Personality and Individual Differences 51 (2011) 618–622

Contents lists available at ScienceDirect

Personality and Individual Differences

journal homepage: www.elsevier.com/locate/paid

Just world beliefs, causal beliefs, and acquaintance: Associations with stigma toward eating disorders and obesity

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ARTICLE INFO

Article history:
Received 26 February 2011
Received in revised form 14 May 2011
Accepted 26 May 2011
Available online 2 July 2011

Keywords:
Just world beliefs
Causal beliefs
Stigma
Eating disorders
Obesity

ABSTRACT

The current study investigated the relationship between just world beliefs and stigmatizing attitudes toward eating disorders and obesity. Further, the associations between stigma and causal beliefs, and between stigma and acquaintance with these conditions, were examined. Participants (n = 447) read four vignettes describing an individual with anorexia nervosa, bulimia nervosa, binge eating disorder, or obesity. After each vignette, participants completed questionnaires assessing stigmatizing attitudes, just world beliefs, causal beliefs, and acquaintance with the condition depicted in the vignette. Stronger just world beliefs were associated with greater stigma toward all three eating disorders, as well as obesity (rs ranging from −.11 to −.18). More stigmatizing attitudes were associated with greater attribution of individual responsibility for the development of the disorder. However, participants with personal experience or who knew someone with the depicted problem did not have lower stigma scores than those who did not. The current study suggests that justification ideologies such as just world beliefs and controllability beliefs may underlie the stigmatization of eating disorders and obesity. These findings provide support for stigma reduction efforts aimed at targeting justification ideologies and altering causal beliefs.
Published by Elsevier Ltd.

1. Introduction

Eating disorders such as anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) affect a large number of individuals in the general population. Lifetime prevalence rates vary between 0.5% and 5% depending on the type of eating disorder and gender of the sufferer (Hudson, Hiripi, Pope, & Kessler, 2007). Obesity rates are significantly higher, with approximately a third of the adult population in the United States being affected (Ogden, Yanovski, Carroll, & Flegal, 2007). Research has demonstrated severe stigma toward both eating disorders (Roehrig & McLean, 2010) and obesity (Puhl & Heuer, 2009). The stigmatization of individuals with these conditions is common (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000) and has been shown to affect sufferers in multiple ways. Stigma may result in low self-esteem and self-efficacy, social isolation, and lower social confidence (Holmes & River, 1998) and may exacerbate the condition through exclusion and stress and may prevent sufferers from seeking treatment (Corrigan & Rüsch, 2002; Puhl & Heuer, 2009). Therefore, understanding the factors that may contribute to stigmatizing attitudes is important for the development of effective stigma reduction interventions.

Two attitudinal factors have been identified as contributing to obesity stigma: the belief that people's fortunes or misfortunes are deserved (just world beliefs; Lerner, 1971), and the belief that obesity is controllable (Puhl & Brownell, 2003). Crandall and Eshleman (2003) postulated that these core attributions for obesity serve as 'justification ideologies', allowing for stigmatizing attitudes without feelings of guilt. Much of the research on just world beliefs has been conducted in the context of psychological phenomena such as the relationship between just world beliefs and victim blaming (Furnham, 2003). Few studies have focused on the relationship between just world beliefs and the stigmatization of mental disorders (e.g. Rüsch, Todd, Bodenhausen, & Corrigan, 2010). Although it has been demonstrated that greater weight stigma is associated with greater endorsement of just world beliefs (Carels et al., 2009), research has not yet examined the relationship between just world beliefs and negative attitudes toward eating and weight disorders such as AN, BN, or BED.

Another potential correlate of stigma toward eating and weight disorders may be causal beliefs, and particularly perceptions of controllability. Individuals who believe obesity is caused by a lack of self-discipline tend to blame obese people for their condition and stigmatize them accordingly (Crandall, 1994). Previous research investigating the relationship between causal beliefs

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0191-8869/$ - see front matter Published by Elsevier Ltd.
doi:10.1016/j.paid.2011.05.029

and stigma toward mental health disorders has resulted in contradictory results. While it has been demonstrated that attributing a mental health disorder to factors outside a person's control such as biological factors may reduce stigma (Martin, Pescosolido, & Tuch, 2000), other studies showed that biological explanations were associated with more stigma (e.g. Dietrich et al., 2004). Therefore, additional research on eating and weight disorders is needed to examine whether causal beliefs related to the controllability of these disorders is associated with their stigmatization.

One factor that may ameliorate the stigmatization of target groups is acquaintance: the 'contact hypothesis' (Allport, 1954) states that contact with marginalized groups may result in more positive attitudes (Pettigrew, 1998). Consequently, it has been suggested that exposure to individuals who suffer from mental health problems may reduce stigma. Research has indeed demonstrated that individuals who have more contact with people seeking mental health treatment hold more positive attitudes toward mental illness (Read & Harre, 2001). However, more research is needed to examine whether acquaintance is related to less stigma toward AN, BN, BED, and obesity.

