

Examining perceptions of anorexia nervosa: Should people with anorexia nervosa receive health-related welfare benefits?

Charlotte Walton

University of Huddersfield, Queensgate, Huddersfield, HD1 3DH
charlottenwalton@outlook.com

ARTICLE INFO

Article history:

Received 18 October 2021

Received in revised form 10
January 2022

Accepted 23 March 2022

Keywords:

Anorexia nervosa

Eating disorders

Benefits

Stigma

Personal Independence

Payment

ABSTRACT

Anorexia nervosa (AN) is a mental illness with multiple serious physical health complications. Despite this, evidence suggests that AN is commonly conceptualised as a choice, and sufferers are regarded as vain, selfish and to blame for their condition. No previous studies appear to have explored the link between these stigmatising views and attitudes towards sickness and disability benefits for people with AN, though general attitudes towards benefits claimants are often negative.

This quantitative study aimed to investigate if people with AN are widely viewed as undeserving of benefits, and to explore if and how stigma and perceptions of personal choice may affect this, using the example of Personal Independence Payment (PIP). The final sample consisted of 20 female undergraduate students from a university in the North of England. Main findings were that most students (80%) believed that people with AN should be eligible to apply for PIP, though higher levels of stigma were associated with disagreement towards PIP. Results showed that levels of stigma towards AN were generally low, but beliefs that AN is a choice and sufferers are to blame were present nonetheless. However, the study found no conclusive evidence of perceptions of choice being associated with attitudes towards PIP.

Background

Anorexia nervosa (AN) is a type of eating disorder (ED) and mental illness characterised by significantly low body weight or rapid weight loss due to behaviours intended to reduce calorie intake (World Health Organization [WHO], 2020). Complications of AN can include tiredness,

weakness, musculoskeletal problems, cardiac abnormalities, and difficulties with memory and concentration (National Health Service [NHS], 2021). Subsequently, the UK's leading ED charity Beat (2017) reports that AN can have huge adverse effects on sufferers' day-to-day lives and compromise all aspects of their wellbeing.

Despite this, EDs are often viewed as conscious choices and sufferers believed to be vain and attention-seeking (Beat, 2021b). These perceptions can be highly damaging; stigma against people with mental health issues can negatively impact their self-esteem and social relationships, as well as creating barriers to the provision and take-up of effective structural support (WHO, 2021). Consequently, many people with mental illnesses perceive the associated stigma and subsequent discrimination as equally or more distressing than the symptoms themselves (Time to Change [TTC], 2021b).

In the UK, one form of structural support is Personal Independence Payment (PIP), designed to support people with long-term illnesses and disabilities in meeting additional costs arising from their conditions. Application for this benefit is available to working-age citizens who have a condition expected to compromise their ability to perform day-to-day tasks for at least nine months (HM Government, n.d.). PIP is recognised as having a vital role in helping people with such conditions achieve good quality of life (Disability Benefits Consortium, 2017). However, poverty charity Turn2us (2020) found substantial evidence of negative attitudes towards benefits claimants, who are subject to widespread societal judgement of how supposedly deserving they are of this support.

The current study

Aim

AN appears to be subject to societal misperceptions and stigma, which can have huge negative impacts on sufferers' lives. As stigma is known to be a barrier to structural support for mental illness, the aim of this research was to investigate whether people with AN are generally deemed deserving of PIP, and how stigma and perceptions of personal choice may affect this.

Prior to specifying research questions, a review of existing literature on both ED stigma and welfare benefits was conducted to establish what is known about both topics, as well as the documented

interaction between them.

Literature review

Attitudes towards EDs

Multiple previous studies have found evidence of both AN and EDs more generally being subject to substantially negative attitudes. For instance, in a study of American undergraduates by Mond et al. (2006), 72% of respondents said they would find the behaviour of somebody with AN irritating, and 54% thought that someone with AN was vain. Additionally, 64% expressed that they would be doubtful or unwilling to interview someone with AN for a job, thus demonstrating how perceptions of the condition can impact other areas of sufferers' lives.

Similarly, Katterman and Klump (2010) found that their American undergraduate sample viewed EDs more negatively than other mental illnesses including obsessive compulsive disorder, schizophrenia and depression. Overall, respondents believed 63% of people with EDs conformed to negative stereotypes including being vain, self-indulgent and having a self-inflicted condition. Such perceptions were also observed by Geerling and Saunders (2015), who found that a character with AN was considered vainer than one with major depressive disorder. Additionally, the AN sufferer was regarded as more to blame for their condition, which led to respondents experiencing anger towards the sufferer.

Volitional stigma

Perceptions of personal choice and control appear prevalent in attitudes towards EDs, and Easter (2012) coined the term 'volitional stigma' (p. 1409) to refer to attitudes that position the conditions as lifestyle choices rather than illnesses. From a sample of 50 American women with EDs, Easter found that 88% had experienced volitional stigma, which participants widely believed to encourage negative stereotypes of ED sufferers as vain and selfish.

Multiple empirical studies analysing attitudes of the general population have also observed volitional stigma. For instance, from two studies of over 1,600 British adults, Crisp (2005) found that one third (33–34%) considered sufferers to blame for their condition, with 35–38% believing that someone with an ED ‘could pull themselves together’ (Crisp, 2005, p. 151). A more recent German study by Angermeyer et al. (2013) resulted in similar findings, with 31% of respondents considering someone with AN to be weak-willed and therefore responsible for their condition.

Stigma and attitudes to support for AN

Identifying that EDs appear subject to a form of stigma distinct from that of other mental illnesses, Crisafulli et al. (2010) formulated the Eating Disorder Stigma Scale (EDSS) to capture this, measuring perceptions of sufferers on four subscales: Trivial, Selfish/Vain, Weak, and Blame. Their quantitative study analysed the impacts of different etiological explanations for AN on attitudes towards the condition and support for better medical insurance for sufferers. The research found that respondents given a biological explanation of AN had both the lowest overall stigma and the highest willingness to sign a petition for better insurance. Therefore, this suggests that greater levels of AN stigma may correspond with lower endorsement of support for sufferers.

A similar study on attitudes to AN was conducted by Bannatyne and Abel (2015), also using measures of the EDSS and willingness to sign a petition. Their findings mirrored those of Crisafulli et al. (2010) in that a biological explanation elicited both the lowest levels of stigma and the most support for better insurance. However, a multifactorial explanation provoked the most stigma, but these respondents had significantly higher willingness to sign than those given a sociocultural explanation, demonstrating that greater AN stigma does not inevitably align with less inclination to help those with the condition. However, as neither this study nor that of Crisafulli et al. (2010) measured the direct interaction between AN stigma and advocacy for formal provision for sufferers, further research

into this relationship would be beneficial. Moreover, these studies referenced medical insurance rather than welfare benefits, which may be viewed differently due to recipients’ abilities to spend the money on goods and services not directly related to their condition (Fang & Huber, 2020).

Benefits deservingness

van Oorschot (2000) identified that perceptions of deservingness originating from historic Poor Laws appear salient in contemporary attitudes towards social welfare claimants. He suggested five key principles commonly used to determine claimants’ deservingness, which have since become known as the “‘CARIN” criteria’ (van Oorschot & Roosma, 2017, p.13). These are: Control (people seen to have less power over their condition are viewed as more deserving); Attitude (claimants viewed as more grateful are perceived as more deserving); Reciprocity (people earn assistance by paying into the system); Identity (claimants are perceived as more deserving if they share characteristics with the person(s) making the judgement); Need (people with greater requirement of help are viewed as more deserving). Though Attitude was not analysed, the initial investigation by van Oorschot (2000) did find significant support for all other criteria in a representative sample of the Dutch population. The strongest support was for Control, followed by Identity, Reciprocity, and Need.

The utility of the CARIN criteria is widely acknowledged across deservingness literature (Bonoli, 2021; De Tavernier & Draulans, 2021), having been substantiated by many empirical studies (e.g., Heuer & Zimmermann, 2020; Meuleman et al., 2020). However, the role of the framework in deservingness of disability and sickness benefits claimants specifically appears underexplored, as there is a general conception of this type of welfare recipient largely being considered more deserving than others (Böheim & Leoni, 2018).

Indeed, from a series of studies across Denmark, the United States and Japan, Jensen and Petersen (2017) found that people who were sick were deemed more deserving of government aid than

those who were unemployed. Thus, the authors suggested that these recipients are not subject to the same scrutiny as other types of claimants. However, in one of their Danish studies, perceived deservingness of government-funded healthcare was significantly reduced when respondents believed a person's condition to be caused by controllable choices such as smoking. This suggests that the Control aspect of CARIN may play still a role within this category.

