

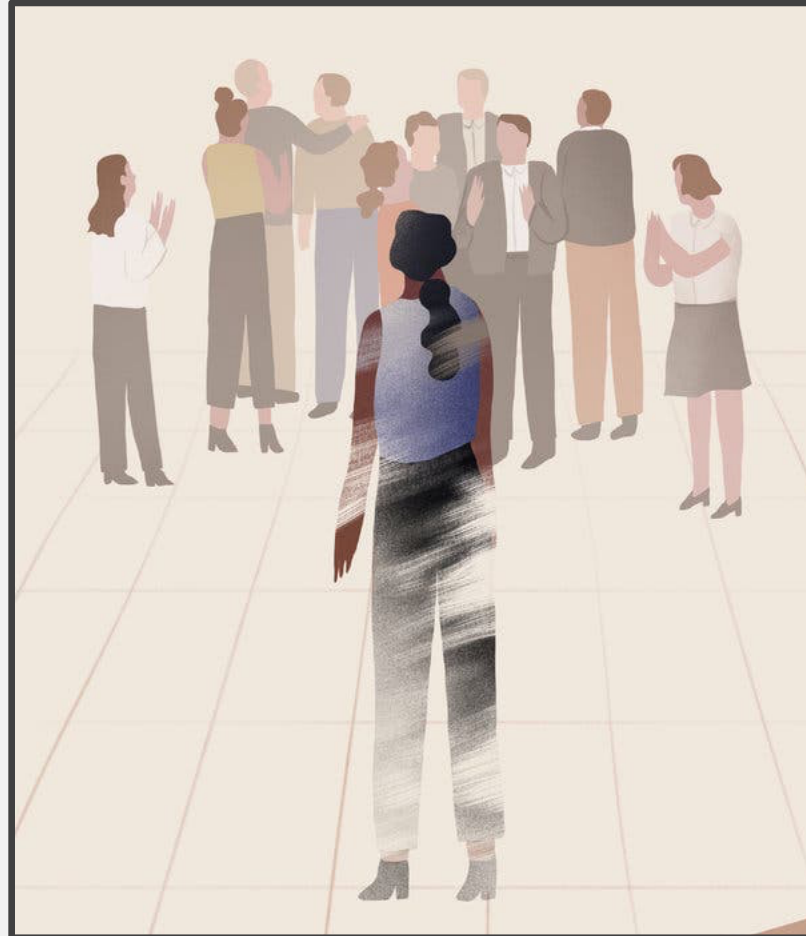
# AN EXPERIMENTAL EXAMINATION OF BINGE EATING DISORDER STIGMA



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# STIGMA

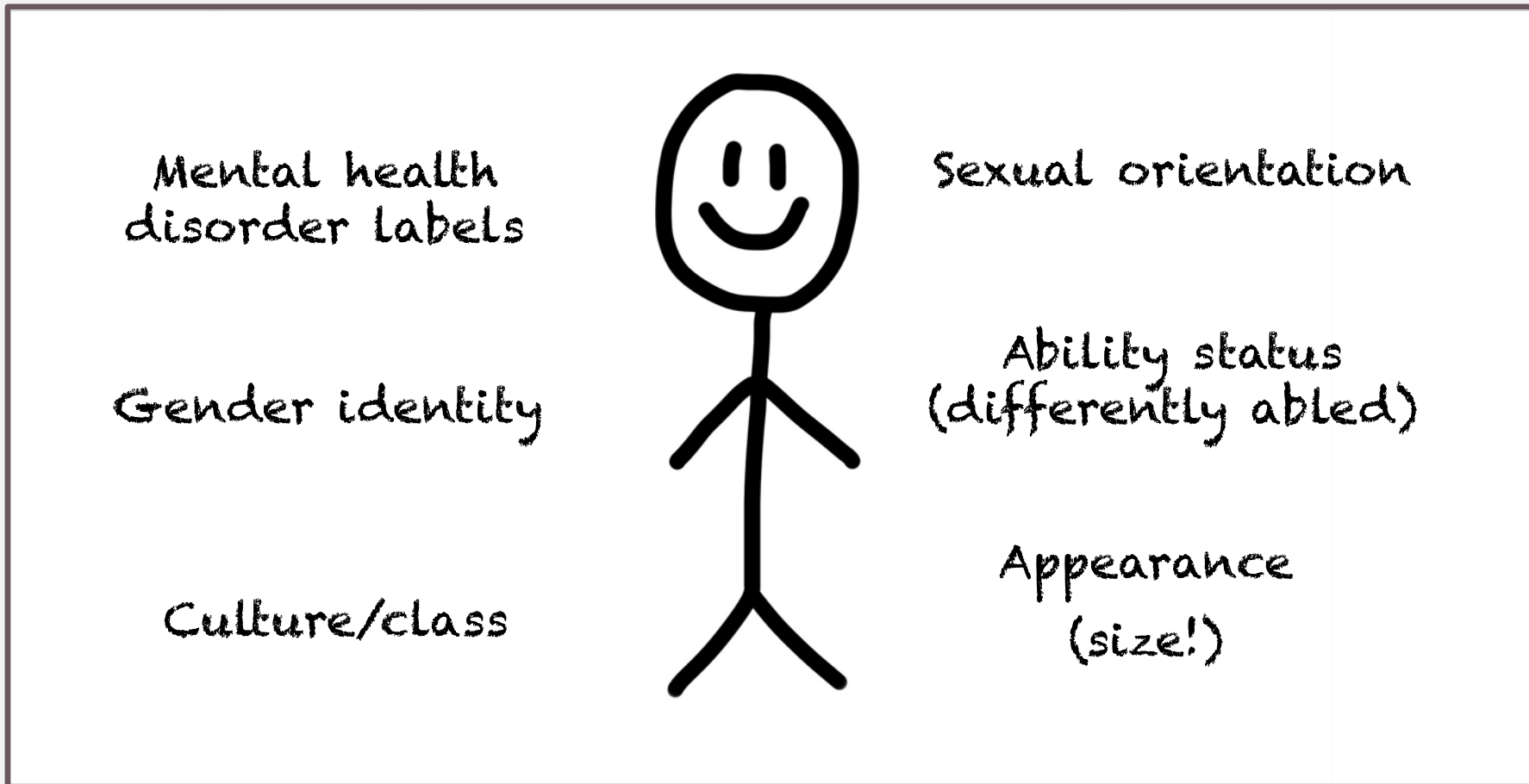
**Experienced by:**  
People with one or more  
socially devalued or  
marginalized attributes



**Experienced as:**  
Stereotypes, prejudice,  
negative emotional  
reactions, discrimination

# STIGMA

**Intersectional** → It depends on a target's intersecting identities



# BINGE EATING DISORDER (BED)

*Recurrent episodes of eating an unusually large amount of food in a short period of time while feeling a sense of loss of control over what and how much is eaten*

Eating more rapidly than normal

Eating when not physically hungry

Feeling disgust, guilt, and shame after

Eating beyond physical discomfort

Eating in secrecy

# BED STIGMA – PREVIOUS STUDIES

## **In studies of BED stigma:**

1. Read a vignette describing a target character
2. Answer questions to assess stigma

## **Findings suggest that BED is stigmatized as:**

- Poor self control
- Lack of self-discipline
- Personal blame
- Bannon et al. (2009) found that a target described as obese faced greater stigma when they also had BED

## BED STIGMA – PREVIOUS STUDIES

- 8 of 9 studies with BED vignettes describe the character as ‘overweight’, ‘obese’, or ‘severely obese’
  - Weight itself is highly stigmatized
  - Weight stigma is a confound
- Murakami et al. (2016) attempted to reduce weight stigma

*Do opinions about **binge eating** and opinions about **larger bodies** intersect to yield stigma?*

# RESEARCH QUESTIONS

**What does BED stigma look like when the target is described as within the recommended weight range?**

**Does the BED stigma faced by the target change when they are described as obese?**

**What does BED stigma look like when the target's weight is not mentioned?**

# HYPOTHESES

The target with BED will be stigmatized to a greater extent than the target without BED

Stigma will be greatest when the target is described having BED and a larger body

When weight is not mentioned, the stigma faced by the target with BED will reflect assumptions about body size that are linked to binge eating



