THE COMPARISON OF HOMOSEXUAL AND HETEROSEXUAL MALES AS REGARDS THEIR DEPRESSION, EATING ATTITUDES AND SELF-ESTEEM RATIOS SAMPLE IN TURKEY

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HOMOSEKSÜEL VE HETEROSEKSÜEL ERKEKLERİN YEME BOZUKLUĞU, DEPRESYON VE BENLİK SAYGISI AÇISINDAN KARŞILAŞTIRILMASI

ÖZET

Amaç: Bu çalışmada homoseksüel ve heteroseksüel erkeklerin yeme bozukluğu ve psikolojik belirtiler açısından karşılaştırılması amaçlamıştır.
Yöntem: Çalışmaya katılanlara (39 heteroseksüel ve 38 homoseksüel erkek) Beck Depresyon Envanteri, Rosenberg Benlik Saygısı Ölçeği ve Yeme tutumu ölçeği (EAT-40) uygulanmıştır.
Bulgular: Homoseksüel erkekler heteroseksüel erkelere göre yeme tutumu testinden daha yüksek puan almışlardır. Çalışmanın sonunda homoseksüellerle heteroseksüeller arasından depresyon ve benlik saygısı arasında fark bulunmazken yeme bozukluğu puanları açısında ise anlamlı bir fark olduğu saptanmıştır.
Tartışma: Çalışmanın sonunda bulunan sonuçlar yeme bozukluğunda homoseksüelitenin bir risk faktörü olduğunu ortaya koyan diğer çalışmaları destekler niteliktedir. Bu konuyla ilgili yapılacak daha fazla araştırma erkeklerde yeme bozukluğu için homoseksüelitenin bir risk faktörü olarak ele alınabileceğiyle ilgili bir kurama katkı sağlayacaktır.
Sonuç: Homoseksüel bireyler arasında yeme bozukluklarının nâdir olmadığı görülmektedir. Yeme bozukluklarının gizlilik içinde var olması, tedavi için başvuru oranının düşüklüğü ve uzun hastalık süresinin prognozu olumsuz etkilemesi, olguların erken tanınmasının ve psikiyatrik yardım sağlama yolları konusunda aydınlatılmasının önemini ortaya koymaktadır.
Anahtar Kelimeler: benlik saygısı, depresyon. homoseküelite, yeme bozukluğu

ABSTRACT

Objective: This study investigated eating disorder symptoms and psychosocial correlates of eating disorders among heterosexual males and homosexual males.
Method: Men (39 heterosexual and 38 homosexual) completed the Beck Depression Inventory (BDI), the Rosenberg Self-Esteem Scale (RSE), and the Eating Attitudes Test (EAT-40).
Findings: The homosexual males scored higher on the Eating Attitudes Test (EAT-40) compared to heterosexual males. At the end of the study, the eating attitude points differ between homosexuals and heterosexuals significantly, the depression and self-esteem points do not differ significantly.
Discussion and Conclusion: These results are consistent with previous studies that have found support for the homosexuality hypothesis in disordered eating. Future research may benefit from exploring aspects of homosexuality that may contribute specifically to risk for disordered eating in men.
Keywords: depression, eating disorders, homosexuality, self-esteem.

INTRODUCTION

While some writers have continued to argue that eating-disordered males represent a "neglected population" (Gordon 1999), there has undoubtedly been a marked increase in interest and research with men over the last 20 years (Andersen 1999). Research examining both sexes indicates that homosexual males suffer in terms of age of onset, dissatisfaction with current body shape, and weight control methods (Keel et al 1998, Olivardia et al 1995). A number of studies concerning eating disorders have investigated the issue of gay sexuality. Although the exact figures are somewhat unreliable in cases of males' clients presenting with anorexia, it appears that as many as one in three male anorexics may be gay (Schneider et al 1995). Community-based studies in both the USA and Europe which have compared similar samples of young gay and heterosexual men have frequently discovered significantly higher frequencies of disturbed eating attitudes and behaviors amongst gay participants (Siever, 1996 Gettelman and Thompson 1993, French et al 1996, Schneider et al 1995, Silberstein et al 1989). Some research (e.g. Brand et al 1992, Pope et al 1986) has cast doubt on the

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association between male homosexuality and disordered eating.

