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Eating Freely: Examining Eating Disorders in the LGBT Community

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I. Introduction

Eating disorders, particularly anorexia nervosa and bulimia, are a relatively new phenomenon endemic of modern medicine. Anorexia Nervosa was coined by William Gull, one of Queen Victoria's personal physicians, in his work Anorexia Hysterica 1873, and was included in the original DSM, DSM-I, in 1952. Bulimia, on the other hand, only entered the DSM in 1980, as part of DSM-III, and was revised to bulimia nervosa in 1987 as part of the revised DSM-III. Anorexia is estimated to affect 2 million people across the globe[1]. It affects up to 4.3% of women and .03% of men in their lifetime. Bulimia is estimated to affect 1% of women at any given time and up to 3% of women over the course of their life. Anorexia and bulimia are believed to affect women ten and nine times more often than men respectively[2]. Furthermore, these disorders are far more prevalent in developed nations. People diagnosed with eating disorders have a higher mortality rate, and those with anorexia are fifty-six times more likely to commit suicide than other members of the population[3]. It is no coincidence that most people diagnosed with an eating disorder have also been diagnosed with depression at some point in their life. Given that anorexia and bulimia combined could possibly affect one in fourteen women, and that they disproportionately affect women as opposed to men, the discourse that surrounds them, and our interpretation of it, has serious implications for our society as a fair and just one.

There are different explanations for the discrepancy between the rates of eating disorders among men and women. Two large currents of thought can be identified. One view is that the difference can be attributed to a contingent fact of biology and genetics. In other words, the differing

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[1] "Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013". *Lancet (London, England)*. 386 (9995): 743–800.
[2] Smink, FR; van Hoeken, D; Hoek, HW (August 2012). "Epidemiology of eating disorders: incidence, prevalence and mortality rates.". *Current psychiatry reports*. 14 (4): 406–14.
[3] Espie J, Eisler I (2015). "Focus on anorexia nervosa: modern psychological treatment and guidelines for the adolescent patient". *Adolesc Health Med Ther*. 6: 9–16.

chromosomes and, thereby, hormonal balance, of the average male and female can be used to explain this phenomenon. For example, in the *Journal of Child Psychology and Psychiatry* a research review of eating disorders noted the following,

> "Interestingly, ovarian hormones have been proposed as a possible mechanism underlying developmental changes in genetic risk in girls, given that these hormones rise during puberty and regulate gene transcription in key neurobiological systems (e.g., serotonin, dopamine) (Ostlund, Keller, & Hurd, 2003). One prior study has investigated this possibility and found that genetic effects on overall disordered eating symptoms were negligible in girls with low levels of estradiol, whereas at high levels of estradiol, substantial genetic influences on disordered eating were found (Klump, Keel, Sisk, & Burt, 2010). Additional replications are certainly needed, but such findings fit with phenotypic data implicating ovarian hormones in the expression of disordered eating symptoms."[4]

The review acknowledges that much more work needs to be done, as well as replicated, before any causality in relation to genes can be firmly established. As the authors note, "It is too early to label most G x E and epigenetic effects as correlates of or risk factors for eating disorders or disordered eating symptoms; significant findings await independent replications, as sample sizes have been small and most studies have explored a different combination of variables"[4] What this does highlight is that genetic accounts remain a key and popular area of investigation of eating disorders.

The second view is that eating disorders represent a medicalization of what is primarily a social phenomenon. One notable thinker, although by no means the only one, Susan Bordo attributed the

[4] Culbert, Kristen M., Sarah E. Racine, and Kelly L. Klump. "Research Review: What We Have Learned about the Causes of Eating Disorders - a Synthesis of Sociocultural, Psychological, and Biological Research." *Journal of Child Psychology and Psychiatry* 56.11 (2015): 1141-164

difference to what she described as a multiple axis of continuity. This is the view that various norms and beliefs within our society lead to this phenomenon. In this way, she tries to separate herself from those who focus on the reinterpretation, and the reappropriation, of works when she says, "But to focus only on multiple interpretations is to miss the important effects of the everyday deployment of mass cultural representations of masculinity, femininity, beauty and success"[5]. For Bordo, one of the chief culprits is the portrayal of the female body in advertising and media. Here she stresses the undue weight we put on female thinness and the overt sexualization of the female form. This, however, serves as the beginning of her investigation rather than its conclusion. She claims that women who pursue this feminine ideal of thinness to the point of being diagnosed with an eating disorder may not be doing anything wrong. In fact, she points out that these women have precisely grasped what it is our society values:

> "when a patient complains her breasts are too large and insists that the only way to succeed in our culture is to be thin because, as one woman described it, "People… think that someone thin is automatically smarter and better," it is described as flawed reasoning, a misrepresentation of reality that the therapist must work to correct. From a feminist cultural perspective, this approach ignores the fact that for most people in our culture, slenderness is indeed equated with competence, self-control, and intelligence, and feminine curvasciousness (in particular large breasts) with wide-eyed, giggly vapidity."[6]

Rather than having a poor, or deficient, understanding of their body these women represent the nadir of our feminine body norms, as portrayed in advertising and media. Bordo's account, however, restricts

[5] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 24
[6] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 55

itself to the group which is most affected, women, and does not examine, or attempt to explain, similar phenomenon among other groups. The first account relies on gender assigned at birth, or sex, and the second relies on the gender one functions as, or gender as a social position and identity. By examining people whose gender assigned at birth differs from the gender they function as, one can begin to parse what, if any, role sex and gender play in the prevalence of eating disorders.

Women are not the only group who disproportionately have eating disorders. Of importance gay men are 4x more likely to experience a sub-clinical eating disorder compared to straight men. Of particular note, however, is, unlike their male counterparts, heterosexual, lesbian and bisexual women did not have significantly different rates of eating disorders as a whole[7]. I posit that we may better understand eating disorders as a social phenomenon and better understand the social condition of LGBT persons as an oppressed group if we consider eating disorders in the LGBT community.

In this paper, I trace our modern conceptions of anorexia and sexuality to the Victorian Era, and then I discuss how they have grown into the modern phenomenon we know today. Next I provide a conceptual background for the medicalization of mental disorders and locate the origin of our modern conception of health. This allows for a discussion of what separates anorexia as a phenomenon from other mental health issues and what can be done to move discussions of anorexia forward. I then consider data concerning eating disorders primarily among gay and bisexual men as they compare with each other and their female counterparts. With this data in mind, I am able to rule out many competing claims as to the cause of anorexia by looking at the different outcomes between men and women as well as between gay, bisexual and heterosexual men. I then use this data to posit a commonality between the groups that I suggest may be the underlying cause of anorexia as a social phenomenon.

