



## Sex differences in attitudes towards females with eating disorders



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### ABSTRACT

**Background:** This study aims to examine the public's attitudes and predictors of social distance towards women afflicted by eating disorders (anorexia nervosa [AN] and bulimia nervosa [BN]) under specific consideration of the respondents' sex. Eating disorders are still often seen as a women's health issue, and those afflicted remain stigmatized in Western societies. The concept of social distance is a frequently used indicator in awareness campaigns. Sex-specific results could add important information to destigmatization programs.

**Methods:** Data originate from a German telephone survey which was conducted in 2011. Vignettes with signs and symptoms either suggestive of AN or BN were presented to the respondents randomly, who subsequently answered questions regarding beliefs about causes, contact to persons afflicted as well as desire for social distance. Stratified multiple linear regression analyses according to disorder under study were performed to examine associations between different predictors and desire for social distance.

**Results:** There were significant sex differences in desire for social distance, causal attributions, and emotional reactions towards women with eating disorders. E.g., with respect to AN, women exhibited a significantly greater desire for social distance than men ( $p < .001$ ), and more frequently believed that AN could be caused by sexual abuse during childhood. Regarding predictors of social distance, there was a significant positive association between age and desire for social distance equally among men and women. However, distinct sex differences came into effect concerning other predictors depending on the eating disorder under study. In BN, attribution of brain disease emerged as significant predictor of social distance among men. This is not true for women, where the attribution of weak will significantly predicted the desire for social distance.

**Conclusion:** Sex-dependent differences in attitudes and predictors of social distance towards females afflicted should be met with tailored measures in anti-stigma campaigns, addressing women and men on different levels.

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## 1. Introduction

### 1.1. Background

Anorexia nervosa (AN) and Bulimia nervosa (BN) are well known eating disorders and recognized mental illnesses. Nevertheless, little is known about public attitudes towards women afflicted by one of these diseases, and still less research is focused on possible sex-dependent divergences in these attitudes. Only very few studies account for sex differences in their analyses. Holliday, Wall, Treasure, and

Weinman (2005) found that lay men and women do not differ in their knowledge about AN. Mond and Arrighi (2011) postulated sex differences in perception of severity of eating disorders and sympathetic feelings towards persons afflicted. Men were less likely to report that the problem (AN or BN) described would be distressing, less likely to report that these conditions would be difficult to treat and they were less likely to report being sympathetic to someone suffering from AN or BN.

Eating disorders (ED) remain stigmatized in Europe and the US. Studies found that they are often perceived within the patient's responsibility, representing an underlying blame-based stigma, while e.g. schizophrenia or depression are perceived as more biological mediated and arouse less dislike (Ebnetter & Latner, 2013; Roehrig & McLean, 2010; Stewart, Keel, & Schiavo, 2006).

According to the definition by Link and Phelan (2001), stigma exists when elements of labeling, stereotyping, separating, status loss and discrimination co-occur. Eating disorders, like most mental disorders, are not always recognizable in the individual, but social restrictions may still arise due to stigmatization processes. Acting secretly out of fear of

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being stigmatized reinforces self-stigma and inhibits the individual's willingness to seek treatment (Link & Phelan, 2001).

A study by Crisafulli, Von Holle, and Bulik (2008) explored the model of origins of blame-related stigmatization in the case of AN. When presented with a genetic and biological etiology of AN, blaming attitudes are greater opposed to a sociocultural explanation of AN. Other studies picked up the concept self-stigmatization among females with eating disorders. Troop, Allan, Serpell, and Treasure (2008) found that AN is associated with 'external shame', a perception that the self is evaluated negatively by others. Symptoms of BN are associated with 'internal shame' as a measure of shame-proneness.

One validated measure of psychiatric stigma is the desire for social distance (Link, Yang, Phelan, & Collins, 2004). With the help of this construct, a person's disposition or reluctance to socially engage with people afflicted by mental illness can be assessed. There are various studies on predictors of social distance, but mainly towards persons with depression or schizophrenia. Desire for social distance is associated with older age (Alexander & Link, 2003; van't Veer, Kraan, Drosseart, & Modde, 2006), lower level of education (Martin, Pescosolido, Olafsdottir, & Mcleod, 2007), biogenetic causal attribution (Jorm & Griffiths, 2008), and emotional reactions (Angermeyer, Matschinger, & Corrigan, 2004; Angermeyer et al., 2013). Decreased desire for social distance could be observed in association with personal contact to a person with mental illness (Angermeyer, Beck, & Matschinger, 2003; Marie & Miles, 2008).

The concept of social distance and its predictors has been applied frequently for certain diagnoses. It is a commonly used indicator to measure the effects of awareness campaigns that aim at decreasing discriminatory behavior against the mentally ill (Dumesnil & Verger, 2009). Nevertheless, eating disorders have not been considered very often in this context.

Previous research accounting for sex differences in their analyses (Mond & Arrighi, 2011) highlights the importance of tailored campaigns regarding ED. This can be underpinned by differences in the utilization of mental health services. Studies found that women exhibit more favorable intentions to seek psychological help and display a greater psychological openness than men (Mackenzie, Gekoski, & Knox, 2006). Moreover, ED are still presented as a women's health issue in public (O'Hara & Clegg Smith, 2007). This can imply different levels of reflection and attitudes between the sexes and underlines the importance to target women and men differently in prevention and information initiatives.