A general risk factor would increase risk for developing any psychiatric disorder, including, but no restricted to, eating disorders. If social stigmatization of homosexuality caused general psychological distress that expressed itself as discomfort with sexual orientation, low self-esteem, depression eating, and then homosexuality might act as a general risk factor. Conversely, homosexuality might be related to factors that specifically increase risk for eating disorders, such factors might include increased feminine gender role identification (Murnen and Smolak 1997) or increased pressure to maintain a thin physique to attract a male partner (Epel et al 1996). Although homosexual men may be more likely than heterosexual men to develop eating disorders because of possible excessive concern with slim bodies and other attitudes traditionally associated with women, to our knowledge, no study has reported on behaviors and attitudes related to eating disorders in a nonclinical sample of homosexual men (Yager et al 1988). This study aimed to determine whether homosexuality is a specific risk factor for disordered eating in men. It was predicted that: Homosexual men would report higher levels of disordered eating attitudes and behaviors compared to heterosexual men.

METHOD

Samples

Snowball sampling was used in this study. Snowball sampling may simply be defined as: A technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on (Vogt 1999). Men (n=77) were recruited from the heterosexual or homosexual men to participate in a study on sexual orientation and eating patterns. Subjects were classified as homosexual if they endorsed a homosexual orientation and reported no sexual contact with a member of the opposite sex over the past 3 years (n=38). Subjects were classified as heterosexual if they endorsed a heterosexual orientation and reported no sexual contact with a member of the same sex over the 3 years (n=39).

Age ranged from 16 to 37 years old. The mean age of the homosexual group (23.81±4.54) was lower than the mean age of the heterosexual group (25.26±5.50). There were no significant differences between the two groups; t (77)=-1.252, ($p>.05$). The two groups differed significantly in demographic variables relating to body mass index (t (77)=-3.867, $p<0.001$) and education (t(77) =-2.897, $p<0.05$). Mean body mass index was 24.6 kg/m^2.

Procedure

When the participants were invited to take part in the study they had access to a sample copy. They completed a questionnaire involving questions about age, height, weight, educational level, relationship status and age of identification of sexual orientation. Participants also completed the following three standardized questionnaires: Beck Depression Inventory ([BDI]; Beck et al 1979) Rosenberg Self-Esteem Scale ([RSE]; Rosenberg 1965) The Eating Attitudes Test [EAT-40] (Garner and Garfinkel 1979).

Beck Depression Inventory (BDI)

The Beck Depression Inventory (Beck et al 1979) was used to assess participants' severity of depression. The reliability and validity of the BDI have been demonstrated through a wide body of research (Beck et al 1988). In accordance with the testing guidelines, a score of 10 or greater indicates the presence of clinically meaningful depression symptoms. The BDI is a self-report inventory which assesses depression by asking the person to rate 21 symptom features associated with depression. The Beck Depression Inventory is adapted to Turkish culture by Şahin (Hisli)(1989).

The Eating Attitudes Test

The Eating Attitudes Test (EAT-40) is a 40-item inventory developed by Garner and Garfinkel (1979) to assess a range of behaviors and attitudes related to eating disorders, specifically anorexia nervosa. A score of 30 and above is commonly identified as a cut-off value identifying individuals with anorexia. EAT scores have been able to discriminate clinical patients with eating disorders and nonclinical populations, demonstrating construct validation for the scale (Garner and Garfinkel 1979). The scale is adapted to Turkish culture by Savaşır and Erol (1989).

Body Mass Index

Body mass was assessed from self-reported weight and height measurements of each individual. Previous measured data correlated highly with self-reported values. A body mass index (BMI) was calculated from the equation (BMI=weight/height2). Although only an index of obesity that fails to account for the fat to muscle ratio, the BMI is a

widely used index for determining body size and body image (Feinleib 1985, Brodie and Slade 1988).

