

The Impact of Relationships on the Association between Sexual Orientation and Disordered Eating in Men

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ABSTRACT

Objective: Robust evidence supports that bisexual and gay (BG) men have increased eating pathology compared to heterosexual men. BG men may be at greater risk due to pressure to attract a male partner; however, the related implication that relationships serve as protective factors for BG men remains untested.

Method: BG ($n = 42$) and heterosexual men ($n = 536$) completed surveys to determine whether relationship status and satisfaction moderate sexual orientation's effect on disordered eating.

Results: Single BG men had increased restrictive disordered eating compared to single heterosexual men, while few differences were found between BG and

heterosexual men in relationships. Relationship satisfaction was not related to restrictive disordered eating; however, low relationship satisfaction was associated with increased bulimic symptomatology in BG men compared to heterosexual men.

Discussion: Being in a relationship, independent of whether or not the relationship is satisfying, may be a protective factor for restrictive disordered eating in BG men. © 2012 by Wiley Periodicals, Inc.

Keywords: sexual orientation; men; disordered eating; relationships

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Introduction

Sexual orientation has emerged as a robust risk factor for disordered eating in men.^{1–3} Previous research has found that bisexual and gay (BG) men have significantly higher body dissatisfaction, disordered eating, and more diagnosed eating disorders than heterosexual men.^{1,4–10} Sexual orientation demonstrates a specific association with eating pathology that is independent of risk for general psychopathology.¹ The association is unique to men in that similar associations have not been found consistently in women.¹¹ Taken together, these findings suggest that there is something about sexual orientation that increases risk for eating pathology above risk for other forms of psychopathology in men. One explanation is that BG men may feel pressure to obtain a lean physique to attract a male partner, as men emphasize physical appearance when selecting mates.⁶ If true, this

pressure may leave single BG men more vulnerable to disordered eating compared to BG men who are in committed relationships. The present study sought to examine the impact of relationship status and satisfaction with those relationships on the association between sexual orientation and disordered eating across men in their 20s, 30s, and 40s.

BG men represent a disproportionate number of men entering treatment for eating disorders; indeed, up to 42% of men seeking treatment for an eating disorder have self-identified as homosexual or bisexual.^{8,12,13} This disparity does not appear to simply reflect biased representation among those seeking treatment, because community-based research has shown that homosexuality has been consistently associated with factors that increase risk for eating disorders, such as drive for thinness^{6,14} and body dissatisfaction,^{5,7} in men.

One of the most compelling theoretical explanations for this association was developed by Siever,⁶ who proposed that heightened emphasis on physical attractiveness in the gay male community leads BG men to be at greater risk for disordered eating because BG men are trying to attract men as romantic partners. Several studies have found that men, regardless of sexual orientation, place a greater emphasis on physical appearance (i.e., thinness and attractiveness) when looking for a romantic partner than do women.^{5,15–17} One study examined personal ads in several regional newspapers and found that

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men, regardless of sexual orientation, asked for more body shape descriptors from potential mates than did women, supporting that men placed a greater emphasis on physical appearance when selecting a partner.¹⁸ These cultural pressures and aesthetic ideals appear to be much more salient for BG men than straight men. Several studies have noted a heightened emphasis on a thin, muscular, and youthful figure as the ideal in the gay male subculture.^{5,6,16,17} In contrast, heterosexual men, who are looking for female partners, have less pressure from potential partners to achieve a thin aesthetic ideal than do BG men. This is because women place less emphasis on physical appearance when selecting a partner and because thinness is not an aesthetic ideal for heterosexual men.

The tendency for men to place heightened emphasis on thinness and physical attractiveness when selecting a partner may lead BG men to internalize these ideals, leaving them vulnerable to disordered eating. Consistent with this idea, several studies have found that gay men place a greater emphasis on physical attractiveness in their own self-evaluation than do heterosexual men.⁵⁻⁷ Epel et al.¹⁸ found that gay men were more concerned with body shape and weight and advertised their own weight to potential partners in personal ads more often than did heterosexual men. Thus, it may be that the heightened emphasis on physical appearance in the gay male subculture leads BG men to overemphasize their own appearance when trying to attract a partner, leading to greater drive for thinness and increased risk for disordered eating.