Similarly, Laenen et al. (2019) found support for Control in a British focus group study, where some participants believed that personal control over ill health was justification for withholding welfare payments or healthcare, for example, viewing somebody with unhealthy eating habits as undeserving of support.

Condition-specific deservingness

Supposed deservingness of government assistance has also been found to vary according to specific diagnoses. In an online forum study by Dumit (2006), the Control element of CARIN appeared intertwined with the perceived authenticity of a condition. Chronic fatigue syndrome (CFS) and multiple chemical sensitivity (MCS) were classified as 'contested illnesses' (Dumit, 2006, p. 578), often having their existence disputed by medical professionals and the public due to fluctuating, invisible symptoms and uncertain causes. The study found that people with CFS and MCS were frequently denied welfare payments due to professionals supposedly doubting the legitimacy of their claims. Sufferers reported scepticism, with one participant being told to 'pull herself together' (Dumit, 2006, p. 582). This echoes findings of Crisp (2005) in relation to AN. Though no studies appear to have explored public perceptions of AN in relation to welfare benefits, AN has been considered a contested illness (Giles, 2006), so it is plausible that investigation into the perceived benefits deservingness of AN would lead to findings similar to Dumit's.

Other qualitative studies have also found visibility of illness to be a prominent factor in deservingness

decisions. Interviewing disability policy-makers across Australia and Canada, McAllister (2020) found clear divisions between welfare candidates deemed ideal and non-ideal. Ideal claimants had conditions that were visible, medically diagnosed and uncontrollable. Consequently, many participants stated that physical illnesses were ideal and mental were non-ideal, and a notable bias emerged against less visible and verifiable conditions.

Geiger (2021) highlighted a paucity in research into the benefits deservingness of specific health conditions, which he subsequently investigated. Findings from large-scale studies across 10 countries suggested that conditions considered more severe were viewed as more deserving of benefits, regardless of the level of individual responsibility ascribed to them or whether they were mental or physical illnesses. However, when mental and physical conditions were deemed similarly serious, mental illnesses were generally viewed as less deserving. This does not support the Control aspect of CARIN and highlights that the classification of mental illness does not automatically translate to low perceived deservingness. Multiple factors appear to contribute, and illnesses with the same broad classification may be judged differently. These results indicate a significant need for further research to build upon Geiger's initial investigation.

Research questions

Overall, findings from the reviewed literature suggest that stigma towards EDs – specifically AN – is prevalent across the Western world, with sufferers often viewed as vain and selfish. Volitional stigma was a prominent theme, and many studies found evidence of AN being perceived as a personal choice and sufferers blamed for their condition.

Welfare benefits literature indicates that conditions seen as more controllable are generally viewed as less deserving. Additionally, mental health conditions are often viewed as less deserving than physical ones. However, there appears a notable gap in knowledge of perceived deservingness of specific

conditions, and no studies appear to directly link attitudes towards AN with perceived benefits deservingness. Therefore, this research aimed to begin to fill these gaps, using the following research questions (RQs):

RQ1: Do students typically believe that people with AN should be eligible to apply for PIP?

Literature indicates AN is associated with multiple characteristics believed to reduce perceived deservingness of government assistance – primarily personal control and classification of mental illness. However, the uncertain status of AN as a contested illness may influence attitudes to PIP. As AN has both physical and mental symptoms it may not fit solely in the category of either physical or mental illness. This first question aimed to quantify support for PIP for AN within the sample, which could be addressed in further detail by subsequent research questions.

RQ2: Does AN stigma affect students' agreement that people with AN should be eligible to apply for PIP?

Higher levels of stigma may be associated with less advocacy of structural support for sufferers. However, this is not consistent across literature, and existing research relates to health insurance rather than benefits. Therefore, investigation is needed into how stigma may relate to attitudes towards sickness/disability benefits for people with AN.

RQ3: Does the belief that AN is a choice affect students' agreement that people with AN should be eligible to apply for PIP?

Volitional stigma was prominent in the literature review; this could link to the Control aspect of CARIN, which has been widely supported as a factor in welfare deservingness decisions. Therefore, this research question aimed to assess the specific role that perceptions of AN being a choice may have in determinations of benefits deservingness.

Methodology

This research utilised the quantitative approach, which involves collecting and analysing measurable data to find relationships between variables (Creswell & Creswell, 2018). Quantitative methods are useful for gaining an overview of opinions (Black, 1999; Ruane, 2016) and allow subjective beliefs to be converted to objective, numerical forms for analysis (Bhaskar, 2016; Grønmo, 2019). Additionally, quantitative methodology can be replicated in future studies, allowing for comparisons between results and for procedures to be validated through repetition (Morgan, 2014).

Research design

Data was collected via an online questionnaire (see Appendix A), created and administered on the Qualtrics platform, Version March 2021. This method was chosen due to its time and cost efficiency (Vehovar & Manfreda, 2017), and its increased sense of privacy and anonymity in comparison to paper-based surveys, thus promoting honest answers (Beins & McCarthy, 2018). Prior to administration, the questionnaire was piloted by the researcher and two members of university staff to test its length and identify areas for improvement (Babbie, 2021).

The final questionnaire contained nine questions, some of which were split into sub-questions. Most survey items were closed-ended, fixed response questions, chosen to maximise chances of questionnaire completion (Ruane, 2016) and eliminate misinterpretation of answers by the researcher (Walliman, 2018). Explanations of both AN and PIP were provided to ensure all respondents had the same basic understanding of these terms, with descriptions obtained from academically respected sources (HM Government, n.d.; NHS, 2021; WHO, 2020) to minimise bias.

An adapted version of the validated EDSS (Crisafulli et al., 2010) was used, containing eight of the original 20 items. The EDSS was condensed to reduce the length of the total survey, as well as to

eliminate perceived repetition of questions, as some of the original items had only subtle differences between them. (For example, ‘they are selfish’ vs. ‘they only care about themselves’ (Crisafulli et al., 2010, p. 764)). However, all four original subscales (Trivial, Selfish/Vain, Weak, and Blame) were retained, with two items chosen from each to maintain a balance of each element of stigma.

Each chosen item contained a statement reflecting a distinct stigmatising view of AN (see Appendix A, Question 5 for full list). Respondents rated agreement with each statement on a 5-point Likert scale (Likert, 1932) (5 = *strongly agree*). The mean score of all items is referred to as overall stigma, as per the original EDSS.

As the scale has previously demonstrated that it measures the intended concept, its use increases the validity of results (Kazi & Khalid, 2012). Since its inception, the EDSS has been used in both full and adapted variants and has demonstrated Cronbach’s alpha values between 0.81 and 0.95 (Bannatyne & Abel, 2015; Bannatyne & Stapleton, 2015), showing excellent internal consistency – a measure of reliability (Field, 2013). Utilising the EDSS allows for direct comparisons between this research and other studies that have used the scale.

Sampling

This research targeted undergraduate students in the School of Human and Health Sciences at the University of Huddersfield, who were recruited through circulation of two invitation emails. The sampling was purposive, as evidence shows that prevalence and risk of EDs are particularly high among university-age individuals (Lipson & Sonnevile, 2017; Ward et al., 2019), and therefore the views of this group were considered particularly relevant. Furthermore, multiple reviewed studies were conducted with university samples (e.g., Bannatyne & Abel, 2015; Crisafulli et al., 2010; Geerling & Saunders, 2015), allowing for direct comparisons between findings. However, individuals with history of an ED were excluded as they may have held biased views about AN (Crisafulli et al., 2008).

Ethics

Prior to any data collection, this study received full ethical clearance from the University of Huddersfield Ethics Committee (Division of Criminology, Politics and Sociology). Ethical guidelines of both the University of Huddersfield (2019) and the British Sociological Association (2017) were consulted and adhered to throughout the project, following the overarching principles of honesty, integrity, safety and confidentiality.

All respondents provided informed consent before progressing to the survey, which was clearly conveyed as voluntary, and respondents were notified about their right to withdraw without penalty. It was clearly communicated that respondents would not be personally identifiable from the data they shared, and an anonymous ID number was generated for all for the purpose of withdrawal. To allow respondents control over disclosure of personal information, a *prefer not to say* option was provided wherever possible.

In addition to minimising bias, another reason for excluding individuals with EDs was that they may be considered vulnerable due to the status of EDs as serious mental health conditions (NHS, 2021). As it was recognised that EDs can be distressing subject matter, information about relevant support services was made available to respondents both before and after the questionnaire, including to those excluded. This included contact details for university wellbeing services, as well as those for ED charity Beat and mental health charity Mind.

