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# Exploring the Stigmatization of Anorexia: A Focus on The Structural, Interpersonal, and Individual Levels of Stigma

Paraskevi Evelynna Kambanis  
Clark University, pkambanis@clarku.edu

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**Abstract**

This paper will review the literature that outlines the stigmatization of anorexia nervosa within society. I will focus on the structural, interpersonal, and individual levels of the ecological system, providing explanations and examples of how the stigmatization of anorexia nervosa manifests on each level. I will describe the consequences of societal stigmatization on individuals' psychological and emotional health and well-being, and will examine how interpersonal stigmatization affects individuals and relationships. I then offer conclusions based on my literature findings, and offer future directions, focusing on all three levels of the ecological system, for dismantling the stigmatization of anorexia nervosa.

## **Introduction**

The stigmatization of anorexia nervosa is rarely included in the discussion of stigma related to mental disorders, as it is typically viewed as a mild disorder, with symptoms, such as restrictive eating or dramatic weight loss, that are socially acceptable, or even seen as desirable. Stigma is defined as a phenomenon by which an individual with a deeply discredited attribute is rejected, stereotyped, or discriminated against by society (Goffman, 1963). Those who grapple with the devastating reality of an eating disorder also face the additional stress and challenges of stigma. The current paper will review literature that outlines the ways in which anorexia nervosa is stigmatized within society. I will describe the consequences of this societal stigmatization on individuals' psychological and emotional health, and will also discuss how this stigmatization influences interpersonal relationships. Finally, I will provide conclusions based on my literature findings, and offer future directions for dismantling the stigmatization of anorexia nervosa.

### **Societal Stigmatization of Anorexia Nervosa**

Anorexia nervosa is a serious psychological disorder characterized by a pathological fear of gaining weight, leading to faulty eating patterns, malnutrition, and excessive weight loss (American Psychiatric Association, 2000). Anorexia has a twenty percent mortality rate, which is the highest mortality rate of any psychiatric disorder (Arcelus, 2011). The mortality rate is associated with cardiovascular complications and high suicide risk (Keel et al., 2005). However, individuals may be less likely to disclose or identify when one is coping with an eating disorder because eating disorders are cloaked by society's perceptions that thinness is healthy and should be strived for. The

media endorses a view of anorexia nervosa as a sociocultural phenomenon, where young girls succumb to the body image ideal set forth in magazines and television.

Skewed media perceptions of beauty can have a detrimental effect on adolescents' mental health. Societal stigma surrounding anorexia nervosa is exacerbated by the media's morbid fascination with the emaciated appearance of models and actors. Due to the media's influence, adolescents are prone to weight-related concerns, which are potential risk factors for the development of eating disorders. A myriad of studies report positive correlations between exposure to the media and magazines, and an increased level of weight-related concerns and eating disorder symptoms in young girls (Tiggeman et al., 2000). Both girls and boys – ages nine to fourteen – who make an effort to look like the figures in the media are more likely than their peers to develop weight concerns and become constant dieters (Field et al., 2001). In a study conducted by Ozer and colleagues (1999), forty-four percent of adolescent girls considered themselves overweight, and sixty percent were actively trying to lose weight, even though most of these young girls were within normal weight ranges. Moreover, the importance of thinness and trying to look like women in the media was predictive of young girls beginning to purge at least weekly (Field et al., 1999). Groesz and colleagues (2002) extrapolated these findings in order to further investigate the effects of media exposure to thin body images. The authors found that body image is significantly more negative after viewing thin media images, than after viewing images of average size models, plus size models, or inanimate objects (Groesz, Levine & Murnen, 2002). While feelings of insecurity are natural and predictable among most populations, the implications of this study could be significantly greater for those coping with anorexia nervosa. These

findings partially explain why many adolescents are so preoccupied with their bodies and dissatisfied with their body image, and are willing to try a variety of dangerous weight-loss practices. Thus, the media plays a pivotal role in creating and intensifying body dissatisfaction in adolescents, and may also be partly responsible for the stigmatization of eating disorders.