The Rosenberg Self Esteem Scale (RSE)

This scale has been widely used in studies conducted in Turkey. It was developed by Morris Rosenberg in 1963 (Rosenberg 1965). The Rosenberg scale consists of 12 subscales and 63 questions. There are 10 items in the self-esteem category. In this category, 0-6 points are given for each item according to the evaluation system in the Rosenberg self-esteem. In evaluating the other subscales, one point is given for each correct answer according to an answer key. The translation of this scale into Turkish and study of validity and reliability in Turkey were performed by Çuhadaroğlu in 1986. The reliability and validity tests were done on adolescents who have psychotic, neurotic disorders and a control group. It was found that the validity scores of the Turkish version of the Rosenberg self-esteem scale was investigated by Dereboy and his colleagues in 1994. Examinations of the Cronbach's internal consistency coefficient for the Turkish version of the Rosenberg self-esteem subscales had sufficient internal reliability. The studies of Çuhadaroglu (1986) and Dereboy et al (1994) indicate that six subscales of the Rosenberg self-esteem scale were found to be valid and reliable. These subscales included self-esteem, depressive affect, daydreaming, psychosomatic symptoms, intensity of discussion, and parental interest. These six subscales were used in this study. Thirty-nine items compromise the self-esteem scale.

FINDINGS

Table 1 presents correlations between variables measured for the full sample. Measures of disordered eating were correlated with depression and self-esteem.

The mean scores obtained from the Beck Depression Inventory, the Eating Attitudes test, and the six subscales of the Rosenberg scale were calculated for each group (see Table 2). The mean scores of self-esteem in the homosexual and heterosexual males were high. The mean scores of depressive affect and psychosomatic symptoms were moderate in both groups. The mean scores of parental interest toward two groups were high in each group. In both groups, the mean scores of self-esteem and the mean scores obtained from other subscales were compared using t-test. There was no significant difference between two groups on the BSE. The mean scores of the eating attitudes test in the homosexual group were high whereas the mean scores of the same test in heterosexual group were low. There was significant difference between the two groups ($t_{(77)}$=3.374, p<0.001). The mean scores of the Beck Depression Inventory were the same in both groups (11.66±9.0, 10.08.±7.37). There were no significant differences between homosexual and heterosexual males in terms of the BDI.

Table 1. Pearson correlations for all variables

	BDI	RSE	EAT-40
RSE	.517**	-	
EAT-40	.229*	.292*	-
*p<0.05	**p<0.01		

The results of MANOVA which was made in order to see whether the depression, eating attitudes and self-esteem of the males differ according to their being homosexuality and heterosexuality show that they carry out significant differences (Wilks Lambda = .797, $F_{(3,73)}$ = 6.21, p<0.001). This finding proves that the depression, eating attitudes and self-esteem points of homosexual and heterosexual males differ. The results of the mean and standard deviation data related to depression, eating attitude and self-esteem points; and the results of one way ANOVA which was made according to being homosexual and heterosexual are given in Table 3. As a result, while the eating attitude points of homosexuals and heterosexuals are displaying significant differences ($F_{(1,75)}$=11.38, p<0.001), the depression and self-esteem points have no significant difference ($F_{(1,75)}$=0.711, p>0.05, $F_{(1,75)}$= 1.39, p>0.05). The mean EAT-40 of homosexual males was higher than the mean EAT-40 heterosexual ones.

DISCUSSION and CONCLUSION

The results of the current study reveal that homosexual men have higher levels of anorexic symptoms, compared to heterosexual men. These results are consistent with previous research finding in association with homosexuality and eating pathology in non-clinical male samples (Beren et al 1996, French et al 1996, Herzog et al 1991, Schneider et al 1995, Siever 1994, Silberstein et al 1989, Williamson and Hartley 1998, Russell and Keel 2001). The mean scores of self-esteem in the homosexual and heterosexual males were high and there was no significant difference between two

Table 2. The Mean Scores of Subscales of the Rosenberg Self-Esteem Scale, The Beck Depression Inventory, and The Eating Attitudes and The Significance of The Differences Between Research Groups.