If attracting a male partner drives increased disordered eating in BG men, then disordered eating levels will be significantly higher in single BG men compared to single heterosexual men, whereas differences should be diminished for men in relationships. Importantly, most studies regarding the influence of sexual orientation on disordered eating in men have focused on younger populations who may be more likely to be single or in uncommitted relationships.^{4-6,12} Further, no studies to date have examined the impact of relationship status on disordered eating in BG men. However, this association has been examined in heterosexual women, who may share similar pressures to attain a thin physique to attract a male partner as those experienced by BG men. Several studies have found that married women have lower disordered eating symptoms than single women.¹⁹⁻²¹ Keel et al.²¹ found that being married predicted significant decreases in drive for thinness, bulimic symptoms, and dieting frequency in women, but not in a sample of men that was predominantly heterosexual.

While these studies examined marital status as opposed to relationship status, results imply that being in a committed relationship may be a protective factor against disordered eating in heterosexual women. A similar finding in BG men would support Siever's theory of increased risk for eating pathology within this population.

Because more stable and permanent relationships are often established at later stages in life, examining relationships in men across various life stages may help elucidate the impact of sexual orientation and relationship status on disordered eating. Developmental research examining relationships in early adulthood has found that men in their 20s navigate a transition period between less mature relationships in adolescence and more committed relationships in adulthood.²² This may be even more salient for BG men in their 20s if this period coincides with when they identify their own sexual orientation.²³ Indeed, Diamond et al.²⁴ reported that the developmental trajectory for romantic relationships among BG youths may be delayed for fear of disapproval from family or peers. In turn, BG youths may have more limited opportunities for dating, which would limit opportunities for stable romantic relationships. Taken together, previous research indicates that stable romantic relationships may be defined differently for men in their 20s as compared to men in their 30s and 40s.

According to Siever's theory, relationship stability and satisfaction should be an important factor influencing disordered eating, as individuals who are unsatisfied with their current relationships may still be interested in attracting a partner. Thus, discovering a link between relationship satisfaction, sexual orientation, and disordered eating may provide further evidence in favor of Siever's theory. A few studies have found an association between low satisfaction with intimate relationships and increased body dissatisfaction and disordered eating in men and women;^{25,26} however, no studies have examined this in relation to sexual orientation. In addition, to the extent that these associations have been found in predominantly heterosexual men, this suggests that effects may reflect the protective influences of social support rather than specific influences on pressures to attain a thin physique specific to BG men.

The current study utilized a cross-sectional dataset of men in their 20s, 30s, and 40s to examine the impact of relationship status and relationship satisfaction on the association between sexual orientation and disordered eating. It was hypothesized that relationship status would moderate the associ-

ation between sexual orientation and disordered eating, such that single BG men would have greater disordered eating than single heterosexual men, while no significant differences would exist for men in relationships. Second, it was hypothesized that relationship satisfaction would moderate the association between sexual orientation and disordered eating, such that lower relationship satisfaction in BG men would predict higher disordered eating to a greater degree than in heterosexual men. Given the first hypothesis, that BG men and heterosexual men in relationships would not differ on disordered eating, we did not expect a main effect of sexual orientation on disordered eating for relationship satisfaction analyses.