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[7] Feldman, Matthew B., and Ilan H. Meyer. "Eating Disorders in Diverse Lesbian, Gay, and Bisexual Populations." *International Journal of Eating Disorders* 40.3 (2007): 218-26.

II. Victorian Hysteria and Sexuality

I endorse Bordo's view that eating disorders ought to be understood as a social phenomenon. Appreciating this requires that we see the way in which bodies are socially constructed; Foucault's work is instructive here. Foucault thinks that bodies are constructed in the sense that they become inscribed with, and internalize, beliefs, and he claims that socially constructed bodies maintain and perpetuate social norms. Consider Foucault's description of the panopticon. It is a prison with every jail cell door facing a single tower from which a guard could see the entirety of each cell, but the prisoners cannot see if there is someone in the tower. Constantly unsure whether they are being watched by a guard in the tower, the prisoners begin to behave at all times as if someone in the tower were looking at them. In this way the prisoners begin to self-regulate such that no person in the tower becomes necessary. As Clare Chambers explains: "Crucially, obedience becomes habitual at the level of the body: Foucault wants to the escape the Enlightenment distinction between the mind and the body and demonstrate that the body plays a role in ensuring our compliance to social norms." And, she emphasizes that on his view, "(p)ower is embodied when certain forms of behavior feel right to us, when our bodies "naturally" take on the correct position for a certain situation."[8] This is significant for two reasons. First, as will be discussed later, individuals ascribed with eating disorders often see their behaviors as natural expressions of themselves or an attempt to approach their 'true' selves. Second, and perhaps more interestingly, is Chamber's indication that such a 'natural' position is correct for a given situation. This then suggests that far from being a mental disorder anorexia and bulimia are proper responses to the environment in which they emerge. The indelible impact that eating disorders have on the body can be understood as the direct result of social behaviors, as opposed to a common medical appeal to genetic predisposition. In examining the prevalence of eating disorders amongst the LGBTQ community, with a

[8] Chambers, Clare. *Sex, Culture, and Justice the Limits of Choice*. University Park (Pa.): Pennsylvania State UP, 2008. Print. Pg. 23

wide variety of genetic diversity, one will see that this assertion is borne out. This means that the existence of anorexia and bulimia, despite the overwhelming medicalization of these disorders, is desirable in and of itself. What this suggests is that eating disorders, and the way they are addressed, are a positive, creative, expression of current power relations intractably linked, and thereby indicative of, our societal norms and beliefs.

To understand eating disorders, then, it is important to examine the social context in which they emerge and continue to exist. Bordo does this by drawing a clear connection between eating disorders and Victorian era hysteria when she says,

> "First, like hysteria in the nineteenth century, the incidence of eating disorders has always been disproportionately high among females: approximately 90 percent of sufferers are girls or women. Second, and again like hysteria, eating disorders are culturally and historically situated, in advanced industrial societies within roughly the past 100 years."[9]

Given such commonality, it is possible to see a continuity between the discourse on Victorian era hysteria and eating disorders today. What is most interesting, however, is that the medical community has managed to persist in a dialogue on eating disorders while simultaneously acknowledging the social construction of hysteria. In this way, though, the social construction of hysteria can begin to point us towards what we should be looking for when providing a social constructivist account of eating disorders among the LGBT community. Bordo describes the cultural root of hysteria in the following manner:

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[9] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 49-50

> "Among the important elements now revealed is the clear continuum on which the normative and the disordered were located for Victorian women; it becomes possible to see the degree to which femininity itself required the holding of breath, the loss of air, the choking down of anger and desire, the relinquishing of voice, the denial of appetite, the constriction of body."[9]

Hysteria can be understood as not the great plague of Victorian culture and women but, rather, its great project. It finds itself bound to the material bodies of these women through its focus on the immaterial through discipline. Eating disorders can be understood in a similar way. The double binds that women experienced continue to persist to this day, and changing social conditions (e.g., mass media) have allowed for the transition from hysteria to eating disorders as their part of their expression. Eating disorders are not simply the reflection of repression but represent a positive instantiation of our cultural values, or demands, embodied through this experience. The varying prevalence of eating disorders in the LGBT community constitute a similar, although by no means exactly the same, embodiment of cultural contradictions within our normative discourse. I say this not to deny people autonomy, and autonomous action, but rather to highlight it as a crucial constitutive element of eating disorders. This is what Bordo herself has to say in relation to medical discourse, "In the context of such requirements, hysteria and anorexia, have challenged modern science, not only with their seeming insistence on the power of the body to behave irrationally and inexplicably (Weir Mitchell once called hysteria "Mysteria"; anorexia was an "enigma" to Hilde Bruch), but also because of the spectacle each presets of the patient (however unconsciously or self-destructively) creating and bestowing meaning on her own body, in a form that is opaque and baffling to the mind of the Cartesian scientist/analyst."[10] The mystification of eating disorders denudes us from the fact that they are rational and explicable.

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[10] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 67

Furthermore, it highlights that, although the interpretation of the body may have been surrendered to the physician, embodiment remains the fundamental characteristic of the patient. In this way, eating disorders are a particularly vivid expression of the doctor patient dialectic that exposes the profound impact of the medical world on the LGBT community.

