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Analysis of the Factors that Contribute to Stigmatization of Binge Eating Disorder and Their Potential Consequences on the Affected Population's Life and Recovery

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Abstract. While being the most prevalent eating disorder (ED), binge eating disorder (BED)remains underrecognized and highly stigmatized in society. This paper reviews the cognitive, emotional, and behavioural components of stigma toward individuals with BED and examine consequences of the stigmatization. After analysis, this paper found that for the cognitive component, stigma is rooted in stereotypes and explicit weight bias, with individuals frequently blamed for their condition and viewed as lacking willpower, self-control, and discipline. In the emotional component, people with BED are often described as lazy, weak, and incompetent, reflecting prejudice and a lack of empathy compared to physical illnesses. In the behavioural component, stigma manifests as discrimination, including disadvantages in employment and housing, as well as broader social exclusion. These stigmatizing attitudes and behaviours mean individuals with BED face double challenges in lives: they need to cope with disorder symptoms and societal misunderstanding and discrimination at the same time. This significantly led to self-stigmatization, reduced self-esteem, and heightened vulnerability to depression. Moreover, stigma fosters social distancing, alienation, and avoidance of professional help, creating barriers to treatment and recovery. Individuals with BED are usually locked in a vicious cycle in which worsening symptoms strengthen existing stereotypes and deepen stigma. While evidence highlights these harmful effects, BED stigma remains underemphasised compared to other mental disorders. Future research could investigate strategies that are effective in reducing stigmas, and ways to build a more supportive medical environment that can encourage treatment engagement and improve recovery outcomes for individuals with BED.

Keywords: Binge eating disorder, Stigmatization, Explicit weight bias, Willpower

1. Introduction

Binge eating disorder (BED) is the most prevalent type of eating disorder (ED). It is characterized by the consumption of objectively large amount of food, and the feeling of losing control over eating by recurrent episodes (so at least once a week for three months). Individuals diagnosed with BED eat much more rapidly than normal, sometimes even when they are not hungry or feeling

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uncomfortably full. This overeating may also be companied by negative emotions such as by distress, guilt, and disgust with oneself [1]. While overeating would burden individuals' body and deteriorate their physical conditions, being subjects to these negative emotions persistently could severely affect their mental well-being and lead to depression, self-stigmatization, greater social distancing and avoidance to seek professional help [2].

While being the most prevalent type of ED, recognition and awareness of BED is poor in the general public globally, and individuals living with BED usually need to confront various social stigmas. A common stigma is the belief that individuals with BED lack willpower, self-control, and are responsible for their own conditions. This could result in social devaluation, negative attitudes and even discrimination in aspects such as employment and house renting [3]. Consequences of this stigmatization and misunderstanding could further affect individuals with BED's social, psychological, physical functions and even lead to increase in BED symptoms and decrease in treatment-seeking behaviours [4].

Many research and reviews have studied the nature of stigmatizations towards different types of mental disorders and related consequences, mostly on psychotic or mood disorders such as schizophrenia or depression [4]. The BED has been relatively overlooked, and usually only one aspect is being examined in each research: content of stigmas, the stigmatizing sources or population, or its consequences. Therefore, this paper aims at synthesizing current knowledge of specific stigma content of BED in cognitive, emotional, and behavioural perspectives respectively, and summarise the consequences of stigmatization towards BED. It attempts to help future researchers to obtain a more comprehensive understanding of the nature of stigmatization of BED and the seriousness of its consequences. In addition, this paper could be used to provide medical sections with insights of how to improve individuals with BED's accessibility of support network and motivation to seek professional treatment, and strategies to diminish psychological barriers which kept individuals from performing treatment-seeking behaviour, thus the fear of potential societal discrimination.

2. Factors that contribute to the stigmatization of individuals with BED

2.1. Cognitive level: explicit weight bias and blame

Stereotypes contribute to the cognitive aspect of stigma. It is the positive or negative believes distributed to a certain population [4]. Individuals with BED are expected to take the blame and responsibility for their own situation and conditions. They are usually considered by the general public as lacking self-discipline, self-control, and willpower. This belief forms the basis of the explicit weight bias, which is negative attitudes toward people (or judging them) based on their weight and physic. Studies have reported that there is a significant correlation between BED, obesity and overweight, with 41.7% and 31.8% of the individuals with BED reported to endure obesity and overweight problem respectively. It has also shown that individuals with BED tend to experience greater amount of exposure to explicit weight bias during lifetime, which would contribute to further binge eating behaviours [3].