# STUDY DESIGN + METHOD

<b>BED + THIN BODY</b>	<b>NO BED + THIN BODY</b>
<b>BED + LARGE BODY</b>	<b>NO BED + LARGE BODY</b>
<b>BED + NO WEIGHT</b>	<b>NO BED + NO WEIGHT</b>

Thin body = RW

Large body = OB

No weight = NMW

Sarah is a 19-year-old university student at MUN. Sarah's overall diet is generally regular, with three meals a day that consist of a wide variety of foods. When she gets home from school, she usually has a snack. However, sometimes she finds that she is unable to stop eating after having the snack and continues to eat a large amount of food even though she is not hungry. For example, she may eat a peanut butter and jelly sandwich, a pack of cookies, two bowls of ice cream, and some chips all in one sitting. Later in the evening, Sarah eats supper and will sometimes lose control again and eat the leftovers that she was planning to save for the next day. During these times Sarah feels out of control of her eating and often continues to eat until she feels uncomfortably full. After these episodes of eating Sarah experiences feelings of disgust and guilt. Sarah feels very distressed by these episodes, but she has never tried to compensate for what she has eaten (e.g., by fasting, vomiting, or using laxatives). Sarah is about 5 feet 4 inches tall and weighs 126 pounds. Her Body Mass Index (BMI) of 21.6 means that she falls within the recommended weight range for her age and height. According to clinical diagnostic criteria, Sarah qualifies for a diagnosis of Binge Eating Disorder.

# STUDY DESIGN + METHOD

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- 1. Social Distance Scale**
- 2. Affective Reactions Scale**
- 3. Characteristics Scale**
- 4. Blame Attribution Scale**

# STUDY DESIGN + METHOD

## 1. Social Distance Scale

How would you feel about being coworkers or classmates with someone like Sarah? *Definitely unwilling* → *definitely willing*

## 2. Affective Reactions Scale

Apprehensive vs. comfortable, irritable vs. patient

## 3. Characteristics Scale

Careless vs. disciplined, weak vs. strong

## 4. Blame Attribution Scale

Sarah could pull herself together if she wanted to.  
*Strongly disagree* → *strongly agree*

# PARTICIPANTS

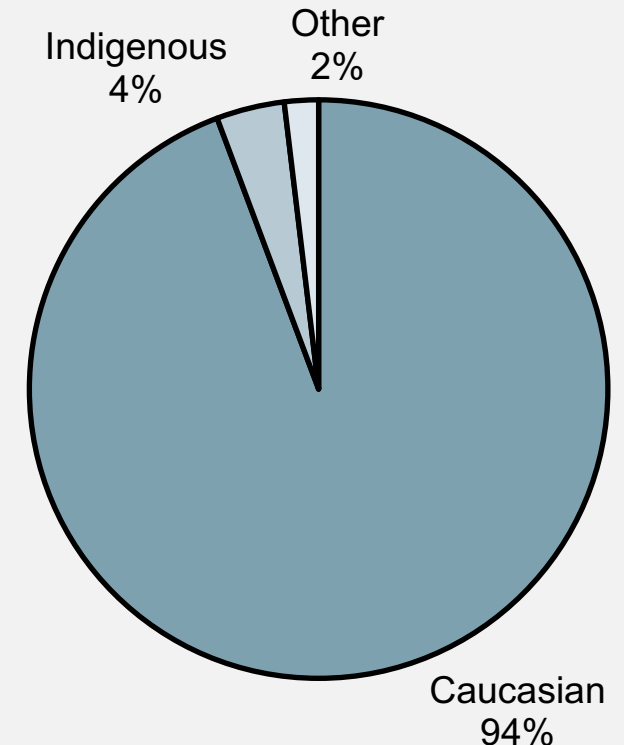
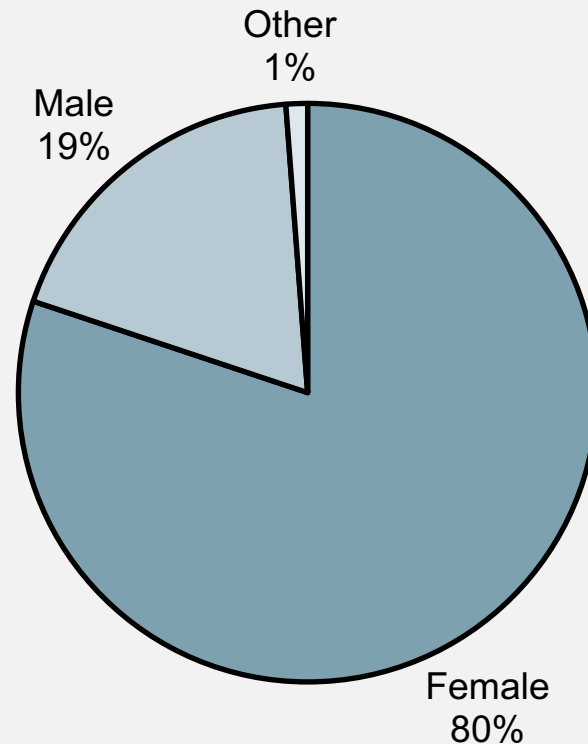
## 454 recruited from the community