With Foucault we can see the impact of the medical community on sexuality and gender from the outset of the disciplinary epoch, or the birth of capitalism. In the *History of Sexuality* Foucault challenges, and explicates, our mythos, or discourse, of sexual liberation. This mythos like hysteria finds its genesis within the Victorian age characterized by the repression of sexuality. The particular placement of sexual repression within our history is critical to its instantiation. This is what Foucault is driving at when he states, "By placing the advent of the age of repression in the seventeenth century, after hundreds of years of open spaces and free expression, one adjusts it to coincide with the development of capitalism: it becomes integral part of the bourgeois order. The minor chronicle of sex and its trials is transposed into the ceremonious history of the mode of production; its trials and aspects fades from view."[11] By fixing the time of sexual repression with that of the advent of capitalism, he claims that modern sexuality can be understood in productionist terms. Sexuality is turned into an object of the modern state and now in the domain of the public. Foucault goes on to highlight how this mythos of sexual repression is further supported by our discourse on sexual liberation:

> "The affirmation of a sexuality that has never been more rigorously subjugated than during the age of the hypocritical, bustling, and responsible bourgeoisie is coupled with the grandiloquence of a discourse purporting to reveal the truth about sex, modify its economy within reality, subvert law that governs it, and change its future. The

[11] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 294

> statement of oppression and the form of the sermon refer back to one another; they are mutually reinforcing."[12]

Thus in the great dialogue of sexual liberation what is upheld and maintained is the belief that sexuality is a subject of public discourse and public interest. Therefore, in order to maintain sexuality as an object of the state what is necessary is perennial sexual liberation. In this way, the legitimization of LGBT rights by the state does not represent significant progress because it reinforces the belief, or assertion, that the state, and public institutions, have a rightful claim to the domain of sexuality. He highlights what is one of the key outcomes of this dialectic of sexual repression/liberation:

> If it was truly necessary to make room for illegitimate sexualities, it was reasoned, let them take their infernal mischief elsewhere: to a place where they could be reintegrated, if not in the circuits of production, at least in those of profit. The brothel and the mental hospital would be those places of tolerance: the prostitute, the client, and the pimp, together with the psychiatrist and his hysteric—those 'other Victorians' as Steven Marcus would say—seem to have surreptitiously transferred the pleasures that are unspoken into the order of things that are counted"[13]

As we have seen with the emergence of support and recognition for LGBT rights, what constitutes legitimate and illegitimate sexuality is fluid. Furthermore, Foucault makes the claim that by moving certain sexualities to the realm of the illegitimate, they are finally rendered into something that can be an object for regulation. This leads Foucault to conclude:

> "A first survey made from this viewpoint seems to indicate that since the end of the sixteenth century, the "Putting into discourse of sex," far from undergoing a process of

[12] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 296
[13] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 293

> restriction, on the contrary has been subjected to a mechanism of increasing incitement; that the techniques of power exercised over sex have not obeyed a principle of rigorous selection, but rather one of dissemination and implantation of polymorphous sexualities; and that the will to knowledge has not come to a halt in the face of a taboo that must not be lifted, but has persisted in constituting—despite many mistakes, of course—a science of sexuality"[14].

Perhaps another way to put this is that only through strict mores can individuation and a multiplicity of beings emerge. By rigidly defining what is normal sexuality, space is created and opened up for a plethora of kinks, fetishes and identities. It is only because they are illicit that illicit sexualities are able to exist. In this way, we begin to define and codify human sexuality for scientific discourse. Through the treatment of various afflictions and disorders, the doctor and the researcher insert themselves into the bedroom.

Hence, eating disorders can be understood as the direct result of discipline and as a creative element of repression which causes the formation of bodies that are then defined as other or disordered. The strict normalizing that allows this first finds its feet in the Victorian Era where both women's health, or women's bodies, and sexuality, for men and women, become a key element of public discourse. As strict norms allow for a great deal of individualization, people can locate their identities with respect to how they differ from the norm.

III. The Medicalization of Eating Disorders

[14] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 300

The interest of the doctor and the researcher with sexuality should not, however, come as a surprise because sex, the act, serves as one of their fundamental interests. They are the moral guardians and wardens of our population. The term "health" which is so natural today emerged in the Victorian era. It is through the population the study of humanity became dehumanized[15]. Doctors, politicians and the public began a discourse centered around numbers and trends with clear and obvious goals: the improvement of our health. This notion of health as a primary concern for society is defined by Foucault as bio-power which he outlines:

> "in short, the progressive emplacement of what was to become the great medical edifice of the nineteenth century cannot be divorced from the concurrent organization of a politics of health, the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy."[16]

On this view, a healthy population is one that consists of docile and productive bodies, and health as such can be understood as that which makes a body docile and productive[17]. Particularly, our current instantiation of health is one in which health is understood in wholly productionist terms. For example, the controversy surrounding the affordable care act, as a government policy, is often debated using economic language, and arguments. It follows that doctors, psychiatrists and other medical professionals should not be looked upon as impartial arbitrators of health acting in the common interest but as agents of a very specific practice of power whose purpose is the production of docile and productive bodies.

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[15] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 308 "One of the great innovations in the techniques of power…"

[16] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 273-274

[17] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 263 "This bio-power was…"

In understanding health not as an indisputable good but a contingently defined goal, one begins to see its normative commitments and normalizing nature. That is because the object of health, particularly public health, is the body politic understood as a population. In this way health is first rendered a societal issue and only then a personal problem[18]. The healthcare system far from being concerned with solely the ill, whether physically or mentally, finds itself primarily situated towards the healthy. So, too, when the citizen becomes a patient, health does not suddenly become a concern because it was always already their primary concern. Thus, living a healthy life is no longer a question of the good life but what is required, and expected, from each citizen. Through our medical institutions, then, the question of health becomes silenced and replaced with the answer of docile and productive bodies[19]. What has changed is the practice of health, concerned with life, has usurped the medieval exercise of sovereign power, concerned with death. Because society shifts its focus from maintaining the life of the sovereign to maintaining the life of a population its methods and practices change as well. Thus, through its concern with a multitude of people a discourse of multiplicity through normativity emerges. That is what Foucault means when he states, "I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory. A normalizing society is the historical outcome of a technology of power centered on life."[20] Capitalism through discipline as a technology of power that finds its object as docile and productive bodies then is inherently centered on life. Thus, the chief purpose and outcome of our medical institutions is their

[18] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 277 "This is the emergence of health and physical well-being of the population in general…"
[19] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 266 "But a power whose task is to take charge of life needs continuous regulatory and corrective mechanisms…"
[20] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 266

normalizing nature. The true purpose of these organizations is not to keep us healthy but to dictate what health is.