Method

Participants

Data for the present study were drawn from a large epidemiological study on eating and health attitudes and behaviors. Participants were recruited from a randomly selected group of men in their freshmen and senior classes at a prestigious northeastern university during the springs of 1982, 1992, and 2002. In 2002, participants from the 1992 and 1982 cohorts were recontacted for 10- and 20-year follow-up, respectively. The current study examined cross-sectional data from men ($n = 578$) collected during the 2002 survey. Participants identified their sexual orientation through a single item with three response options: heterosexual ($n = 536$), bisexual ($n = 15$), or homosexual ($n = 27$). Bisexual and homosexual males were analyzed as a combined group, BG men, consistent with how these groups have been analyzed in previous studies.^{2,8} The present study examined heterosexual men and BG men in two groups: one composed of men in young adulthood, adulthood, and mid-life [heterosexual men $n = 536$, BG men = 42; mean (SD) age = 29.14 (8.69) years] and one composed of men in adulthood and midlife only [heterosexual men $n = 322$, BG men = 23; mean (SD) age = 35.45 (5.35) years]. The proportion of BG men in the current sample (42/578 or 7%) is roughly representative of what would be expected from population-based samples.^{27,28} The proportion of heterosexual men and BG men did not differ among cohorts ($\chi^2(2) = 1.748, p = .417$), and heterosexual men and BG men did not differ in ethnic composition ($\chi^2(6) = 7.292, p = .295$), with the majority of the sample being Caucasian (76.5%). Cohorts differed in ethnic diversity ($\chi^2(12) = 25.071, p = .014$), with increased representation of ethnic minorities in more recent cohorts. Participation rates for the 2002 survey were good (66.3% for all cohorts; 69% for men in adult-

hood and mid-life only). There was no evidence of biased attrition in comparisons of baseline variables between participants and non-participants at 10- and 20-year follow-up (all p -values $> .10$). Because the 2002 survey was the first time that sexual orientation was assessed, it was not possible to determine if attrition was associated with sexual orientation, and it was not possible to impute missing values among those lost to follow-up.

Procedures and Measures

Participants were mailed consent forms and a self-report survey including information regarding demographics, height, weight, and eating and health attitudes and behaviors. Self-reported height and weight were used to compute body mass index (BMI; kg/m^2).

Relationship Status and Relationship Satisfaction. Participants' relationship status was assessed using a single dichotomous item regarding current involvement in a steady relationship ("Yes" or "No"). As the definition of a steady relationship may be different for individuals in their 20s, 30s, and 40s, two sets of analyses were conducted. The first examined all age groups together, and the second was restricted to men in their 30s and 40s only. For individuals who endorsed being involved in a steady relationship, relationship satisfaction was assessed using a single item on a seven-point scale from 1 (Not at all satisfied) to 7 (completely satisfied). Single-item measures of marital satisfaction, an analogous construct, have demonstrated similar associations to multi-item measures of marital satisfaction.²⁹

Eating Disorder Inventory (EDI). The EDI is a self-report, six-point forced choice inventory that assesses behavioral and psychological traits common in anorexia and bulimia nervosa, including Drive for Thinness and Bulimia subscales.³⁰ Of note, these subscales assess disordered eating levels rather than formal eating disorder diagnoses. The EDI is a well-validated measure of eating pathology with research supporting the discriminant validity and internal consistency of the EDI-2.³¹ Additionally, the EDI has demonstrated test-retest reliability for individuals both with and without eating disorders³² and factor invariance in men and women from their 20s to their 40s.²¹ Cronbach's alpha in the current sample was $>.99$ for Drive for Thinness and $.98$ for Bulimia.

Dieting Frequency. Current dieting frequency was assessed through a single item with five response options: "Never," "Rarely," "Sometimes," "Usually," and "Always." Single-item measures of dieting frequency have demonstrated concurrent validity with self-report measures of caloric intake in men and have demonstrated similar associations to multi-item measures of dietary restraint.³³

TABLE 1. Associations between sexual orientation, relationship status, relationship satisfaction, and drive for thinness

Sample	BG Men				Heterosexual Men				F	p	Part eta ²
	Single		Relationship		Single		Relationship				
	M	SD	M	SD	M	SD	M	SD			
20s 30s and 40s	13.50	6.58	12.00	6.25	8.87	4.42	8.79	3.93	1.057	.304	.002
30s and 40s	16.50 ^a	7.78	12.27 ^b	6.46	8.55 ^c	4.34	8.94 ^c	3.67	6.030	.015	.018
Drive for Thinness N = 373											
Variable	Beta	t	p	Partial r	R square						
Relationship satisfaction	-.078	-1.516	.130	-.079	.057						
Orientation	.157	2.960	.003	.152							
Satisfaction × orientation	-.092	-1.738	.083	-.090							
Age	.080	1.556	.121	.081							

Note: Superscripts of differing values denote significant differences between groups.

