

DISSERTATION

GENDER DIFFERENCES IN THE ATTRIBUTION OF STIGMA TO INDIVIDUALS
WITH ANOREXIA NERVOSA: A GROUNDED THEORY EXPLORATION

Submitted by

Janean M. Anderson

Department of Psychology

In partial fulfillments of the requirements

For the degree of Doctor of Philosophy

Colorado State University

Fort Collins, Colorado

Summer 2013

Doctoral Committee:

Advisor: Kathryn Rickard

Mark Benn

Deana Davalos

Sharon Anderson

ABSTRACT

GENDER DIFFERENCES IN THE ATTRIBUTION OF STIGMA TO INDIVIDUALS WITH ANOREXIA NERVOSA: A GROUNDED THEORY EXPLORATION

Eating disorder research has minimally examined how eating disorders affect men and women differently, how individuals with eating disorders are perceived by others, and barriers to seeking treatment that individuals with eating disorders face (Corrigan, 1998; Crisp, 2005;). However, it is unknown how men and women may uniquely experience the stigma associated with eating disorders. Moreover, the complex relationship between gender and stigma are unknown. Examination of gender's impact on eating disorders needs to expand beyond research that examines gender only in the context of self-reported gender role orientation and eating disorder symptoms to include how gender creates norms and attitudes which affect those with eating disorders. Specifically, there is a dearth of literature regarding how stigma for men with eating disorders is different than it is for women with eating disorders. This study attempted to describe the phenomenon of gender-specific stigma in Anorexia Nervosa.

DEDICATION

For my patients, the most remarkable people I have known, this is dedicated to your recovery.

ACKNOWLEDGMENTS

I would like to thank the faculty in my program, my primary advisor, and my dissertation committee for their invaluable support and feedback during this process.

I would also like to thank my fellow researchers in the field. First, Caitlin Shepherd, Ph.D., for her help with the original project that served as the basis for this dissertation as well as for her assistance in coding the data for this dissertation, and most importantly, for being an amazing colleague, woman, and friend to me. Secondly, to members of my intern cohort who supported me while working on my dissertation during our hectic internship.

For my family and friends, the family who I chose and was lucky to be chosen by. Without your love, encouragement, and continuous support throughout my academic career this dissertation would not have been possible.

On a final note, I would like to acknowledge Starbucks for their fine caffeinated beverages, especially Starbucks canned Refresher energy drinks, without which this dissertation would never have come to fruition.

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Chapter 1: Introduction

Organization of the chapter

The first chapter of this study provides background information about eating disorders and stigma, defining and clarifying the meanings of both phrases. Further, a brief introduction to eating disorder and stigma literature is provided. Research regarding concepts of gender, eating disorders, and violating gender norms are also introduced. The chapter then discusses the rationale and purpose of the study as well as its significance. Finally, the chapter ends by listing research questions that guided the study.

General Introduction to the Topic Area

The DSM-IV-TR describes eating disorders as “severe disturbances in eating behaviors” (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994). Within the Eating Disorder chapter of the DSM-IV-TR, there are 3 broad categories of eating pathologies that occur. The first is Anorexia Nervosa, a disorder characterized by a refusal to maintain a healthy body weight despite being underweight, an intense fear of gaining weight, restricting caloric intake to lose weight, preoccupation with weight and shape, and, in post-menarchal females, amenorrhea. The DSM-IV-TR also identifies Bulimia Nervosa (BN), which is characterized by episodes of binge eating followed by purging behaviors and EDNOS (Eating Disorder Not Otherwise Specified), used by clinicians and researchers to describe individuals whose symptoms do not neatly fit into the criteria for AN or BN.

This study focuses on Anorexia Nervosa for several reasons. First, it is of personal interest to the researcher as a clinician specializing in eating disorder treatment who also identifies as recovered from AN. Secondly, AN is considered not only the most dangerous

eating disorder but the mental disorder with the highest mortality rate, surpassing even substance use and depression with the deaths that result from it each year (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994). Moreover, AN is associated with serious physical complications from malnutrition, restricting, and fasting such as amenorrhea (cessation of menstrual cycles), infertility, bradycardia (abnormally slow heart action), cold intolerance, digestive upset, digestive slowing, constipation, vitamin and other nutrient deficiencies, electrolyte imbalance, fatigue, fainting spells, dehydration, heart attack, and in some cases, death (Sharp & Freeman, 1993).

As aforementioned, osteoporosis is one of the major health consequences that can result from AN. Osteoporosis is particularly concerning given that its damage cannot always be reversed. Individuals who develop osteoporosis as a result of AN are at increased risk for fractures and joint problems for the duration of their lifetime. Osteoporosis is associated with significant weight loss, usually occurring at the beginning of the onset of AN. Mehler, Clearly, and Gaudiani (2011) discuss the prevalence, impact, and treatment of osteoporosis in anorexic patients. They report that when AN is treated early, outcomes for reducing the risk of osteoporosis or other permanent bone damage, improves. The authors state the “early treatment for anorexia is paramount in preventing osteoporosis” (p. 194). If early treatment for AN is crucial, it is also crucial that seeking treatment be as easy as possible.

Given the severe, and sometimes fatal consequences of AN, it is important to understand individual’s treatment-seeking behavior, investigating how barriers to seeking treatment can be minimized and access to treatment can be maximized. One major barrier to seeking treatment for any mental illness is the stigma that is associated with the mental illness itself as well as the stigma of being “in treatment” for the disorder. This study investigates some of the unique ways

in which stigma manifests for individuals who have AN, particularly focusing on how having an eating disorder, especially AN is associated with ideas of masculinity and femininity.

When individuals with AN seek treatment, they not only face the two forms of stigma mentioned above but they also face stigma that is associated with being a woman with an eating disorder, considered to be stereotypical, resulting in minimization of severity of symptoms and need to seek treatment by others, or contrastingly, as a man with an eating disorder, who is likely to be seen as violating traditional masculine gender norms and, therefore, a less valuable man. In either circumstance, stigma creates a barrier to easily accessing treatment that is necessary for preventing dire medical and psychological consequences.

Rationale and Problem Statement

Anorexia Nervosa is a severe, potentially deadly, mental illness affecting men and women. Early treatment for AN is critical for guaranteeing positive treatment outcomes (Mehler, Cleary, & Gaudiani, 2011). Individuals with AN not only bear the stigma of having a mental illness in general, but face stigma that is uniquely associated with the disorder such as being thought of as weak, conceited, or insecure (Crisp, 2005). Research in the field, however, has not examined how stigma may be assigned to men and women with AN in different ways or to varying degrees. Furthermore, there is a dearth of literature regarding stigma and gender role. For example, analyzing stigma within a gender role framework might explore how having AN is consistent or inconsistent with what is expected of an individual based on their gender. This study aims to analyze how men and women with AN are viewed by others, examining the aspects of stigma that are attributed to them, specifically stigma that is related to violation of socially constructed gender roles.

Purpose of the Study

The purpose of the study was to examine stigma within AN, specifically taking into account stigma related to gender. This study reviewed how women with AN were perceived and stigmatized, accounting for stigmatizing statements that referenced gender role-related concepts. Similarly, the study reviewed how men with AN were perceived and stigmatized, analyzing stigmatizing statements that referenced gender role-related concepts, in men violation of tradition masculine gender norms.

Research Questions

One central research question was the impetus for this study: do men and women with Anorexia Nervosa experience stigma and if so, are there gender-role related contributors to this? As the data was coded, more questions were generated, consistent with grounded-theory methodology. Additional research questions that arose were:

1. How is stigma expressed toward individuals with AN?
2. What are common themes in how stigma is attributed to males and females?
3. How do participants use gender constructs to proliferate stigma or to protect individuals from stigma?
4. What are the common colloquialisms used to describe men and women with AN?
5. What are the similarities and dissimilarities between AN stigma for men and women in comparison to other mental illnesses?

Significance of the Study

There is a wide body of literature documenting the stigmatization of mental illness and of the stigmatization of AN (Crisp, 2005; Crisp, Gelder, Rix, Metzler & Rowlands, 2000; Overton

& Medina, 2008; Penn & Corrigan, 1999). Stigma has been identified as a factor that reduces one's likelihood to seek treatment (Hinshaw, 2006). AN holds some of the most severe medical complications associated with a psychological illness including osteoporosis, heart problems, and electrolyte imbalance. Further, AN is also recognized as the mental illness with the highest mortality rate (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994), arguably increasing the need for individuals to easily access treatment for their condition even more critical. Despite the devastating psychological and physical effects AN can cause and the documented stigma that is associated with the disorder, little research has examined in detail stigma for men with the disorder compared with woman AN. Moreover, there is no research to the researcher's knowledge that examines how the stigma assigned to individuals with AN is related to gender role concepts, specifically how individuals with the disorder are complying with gender role expectation or violating gender role norms. Additionally, to the researcher's knowledge, there is no literature conducted using qualitative methodology to unearth the complexity of the stigma of AN. Increasing understanding, knowledge, and awareness of how the stigma of AN operates for men and women with the disorder can help to develop interventions to overcome the barrier of said stigma, providing easier access to treatment and treatment that is multiculturally competent, taking into account aspects of stigma associated with the individual's gender.

Key Terms

1. Eating Disorder (ED):

The term "Eating Disorder" is used in this study to describe any disorder defined by the DSM-IV-TR as an eating disorder. This is an umbrella term used to describe Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified (such

as Binge Eating Disorder). This umbrella term is useful in describing past literature given that many studies are not conducted on one particular eating disorder, but rather on eating pathology in general. Further, it should be noted that many individuals with eating disorders display symptoms of multiple eating disorders at different times (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994). For example, it is not uncommon for an individual to restrict for a period of time then switch to binge eating, making eating disorder research difficult to define clearly.

2. Anorexia Nervosa (AN):

Anorexia Nervosa (AN) refers to the disorder defined in the DSM-IV-TR as a disorder of restricted caloric intake, undue influence of weight on self-esteem, distorted body image perceptions, and amenorrhea. AN is discussed in detail in upcoming sections of this study. This study focuses on AN specifically within a broader context of eating disorders and mental illness stigma.

3. Stigma:

Stigma is used to describe stereotypes, prejudices, and discrimination of individuals of various identities. In this study, stigma is used to refer to all of the aforementioned aspects that individuals with mental illness face. Stigma, as defined by Hinshaw (2007) states that stigma primarily relates to attitudes about people with mental illness, which is consistent with how stigma is used throughout this study.

Organization of the Study

This study begins with Chapter 2, the literature review, which examines research that has been generated in the field of stigma and mental illness, eating disorders, and conceptualizations

of gender. The literature review begins by summarizing past literature on stigma and mental illness, with a focus on how individuals ascribe stigma others. Then, a more focused examination of eating disorder specific stigma is included. Then, research specific to concepts of gender, namely social constructivism, are defined and linked in their implications to treatment-seeking behaviors for men and women.

Chapter 3, Methodology, details the design of the study, information about participants and measures, and procedures that were used. Chapter 4, Results, discusses the qualitative data using a grounded-theory framework, examining multiple levels of coding. Most importantly, the Results section ends with the proposed theory based on the data. The Discussion section, Chapter 5, reviews the results of the data and discusses them within a context of prior literature. Chapter 5 also details the clinical implications of the study and suggestions for future research.

Chapter 2: Literature Review

Stigma and Mental Illness

Research has demonstrated that mental illness is stigmatized (Crisp, Gelder, Rix, Metzler & Rowlands, 2000; Overton & Medina, 2008). When thinking of mental illness, the word stigma may be associated with ideas of shame or dishonor. Stigma has been defined in numerous ways including: “a deep shameful mark or flaw related to being a member of group that is devalued by the societal mainstream,” (Hinshaw, 2006), “negative stereotyping,” (Penn & Corrigan, 1999), and “negative attitudes held by members of the public about people with devalued characteristics,” (Corrigan & Roa, 2012). All definitions of stigma reflect a negative evaluation of the individual regarding some characteristic or identity the person holds. Further, definitions of stigma focus heavily on the attitudes, thoughts, and emotional reactions to the characteristic of interest. Stigma can also be defined as “the spectrum of cognitions, emotions, and behaviors that interfere with interpersonal relationships as well as functions required for work, at home and in school” (Overton & Medina, 2008, p. 143). This is definition which this study bases its statements upon.

Stigma can be parsed into public stigma and self-stigma (Corrigan & Roa, 2012; Stier & Hinshaw, 2007). Public stigma refers to members of the community’s perception of an individual and the broader cultural concepts associated with a specific identity. When discussing mental illness, public stigma would be exemplified by terms and ideas associated with mental illness, such as being “crazy,” or people with mental illness being thought of as unstable, less competent, or dangerous. The corollary to public stigma is self-stigma. Self-stigma is the negative attitudes, emotional reactions, and ideas about an identity that an individual with that

identity has internalized about him or herself. Individuals with mental illness have been found to exhibit self-stigma, indicating that they hold negative beliefs about themselves and feelings of shame due to their mental illness (Corrigan & Roa, 2012). Another described form of stigma is known as structural stigma. Structural stigma encompasses external appraisal of individuals based on societal norms. This paper focuses on structural stigma by exploring how individuals perceive those with eating disorders and the subsequent evaluations that ensue. Structural stigma and public stigma are used interchangeably in this study. It is important to understand the various forms of stigma in order to examine how stigma affects behavior, specifically treatment-seeking behavior.

Stigma has been established as a widespread phenomenon occurring within various cultures and locations (Stier & Hinshaw, 2007) and the stigma surrounding mental illness is also not culture-bound. Further, the stigma surrounding mental illness has deep historical roots beginning with trephination, the drilling of holes in human skulls to alleviate symptoms of mental illness that were at that time attributed to evil spirits, thousands of years ago. Other forms of stigma can be seen in the development of institutional treatment settings once called “insane asylums,” where individuals with mental illness were often physically abused. Mental illness stigma pervades our modern culture as well. Television programming exemplifies the presence of mental illness stigma in the modern media by portraying people with mental illness as violent at a greater base rate than we would expect based on the actual prevalence of mentally ill individuals who exhibit violent behavior (Hinshaw, 2006).