Data analysis

The survey yielded 30 responses. However, seven respondents divulged personal history of an ED and were therefore excluded, leaving a sample size of 23. Data was exported from Qualtrics into SPSS Version 26.0 for Windows. Prior to substantive analysis, several tests were run to ensure the

reliability and validity of the data. Cronbach's alpha for the adapted EDSS was calculated as 0.916, demonstrating excellent internal consistency (Field, 2013). Histograms and Shapiro-Wilk tests showed the data was not normally distributed and therefore non-parametric tests were used for analysis, as they are more versatile than parametric equivalents and do not rely on data falling within a certain range (Abu-Bader, 2021; Bathke et al., 2008). In subsequent inferential statistical tests, the statistical significance level of 0.05 was used, as is the industry standard (Wagner, 2013). Percentage figures were rounded to two decimal places.

Findings

Demographics

Demographic information was collected from respondents to enable recognition of patterns and detect any potential bias from over-representation of certain characteristics (Hughes et al., 2016). It was subsequently identified that the sample was predominantly female (87%), therefore, further data analysis was performed on responses from females only ($n = 20$), as the number of non-female respondents was not high enough to detect meaningful differences between genders (Blann, 2018). Within this final sample, the modal age was 18–24 years (75%), followed by 25–34 years (20%), and 45–54 years (5%).

Results

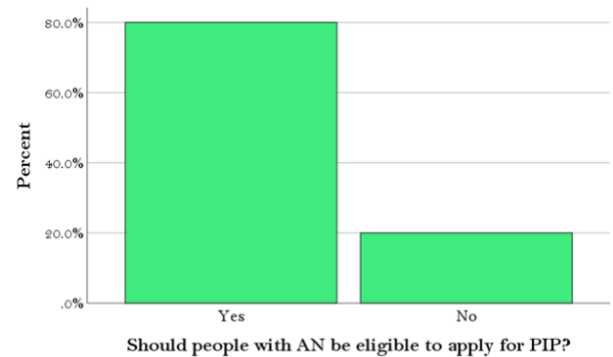
Eligibility for PIP

RQ1 asked: Do students typically believe that people with AN should be eligible to apply for PIP?

Figure 1 illustrates the percentage of respondents that answered yes to the question 'Do you believe that people with AN should be eligible to apply for PIP?'

Figure 1

Belief that someone with AN should be eligible to apply for PIP



The majority of respondents (80%) believed that people with AN should be eligible to apply for PIP, thus answering RQ1.

To examine this finding, variables that may have contributed to respondents' agreement with PIP were explored. Respondents recognised that AN could be a long-term condition, with all selecting an expected average duration of at least one to two years, with the modal response of three to five years (42.1%), and the second most common of >10 years (31.6%). However, cross-tabulation detected no apparent connection between anticipated duration of AN and attitudes to PIP.

Respondents were also asked to classify AN, selecting as many as applicable from 'mental illness', 'physical illness', 'disability', and 'choice'. The results are presented in Table 1.

Table 1

Frequency of responses for each classification label

Classification	Percent of Cases
Mental illness	95.0%
Physical illness	70.0%
Disability	25.0%
Choice	15.0%

Notably, many of these responses overlapped, which speaks to the general ambiguity around the nature of AN.

All classification labels were cross-tabulated with agreement for PIP, and Pearson's chi-square tests

of association were conducted. Results showed that only the association for physical illness was statistically significant (Pearson’s chi-square = 4.821, df = 1, p = .028). Following this result, the cross-tabulation of physical illness and agreement for PIP is presented in Table 2.

Table 2
Cross-tabulation of classification of physical illness and agreement for PIP

Table 2 shows that most respondents who believed that AN was a physical illness agreed that people with AN should be eligible to apply for PIP (92.9%). This indicates that respondents may have associated PIP with difficulties induced by physical illness, though the questionnaire’s description of

		PIP		Total
		Yes	No	
Physical	Yes	92.9%	7.1%	100.0%
	No	50.0%	50.0%	100.0%

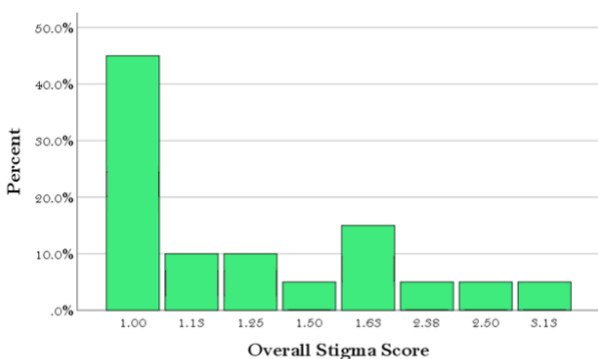
PIP made no reference to type of health condition required for eligibility.

Effect of stigma on PIP eligibility

RQ2 asked: Does AN stigma affect students’ agreement that people with AN should be eligible to apply for PIP?

Figure 2 shows the distribution of overall stigma scores.

Figure 2
Overall stigma scores across the sample



Results show that most respondents (95%) had

overall stigma scores of below the scale midpoint of 3.00, indicating that overall attitudes towards AN were not substantially stigmatising. Additionally, the modal score was 1.00 (45%) – the lowest possible value – revealing that many respondents did not report any stigmatising beliefs about AN.

The mean values of overall stigma and each EDSS subscale are reported in Table 3.

Table 3
Mean values for overall stigma and EDSS subscales across the sample

Table 3 shows low overall stigma (M = 1.41, SD = 0.60). The subscale that elicited the highest score was Blame (M = 1.68, SD = 0.99), indicating this to be the most prominent aspect of stigma.

To address RQ2, overall stigma values were cross-tabulated with PIP. There was a clear split in overall stigma scores occurring at 1.50, as most respondents answering yes to PIP (75.1%) had scores that fell below this, whereas most respondents answering no (75%) had scores of 1.50 or higher. This demonstrates that respondents who disagreed with PIP tended to hold higher levels of stigmatising beliefs towards AN. A Mann-Whitney

	Overall Stigma	Trivial	Selfish /Vain	Weak	Blame
Mean	1.41	1.38	1.28	1.30	1.68
Std. Deviation	.60	.60	.53	.57	.99

U test was subsequently conducted to analyse the difference between overall stigma scores for respondents answering yes and no for PIP.

Table 4
A Mann-Whitney U test to show difference in mean ranks of overall stigma scores between answers to PIP

PIP	Mean Rank	Sum of Ranks
Yes	9.34	149.50
No	15.13	60.50

Table 4 shows the mean rank of overall stigma of respondents that answered yes to PIP (9.34) is substantially lower than the mean rank of respondents that answered no (15.13). This strengthens the finding that overall, those who answered yes held fewer stigmatising beliefs. However, this was not a statistically significant difference ($U = 13.500, p = .080$).

answered yes to PIP generally had higher levels of disagreement with individual EDSS items than those who answered no. The biggest differences were observed for statements of a person with AN causing their condition (yes = 93.8%, no = 50%) and being responsible for the condition (yes = 75.1%, no = 50%). Both groups entirely disagreed (100%) with the statement that people with AN only care about looking good. Respondents that answered yes to PIP only showed lower disagreement for the statement that someone with AN is weak (yes = 93.8%, no = 100%).

Table 5

Levels of disagreement with EDSS items, split between yes and no responses to PIP

EDSS Item	PIP: Yes			PIP: No		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
'Their illness is not as serious as other mental illnesses.'	93.8%	6.3%	0%	75%	25%	0%
'Their illness is not as serious as other physical illnesses.'	100%	0%	0%	75%	25%	0%
'They are selfish.'	93.8%	6.3%	0%	75%	0%	25%
'They only care about looking good.'	100%	0%	0%	100%	0%	0%
'They are weak.'	93.8%	0%	6.3%	100%	0%	0%
'They are pathetic for not being able to control their anorexia.'	100%	0%	0%	75%	25%	0%
'They caused their anorexia.'	93.8%	0%	6.3%	50%	25%	25%
'They are responsible for their anorexia.'	75.1%	18.8%	6.3%	50%	25%	25%

Table 5 shows differences in levels of disagreement with individual EDSS items between those who answered yes and no to PIP. This allows trends to be observed in which statements were most frequently endorsed and thus contributed to higher overall stigma scores. The choices of 'strongly' and 'somewhat' disagree/agree were collapsed so that responses fell into three categories.

In addition to observed differences in overall stigma scores, Table 5 shows that respondents that

Considering these findings, in this study stigma did appear to affect students' agreement that people with AN should be eligible to apply for PIP. Though the Mann-Whitney test did not yield statistically significant results, there was a clear relation between higher stigma and disagreement with PIP. Respondents that disagreed with PIP for AN regularly showed higher endorsement of stigmatising statements about AN and generally had higher overall stigma scores.

