

# Stigmatizing Effects of Perceived Responsibility for Causing and Resolving One's Eating Disorder

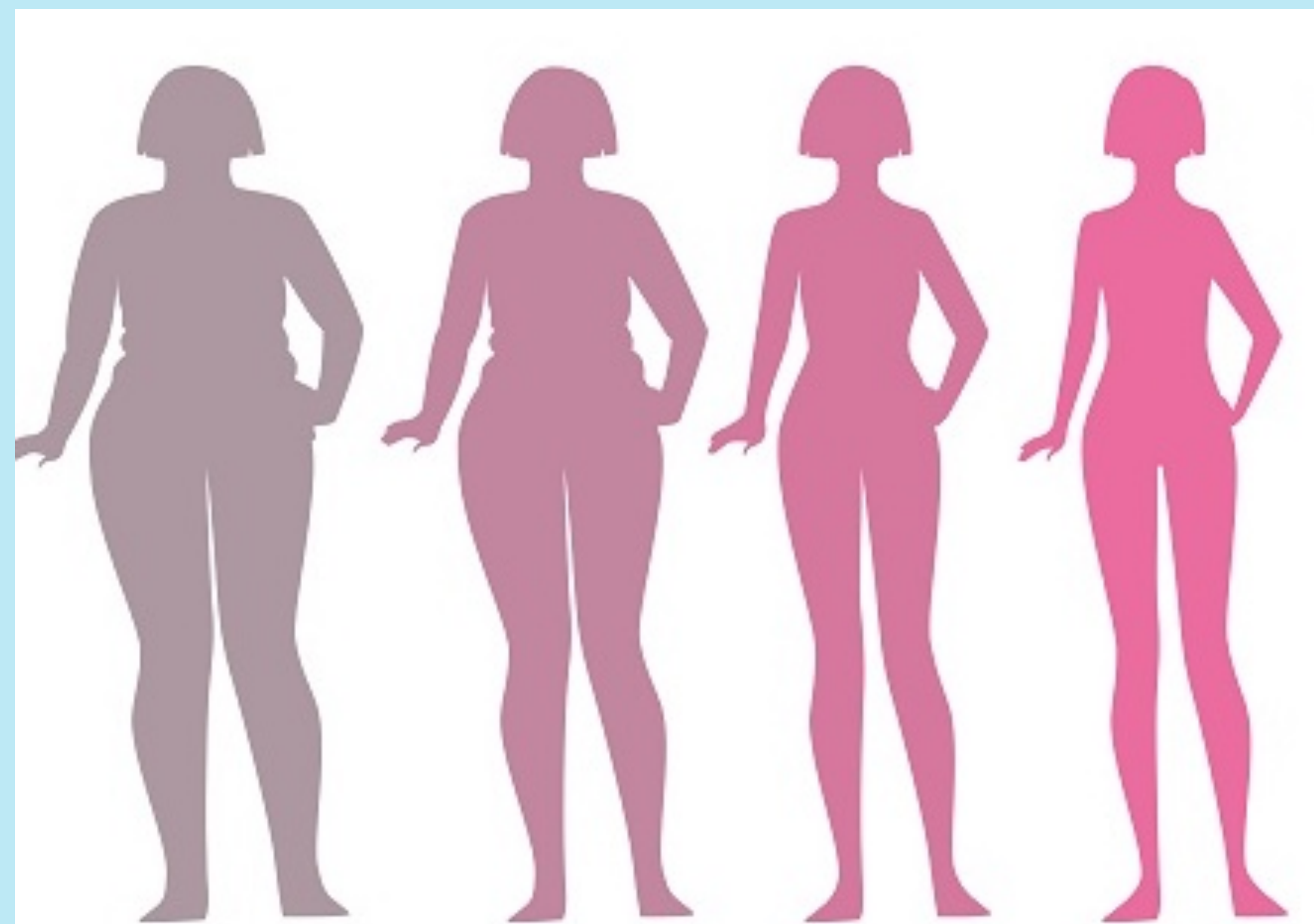
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## Abstract