The stigma of mental illness is evidenced in our current culture through the language that we use. Phrases such as “crazy,” “insane,” “psycho,” “psychotic,” “schizophrenic,” “bipolar,” “borderline,” and “nuts” are all derogatory words connected with mental illness, usually utilized

to describe undesirable behaviors. The language that our culture introduces, and that individuals perpetuate, becomes a powerful mechanism for enforcing social norms and quashing deviance. Hinshaw (2006) posits that stigma serves to discourage deviance and enforce group coherence. When individuals with mental illness act in ways that are perceived as deviant, they are thought of as a threat to group cohesion and harmony, which results in various forms of retaliation toward the individual be they overt acts of discrimination or shaming or subtle messages that convey disapproval.

The consequences of stigma are prolific, including decreased opportunities in the workplace, attaining housing, and in forming long-term relationships (Corrigan, 1998; Corrigan & Watson, 2002; Wahl, 1999). Further, individuals with mental illness encounter difficulties such as reduced admittance to schools, decreased self-esteem, and reticence to pursue goals (Corrigan, 1998; Corrigan & Watson, 2002; Wahl, 1999). According to Hinshaw, these disadvantages people with stigma face serve as ways that the collective is punishing individuals for threatening group cohesion. Stigma exists not only as an attitude but clearly also harbors real-world behavioral impact for the stigmatized.

Eating Disorders and Stigma

Many studies have examined differing types of stigma experienced by those with various mental illnesses. For example, Crisp et. al 2000 found that individuals with eating disorders were perceived as “hard to talk to,” “could pull themselves together,” and “have only themselves to blame” (p. 5). Other studies have found similar results, specifically for Anorexia Nervosa (AN). Stewart, Keel, and Schiavo (2006) utilized measures previously developed by Crisp et. al (2000) and found that participants viewed individuals diagnosed with AN as responsible for their

own condition. Additionally, participants indicated the belief that individuals with AN could pull themselves together if they so desired and were behaving as they were for attention.

The stigma experienced by individuals with AN differs from stigma attributed to other mental or physical illnesses. Unlike other mental illnesses, such as schizophrenia, individuals with AN are not perceived as dangerous (Crisp, Gelder, Rix, Metzler & Rowlands, 2000). Other measures related to interpersonal interactions, however, show that individuals with AN are stigmatized because they are thought of as “being difficult to talk to or empathize with” (Crisp, 2005). In a similar study conducted by Mond, Robertson-Smith, and Vetere (2006), participants described a vignette character with AN as attention-seeking. Additionally, they perceived the character as less competent in the workplace. Participants in this study also endorsed items indicating that having AN would not be “a bad problem to have” (p. 527). Other studies examining attitudes towards individuals with AN have found that participants endorsed personality traits such as perfectionistic, vain, sad, unsocial, emotional, fake, and sensitive for vignette characters with AN (Johnstone & Rickard, 2006).

Negative perceptions of individuals with AN are not limited to the realm of evaluation of the effect of the disorder on others, but include stigmatizing attitudes about the cause of AN as well. When vignette characters with AN were compared with vignette characters with physical illnesses, results showed that participants endorsed more stigmatizing statements for the AN condition (Stewart, Schiavo, Herzog, & Franko, 2008). In this study, participants did not attribute the etiology of AN to biological factors. AN was thought of as being within a person’s control and responsibility, which has been shown to increase the overall stigmatization of the disorder. Similarly, Holliday, Wall, Tressure, and Weinman found that lay participants viewed recovery from AN as more controllable than did participants with AN (2005). Crisafulli, Von

Holle, and Bulik (2008) investigated the effect of perceived etiology of the disorder, biological or environmental, on stigmatizing attitudes towards AN, and found that when AN was presented as biologically based, participants assigned less stigma than when participants read an article describing the environmental contributors of AN. These findings are important because they demonstrate that perceptions of the cause of a disorder are linked to its subsequent stigmatization. Individuals who are perceived as having control over the cause of their disorder experience stigmatization and anger from others, whereas individuals whose condition is judged as not within their control receive support and sympathy (Weiner, 1993).

All of the aforementioned experiences of stigma toward individuals with AN may inhibit individuals' recovery from the disorder. In an interview study of men recovered from substance abuse, stigma was found to contribute 20% of the variance in depressive symptoms one year post-treatment, indicating that stigma affected symptoms even after individuals had completed treatment (Link, Struening, & Rahav, 1997). A qualitative study of factors individuals with AN attributed to their recovery revealed that support from non-familial relationships was one of the most important aspects of recovery (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). This study highlighted the vital contribution interpersonal interactions have on recovery. However, research on stigma indicates a decreased likelihood for positive interpersonal interactions. It is possible that individuals with AN are less likely to experience supportive non-familial relationships since they are perceived as difficult to talk to and empathize with.

Eating Disorders and Gender Role Norms

In contrast to the literature on stigma and eating disorders, the relationship between gender role and eating disorders has been extensively investigated. Some have postulated that

femininity increases the risk for eating disorders, referred to as the femininity hypothesis, while masculinity has been presumed to be related to decreased risk for eating disorders. In a meta-analytic review, Murnen and Smolak (1997) found a weak positive relationship between femininity and eating disorders, and a weak negative relationship between masculinity and eating disorders. The impact of gender role-related factors and eating disorders, however, remains largely inconclusive.

One common factor observed across studies that investigated this relationship has been a main effect for gender role when controlling for other variables, suggesting the importance of further investigating the impact of gender role on eating disorders (Cantrell & Ellis, 1991; Hepp, Spindler, Milos, 2005; Lewinsohn, Seeley, Moerk, & Striegel-Moore, 2002). Although it is understood that this relationship is influential, the manner in which gender role influences eating disorder risk and symptomology is unknown, likely due to the numerous confounds within the literature. For example, many studies examine gender role orientation and sexual orientation together, making it difficult to isolate the gender role-eating disorder relationship. It remains unclear how gender may impact eating disorders since numerous studies combine gender-orientation measures with sexual orientation measures. When these studies include both male and female participants, many of the male participants identify as sexual minorities.

Furthermore, the research literature that does examine gender role and eating disorders fails to examine how others perceive the gender role of an individual with AN. Instead the studies that have been conducted explore the AN patient's perception of his or her own gender role. This results in an incomplete picture of how gender role influences eating disorders because of the dearth of diversity in participants and a lack of research investigating one variable i.e. gender, ethnicity, or sexual orientation by itself. It is important to understand how others perceive

gender role in individuals with AN as well as how those individuals perceive themselves in order to obtain a complete picture of broader cultural attitudes toward the disorder.

The exclusion of male participants in general, but especially heterosexual males, reflects stigma as well. Conceptually, eating disorders have been linked with femininity and have been referred to as “uniquely feminine disorders” (Boskind-White & White, 1986, p. 362) or as “feminine addictions” (Reid & Burr, 2000). This creates problems for women and men with eating disorders. Conceptualizing eating disorders as a feminine condition has numerous ramifications. First, it leads to underdiagnosis in males because clinicians are less likely to assess for symptoms if the disorder occurs, in their minds, in women. Secondly, associating eating disorders with femininity has become so commonplace and pervasive that it is expected for part of femininity to include eating disordered ideas, thoughts, and behaviors. In 1987, Rodin, Silberstein, and Striegel-Moore coined the term “normative discontent” to describe the pervasive pattern of body dissatisfaction women reported in their studies. Further research in this field indicated that women who experienced body dissatisfaction exhibited lowered self-esteem and increased likelihood of attempting to lower their weight (Tiggeman, 2005; 2004;1992; Webster & Tiggeman, 2003), especially through dieting (Tiggeman, 1997). When thought patterns, such as body dissatisfaction, and behaviors, such as dieting, are collectively thought of as “normal,” if not expected, the severity of eating disorders is minimized. Research on the stigma of eating disorders conducted by Crisp (2005) demonstrates evidence for this idea when participants in the study rated a vignette character with AN as having only a minor problem. Though the lay public cannot be expected to recognize and diagnose eating disorders, it is important for the general public to have a foundational understanding of the difference

between gender-role related body dissatisfaction and a clinically diagnosable, potentially fatal eating disorder.

Contrastingly, the idea that eating disorders are a feminine condition results in males with eating disorders to face not only the stigma encountered by those with eating disorders, but also to suffer the consequences of violating masculine norms by having a “feminine” disorder. In this way, males’ experience of eating disorder stigma is unique because of the linkages to their perceived masculinity and their own, internal gender role orientation. To our knowledge the stigma experienced by males with eating disorders has not been studied.

Eating Disorders in Men

Increased attention has been drawn to men’s health issues, particularly highlighting the need for further study of men’s mental health. Men account for approximately 10% of cases of AN (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994), double the 5% prevalence listed in the DSM-III. The clinical presentation of anorexia for males and females is similar, with most studies finding that there are few differences between men and women in terms of symptoms (Burns & Crisp, 1985; Crisp & Burns, 1983; Ousley, Cordero, & White, 2008; Weltzin, Weisenel, Franczyk, Burnett, Klitz, & Bean, 2005; Woodside, Garfinkle, Lin, Goering, & Kaplan, 2001). Even when examining self-silencing, defined as the withholding of disclosure about one’s struggles, men and women show similar levels of eating disordered pathology (Locker, Heesacker, & Baker, 2012) though men are typically thought of as more withholding than women. Additionally, similarities have been found in normative discontent for men and women with eating disorders. According to research conducted by Tenteff-Dunn, Barnes, and LaRosa (2011) men report similar levels of dissatisfaction with their bodies, the experience of

normative discontent. Despite the similarity in the clinical presentation of AN for men and women, research surrounding the ways both men and women experience AN and AN treatment are nevertheless particularly relevant. Stigma research is one of the means of investigating how men and women experience AN. For men especially, since stigma related to violation of traditional masculine norms is an aspect of AN that is distinctly male, variables such as help-seeking behavior could be affected and should be researched further.

Recently, traditionally masculine ideologies have been linked to increased mental health problems (Addis & Mahalik, 2003). Addis and Cohane (2005) describe masculine ideologies as “beliefs about both what it means to be a man and what are acceptable and desire to become thinner, rather than more muscular, violates traditional masculine norms. In fact, femininity, according to O’Neil (1981) is deeply feared as a threat to masculinity. O’Neil posits that valuing one’s identity through a traditional masculine lens requires the devaluation of feminine traits. In this model, men are pressured to embody masculine traits and to squelch feminine characteristics. Similarly, Moss-Racusin, Phelan, and Rudman (2010) report that men who were observed breaking traditional masculine gender norms, such as demonstrating modesty, were rated as being “weak” and “uncertain.”

Having AN as a man is “unacceptable” because of the pursuit of weight-loss, dieting behavior, and preoccupation with one’s body image, which have been shown to be viewed as feminine, and are inconsistent with the “masculine” pursuit of large muscles. Those norms are further challenged when men with eating disorders engage in activities to become thinner rather than to gain muscle. Even preoccupation with one’s body is viewed as normal for women yet abnormal for men (McVittie, Cavers, & Hepworth, 2005; Tiggeman, 2005; 2004). In fact, the notion that AN is an exclusively female disorder is so deeply ingrained that males with AN are

often rated by others as having more inherent feminine characteristics (Soban, 2006) and as mentally weak (McVittie, Cavers, & Hepworth, 2005). With regard to eating disorder related symptoms, traditional masculinity has been found to be associated with drive for thinness and drive for leanness (Mussap, 2008; Pritchard, 2008). The heavy influence of traditionally masculine norms has widespread implications for eating disorder treatment in men; due to the strong conceptual linkages with femininity, males with AN may be thought of as lesser men.

Despite the increased risk for mental health problems, men are less likely to seek help generally (Addis & Mahalik, 2003), to seek help for their eating disorder (Weltzin, Weisenel, Franczyk, Burnett, Klitz, & Bean, 2005), or to indicate that they have ever wanted treatment for eating disordered behavior (Lewinsohn, Seeley, Moerk, & Strigel-Moore, 2002). This may be caused by the aforementioned shame males with AN may experience due to having a disorder that is thought of as feminine, preventing them from seeking treatment at all. Further treatment complications for men with AN arise when they do seek treatment, as men who have AN are often incorrectly diagnosed (Romeo, 1994). If men with AN do manage to obtain treatment, there is little attention paid to men's specific concerns about AN and the appropriate modalities of therapy, though some feminist scholars have called for eating disorder treatment tailored to men (Soban, 2006). It is clear that men with AN face many barriers to successful treatment for their eating disorder. Men's ability to seek treatment for AN is critical since the prognosis for males is worse than the mere one-third likelihood for full recovery for females (Romeo, 1994).

Help and Health-Seeking Behaviors in Men and Women

The pervasive stigma surrounding mental illness is likely to create difficulties in seeking treatment. Despite the global affect of stigma in reducing the likelihood for seeking treatment,

men and women have different experiences of seeking help. Generally speaking, it is more acceptable for women to seek help than it is for men though mental health services continue to be underutilized (Rickwood & Braithwaite, 1994).

The research literature on psychological help-seeking reflects a tendency to examine women's help-seeking within the context of domestic violence relationships. Numerous studies examine women's motivation to seek help when they are in relationships with domestic violence, however, research is absent regarding women's psychological help-seeking, and further, help-seeking behavior with an exploration of gender norms for women. The research literature regarding men's psychological help-seeking is vast and has shown increased publications and research in this area over the past decade. This is potentially related to the growing popularity of the Psychology of Men and Masculinity as a division of the American Psychological Association and as a peer-reviewed journal. One study by Kimoya, Good, and Sherrod (2000) examined help-seeking in male and female college students. The researchers conducted a multiple linear regression to identify what characteristics predicted psychological help-seeking. Results showed that individuals who were less emotionally open, feared stigma, and who exhibited lower levels of psychological distress reported more negative views about seeking psychological help. Additionally, the greatest single predictor of negative attitudes toward seeking psychological help in the study was male gender. This result makes sense when reflecting on prior research and theory regarding masculinity and help-seeking behavior. First, women may be more likely to display emotional openness because feminine gender norms allow this behavior, if not encourage it. In contrast, masculine gender norms inhibit men from demonstrating emotional openness. Further, help-seeking itself could be viewed as a form of admitting weakness, violating the norms.