Excluded if:

- < 7 s reading the vignette (n = 25)
- Completed < 1 full stigma scale (n = 6)
- < 19 years of age (n = 2)

## 421 in final sample

- M age = 32.7 years (range = 19-80)
- 65.1% in a relationship/married
- 56.1% employed full-time
- 40.6% student full-time
- 22.8% experience with ED populations



## MANIPULATION CHECKS

*To what extent does Sarah engage in binge eating?* (1 = not at all; 5 = very much)

*To what extent does Sarah have control over her eating?* (1 = not at all; 5 = very much)

*Which of the following best describes Sarah's weight?* (categories listed)

*Which of the following best describes Sarah's weight in pounds?* (weight ranges listed)



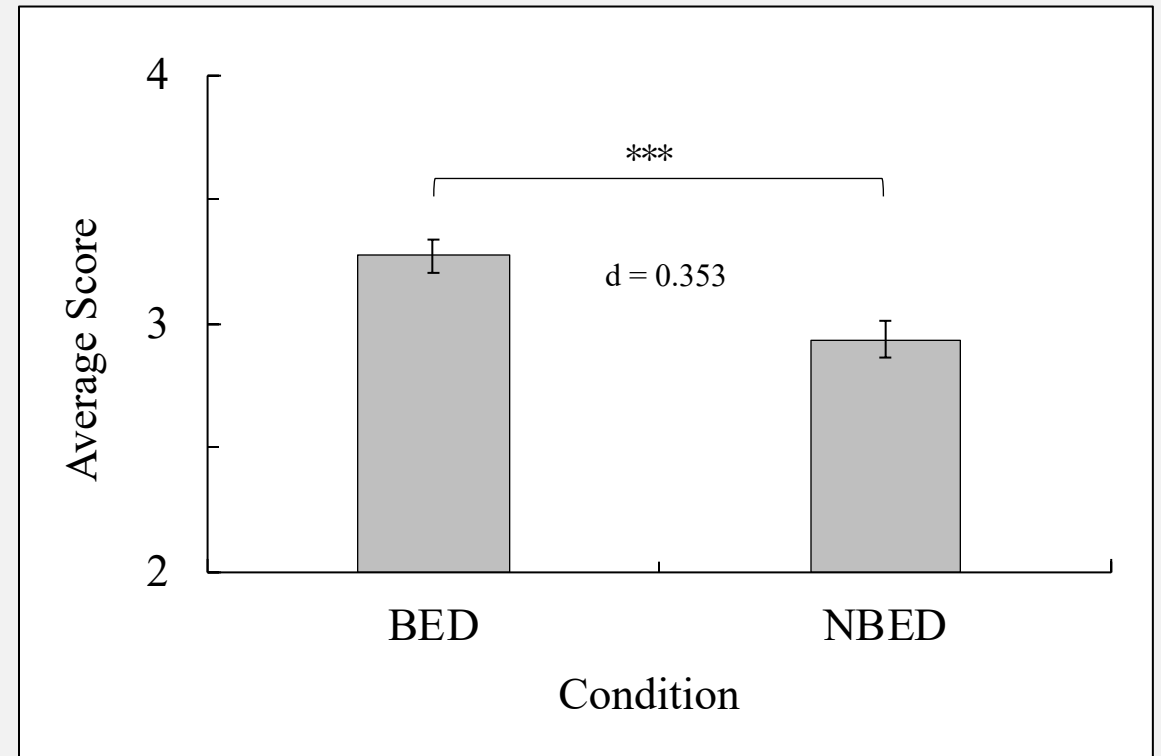