As the negative beliefs against individuals BED includes many traits that are differ and discouraged by the of contemporary societal norms, individuals with BED not only need to face the distress of losing control over food consumption and associated physical health issues, but also stigma, rejection, and social devaluation. This is especially the case for those who have both BED and obesity, as someone with a visible stigma are more likely to be targeted and discredited than those with a non-visible stigma. This thus has made explicit weight bias an essential factor that

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explains the stigmatization of BED, at the same time highlights the importance of correcting general population's misconception that BED is simply a matter of controllability to the diminish of stigma regarding to this disorder.

2.2. Emotional level: prejudice and unfavourable personality traits

The emotional aspect of stigma includes various prejudice and linking unfavourable personality characteristics to individuals with BED. Studies have suggested that while some prosocial reactions (such as offering help and feeling sorry for them) may be displayed towards people with mental disorders, discomfort, disgust, and fear could also present. Individuals with mental disorders are generally less appreciated, understood, and less likely to obtain the same level of sympathy and emphasise compared to people with physical illness [4].

Similar situation and experience also apply to individuals with BED. They are usually described with less appreciated and favourable traits such as lazy, careless, incompetent and weak. This is supported by the study by O'Connor et al., which investigated and compared adolescents' understanding and attitudes towards different types of EDs (anorexia nervosa, bulimia nervosa, BED), depression or type 1 diabetes [5]. Result suggested that the recognition of EDs are relatively poor compared to depression or type 1 diabetes. In addition, participants perceive individuals with EDs as more personally responsible for their conditions and assigned them with more negative personality traits. Their result also presented a particularly negative and unfavorable view towards BED, as participants perceive the disorder as one's failure to control and organise their desires and lives, rather than a medical condition. This study supported the findings of previous research on adult samples and extended the study of BED to adolescents' cohort. This further suggest the existence of prejudice and misunderstanding of the nature and personalities of individuals with BED in different year groups, and the normalization of BED behavioural pattern and related consequences, thus provides an explanation of the stigmatization of the disorder.

2.3. Behavioural level: discrimination

The behavioral component of stigma towards BED is discrimination, which is defined by negative behaviours or unfair treatments directed at individuals based on their social group membership. Individuals with BED could become targets of discriminatory behaviour due to their overeating behaviour or difference from the cultural weight standard [4]. Individuals with BED face double challenges: they have to manage disorder symptoms, and deal with societal misunderstanding and negative attitudes which lead to stigmas and disadvantageous treatments and situations at the same time [6]. For example, there could be employment discrimination which makes it hard for them hard to find a job. This would further complicate their management or balance of independent living and work. This is supported by a meta-analysis conducted by Mason et al., which reported a small-to-medium association between various types of discriminations such as general, racial, gender, LGBT, weight or obesity, and sexual harassment, and ED symptoms which include general ED symptoms, binge eating, body dissatisfaction, and night eating [7]. It suggests discrimination increases an individual's risk of developing EDs or could contribute to the maintenance or deterioration of an existing ED symptoms, and this includes BED.

Discrimination and stigmatization of the disorder in general would restraint individuals in a vicious circle, as fear of stigma and stigma itself would significantly reduce individuals' decision and behaviour of seeking professional help or social support. This could have severe psychological and social consequences.

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3. Consequences of stigmatization

3.1. Social cognitive model of self-stigma

The social Cognitive Model of Self-Stigma uses three components (stereotyping, prejudice, and discrimination) to provide an explanation of how stigmatization of individuals with BED could lead to consequences such as self-stigmatization [7]. Self-stigmatization is when stigmatized individuals internalize external negative comments, believed in the legitimacy of stigmatising individuals and their believes, and turn against themselves [4]. Firstly, individuals with BED perceived external stereotypes and stigmas towards them from others and agree with the stereotypes: “It is my fault that I can’t control my own condition, this is all because I am weak and incompetent.” This self-devaluation and prejudice lead to the further generation of negative believes and emotions of themselves, which would lead to low confidence, self-esteem and self-efficacy. In addition, self-prejudice would also lead to negative behavioural responses such as reduction in attempts of job pursue due to fear of rejection and stigma, and avoidance or failing independent living. Studies have shown that a major reason individuals with mental disorders failed to perform goal-oriented behaviours and to reach their goals is their self-discriminating behaviours, rather than the disorders themselves [8].