For men, traditional masculine norms such as self-reliance, avoiding appearing weak, and not revealing fears, directly contrasting seeking help itself. Men could interpret seeking help as being dependent, showing weakness, and disclosing fears. Several authors have discussed how traditional masculine norms inhibit men from seeking help (O’Neil, 1981; White, 2009). Men have been found to be less likely to utilize health care services, including medical services (Boman & Walker, 2010). For psychological help-seeking, men have been shown to be less likely to use career counseling services (Graef, Tokar, & Kaut, 2010) and psychotherapy (White, 2009). In one study, men who endorsed higher levels of traditional masculine norms, such as higher levels of emotional restriction, displayed more negative attitudes toward seeking therapy (Tsan, Day, Schwartz, & Kimbrel, 2011). This is consistent with the aforementioned study conducted by Kimoya and colleagues (2000). Another study by McCusker and Galupo (2011) examined how others perceived masculinity and femininity in a fictional vignette of a man suffering from depression. Findings revealed that the construct of masculinity was not impacted by whether the fictional vignette character was seeking help or was not seeking help; however, the construct of femininity was affected. Data indicated that participants perceived the man in the vignette in the help-seeking condition as more feminine. This is problematic for encouraging help-seeking behaviors in men. This research suggests that while perceptions of masculinity may not be reduced after seeking psychological help, perceptions of femininity will increase. This may result in increased self and structural stigma for men who seek help. Additionally, it should be noted that McCusker and Galupo’s research used a vignette with a male suffering from depression. Depression, unlike AN, has been given attention in the media with specific public awareness campaigns devoted to destigmatizing depression in men e.g. the “Real Men, Real Depression” campaign (Rochlan, McKelley, & Pituch, 2006).

Though efforts have been made to help men feel more comfortable seeking psychological help, men continue to underutilize psychological services. In the following section, the Theory of Planned Behavior is introduced as an explanation in behavior terms for the help-seeking behaviors observed in men and women.

Theory of Planned Behavior

The preceding sections explored how traditionally masculine norms are related to treatment seeking behavior. The Theory of Planned Behavior (TPB) has been used to relate research findings to real-world application, specifically in this case, implications for the likelihood of seeking treatment for an eating disorder. The TPB (Ajzen, 1991) is used to predict human behavior. The TPB can also be used to explain behavior that has already taken place. The theory asserts that the intention to perform a behavior, meaning how hard someone is willing to try, can be predicted based on the following three concepts: attitudes towards the target behavior, subjective norms, and perceived behavioral control.

Attitudes indicate the degree to which a person favorably evaluates the target behavior. In the case of men with AN, they may not evaluate the target behavior of seeking treatment positively, indicating an overall negative attitude towards seeking help. Subjective norms refer to the perceived pressure to perform the target behavior. A man with AN is not likely to feel much pressure to seek treatment since his disorder may not be recognized. Attitudes and subjective norms are powerful components in TPB's prediction of behavior because they impact perceived behavioral control. Perceived behavioral control is defined as a person's perception of the ease or difficulty to perform the target behavior. Ajzen (1991) explained that more favorable

attitudes and subjective norms regarding the behavior of interest increase perceived behavioral control. Considering that perceived behavioral control has the strongest predictive power of the three constructs in the model, it is critical to understand the factors that affect it. Men with AN are not likely to experience much perceived behavioral control since they are likely to have negative attitudes toward seeking treatment and are unlikely to be pressured by others to pursue this course of action. In turn, men with AN may perceive treatment seeking as difficult, leading to decreased likelihood to complete this behavior. A study conducted by Wester, Arndt, Sedivy, and Arndt (2010) elucidated TPB and masculine gender norms impacting psychological help-seeking. The researchers studied male police officer's views about seeking counseling. Specifically, they examined cops' perceived benefit from seeking help against the risks involved in violating norms by seeking help, and therefore, risking experiencing stigma. Wester and colleagues concluded that male cops who reported higher levels of adherence to traditional masculine norms anticipated greater risks and listed fewer benefits for seeking treatment. This study offers a concrete example for using TPB to understand treatment seeking as it relates to attitudes.

The TPB has previously been used specifically to examine psychological help-seeking behavior in men (Shepherd & Rickard, 2012). Smith, Tran, and Thompson (2008) found that attitudes towards seeking psychological help mediated the relationship between intentions to seek psychological help and traditional masculine ideology. More recently, research by Tsan, Day, Schwartz, and Kimbrel (2011) support a TPB conceptualization of men's psychological help-seeking, with men with more negative attitudes toward help-seeking endorsing lowered likelihood to complete help-seeking behaviors.

Since the TPB has been applied to the understanding of men's psychological help-seeking in general, it is useful to investigate its utility in explaining help-seeking for specific psychological problems, especially those that are deeply connected to traditional masculine ideology. For AN in particular, men have poor prognosis for recovery that is only lessened as the gap in time from the onset of the disorder to the time when treatment is sought widens.

Summary

The stigma surrounding mental illness is pervasive in our culture, ranging from shaming colloquial phrases that describe people in derogatory ways to real-life manifestations of stigma in the form of discrimination. Individuals with AN experience the stigma associated with having a mental illness. They also experience stigma associated with their disorder that is connected to whether the disorder itself is congruent or contrary to norms associated with their respective gender. For women with AN, their symptoms are viewed as less severe due to normative discontent: expecting, normalizing, and trivializing the profundity of women's dissatisfaction with their bodies and the use of eating disordered behaviors to modify their weight. Men with AN, on the other hand, violate traditional masculine gender norms by having a disorder that is characterized by feminine qualities such as desire to lose weight and preoccupation with body size.

The symptomology of AN presents as remarkably similar for men and women. The stigma men and women with AN experience, however, shows significant differences. Understanding the mechanisms by which stigma is proliferated is vital to reducing stigma, a major barrier against seeking psychological help. The severity of symptoms as well as the medical complications associated with AN require that individuals seek treatment. Stigma

creates a block to seeking the life-saving treatment for AN. Stigma can be understood using the Theory of Planned Behavior as a framework for incorporating attitudes and subsequent completion of treatment-seeking behaviors, particularly accounting for the ways in which gender role norms influence attitudes toward treatment.

Current Study

In a previous study (Anderson & Rickard, unpublished manuscript in preparation for publication), stigma specific to one's gender was investigated using several open-ended questions. They were as follows: 1) What do you think of (vignette character's name) as a man/woman? 2) What kind of a man/woman do you think he/she is? 3) Is he/she like other men/women? Why? 4) In what ways is he/she similar/different from other men/women?

Preliminary analyses of the data revealed that the male character vignette was uniquely stigmatized for having an eating disorder. Specifically, participants referenced the vignette character's violation of traditional masculine norms due to having an eating disorder. Themes such as "Sam is less of a man" were discovered.

The goal of this study was to conduct a rigorous qualitative analysis of the data using a grounded theory framework. The objective of the study upon completion was to propose an innovative theory that offers an explanation as to why participants stigmatized the male vignette character and the female vignette character in different ways. The overarching research question of this study was: do men and women with Anorexia Nervosa experience stigma, and if so, are there gender-role related contributors to this? In order to begin to explore this, and to propose a theory regarding it, we hoped to understand why participants stigmatized the male and female vignette characters in different ways.

Chapter 3: Methodology

Organization of the Chapter

This research is a grounded-theory qualitative study that examines the attributions of stigma toward men and women with Anorexia Nervosa via a qualitative design utilizing clinical vignettes and open-ended questions. The methods chapter is divided into four subsections. First, the study's research questions are restated. Second, information about the participants is discussed. Third, the qualitative measures are listed and examined. Next, the procedures that participants engaged in are presented. Lastly, a detailed account of the data analysis is given including subheadings that specifically address trustworthiness, clarifying research bias, research journaling and reflexivity, peer consultation, and finally, a short review of grounded-theory data analysis.

Research Questions

As previously mentioned, a single research question was the impetus for this study: do men and women with Anorexia Nervosa experience stigma and if so, are there gender-role related contributors to this? As the data was coded, more questions were generated, consistent with grounded-theory methodology. Additional research questions that arose were:

1. How is stigma expressed toward individuals with AN?
2. What are common themes in how stigma is attributed to males and females?
3. How do participants use gender constructs to proliferate stigma or to protect individuals from stigma?
4. What are the common colloquialisms used to describe men and women with AN?

5. What are the similarities and dissimilarities between AN stigma for men and women in comparison to other mental illnesses?

Participants

Participants consisted of 162 introductory psychology students at a large, Western university. Age of participants ranged from 18 to 30 years ($M = 19.65$ years, $SD = 1.70$). Ethnic composition of the participants was as follows: 89% Caucasian, 3.0% Hispanic, 2.1% Asian American, 1.7% African American, and 4.2% “other”. Participants completed this study as part of a course research requirement and received credit. All participants who were enrolled in introductory psychology and were 18 years or older were included.

Procedures

After giving informed consent, participants were administered a survey within one of two conditions. Surveys contained the same contents except the sex of the vignette character was male in one case and female in the other. This is a sample of the vignette:

“Sam is average height, but s/he appears to be extremely underweight. Although s/he is 15% below the expected weight for his/her height and age, s/he does not see him/herself as underweight. Because of his/her weight loss, she has not had her period for three months. Sam has an intense fear of gaining weight and becoming fat. S/he often experiences feelings of anxiety and guilt after eating. This preoccupation with food and body image takes up a majority of Sam’s time.”*

*This sentence does not exist in the male character vignette.

Participants completed measures as part of a broader survey. After completing other measures not included in this study, participants read the vignette. Then participants completed the qualitative outcome measures assessing stigma and gender role-specific stigma. Qualitative outcome measures were open-ended questions described in the next section. Finally, participants were given a debriefing sheet explaining in detail the purpose of the study.

Qualitative Measures

Questions were posed to participants to investigate whether possible stigma assigned to the vignette character has specifically related to violation of gender norms. The questions were designed to elicit responses that would reflect the participants' reactions to the vignette character's norm-violating behavior and, subsequently, how the participant may have attributed stigma to the character. The qualitative measures are listed below:

- 1) *What do you think of (vignette character's name) as a man/woman?*
- 2) *What kind of a man/woman do you think he/she is?*
- 3) *Is he/she like other men/women? Why?*
- 4) *In what ways is he/she similar/different from other men/women?*

Data Analysis

Trustworthiness

Within qualitative research, trustworthiness is the means by which the validity of the research results and conclusions is assured. Several approaches addressing trustworthiness were

employed in order to ensure the quality and rigor of the study. Creswell (2007) recommends using at least two strategies to confidently and adequately address the issue of trustworthiness. In the present study, the following three strategies were included in the methodology:

Clarifying Research Bias

Consistent with many grounded-theory studies, the researcher bracketed her personal experiences and biases in order to be clear about her intention in the study and the assumptions she might bring into it. The researcher's paradigms, beliefs, and intent have been made clear and are discussed in the following paragraph.

In this study, the researcher had access to the qualitative data and had summarized results briefly for a previous research project. Contact with the data ahead of time creates some bias on the part of the researcher, since she did not see the data for the first time upon beginning of the grounded theory analysis. However, steps were taken to reduce this bias. The researcher did not review any of the past results and had no contact with the data before beginning the formal grounded theory analysis for this study.

The researcher also has values surrounding the content of the study. First, the researcher is a clinician and researcher in the field of eating disorders, and is invested in making the process of seeking treatment for an eating disorder as part of her broader career goals. Further, the researcher is recovered from Anorexia and feels sympathetically toward other individuals who have endured stigmatization for an eating disorder, as she has experienced in the past. Moreover, the researcher has also participated in past research studies in related areas, particularly concerning difficulties that men face in seeking treatment for psychological disorders. The

researcher is especially interested in responses regarding the male vignette character. A brief review of this data in a previous study showed stigmatization toward the male vignette character and the researcher is aware of this pattern in the data.

Research Journal and Reflexivity

Additionally, the researcher engaged in self-reflection by keeping a research journal that included hypotheses, questions, concerns, additions, philosophical musings, methodological considerations, and other topics related to the process of conducting the research. The reflective journal entries were intended to make the researcher's role as the interpreter of data more explicit, especially to others, and remain aware of assumptions and biases that could influence the research process (Creswell, 2007; Morrow, 2005). This journal also provides a record for other researchers to review and provide accountability to the researcher.

Peer Consultation

During the data analysis process, the researcher consulted with a research committee, consisting of qualitative research peers and a counseling psychology faculty member. These individuals commented on the quality of the researcher's analysis and provided feedback on methodology. Individuals on the team are trained in qualitative methodology, and monitored researcher bias and help to generate alternative themes and codes (Creswell, 2007; Morrow, 2005).

Grounded Theory Research

Grounded Theory is one of the foremost methods for analyzing qualitative data in the field of counseling psychology (Fassinger, 2005). Grounded theory research aims to explain participant's behavior in a natural setting, usually through analysis of interview information or by reviewing other information such as case notes, health records, and case studies. This theory enables the researcher to adapt his or her explanations of the data during the process of analysis, as the researcher continually reviews new material and revises conclusions made about data that has been collected.

In this study, qualitative data from 162 participants was analyzed using a Grounded-Theory approach. The three steps identified by Fassinger (2005) were used to ensure quality of analysis. First, open-coding was used to identify concepts. Concepts are small units of meaning or ideas that come from analyzing selected portions of the data. In this study, a participant's response to a single question served as the unit of measurement to be analyzed for concepts. Concepts were gathered for all four questions and included both the male and female vignette character conditions.