Perceptions of choice and PIP eligibility

RQ3 asked: Does the belief that AN is a choice affect students' agreement that people with AN should be eligible to apply for PIP?

Table 6 presents disagreement with the statement 'a person with AN can choose to stop their behaviour if they want to', as well as cross-tabulation with how respondents answered the PIP question. Levels of agreement were collapsed into three categories: disagree, neutral, and agree.

Table 6

Cross-tabulation of agreement with PIP and agreement with the statement 'a person with AN can choose to stop their behaviour if they want to'

		Statement			Total
		Disagree	Neutral	Agree	
PIP	Yes	87.5%	6.3%	6.3%	100.0%
	No	50.0%	0.0%	50.0%	100.0%
Total		80.0%	5.0%	15.0%	100.0%

Most respondents (80%) disagreed with the statement, however, more respondents agreed (15%) than were neutral (5%). Though this split is very similar to the divide between 'yes' and 'no' answers for PIP seen in Figure 1, it does not comprise the same respondents. Most who answered yes to PIP disagreed with the statement (87.5%). Of those who answered no to PIP, there was an even split between disagreement (50%) and agreement (50%) with the statement.

To further explore this relationship, responses were also analysed in their original form as ordinal variables (1 = *strongly disagree*, 5 = *strongly agree*). Table 7 presents the results of a Mann-Whitney U test performed to assess differences in mean ranks of choice scores between those who answered yes and no to PIP.

Table 7

A Mann-Whitney U test to show difference in mean ranks of choice scores between answers to PIP

PIP	Mean Rank	Sum of Ranks
Yes	9.50	152.00
No	14.50	58.00

Table 7 shows that the mean rank is lower for respondents that answered yes (9.50), compared to those who answered no (14.50). This indicates that respondents that answered yes were more likely to disagree with the statement. However, this difference was not statistically significant ($U = 16.000$, $p = .148$).

Choice was also an element of Question 7 (see Appendix A), which asked respondents to classify AN. However, the cross-tabulation of classification of choice and PIP showed a non-statistically significant association ($p = .531$). This high p value combined with the fact that choice was only selected by a minority of respondents ($n = 3$) meant that there was unlikely to be enough data to detect a meaningful relationship between variables (Martínez-Mesa et al., 2014). Therefore, further analysis was not conducted.

Overall, these results do not provide substantial evidence to support that belief that AN is a choice affects students' attitudes towards PIP for people with AN. Though many respondents who answered yes to PIP disagreed that AN is a choice, responses were too mixed to draw definitive conclusions and findings were not statistically significant.

Discussion

Though the results of this study did not show a statistically significant association between stigma and endorsement of PIP for people with AN, respondents who answered no to PIP were nonetheless found to generally have higher levels of stigmatising beliefs than those who answered yes. Many scholars (see e.g., LoBiondo-Wood, 2018; Mehler et al., 2019) claim that although they may not be *statistically* significant, any differences highlighted in data analysis have potential to be significant to the discipline. Though it is widely used, the 0.05 significance value is still argued to be an arbitrary boundary, and conclusions based solely

on their adherence to this may overlook important findings (Di Leo & Sardanelli, 2020; Wasserstein & Lazar, 2016). This is particularly salient in social science, as effects labelled non-significant can still have notable impacts on society and real people's lives (Ziliak & McCloskey, 2008). Therefore, the trends observed in this study's results should be considered valuable contributions to the knowledge base and not dismissed purely because of the p value.

Attitudes to PIP

This study found considerable support for PIP for people with AN, with 80% of respondents agreeing that people with the condition should be eligible to apply for the benefit. This is a positive finding and suggests that most respondents realised the significant impact AN can have on a person's day-to-day life.

It is possible that the sociocultural context of the COVID-19 pandemic ongoing at the time of the research may have contributed to these largely favourable attitudes to PIP. The pandemic stimulated a wide-scale increase in the number of people reliant on state welfare, which was speculated to potentially lead to more accepting attitudes towards claimants (Clair et al., 2021; Curtice, 2020). Preliminary research into post-pandemic public attitudes to benefits suggests that these may be ameliorating, with people showing increased leniency towards those who may previously have been regarded undeserving (Duffy et al., 2021; Patrick et al., 2021).

Another reason for this finding may be the theory that people with illnesses and disabilities are generally regarded as deserving and not subject to the same scrutiny as other welfare claimants (Böheim & Leoni, 2018; Jensen & Petersen, 2017). However, as comparison between people with AN and other benefits claimants was outside the scope of this study, this theory cannot be substantiated by the current research.

Data analysis revealed a significant association between the classification of AN as a physical illness and agreement for PIP. This supports findings of

both McAllister (2020) and Geiger (2021) that physical illness is often viewed as highly deserving of sickness and disability benefits. However, this study was not able to draw comparisons with the classification of AN as a mental illness, as the association between this classification and agreement for PIP was not statistically significant and many respondents simultaneously viewed AN as both a physical and mental illness.

Though the majority of the sample agreed that individuals with AN should be eligible to apply for PIP, the fifth that did not is still concerning. Irrespective of changes induced by the pandemic, British sickness and disability benefits have become increasingly aligned with the worklessness discourse over recent years, with policies more focused on determining which conditions are deserving of support (Böheim and Leoni, 2018; Ciccia et al., 2020; Wiggan, 2012). This enhanced conditionality has been linked with a deterioration in public attitudes towards claimants and argued to have intensified the scrounger narrative that positions people on sickness and disability benefits as unnecessarily dependent on taxpayer money (Briant et al., 2013; Burch, 2018).

Previous research has shown that claimants are aware of this narrative, and that it often results in feelings of guilt and shame (Garthwaite, 2015; Patrick, 2016). Furthermore, such negative perceptions have been associated with reduced benefit take-up (Baumberg, 2016). Correspondingly, lack of access to sickness and disability benefits has been linked to deteriorations in both physical and mental health (Saffer et al., 2018; Shefer et al., 2016). Therefore, views that somebody with AN is undeserving of applying for PIP could have detrimental impacts on a person's self-esteem and finances, and compound existing health issues.

AN stigma

In his seminal work, Goffman (1963) described a stigma as a characteristic that differs from societal norms and is thus seen as undesirable. Someone with such a trait is 'reduced... from a whole and

usual person to a tainted, discounted one' (Goffman, 1963, p. 3). Link and Phelan (2001) believe the formation of stigma to be a multi-faceted process involving 'labeling, stereotyping, separation, status loss, and discrimination' (p. 367).

Similarly, Tyler and Slater (2018) propose that stigma is a form of power that operates beyond the individual level and incorporates social and political structures. These structures activate discourses of stigma to control and negate citizens with socially undesirable characteristics, such as having a mental illness. This has been referred to by others (e.g., Hatzenbuehler, 2018; Henderson et al., 2014) as structural stigma that informs public opinion and policies in a way that restricts opportunities for stigmatised groups and compromises their wellbeing. Structural stigma has been repeatedly related to illness, particularly mental health conditions (e.g., Corrigan et al., 2004; Sheehan et al., 2017).

It is well documented that stigma can be greatly detrimental to a person's quality of life (Gates, 2019), with effects including lowered self-esteem (Vass et al., 2017), reduced access to employment (Ong et al., 2020), and social exclusion (Krupchanka & Thornicroft, 2017). Additionally, stigma of EDs has been associated with low levels of help-seeking and increased symptom severity (Foran et al., 2020).

This study extended the work of Crisafulli et al. (2010) and Bannatyne and Abel (2015) in recognising the potential link between AN stigma and endorsement for structural support for sufferers. The findings illustrate another way in which stigma can impact upon the lives of affected individuals; discrediting people with AN and discounting their right to social security. This stigma should therefore be considered structural.

However, despite its relationship with lack of agreement for PIP, overall stigma was low across the sample ($M = 1.41$, $SD = 0.60$), with most scores (95%) falling below the scale midpoint. The mean was below that elicited by the first use of the EDSS by Crisafulli et al. (2010), which demonstrated a value of 2.13 ($SD = 0.52$). Additionally, this study

reported perceptions of AN that were largely more positive than previous research, particularly in regard to vanity. Across the sample, no respondents agreed that someone with AN 'only cares about looking good', despite this being one of the most highly endorsed viewpoints of the original EDSS study (Crisafulli et al., 2010). Stereotypes of people with EDs as vain are a persistent finding across the literature (Geerling & Saunders, 2015; Katterman & Klump, 2010; Mond et al., 2006), so it is an unexpected, but welcome, result that they were not found in this study.