This study strives to explore present public attitudes which might be underlying stigmatizing behavior towards women suffering either from AN or BN. We test whether known predictors (age, education, personal contact, causal attributions and emotional reactions) of desire for social distance also pertain to eating disorders. Taking account of existing sex differences in previous research, we want to explore whether different predictors of social distance emerge according to the respondents' sex. We hypothesize age to be positively associated with desire of social distance, regardless of disorder or respondent's sex, while we expect personal contact to be negatively associated with social distance. With regard to emotional reactions we hypothesize that predictors of social distance differ according to sex.

## 2. Methods

### 2.1. Study design and sample

The data used for current analyses originate from a telephone survey (Computer Assisted Telephone Interview, CATI) conducted in two German metropolises (Hamburg and Munich) in 2011. The survey was part of a large project on mental health in Hamburg which aimed at improving treatment of mental disorders (Härter et al., 2012). Amongst others, one major component of the project is an awareness and education campaign about mental illnesses. The survey intended

to evaluate the effect of the campaign in Hamburg, while Munich served as control region. The baseline survey was conducted before the start of the campaign; a replication is planned for 2014. The sample consisted of adults aged 18 and older, living in private households in one of the two cities with access to a conventional telephone connection. It was drawn from all registered private telephone numbers at random, additional computer-generated numbers also allowed for ex-directory households. 2,014 women and men participated in the study (1,009 in Hamburg and 1,005 in Munich), reflecting a response rate of 51%. Socio-demographic characteristics of the sample are reported in Table 1. Comparisons with official statistics show that the distribution of gender, age, education and marital status in the sample are similar to those in the general population.

Informed consent was considered to have been given when individuals completed the interview. The study was approved by the Ethics Committee of the Medical Association in Hamburg.

The field work was accomplished by USUMA, a company in Berlin specialized in market and social research. In the interviews, written vignettes with typical signs and symptoms suggestive of depression, schizophrenia and eating disorders (either AN or BN; see Appendix A) were presented to the participants. All vignettes were developed in cooperation with experienced clinicians based on the relevant ICD-10 and DMS-IV criteria for the respective disorder and were audio-recorded with a trained speaker. The 'patient's' sex in the vignettes for depression and schizophrenia was systematically varied. In the vignettes displaying AN or BN only female sex was used. Epidemiologic rationale for only using young females in these vignettes is elevated lifetime prevalence among women and the early age of onset of ED (Preti et al., 2009). In order to avoid excessive demands on the interviewees, only two vignettes out of the four were included in one interview at a time. For

**Table 1**

Socio-demographic characteristics of study samples compared to official figures.

	Sample Hamburg (N = 1009) %	Population Hamburg Official Statistics	Sample Munich (N = 1005) %	Population Munich Official Statistics
Gender				
Male	48.4	48.9 <sup>1</sup>	48.9	48.5 <sup>1</sup>
Female	51.6	51.1 <sup>1</sup>	51.1	51.5 <sup>1</sup>
Age				
18-25	12.6	9.8 <sup>1</sup>	13.3	10.1 <sup>1</sup>
26-45	37.2	37.9 <sup>1</sup>	38.7	40.4 <sup>1</sup>
46-65	28.7	30.1 <sup>1</sup>	28.0	28.7 <sup>1</sup>
>65	21.6	22.2 <sup>1</sup>	20.0	20.8 <sup>1</sup>
Education				
Secondary elementary (9 years)	33.5	34.0 <sup>2</sup>	32.0	33.5 <sup>4</sup>
Secondary modern (10 years)	25.6	25.3 <sup>2</sup>	20.6	20.2 <sup>4</sup>
Grammar school (12-13 years)	41.0	40.7 <sup>2</sup>	47.3	46.3 <sup>4</sup>
Marital Status				
Married	43.9	38.0 <sup>3</sup>	41.7	44.3 <sup>5</sup>
Divorced	10.9	8.0 <sup>3</sup>	12.1	9.7 <sup>5</sup>
Widowed	9.0	6.0 <sup>3</sup>	7.2	5.9 <sup>5</sup>

<sup>1</sup> Federal Office of Statistics 2011: <https://www.regionalstatistik.de/genesis/online> (Accessed 08-14-2014).

<sup>2</sup> Federal Office of Statistics 2011: <https://www.destatis.de/DE/Publikationen/Thematisch/BildungForschungKultur/Bildungsstand/BildungsstandBevoelkerung5210002117004.pdf> (Accessed 08-14-2014).

<sup>3</sup> Office of Statistics North 2010: [http://www.statistik-nord.de/uploads/tx\\_standocuments/MIKRO\\_j10\\_01.pdf](http://www.statistik-nord.de/uploads/tx_standocuments/MIKRO_j10_01.pdf) (Accessed 08-14-2014).

<sup>4</sup> Microcensus 2009: Statistical Office of the City of Munich (upon request).

<sup>5</sup> Statistical Office of the City of Munich (upon request).

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