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The relationship between disordered eating and sexuality amongst adolescents and young adults

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ABSTRACT

Research shows that gay and bisexual males are at increased risk for disordered eating symptoms (DES); however, studies examining DES amongst lesbians and bisexual women have produced mixed findings. Furthermore, few studies have included questioning or "unsure" individuals. This study examined DES symptoms in adolescents and young adults across self-reported sexual attraction and behavior. Participants were recruited from ten primary care sites in Pennsylvania and administered the Behavioral Health Screen (BHS) – a web-based screening tool that assesses psychiatric symptoms and risk behaviors – during a routine visit. As expected, males who were attracted to other males exhibited significantly higher disordered eating scores than those only attracted to members of the opposite sex. Males who engaged in sexual activities with other males also exhibited significantly higher scores than those who only engaged in sexual activities with females. Amongst females, there were no significant differences in DES scores between females who were only attracted to females and those only attracted to males. Those who reported being attracted to both sexes, however, had significantly higher scores, on average, than those only attracted to one sex. More surprisingly, females who were unsure of who they were attracted to reported the highest DES scores of all. These findings are contrary to previous assumptions that same-sex attraction plays a protective role against eating pathology in females. Females who are unsure or attracted to both sexes may actually be at increased risk for developing DES.

1. Introduction

Anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) typically emerge during adolescence, affecting roughly 0.3%, 0.9%, and 1.6% of youth living in the United States, respectively (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). The early ages of onset for these disorders are particularly troubling given the numerous deleterious effects of eating disorders (EDs) and disordered eating symptoms (DES). AN has one of the highest mortality rates of any psychiatric disorder, taking the lives of 5.6% of sufferers each decade (Sullivan, 1995). This heightened mortality is attributed not only to starvation but also to an increased risk of suicide (Bulik et al., 2008). ED sufferers also exhibit elevated rates of psychiatric co-morbidity compared with the general population (O'Brien & Vincent, 2003).

Lesbian, gay, bisexual, and questioning (LGBQ) adolescents also experience increased risk of psychiatric problems, including anxiety, depression, and suicidal ideation (D'augelli, 2002). Amongst men, being gay or bisexual has consistently been shown to increase one's susceptibility to EDs (e.g., Feldman & Meyer, 2007; Russell & Keel, 2002). Two theories in particular have been used to explain this phenomenon. The first, Objectification Theory, which was originally developed to explain the female gender bias in EDs and body shame, emphasizes the sociocultural factors that contribute to ED symptomatology. Specifically, Objectification Theory argues that women experience greater societal pressure to appear thin and attractive, resulting in a female gender bias for EDs (Fredrickson & Roberts, 1997). Further, the theory states that internalization of these unrealistic standards can result in body shame and consequently, disordered eating. Because men value physical attractiveness more than women, GB men may face similar sociocultural pressures to heterosexual women (Beren, Hayden, Wilfley, & Grilo, 1996). Indeed, peer pressure related to physical appearance and body dissatisfaction is stronger for gay men than heterosexual men (Hospers and Jansen, 2005).

Another theory that may explain the association between sexual identity and DES is the minority stress hypothesis, which states that minority groups such as LGBQ individuals are at increased risk for mental health problems as a result of stress caused by societal stigmatization (Meyer, 2003). For LGBQ individuals, this stress manifest as: 1) external, objective stressors, such as antigay discrimination; b) the expectation of prejudice, resulting in vigilant monitoring; and c) internalization of

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stigma and prejudice (e.g., internalized homophobia). These factors (not identity itself) account for higher rates of mental health problems in LGBQ populations.

The increased risk of EDs amongst GB men has led some to hypothesize that lesbians should be protected from these issues (Guille & Chrisler, 1999; Siever, 1994). This assumes that lesbians are more immune from sociocultural norms related to attractiveness than heterosexual women. However, all women, regardless of identity, are exposed to societal messages that promote the association between one's appearance and one's self-worth (Bartky, 1990). Indeed, researchers have found no significant differences between lesbians and heterosexual women on endorsement of sociocultural norms regarding thinness and attractiveness or on perceived sociocultural pressure for thinness (Heffernan, 1996; Strong, Williamson, Netemeyer, & Geer, 2000). Moreover, the media frequently exploits female same-sex sexuality as a way of enticing male viewers (Brewster & Moradi, 2010). This type of objectification is unique to LGBQ women. In addition, LGBQ adolescent females report more sexual harassment than their heterosexual peers, which may further contribute to body shame and disordered eating (Mitchell, Ybarra, & Korchmaros, 2014; Williams, Connolly, Pepler, & Craig, 2005). Although gender is a primary factor in exposure to objectification experiences, LGBQ men and women may experience these sociocultural pressures in a distinctive way.

