

Article 27

Eating Attitudes and Behaviors of a Sample of Sexual Minority Men

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Abstract

The goal of the present study was to learn more about eating disorder behaviors in a sample of sexual minority men across different stages of gay identity development in order to provide evidence-based recommendations for clinicians and researchers. Participants were recruited via a university GLBT/LGBT listserv, resulting in 142 eligible participants. Significant differences were found on the Mizes Anorexic Cognitions Questionnaire-Revised (Mizes et al., 2000) scale. The group representing Stages 3 (Identity Tolerance) and 4 (Identity Acceptance) of Cass's (1979) model had the highest eating disordered scores. Discussion of the findings is accompanied by recommendations for practice and research.

Keywords: sexual minority men, eating disorders, gay identity development

Eating disorders, such as bulimia nervosa and anorexia nervosa, affect millions of Americans. Estimates of incidence of these diseases range from 6% to 10% of the U.S. population (Hudson, Hiripi, Pope, & Kessler, 2007). Because individuals engaging in eating disorders are often unwilling to report doing so, the actual number is probably considerably higher (Hudson et al., 2007; National Eating Disorders Association [NEDA], 2009). Although eating disorders historically have been viewed as challenges for girls and women, men suffer as well. Recent data indicate an increasing level of eating disorders in the male population. Related research findings indicate that 10% to 15% of persons diagnosed with eating disorders are men (i.e., approximately 2.4 to 3.6

million men (Carlat, Camargo, & Herzog, 1997). According to NEDA (2009), ratios for women and men were estimated at 4 to 1 for anorexia and 8–11 to 1 for bulimia.

Sexual minority men with eating disorders often do not seek treatment due to fear of being judged and potentially being labeled as gay (Eliot & Baker, 2001). Clinicians attempting to serve men with eating disorders are limited by the preponderance of diagnostic and treatment methods based on research with female clients that do not necessarily apply to male clients. For example, while it is easier to notice the physical symptoms of anorexia in women, men who are engaging in disordered eating habits generally have more muscle tissue, and their dysfunctional behavior is less likely to be noticed or diagnosed accurately (O’dea & Anderson, 2002). The effect of anorexia on men is more likely to be decreased testosterone levels and a decreasing sexual libido, symptoms not easily shared because of potential embarrassment (Eliot & Baker, 2001). Due to the paucity of evidence-based information about male eating disorders, clinicians often attempt to apply treatment strategies for women to their male clients (Hudson et al., 2007).

There is some evidence that gay men are more likely than heterosexual men to suffer from eating disorders because of a higher likelihood for body dissatisfaction and a greater tendency to prefer a thinner body image (Borroughs & Thompson, 2001; Hudson et al., 2007). There is also evidence that gay men are judged on their physical attractiveness within their gay communities similar to the way women are judged in the heterosexual community (Hudson et al., 2007).

Because of the higher prevalence of eating disorders in gay versus heterosexual men, sexual orientation appeared to be an important factor to address in the quest to enhance knowledge about and treatment of eating disorders in men (Hudson et al., 2007). This population is often under a tremendous amount of societal stress and more likely to commit suicide than heterosexual males (Williamson & Hartley, 1998). In a pilot survey study, the first author of the present study found that 39% of the participants who identified themselves as gay males would be considered at risk for an eating disorder compared to 20% of the heterosexual males, based on a brief eating disorders survey. Other research findings indicating a possible relationship between male eating disorders and sexual orientation (Shivley, Jones, & De Cecco, 1984) influenced a decision to base the present study on gay identity development and eating disorder cognitions in a sample of sexual minority men. The term *sexual minority* was employed to depict the population in the present study because the sample that responded to the survey included self-identified gay and bisexual men and men who did not identify themselves as gay, bisexual, or heterosexual, yet had sexual feelings or thoughts toward or engaged in sexual behaviors with other males. The goal of the present investigation was to learn more about eating disorder behaviors of these specific sexual minority men across different stages of gay identity development in order to provide recommendations for clinicians and researchers. To our knowledge, there currently are no existing models of bisexual identity development.

Models of gay identity formation have progressed from the mid 1970s to the present. Troiden (1979) developed a model to help people understand how men engaging in same-sex sexual behaviors accepted being gay as their way of life. Troiden (1989) later presented a model using sociological theories to portray an ideal and typical model of homosexuality identity formation (HIF). In the meantime, Cass (1979) presented her

Homosexual Identity Formation Theory that focused on a process by which individuals acquire gay identity. A key tenant of her theory was the belief that gay men overcome internal conflicts about their sexual orientation (Cass, 1984). The theory consists of six stages of gay identity development that depict individuals moving from conflict to gradual acceptance of their same gender attractions. Cass (1979) developed the Homosexual Identity Questionnaire (HIQ) for individual classification purposes.