AN and blame

Analysing the EDSS at subscale level, some findings appear more consistent with those of previous research. The highest mean subscale value was Blame ($M = 1.68$ $SD = 0.99$), which is a recurrent finding in studies that have utilised the EDSS (Bannatyne & Abel, 2015; Bannatyne & Stapleton, 2017; Crisafulli et al., 2010). Though in the current study most respondents still disagreed with the Blame statements, the noticeably higher endorsement of these items compared with others indicates that blame is a pivotal aspect of AN stigma. This finding is also consistent with previous studies that did not use the EDSS, as Crisp (2005), Angermeyer et al. (2013), and Geerling and Saunders (2015) all found significant evidence of people with EDs being blamed for their condition.

Though choice as an independent variable was not shown to have a statistically significant association with PIP, the Blame subscale statements could be interpreted to reflect choice through their references to responsibility and causation. Therefore, findings may indicate volitional stigma (Easter, 2012). While the EDSS encapsulates the unique stigma of EDs, some items may overlap with general perceptions of welfare deservingness; statements from the Blame subscale are also relevant to the Control element of CARIN (van Oorschot, 2000). Therefore, findings are consistent with previous studies (Jensen & Petersen, 2017; Laenen et al., 2019; McAllister, 2020), as higher endorsement of control over AN was associated with disagreement with government support for the

condition.

Classification of AN

Separately from agreement with PIP, results offered an insight into how respondents classified AN. The variance and overlap in responses exemplify the general ambivalence around AN's classification and give weight to the notion of AN as a contested illness (Giles, 2006). Contested illnesses have been defined as conditions with uncertain causes, unclear effective treatments, and disputed classifications among professionals and the public (Schone, 2019; Swoboda, 2006). Giles (2006) identifies AN as a contested illness due to its combination of physical and mental symptoms and the widespread uncertainty about the role that psychological, physiological and sociocultural factors play in its onset.

Despite AN being widely referred to as a mental illness (e.g., NHS, 2021; van den Berg et al., 2019), some specialists have argued that psychiatric symptoms may be induced by physical effects of starvation, rather than vice versa (e.g., Gutiérrez & Carrera, 2021; Södersten et al., 2019). Furthermore, diagnosis of AN is dependent on weight and has a vast number of physical complications (WHO, 2020). Therefore, it is understandable that many respondents (65%) viewed AN as both a physical and mental illness.

Importantly, people with AN often experience high levels of physical, social and occupational impairment, leading some to consider it a significantly disabling condition (Mond et al., 2004; Siegel & Sawyer, 2019; Tan et al., 2020). Regarding long-term illnesses more generally, there has been consistent hesitancy among sufferers, policy-makers and the public to consider long-term illnesses as types of disability, despite acknowledging that they have significantly disabling symptoms (Hale, 2018; Price et al., 2020). The findings of this study indicate this hesitancy may apply to AN, as only 25% of the sample classified the condition as a disability, despite all respondents recognising it as some form of illness lasting for at least one year.

Conclusion

The main findings of this study were that most respondents agreed that individuals with AN should be eligible to apply for PIP, though stigma of AN was associated with lack of agreement with PIP. This research did not find substantive evidence that perceptions of AN being a choice were associated with attitudes towards PIP. Overall, stigma towards AN was not prevalent among respondents, which was a welcome result. However, views reflecting volitional stigma were still present, and some respondents blamed sufferers for having AN.

Study limitations

Though this study fulfilled its aim and thus offered a valuable starting point for investigating the impact of stigma on perceived deservingness of benefits, it did have several limitations. Firstly, the sample size was small ($n = 20$), which is likely to have contributed to the observed scarceness of statistical significance (Martínez-Mesa et al., 2014). The low response rate may be explained by students experiencing survey fatigue (Van Mol, 2017) and decreased levels of motivation and engagement amidst the COVID-19 pandemic (Daniels et al., 2021; Hill & Fitzgerald, 2020). Despite the limited data pool, small-scale studies are useful for initial investigation of phenomena (Denscombe, 2014), so this project is still regarded to have considerable merit in the field.

Secondly, findings were potentially influenced by the adaptation of the EDSS. Though included items were thought to satisfactorily reflect the four elements of AN stigma, respondents still may have responded more/less favourably to excluded items from the full scale, thus resulting in notably different overall stigma scores.

Another limitation of this research was the homogeneity of the sample. AN has historically been regarded a female problem (Bray, 1996; MacLean et al., 2015; Smith et al., 2021), which may have made females more inclined to respond (Saleh & Bista, 2017). However, attitudes of people who do

not identify as female may differ from those reported by this research. Additionally, as Human and Health Sciences incorporates courses such as Psychology, Mental Health Nursing and Occupational Therapy, respondents may have had teaching on and exposure to AN that resulted in knowledge and understanding of the condition atypical of the general student population. This may have contributed to the largely non-stigmatising attitudes found.

Future research recommendations

It would be beneficial to repeat this research in a larger sample that is representative of the British population to allow results to be generalisable (Hartley et al., 2021), and to detect differences between responses from people with different characteristics (Hughes et al., 2016), for example those of different genders, ethnicities and educational backgrounds. Additionally, a larger sample may result in more cases of statistical significance than seen in this study – the lack of which particularly impeded investigation of how perceptions of choice related to agreement with PIP.

The largely positive views found by this study may indicate that attitudes towards AN have ameliorated since previous research, which is consistent with claims from charities and academics that mental illness stigma has reduced, possibly owing to anti-stigma campaigns (e.g., Henderson et al., 2020; TTC, 2021a). Further research is needed to investigate this, as one small-scale study is not sufficient to substantiate the theory. Moreover, it is worth noting that this study was unintentionally launched during ED Awareness Week 2021 (Beat, 2021a), which may have contributed to the largely favourable views. However, long-term efficacy of such interventions is unknown (Doley et al., 2017), so it would be worthwhile to repeat this research at a later date.

It may also be beneficial for future research to utilise the full EDSS scale, or different adaptations, to analyse the impact of including different statements to measure stigma. Furthermore, this study used

the examples of AN and PIP, but future research could broaden the evidence base by investigating attitudes towards other EDs and benefits, which may be viewed differently.

Finally, this study demonstrated just one way that ED stigma can impact upon other attitudes towards sufferers. Future research should endeavour to understand more about potential impacts of stigma, analysing, for example, effects of ED stigma on respondents' attitudes towards healthcare or employment opportunities for sufferers.

Overall, this study has highlighted a crucial way in which the stigma of AN can impact sufferers' lives. This research made a novel contribution to the knowledge base on both EDs and benefits, and provided a starting point for other scholars to build upon in future.

Appendix A. Research questionnaire

Have you ever been diagnosed with, or believe that you have ever had an eating disorder?

Yes No

Section One: About you

Question 1: What is your gender identity?

Female
Male
Non-binary
Prefer not to say

Question 2: How old are you?

18–24 years
25–34 years
35–44 years
45–54 years
55+ years
Prefer not to say

Question 3: What year of undergraduate study are you in at the University of Huddersfield?

First year
 Second year
 Third year
 Other (please state)

Question 4: Which academic school does your course of study belong to?

Applied Sciences
 Art, Design and Architecture
 Business
 Computing and Engineering
 Education and Professional Development
 Human and Health Sciences
 Music, Humanities and Media
 Don't know
 Prefer not to say

Section Two: Examining perspectives towards anorexia nervosa

Please read the following information carefully:

Anorexia nervosa is a condition where a sufferer has a significantly low body weight or rapid weight loss caused by behaviours intended to reduce overall calorie intake, such as restrictive eating, excessive exercise or self-induced vomiting (World Health Organization, 2020). Physical complications of anorexia nervosa can include tiredness, weakness, concentration and memory difficulties, low blood pressure, osteoporosis (weakened bones), fertility issues, and heart problems (National Health Service, 2021).

Question 5: How strongly do you agree that the following statements apply to a person with anorexia nervosa?

(Please read each statement carefully and select an option for each statement. 1 means *strongly disagree* and 5 means *strongly agree*.)

5a: 'Their illness is not as serious as other mental illnesses.'
 5b: 'Their illness is not as serious as other physical

illnesses.'

5c: 'They are selfish.'

5d: 'They only care about looking good.'

5e: 'They are weak.'

5f: 'They are pathetic for not being able to control their anorexia.'

5g: 'They caused their anorexia.'

5h: 'They are responsible for their anorexia.'

[NB: Each statement had an interactive answer scale with the relevant options.]