Eating disorder symptomatology may often be overlooked because of society's valuation of thinness. Individuals coping with Anorexia may be seen as vain or self-centered (Hall & Ostroff, 1998). They may also be viewed as more able to pull themselves together than individuals with severe mental illness (Hayward & Bright, 1997). Indeed, there currently exists a commonly held belief that an eating disorder is a lifestyle choice, and that recovery simply means altering a negative behavior (Stewart et al., 2006). Many feel as though individuals suffering from Anorexia Nervosa have the power to control their disorder by simply eating more, or putting on weight. This, plus admiration of restrictive eating or extreme weight loss tend to trivialize eating disorders as insignificant, and about food and weight, rather than serious conditions needing medical and psychological support.

One way to shed light on the perceived controllability of anorexia nervosa is to examine the perceptions of the general public regarding the degree to which symptoms of different mental illnesses are controllable by individuals, and the degree to which individuals are responsible for these symptoms. Stewart and colleagues (2006) asked participants to compare scripts for a 'healthy' person, individuals with anorexia, schizophrenia, and asthma. They found that participants evaluate individuals with anorexia more negatively than individuals with schizophrenia or asthma (Stewart et al.,

2006). Participants regarded those with anorexia nervosa as most to blame for their condition, and most able to pull themselves together if they wanted to. They believed that individuals affected by anorexia were mostly just acting this way for attention, and that biological factors were least relevant in the development of the disorder (Stewart et al., 2006). This may be due to the belief that self-discipline, lack of social support, and parenting contribute more to the development of anorexia than to the development of either schizophrenia or asthma (Stewart, Keel, and Schiavo, 2006). These blaming attitudes are further exhibited in a study indicating that people with anorexia are viewed as choosing to remain ill and using their symptoms for attention-seeking (Holliday et al., 2005). Holliday and colleagues (2005) found that individuals without an anorexia nervosa diagnosis believed that individuals with anorexia nervosa have much more control over their illnesses, and an increased prognosis and optimism about recovery than do individuals with other mental illness (Holliday et al., 2005). However, those with a diagnosis often question the effectiveness of treatment and their own ability to overcome the illness. Taken together, these findings show that the blaming and shaming attitudes surrounding this disorder impact the stigma that perpetuates it. In the next section, I outline the interpersonal and individual consequences of societal stigmatization around anorexia nervosa.

### **Interpersonal Consequences of Anorexia Nervosa Stigma**

The evidence of stigma towards individuals affected by Anorexia Nervosa may be expressed in interpersonal contexts. For example, those dealing with Anorexia Nervosa may not be considered as suitable friends or partners (Link & Phelan, 2001) due to a perception that these individuals are unlikely to make a useful contribution to society

(Jorm et al., 1999). For example, Smith and colleagues' (1986) research shows that female high school and college students rejected individuals with eating disorder symptomatology as friends, while male students rejected them as dating partners. Moreover, hiding an eating disorder often requires a paramount degree of secrecy, often creating a barrier between the individual coping with the disorder and their loved ones (Hartmann et al., 2010). Individuals may distance themselves from those who may notice their symptoms (Hartmann et al., 2010), creating a barrier on potentially helpful interpersonal relationships.

Interpersonal stigmatization may also manifest in the patient-provider context. Health professionals' beliefs often reflect the dominant ideas of their society, and in turn, types of misconceptions by providers may negatively influence the responses and explanations those with an anorexia diagnosis receive when they seek help. Several researchers have examined how exposure to a sociocultural versus a biological or genetic explanation for the etiology of anorexia nervosa differentially affects providers' attitudes toward the disorder. Crisafulli and colleagues (2008) examined the extent to which the type of information nursing students receive about the etiology of the disorder (biological versus sociocultural) influences their tendency to blame and stigmatize those coping with it. The researchers hypothesized that participants who received a biological explanation of the etiology of anorexia would be significantly less likely to blame and stigmatize affected individuals than those who received a sociocultural explanation of the disorder. Indeed, those who were presented with even minimal information about the biological and genetic underpinnings of anorexia nervosa placed less blame on people for their condition than those who are only informed of the sociocultural factors that may