Within the discipline of psychiatry, one finds the doctor as a moralizing agent. It is through doctors that madness becomes fixed not only within the asylum but within our culture as well. In turn, what is made clear is that what constitutes both madness and criminality is the inability to be a productive member of society. It is no coincidence that both criminals and those with mental illness find themselves confined and labeled for their transgressions. It is psychiatry, however, that tells us of the substantial difference between these two groups, and it is psychiatrists that our legal community continues to look to in this regard. What becomes immediately clear is the intractable relationship between the methods of the cure and the concrete experience of madness[21]. That is to say that within the asylum, or anywhere that finds psychiatry in practice like the therapist's couch, madness is always forced in relationship to the cure. In turn the cure always finds itself to be discipline. Thus, the substantial difference between the madman and the criminal is not in the lack of docility/productivity that they share but, rather, their abilities to recognize their transgression as such, which is their particular capacity for self-discipline. The madman does not understand the reason, he is being punished and thus he is found to be unreasonable[22].

The asylum, however, is ostensibly not a part of the justice system but is a function of our public health enterprises[23]. And, the purpose of the asylum is inherently a moralizing one. It is one in which first and foremost the gospel of productivity embodied in discipline is preached. Eating disorders as they find themselves located in the domain of the asylum and the object of the psychiatrist must be

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[21] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 142 "The legends of Pinel and Tuke transmit mythical values…"

[22] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 145 "The obscure guilt that once linked transgression and unreason is thus shifted…"

[23] Foucault, Michel, and Paul Rabinow. *The Foucault Reader*. New York: Pantheon, 2010. Print. Pg. 159 "But within the asylum itself, the doctor takes a preponderant place, as he converts it into a medical space…"

understood as in some way inimical to the aim of a docile and productive body. Furthermore, they must be understood in the context of contemporary morality which Saukko neatly outlines:

> "Anorexics are commonly perceived to be young girls, who try too hard to be pretty and successful, having fallen victim to parental and peer pressures and ubiquitous images of thin models in the media (e.g. Wykes and Gunther, 2005). The notion of the perfectionist 'goody' girl, rendered neurotically compliant by the overly demanding middle-class family was popularized in the media coverage of Karen Carpenter, whose death from complications arising from anorexia in 1983 made the condition widely known."[24]

What makes anorexia of particular interest, however, is its association with self-discipline. This has important implications for not only how it is understood by the medical community but the patient as well. In most cases the purpose of the asylum is to assert self-discipline in opposition to madness. It is different with anorexia. Saukko says: "Psychiatric treatment for eating disorders defines mental health in terms of strength and fitness, which are the same goals the anorexic sets out to achieve (Gremillion, 2003)"[25] Anorexia as an eating disorder presents a unique challenge because its cause can be loosely understood to be the same as the objective of the cure. Thus, a practice of health that only understands itself in the context of the cure with the object of docile and productive bodies will find itself inherently unable to address such a phenomenon.

Furthermore, it seems that, if the cure of proscribing and prescribing more self-discipline is applied, the problem is only exacerbated. Saukko stresses: "The experience of anorexia is frequently

[24] Saukko, Paula (2009) A critical discussion of normativity in discourses on eating disorders. In: Malson, H. and Burns, M., eds. (2009) *Critical Feminist Approaches to Eating Dis/Orders.* London: Routledge, pp. 66

[25] Saukko, Paula (2009) A critical discussion of normativity in discourses on eating disorders. In: Malson, H. and Burns, M., eds. (2009) *Critical Feminist Approaches to Eating Dis/Orders.* London: Routledge, pp. 67

characterized by a fixated pursuit of normative absolutes, such as strength and self-determination. Therapeutic approaches often end up complicit with this pursuit, prescribing more of the same norms, such as strength and self-determination which may account for the poor recovery rates. "[26] If anything this supports the position that anorexia does not represent a misunderstanding of our societal norms or values but their very nadir. So, Saukko's work suggests that the anorexic is rendered the subject of medical practice and the victim of the disease which in many ways ignores the creative elements that led to its emergence as a mode of behavior. The creative element of anorexia can be found in the substantial link between perfectionism as embodied in anorexia as a concomitant factor for individual success. The fault with anorexia, then, is not with an overzealousness in self-discipline but the inability to act as a docile and productive body. Nutritional issues will reduce a person's ability to act, and a preoccupation with diet will distract their thoughts from more productive goals. The anorexic finds herself/himself unhealthy not because the act of committing extreme violence against oneself, through discipline, is wrong but because it is inhibiting an individual's ability to produce. In this way, the anorexic finds herself/himself in a double bind.

Only within a medical discourse that concerns itself with the health of populations as docile and productive bodies is anorexia, or eating disorders at large, an endemic and ephemerous problem. Hopefully, what this also shows is that through a change in our medical discourse, particularly the definition of health, new avenues to engage with anorexia can be explored.

[26] Saukko, Paula (2009) A critical discussion of normativity in discourses on eating disorders. In: Malson, H. and Burns, M., eds. (2009) *Critical Feminist Approaches to Eating Dis/Orders.* London: Routledge, pp. 71

IV. Data Summary

It is, however, our modern medical edifice and the practice of population statistics that we must draw recourse to alongside post-modern theories of social construction in order to make informed conclusions about the nature of eating disorders. Foucault's critique is not an admonition of statistics rather his careful genealogies, and defense of genealogy as a practice as opposed to History, demonstrate the validity, and rhetorical strength, of looking at source data. His purpose in pointing out the emergence of the modern medical edifice is not to tear it down but rather to reign in its excesses. Thus, when responsibly used population statistics can be a valuable resource as long as we acknowledge their limitations and avoid making normalizing claims from them. In avoiding normalizing claims we make a significant shift in the medical discourse by avoiding a Manichean system of the cure and talking about the complexities truly encountered in peoples lived experiences.

There are some general things to note about studies conducted on LGBT individuals and eating disorders, particularly the ones included here. In the first place, they are predominantly conducted in the United States or in the "West". Although there are some attempts at cross-cultural examination in studies, homosexuality is stigmatized in some parts of the world (including the west) and/or illegal, data is limited and an increase in cross-cultural studies is unlikely to happen anytime soon. Furthermore, a relatively small population of individuals identify as LGBT, and those with eating disorders are a subset the number of participants in these studies. Some of the elements of these studies rely on self-reporting which can also skew results both in responses and who chooses to respond. Furthermore, clinical diagnosis of an individual with eating disorders is by no means an exact science.

Those responsible for conducting these studies, however, are aware of some of these limitations and have done their best to accommodate them. For evaluating the validity of the appended tables, it is perhaps best to look at each individual study's methodology. I have tried to select those which I found

to be most compelling and informative. Although these numbers should be taken with a grain of salt, the trends they outline are consistent with the trends found in most other studies[27].