Consequences of stigmatization are not limited to creating self-doubt, devaluation in stigmatized individuals’ minds, and reducing the accessibility and possibility of pursuing greater accomplishment in lives and obtaining independency. Studies suggested that self-stigmatization can significantly predict undiagnosed EDs, which include BED, and it is linked to a more negative attitude of treatment and recovery [4]. Stigma also negatively predict BED individuals’ psychological and physical well-being. It is associated with greater rates of depression in individuals with BED. This is particularly the case for those who have both obesity and BED. People with visible stigmas and differs from the contemporary social norms need to confront more societal pressures and judgements, thus they are also more likely to become subjects of negative experiences, emotions, and develop depression.

Therefore, stigmatization towards individuals with BED would lead to serious distress and pressure which associates with an increase in medical and psychiatric comorbidities, and a constrained life with less possibilities and opportunities.

3.2. Treatment avoidance and social alienation

Stigmatization of individuals with BED frequently manifests in the form of social distancing and alienation, with affected individuals being perceived as personally responsible for their condition and ascribed negative personality traits such as weak, lazy, and lack of self-control [5]. This attribution of blame is particularly damaging because it combines elements of both eating disorder stigma and weight stigma, leading to compounded prejudice [3]. Stigmatizing public service announcements, have been shown to lower perceived warmth and competence in individuals with BED, and directly eliciting feelings of contempt and reducing the likelihood of empathy and gaining social support [9]. Consequently, people with BED frequently experience alienation, social withdrawal, and diminished social support networks, which further worsens existing distress [2]. Furthermore, individuals with BED are consciously aware of existing social stigmas and expect negative treatment and rejection if their disorder is disclosed. This heightened vigilance towards stigma can prevent individuals from seeking or accepting social and emotional support, while even well-intentioned advice from family or peers may be perceived as unhelpful if it reflects

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misconceptions about BED [7]. In this way, stigma not only fosters isolation but also undermines the quality and effectiveness of the support systems available, locking those with BED into vicious cycles of alienation and emotional distress.

The consequences of stigmatization of individuals with BED extend beyond social life and directly influence treatment-seeking and recovery-related outcomes. The belief that disclosure will lead to discrimination act as barriers which keeps individuals from accessing professional help. Research consistently demonstrates that stigmatization is negatively related to recovery by increasing avoidance of treatment, worsening attitudes towards therapy, and even exacerbating eating disorder symptoms such as bingeing or dietary restraint [2]. This results in a vicious cycle: stigma reduces treatment-seeking, delayed treatment contributes to symptom severity, and worsening symptoms reinforce stigmatizing stereotypes. Importantly, evidence suggests that resistance to stigma, such as the ability to reject or counteract negative beliefs is associated with improved psychological outcomes, including enhanced self-esteem and more positive attitudes toward treatment [7]. However, in the absence of systematic stigma-reduction strategies, many individuals with BED struggle between the disorder itself and the societal misconceptions that surround it. Thus, stigma not only compounds the psychological and social burden of BED but also undermines the very processes required for effective recovery.

4. Conclusion

This paper has discussed the content of stigmatization of BED by examining its cognitive, emotional, and behavioural components, as well as the consequences for affected individuals. Cognitive stigma often takes the form of stereotypes and explicit weight bias, where individuals with BED are perceived as lacking willpower or self-control. In the emotional perspective, unfavourable personality traits such as lazy and weak are assigned to individuals with BED. In the behavioural perspective, individuals with BED may encounter discrimination in areas like employment and housing. These stigmatizing attitudes and actions reinforce social distancing, alienation, and self-stigmatization, leaving individuals to struggle in cycles of guilt, isolation, and avoidance of professional help. The consequences are severe, including diminished social support, reduced self-esteem, increased rates of depression, avoidance of treatment, and ultimately the worsening of BED symptoms.

Although growing research highlights these damaging effects, BED remains relatively underrecognized and under-emphasised compared to other eating disorders or psychiatric conditions. This paper only synthesized current findings on the content of stigmas associated with BED and psychosocial consequences on affected individuals. It did not research into existing social policies, benefits, help and treatment available to individuals with BED, and how their lives are affected. Future studies could expand on this by investigating interventions that reduce stigma, such as educational campaigns, media representation, and therapeutic strategies that empower individuals to resist both external and internal stigma. By addressing both public misconceptions and self-stigmatization, research can help dismantle barriers to treatment and promote recovery for individuals living with BED.

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