1991), also known as EDI-2, will be used to assess eating disordered behaviors in participants. The EDI-2 is a questionnaire in which eating disordered behaviors and symptoms are self-reported by an individual. It consists of 91 questions, each containing a six point Likert scale. Individuals are asked if an item applies to them "always," "usually," "often," "sometimes," "rarely," or "never." There are eight subscales on the inventory, consisting of the drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interoceptive awareness, and maturity fears. The EDI-2 also provides three provisional subscales, consisting of asceticism, impulse regulation, and social insecurity. The EDI-2 is not a diagnostic instrument, but is used to assess eating disordered behaviors and symptoms.

The EDI-2 has been shown to have good reliability and consistency over time. The internal reliability coefficients for the EDI-2 subscales are above .80 for the eating disorder sample (Garner, 1991). Three test-retest studies were conducted on the EDI-2. In the studies, the inventory was taken one week apart, three weeks apart, and one year apart. The correlation coefficients for the one week study were .79 to .95 on all subscales, except for the interoceptive awareness subscale, which was found to be .67. The correlation coefficients for the three week study were above .80 on all subtests, except for the maturity fear subtest. The correlation coefficients for the one year study ranged from .41 to .75. The lowest correlations were found on the interoceptive awareness and body dissatisfaction subscales. These reliability studies have shown that the EDI-2 is a reliable and consistent measure of eating disordered symptomology.

The EDI-2 has been found to have high validity (Garner, 1991). In order to achieve content validity, 146 questions were developed by clinicians who were knowledgeable about

eating disorder research and who also worked with eating disordered patients. Items that were kept have a high level of face validity. In the original EDI validation study, criterion validity was met. Criterion validity is the ability of the items to discriminate between the eating disordered and non-eating disordered samples. The EDI-2 has been shown to have concurrent validity by comparing eating disorder patients' self reports to the judgment of consultants or therapists familiar with the patient. Correlations were conducted between the EDI-2, EAT-26, and the restraint scale for eating disorder patients. Correlations were found to be statistically significant with most subscales of the EDI-2. The EDI-2 has been shown to have good validity in regard to content validity, face validity, criterion validity, and concurrent validity.

Secrecy Questionnaire. Because no known assessments exist for measuring levels of secrecy, a questionnaire will be developed by the researcher specifically for this study. The measure will consist of items on a Likert scale in order to obtain frequencies of secretive thoughts or behaviors. Items on the questionnaire will measure levels of self-awareness regarding eating patterns, denial of eating disordered behaviors, secrecy related to eating, family secrecy, and the readiness to change disordered eating patterns. The reliability of the questionnaire will be assessed by carrying out a test-retest study on an adequate number of individuals. A one week and one month study will be conducted. Test-retest reliability will be shown if the participants answer similarly on both trials. The secrecy questionnaire will be able to be tested for face validity by having others look at the scale and determine if the questionnaire appears to be measuring levels of secrecy.

Data Collection Procedures

Each participant will be given the Eating Disorder Inventory-2 (EDI-2), as well as the secrecy questionnaire. Both inventories will be completed during the participants' General

Psychology class. Testing time will be approximately one hour. Participants will be read the description of the study and the instructions for the inventories. After completing the inventories, participants will place them in an envelope in order to ensure confidentiality of data. Participants will be allowed time to ask questions about the study.

Data Analysis

The data will be analyzed to determine if there are any trends in responses relating to eating disordered thoughts or behaviors and levels of secrecy. Correlational relationships will be explored between answers on the EDI-2 and the secrecy questionnaire. This will reveal any patterns or connections between secrecy and eating disordered behavior. In addition, subscales on the EDI-2 will be compared to one another to determine if eating disordered symptoms are interrelated. Subscales on the secrecy questionnaire will also be compared to one another to determine if different types of secretive thoughts and behaviors are correlated.

Limitations

The methodology may contain several limitations. First, all participants are students at a Wisconsin university, and the findings may be limited by ability to draw a representative sample. Second, participants may not answer inventory items honestly. Since the inventories assess sensitive subjects (eating disorder symptoms and secrecy), participants may not provide the whole truth. Third, since the inventories are being distributed in class, participants may answer quickly or carelessly, as their responses will not be graded or used for diagnostic purposes.

Conclusion

Eating disorders have become widespread, especially amongst young adolescents. Eating disorders are a serious threat to a person's physical and emotional well-being. There is a need for more information regarding the underlying factors in the formation and the maintenance of

eating disorders. This paper reviewed the literature on the relationship between levels of secrecy and the prevalence of eating disorders. The goal of the research was to determine if secrecy plays a role in the prominence of an eating disorder. Further, this paper proposed a methodology in which the relationship between levels of secrecy and eating disordered thoughts and behaviors could be explored. By researching the role of secrecy in eating disordered thoughts and behaviors, more information can be provided to practitioners, school personnel, and parents regarding the etiology, prevalence, and behaviors in eating disorders. With increased knowledge in the area of eating disorders, there is hope that eating disorders will be better understood, prevented, and successfully treated.

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