Impacts of weight stigma, bullying and trauma on the genesis and maintenance of eating disorders

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Prevention

Appearance Idealization & Weight stigma
Eating Disorders
High BMI Non-communicable disorders
Childhood Adversities

Mental Health Impacts of bullying and trauma are well known...

~30% of mental illness cases
“...No severe or prolonged bodily illness followed the incident in the red-room: it only gave my nerves a shock of which I feel the reverberation to this day....

...if she were a nice pretty child one might feel compassionate..”

(Excerpts from Jane Eyre – Charlotte Bronte)

...often the trigger for onset of eating disorders:

“I was always a bit overweight but when I went to secondary school ....they called me “Fatty, Fatso, Bill bunter etc etc . I decided to get rid of that fat as soon as possible.”

(Noordenbos Recovery from Eating Disorders 2013 p14)

Increased risk for an eating disorder with:
- All types of abuse, adult and child including neglect & bullying
- Strongest relationship of sexual abuse with bulimia nervosa
Considering people with high BMI and an eating disorder

- Eating disorders and disordered eating and weight control behaviours exist in people across the weight spectrum, and due to additional stigma may be more burdensome among larger bodied people

  ➢ Recent push to consider risk factors that might be shared across the full “spectrum of disordered eating and weight phenomena”, including high and lower weight, forms of disordered eating, and eating disorders (Sanchez-Carracedo, Neumark-Sztainer et al. 2012)

With an increasing recognition of relationships between

- high BMI,
- disordered eating, and
- mood/traumatic stress disorders

**Aims**

- Assess lifetime bullying and sexual abuse as risk factors for disordered eating/weight control behaviours, EDs, and higher (BMI > 30) and lower (BMI < 18.5) weight
- Assess the extent to which a history of bullying or sexual abuse results in additional impairment in people with EDs or a BMI ≥ 30 or < 18.5.
Materials and Methods

2015 Health Omnibus Survey
• Total N = 3,005 (participation rate 71%)
• Household interview-based survey
• Person with most recent birthday in randomly selected metropolitan and rural dwellings throughout South Australia
• “Adults” 15-100 years (M = 46.7 years; SD = 19.2), 50.8% female

• Eating Disorder Symptoms: Overvaluation weight/shape, objective binge eating, extreme dietary restriction, purging, ARFID-type dietary restriction
• Health-related quality of life: PCS (physical) and MCS (mental) scales of the SF-12
• Adversity: Lifetime bullying (school/work) and sexual abuse, age and duration of last episode.
• Demographics, self-reported height and weight (BMI)

Participants

• Representative general population sample SA 2015
• 1527 woman and 1478 men aged > 15 years
• 974 (32.7%) current eating disorder symptoms
• 633 (21.1%) weight/shape extreme overvaluation
• 390 (13%) weekly or more binge eating
• 694 (25.2%) had BMI>30

<table>
<thead>
<tr>
<th>Lifetime sexual abuse, n (%)</th>
<th>N (%)</th>
<th>37% of sexual abuse in adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED symptoms</td>
<td>No ED symptoms</td>
<td>$\chi^2$ (df), p</td>
</tr>
<tr>
<td>124 (43.2)</td>
<td>173 (9.0)</td>
<td>12.2 (1), &lt;0.001</td>
</tr>
<tr>
<td>Obese</td>
<td>Not obese</td>
<td></td>
</tr>
<tr>
<td>85 (12.5)</td>
<td>175 (8.0)</td>
<td>7.54 (1), 0.006</td>
</tr>
<tr>
<td>Underweight</td>
<td>Not underweight</td>
<td></td>
</tr>
<tr>
<td>3 (4.8)</td>
<td>256 (9.9)</td>
<td>--</td>
</tr>
</tbody>
</table>
16/03/2019

**Lifetime bullying, n (%)**

<table>
<thead>
<tr>
<th>ED symptoms</th>
<th>No ED symptoms</th>
<th>$\chi^2$ (df, p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>494 (50.7)</td>
<td>883 (44.1)</td>
<td>11.7 (1), 0.001</td>
</tr>
<tr>
<td>Obese</td>
<td>Not obese</td>
<td>3.84 (1), 0.050</td>
</tr>
<tr>
<td>342 (49.3)</td>
<td>925 (45.0)</td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>Not underweight</td>
<td>4.42 (1), 0.036</td>
</tr>
<tr>
<td>43 (58.1)</td>
<td>1224 (45.8)</td>
<td></td>
</tr>
</tbody>
</table>