			X	SD	t
RSE	**Self-esteem** 1-2: high 3-4: moderate 5-6: low	Homosexual Heterosexual	 1.24 1.62	 1.30 1.49	-1.182
	Depressive affect 1-2: low 2-3: moderate 4: high	Homosexual Heterosexual	2.63 2.67	1.82 1.80	-.085
	Daydreaming 0-1: low 2-3: moderate 4: high	Homosexual Heterosexual	1.82 1.59	1.39 1.14	.780
	Psychosomatic symptoms 0-2: low 3-4: moderate 5 or more: high	Homosexual Heterosexual	3.24 2.72	2.81 2.09	.920
	Intensity of discussion 0: low 1: moderate 2: high	Homosexual Heterosexual	1.18 0.97	0.73 0.90	1.120
	Parental interest 0-2: high 3-4: moderate 5-7: low	Homosexual Heterosexual	1.63 1.41	1.44 1.60	.637
BDI		Homosexual Heterosexual	11.66 10.08	9.01 7.37	.843
EAT-40		Homosexual Heterosexual	16.00 11.31	7.28 4.68	3.374**
$N^{(1)}$=38		$N^{(2)}$=39			(*)
p<0.05					

groups on the BSE. In addition, there were no significant differences between homosexual and heterosexual males on the BDI. That is, sexual orientation did not account for significant variance in depression and self-esteem. The investigation by Russell and Keel (2001) was similar to our study in that homosexual and heterosexual males were sampled and a variety of eating disorder symptoms and other psychosocial correlates of eating disorders were measured. Russell and Keel (2001) reported that homosexual men had more pathological scores EAT-26, which is consistent with the findings of our investigation, but while Ressell and Keel (2001) found that homosexual men had more pathological scores in the BDI and RSE, our study found no significant difference in the BDI and RSE between the two groups. Previous research has illustrated a clear overlap between gender traits and self-esteem as both constructs assess self-descriptions about abilities, attitudes, and behaviors (Berk 1997, Marsh and Myers 1986, Russell and Antill 1984). Moreover, several studies have identified the role of self-esteem in disordered eating (e.g. Button et al 1996). However, self-esteem is too broad as a psychological construct to offer more than a description of behavioral and emotional problems (Leary et al 1995). Self-esteem provides a global evaluative judgment of one's self-worth but tells us little about the mechanism.

The current study expands upon previous research by examining whether general psychological distress, this suggest that homosexuality may be a specific factor for eating in the male population. At the end of the study, the eating attitude points differ significantly between homosexuals and heterosexuals, the depression and self-esteem points do not differ significantly.

There are several possible explanations as to why homosexuality might be linked to high levels of eating disturbance. One model implicates societal factors, with an increase in the importance of thinness in the feminine role orientation resulting from western society's thin ideal. A more plausible model involves the role of personal conflict and the resulting emotional responses. For example, in homosexual men, a conflict between the individual's feminine role-orientation and society's view of men as

Table 3. The mean and standard deviation of ANOVA results related to the depression, eating attitudes and self-esteem of males according to their being homosexual or heterosexual.

		n	Mean	S.D.	D.F.	F	P
BDI	Homosexual	38	11,6579	9,0113	1-75	0.711	.402
	Heterosexual	39	10,0769	7,3749			
EAT-40	Homosexual	38	16,0000	7,2783	1-75	11.382	.001
	Heterosexual	39	11,3077	4,6800			
RSE	Homosexual	38	1,2368	1,3035	1-75	1.397	.241
	Heterosexual	39	1,6154	1,4976			

physically strong and masculine might lead to emotional discomfort, which the individual would then try to reduce.

Our hope was that these measures might reflect general psychological distress. In conclusion, the present study supports a specific association between eating pathology and male homosexuality. These findings suggest that among some homosexual males, behaviors and attitudes related to eating disorders are those which would be expected if these homosexual men were at greater risk for eating disorders. On the basis of these findings, larger community-based prospective studies are warranted. Such research may help increase awareness of disordered eating in men and identify targets for prevention and intervention efforts.

Snowball-based methodologies may also be used to compliment this research methodology in the study of less stigmatized and even elite groups. Advances in the quantitative application of snowball techniques and the increasing need for ascending methodologies to fill in gaps in our knowledge of more obscure social situations suggest both a complementary and substitute role for snowball sampling. The real promise of snowball sampling lies in its ability to uncover aspects of social experience often hidden from both the researcher's and lay person's view of social life.

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