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ScienceDirect
Comprehensive Psychiatry 68 (2016) 134 – 139
COMPREHENSIVE PSYCHIATRY
www.elsevier.com/locate/comppsych

Examining weight and eating behavior by sexual orientation in a sample of male veterans

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Abstract

Objective: Eating disorders are understudied in men and in sexual minority populations; however, extant evidence suggests that gay men have higher rates of disordered eating than heterosexual men. The present study examined the associations between sexual orientation, body mass index (BMI), disordered eating behaviors, and food addiction in a sample of male veterans.
Method: Participants included 642 male veterans from the Knowledge Networks-GfK Research Panel. They were randomly selected from a larger study based on previously reported trauma exposure; 96% identified as heterosexual. Measures included the Eating Disorder Diagnostic Scale, the Yale Food Addiction Scale, and self-reported height and weight.
Results: Heterosexual and sexual minority men did not differ significantly in terms of BMI. However, gay and bisexual men (n = 24) endorsed significantly greater eating disorder symptoms and food addiction compared to heterosexual men.
Conclusions: Our findings that sexual minority male veterans may be more likely to experience eating disorder and food addiction symptoms compared to heterosexual male veterans highlight the importance of prevention, assessment, and treatment efforts targeted to this population.
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1. Introduction

Although disordered eating has traditionally been thought to primarily affect heterosexual Caucasian adolescent girls and young adult women [1,2], recent research demonstrates a higher prevalence of eating disorders among men [3] and other groups traditionally considered at low risk, including ethnic/racial minorities [1], older adults [4], veterans [5], and sexual minority individuals [6], than previously recognized. Despite epidemiological evidence that these groups are affected by eating disorders, clinician bias and under-representation in the research literature contribute to under-detection of disordered eating behaviors and diagnoses among demographically diverse individuals [7]. Underserved groups are less likely to access care for eating disorders [8], and therefore data regarding the efficacy of treatment for these populations are lacking.

The present study focused on associations between sexual orientation and eating disorder symptoms and food addiction in a sample of male veterans. Extant evidence suggests that both veterans and sexual minority individuals are at increased risk for a variety of mental health conditions, including depression, posttraumatic stress disorder (PTSD), substance use disorders (SUDs), and eating disorders [9–13]. However, compared to other mental health conditions, eating disorders have been relatively understudied in these populations. The literature suggests that veterans may be at increased risk for disordered eating for several reasons. Previous studies have suggested that military veteran exposure to high levels of trauma, including military sexual trauma [14] and combat exposure [15], may

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http://dx.doi.org/10.1016/j.comppsych.2016.03.007
0010-440X/Published by Elsevier Inc.

increase their risk of disordered eating. Elevated rates of overweight and obesity among veterans also may increase their risk, as a higher body mass index (BMI) is a primary predictor of eating disorder symptoms, specifically in men [16]. Food addiction, or compulsive overeating of certain foods (i.e., high fat, high sugar), has received increasing attention in the eating disorder literature, though it is not yet a formal diagnosis. The high rates of SUDs in veteran populations, and the possibility that food addiction and SUDs may co-occur, given their shared biological mechanisms, indicate that this construct may be relevant to veterans [17,18]. Further, recent studies have also found high rates of food addiction among individuals with obesity and binge eating disorder (BED) [18].

Taken together, research suggests that veterans and sexual minority individuals may be at greater risk for disordered eating than previously assumed, but there is a general paucity of research examining disordered eating among both veterans and sexual minority individuals. Some early findings in civilian populations suggest that gay men and heterosexual women have greater body dissatisfaction and therefore increased risk of eating disorder symptomatology compared to heterosexual men and lesbian women [13]. More recent research comparing disordered eating behaviors of sexual minority men to heterosexual men suggests that sexual minority men are at increased risk of disordered eating [6]. Moreover, relative to heterosexual men, gay men have demonstrated increased vulnerability to body dissatisfaction, greater drive for thinness, dieting frequency, and bulimic behaviors [20]. Research has also suggested that differences in body mass index (BMI) may exist between heterosexual and sexual minority men. Evidence suggests that sexual minority men have lower BMIs relative to heterosexual men and also are less likely to be overweight or obese, although the potential factors accounting for these observations are not well understood [21]. These findings highlight the importance of studying disordered eating among sexual minority men.

In particular, to our knowledge, no study has examined disordered eating among sexual minority veterans. Moreover, there are no published investigations of sexual orientation and food addiction. The current study aimed to compare (1) BMI; (2) eating disorder symptoms, including anorexia, bulimia, and BED symptomatology; and (3) food addiction, between heterosexual and sexual minority male veterans. Although sexual minority veterans comprise a relatively small segment of the veteran population, data describing the phenomenology of disordered eating in underrepresented populations may enrich models of risk, enhance prevention and screening efforts, and inform strategies for the development of eating disorder interventions.

2. Method

2.1. Participants

Participants in the current study were from a larger study of veterans (N = 3156) from the population-based Knowledge Networks-GfK Research Panel [22]. Of the cohort of 2175 veterans who reported trauma exposure in the original study, 1126 were randomly selected and invited to participate in a survey of PTSD, dissociation, and disordered eating. Of these individuals, a total of 787 male veterans and 73 female veterans responded (N = 860).

Participants were excluded from the current analyses if their responses to questions were deemed invalid. Specifically, 142 were omitted because they completed the survey either so quickly (< 15 min; n = 6) or so slowly (>2 h, n = 136) compared to the average participant, that it raised doubt about the validity of the assessments, and 23 were eliminated because they achieved a T-score of 90 or greater on an index of symptom over-reporting (the revised Infrequency Psychopathology [Fp-r] validity scale on the Minnesota Multiphasic Personality Inventory-2 Restructured Form) [23]. Two participants were omitted from analyses because they achieved an Fp-r T-score of 90 or greater and took over two hours to complete the survey. We excluded women (n = 55) from these analyses, given that the subsample was too small to make comparisons by sex, resulting in a final analysis sample of 642 men.

2.2. Procedure

The Knowledge Networks-GfK Research Panel, which includes over 80,000 households, is recruited through probability-based sampling methods that cover approximately 98% of the population. Households without internet access are provided with internet access and hardware if needed. Participants in the panel are recruited to individual web-based studies via email and provided with incentives for study completion, including points that can be redeemed for prizes, cash rewards, and raffles. Post-stratification weights were computed based on demographic characteristics (age, gender, race/ethnicity, education, census region, and metropolitan area) of US veterans in the GfK Knowledge Networks survey panel, which is based on the 2013 US Census data. A previous study found that the demographic characteristics, including sex, age, race/ethnicity, and education level, of this cohort are highly similar to those of veterans in the 2013 US census [24]. The sample weights for the current study also accounted for selection based on trauma exposure.

The survey took an average of 36.5 min (SD = 17.7) to complete, and participants were awarded 50,000 points (approximately $50) for completion. The survey was available for approximately two weeks. The act of completing the survey implied consent; the local human subjects review board approved all study procedures.

2.3. Measures

2.3.1. Eating Disorder Diagnostic Scale (EDDS)

The EDDS is a 22-item self-report survey of anorexia, bulimia, and binge eating symptomatology experienced in the past three to six months [25]. This measure is based on the *Diagnostic and Statistical Manual of Mental Disorders-IV*

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