**Differential symptom response**

<table>
<thead>
<tr>
<th>Bullying</th>
<th>Extreme Dieting</th>
<th>Purging</th>
<th>Overvaluation Weight/Shape</th>
<th>High Weight</th>
<th>Low Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying</td>
<td>1.22 (0.98, 1.51)</td>
<td>1.46 (1.06, 2.00)</td>
<td>2.83 (1.17–6.84)</td>
<td>1.31 (1.10, 1.56)</td>
<td>1.33 (1.11, 1.58)</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>1.69 (1.21, 2.36)</td>
<td>1.77 (1.14, 2.75)</td>
<td>2.57 (0.81, 8.52)</td>
<td>1.24 (0.94, 1.64)</td>
<td>1.34 (1.00, 1.79)</td>
</tr>
<tr>
<td>Both</td>
<td>1.89 (1.27, 2.79)</td>
<td>2.40 (1.45, 4.00)</td>
<td>5.13 (1.44, 18.27)</td>
<td>1.39 (0.99, 1.95)</td>
<td>1.34 (0.93, 1.93)</td>
</tr>
</tbody>
</table>

**Effects long standing...**

Median time since last bullied: 9 - 22 years
Median time since last sexual abuse experience: 28-36 years
Effects not found for under or high weight status and history bullying or sexual abuse.

Mental Health Related Quality of Life & Eating Disorder symptoms

Take Home Messages:

Bullying and sexual abuse are common risk factors for the spectrum of eating and weight phenomena
Risk is maintained over decades without intervention
The pattern of weight/eating phenomena differs according to the adversity experienced
These adversities add to impairment, particularly bullying in people with eating disorders

Do the different patterns of symptoms associated with bullying vs sexual abuse indicate different coping mechanisms for these adversities?

i.e. perusal of the thin ideal to better "fit in" after bullying; emotional avoidance through binge eating following sexual abuse.
Do words matter? Weight teasing

Associations between parental teasing in regards to their child’s weight, body and/or shape, and eating problems in adolescents: A systematic review. Dahill et al. in preparation

Synthesis of results

- Parents as socializers of adolescents appearance concerns.
  - Parents’ perpetration of weight-based teasing
  - Parents’ socializers of adolescents appearance concerns from their own relationship with body image concerns
  - Weight stigma and victimization are increased when both/ two parents were high BMI
  - Parents and Adolescents have differing perceptions of what is a problem weight – either both perceive overweight when the child is not, or parent’s perceive overweight is present if the child does not

- Emotional internalization
  - Parental teasing related to appearance rejection sensitivity, anxiety, body dysmorphic disorder, eating disorders, emotional eating and binge eating, and depression
  - “Where the person who loves me the most does not positively regard me, I think so how can I change myself” – leads to disorders through controlling behaviors around food and eating

- Family environment
  - Irregular and conflictual family meals, regular meals in contrast are protective
  - Mothers Thin idealisation - home milieu of weight concern
  - Fathers and sons – Drive for Masculinity – milieu – late puberty is a cause of concern for boys.
  - Parent teasing significantly increased sibling teasing – permissive effects of more extensive teasing and confirmation of peer teasing
Body of research - Weight based teasing in adolescence contributes to

- High levels of body dissatisfaction
- Low levels of physical activity efficacy/confidence
- Eating to reduce negative affect – emotional overconsumption,
- And a higher BMI in adults and the current epidemic of 'non-communicable disease'

Turning to prevention

A different approach to Prevention – Can it be integrated?

Interventions designed to prevent both excessive weight gain and eating disorders have had limited success at reducing onset of high weight (i.e. BMI ≥ 30) and eating disorders in young people.

The reasons for this are likely complex and multifaceted but conflicting messages don’t help and can harm:
- Diet/don’t diet
- Like your body/ hate fat
Prevention of eating disorders


Effective interventions reducing eating disorder risk:

• Media literacy - universal
• Cognitive dissonance – selective, & cost effective preventing AN/BN
  ➢ Both aim to reduce impact of internalisation of the thin ideal
• Cognitive behavioural therapy (CBT) interventions - selective
• Healthy weight intervention - selective
  ➢ Also reduced body mass index

Concluding thoughts:

Most eating disorder prevention interventions might be thought to also prevent high BMI via
  Reducing weight stigma &
  Increasing body appearance satisfaction

But may need to be combined with
  health promotion (nutrition and activity) &
  enhanced with programs to reduce child adversities especially weight related teasing
Thanks

• Deborah Mitchison
• Lucy Dahill
• Long Khanh-Dao Le