# **RESULTS + DISCUSSION**

# SOCIAL DISTANCE SCALE

- 1) No effect of BED status; 2) no effect of weight status; 3) no interaction
- Neither the presence of BED or having a larger body impacted desired social distance from Sarah
- Bannon et al. (2009): participants desired greater social distance from a target described as obese when they also had BED
  - Younger sample, more males (42%), different measure of social distance
- Jorm & Oh (2009): perceived dangerousness of target

# AFFECTIVE REACTIONS SCALE

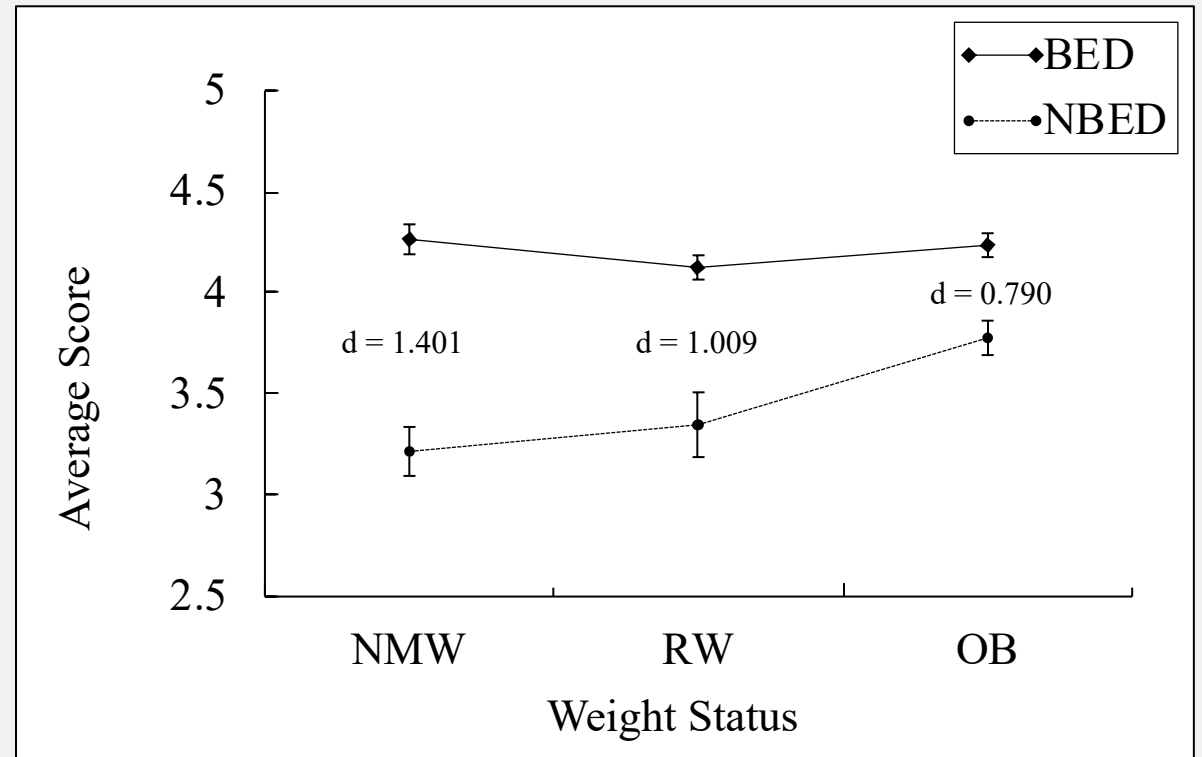
- 1) Significant main effect of BED
  - 2) No main effect of weight status
  - 3) No interaction
- The presence of BED led participants to report less-positive emotions
  - Having a larger body did not impact emotions