A number of key relationships emerge from these studies. Gay and bi-sexual men are much more likely to display disordered eating than heterosexual men. Gay and bi-sexual men are more likely to have experienced childhood sexual abuse, CSA, than the general male population, and individuals who have experienced CSA are more likely to develop psychiatric disorders[28]. There is a high comorbidity between metal health disorders at large and eating disorders with diagnosis, or onset, of other mental health disorders almost always proceeding eating disorders[29]. Gay and bi-sexual men who did experience CSA are more likely to develop eating disorders. Black and Latino men were more likely than white men to experience both CSA and disordered eating with Latinos being the most affected in each case. Bi-sexual men are more likely to have experienced CSA and are more likely to develop eating disorders than gay men. Gay men had a lower mean weight than heterosexual men, but both groups had very little variance between mean weight and their ideal weight. Given that both groups had similar mean heights, this mean that Gay men had a lower mean body-mass-index; BMI. When accounting for the discrepancy in the BMI, the impact of sexual identification on rates of eating disorders was severely diminished but still significant[30]. Gay men showed a higher level of body dissatisfaction, drive for muscularity, fear of fatness and drive for thinness than heterosexual men but did not significantly differ

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[27] Castellini, Giovanni, Lorenzo Lelli, Valdo Ricca, and Mario Maggi. "Sexuality in Eating Disorders Patients: Etiological Factors, Sexual Dysfunction and Identity Issues. A Systematic Review." *Hormone Molecular Biology and Clinical Investigation* 25.2 (2016)

[28] Lalor, Kevin, and Rosaleen Mcelvaney. "Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs." *Trauma, Violence, & Abuse* 11.4 (2010): 159-77.

[29] Feldman, Matthew B., and Ilan H. Meyer. "Comorbidity and Age of Onset of Eating Disorders in Gay Men, Lesbians, and Bisexuals." *Psychiatry Research* 180.2-3 (2010): 126-31.

[30] Kaminski, Patricia L., Benjamin P. Chapman, Sandra D. Haynes, and Lawrence Own. "Body Image, Eating Behaviors, and Attitudes toward Exercise among Gay and Straight Men." *Eating Behaviors* 6.3 (2005): 179-87.

in relation to over exercise. Finally, greater participation within the gay community did not result in higher rates of disordered eating.

What the complete data shows is, neither birth sex, gender identity, sexual identity, CSA, or strict cultural norms of thinness alone can explain the rates of disordered eating, particularly anorexia, that we observe in these populations. Furthermore, even adjusting for all these factors together we remain unable to fully account for the rate of disordered eating observed. This indicates that there must be some other underlying cause that ties these diverse groups together.

V. Critical Analysis

When we consider these findings in relation to each other, a clearer picture of eating disorders begins to emerge. What is clear is that neither sexual orientation nor gender identification alone can be used to explain discrepancy in eating disorders. Although lesbians and heterosexual women show the same rates of disordered eating overall, gay men and heterosexual men do not. Furthermore, lesbians are more likely to be obese but less likely to be anorexic when we consider particular eating disorders. Thus, gender identification, as well as birth sex, alone is insufficient. Gay men and heterosexual women are both attracted to men but experience different rates of eating disorders just as lesbians and heterosexual men do. Thus, sexual orientation towards a specific gender alone is insufficient. Therefore, only by looking at the intersection of gender identification and sexual orientation can we begin to explain the full phenomenon of eating disorders.

By examining why gay, and bi-sexual, men have higher rates of disordered eating we can shed light on how these eating disorders come about. In particular, by ruling out some commonly suggested causes for disordered eating, I suggest another hypothesis. Given that 14.2% of males experienced

childhood sexual abuse[31] and that 1.8% of men identify as gay and .4% as bisexual[32] the majority of male survivors of CSA are gender performative heterosexual. This means we should expect a higher rate of eating disorders among heterosexual men if CSA was the driving factor. Thus, CSA is a significant contributory cause but not the primary cause of disordered eating. Furthermore, it cannot be the case that stricter body norms in the gay community are the cause of disordered eating for two reasons. First although participation in the gay community was significantly correlated with sub-clinical eating disorders it did not impact clinical eating disorders. This can go a ways to explaining gay men's lower BMI but not disordered eating as a whole. Consider a 2013 Pew Research survey: "When it comes to community engagement, gay men and lesbians are more involved than bisexuals in a variety of LGBT-specific activities, such as attending a gay pride event or being a member of an LGBT organization."[33] Community participation does not explain the high rate of eating disorders amongst bi-sexual men. Thus, community participation, as the main vehicle for promoting and embodying norms and thereby the existence of stricter body norms does not explain disordered eating itself. In a similar way, occupational norms and gay/lesbian individuals preference for certain occupations does not explain eating disorders in gay men. Bordo's claim that, "Men *do* develop eating disorders, by the way, and, strikingly, those who do so are almost always models, wrestlers, dancers, and others whose profession demands a rigid regime of weight control"[34] has been born out[35]. It is, however, the case that gay men remain a minority in these male dominated professions in which body image control is crucial. If

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[31] Lalor, Kevin, and Rosaleen Mcelvaney. "Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs." *Trauma, Violence, & Abuse* 11.4 (2010): 159-77.

[32] Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013. 18 pp. (PHS) 2014-1250. July 15, 2014. Center for Disease Control and Prevention

[33] "A Survey of LGBT Americans." *Pew Research Center's Social & Demographic Trends Project*. N.p., 13 June 2013. Web. 28 Mar. 2017. (Appendix D)

[34] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 53

[35] Tilcsik, Andrrs, Michel Anteby, and Carly Knight. "Concealable Stigma and Occupational Segregation: Toward a Theory of Gay and Lesbian Occupations." *Administrative Science Quarterly* 60 (2015): 446-81.

occupational norms was the driving factor we would higher rates of disordered eating in their heterosexual counterparts and a greater rate of disordered eating among heterosexual men than currently observed. Strict body norms then do not explain the discrepancy of eating disorder rates between gay and heterosexual men.