contribute to the disorder (Crisafulli et al., 2008). Health care professionals in a general hospital may also endorse the beliefs that sociocultural factors contribute more to the development of anorexia nervosa, and may hold individuals with the disorder more responsible for their symptomatology (Fleming & Szmuckler, 1992). These types of misconceptions affect the responses and explanations individuals receive when they ask for help from health professionals. This may lead to a failure to diagnose or delays in diagnosis. It may also contribute to feelings of shame and reluctance to seek further help. Biological and genetic factors are infrequently cited as causes of anorexia nervosa. However, there is strong evidence for the possibility of susceptible genes on chromosome one that predisposes someone to anorexia (Grice et al., 2002). These genes may include personality variables (i.e., anxiety, perfectionism, or perseverance), or hormonal, metabolic, and appetite factors. The accumulating evidence for contributory biological, family, and genetic components (Grice et al., 2002), suggests that much like other psychiatric disorders, anorexia nervosa does appear to have genetic susceptibilities that should be vastly considered in the patient-provider context.

Another way in which societal stigmatization of anorexia nervosa may shape interpersonal relationships is through a lack of empathy for those dealing with the disorder. This lack of empathy exists due to the belief that anorexia nervosa is controllable, and that those coping with the disorder are to blame for their symptoms. Crisp and colleagues (2005) found that the general public finds it difficult to communicate with, and hard to sympathize with individuals struggling with anorexia nervosa. In a study exploring how people regard individuals struggling with different types of mental illness, eating disorders were perceived as being self-inflicted (Crisp et



al., 2005). Participants believed that individuals with eating disorders should easily be able to pull themselves together, as they only have themselves to blame for their illnesses (Crisp et al., 2005). Eating disorders are often trivialized in contrast to other severe mental illnesses. This may be attributed to the degree of controllability individuals with eating disorders are perceived to have. Stangor and Crandall (2000) suggest that stigma worsens when it is perceived as being the fault of its bearer, as anorexia nervosa often is. If a certain stigma is perceived as controllable, the individual that bears the negative label may be looked down upon, or be less likely to be empathized with. Thus, controllability plays a role in the stigmatization of anorexia nervosa, whether pertaining to controlling one's weight, or the negative reactions people have to his or her inability to put on weight. The blaming attitudes associated with such stigmatized portrayals of eating disorders may contribute to a host of serious problems that negatively affect the lives of those affected.

### **Individual Consequences of Anorexia Nervosa Stigma**

The interpersonal context of the stigmatization of Anorexia Nervosa can vastly affect the individual coping with the disorder. For some, stigma may lead to fear of being evaluated negatively by family, friends, teachers, and employers. For others, stigma may lead to self-disgust and self-loathing about their physical appearance and their eating and purging behaviors. Often times, individuals suffering from an eating disorder may experience themselves as defective, flawed, or different from others because they are not meeting with what one sees as familiar or societal standards and expectations. Individuals coping with an eating disorder may have concerns that disclosure of their illness will result in others trivializing their difficulties, self-blame, shame, and fear of being

assigned negative stereotypes (Dimitropoulos, 2008). This may lead to internalized stigma. Internalized stigma is described as the process by which individuals endorse stereotypes about their mental illness, “anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society” (Corrigan et al., 2004). There are two types of stigma that this can result in: felt stigma, and self-stigma. Felt stigma results from an individual’s awareness of how society perceives their disorder, and how they will react, whereas self-stigma results from an individual accepting society’s negative evaluations, and incorporating it into their own self schema (Corrigan et al., 2004). As such, the interpersonal and individual levels interact to influence a subjective conceptualization of the self, based on the stigmatization brought forth by others.

Unfortunately, the experience of stigma often means delay or avoidance of treatment seeking, which is true of many disorders, however, when left untreated, eating disorders can lead to permanent physical damage ranging from hair loss, to damage to the heart, organ failure, osteoporosis, and the inability to conceive. While the quality and effectiveness of mental health services have improved tremendously over the past several decades, only a few individuals who suffer from eating disorders ever seek treatment for their condition (Fairburn et al., 2000). In a report on the state of mental health in the United States, the office of the U.S. Surgeon General cited stigma as a significant barrier to the treatment seeking of mental disorders (U.S. Department of Health and Human Services, 1999). Thus, one possible barrier to treatment seeking among individuals with eating disorders is the fear of being stigmatized. This may be due to concerns that employers and educators may treat a person differently for having an eating disorder or

for pursuing psychiatric treatment. Other reasons for lack of treatment-seeking may include unwillingness to seek treatment, lack of awareness of their disorder, lack of awareness of treatment resources, embarrassed to seek treatment, lack of treatment resources, and perceived lack of anonymity in treatment.