More recently, Marszalek and Cashwell (1999) presented the Gay and Lesbian Affirmative Development Model (GLAD) that was designed to help clinicians work with GLBT clients by providing specific therapeutic techniques and interventions based on clients' homosexual identity formation. They merged Cass's (1979) model with Ivey's (1990) developmental therapy approach to aid clinicians who were working with sexual minority clients.

Cass's (1979, 1984) model and definition of gay identity were employed in the present study. Cass placed an emphasis on the importance of individual self-image and understanding what characterizes one as gay as the foundations of gay identity development. The process includes integration of one's own interpretation of socially prescribed notions and self-developed formulation and requires self-disclosure to others to achieve the highest developmental stage. The specific stages are Identity Confusion, Identity Comparison, Identity Tolerance, Identity Acceptance, Identity Pride, and Identity Synthesis. Brady and Busse (1994) developed a Gay Identity Questionnaire (GIQ) that is based on Cass's HIF model, and it was used as a measure in the present study.

Because Cass (1979) posited that individuals in the later stages of identity development were mentally healthier, it was hypothesized that individuals in lower stages of gay identity development would report higher levels of eating disorder attitudes and behaviors. The research question tested was: Are there differences in eating disorder attitudes and behaviors of a sample of sexual minority men across different stages of gay identity formation?

Method

Research Design

The present investigation was a descriptive field study. Descriptive information about the participants was acquired via an online survey, and the data were analyzed via between group comparisons. According to Heppner, Wampold, and Kivlighan (2008), descriptive field studies tend to be high on external and low on internal validity. The independent variables in the present study could not be manipulated (i.e., Cass's gay identity development stages). Consequently, the design was ex post facto in nature (Heppner et al., 2008).

Participants

The targeted population was a set of sexual minority men. Men who were attracted to other men and/or engaged in same sex sexual behaviors were considered gay or bisexual. Those men who did not identify themselves as gay or bisexual yet had sexual feelings or thoughts toward or engaged in sexual behaviors with other men were classified as "other" in the present study. Two hundred and twenty-five participants completed at least one questionnaire, and 142 met the criteria for inclusion in the study.

Of the 142 participants in the study, 106 (74.7 %) identified themselves as gay, 27 (19%) as bisexual, 9 (6.3%) as “other,” and none of them classified themselves as heterosexual men. All participants were at least 18 years of age, had identified themselves as sexual minority men, and completed all the data collection instruments. Ninety-three participants indicated their ages were between 18 and 24 (65.5%), 35 between 25 and 34 (24.7%), 13 between 35 and 54, and one over 54. The mean age was 21.5 ($SD = 10.7$). The ethnicity distribution was 122 White, 6 Hispanic, 5 Black/African American, 3 Asian/Pacific Islander, and 6 Other/Multi-racial participants. Three statistical power sources were consulted in order to determine the appropriate sample size. According to Survey Systems (2010), 96 participants would have been needed to achieve a 95% confidence interval. Cohen (1988) recommended a minimum of 64 participants to report a medium effect size for an analysis of variance. Heppner et al. (2008) advocated at least 56 participants to account for 10% of the variance with three independent variables to have a medium level of power at the .05 alpha level.

Instrumentation

Demographic questionnaire. The purpose of this brief questionnaire was to determine the self-reported sexual orientation (i.e., gay, bisexual, other, or heterosexual) of the participants, their ages, and their ethnicity.

Assessment of the gay identity development construct. The Gay Identity Questionnaire (GIQ; Brady & Busse, 1994) was designed to identify different stages of gay male identity formation. It was derived from Cass’s (1979) Homosexual Identity Formation (HIF) model and her original Homosexual Identity Questionnaire. The GIQ consists of 44 true or false items, each of which is specifically related to one of Cass’s six HIF stages. For example, if a participant answered true for the question “I doubt that I am gay, but still am confused about who I am sexually,” the response would be indicative of a person in Stage 1 in the HIF schemata. Respondents’ answers are tallied for each stage. The stage category that has the highest number of questions answered as true is considered to be the level of the respondent’s HIF. If participants’ highest scores are equal in more than one stage, the classification is “dual stage.” Brady and Busse (1994) established inter-rater reliability between the HIQ and the GIQ via four raters who studied the HIF model independently and rated the validity of the proposed items as representative of respective assigned HIF stages. Sixty-three items received 75% agreement across the raters. The item pool was further reduced to 44 following pilot testing to provide reliability estimates. Stages 1 and 2 did not contain enough respondents to perform statistical analyses. The following reliabilities were reported for the remaining four stages: Stage 3, $r = .76$; Stage 4, $r = .71$; Stage 5, $r = .44$; and Stage 6, $r = .78$.