Question 6: How strongly do you agree with the following statement?: 'A person with anorexia nervosa can choose to stop their behaviour if they want to.'

(Please read the statement carefully and select an option. 1 means *strongly disagree* and 5 means *strongly agree*.)

[NB: The statement had an interactive answer scale with the relevant options.]

Section Three: Classifying anorexia nervosa and providing support

Question 7: Which of these labels do you think apply to anorexia nervosa? Please select all that apply

Choice
 Disability
 Mental illness
 Physical illness
 Other (please state)

Question 8: On average, how long do you think somebody with anorexia nervosa will have the condition?

Less than 6 months
 Over 6 months but less than 1 year
 1-2 years
 3-5 years
 6-10 years
 Over 10 years

Please read the following information carefully:

Personal Independence Payment (PIP) is a type of benefit available to help with additional costs of living for people with long-term health conditions or disabilities. PIP is available to both employed and unemployed UK citizens aged between 16 years and state pension age. People are eligible to apply for PIP if they have a health condition or disability that causes them to have difficulty with daily living and/or getting around. Applying for PIP does not mean that a person will automatically receive it – they will have to undergo an assessment to determine the effects of their condition on their daily life (HM Government, n.d.).

Question 9: Do you believe that people with anorexia nervosa should be eligible to apply for Personal Independence Payment (PIP)?

Yes

No

Please click the blue arrow button to submit your responses and proceed to the end of the survey.

References

- Abu-Bader, S. H. (2021). *Using statistical methods in social science research – With a complete SPSS guide* (3rd ed.). Oxford University Press.
- Angermeyer, M. C., Mnich, E., Daubmann, A., Herich, L., Wegscheider, K., Kofahl, C., & Von Dem Knesebeck, O. (2013). Biogenetic explanations and public acceptance of people with eating disorders. *Social Psychiatry and Psychiatric Epidemiology*, *48*(10), 1667–73. <https://doi.org/10.1007/s00127-012-0648-9>
- Babbie, E. (2021). *The practice of social research* (15th ed.). Cengage Learning.
- Bannatyne, A. J., & Abel, L. M. (2015). Can we fight stigma with science? The effect of aetiological framing on attitudes towards anorexia nervosa and the impact on volitional stigma. *Australian Journal of Psychology*, *67*(1), 38–46. <https://doi.org/10.1111/ajpy.12062>
- Bannatyne, A. J., & Stapleton, P. (2015). Educating medical students about anorexia nervosa: A potential method for reducing the volitional stigma associated with the disorder. *Eating Disorders*, *23*(2), 115–33. <https://doi.org/10.1080/10640266.2014.976102>
- Bannatyne, A. J., & Stapleton, P. B. (2017). Attitudes towards anorexia nervosa: Volitional stigma differences in a sample of pre-clinical medicine and psychology students. *Journal of Mental Health*, *26*(5), 442–8. <https://doi.org/10.3109/09638237.2016.1149801>
- Bathke, A. C., Harrar, S. W., & Madden, L. V. (2008). How to compare small multivariate samples using nonparametric tests. *Computational Statistics & Data Analysis*, *52*(11), 4951–65. <https://doi.org/10.1016/j.csda.2008.04.006>
- Baumberg, B. (2016). The stigma of claiming benefits: A quantitative study. *Journal of Social Policy*, *45*(2), 181–99.

<https://doi.org/10.1017/S0047279415000525>

Beat. (2017). *Delaying for years, denied for months*.

<https://www.beateatingdisorders.org.uk/documents/58/delaying-for-years-denied-for-months.pdf>

Beat. (2021a). *Eating disorders awareness week, 1–7 March 2021*.

<https://www.beateatingdisorders.org.uk/edaw>

Beat. (2021b). *Eating disorder myths*. <https://www.beateatingdisorders.org.uk/recovery-information/eating-disorder-myths>

Beins, B. C., & McCarthy, M. A. (2018). *Research methods and statistics*. Cambridge University Press.

Bhaskar, R. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge.

Black, T. R. (1999). *Doing quantitative research in the social sciences: An integrated approach to research design, measurement and statistics*. SAGE Publications.

Blann, A. (2018). *Data handling and analysis* (2nd ed.). Oxford University Press.

Böheim, R., & Leoni, T. (2018). Sick and disabled: Reform paths in OECD countries between 1990 and 2014: Sick and disabled policies. *International Journal of Social Welfare*, 27(2), 168–85. <https://doi.org/10.1111/ijsw.12295>

Bonoli, G. (2021). Unpacking CARIN: Four questions on the study of perceptions of deservingness to social benefits. In T. Laenen, B. Meuleman, A. Otto, F. Roosma, & W. Van Lancker (Eds.), *Leading social policy analysis from the front: Essays in honour of Wim van Oorschot* (pp. 233–42). KU Leuven.

Bray, A. (1996). The anorexic body: Reading disorders. *Cultural Studies*, 10(3), 413–29. <https://doi.org/10.1080/09502389600490251>

Briant, E., Watson, N., & Philo, G. (2013). Reporting disability in the age of austerity: The changing face of media representation of disability and disabled people in the United Kingdom and the creation of new ‘folk devils’. *Disability & Society*, 28(6), 874–89. <https://doi.org/10.1080/09687599.2013.813837>

British Sociological Association. (2017). *Statement of ethical practice*. https://www.britisoc.co.uk/media/24310/bsa_statement_of_ethical_practice.pdf

Burch, L. (2018). ‘You are a parasite on the productive classes’: Online disablist hate speech in austere times. *Disability & Society*, 33(3), 392–415. <https://doi.org/10.1080/09687599.2017.1411250>

Ciccio, R., French, D., Kee, F., & O’Doherty, M. (2020). Deservingness, conditionality and public

perceptions of work disability: The influence of economic inequality. *Work, Employment & Society*. Advanced online publication. <https://doi.org/10.1177/0950017020967229>

Clair, A., Fledderjohann, J., & Knowles, B. (2021). *A watershed moment for social policy and human rights? Where next for the UK post-COVID*. Policy Press.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia bulletin*, *30*(3), 481–91. <https://doi.org/10.1093/oxfordjournals.schbul.a007096>

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.

Crisafulli, M. A., Von Holle, A., & Bulik, C. M. (2008). Attitudes towards anorexia nervosa: The impact of framing on blame and stigma. *International Journal of Eating Disorders*, *41*(4), 333–9. <https://doi.org/10.1002/eat.20507>

Crisafulli, M. A., Thompson-Brenner, H., Franko, D. L., Eddy, K. T., & Herzog, D. B. (2010). Stigmatization of anorexia nervosa: Characteristics and response to intervention. *Journal of Social and Clinical Psychology*, *29*(7), 756–70. <https://doi.org/10.1521/jscp.2010.29.7.756>

<https://doi.org/10.1521/jscp.2010.29.7.756>

Crisp, A. (2005). Stigmatization of and discrimination against people with eating disorders including a report of two nationwide surveys. *European Eating Disorders Review*, *13*(3), 147–52. <https://doi.org/10.1002/erv.648>

Curtice, J. (2020). Will Covid-19 change attitudes towards the welfare state? *IPPR Progressive Review*, *27*(1), 93–104. <https://doi.org/10.1111/newe.12185>

Daniels, L. M., Goegan, L. D., & Parker, P. C. (2021). The impact of COVID-19 triggered changes to instruction and assessment on university students' self-reported motivation, engagement and perceptions. *Social Psychology of Education*, *24*, 299–318. <https://doi.org/10.1007/s11218-021-09612-3>

Denscombe, M. (2014). *The good research guide: For small-scale social research projects* (5th ed.). Open University Press.

De Tavernier, W., & Draulans, V. (2021). Is CARIN alive and well? Revisiting the relationship between stereotypes and identity as the foundations of welfare deservingness. In T. Laenen, B. Meuleman, A. Otto, F. Roosma, & W. Van Lancker (Eds.), *Leading social policy analysis from the front: Essays in honour of Wim van Oorschot* (pp. 243–52). KU Leuven.