This rules out many common explanations offered as the cause of higher rates of eating disorders among gay and bisexual men and further draws into question similar theories for women. What this indicates to us, however, is that there is most likely another cause for this phenomenon. In fact by looking at the relationship between eating disorders and CSA in women we can get a glimpse of the primary cause of extreme disordered eating. That is because in many interviews women describe their attempts to lose weight as a way to desexualize their bodies[36]. This happens in quite a literal sense as severe weight loss can lead to cessation in menstrual periods. Furthermore, many women who experience CSA, or assault later in life, are constructed by their male attackers as having invited this upon themselves through the speech of their body. This is clearly evidenced by our victim blaming culture. It is part of a greater cultural milieu, stemming from the Victorian era at the very least, where female sexuality is viewed as out of control or in need of control implying a default state of out of control[37]. This in fact is precisely what women and LGBT individuals have in common. The belief that their sexuality is out of control by traditional members of our society. Two recent examples of this would be the current controversy over bathrooms and the debate surrounding the don't ask don't tell policy. In the first case, there is an overwhelming fear that transgendered peoples will assault people in bathrooms if allowed into the bathroom of their choice even though they are far more likely to be victims of assault than perpetrators. The 2015 US Transgender survey, .6% of respondents said they

[36] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 6-8,147-148, 155-156

[37] Bordo, Susan. *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, Calif.: U of California, 2013. Print. Pg. 161-164

were victims of sexual assault in a bathroom in the past year[38]. The National Crime Victimization Survey for the same year found 1.6 in 1000 American's were sexually assaulted or .16% anywhere[39]. This persistent belief despite demonstrable data to the contrary demonstrates an assumption that transgendered people cannot control their sexuality and therefore will assault people in bathrooms. In the latter case, the concern was that allowing gay people to serve openly would reduce unit cohesion. A common belief is that LGBT troopers would be unable to put their feelings aside and more importantly unable to refrain from developing romantic feelings for people in their unit. It is, however, the case that many workplaces have no-dating policies which plenty of people manage to honor. The belief that gay service members could not manage to do similarly shows a clear belief for some that gay people are unable to control their sexuality. Thus, I argue what is operative in eating disorders, both for women and LGBT people, is not merely the existence of strict body norms and oppressive media landscape but the perception that their sexuality is out of control.

In fact, the behaviors of disordered eating seem to correspond with this very idea. As already mentioned the malnourished body stops displaying sexual characteristics which can be seen as tempting for potential predators. It is also the case, however, that a malnourished body is also less threating. Thus, in the case of LGBT individuals their sexuality would also be perceived as less threatening. Furthermore, in so far as a body is tempting or threating it portrays an image of bodily space that is intruding on others. By literally shrinking the body the individual confines their bodily space. Insofar such confinement requires extreme discipline so as not to make others uncomfortable it is no surprise that diseases like anorexia, for which extreme discipline is a precondition, emerge in these populations. Anorexia in particular demonstrates extreme control that can be seen as a response to the assumption

[38] James, Sandy E. et al. The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. December, 2016

[39] Truman, Jennifer L. and Rachel E. Morgan. Criminal Victimization 2015. U.S. Department of Justice, Bureau of Justice Statistics. October 2016

that such a body is inherently out of control. The impact of mass media then is not only in so far that it promotes extreme ideals of thinness but that it reinforces the idea that the sexuality of these bodies is out of control. The former explains the high prevalence of sub clinical eating disorders but it is the latter that defines extreme pathologies.

VI. Conclusion

Our conceptions of anorexia and sexuality stem from a cultural tradition dating back to the Victorian era. For a long time, and in some places to this day, non-heterosexuality has been seen as a mental disorder alongside eating disorders. Both, however, are only disorders in so far that they differ from our strict bodily norms. It is clear that eating disorders have been exacerbated by the emergence of mass media as it helps reinforce our strict cultural norms, especially concerning thinness and sexuality. Furthermore, eating disorders and various 'alternate' sexualities have emerged through strict norm definition and been made visible through our modern medical apparatus and the asylum. The phenomenon of eating disorders is clearly cultural located and socially driven. Although there may be some amount of genetic influence it is negligible compared to the overwhelming evidence of the impact of cultural factors. By expanding the investigation of anorexia from the most impacted, women, to LGBT individuals new aspects of the phenomenon emerge. Through examining the difference that gender and sexuality creates in rates of eating disorders what is shown is that mass media and the cult of thinness is not enough to explain eating disorders. Rather what is highlighted by the increased rates of eating disorders in gay and bi-sexual men is that what is also operative in the phenomenon of eating disorders is the fear of these bodies, sexuality, or more particularly the belief that their sexuality, and thereby them as well, are out of control. Eating disorders as an attempt to control and diminish the body, and one's sexuality, then serve to create docile and productive bodies through assuaging the unfounded fears of others.

What is also shown is that eating disorders as a mental health phenomenon are unique because they demonstrate an adroit understanding of our cultural values. Both thinness and self-discipline are desired things in our society. Furthermore, many people with eating disorders feel like it is one of the few things in their life they can control. Insofar as this is true, eating disorders can serve as a possible site of resistance. In fact, many people who demonstrate sub-clinical eating disorders most likely receive positive benefits from their behavior. That is because thin people are considered smarter and more in control than others. Disordered eating then is only a problem when it begins to present significant negative health outcomes. If our goal is to promote individual second order autonomy, where that is understood as a person's ability to question any given norm, then severe eating disorders remain an immediate concern. Someone who is too weak to get out of bed or engage in a variety of activities due to malnourishment cannot assert their autonomy. Forward thinking treatments, that acknowledge the strong social construction of eating disorders, certainly are a step in the right direction in increasing individual autonomy rather than traditional psychoanalysis which reinforces norms that result unsurprisingly in high relapse rates. New methods of psychoanalytic treatment, however, are not enough as they merely treat the symptoms of a greater societal ill. In order to truly address the gender-sexuality inequality in eating disorders what is necessary is not the liberation of sexuality but rather its demystification. An obvious place for state action in this regard is in the sexual education classroom. Public service announcements/informational campaigns and providing programs that help expose people to difference are other options. Obviously further research is certainly necessary to examine the intersectionality between gender-sexuality and eating disorders including much larger and more comprehensive studies.