Overall, research on LGBQ women and DES has demonstrated mixed findings. For example, a few early studies found that lesbians experience lower rates of body dissatisfaction and DES than heterosexual women (Guille & Chrisler, 1999; Siever, 1994), while others found no differences between the two groups (e.g., Beren et al., 1996; Feldman & Meyer, 2007; Heffernan, 1996; Moore & Keel, 2003; Share & Mintz, 2002). More recently, a number of studies suggest that LGBQ females, like LGBQ males, may be at increased risk for ED behaviors and/or unhealthy weight control practices during adolescence and young adulthood (e.g., Austin et al., 2009; Hadland, Austin, Goodenow, & Calzo, 2014; Robin et al., 2002; Wichstrøm, 2006). For instance, in one sample, adolescents who identified as gay/lesbian, bisexual, and "mostly heterosexual," reported higher past-year rates of binge eating compared to their heterosexual peers. In addition, gay, bisexual, and "mostly heterosexual" males as well as "mostly heterosexual" and bisexual females were more likely to report purging than their heterosexual peers (Austin et al., 2009). In another sample of Massachusetts high school students, LGB students were also more likely to engage in unhealthy weight control behaviors than their heterosexual peers (Hadland et al., 2014). Same-sex sexual experiences have also been shown to predict bulimic symptoms five years later for both genders (Wichstrøm, 2006).

Although researchers are increasingly recognizing bisexual persons as a distinct subgroup, questioning or "unsure" individuals continue to be overlooked. Even when data are collected on these groups, researchers have often chosen to exclude them from analyses (e.g., Austin et al., 2004, 2009; Boehmer, Bowen, & Bauer, 2007; Hadland et al., 2014), despite evidence that, like their LGB peers, these adolescents are at increased risk of suicidality and other psychosocial problems (Williams, Connolly, Pepler, & Craig, 2005; Zhao, Montoro, Igartua, & Thombs, 2010). Given that sexual identity development is critical in adolescence and young adulthood, questioning samples may be especially important for studying disorders that emerge during this time. One exception is a study that examined ED behaviors amongst U.S. college students (Matthews-Ewald, Zullig, & Ward, 2014). They found that unsure, gay, and bisexual males were more likely to report ED behaviors and unsure, gay, and bisexual females were more likely to report dieting than their heterosexual peers. Another study conducted with college students found that gay and unsure males were more likely to engage in unhealthy weight control behaviors than heterosexual males (Laska et al., 2015).

The purpose of the present study is to examine DES across sexual minority adolescents and young adults. We have also included an unsure group (Laska et al., 2015; Matthews-Ewald et al., 2014) in light of the pressures of sexual identity formation faced by these age groups (Rosario, Schrimshaw, Hunter, & Braun, 2006). Based on past findings, we hypothesized that 1) males reporting same-sex attraction would exhibit higher rates of DES than opposite-sex attracted males, and 2) there would be no differences amongst females, regardless of attraction. We did not have a hypothesis regarding the unsure group given the paucity of literature for this population. Since sexuality is a complex (Diamond, 2000), we also examined DES and sexual behavior. We hypothesized that 1) males who engage in sexual behavior with other males or with both sexes would exhibit more DES than males who only engage in sexual behavior with females, and 2) there would be no differences between females, regardless of behavior.

2. Materials and methods

2.1. Participants

Participants in the present study were 2513 youth (61.2% female), ages 14 to 24 ($M = 17.24$, $SD = 2.86$). The majority of the sample racially identified as White; however, some identified as Biracial (8.1%), Black/African American (4.7%), Asian (1.8%), "Other" (1.5%), "Not Sure" (7.6%) or chose not to disclose their race (1.5%), and 16.6% also identified as Hispanic. Finally, 91.7% of the sample was attracted to the opposite sex, 3.9% was attracted both sexes, 1.6% was unsure of who they were attracted to, and 2.0% was attracted to the same sex (1.2% were females attracted to females and 0.8% were males attracted to males specifically). Seventeen participants' (0.7%) self-reported attraction could not be determined due to missing data.

2.2. Procedure

The data were collected as part of a behavioral health-screening program in primary care. Ten primary care sites, spanning rural to semi-urban areas in the northeastern part of Pennsylvania, participated. At participating sites, the screening tool – the Behavioral Health Screen (BHS) – was administered prior to their exam. Although we encouraged clinicians to screen universally, administration was ultimately left to their discretion.

2.3. Measure

The BHS was designed to screen for behavioral health problems using questions derived from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) criteria. It is comprised of a total of 13 modules, which assess the following areas: demographics, medical, school, family, safety, substance use, sexuality, nutrition and eating, anxiety, depression, suicide, psychosis, and trauma and abuse (Jenkins, Singer, Conner, Calhoun, & Diamond, 2014). There are 55 core questions across these domains, and responses are coded on a three-point scale (0–2), with a score of 0, 1, or 2 (no symptoms, moderate symptoms, and severe symptoms, respectively). A twenty-member group of national experts and local focus groups consisting of medical practitioners helped select the items.

Extensive psychometric validation has confirmed the validity and reliability of the scales. For instance, in a sample of 415 adolescents recruited from primary care, the scale exhibited both good discriminant validity and good internal consistency (Diamond et al., 2010). In addition, the subscales showed good sensitivity and specificity, with overall accuracy ranging from 78 to 85%. Moreover, implementation in an emergency department significantly increased the percentage of mental illness or behavioral problems identified, from 2.5% to 10.5% (OR = 4.58, 95% CI = 3.53, 5.94; Fein et al., 2010).

2.3.1. Eating behavior

A DES score was calculated for each of the participants based on the responses to the following four questions: 1) How often do you think