Di Leo, G., & Sardanelli, F. (2020). Statistical significance: P value, 0.05 threshold, and applications to radiomics-reasons for a conservative approach. *European Radiology Experimental*, 4(18), 1–8. <https://doi.org/10.1186/s41747-020-0145-y>

Disability Benefits Consortium. (2017). *Supporting those who need it most? Evaluating personal independence payment. A report by the Disability Benefits Consortium.*

<https://disabilitybenefitsconsortium.files.wordpress.com/2017/09/supporting-those-who-need-it-most-full-report.pdf>

Doley, J. R., Hart, L. M., Stukas, A. A., Petrovic, K., Bouguettaya, A., & Paxton, S. J. (2017). Interventions to reduce the stigma of eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders*, 50(3), 210–30. <https://doi.org/10.1002/eat.22691>

Duffy, B., Hewlett, K., Hesketh, R., Benson, R., & Wager, A. (2021). *Unequal Britain: Attitudes to inequalities after Covid-19.* King's College London & The Policy Institute. <https://doi.org/10.18742/pub01-043>

Dumit, J. (2006). Illnesses you have to fight to get: Facts as forces in uncertain, emergent illnesses. *Social Science & Medicine*, 62(3), 577–90. <https://doi.org/10.1016/j.socscimed.2005.06.018>

Easter, M. M. (2012). 'Not all my fault': Genetics, stigma, and personal responsibility for women with eating disorders. *Social Science & Medicine*, 75(8), 1408–16. <https://doi.org/10.1016/j.socscimed.2012.05.042>

Fang, A. H., & Huber, G. A. (2020). Perceptions of deservingness and the politicization of social insurance: Evidence from disability insurance in the United States. *American Politics Research*, 48(5), 543–59. <https://doi.org/10.1177/1532673X19863439>

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th ed.). SAGE Publications.

Foran, A-M., O'Donnell, A. T., & Muldoon, O. T. (2020). Stigma of eating disorders and recovery-related outcomes: A systematic review. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, 28(4), 385–97. <https://doi.org/10.1002/erv.2735>

Garthwaite, K. (2015). 'Keeping meself to meself' – How social networks can influence narratives of stigma and identity for long-term sickness benefits recipients. *Social Policy & Administration*, 49(2), 199–212. <https://doi.org/10.1111/spol.12119>

Gates, G. (2019). *Trauma, stigma, and autism: Developing resilience and loosening the grip of shame.*

Jessica Kingsley Publishers.

Geerling, D. M., & Saunders, S. M. (2015). College students' perceptions of individuals with anorexia nervosa: irritation and admiration. *Journal of Mental Health, 24*(2), 83–87. <https://doi.org/10.3109/09638237.2014.998807>

Geiger, B. B. (2021). Disabled but not deserving? The perceived deservingness of disability welfare benefit claimants. *Journal of European Social Policy, 31*(3), 337–51. <https://doi.org/10.1177/0958928721996652>

Giles, D. (2006). Constructing identities in cyberspace: The case of eating disorders. *British Journal of Social Psychology, 45*(3), 463–77. <https://doi.org/10.1348/014466605X53596>

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.

Grønmo, S. (2019). *Social research methods: Qualitative, quantitative and mixed methods approaches*. SAGE Publications.

Gutiérrez, E., & Carrera, O. (2021). Severe and enduring anorexia nervosa: Enduring wrong assumptions? *Frontiers in Psychiatry, 11*(538997) 1–20. <https://doi.org/10.3389/fpsy.2020.538997>

Hale, C. (2018). *Reclaiming 'chronic illness': An introduction to the chronic illness inclusion project*. The Centre for Welfare Reform.

<https://www.centreforwelfarereform.org/uploads/attachment/617/reclaiming-chronic-illness.pdf>

Hartley, R. D., Ellis, L., & Walsh, A. (2021). *Research methods for criminology and criminal justice*. Rowman & Littlefield.

Hatzenbuehler, M. L. (2018). Structural stigma and health. In B. Major, J. F. Dovidio, & B. G. Link (Eds.), *The Oxford handbook of stigma, discrimination, and health* (pp. 105–21). Oxford University Press.

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet. Psychiatry, 1*(6), 467–82. [https://doi.org/10.1016/S2215-0366\(14\)00023-6](https://doi.org/10.1016/S2215-0366(14)00023-6)

Henderson, C., Potts, L., & Robinson, E. J. (2020). Mental illness stigma after a decade of time to change England: Inequalities as targets for further improvement. *European Journal of Public Health, 30*(3), 526–32. <https://doi.org/10.1093/eurpub/ckaa013>

Heuer, J., & Zimmermann, K. (2020). Unravelling deservingness: Which criteria do people use to judge the relative deservingness of welfare target groups? A vignette-based focus group study. *Journal of European Social Policy, 30*(4),

389–403.

<https://doi.org/10.1177/0958928720905285>

Hill, K., & Fitzgerald, R. (2020). Student perspectives on the impact of COVID-19 on learning. *All Ireland Journal of Higher Education*, *12*(2). <https://ojs.aishe.org/index.php/aishe-j/article/view/459/801>

HM Government. (n.d.). *Personal Independence Payment (PIP)*. Gov.uk. <https://www.gov.uk/pip/print>

Hughes, J. L., Camden, A. A., & Yangchen, T. (2016). Rethinking and updating demographic questions: Guidance to improve descriptions of research samples. *Psi Chi Journal of Psychological Research*, *21*(3), 138–51. <https://doi.org/10.24839/2164-8204.JN21.3.138>

Jensen, C., & Petersen, M. B. (2017). The deservingness heuristic and the politics of health care. *American Journal of Political Science*, *61*(1), 68–83. <https://doi.org/10.1111/ajps.12251>

Katterman, S. N., & Klump, K. L. (2010). Stigmatization of eating disorders: A controlled study of the effects of the television show *Starved*. *Eating Disorders*, *18*(2), 153–64. <https://doi.org/10.1080/10640260903585599>

Kazi, A. M., & Khalid, W. (2012). Questionnaire designing and validation. *Journal of*

the Pakistan Medical Association, *62*(5), 514–16.

<https://jpma.org.pk/article-details/3414>

Krupchanka, D., & Thornicroft, G. (2017). Discrimination and stigma. In W. Gaebel, W. Rössler, & N. Sartorius (Eds.), *The Stigma of mental illness – End of the story?* (pp. 123–39). Springer.

Laenen, T., Rossetti, F., & van Oorschot, W. (2019). Why deservingness theory needs qualitative research: Comparing focus group discussions on social welfare in three welfare regimes. *International Journal of Comparative Sociology*, *60*(3), 190–216. <https://doi.org/10.1177/0020715219837745>

Likert, R. (1932). A technique for the measurement of attitudes. In R. S. Woodworth (Ed.), *Archives of Psychology*, *22*(140). (pp. 5–55). The Science Press.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–85. <https://doi.org/10.1146/annurev.soc.27.1.363>

Lipson, S., & Sonnevile, K. (2017). Eating disorder symptoms among undergraduate and graduate students at 12 U.S. colleges and universities. *Eating Behaviors*, *24*, 81–8. <https://doi.org/10.1016/j.eatbeh.2016.12.003>

LoBiondo-Wood, G. (2018). Understanding research findings. In G. LoBiondo-Wood, & J.

Haber (Eds.), *Nursing research: Methods and critical appraisal for evidence-based practice* (pp. 305–16). Elsevier.

MacLean, A., Sweeting, H., Walker, L., Patterson, C., Räisänen, U., & Hunt, K. (2015). “It’s not healthy and it’s decidedly not masculine”: A media analysis of UK newspaper representations of eating disorders in males. *BMJ Open*, *5*(5), e007468, 1–8. <https://doi.org/10.1136/bmjopen-2014-007468>

Martínez-Mesa, J., González-Chica, D. A., Bastos, J. L., Bonamigo, R. R., & Duquia, R. P. (2014). Sample size: How many participants do I need in my research? *Anais Brasileiros De Dermatología*, *89*(4), 609–15. <https://doi.org/10.1590/abd1806-4841.20143705>

McAllister, A. (2020). Mental illnesses are not an ‘ideal type’ of disability for disability income support: Perceptions of policymakers in Australia and Canada. *Scandinavian Journal of Public Health*, *48*(4), 452–9. <https://doi.org/10.1177/1403494818816903>

Mehler, D. M. A., Edelsbrunner, P. A., & Matić, K. (2019). Appreciating the significance of non-significant findings in psychology. *Journal of European Psychology Students*, *10*(4), 1–7. <https://doi.org/10.5334/e2019a>

Meuleman, B., Roosma, F., & Abts, K. (2020). Welfare deservingness opinions from heuristic to measurable concept: The CARIN deservingness principles scale. *Social Science Research*, *85*(102352) 1–15.