The following step employed axial coding to examine the relationships between concepts. Axial coding compiles the fragment concepts into broader sub-categories through a constant comparison method. In constant comparison the researcher compares the concepts using four distinct strategies: 1) Comparing and relating subcategories to categories, 2) comparing categories to new data, 3) expanding the density and complexity of the categories by describing their properties (attributes of a category) and dimensions (ordering of the properties along a continuum), and 4) exploring variations (disconfirming instances) in the data and revising the

conceptualization as needed. Axial coding provided sub-categories that will be used to help form the concluding substantive theory of this study.

The final step of the analysis utilized selective coding. During the selective coding phase, a substantive theory was formed from the previously discovered subcategories. In this step, a “core theory” was presented that will provide an overarching explanation for the data and begin to answer the research question.

Chapter 4: Results

Organization of the Chapter

This chapter describes the three levels of data analysis used in a grounded theory framework: open coding, axial coding, and selective coding. The sections begin by defining the respective levels of analysis. Each section also contains excerpts from the data and explanations of themes. Finally, a summary following the selective coding section introduces the proposed theory: “gender-role congruence theory of stigma.”

Open Coding

Open coding was analyzed by question, then by condition. For example, question 1 was analyzed for each condition. Then, question 2 was analyzed for each condition until coding of all data was complete. The researcher completed multiple entries in her research diary, disclosing thoughts, biases, and questions for further investigation. After the researcher completed the open coding of all data, 25% of the data was randomly selected for analysis by a fellow psychologist who is an expert in this area of research. The researchers coded all data independently of one another. Data from the two separate analyses was then compared for similar themes and discrepancies were investigated. Researchers agreed on themes for open coding and proceeded with further analyses.

Open Coding of Question 1: *What do you think of (vignette character’s name) as a man/woman?*

Responses to this question were placed into the following categories: Empathic, Concerned, Neutral, Stereotypical, Normalizing/Trivializing, and Critical. Empathic responses

were characterized by positive evaluations of the character without indicating concern.

Empathic responses were the least frequent type of response given (0.5%), which is consistent with the body of literature that reflects the stigma of mental illness and eating disorders. Further, empathic responses were only found in the male vignette character condition. Examples are listed below:

“ I think that he is a man that is a part of society that puts so much pressure on young people to be thin.”

“He is a good person. He just needs some mental and emotional help.”

One explanation for the presence of empathic responses being absent from the female vignette character condition is that due to the widespread normative discontent and expectation of women to use eating disorder behaviors, women are less likely to receive support or empathy. This data supports the position that eating disorder behaviors in women are trivialized, even when the behaviors are described at a clinically significant level, as was the case for the vignette character.

Concerned responses demonstrated some form of concern or worry for the vignette character, without making a negative evaluation of the character. Concerned responses comprised the second lowest frequency of response (13%). Contrary to the Empathic category, Concerned responses were only found in the female character vignette condition. Examples are shown below:

“Don’t know but I feel bad for her.”

“She should stop worrying. She is harming herself.”

Neutral responses made no indication of positive or negative evaluations of the character. Additionally, Neutral responses were factually accurate rather than based on opinion. Like Concerned category responses, Neutral responses were only exhibited in the female character vignette condition. Examples are listed below:

“Hard to tell what to think of her”

“Self-conscious about her weight”

“She just has a problem. Doesn’t seem to change who she is”

“I think she is a woman with an eating disorder”

“Might be concerned with her weight but doesn’t need to be.”

The next category of responses, Stereotypical responses, contained answers that are consistent with stereotypical evaluations of individuals with eating disorders as determined by prior literature. Traits that have been well documented in the eating disorder stigma literature include people evaluating individuals with eating disorders as “vain,” “weak,” and “conceited,” though there are many more (Crisp, 2005). Stereotypical responses accounted for 31% of responses. Stereotypical responses, such as the ones listed below, were only observed in the female vignette condition.

“She is not necessarily a bad person or vain woman but she may just be insecure in who she is.”

“Confused and insecure.”

“Sam is unsure of herself and works badly to fit in.”

“She has low self-esteem and poor body image.”

As aforementioned, stereotypical responses reflect common stigmatize attitudes toward individuals with eating disorders. It is worth noting, however, that stereotypical responses were seen only in the female vignette character condition. One reason for this pattern in the data could be that the lay public have stereotypical archetypes for Anorexia. This archetype is not likely to be thought of as male, rendering all stereotypical concepts about Anorexia constrained to women. Men are not represented as part of the AN population and, therefore, are not incorporated into people's general conceptions of AN.

The Normalizing/Trivializing response category (13%) was also only found in the female vignette condition. Normalizing/Trivializing responses were characterized by statements that minimized the severity of the information presented. The vignette provided to participants contained all the diagnostic criteria of AN, including the individual being at less than 85% ideal body weight and exhibiting amenorrhea. Though participants in this study were laypeople, non-experts in diagnosis, Normalizing/Trivializing responses greatly underestimated the profundity of the information they were presented with. Normalizing/Trivializing responses were found only in the female vignette character condition. Responses are listed below:

“Goes through same problems as most women, only more extreme.”

“She sounds like an average woman trying to be skinny.”

“She seems to have the typical feelings of wanting to be thin so society will appreciate her.”

The presence of Normalizing/Trivializing responses in solely the female vignette character condition again reflects a biased conceptualization of AN as being a female problem. Normative discontent and expectations for women to engage in weight modifying behaviors

appears to be so pervasive and acceptable that even in situations where these behaviors meet diagnostic criteria for the most dangerous eating disorder in the DSM-IV-TR, people downplay the severity of the symptoms. The corollary to this also offers support for the idea that gender norms influence attitudes about AN. Normalizing/Trivializing responses were not found in the male character vignette condition. One could postulate that based on traditional masculine gender norms, which discourage weight loss and preoccupation with body size, that a man who exhibited these characteristics would be seen as an outlier from the general male population.

The final category, Critical responses, were responses that demonstrated negative evaluation or judgment of the vignette character. Critical responses accounted for 22% of responses. First, sample Critical responses are listed for the female vignette character condition:

“Weak, naïve, undesirable (as a friend to the opposite sex).”

“Conceited. Not one I would want to date. However, she needs help. She may be intelligent.”

“She is too preoccupied with her weight and appearance.”

“Obviously preoccupied with the wrong thing.”

The following are Critical responses from the male vignette character condition:

“I think less of him as a man (as bad as that sounds).”

“Men can control themselves and their bodies. He can choose to be better. Until then, he’s not a man.”

“He seems more like a chick than a man and I have little respect for him as a man.”

“He seems insecure and that is not a good quality to have as a man.”

“I think Sam is unusual because most men want to get ‘big’ and don’t like being small or skinny. I also think Sam is self-conscious about his weight.”

Several observations from the critical responses are worth noting. First, Critical responses for the female vignette character condition were consistent with prior findings (Crisp, 2005), with participants referencing themes of vanity and weakness on the part of the character. Secondly, when examining the male vignette character conditions, the data shows that participants noted how the male vignette character was “odd.” The male vignette character exhibits AN behaviors, which were not consistent with participants’ ideas of what individuals with AN are like or how men behave. Here, the idea of deviance from social norms, introduced by Hinshaw (2006) as a part of the mechanism of stigma, is evident.

Summary of Open Coding for Question 1

Open coding for question 1 yielded interesting results. The data shows that the female vignette character condition contained a wider variety of responses, including Empathic, Stereotypical, Normalizing/Trivializing, and Critical. In contrast, the male vignette character condition offered only two types of responses: Critical and Empathic. This may reflect a general perception of AN as being female, supported by the nuanced categories of responses for the female vignette character. In contrast, the male vignette character condition offered fewer descriptive categories, likely reflecting a limited frame of reference for AN in men.

Another theme observed in the data was the qualitative strength of the response, meaning how forceful or opinionated the response to the vignette character was. The Critical responses for both male and female character conditions demonstrated the most forceful responses. For the

female character condition, participants described her as “weak, naïve, and undesirable.” Similar responses to the female vignette character were observed in the Stereotypical response category. This indicates that participants hold negative, critical views of women with AN but that these critical views are part of a traditional (stereotypical) conceptualization of AN in women.

The opposite was true for the male vignette character condition. Participants showed the strongest responses in the Critical response category. Moreover, the critical responses for the male character condition specifically referenced how the male vignette character violated traditional masculine norms. Participants went further in their stigmatizing responses of the male character by providing responses such as “he is not a man.” Comments such as these exemplify Hinshaw’s (2006) idea how people use stigma to deter deviance from social norms. Violating traditional masculine norms by having AN appears to represent a significant deviance and threat to group cohesion.

Open Coding of Question 2: *What kind of a man/woman do you think he/she is?*

Similar to Question 1, responses to Question 2 were placed into the following categories: Neutral, Stereotypical, Normalizing/Trivializing, Complimentary, and Critical. For categories that were also found in Question 1 (all categories except Complimentary) the same definitions for categories were applied.

Neutral responses were observed only in the female vignette character condition (19%). Neutral responses made no indication of positive or negative evaluations of the character. Neutral responses were the most infrequent responses for both conditions, though the female vignette condition had more neutral responses overall. One example of a Neutral response for the male

condition was that a participant described him as “normal.” Examples of Neutral responses for the female condition are listed below:

“Having an eating disorder doesn’t negate who she is.”

“She sticks to being thin.”

The next category of responses, Stereotypical responses were only observed in the female vignette character condition (31%). The same pattern was found in the open coding analysis of question 1. Stereotypical responses contained answers that are consistent with stereotypical evaluations of individuals with eating disorders as determined by prior literature including the ideas that individuals with AN are “vain,” “weak,” and “conceited.” Examples of Stereotypical responses are listed below:

“Unconfident.”

“Insecure.”

“An insecure woman.”

“Quiet, shy, impressionable.”

“Frail. Self-conscious. Insecure.”

As described earlier, stereotypical responses were observed in the female condition but not in the male character condition. Consistent with question 1, participants may have provided stereotypical responses to the female condition only due to lack of familiarity and, therefore, stereotypes regarding men with AN.

Normalizing/Trivializing responses were statements that minimized the severity of the information presented, severely misunderstand the severity of the information presented in the

vignette. Like other categories, Normalizing/Trivializing responses were found only in the female vignette character condition and accounted for 13% of total responses. Examples of Normalizing/Trivializing responses follow:

“Pretty similar to the majority of college females.”

“Seems average.”

“A regular woman.”

As was the case in open coding analysis of question 1, the Normalizing/Trivializing reveal the participant’s failure to understand the severity of the vignette character’s condition. Again, it is reasonable to assume individuals without detailed knowledge about psychological disorders should be able to identify circumstances of severe symptoms. The data found in the Normalizing/Trivializing responses from question 2 also lend support for the idea that the severe symptoms associated with AN are downplayed by others given the pervasive cultural beliefs regarding normative discontent.

For question 2, a new category of responses, named Complimentary responses, was developed. Some participants (less than 5) listed responses that gave praise to the vignette character. Examples of complimentary responses follow:

“Nice woman struggling with self-image.”

“A good woman who doesn’t think good things about herself.”

“Athletic and skinny but she could be nice.”

The Complimentary response category (2%) was developed to capture responses that did not fit the criteria for Neutral category or any other category. Complimentary responses provide

several interesting points of evidence. First, Complimentary responses could be considered the least stigmatizing type of response. In all Complimentary responses, the participant attributed positive features to the vignette character herself. They did not make positive remarks about the eating disorder behaviors. This may be evidence that some participants do not fault the individual for their behavior. Another noteworthy observation is that no participants gave Complimentary responses to the male vignette character. This provides evidence that it is more acceptable for woman to have AN than it is for men.

The final category of responses, Critical responses, was seen in both male and female vignette character conditions. Critical responses negatively evaluated or judged the vignette character. As was the case in question 1, Critical responses were the most frequent response category for question 2 for the male character condition (22%). The most common category for the female condition in question 2 was Stereotypical responses. Examples of Critical responses for the female vignette character condition follow:

“Has priorities all mixed up.”

“Jealous, always trying to look better.”

Examples of Critical responses for the male vignette character condition:

“He is a self-centered bitch with a vagina.”

“Sam is a pussy.”

“A weak, feminine man.”

“I’d assume he’s gay, weaker, feminine.”

“He’s too concerned with physical appearance which is societally deemed as ‘feminine’.”

The last response listed above encapsulates what has been proposed throughout this study. Participants clearly respond in a more forceful manner to the male vignette character, going as far as to use epithets. Interestingly, the epithets that were used all demonstrated attempts to emasculate the male character by using femininity-related insults such as “pussy” or emasculating him by implying that the character is gay.

Critical responses for the female vignette character condition were negative, describing the character as “jealous,” however, none of the responses contained epithets. It appears that the Critical responses to the male condition were more stigmatizing.