Individuals who have eating disorders or are obese experience stigmatization, which can lead to a variety of negative outcomes including further disordered eating and lower self-esteem (Puhl & Suh, 2015). In the present study, we examine perceptions of individuals with anorexia nervosa (AN) and binge eating disorder (BED) in relation to views of a client's responsibility for having an eating disorder and for overcoming it. The goals of the study are: (1) to compare stigmatizing perceptions of young women with BED and AN, and (2) drawing on Brickman et al. (1982), to explore the implications for stigmatization of information presented by a therapist about, and participants' perceptions of, the client's personal responsibility for causing and resolving her eating disorder. We hypothesized that high responsibility for causing the disorder would have more negative implications than high responsibility for resolving it. Participants read a one-page vignette describing a female college student diagnosed with either AN or BED. One of five therapist assessments of the client was then presented: Low responsibility for cause/Low responsibility for solution, High responsibility for cause/Low responsibility for solution, Low responsibility for cause/High responsibility for solution, High responsibility for cause/High responsibility for solution, and a Control/No further information condition. Scales measured perceived causality and responsibility, and multiple aspects of stigma. The client with BED was viewed as more personally responsible for causing her condition than the woman with AN; however, the woman with AN was viewed as more impaired or maladjusted, confirming previous research. Responsibility for causing one's eating disorder was found to have a greater impact on stigmatization than responsibility for resolving the disorder, especially when participants' perceptions of responsibility rather than manipulated responsibility were analyzed.

## Introduction

Binge eating disorder (BED) is characterized by eating significantly more food over a shorter period of time than the typical person would eat (American Psychiatric Association, 2013). Anorexia nervosa (AN) is characterized by restrictive eating, low body weight, fear of weight gain, and distorted body image. The present study was designed: (1) to compare stigmatizing perceptions of a young woman with binge eating disorder to perceptions of a similar individual with anorexia, and (2) drawing on Brickman et al. (1982), to explore the implications for stigmatization of both presented information from a psychotherapist about, and participants' perceptions of, the individual's personal responsibility. Stigma is defined in terms of negative responses on: trait perceptions, emotional response, and social distance. The present study extends previous research by assessing personal responsibility for cause and responsibility for solution separately.



## Methods

### Participants:

206 college students ( $M_{age} = 19$ ; 159 females, 47 males), for course credit.

### Procedure:

Participants read vignettes describing Amy, a college student with either BED or AN. Five variations were created to manipulate her therapist's perceptions of her responsibility for causing and responsibility for resolving her disorder. Participants then answered Likert items ranging from 1 (not at all) to 7 (very much) regarding causal beliefs, perceptions of responsibility, trait perceptions, emotional reactions, and perceptions of therapy outcomes.

### Measures:

#### Causal Beliefs

How much do you feel each of the factors contributed to Amy's disorder: genetics, metabolism, lack of self-control, poor emotional regulation, negative family influences, life stressors, and negative cultural factors?

#### Personal Responsibility for Cause and Solution

How responsible is Amy for causing or solving her problem?

#### Trait Perceptions

Items presented bipolar traits (e.g., emotionally stable-emotionally unstable) that assessed (a) competence, (b) likeability, (c) adjustment, and (d) personal strength.

#### Anger and Pity

Assessment of emotional reactions of pity and anger (Weiner, 1986, Weiner, Perry, & Magnusson (1988).

#### Willingness to Interact

How willing would participants be to interact with Amy in a variety of ways.

#### Likely Therapy Outcomes

How successful is therapy likely to be.

## Results

Analyses were 2 x 5 ANOVA with the factors Disorder (anorexia vs binge eating disorder) and Treatment Condition. Because a number of significant effects of disorder were found and effects of treatment condition were rare, we report in Tables 1 and 2 the means for the client with anorexia and the client with binge eating disorder for all measures.

### Specific Causes

See Table 1. Compared to AN, BED was viewed as more influenced by genetics, abnormal metabolism, and lack of self control, with lack of self-control being the dominant lay theory. AN was more associated than BED with life stressors and cultural influences. Causal beliefs were generally not affected by responsibility manipulations.

### Judgments of Personal Responsibility

See Table 2. Participants were influenced by both disorder and treatment in their judgments of personal responsibility. The woman with AN was viewed as less responsible for her disorder than the woman with BED across conditions. Treatment condition did not significantly influence perceptions of personal responsibility for solving the problem.