This study tested the hypothesis that stronger just world beliefs, and stronger beliefs that a disorder is caused by more controllable factors, are associated with more stigmatizing attitudes toward eating disorders and obesity. It was also hypothesized that people acquainted with a particular disorder, endorse less stigmatizing attitudes toward that disorder. Finally, it was hypothesized that stigmatizing attitudes would have no significant relationship with socially desirable response styles, which would suggest that stigmatizing attitudes are independent from participants' desire to appear unprejudiced.

2. Method

2.1. Participants

Participants aged 18 and over were recruited from psychology undergraduate classes at the University of Hawaii and received course credit for their participation. Participants answered questionnaires online on www.surveymonkey.com. Participants completed a demographic questionnaire assessing gender, ethnicity, weight, and height. Participants (n = 447, 68.5% women) self-identified as Asian (59.3%), Caucasian (25.1%), Pacific-Islander (10.1%), Hispanic (3.1%), African-American (1.3%) and Native-American (0.2%). Participants' mean (SD) age was 21 (3.5) years and mean body mass index (BMI; kg/m^2) was 23.09 (4.59). The study was approved by the University of Hawaii Institutional Review Board (IRB), and informed consent was obtained from all participants.

2.2. Measures

2.2.1. Vignettes

Four vignettes were developed, describing a 19-year old woman suffering either from AN, BN, BED, or obesity. All participants read and responded to stigma questionnaires for all four vignettes, presented in counterbalanced order. The AN, BN and BED vignettes were adapted from vignettes used by Mond, Hay, Rodgers, Owen, and Beumont (2004); Mond, Robertson-Smith, and Vetere (2006); Mond and Marks (2007). Based on previous research indicating that 70% of individuals with BED in a community sample report a BMI of 30 and above (Grucza, Przybeck, & Cloninger, 2007), the woman in the BED vignette was described as obese. The obesity vignette was adapted from Bannon, Hunter-Reel, Wilson, and Karlin (2009). All vignettes were made uniform so that language and details unrelated to disorder criteria matched across conditions. The vignettes described cases that met full DSM-IV criteria for AN, BN, and BED (American Psychiatric Association, 1994), while the obesity vignette did not meet any of the BED criteria. Participants were asked to think about the person depicted in the vignette they had just read and to answer questions regarding that person.

2.2.2. Stigma questionnaire

A self-report stigma questionnaire was adapted from previous measures to assess participants' attitudes toward the targets in the vignettes. This composite measure included seven items from Griffiths, Christensen and Jorm's nine-item Depression Stigma Scale (DSS; 2008; sample item: "A problem like Katie's is a sign of personal weakness") and four items from Crisp et al.'s eight-item Opinions Scale (2000; sample item: "In your opinion, do you think Katie could pull herself together if she wanted to?"). One item ("In your opinion, do you think Katie is acting this way for attention?") was added from Stewart, Keel, and Schiavo (2006). The Opinions Scale and DSS have been used to examine stigma toward similar disorders in previous studies (e.g. Crisp et al., 2000; Stewart et al., 2006; Roehrig and McLean, 2010; Griffiths et al., 2006). Two of the nine items from the DSS were not administered because they were worded identically to two included items of the Opinions Scale ("People with depression are unpredictable" and "People with depression are dangerous"). Four items of the Opinions Scale were not administered because they were considered measures of disorder severity rather than stigma (e.g., "People with this disorder would not improve with treatment"). The resulting stigma questionnaire included 12 items, rated on a 5-point Likert scale from 1 = *strongly agree* to 5 = *strongly disagree*. Lower scores indicate more stigmatizing attitudes. Acceptable internal consistency was found in each of the four versions (αs ranged from .76 to .82).

2.2.3. Beliefs in a just world

The Just World Scale (JWS; Rubin & Peplau, 1975) assesses beliefs that the world is ultimately fair. The measure includes 20 items rated on a 7-point Likert scale from 1 = *strongly disagree* to 7 = *strongly agree* (sample item: "People who meet with misfortune have usually brought it on themselves"). Higher scores reflect stronger beliefs in a just world. The JWS is the most commonly used questionnaire on just world beliefs (Furnham, 2003) and has demonstrated adequate internal consistency (α = .80; Rubin & Peplau, 1975).

2.2.4. Causal attributions

Following each vignette, participants answered seven questions examining their beliefs about the contribution of different factors (environmental, parenting, genetics, imbalance of neurotransmitters in the brain, lack of social support, media influences, and lack of self-discipline) to the development of each condition. The current study extended previous research on causal beliefs by including specific factors that may fall under broader categories such as biological or psychological factors and examining whether these are associated with different degrees of stigma. Three of the causal factors (parenting, lack of social support, lack of self-discipline) were included from previous studies examining stigma (Stewart et al., 2006; Stewart, Schiavo, Herzog, & Franko, 2008). The "lack of self-discipline" item was conceptualized as an attribution to more controllable causal factors, whereas other items were developed and conceptualized by the authors as attributions to less controllable causal factors. Items were rated on a 5-point Likert Scale from 1 = *main causal factor* to 5 = *does not contribute* (sample item: "In your opinion, which of these factors contribute to the development of Katie's problem: Environmental risk factors"). Higher numbers reflect lower perceived contribution of a factor to the development of a condition.