<https://doi.org/10.1016/j.ssresearch.2019.102352>

Mond, J., Rodgers, B., Hay, P., Korten, A., Owen, C., & Beumont, P. (2004). Disability associated with community cases of commonly occurring eating disorders. *Australian and New Zealand Journal of Public Health*, *28*(3), 246–51. <https://doi.org/10.1111/j.1467-842X.2004.tb00703.x>

Mond, J. M., Robertson-Smith, G., & Vetere, A. (2006). Stigma and eating disorders: Is there evidence of negative attitudes towards anorexia nervosa among women in the community? *Journal of Mental Health*, *15*(5), 519–32. <https://doi.org/10.1080/09638230600902559>

Morgan, D. L. (2014). *Integrating qualitative & quantitative methods: A pragmatic approach*. SAGE Publications.

National Health Service. (2021). *Overview – Anorexia*. <https://www.nhs.uk/mental-health/conditions/anorexia/overview/>

Ong, W. J., Shahwan, S., Goh, C. M. J., Tan, G. T., H., Chong, S. A., & Subramaniam, M. (2020).

Daily encounters of mental illness stigma and individual strategies to reduce stigma – Perspectives of people with mental illness. *Frontiers in Psychology*, 11(590844), 1–9
<https://doi.org/10.3389/fpsyg.2020.590844>

Patrick, R. (2016). Living with and responding to the ‘scrounger’ narrative in the UK: Exploring everyday strategies of acceptance, resistance and deflection. *Journal of Poverty and Social Justice*, 24(3), 245–59.
<https://doi.org/10.1332/175982716X14721954314887>

Patrick, R., Kaufman, J., & Power, M. (2021). *Post-pandemic futures: Social security reimaged* (A Covid Realities briefing note).
<https://cdn.sanity.io/files/brhp578m/production/d8c86eb682c12dd57c7cdebf1a2c20c6416cc1e3.pdf?dl=>

Price, E., Walker, L., & Booth, S. (2020). Feeling the benefit? Fluctuating illness and the world of welfare. *Disability & Society*, 35(8), 1315–36.
<https://doi.org/10.1080/09687599.2019.1680346>

Ruane, J. M. (2016). *Introducing social research methods: Essentials for getting the edge*. John Wiley & Sons.

Saffer, J., Nolte, L., & Duffy, S. (2018). Living

on a knife edge: The responses of people with physical health conditions to changes in disability benefits. *Disability & Society*, 33(10), 1555–78.
<https://doi.org/10.1080/09687599.2018.1514292>

Saleh, A., & Bista, K. (2017). Examining factors impacting online survey response rates in educational research: Perceptions of graduate students. *Journal of MultiDisciplinary Evaluation*, 13(29), 63–74.
<https://files.eric.ed.gov/fulltext/ED596616.pdf>

Schone, H. Q. (2019). *Contested illness in context: An interdisciplinary study in disease definition*. Routledge.

Sheehan, L., Nieweglowski, K., & Corrigan, P. W. (2017). Structures and types of stigma. In W. Gaebel, W. Rössler, & N. Sartorius (Eds.), *The stigma of mental illness – End of the story?* (pp. 43–66). Springer.

Shefer, G., Henderson, C., Frost-Gaskin, M., & Pacitti, R. (2016). Only making things worse: A qualitative study of the impact of wrongly removing disability benefits from people with mental illness. *Community Mental Health Journal*, 52(7), 834–41.
<https://doi.org/10.1007/s10597-016-0012-8>

Siegel, J. A., & Sawyer, K. B. (2019). Eating disorders in the workplace: A qualitative investigation of women’s experiences. *Psychology of*

Women Quarterly, 43(1), 37–58.
<https://doi.org/10.1177/0361684318812475>

Smith, A. J., Farstad, S. M., & von Ranson, K. M. (2021). Self-reported eating disorder psychopathology prevalence in community-based female and male Albertans: Gender and age group comparisons. *The International Journal of Eating Disorders*, 54(3), 438–44.
<https://doi.org/10.1002/eat.23434>

Södersten, P., Brodin, U., Zandian, M., & Bergh, C. E. K. (2019). Verifying Feighner's hypothesis; anorexia nervosa is not a psychiatric disorder. *Frontiers in Psychology*, 10(2110), 1–15
<https://doi.org/10.3389/fpsyg.2019.02110>

Swoboda, D. A. (2006). The social construction of contested illness legitimacy: A grounded theory analysis. *Qualitative Research in Psychology*, 3(3), 233–51.
<https://doi.org/10.1191/1478088706qrp061oa>

Tan, E. J., Cistullo, L., Castle, D. J., Rossel, S. L., Jenkins, Z. M., & Phillipou, A. (2020). Depression, perceived disability and unemployment are associated with reduced life satisfaction in anorexia nervosa. *Eating Disorders*, 1–8. Advance online publication.
<https://doi.org/10.1080/10640266.2020.1836890>

Time to Change. (2021a). *About our closure.*

<https://www.time-to-change.org.uk/about-us/about-our-closure>

Time to Change. (2021b). *Why attitudes to mental health matter.* <https://www.time-to-change.org.uk/why-attitudes-mental-health-matter>

Turn2us. (2020). *Poverty charity calls for changes to reduce benefit stigma.* <https://www.turn2us.org.uk/About-Us/Media-Centre/Press-releases-and-comments/Poverty-charity-calls-for-changes-to-reduce-benefi>

Tyler, I., & Slater, T. (2018). Rethinking the sociology of stigma. *The Sociological Review*, 66(4), 721–43.
<https://doi.org/10.1177/0038026118777425>

University of Huddersfield. (2019). *Code of practice for research.* <https://www.hud.ac.uk/media/policydocuments/Code-of-Practice-for-Research.pdf>

van den Berg, E., Houtzager, L., de Vos, J., Daemen, I., Katsaragaki, G., Karyotaki, E., Cuijpers, P., & Dekker, J. (2019). Meta-analysis on the efficacy of psychological treatments for anorexia nervosa. *European Eating Disorders Review*, 27(4), 331–51. <https://doi.org/10.1002/erv.2683>

Van Mol, C. (2017). Improving web survey efficiency: The impact of an extra reminder and

- reminder content on web survey response. *International Journal of Social Research Methodology*, 20(4), 317–27. <https://doi.org/10.1080/13645579.2016.1185255>
- van Oorschot, W. (2000). Who should get what, and why? On deservingness criteria and the conditionality of solidarity among the public. *Policy and Politics*, 28(1), 33–48. <https://doi.org/10.1332/0305573002500811>
- van Oorschot, W., & Roosma, F. (2017). The social legitimacy of targeted welfare and welfare deservingness. In W. van Oorschot, F. Roosma, B. Meuleman, & T. Reeskens (Eds.), *The social legitimacy of targeted welfare: Attitudes to welfare deservingness*. (pp. 3–33). Edward Elgar Publishing.
- Vass, V., Sitko, K., West, S., & Bentall, R. P. (2017). How stigma gets under the skin: The role of stigma, self-stigma and self-esteem in subjective recovery from psychosis. *Psychosis*, 9(3), 235–44. <https://doi.org/10.1080/17522439.2017.1300184>
- Vehovar, V., & Manfreda, K. L. (2017). Overview: Online surveys. In N. G. Fielding, R. M. Lee, & G. Blank (Eds.), *The SAGE handbook of online research methods* (2nd ed., pp. 143–61). SAGE Publications.
- Wagner, W. E. (2013). *Using IBM® SPSS® statistics for research methods and social science statistics* (4th ed.). SAGE Publications.
- Walliman, N. (2018). *Research methods: The basics* (2nd ed.). Routledge.
- Ward, Z. J., Rodriguez, P., Wright, D. R., Austin, S. B., & Long, M. W. (2019). Estimation of eating disorders prevalence by age and associations with mortality in a simulated nationally representative US cohort. *JAMA Network Open*, 2(10), e1912925. <https://doi.org/10.1001/jamanetworkopen.2019.12925>
- Wasserstein, R. L., & Lazar, N. A. (2016). The ASA statement on p-values: Context, process, and purpose. *The American Statistician*, 70(2), 129–33. <https://doi.org/10.1080/00031305.2016.1154108>
- Wiggan, J. (2012). Telling stories of 21st century welfare: The UK coalition government and the neo-liberal discourse of worklessness and dependency. *Critical Social Policy*, 32(3), 383–405. <https://doi.org/10.1177/0261018312444413>
- World Health Organization. (2020). *6B80 Anorexia Nervosa*. ICD-11 for Mortality and Morbidity Statistics. <https://icd.who.int/browse11/l1-m/en#/http%3a%2f%2fid.who.int%2fcd%2fentity%2f263852475>
- World Health Organization. (2021). *Stigma*

and discrimination. WHO Regional Office for Europe. <https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination>

Ziliak, S. T., & McCloskey, D. N. (2008). *The cult of statistical significance: How the standard error costs us jobs, justice, and lives.* The University of Michigan Press.