### Stigmatizing Perceptions

The AN client was viewed as less well-adjusted than the BED client. Adjustment was viewed as significantly poorer when responsibility for cause and solution were both high than when responsibility for cause was high but responsibility for solution was low. The client with AN was also perceived as stronger than the client with BED. Other perceptions were similar across disorders and treatments.

### Correlational Analysis

See Table 3. For the client with AN, high perceived responsibility for cause was moderately correlated with low perceived competence, likeability, and strength, as well as low pity, high anger, and low willingness to interact. High perceived responsibility for solving AN was associated only with greater anger. For BED, high perceived responsibility for causing the disorder was moderately correlated with low strength and low pity, but greater optimism about treatment outcome. High perceived responsibility for solving BED was correlated with low personal strength and low willingness to interact.

Table 1  
Perceptions of Specific Causal Contributors to Anorexia vs. Binge Eating Disorder

| Measure                      | AN Mean (n=101) | BED Mean (n=105) |
|------------------------------|-----------------|------------------|
| Genetics                     | 2.59            | 3.03*            |
| Metabolism                   | 2.68            | 3.54***          |
| Lack of self-control         | 3.36            | 5.63***          |
| Poor emotional regulation    | 5.51            | 5.51             |
| Negative family influences   | 3.43            | 3.09             |
| Life stressors               | 6.08**          | 5.62             |
| Negative cultural influences | 5.35***         | 4.35             |

Note: \*p<.05 \*\*p<.01 \*\*\*p<.001

Table 2  
Perceptions of Personal Responsibility and Stigmatizing Reactions to Anorexia vs. Binge Eating Disorder

| Measure                              | AN Mean (n=101) | BED Mean (n=105) |
|--------------------------------------|-----------------|------------------|
| Personal responsibility for cause    | 3.66            | 4.37***          |
| Personal responsibility for solution | 4.63            | 4.92             |
| Competence                           | 4.62            | 4.53             |
| Likability                           | 4.62            | 4.51             |
| Adjustment                           | 2.63            | 3.03***          |
| Strength                             | 4.34            | 3.55***          |
| Pity                                 | 5.49            | 5.26             |
| Anger                                | 3.34            | 3.01             |
| Social distance                      | 4.50            | 4.49             |
| Outcomes                             | 4.79            | 4.98             |

Note: \*p<.05 \*\*p<.01 \*\*\*p<.001



## Conclusions

The target with BED was seen as more personally responsible for causing her condition, as well as more lacking in self-control and personal strength, but the target with AN was seen as more maladjusted, consistent with Ebner and Latner (2013) and Puhl and Suh (2015). Perceived responsibility for causing the disorder was associated with more stigmatization than perceived responsibility for solving it, possibly because both clients were expected to take responsibility for overcoming their problem. More research, involving stronger manipulations of responsibility, is necessary to understand the influence of high or low responsibility for resolving eating disorders on perceptions of individuals with these disorders.

Table 3  
Correlations between Responsibility Ratings and Stigmatizing Perceptions

|                         | Anorexia Responsibility for Cause | Anorexia Responsibility for Solution | Binge Eating Responsibility for Cause | Binge Eating Responsibility for Solution |
|-------------------------|-----------------------------------|--------------------------------------|---------------------------------------|--|
| Competence              | -.34***                           | -.11                                 | -.10                                  | -.16                                     |
| Likability              | -.35***                           | -.026                                | -.09                                  | -.05                                     |
| Adjustment              | -.15                              | -.12                                 | -.06                                  | -.09                                     |
| Strength                | -.38***                           | -.17                                 | -.33***                               | -.32***                                  |
| Pity                    | -.35***                           | -.01                                 | -.31***                               | -.10                                     |
| Anger                   | .26**                             | .25*                                 | .18                                   | -.03                                     |
| Willingness To Interact | -.21*                             | -.01                                 | -.14                                  | -.20*                                    |
| Outcomes                | .11                               | .04                                  | .21*                                  | -.02                                     |

Note: n's range from 99 to 101 for AN and 103 to 105 for BED  
\*p < .05 \*\*p < .01 \*\*\*p < .001

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