Assessment of the eating disorder construct. In order to enhance the construct validity for this variable, two instruments were employed in the present study.

Eating Attitudes Test-26 (EAT-26). The EAT-26 (Garner, Olmstead, Bohr, & Garfinkel, 1982) is the most widely used screening measure of symptoms and concerns characteristic of eating disorders (Yoon & Funk, 2008). The EAT-26 consists of 26 items that are assessed on a 6-point Likert scale ranging from Always to Never. Sample items are “I am terrified about being overweight” and “I enjoy trying new rich foods.” Total scores can range from 0 to 78 with higher scores indicating more disordered eating behaviors. Garner et al. (1982) suggested that scores above 20 indicate eating disorders.

A factor analysis indicated that dieting, bulimia, preoccupation with food, and oral control are indicative of eating disorder behaviors and attitudes (Garner et al., 1982). An alpha coefficient of .94 suggested high internal consistency reliability for both anorexic and normal participants (Garner et al., 1982). Williamson, Anderson, Jackman, and Jackson (1995) found that the EAT-26 correlated well with the Eating Disorders Inventory (EDI) and the Restrained Eating Inventory (EI).

Mizes Anorexic Cognitions Revised (MAC-R). The MAC-R (Mizes et al. 2000) was designed to assess the cognitions of all eating disorders, including anorexia, bulimia, and binge eating disorder. The MAC-R consists of 33 items that are assessed on a Likert scale ranging from Strongly Disagree to Strongly Agree. Scores range from 33 to 165 with higher scores indicating more disordered cognitions. The items were designed to represent three eating disorder cognitions that are based on Garner and Bemis's (1982) three areas of cognitive distortions: strict weight regulation and fear of weight gain, self-control as a basis of self-esteem, and weight and eating behavior as the basis of approval. Sample questions are "If others comment on my weight gain, I won't be able to stand it" and "Gaining 5 pounds would push me over the brink." Mizes et al. (2000) estimated a coefficient alpha of .90. Concurrent validity was assessed by significant correlations between the MAC-R and the Eating Disorder Inventory (EDI) and the Restraint Scale (RS). The correlation between the MAC-R and the original MAC was .95.

Procedure

Data collection. The study was approved by the institutional review board at a southeastern Research I land grant university. Invitations to participate were sent electronically via the Survey Gizmo link (hides all IP addresses of respondents) to the university's GLBT listserv and their Facebook group and Twitter accounts. Listserv membership included current and former students, faculty, staff, and community members of differing ages, races, genders and sexual orientations. The Facebook and Twitter accounts consisted of individuals from around the world who had added themselves to the university's groups. The first component of the online survey was an informed consent statement. Those who chose to participate clicked on the "agree" button and continued to take the survey. Participants then opened the demographic questionnaire, the GIQ, the EAT-26, and the MAC-R that were to be completed online. Since the pool of respondents consisted of a number of individuals who were not members of the targeted population sample of sexual minority men, and it was impossible to prevent them from receiving the invitation, it was also impossible to determine the response rate of the sample versus the total number of possible qualified respondents. In order to enhance the response rate, the survey was sent out three times over the duration of one month.

Data analysis. Demographic questionnaire data were used to determine which respondents qualified as representatives of the targeted population. Participants' GIQ scores were used to assign them to Cass's gay identity stages. Reflecting suggestions by Marszalek and Cashwell (1999) and Brady and Busse (1994), Cass's (1979) six-stage model was reduced to three stages for data analysis in the present study. Brady and Busse's reason for the recommendation to revise the stages was that too few participants were found in the first two stages during their studies, and this phenomenon also proved to be the case in the present study. A one-way analysis of variance was used to compare

the three CIQ identity stage groups on both the EAT-26 and MAC-R data. A secondary analysis involved a correlation of the EAT-26 and MAC-R scores.

Results

Gay Identity Development Findings

GIQ data for 14 participants classified them as in the Stage 1 and Stage 2 combined group. In Cass's (1979) Gay Identity Formation model, Stage 1 is labeled Identity Confusion and Stage 2 is labeled Identity Comparison. This group consisted of eight males who were in the bisexual category, one gay male, and five who had selected the other category.