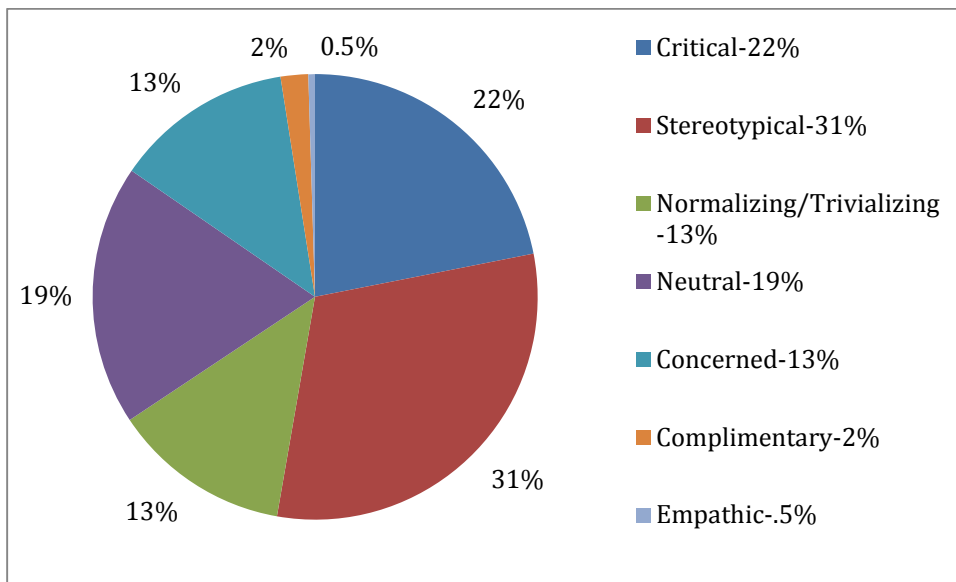


Figure 1: *Percentage of Responses by Type*

Summary of Open Coding for Question 2:

Patterns found in the data for question 2 were congruent with patterns found in question 1. In question 2, the strongest, most stigmatizing responses were observed in the Critical responses. Moreover, Critical male responses demonstrated more criticism than did Critical responses for the female condition, attacking the male character with epithets attempting to

immasculate him. Participant's most frequent response for the male vignette character condition was Critical.

Regarding the female vignette character condition, the most frequent response was Stereotypical. Though Stereotypical responses showed negative evaluations, they were less severe than Critical responses. Additionally, Stereotypical responses have been well-documented in past literature (Crisp, 2005), providing support for a widespread archetype of what a woman with AN might be like. Further, no Critical responses in the female vignette character condition referenced anything about the character being less of a woman or impugning her femininity.

Open Coding of Question 3: Is he/she like other men/women? Why?

Open coding of questions 3 and 4 observed overarching themes from participant responses rather than categorizing responses into discrete categories. Several themes were found. First, for the male vignette character condition, the majority of participants said that the character was unlike other men (69%). Examples of participant responses are provided:

"No. He thinks about weight/fat too much. Most guys love food and don't care about getting fat."

"No, he is more fragile."

"I don't know anyone personally or otherwise that is male and has his issues. Usually I would believe females to have these worries. Few men I know feel this way."

"No. He is not looking to increase his masculinity."

"No, other men try to gain weight to build muscle. Men always eat a ton of food and never feel guilty."

These responses reference how the male vignette character's eating behavior contradicts traditional masculine norms, perceiving him as unlike other men. Other responses represented a more neutral stance toward the male vignette character, listing ways that the character is similar to other men. Neutral responses (31%) accounted for approximately one-third of all responses to the male condition for question 3. Examples of neutral responses for question 3 are listed below:

"Some possibly. Everybody goes through a stage of difficulty and everyone's different."

"Some. Some men are shy and softspoken."

"Yes. There are lots of men like Sam who are insecure, largely because of men in the media and sports they feel like they need to be like."

In sum, responses to question 3 showed less variety than questions 1 and 2. Responses to question 3 instead offered primarily responses stating that the male character was unlike most men. However, there were responses that indicated participants felt Sam was like or could be like most other men.

Regarding the female character vignette condition for question 3, two themes for responses were found. Fewer than 10 total participants (7%) indicated that the female vignette character was unlike other women. Examples are listed here:

"No because she obviously has a weight problem."

"No. She has taken the desire to be thin to the extreme."

"No because she has not had a period in a while."

These responses, though few in number, demonstrate some level of understanding of the abnormality of the character's symptoms. Most participant responses, however, described how the female vignette character was like most other women (93%). The following are examples of these responses:

"Yes. Many women have eating disorders."

"Yes, a lot of women are afraid of how they look and a lot don't eat as much as they should."

"She is like other women who aren't sure of themselves and sometimes would like to be someone else."

Participant responses stating that the female vignette character is similar to most other women exhibited aspects of normative discontent discussed earlier in this study. The majority of participants viewed the female character, who displayed all diagnostic symptoms of AN, as like most other women. Specifically, they indicated that most women feel and eat in similar ways to women with AN.

Open Coding of Question 4: In what ways is he/she similar/different from other men/women?

Question 4 was coded in the same manner as question 3 showing two emergent themes. The first theme indicated that the character was similar to other men/women. The second theme discussed how the character was different than other men and women. For the female vignette character condition, most participants (86%) stated that the character was similar to other women. Some of the ways participants viewed the character as similar to other women were: worrying about physical appearance, dissatisfaction with body or weight, and that most women pursue weight loss. For example, participants' responses included responses such as these:

“She’s similar in that she is unhappy with her physical appearance.”

“Similar because most women try to be skinny to the point of unhealthiness and unattractiveness.”

Participants also shared ways in which they perceived the female vignette character as different from other women, most of them highlighting the extremity of the vignette character’s thoughts and behaviors. “Different” responses accounted for 14% of responses to this question. Examples of “different” responses are listed:

“She is different from other women because she is letting the fear of being overweight interfere with almost every aspect of her life.”

“Different in how far she takes it [behaviors] and the guilt that she feels.”

“Other women are not usually so concerned that they abuse their bodies to the point that they stop having their periods.”

Participants described the male vignette character in ways that he was similar to other men and different from other men. Most participants (91%) stated that the character was different from other men, giving fewer responses than in the female condition detailing how the character was similar to their respective gender. Examples of participant responses follow:

“Probably similar in the fact that most men care about what they look like ‘muscle-wise.’ Different in the fact that it consumes his everyday life.”

“He is similar to other men because he wants to look good but different because he does it by losing weight.”

“Few men I know feel this way”

“Weaker, doesn’t enjoy eating, more gentle.”

“He is way too preoccupied with his weight and he is a douche.”

Responses for the male character vignette condition resembled those of the female character condition. Two important differences in themes from the two conditions for question 4 were found. First, participants were more likely to describe the female vignette character as both similar to and different from other women whereas fewer participants identified similarities in the male vignette condition. Secondly, responses for the female character condition showed no critical or insulting statements. The male character condition, however, contained critical responses to the character such as stating that he is a “douche.”

Summary of Open Coding Results

Results of the open coding analysis revealed that, consistent with other literature, AN was stigmatized. Over all questions, critical or stereotypical responses and themes were the most prevalent. Within stigmatized responses, AN in females appeared to be minimized with participants citing examples of many women feeling dissatisfied with their bodies and losing weight. Additionally, most participants viewed the female vignette character as similar to other women. Differences that participants listed between the vignette character and other women tended to refer to the extremity of the thoughts and behaviors exhibited in the vignette. Stigmatizing responses for men reflected severely negative evaluations of the male vignette character, some participants going as far as to use epithets to describe the character. Of note, the insults stated about the male character were feminized insults such as “pussy,” “bitch,” and “douche.”

Analyzing responses for similarity and difference of the character to other members of the character's gender revealed that in both conditions, participants were able to list ways in which the character was both different and similar to other men and women. However, the female vignette character condition contained more responses that named similarities and differences. The male character condition presented more responses that identified ways in which the character was different from other men. One potential explanation for this is that the lay public have greater knowledge and exposure to AN in women, providing them with the ability to give nuanced descriptions for the female character condition. This level of nuance and variety of responses was not seen in the male character condition.

Perhaps the most interesting data analyzed in the open coding analysis were related to participants' tendency to reference how the characters conformed or defied traditional gender role norms. The male character was violating traditional masculine norms by being preoccupied with weight, wanting to lose weight, and by not wanting to increase his muscularity. Participants identified the female vignette character as conforming to what they expect from women, stating that most women want to lose weight, most women experience dissatisfaction with weight, and most women change their behaviors (e.g. diet) to lose weight.

Axial Coding

Axial coding, the second phase of analysis within a grounded theory model, combines smaller units of meaning from the open coding phase into larger, more cohesive themes. Often, results from axial coding analysis reflect relationships between codes in the opening coding phase. Fassinger (2005) describes axial coding as “put[ting] fractured data back together in the form of categories and their interrelationships, the next step in generating a theory,” (p. 160). Axial coding creates several broad categories into which open codes are categorized. Further,

the axial coding phase of analysis utilizes the “constant comparison method” wherein data are compared with one another, how they relate to each other, and discrepant data are accounted for.

During axial coding, three categories were derived from open coding data. They are as follows:

1. Modes of Stigmatizing AN
2. Castigation of AN in males
3. Discounting of AN in females

The first category, Modes of Stigmatizing AN, was created to reflect the overall negative attitudes toward the vignette characters with AN. Further, this category provides examples of the ways in which stigma operated in this study, following Hinshaw’s (2006) example of depicting mechanisms of stigmatization. Stigmatization functioned using several methods. First, the frequency of participants’ critical and stereotypical responses was greater than positive responses. In fact, positive responses were so rare, this can also be considered one of the ways in which stigma operates. The stigma of AN elicited both criticism (punishment) and lacked positive responses (encouragement or support). Even neutral responses, which were less frequent than critical and stereotypical responses but still infrequent reflect that the participants held stigmatizing attitudes toward AN. This is consistent with other literature in the field that reported stigma with regard to AN being the primary response of participants toward a vignette character (Crisp, 2005; 2000). This category describes how AN for males and females was stigmatized.

The second category created during axial coding was “Castigation of Males with AN.” This category details stigma that was specific to the male character, predominantly referencing the male character’s violation of traditional masculine norms. Stigmatization of males with AN exists on several levels. The first level describes how participants reported that the male vignette

character deviated from other men. Simple statements such as “he’s not like men I know,” and “guys don’t worry about their weight,” epitomize the stigmatization of the male character. By relating how the male character is different from most men, participants create social distance between the character and his male peers. According to Hinshaw (2006), when people with mental illness are seen as extremely different than others, as non-representative outliers, they experience more stigma. In addition to highlighting the male vignette character’s deviance from their schemas of men, participants also perceived the male character as more feminine. This is illustrated through statements calling the vignette character “Weaker,” and “more feminine.” One participant stated that the male character was “more like a chick than a dude.” Feminizing the male character creates a unique form of stigma. O’Neil (1981) posits that feminization is threatening to males, degrading their masculine identities and rendering them less likely to gain acceptance from their male peers. The final aspect of the “Castigation of Males with AN” category depicts another manner in which the character was stigmatized. The male vignette character suffered insults, including epithets and profane remarks. These castigating words included calling the character “a self-centered bitch with a vagina,” “a pussy,” “probably gay,” and “a douche.” The aforementioned responses are all feminized insults, alluding to the male character having feminine qualities, which in this case, are considered derogatory. These comments illustrate a direct threatening or degradation of the male character’s masculinity.

The final category generated during axial coding was “Discounting of AN in females.” Open coding data demonstrated that participants had less severe, castigating remarks than the male vignette character condition. Negative responses toward the female character included calling her “weak,” “fragile,” “conceited,” and “unattractive.” Though those remarks are damning and stigmatizing in their own way, they differ from male responses in that they do not

attempt to denigrate the female character's feminine identity. Analogous responses of castigation for the female character condition would be calling the character a "dick" or a "prick," or potentially referring to her as "butch." However, none of the participant responses displayed an attempt to degrade the character's femininity by attributing negative male qualities to her. In contrast to the male character, the female character received primarily "stereotypical" responses rather than "critical" responses. Stereotypical responses are stigmatizing, however, they can be considered less stigmatizing than the feminizing epithets observed in the other condition. Moreover, the stereotypical responses exemplify the idea of normative discontent. Participants stigmatized the female character by failing to recognize how she is different than other females, thus minimizing the severity of her condition. Again, participants in this study were not expected to demonstrate advanced diagnostic skills but should be able to differentiate between full-criteria AN and typical dieting behavior. Fewer than 10 participants total stated that the female vignette character had a serious problem or that she had an eating disorder. Normative discontent regarding the presence of a deadly eating disorder in a woman may reflect stigma functioning in the form of apathy. Without recognizing, let alone validating, the severity of AN the a barrier to seeking treatment.

Axial coding analysis developed three categories or themes among the open coding data. The first category, Stigmatization of AN, illustrated how AN demonstrated stigma associated with this mental illness. Stigmatization in this category is not specific to gender roles. The second category, Castigation of Males with AN, explored how men with AN were perceived as deviant outliers from the standard male population. Further, it depicts how men with AN are stigmatized by having their masculinity attacked through feminizing insults. The final category, Discounting of AN in females, reflects participants' inability to recognize the profundity of the

diagnosis of AN. Additionally, this category of stigma contrasts the Castigation of Males with AN category by offering a point of comparison regarding the intensity of criticism of the character. The female vignette character condition did not reveal any attack on the character's femininity by attributing masculine characteristics to her. The next level of analysis attempts to unify themes found in the data resulting in a substantive theory, offering explanations for patterns in the data.

Selective Coding

The final phase of data analysis in a grounded theory framework is selective coding. Selective coding incorporates themes previously derived from the data, continues using the constant comparison method to examine discrepancies, and provides a theory that explains the data. This level of analysis considers relationships between concepts and concepts at the micro and macro levels that they are observed in the world. Selective coding yields a cogent narrative, telling the story of the data based on prior levels of analysis. Previous levels of analysis revealed three overarching themes in the data: 1) A general stigmatization of AN as a mental illness 2) stigmatization of males with AN by feminization and 3) stigmatization of females with AN via trivialization of their problems.

The first theme was observed in numerous ways during the open coding phase of data analysis. Stigma of AN was demonstrated by participants' negative descriptions of individuals with AN. Those results, combined with a lack of positive evaluations, illustrates stigma. Aside from the general indifferent to unsupportive responses to the character, the male and female vignette characters were stigmatized in ways that related to gender role norms. In the male

condition, the character was primarily described as being different from other men, thought of as an anomaly. Moreover, the reaction to this anomaly was extremely, passionately negative, using insults. The insults reflected a devaluation of the male character's masculinity by calling him "bitch," and "pussy." In this case, participants appeared to react directly, and negatively, to their perception of the male character's violation of masculine norms. In contrast, the stigmatization of females with AN seemed to results from the participants' perception that the female character conformed to gender role norms by dieting, losing weight, and displaying negative body image. Unlike the male character, participants described the female character as "normal," and "like most other women," vastly underestimating the consequences of the disorder and the need for treatment. In this way, women with AN experience stigma by having a disorder that is considered typical or even expected of women, discounting their plight and pigeon-holing them into stereotypes and pre-conceived notions about AN.