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Appendix A

Childhood Abuse and Eating Disorders in Gay and Bisexual Men

TABLE 1. Prevalence of histories of childhood sexual and physical abuse in gay and bisexual men

	Childhood Sexual Abuse (%)	OR (CI)	Childhood Physical Abuse (%)	OR (CI)
All ($n = 193$)	34		33	
Sexual orientation				
Gay ($n = 165$)	31	2.6 (1.1, 5.8)	32	1.4 (0.6, 3.1)
Bisexual ($n = 28$)	53		39	
Race				
White ($n = 65$)	17		25	
African-American ($n = 64$)	36	2.7 (1.2, 6.3)	33	1.5 (0.7, 3.2)
Latino ($n = 64$)	50	5.0 (2.2, 11.1)	42	2.2 (1.0, 4.7)
Age				
18–30 ($n = 94$)	28	1.6 (0.8, 3.0)	31	1.2 (0.7, 2.2)
31–59 ($n = 99$)	39		35	
Education				
High school diploma or less ($n = 45$)	51	2.5 (1.3, 5.0)	40	1.5 (0.7, 3.0)
Negative net worth ($n = 104$)	37	1.4 (0.7, 2.5)	36	1.4 (0.7, 2.5)

TABLE 2. Lifetime and current (12-months) eating disorders among gay and bisexual men with and without a history of childhood sexual abuse

	Childhood Sexual Abuse		
	Yes ($n = 66$) (%)	No ($n = 127$) (%)	OR (CI)
Lifetime history of DSM-IV full-syndrome anorexia	0	1.6	$\chi^2 = 1.0$, ns[a]
Lifetime history of DSM-IV full-syndrome bulimia	9.1	4.7	2.0 (0.6, 6.5)
Lifetime history of full-syndrome DSM-IV binge eating disorder	6.1	4.7	1.3 (0.3, 4.8)
Subclinical anorexia	4.5	2.4	2.0 (0.4, 10.0)
Subclinical bulimia	16.7	5.5	3.4 (1.2, 9.3)
Subclinical binge eating disorder	13.6	7.1	2.0 (0.8, 5.5)
Any lifetime full-syndrome or subclinical eating disorder	24.2	11	2.6 (1.2, 5.7)
Any current full-syndrome or subclinical eating disorder	13.6	3.9	3.8 (1.2, 12.0)

[a] Fisher's exact test performed because odds ratios are not calculable.

Appendix B

Eating Disorders in Diverse Lesbian, Gay and Bisexual Populations

TABLE 1. Lifetime prevalence estimates (and standard errors) of full syndrome and subclinical[a] eating disorders in diverse New York City populations ($n = 516$)

	Lifetime Prevalence Estimates									
	Men					Women				
	Gay and Bisexual				Heterosexual	Gay and Bisexual				Heterosexual
Diagnosis	White ($n = 65$)	Black ($n = 64$)	Latino ($n = 64$)	All Gay and Bisexual Men ($n = 193$)	White ($n = 65$)	White ($n = 67$)	Black ($n = 64$)	Latino ($n = 64$)	All Lesbian and Bisexual Women ($n = 195$)	White ($n = 63$)
Full syndrome anorexia	1.5 (1.5)[b]	1.6 (1.5)	0 (NA)	1 (.7)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)
Full syndrome bulimia	4.6 (2.6)	4.7 (2.6)	9.4 (3.6)	6.2 (1.7)	0 (NA)	4.5 (2.5)	3.1 (2.2)	6.3 (3)	4.6 (1.5)	3.2 (2.2)
Full syndrome binge eating	1.5 (1.5)	4.7 (2.6)	9.4 (3.6)	5.2 (1.6)	1.5 (1.5)	4.5 (2.5)	1.6 (1.5)	7.8 (3.3)	4.6 (1.5)	1.6 (1.6)
Any full syndrome eating disorder	7.7 (3.3)	7.8 (3.3)	11 (4)	8.8 (2)	1.5 (1.5)	7.5 (3.2)	3.1 (2.1)	11 (4)	7.2 (2)	4.8 (2)
Subclinical anorexia	1.5 (1.5)	4.7 (2.6)	3.1 (2.2)	3.1 (2.1)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	0 (NA)	3.2 (2)
Subclinical bulimia	7.7 (3.3)	4.7 (2.6)	15.6 (4.5)	9.3 (2)	0 (NA)	6 (3)	3.1 (2.2)	7.8 (3.3)	5.6 (1.6)	4.8 (2.7)
Subclinical binge eating	6.2 (3)	11 (4)	11 (4)	9.3 (2)	4.6 (2.6)	4.5 (2.5)	3.1 (2.1)	11 (4)	6.2 (1.7)	1.6 (1.6)
Any subclinical eating disorder	12.3 (4)	15.6 (4.5)	18.8 (5)	15.5 (2.6)	4.6 (2.6)	9 (3.5)	4.7 (2.6)	15.6 (4.5)	9.7 (2.1)	8 (3.4)

[a] Subclinical categories include cases who also met criteria for full syndrome disorders.
[b] Values in parentheses indicate standard errors.

TABLE 2. Differences in prevalence of lifetime full syndrome and subclinical[a] eating disorders in diverse New York City populations by sexual orientation, gender, race/ethnicity, age, and sexual identity[b,c]

	Full Syndrome				Subclinical			
	Anorexia	Bulimia	Binge Eating	Any Eating Disorder	Anorexia	Bulimia	Binge Eating	Any Subclinical Eating Disorder
a. Lesbians, gay men, and bisexuals versus heterosexuals (n = 516)								
Sexual orientation by gender								
Men								
Gay/bisexual	$\chi^2 = .67$, $p = 1.0$	$\chi^2 = 4.2$, $p = .04$	3.5 (0.4, 28)	6.1 (0.8, 47.4)	$\chi^2 = 2.06$, $p = .34$	$\chi^2 = 6.5$, $p = .009$	2.1 (0.6, 7.4)	3.8 (1.1, 13)
Heterosexual			1.0	1.0			1.0	1.0
Women								
Lesbian/bisexual	NA	1.5 (0.3, 7)	3.0 (0.4, 24.1)	1.5 (0.4, 5.5)	$\chi^2 = 6.24$, $p = .06$	1.2 (0.3, 4.4)	4.0 (0.5, 32)	1.2 (0.4, 3.5)
Heterosexual		1.0	1.0	1.0		1.0	1.0	1.0
b. Lesbian, gay, and bisexual subgroups (n = 388)								
Gender								
Male	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Female	NA	0.7 (0.3, 1.7)	0.88 (0.35, 2.23)	0.80 (0.43, 1.67)	NA	0.6 (0.2, 1.2)	0.64 (0.29, 1.36)	0.58 (0.32, 1.08)
Race/ethnicity								
White	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Black	1.0 (0.06, 16.6)	0.8 (0.2, 2.8)	1.03 (0.25, 4.21)	0.70 (0.26, 1.91)	3.1 (0.3, 30.6)	0.5 (0.1, 1.7)	1.35 (0.48, 3.74)	0.95 (0.43, 2.11)
Latino	NA	1.7 (0.6, 5.0)	3.0 (0.93, 9.70)	1.49 (0.64, 3.50)	2.0 (0.2, 23.2)	1.8 (0.7, 4.3)	2.19 (0.85, 5.62)	1.75 (0.85, 3.59)
Sexual identity								
Gay/lesbian	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Bisexual	4.6 (0.3, 74.3)	1.4 (0.5, 4.1)	1.22 (0.39, 3.80)	1.65 (0.70, 3.87)	2.3 (0.4, 12.8)	1.8 (0.7, 4.3)	1.15 (0.45, 2.92)	1.78 (0.89, 3.58)
Age								
30–59 years	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
18–29 years	NA	2.1 (0.8, 5.4)	1.15 (0.46, 2.90)	1.70 (0.80, 3.61)	1.0 (0.2, 5.1)	3.0 (1.2, 6.7)	0.77 (0.36, 1.64)	1.31 (0.71, 2.39)