Twenty-three participants were assigned to the combined Stage 3 and Stage 4 group. Stage 3 is entitled Identity Tolerance and Stage 4 Identity Acceptance in Cass's model. Fifteen of these participants identified themselves as gay males, seven were in the bisexual category, and one identified his orientation as other.

The Stage 5 and 6 grouping contained 105 participants, of which 90 identified themselves as gay males, 12 as bisexual, and 3 as other. Stages 5 and 6 are identified as Identity Pride and Identity Synthesis respectively in Cass's model. This kind of skewed distribution has been common in previous research based on the GIQ (Brady & Busse, 1994). A common explanation of this phenomenon is that, due to the nature of the coming out process, it is unlikely that participants will classify themselves as gay if they are indeed in the early stages of gay identity development. Therefore, they may not have been included in the sample for lack of selecting themselves as qualified participants.

Gay Identity Stage Versus Eating Attitudes and Behaviors Findings

EAT-26. There was no evidence of a significant effect of the participants' gay identity stage on their EAT-26 scores: $F(2, 139) = 1.99, p = 0.14$. The findings indicated that gay identity stage did not affect scores on the EAT-26 differentially within the sample for the present study.

MAC-R. There was a significant effect of the participants' gay identity stage on their MAC-R scores: $F(2, 139) = 3.86, p = 0.02$, estimated eta square = .05. A post hoc Tukey HSD comparisons test indicated that there were significant differences between group 1 (Stages 1 and 2) and group 2 (Stages 3 and 4) and between group 2 and group 3 (Stages 5 and 6), but not between groups 1 and 3. These findings indicated that one's gay identity stage had an effect on eating disorder attitudes and behaviors as estimated by MAC-R scores in the present sample. Interestingly, the group 2 participants (Identity Tolerance and Identity Acceptance) had the highest MAC-R mean versus those in the Identity Confusion, Identity Comparison, Identity Pride, and Identity Synthesis stages that were essentially at the same level of eating attitudes and behaviors on the MAC-R. Table 1 contains the descriptive data for the analyses.

Correlation Analysis

The correlation between the EAT-26 and the MAC-R for the present sample was $r = .58, p = .01, r^2 = 33\%$ of variance accounted for. This small to moderate correlation between the two instruments was similar to previous findings (Mizes, 1988).

Table 1

Descriptive Data for Gay Identity Stage Versus Eating Attitudes and Behaviors Comparisons

Group	EAT-26		MAC-R	
	Mean	Standard Deviation	Mean	Standard Deviation
1	8.29	4.03	78.64	15.05
2	11.96	10.34	90.74	12.12
3	8.14	8.29	83.01	14.43

Note. Group 1 = Cass's (1979) Identity Confusion and Identity Comparison stages; Group 2 = Identity Tolerance and Identity Acceptance stages; Group 3 = Identity Pride and Identity Synthesis stages.

Discussion

It was predicted that individuals at lower levels of identity development would exhibit more eating disordered behaviors than those at higher stages. Differences between stages of gay identity development were found on one of the two eating disorders measures. However, it was the middle stages rather than the lower stages where higher averages of dysfunctional attitudes and behaviors occurred. The two Cass (1979) stages represented in this grouping are Identity Tolerance (3) and Identity Acceptance (4).

According to Cass (1979), characteristics of these stages are: (a) tolerance rather than acceptance of being gay [stage 3] or beginning to form positive views about being gay [stage 4], (b) a strong need to meet others who have a similar identity in order to decrease feelings of isolation, (c) a desire to avoid others who are not gay, (d) a quest to learn and understand more about being gay, (e) extremely limited self-disclosure, (f) fearfulness about exposure at school and work leading to a variety of negative reactions, and (g) a tendency to try to pass for being heterosexual

The findings indicate that an appropriate way to view the relationship between gay identity development and potential for eating disorders for sexual minority men may be that the greatest risk is during the middle or transitional stages that appear to be more turbulent than other stages, rather than at the lowest stage. Therefore, sexual minority male clients who are in the middle gay identity development stages are more likely to be prone to engaging in eating disordered attitudes and behaviors. On the other hand, this finding does not preclude incidences of eating disordered attitudes and behaviors for individuals in the other stages as well. There is evidence of the potential for incidences across all of the stages.