Themes in this study compliment conclusions drawn by other researchers(Crisp 2005; 2000; Wahl 1999; Corrigan & Watson, 2002; Corrigan, 1998). A wide body of evidence has documented the stigmatization of mental illness and further, the stigma of AN specifically, showing that individuals with mental illnesses such as AN experience numerous forms of stigma including negative perceptions from others, verbal degradation, and discrimination in relationships, education, housing, and employment settings.

The first theme, that AN was stigmatized, is congruent with past research (Crisafulli, Van Holle, & Bullik, 2008; Overton & Medina, 2008; Crisp, 2005). This study, however, examined the stigma of AN specifically related to gender role norms. From this, the second and third themes emerged. Males with AN were stigmatized harshly, using slights against their masculinity to instill shame. Research regarding traditional masculine norms has shown that the

greatest threat to masculinity is femininity (O'Neil, 1981). It appears that participants perceived the male vignette character as feminine, violating traditional masculine norms. The vignette character exhibits behaviors that participants associated with femininity such as dieting, drive for thinness, and preoccupation with body image. Romeo (1994) found that eating disorders were thought of as feminine afflictions, which was replicated in a later study by Reid and Burr (2008). The male vignette character was sanctioned, interestingly using feminized insults, for his violation of traditional masculine norms.

The female vignette character experienced stigma in the form of minimization of her diagnosis. This type of stigma produces negative attitudes toward the disorder, individuals with the disorder, and creates a barrier to seeking treatment. Participants stigmatized the AN character by sharing that they thought she was like most women they knew or most other college-age women. This is consistent with the concept of normative discontent introduced by Rodin, Silberstein, and Streigel-Moore in 1987. Participants' responses reflect a pervasive cultural belief that most women are discontented with their body size and weight, condoning weight loss, even if that is accomplished through restricting caloric intake. If AN is thought of as normative for women, it would be perceived as unwarranted and shameful to seek treatment for a problem that is expected in women, a form of stigma. Women with AN are not violating traditional feminine norms, such as normative discontent, desire for thinness, and pursuit of weight loss, yet they endure stigma.

Stigmatization of AN is deeply connected to cultural concepts of gender role norms and the subsequent expected behaviors associated with those roles. It appears that mental illness creates stigma but that stigma for men and women operate in different manners. For men, they deviate from what is expected of their gender role and are stigmatized, discouraging deviance

from the collective as Hinshaw (2006) introduced. For women, AN fits within what is expected based on gender role norms, however, the behaviors exhibited by the vignette character should be recognized as deviant, extreme behaviors. The character was described as weighing below 80% ideal body weight, exhibiting amenorrhea, and was continuing to pursue weight loss. Participants were blinded by their expectations based on female gender role, rendering them unable to recognize that the behavior was significantly different, significantly more pathological, than what would be expected from women without AN. In this way, women experience the stigma of AN as a blindness or lack of seriousness toward their condition. As was introduced in the literature review section of this paper, gender role norms are socially constructed ideas that are reinforced throughout one's lifetime, clearly delineating acceptable and unacceptable behavior. The idea that men and women with AN face stigma in different forms to varying degrees based on conformity or violation of gender role related norms introduces a theory called "perceived gender-role congruence theory of stigma." Regardless of gender, stigma harms everyone.

Summary of Results

Analyses from this study support a social constructivist framework for understanding how AN is gendered, how masculine and feminine norms are attributed to AN, and the interplay of how individuals with AN conform to or violate gender role norms. A new theory is necessary to explain these specific factors. The proposed theory, called perceived gender-role congruence theory of stigma, describes the phenomenon of differences in the stigma of AN assigned to males and females.

Chapter 5: Discussion

Organization of the Chapter

Chapter 5 starts with a synopsis of significant findings from the results section. Then, results from this study are discussed within the larger context of literature in this field. Following the exploration of the literature, implications of the results from this study are discussed within a clinical context and suggestions for future research are listed. Limitations of the study are also described before the chapter concludes with a summary of this research project.

Summary of Key Findings

This study set out to explore the ways in which stigma existed in AN. Further, it aimed to examine how stigma for men and women with the disorder is similar or different. During the open coding phase of data analysis, participant responses were placed into categories including: empathic responses, neutral responses, concerned responses, normalizing/trivializing responses, stereotypical responses, and critical responses. Both AN men and women were stigmatized more than supported or admired. The ways in which men with AN and women with AN were stigmatized varied. Women experienced primarily a discounting of their troubles, with participants noting that they viewed the vignette woman as being like other women they knew and failing to note the severity of her eating disorder. Men with AN experienced stigma in the form of castigation, with participants attributing feminine characteristics to the character, which was intended to be derogatory.

Results of this study can be explained through a social constructivist paradigm for understanding gender role norms. Gender role norms are socially constructed ideas that

influence behaviors enacted by men and women. These roles are arbitrary, hence socially constructed, and are vehemently reinforced in broader culture. Violations of these norms result in censure. Individuals also experience censure, castigation, and reprimand in the form of stigma. Similar to the ways in which individuals are punished for violating gender role norms, individuals with mental illness are punished for violating norms and threatening group cohesion. With AN, there is a two-fold impact of stigma. This first component is that the mental illness itself threatens group cohesion and, therefore, induces stigma. The second component is that AN is tied to adherence or violation of gender norm behavior for women and men respectively. Perceived gender role congruence theory of stigma was introduced as a substantive theory that illustrates the narrative of the data.

Discussion of Results

Recent research suggests that eating disorders are stigmatized (Crisp, Gelder, Rix, Metzler & Rowlands, 2000) and that stigma impedes treatment seeking for psychological problems, especially for men (Addis & Mahalik, 2003). The aim of this study was to investigate the role that gender plays in the stigma of eating disorders, providing a reason for stigmatizing attitudes that are held against individuals with eating disorders and for low rates of treatment-seeking behavior.

In this study, the severity of AN in women was found to be minimized in qualitative responses. This idea demonstrates that viewing the vignette character as feminine and the vignette character having AN are conceptually congruent. Boskind-White and White (1986) described AN as a specifically feminine disorder and other research has proposed the idea that discontent with one's body is normative. It is important that individuals are educated about eating disorders, AN in particular, and can accurately recognize them since eating disorders, AN

in particular, pose a serious threat to one's health without treatment. If eating disorders are normalized and the severity of their impact is therefore trivialized, it is far less likely that people will hold positive attitudes about seeking treatment. Data also showed that men were stigmatized for having AN by means of attributing negative, feminine attributes to them.

Several conclusions can be taken from these themes as a whole. Overall it is clear that there is an association between gender and ways in which it is appropriate to change the appearance of one's body or alter one's eating habits. For women, the desirable outcome is thinness. Results indicated that women should want to be thin. Moreover, that the desire to be thin is the norm held by most women. Thinness seems to be so important to achieve that unhealthy strategies for achieving thinness are not only sanctioned but are encouraged, such as the restriction of food intake described in the vignette. The qualitative data revealed that participants held the belief that all women want to be thin. Further, participants expressed that unhealthy dieting behavior and excessive exercise is normative. Perhaps the most disturbing finding was that participants identified with these norms about female eating and exercise behaviors so strongly they appeared to be unable to recognize the severity and dangerousness of the presented eating disorder, anorexia nervosa. The majority of the participants thought that the behavior of the female was typical, despite reading the diagnostic criteria in the vignette. Even when the vignette stated that the female character was experiencing amenorrhea, participants still regarded this behavior as normal and understandable.

These attitudes pose serious potential problems for women with AN. First, in examining the components of TPB, there seems to be a subjective norm that AN is acceptable, if not even desirable, for women. When a norm such as this is salient in the population, it is less likely that there will be norms that make it acceptable or desirable for women to seek treatment for their

disorder. Results from this study indicate that norms and attitudes towards women with AN influence intentions to seek treatment, which may, in turn, reduces actual treatment seeking behavior. This is a disconcerting finding considering the fact that AN is one of the most fatal mental illnesses with which one can be diagnosed (4th ed.; DSM-IV-TR; American Psychiatric Association, 1994). Future interventions should strive to impact subjective norms and attitudes that support treatment seeking behavior in order to increase intentions to seek treatment and actual treatment seeking behavior.

Similarly, data revealed that participants held the belief that all men should be muscular. Moreover, it is not acceptable for men to want to attain thinness. Qualitative responses included responses such as “men need a little meat on their bones,” “men don’t worry about their weight,” “men don’t watch what they eat. They indulge whenever they want,” and “guys should want to get bigger, not smaller.” These responses are reflective of the norms for eating and exercise behavior in men (McVittie, Cavers, & Hepworth, 2005). In addition to these ideas of how men should appear, qualitative data also showed that men were perceived as having control over the disorder, stating that men could stop their disorder if they wanted to or by stating things such as “men can control their weight and their bodies.” Also, data suggested that if men did not exercise control over their disorder by stopping those behaviors they were lesser men, feminine men, “girlie” men, or gay men. The second category derived during the axial coding phase of data analysis, Castigation of Males with AN, showed that men with AN were perceived as deviant outliers from the standard male population. Further, it demonstrates how men with AN are stigmatized by having their masculinity attacked through feminizing insults.

This clearly demonstrates the relationship between gender and stigma. In this instance, stigma is not only exhibited by limiting how men should behave (in only masculine ways. As

per Addis and Cohane's (2005) definition of masculine ideologies, beliefs about both what it means to be a man and what are acceptable and unacceptable behaviors for men, it is unacceptable for men to be thin, want to be thin, and to not change these behaviors to achieve a more muscular physique. Even preoccupation with one's body is viewed as normal for women but abnormal for men.

This relates to another theme that emerged which states that the most critical responses found in the qualitative data were toward the male character and were written by men. Expletives were used to describe the male vignette character, all of which were feminized epithets. Comments listed were related directly to the character's lack of masculinity and similarity to women. This chastisement is evidence of the consequence of violating traditional masculine norms. The responses seem to indicate that it is imperative to remain within the traditional bounds of masculinity and, therefore, viewing treatment seeking for men with AN is not likely to be considered normative or positive, creating barriers to treatment.

The three categories from the axial coding phase (stigmatization of AN, castigation of men with AN, and trivialization of AN in women) were explained within a social constructivist paradigm. A new theory, the theory of gender-role congruence of stigma, was introduced. The theory posits that stigma of AN functions along the boundaries set by traditional gender role norms. For women, stigma is expressed in the form of minimizing the effect of AN whereas in men stigma is conveyed through criticism of one's masculinity. Stigma functions as another form of encouraging compliance with gender role norms in an effort to discourage differences and increase group cohesion.

Clinical Implications

The results of this study have numerous implications for clinical work with the AN population. First, as practitioners working in the eating disorder or greater mental health field increase their understanding, they can better identify with and empathize with their clients. Further, this study provides insight into the stigma that the individual seeking treatment may have experienced before coming to the therapy office. Practitioners can provide psychoeducation to clients, normalizing their experience of stigma and explaining that it results from pressure to adhere to traditional gender role behavior.

The information produced by this study can also be used to tailor interventions for women and men with AN, addressing their unique needs in terms of stigma. Campaigns to increase awareness and treatment-seeking behavior for women might emphasize that behavior observed in AN should not be considered normal and should not be trivialized. Underscoring the critical nature of AN is key to helping people understand that AN is not merely dissatisfaction with one's body, trying to lose a few pounds, or a phase a woman goes through. Instead, AN should be portrayed as what it actually is: a severe mental illness that often entails complications to health, and in some cases, death.

For men, interventions to increase awareness and treatment-seeking behavior should begin by debunking myths about men with AN. Particularly, interventions should promote knowledge that men with AN are not necessarily more feminine, and therefore bad, men. Further, inherent themes of homophobia must be addressed as well so that men with AN are not consistently and incorrectly identified as gay. Interventions should aim to increase individuals' appreciation for the severity of AN as a disorder in women and also strive to normalize the presence of AN in men. Through the use of TPB, the steps in the process of seeking treatment

for men and women with AN can be examined, enabling barriers to be addressed at multiple levels of the behavioral process. In doing this, women would be able to get the proper care for their AN because its severity will be recognized and men will be able to seek out services with greater support and less prejudice from others.

Limitations and Suggestions for Future Research

This study has several limitations. First, the study utilized a primarily Caucasian, traditionally-aged undergraduate population which may not reflect the heterogeneity of the eating disordered population at large. Future studies should aim to utilize more representative samples from the community to see how individuals from varying backgrounds respond on stigma measures. This would provide information that would help in shaping specific interventions tailored at altering the unique attitudes, norms, and intentions of diverse groups.

A second limitation of this study was that it relied on self-report and other report measures. Participants reported information about themselves but were also asked to imagine and, subsequently rate, a character that they had not encountered. Future studies would benefit from using confederates or individuals with AN in a lab setting rather than a vignette character to create a more ecologically valid experience for participants.

Thirdly, the qualitative responses were originally gathered as part of a larger qualitative and quantitative study. Future studies would benefit from drawing on a smaller sample size and conducting at length interviews with participants. Grounded theory research often entails interviews with participants that are recorded and later coded. By interviewing fewer participants yet allowing more time, results might yield richer data that could more clearly illustrate the underlying concepts at play. Additionally, this study did not conduct analyses

regarding how the gender of the participant affected the types of responses they gave. Future studies should examine by gender, stigmatization of AN, expanding on the aggregate picture generated by this study.