### **Conclusions and Future Directions**

The gender difference present in the vulnerability for eating disorders has largely contributed to sociocultural explanations for the etiologies of these disorders that lend themselves to the examination of psychosocial risk factors. Anorexia Nervosa is often seen as a women's issue, and there may be less of a push to consider Anorexia Nervosa as a serious mental disorder (Stewart et al., 2006). Recent changes to the United States diagnostic system challenge these beliefs. Specifically, the introduction of the DSM-5 changed the diagnostic criteria of eating disorders to increase awareness of significant differences in symptoms, to account for the inability of males and pre-menarche and peri-menopause females to meet the amenorrhea criteria of anorexia nervosa, to acknowledge the role food and eating have across cultures, and to remove the arbitrary nature of body mass index (BMI) as related to eating disorder behaviors. Changes like these are a good first step in reducing the visibility component of the disorder, and placing greater emphasis on the fact that eating disorders affect individuals cross-culturally.

The starting point to unraveling the many layers of stigma is to build community awareness of anorexia nervosa, its prevalence, and its impact. Stigma is a significant barrier to help seeking. It robs people (who are already vulnerable) of their dignity, increases their sense of isolation, and further reduces their self-esteem. The prevalence and health consequences of eating disorders should prompt an increased discussion of

potential policy actions to address these public health concerns. There is currently inadequate insurance coverage for Anorexia for individuals who are not deemed suicidal, or medically unstable. This, in addition to a dearth of federal funding for critical research aimed at understanding Anorexia Nervosa, is an unfortunate clinical demonstration of the continual stigma that results with mental health disorders. The practice of limiting services to eating disorder patients continues in light of the strong research support that is developing related to the genetic and biological nature of eating disorders. The development, testing, and implementation of appropriate de-stigmatization campaigns for treating eating disorders is therefore warranted. Building community and individual awareness of the warning signs and fostering an understanding of just how important it is for a person to receive support and treatment is the first step to increasing education surrounding the stigma of eating disorders.

The next step, targeted at interventions on the interpersonal level, is to encourage increased education and awareness of those who are likely to work directly with people with eating disorders and their families. Physicians, nurses, and dieticians will inevitably encounter clients struggling with eating disorders, and thus, it is vital to dismantle the discourse and stigma surrounding eating disorders at this level. Strategies to improve school-based health curriculum, primarily in middle school and high school should include content aimed at preventing eating disorders, training for educators on the early identification of eating disorders, and anti-bullying policies that protect students from being bullied about their weight. These strategies may prompt an increase in public education programs and anti-stigma campaigns that challenge the myths and stereotypes about eating disorders by replacing them with factual information. In the development of

anti-stigma campaigns, it may be useful to adopt the strategies that have been used to challenge the stigma against other mental illnesses (such as depression and substance abuse). Highlighting stories of individuals coping with eating disorders, and individuals who have recovered, may help break the silence and shame that often plagues the lives of individuals who struggle with the disorder. In particular, recovery stories may be a useful tool to show those currently coping with anorexia nervosa, that recovery is possible.

Society as a whole must challenge the stigma surrounding eating disorders, and must recognize how the discourse surrounding them may discourage those coping with these problems to disclose them. Negative comments, belittling remarks, and jokes about an individual's appearance and eating patterns will only push individuals further into their eating disorder and increase their fear of being harshly judged. Prevention strategies must be taken into consideration when addressing the discourse and stigma surrounding eating disorders. Interventions aimed at individual level may enable those coping with eating disorders to challenge their self-stigma, or the stigmatizing beliefs they have toward themselves. Challenging these beliefs may, in turn, positively influence coping strategies. Taken together, the etiology of the stigmatization of anorexia nervosa, implication of blaming attitudes, and lack of awareness surrounding the disorder should prompt an increased discussion of the strategies society can undertake to dismantle the stigma surrounding eating disorders, and in particular, anorexia nervosa.

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