Several limitations in the present study suggest caution for readers. The challenges associated with psychosocial development and being open about one's sexual identity that sexual minority men face in our current society made it difficult to find and attract a sample of the population of interest. It seems to be especially challenging to identify and survey sexual minority men who are in the earlier stages of sexual identity development. The sample also proved to be homogeneous, that is, primarily Caucasian men. The homogeneity of the sample may have been affected by the reluctance of

minority males to identify themselves as gay or bisexual (Grov, Bimbi, Nanin, & Parsons, 2006).

Mays and Cochran (2001) found discrimination occurs more often to gay and bisexual males who are also a racial/ethnic minority than to those who are not. In addition, Choi, Paul, Ayala, Boylan, and Gregorich (2013) noted a difference between rates of familial discrimination in African American, Asian, Latino, and Caucasian gay and bisexual men. They surmised the difference could be due to the abundance of minority male participants who ceased contact with their families prior to the study and therefore reported less familial discrimination during the study than Caucasian males. Living on the “down low,” a term given to African American males who have sex with men in secret, also highlights the differences between ethnicities and acceptance of sexual orientation (Lapinski, Braz, & Maloney, 2010).

Identity acceptance and clinical treatment modes for this population are challenged by factors that make these individuals difficult to identify and provide with helpful clinical treatments. The eating disorder instruments were normed on women, and the item content may not have been sensitive enough to acquire valid information from male respondents. Cass’s (1984) instrument was designed for gay men and the questions may have been challenging for respondents who were bisexual or undecided about their sexual identity. Unfortunately, the sexual identity development and eating disorder measures currently available were not designed for sexual minority men, yet, were the best instruments currently available.

Recommendations for clinical practice fall into two broad categories: prevention and treatment interventions. Because of the identity development and stigmatization challenges encountered by sexual minority men, psychoeducational prevention programming offered during the upper elementary, middle, secondary, and college attending years seems appropriate.

The primary clinical issue for our recommendations is disordered eating by sexual minority men, especially those who would be classified as fitting within the middle stages of Cass’s (1979) model. Although directed toward sexual minority clients herein, cognitive-behavioral therapy (Anderson & Jager, 2009; Garner & Bemis, 1982) and dialectical behavior therapy (Telch, Stewart, & Linehan, 2001) are also considered best evidence-based practices for all eating disordered clients. While the recommended treatment modalities are relatively common for eating disordered clients, the higher rates of eating disorder among sexual minority clients than among men generally, the stigma associated with being perceived as gay, and the different presenting symptoms for eating disordered men and women, indicate that treatment strategies and centers for men may be more effective than mixed-sex treatment strategies and centers. There seems to be sufficient evidence that men generally, and especially sexual minority men, who have eating disorders would best be served by clinicians who recognize the differences between eating disorder symptomatology for men and women and also understand the possible need for different treatment intervention approaches for men and women experiencing eating disorders.

School counselors have a unique opportunity to play a critical role in assisting male students who are either at risk or overcoming an eating disorder and should be aware of the “six red flags” of developing an eating disorder (Ray, 2004). The risk factors are; age, (14–18 years), participation in athletics, sexual orientation, occurrence of other

mental disorders which are often comorbid with eating disorders, recent turmoil at home, and the presence of family members with eating disorders. It is imperative for school counselors to be aware of community resources and have relationships with those agencies. Being able to refer a parent and student to a known agency will positively affect the treatment process (Ray, 2004).

It is important for school counselors to be vigilant in educating parents, teachers, coaches, and community members about the signs and symptoms of eating disorders in males that can be incorporated into parent education programs or parent teacher association presentations. Recommended goals for prevention education include increased awareness, reduced stigma, and provision of better ways to understand signals presented by individuals who are struggling with sexual orientation issues (Ray, 2004).

The paucity of information about men in general, and sexual minority men specifically, indicates a need for more research that uncovers useful information about eating disorder symptoms, treatment modalities, and prevention programming. Regarding sexual identity development theories and related measures for sexual minority men, the focus needs to be broadened beyond men who identify themselves as gay. Scholars and clinicians are challenged to develop and evaluate a more inclusive eating disorder treatment model for sexual minority men that will enhance navigation of stigma and resistance as well as an understanding of the issues of the larger GLBT/LGBT community.

The coming out process and the increased likelihood of developing an eating disorder creates a perfect storm analogy for sexual minority men. They face increasing sources of psychological stress and are challenged not to develop dysfunctional coping mechanisms. Individuals within the GLBT/LGBT community struggle in ways that others do not experience. The coming out process can be tumultuous and result in enormous losses, including friends, family, and one's home. Ever-increasing efforts to understand the challenges that sexual minority men face in order to discover useful therapeutic interventions are needed in order to better serve this high-risk population.

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