Finally, though this study aims to advance knowledge within the larger context of understanding gender role construction, gender in this study was discussed using a binary framework. As more research is generated that uses fluid measures of gender rather than bipolar one, as well as when individuals who identify as “gender queer” or “transgender” knowledge regarding gender role norms will expand.

Summary and Conclusions

There is limited information regarding the way in which eating disorders affect men and women differently, how individuals with eating disorders are perceived by others, and barriers to seeking treatment that individuals with eating disorders face (Crisp, 2005; Corrigan, 1998). Moreover, it is unclear how men and women may uniquely experience the stigma associated with AN. In addition to the stigma that is experienced from having a mental illness, stigma related to gender roles is also felt. The complex relationship between gender and stigma were explored in this study revealing severe castigation of men with AN and trivialization of AN in women. The theory of the gender-role congruence theory of stigma explains the results by proposing that men are censured for AN because it violates traditional masculine norms whereas women experience stigma in the form of minimizing their difficulties because these difficulties are congruent with female gender role norms such as normative discontent. Gaining a richer understanding of stigma is critical to advancing research in the field as well as in developing interventions that increase treatment-seeking behavior for this potentially deadly disease.

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Appendix A: Informed Consent

This study will examine attitudes about mental illness and gender. You will be asked to complete a survey containing several multiple choice and open-ended measures asking you for your opinion based on information that is presented. At the beginning of the survey, you will be asked for basic demographic information though none of the information will be linked to your identity. The results of the survey will be completely anonymous and the data stored securely until the completion of the study. When you are finished, you will be given a debriefing form that will explain in detail the objectives, methods, and significance of this experiment.

I agree to participate in the survey regarding mental illness and gender being conducted by Janean Anderson, B.S., a graduate student in the Counseling Psychology Ph.D. program at Colorado State University under the supervision of Kathryn Rickard, Ph.D. The nature of the study and my participation in it has been explained to me and I understand the following:

1. My participation involves minimal risk to me beyond the possibility of some mild anxiety in considering and responding to the topic and questions.
 2. My participation results in receiving 1 research credit toward the fulfillment of the PSY100 General Psychology course research participation requirement.
 3. My confidentiality will be protected to the full extent of the law. No identifying information is required to participate in the study.
 4. If I have any questions or problems as a result of participating in the study I may contact Janean Anderson at janean.anderson@gmail.com, or her faculty advisor, Kathryn Rickard, Ph.D. at Kathryn.Rickard@colostate.edu.
 5. My participation is completely voluntary and has been gained without coercion. My refusal to participate will involve no penalty or loss of benefits and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled.
 6. I may receive further information regarding the purpose and/or results of the study following participation by emailing Janean Anderson at janean.anderson@gmail.com.
1. Please indicate below if you agree to participate in this research survey (required).

- I have read the informed consent and I AGREE to participate.
 I do NOT agree to participate.

Appendix B: Character Vignettes

Male Character Condition

Please read the following paragraph carefully. Then answer the question at the end.

Sam is average height, but he appears to be extremely underweight. Although he is 15% below the expected weight for his height and age, he does not see himself as underweight. Sam has an intense fear of gaining weight and becoming fat. He often experiences feelings of anxiety and guilt after eating. This preoccupation with food and body image takes up a majority of Sam's time.

What sex is Sam? Male Female

Female Character Condition

Please read the following paragraph carefully. Then answer the question at the end.

Sam is average height, but she appears to be extremely underweight. Although she is 15% below the expected weight for her height and age, she does not see herself as underweight. Because of her weight loss, she has not had her period for three months. Sam has an intense fear of gaining weight and becoming fat. She often experiences feelings of anxiety and guilt after eating. This preoccupation with food and body image takes up a majority of Sam's time.

What sex is Sam? Male Female

Appendix C: Complete Surveys

Thesis Survey- Male Vignette Condition

List the last six digits of your student ID number after the letter: F _____

Please fill out the following demographic information:

1) What is your gender? Female Male

2) What is your age? _____

3) What is your ethnicity? *Circle one*

Caucasian

African American

Hispanic

Asian American

American Indian/Alaska Native

Other

BMI

Please list your current height _____

Please list your current weight _____

MCSDS

Please respond to the following statements by indicating if they are true (T) or false (F) of you.

- | | | |
|--|---|---|
| 1) Before voting I thoroughly investigate the qualifications of all the candidates | T | F |
| 2) I never hesitate to go out of my way to help someone in trouble | T | F |
| 3) It is hard sometimes for me to go on with my work if I am not encouraged | T | F |
| 4) I have never intensely disliked someone | T | F |
| 5) On occasion I have had doubts about my ability to succeed in life | T | F |
| 6) I sometimes feel resentful when I don't get my way | T | F |
| 7) I am always careful about my manner of dress | T | F |
| 8) My table manners at home are as good as when I eat out at restaurants | T | F |
| 9) If I could get into a movie without paying and be sure I was not seen I would probably do it. | T | F |
| 10) On a few occasions, I have given up doing something because I thought too little of my ability. | T | F |
| 11) I like to gossip at times | T | F |
| 12) There have been times when I felt like rebelling against people in authority even though I knew they were right | T | F |
| 13) No matter who I'm talking to, I'm always a good listener | T | F |
| 14) I can remember "playing sick" to get out of something | T | F |

- 15) There have been occasions when I took advantage of someone T F
- 16) I'm always willing to admit it when I make mistakes T F
- 17) I always try to practice what I preach T F
- 18) I don't find it particularly difficult to get along with loud mouthed,
obnoxious people. T F
- 19) I sometimes try to get even rather than forgive and forget T F
- 20) When I don't know something I don't mind at all admitting it T F
- 21) I am always courteous, even to people who are disagreeable T F
- 22) At times I have really insisted on having things my way T F
- 23) There have been occasions when I felt like smashing things T F
- 24) I would never think of letting someone else be punished for my wrongdoing T F
- 25) I never resent being asked to return a favor T F
- 26) I have never been irked when people expressed ideas very different from
my own T F
- 27) I never make a long trip without checking the safety of my car T F
- 28) There have been times when I was quite jealous of the good fortune of others T F
- 29) I have almost never felt the urge to tell someone off T F
- 30) I am sometimes irritated by people who ask favors of me T F
- 31) I have never felt that I was punished without a cause T F
- 32) I sometimes think when people have a misfortune they only got what they
deserved T F
- 33) I have never deliberately said something that hurt someone's feelings T F

EAT-26

Please respond to the following statements about yourself:

1. Am terrified about being overweight

Always Usually Often Sometimes Rarely Never

2. Avoid eating when I am hungry

Always Usually Often Sometimes Rarely Never

3. Find myself preoccupied with food

Always Usually Often Sometimes Rarely Never

4. Have gone on eating binges where I feel that I may not be able to stop

Always Usually Often Sometimes Rarely Never

5. Cut my food into small pieces

Always Usually Often Sometimes Rarely Never

6. Aware of the calorie content of foods that I eat

Always Usually Often Sometimes Rarely Never

7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)

Always Usually Often Sometimes Rarely Never

8. Feel that others would prefer if I ate more

Always Usually Often Sometimes Rarely Never

9. Vomit after I have eaten

Always Usually Often Sometimes Rarely Never

10. Feel extremely guilty after eating

Always Usually Often Sometimes Rarely Never

11. Am preoccupied with a desire to be thinner

Always Usually Often Sometimes Rarely Never

12. Think about burning up calories when I exercise

Always Usually Often Sometimes Rarely Never

13. Other people think that I am too thin

Always Usually Often Sometimes Rarely Never

14. Am preoccupied with the thought of having fat on my body

Always Usually Often Sometimes Rarely Never

15. Take longer than others to eat my meals

Always Usually Often Sometimes Rarely Never

16. Avoid foods with sugar in them

Always Usually Often Sometimes Rarely Never

17. Eat diet foods

Always Usually Often Sometimes Rarely Never

18. Feel that food controls my life

Always Usually Often Sometimes Rarely Never

19. Display self-control around food

Always Usually Often Sometimes Rarely Never

20. Feel that others pressure me to eat

Always Usually Often Sometimes Rarely Never

21. Give too much time and thought to food

Always Usually Often Sometimes Rarely Never

22. Feel uncomfortable after eating sweets

Always Usually Often Sometimes Rarely Never

23. Engage in dieting behavior

Always Usually Often Sometimes Rarely Never

24. Like my stomach to be empty

Always Usually Often Sometimes Rarely Never

25. Enjoy trying new rich foods

Always Usually Often Sometimes Rarely Never

26. Have the impulse to vomit after meals

Always Usually Often Sometimes Rarely Never

FED

1) Have you ever or are you currently diagnosed with an eating disorder? Yes No

2) Have you ever or do you currently know someone who has been diagnosed
with an eating disorder? Yes No

Please read the following paragraph carefully. Then answer the question at the end.

Sam is average height, but he appears to be extremely underweight. Although he is 15% below the expected weight for his height and age, he does not see himself as underweight. Sam has an intense fear of gaining weight and becoming fat. He often experiences feelings of anxiety and guilt after eating. This preoccupation with food and body image takes up a majority of Sam's time.

What sex is Sam? Male Female

OS

Please respond to the following statements about Sam, the character in the paragraph. Circle your answer.

1) Danger to others

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

2) Unpredictable

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

3) Hard to talk to

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

4) Feels different from me

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

5) Sam is to blame

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

6) Sam could pull himself together

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

7) Treatment would not help

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

8) Will never recover

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

CS

Based on your interpretation of Sam, rate him on the following characteristics:

| | Neutral | | | | | | | |
|-------------------|---------|---|---|---|---|---|---|----------------|
| 1) Strong | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Weak |
| 2) Boring | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Interesting |
| 3) Insensitive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Sensitive |
| 4) Sophisticated | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Naive |
| 5) Bold | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Shy |
| 6) Sociable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Unsociable |
| 7) Emotional | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Rational |
| 8) Cruel | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Kind |
| 9) Poised | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Awkward |
| 10) Unintelligent | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Intelligent |
| 11) Sad | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Happy |
| 12) Unsuccessful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Successful |
| 13) Enthusiastic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Unenthusiastic |

| | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|-------------|
| 14) Insecure | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Secure |
| 15) Open | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Defensive |
| 16) Cold | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Warm |
| 17) Untrustworthy | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Trustworthy |
| 18) Interesting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Boring |
| 19) Secure | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Insecure |
| 20) Effective | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Ineffective |

ARS

If you were to interact with Sam, indicate how you would feel:

| | Neutral | | | | | | | |
|-----------------|---------|---|---|---|---|---|---|-------------|
| 1) Pessimistic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Optimistic |
| 2) Tranquil | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Anxious |
| 3) Supportive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Resentful |
| 4) Fearful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Confident |
| 5) Empathic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Angry |
| 6) Disgusted | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Sympathetic |
| 7) Apprehensive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Comfortable |
| 8) Irritable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Patient |
| 9) Relaxed | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Tense |
| 10) Calm | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Nervous |

SDS

Based on the description of Sam, rate the following statements using the following scale:

Definitely willing = 0

Probably willing = 1

Probably unwilling = 2

Definitely unwilling = 3

1) How would you feel about renting a room in your home to someone like Sam?

0 1 2 3

2) How about as a worker on the same job as someone like Sam?

0 1 2 3

3) How would you feel having someone like Sam as a neighbor?

0 1 2 3

4) How about as the caretaker of your children for a couple of hours?

0 1 2 3

5) How about having your children marry someone like Sam?

0 1 2 3

6) How would you feel about introducing Sam to a young woman you are friendly with?

0 1 2 3

7) How would you feel about recommending someone like Sam for a job working for a friend of yours?

0 1 2 3

BSRI

Please respond to the following statements about Sam using the scale below. Circle your answer.

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|------------------------|---|---|---|---|---|---|---|
| 1. Self-reliant | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Yielding | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Helpful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Defends own beliefs | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Cheerful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Moody | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Independent | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Shy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Conscientiousness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Athletic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. Affectionate | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Theatrical | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Assertive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|---|
| 14. Flatterable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. Happy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Strong personality | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Loyal | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Unpredictable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. Forceful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Feminine | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. Reliable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. Analytical | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. Sympathetic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. Jealous | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. Has leadership abilities | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. Sensitive to the needs of others | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. Truthful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. Willing to take risks | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. Understanding | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30. Secretive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. Makes decisions easily | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32. Compassionate | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|-----------------------------------|---|---|---|---|---|---|---|
| 33. Sincere | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34. Self-sufficient | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35. Eager to soothe hurt feelings | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. Conceited | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37. Dominant | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38. Soft Spoken | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39. Likable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40. Masculine | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41. Warm | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42. Solemn | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43. Willing to take a stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44. Tender | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 45. Friendly | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 46. Aggressive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 47. Gullible | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 48. Inefficient | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49. Acts as a leader | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 50. Childlike | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 51. Adaptable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|---------------------------------|---|---|---|---|---|---|---|
| 52. Individualistic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 53. Does not use harsh language | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 54. Unsystematic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 55. Competitive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 56. Loves children | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 57. Tactful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 58. Ambitious | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 59. Gentle | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 60. Conventional | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

QQ

1) What do you think of Sam as a man?

2) What kind of a man do you think he is?

3) Is he like other men? Why?

4) In what ways is he similar or different from other men?

Sam is most a likely:

- 1- Traditional Male
- 2- Metrosexual
- 3- Neither

It would be best for Sam to go to a _____ for his problem

- 1- Medical Doctor
- 2- Psychologist
- 3- Coach
- 4- Nutritionist
- 5- No need to go to someone

After reading the vignette, which of the following most closely resembles how you thought of

Sam?

- 1- A successful business person
- 2- An athlete
- 3- A person with mental illness

VC

Please respond to the following statements about Sam, the character in the paragraph. Circle your answer.