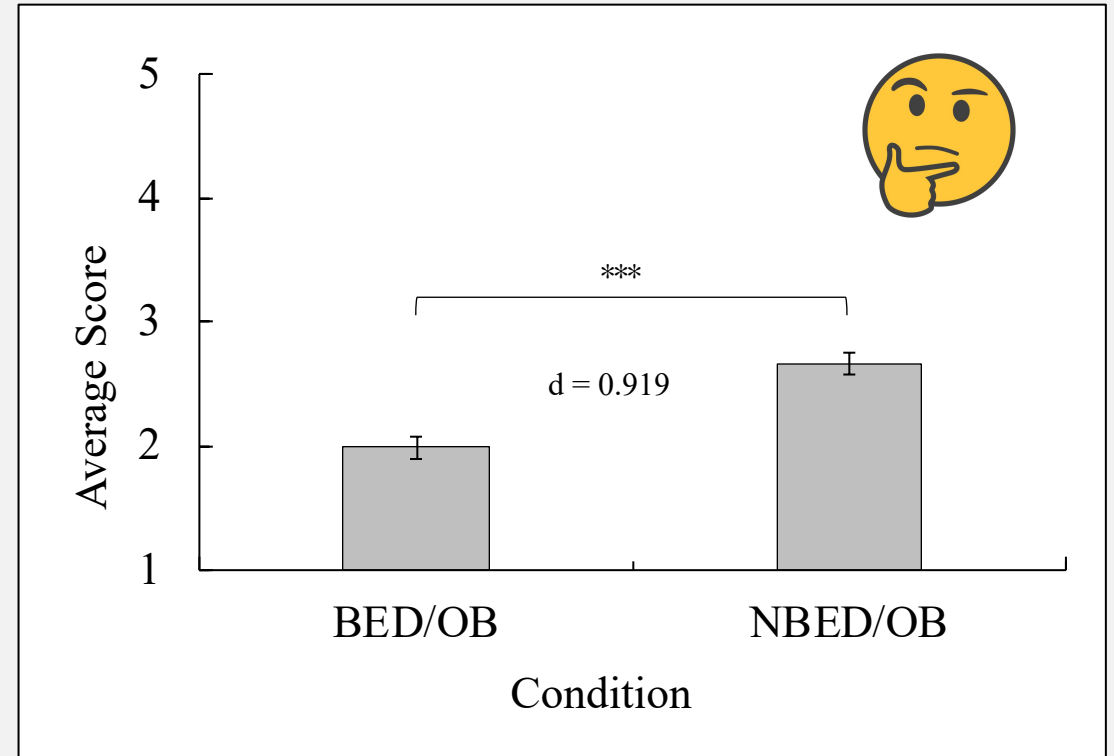
# CHARACTERISTICS SCALE

- 1) Significant main effect of BED
  - 2) Significant main effect of weight status
  - 3) Significant interaction
- Negative assumptions about personality associated with BED, regardless of weight status
  - O'Connor and colleagues (2016): BED target ascribed less positive traits than targets with depression or AN



# BLAME ATTRIBUTION SCALE

- 1) No effect of Weight Status when Sarah had BED
- 2) Significant effect of BED Status when Sarah had a larger body
  - Bannon and colleagues (2009):  
Participants more likely to blame a person for their size when binge eating present
  - Latner and colleagues (2014):  
Participants less likely to blame a person for their size when “food addiction” present



# LIMITATIONS AND FUTURE DIRECTIONS

- Sample: mean age = 32.7 years, 79.8% female
- The vignette target was described as a young female
- Psychometric properties of stigma scales need to be further established
- I assessed **public stigma**
  - Future research: experiences of public stigma and self-stigma among individuals with binge eating

## PRACTICAL RELEVANCE

- BED is associated with significant distress and poor health outcomes
- The only option for adults to seek help in NL is to seek private therapy
- Binge eating stigma – feeling rejected, shamed, and misunderstood
  - May be less likely to see help
- We can challenge our attitudes that perpetuate BED stigma



Social Sciences and Humanities  
Research Council of Canada



**HOPE ALWAYS**

EATING DISORDER FOUNDATION OF NEWFOUNDLAND AND LABRADOR



Canadian Mental  
Health Association  
Newfoundland and Labrador



Women's Association

**DR. JACQUELINE  
CARTER-MAJOR**

**DR. NICK HARRIS**

**DR. MARTIN DAY**

**JENNA PENNELL**