[a] Subclinical categories include cases who also met criteria for full syndrome disorders.
[b] Fisher's exact test and probability values are provided where a comparison group had 0 cases.
[c] Values given indicate odds ratios (95% confidence intervals).

TABLE 3. Current (1 year) and lifetime full syndrome and subclinical[a] eating disorders by community participation in gay and bisexual men[b] (n = 193)

	Current (12 months)		Lifetime	
	Full Syndrome	Subclinical	Full Syndrome	Subclinical
Collective self-esteem (membership)	0.79 (0.41, 1.52)	0.65 (0.40, 1.05)	0.69 (0.45, 1.08)	0.72 (0.51, 1.02)
% of organizations that are LGB	1.01 (.99, 1.04)	1.01 (0.99, 1.03)	1.00 (0.98, 1.01)	1.00 (0.99, 1.01)
Gym membership				
No	1.0	1.0	1.0	1.0
Nongay gym	0.62 (0.05, 7.07)	0.48 (0.09, 2.61)	0.70 (0.19, 2.52)	0.86 (0.30, 2.44)
Gay gym	2.33 (0.41, 13.19)	1.64 (0.49, 5.46)	0.96 (0.30, 3.02)	1.58 (0.64, 3.90)
Member of a gay professional organization				
No	1.0	1.0	1.0	1.0
Yes	0.39 (0.04, 3.37)	1.39 (0.44, 4.36)	0.73 (0.22, 2.35)	1.2 7(0.55, 2.92)
Member of a gay recreation organization				
No	1.0	1.0	1.0	1.0
Yes	3.46 (0.65, 18.30)	3.63 (1.09, 12.02)	1.55 (0.57, 4.20)	1.39 (0.64, 3.05)
Member of a religious organization				
No	1.0	1.0	1.0	1.0
Yes	1.07 (0.12, 9.29)	1.07 (0.22, 5.11)	1.42 (0.38, 5.34)	1.35 (0.46, 3.92)
Member of a gay political organization				
No	1.0	1.0	1.0	1.0
Yes	0.52 (0.61, 4.45)	0.86 (0.23, 3.23)	0.66 (0.18, 2.41)	0.77 (0.29, 2.01)
Member of a gay charity organization				
No	1.0	1.0	1.0	1.0
Yes	2.28 (0.49, 10.57)	1.70 (0.54, 5.35)	0.89 (0.28, 2.88)	1.60 (0.68, 3.68)

[a] Subclinical categories include cases who also met criteria for full syndrome disorders.
[b] Values given indicate odds ratios (95% confidence intervals).

Appendix C

Body Image Eating Behaviors and Attitudes toward Exercise among Gay and Straight Men

Table 1
Body size variables by sexual orientation

Variable	Gay men (N=25)		Heterosexual men (N=25)		t
	Mean	S.D.	Mean	S.D.	
Weight	159.56	19.19	180.80	30.36	2.96**
Height (in.)	69.88	2.37	70.60	2.72	−.998
Pounds from IW	.08	11.83	−1.04	17.74	.259
BMI	22.77	2.28	25.23	3.25	3.10**
Self-reported "ideal" weight	160.25	16.61	180.00	35.18	2.49*

IW=self-reported pounds from ideal weight (actual weight−ideal weight); BMI = body mass index (kg/height [m^2]; Garrow & Webster, 1985).
* Significant at $p<.05$.
** $p<.01$.

Table 2
Descriptive statistics and univariate comparisons of gay and heterosexual men on MEBBIE subscales, with body mass index statistically controlled

MEBBIE subscale	Gay men		Heterosexual men		F	η^2
	M	S.D.	M	S.D.		
Subscales with a priori hypotheses						
Body Dissatisfaction	2.50	.71	1.69	.68	21.37**	.31
Drive for Muscularity	2.47	.81	1.84	.77	9.07*	.16
Fear of Fatness	2.72	.72	2.00	1.03	12.21**	.21
Drive for Thinness	1.53	.99	1.19	.79	7.40*	.14
Overexercise	2.17	.77	1.92	.94	.48	.01
Subscales with no a priori hypotheses						
Emotional Eating	1.32	.57	1.05	.81	5.05*	.10
Distorted Cognitions	2.52	.77	2.06	.98	5.63*	.11

η^2=effect size: variance in MEBBIE subscales attributable to sexual orientation.
* $p<.01$.
** $p\leq.001$.

Appendix D

A Survey of LGBT Americans

Gay Men and Lesbians More Connected to LGBT Issues, Events and Groups

% saying they have ever done each

			------Bisexuals-----		
	Gay men	Les-bians	NET	*Men*	*Women*
Attended an LGBT pride event	72	61	33	25	37
Didn't buy a product or service because of lack of support for LGBT rights	68	58	34	28	36
Bought a product or service because of support for LGBT rights	61	62	36	24	40
Attended a rally or march in support of LGBT rights	58	44	25	23	26
Been a member of an LGBT organization	48	49	28	12	34
Donated to politicians or political orgs. because of support for LGBT rights	44	39	21	12	23

Note: Based on all LGBT (N=1,197).

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