1- Sam is to blame

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

2- Feels different from me

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

3- Will never recover

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

Thesis Survey- Female Vignette Condition

List the last six digits of your student ID number after the letter: F _____

Please fill out the following demographic information:

4) What is your gender? Female Male

5) What is your age? _____

6) What is your ethnicity? *Circle one*

Caucasian

African American

Hispanic

Asian American

American Indian/Alaska Native

Other

BMI

Please list your current height _____

Please list your current weight _____

MCSDS

Please respond to the following statements by indicating if they are true (T) or false (F) of you.

- | | | |
|--|---|---|
| 1) Before voting I thoroughly investigate the qualifications of all the candidates | T | F |
| 2) I never hesitate to go out of my way to help someone in trouble | T | F |
| 3) It is hard sometimes for me to go on with my work if I am not encouraged | T | F |
| 4) I have never intensely disliked someone | T | F |
| 5) On occasion I have had doubts about my ability to succeed in life | T | F |
| 6) I sometimes feel resentful when I don't get my way | T | F |
| 7) I am always careful about my manner of dress | T | F |
| 8) My table manners at home are as good as when I eat out at restaurants | T | F |
| 9) If I could get into a movie without paying and be sure I was not seen I would probably do it. | T | F |
| 10) On a few occasions, I have given up doing something because I thought too little of my ability. | T | F |
| 11) I like to gossip at times | T | F |
| 12) There have been times when I felt like rebelling against people in authority even though I knew they were right | T | F |
| 13) No matter who I'm talking to, I'm always a good listener | T | F |
| 14) I can remember "playing sick" to get out of something | T | F |

- 15) There have been occasions when I took advantage of someone T F
- 16) I'm always willing to admit it when I make mistakes T F
- 17) I always try to practice what I preach T F
- 18) I don't find it particularly difficult to get along with loud mouthed,
obnoxious people. T F
- 19) I sometimes try to get even rather than forgive and forget T F
- 20) When I don't know something I don't mind at all admitting it T F
- 21) I am always courteous, even to people who are disagreeable T F
- 22) At times I have really insisted on having things my way T F
- 23) There have been occasions when I felt like smashing things T F
- 24) I would never think of letting someone else be punished for my wrongdoing T F
- 25) I never resent being asked to return a favor T F
- 26) I have never been irked when people expressed ideas very different from
my own T F
- 27) I never make a long trip without checking the safety of my car T F
- 28) There have been times when I was quite jealous of the good fortune of others T F
- 29) I have almost never felt the urge to tell someone off T F
- 30) I am sometimes irritated by people who ask favors of me T F
- 31) I have never felt that I was punished without a cause T F
- 32) I sometimes think when people have a misfortune they only got what they
deserved T F
- 33) I have never deliberately said something that hurt someone's feelings T F

EAT-26

Please respond to the following statements about yourself:

1. Am terrified about being overweight

Always Usually Often Sometimes Rarely Never

2. Avoid eating when I am hungry

Always Usually Often Sometimes Rarely Never

3. Find myself preoccupied with food

Always Usually Often Sometimes Rarely Never

4. Have gone on eating binges where I feel that I may not be able to stop

Always Usually Often Sometimes Rarely Never

5. Cut my food into small pieces

Always Usually Often Sometimes Rarely Never

6. Aware of the calorie content of foods that I eat

Always Usually Often Sometimes Rarely Never

7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)

Always Usually Often Sometimes Rarely Never

8. Feel that others would prefer if I ate more

Always Usually Often Sometimes Rarely Never

9. Vomit after I have eaten

Always Usually Often Sometimes Rarely Never

10. Feel extremely guilty after eating

Always Usually Often Sometimes Rarely Never

11. Am preoccupied with a desire to be thinner

Always Usually Often Sometimes Rarely Never

12. Think about burning up calories when I exercise

Always Usually Often Sometimes Rarely Never

13. Other people think that I am too thin

Always Usually Often Sometimes Rarely Never

14. Am preoccupied with the thought of having fat on my body

Always Usually Often Sometimes Rarely Never

15. Take longer than others to eat my meals

Always Usually Often Sometimes Rarely Never

16. Avoid foods with sugar in them

Always Usually Often Sometimes Rarely Never

17. Eat diet foods

Always Usually Often Sometimes Rarely Never

18. Feel that food controls my life

Always Usually Often Sometimes Rarely Never

19. Display self-control around food

Always Usually Often Sometimes Rarely Never

20. Feel that others pressure me to eat

Always Usually Often Sometimes Rarely Never

21. Give too much time and thought to food

Always Usually Often Sometimes Rarely Never

22. Feel uncomfortable after eating sweets

Always Usually Often Sometimes Rarely Never

23. Engage in dieting behavior

Always Usually Often Sometimes Rarely Never

24. Like my stomach to be empty

Always Usually Often Sometimes Rarely Never

25. Enjoy trying new rich foods

Always Usually Often Sometimes Rarely Never

26. Have the impulse to vomit after meals

Always Usually Often Sometimes Rarely Never

FED

1) Have you ever or are you currently diagnosed with an eating disorder? Yes No

2) Have you ever or do you currently know someone who has been diagnosed
with an eating disorder? Yes No

Please read the following paragraph carefully. Then answer the question at the end.

Sam is average height, but she appears to be extremely underweight. Although she is 15% below the expected weight for her height and age, she does not see herself as underweight. Because of her weight loss, she has not had her period for three months. Sam has an intense fear of gaining weight and becoming fat. She often experiences feelings of anxiety and guilt after eating. This preoccupation with food and body image takes up a majority of Sam's time.

What sex is Sam? Male Female

OS

Please respond to the following statements about Sam, the character in the paragraph. Circle your answer.

9) Danger to others

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

10) Unpredictable

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

11) Hard to talk to

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

12) Feels different from me

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

13) Sam is to blame

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

14) Sam could pull herself together

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

15) Treatment would not help

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|-------------------|----------|---------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 |

16) Will never recover

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|-------------------|----------|---------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 |

CS

Based on your interpretation of Sam, rate her on the following characteristics:

| | Neutral | | | | | | | |
|-------------------|---------|---|---|---|---|---|---|-------------|
| 21) Strong | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Weak |
| 22) Boring | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Interesting |
| 23) Insensitive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Sensitive |
| 24) Sophisticated | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Naive |
| 25) Bold | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Shy |
| 26) Sociable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Unsociable |
| 27) Emotional | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Rational |
| 28) Cruel | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Kind |
| 29) Poised | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Awkward |
| 30) Unintelligent | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Intelligent |
| 31) Sad | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Happy |
| 32) Unsuccessful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Successful |

| | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|----------------|
| 33) Enthusiastic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Unenthusiastic |
| 34) Insecure | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Secure |
| 35) Open | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Defensive |
| 36) Cold | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Warm |
| 37) Untrustworthy | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Trustworthy |
| 38) Interesting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Boring |
| 39) Secure | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Insecure |
| 40) Effective | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Ineffective |

ARS

If you were to interact with Sam, indicate how you would feel:

| | Neutral | | | | | | | |
|------------------|---------|---|---|---|---|---|---|-------------|
| 11) Pessimistic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Optimistic |
| 12) Tranquil | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Anxious |
| 13) Supportive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Resentful |
| 14) Fearful | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Confident |
| 15) Empathic | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Angry |
| 16) Disgusted | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Sympathetic |
| 17) Apprehensive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Comfortable |
| 18) Irritable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Patient |
| 19) Relaxed | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Tense |
| 20) Calm | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Nervous |

SDS

Based on the description of Sam, rate the following statements using the following scale:

Definitely willing = 0

Probably willing = 1

Probably unwilling = 2

Definitely unwilling = 3

8) How would you feel about renting a room in your home to someone like Sam?

0 1 2 3

9) How about as a worker on the same job as someone like Sam?

0 1 2 3

10) How would you feel having someone like Sam as a neighbor?

0 1 2 3

11) How about as the caretaker of your children for a couple of hours?

0 1 2 3

12) How about having your children marry someone like Sam?

0 1 2 3

13) How would you feel about introducing Sam to a young man you are friendly with?

0 1 2 3

14) How would you feel about recommending someone like Sam for a job working for a friend of yours?

0 1 2 3

BSRI

Please respond to the following statements about Sam using the scale below. Circle your answer.

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|
| 61. Self-reliant | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 62. Yielding | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 63. Helpful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 64. Defends own beliefs | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 65. Cheerful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 66. Moody | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 67. Independent | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 68. Shy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 69. Conscientiousness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 70. Athletic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 71. Affectionate | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|----------------|---|---|---|---|---|---|---|
| 72. Theatrical | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------|---|---|---|---|---|---|---|

| | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|---|
| 73. Assertive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 74. Flatterable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 75. Happy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 76. Strong personality | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 77. Loyal | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 78. Unpredictable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 79. Forceful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 80. Feminine | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 81. Reliable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 82. Analytical | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 83. Sympathetic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 84. Jealous | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 85. Has leadership abilities | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 86. Sensitive to the needs of others | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 87. Truthful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 88. Willing to take risks | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 89. Understanding | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 90. Secretive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | |
|----------------------------|---|---|---|---|---|---|---|
| 91. Makes decisions easily | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------------------|---|---|---|---|---|---|---|

| | | | | | | | | |
|-----------------------------------|---|---|---|---|---|---|---|---|
| 92. Compassionate | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 93. Sincere | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 94. Self-sufficient | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 95. Eager to soothe hurt feelings | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 96. Conceited | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 97. Dominant | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 98. Soft Spoken | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 99. Likable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 100. Masculine | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 101. Warm | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 102. Solemn | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 103. Willing to take a stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 104. Tender | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 105. Friendly | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 106. Aggressive | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 107. Gullible | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 108. Inefficient | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 109. Acts as a leader | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7= Always or almost always true about Sam

4= Half true, half untrue about Sam

1= Always or almost always untrue about Sam

| | | | | | | | | |
|----------------|--|---|---|---|---|---|---|---|
| 110. Childlike | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------|--|---|---|---|---|---|---|---|

| | | | | | | | | |
|------|-----------------------------|---|---|---|---|---|---|---|
| 111. | Adaptable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 112. | Individualistic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 113. | Does not use harsh language | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 114. | Unsystematic | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 115. | Competitive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 116. | Loves children | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 117. | Tactful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 118. | Ambitious | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 119. | Gentle | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 120. | Conventional | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

QQ

1) What do you think of Sam as a woman?

2) What kind of a woman do you think she is?

3) Is she like other women? Why?

4) In what ways is she similar or different from other women?

Sam is most a likely:

- 4- Traditional Female
- 5- Very Feminine
- 6- Neither

It would be best for Sam to go to a _____ for her problem

- 6- Medical Doctor
- 7- Psychologist
- 8- Coach
- 9- Nutritionist
- 10- No need to go to someone

After reading the vignette, which of the following most closely resembles how you thought of

Sam?

- 4- A successful business person
- 5- An athlete
- 6- A person with mental illness

VC

Please respond to the following statements about Sam, the character in the paragraph. Circle your answer.

4- Sam is to blame

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 2 | 2 | 3 | 4 | 5 |

5- Feels different from me

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 2 | 2 | 3 | 4 | 5 |

6- Will never recover

| | | | | |
|-------------------|----------|---------|-------|----------------|
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

Appendix D: Debriefing Form

Debriefing Information

Project Title: Gender Differences in the Stigma of Anorexia Nervosa

Investigator: Janean M. Anderson,

Primary Investigator

Phone:

Office: C Clark Building

Email: janean.anderson@gmail.com

Purpose of the Study

This is a research study about the stigmatization (discredit or rejection of a person because of an attribute) of eating disorders, specifically anorexia nervosa and how persons of different genders are stigmatized differently for having anorexia. I am specifically interested in the way people endorse stigmatizing statements about people with anorexia, how more stigmatic attitudes are given to males than to females, if men with eating disorders are seen more femininely, and how males with eating disorders are seen as violating traditional masculine ideals. The results of this study will help to understand stigmatization of anorexia nervosa. Particularly, this study will provide greater insight into if men are viewed differently than women for having the same eating disorder. The information provided will also give some idea of why men are viewed as different. One idea is that men may seem to have less masculine characteristics, and more feminine characteristics, leading to more stigmatization, whereas this would not happen as much for females because having feminine traits is valued.

Methods/Procedures

As a participant in this study you were asked to read a paragraph on a character named Sam and then answer a set of questions. There were two conditions. In one condition people read the paragraph with Sam as a female, and in the other condition people read the paragraph with Sam as a male. Everything except for the change in gender was identical. The paragraphs were describing a person with anorexia nervosa with characteristics including, a refusal to meet a healthy body weight, intense fear of gaining weight and becoming fat, even though they are underweight, a disturbance in how a person sees their body, and in the case of women Amenorrhea. You were then asked to complete a set of questions which assessed stigma and gender-role stigma in regards to the eating disorder.

Use of the Data

All the responses you gave in this study are confidential, and can't be traced to you in any way. Your information will be combined with information from other people taking part in the study and your individual answers will not be taken into account unless combined with other people's answers. When I write about the study to share it with other researchers, I will write about the combined information gathered. You will not be identified in these written materials.

Implications and applications

While there are no direct benefits from participation in this study, your participation will help us to understand stigmatization in eating disorders as well as the difference between females and males stigmatization in eating disorders. This knowledge will contribute to the knowledge on this vast field of study.

I would like to thank you for participating in this study. If you are interested in learning about the results of this study once the data has been collected, analyzed, and interpreted, please notify the researchers. Since we are currently running this study with more people, we would also like to ask that you don't tell others about the specific content of the study because they may answer questions differently based on this knowledge.

It is important to remember that eating disorders, including anorexia nervosa, can be dangerous with very serious health risks. While these diseases are real the character you read about was entirely fictional and not based off anyone in particular. If you felt any discomfort answering questions about this character suffering from anorexia nervosa, or have any concerns of your own you are encouraged to talk to the researcher as well as seek further help in contacting the health center.

Colorado State University Health Center
Counseling Services
www.Health.Colostate.edu
(970) 491-6053