Data Analyses

As expected, preliminary analyses indicated that no differences were found between bisexual and gay men on any dependent variables (all p values $>.20$), supporting the decision to combine these into a single BG group for further analyses. To address the first hypothesis, that relationship status would moderate the effect of sexual orientation on disordered eating for men, separate 2 (sexual orientation) \times 2 (relationship status) analyses of variance (ANOVA) were conducted with EDI Drive for Thinness, EDI Bulimia, and dieting frequency as dependent variables. To address the second hypothesis, that relationship satisfaction would moderate the association between sexual orientation and disordered eating, regression analyses were conducted. Given the inclusion of three cohorts, age was entered as a covariate. Significant interactions were probed to examine the effect of sexual orientation at high (1 SD above the mean) and low (1 SD below the mean) levels of relationship satisfaction.

Results

Drive for Thinness

Table 1 presents associations between sexual orientation, relationship status, relationship satisfaction, and drive for thinness. For men across age groups, there was a significant main effect of sexual orientation, such that BG men had greater drive for thinness compared to heterosexual men ($F(1, 570) = 32.143, p < .001, \text{partial } \eta^2 = .053$). There was neither a significant main effect of relationship status nor a significant interaction between sexual orientation and relationship status (all p values $>.20$). Restricting analyses to men in their 30s and 40s, there was a significant main effect of sexual orientation ($F(1, 338) = 35.858, p < .001, \text{partial } \eta^2 = .096$)

and a significant main effect of relationship status, with single men having greater drive for thinness than men in a relationship ($F(1, 338) = 4.172, p = .042, \text{partial } \eta^2 = .012$). Additionally, a significant interaction between sexual orientation and relationship status was found for men in their 30s and 40s. Specifically, single BG men had greater drive for thinness than single heterosexual men ($F(1, 338) = 26.396, p < .001, \text{partial } \eta^2 = .072$), BG men in a relationship ($F(1, 338) = 5.717, p = .017, \text{partial } \eta^2 = .017$), and heterosexual men in a relationship ($F(1, 338) = 9.587, p = .002, \text{partial } \eta^2 = .028$). BG men in a relationship also had greater drive for thinness than heterosexual men in a relationship ($F(1, 338) = 9.607, p = .002, \text{partial } \eta^2 = .028$).

Analyses for the regression model examining sexual orientation and romantic relationship satisfaction revealed that the overall model significantly predicted drive for thinness ($R^2 = .057, F(4,368) = 5.535, p < .001$). In contrast to our hypotheses, there was a main effect of sexual orientation, such that BG men in relationships had increased drive for thinness compared to heterosexual men. There was neither an observed main effect of relationship satisfaction nor a significant interaction between sexual orientation and relationship satisfaction.

Bulimia

Table 2 presents associations between sexual orientation, relationship status, relationship satisfaction, and bulimic symptoms. For men in all age groups, there was a significant main effect of sexual orientation, such that BG men had greater bulimic symptoms than heterosexual men ($F(1, 569) = 9.170, p = .003, \text{partial } \eta^2 = .016$). Neither the main effect of relationship status nor the interaction between sexual orientation and relationship status were significant (both p -values $>.09$). As with men in all age groups, there was a main effect

TABLE 2. Associations between sexual orientation, relationship status, relationship satisfaction, and bulimic symptomatology

Sample	BG Men				Heterosexual Men				F	p	Part eta ²
	Single		Relationship		Single		Relationship				
	M	SD	M	SD	M	SD	M	SD			
20s 30s and 40s	11.55	5.14	10.19	4.55	9.52	2.80	9.25	2.88	1.24	.266	.002
30s and 40s	13.50	7.41	10.93	4.93	9.30	3.01	9.03	2.55	2.825	.094	.008

Bulimic Symptomatology N = 373					
Variable	Beta	t	p	Partial r	R square
Relationship satisfaction	-.059	-1.144	.253	-.060	.032
Orientation	.020	.365	.715	.019	
Satisfaction × orientation	-.138	-2.576	.010	-.133	
Age	-.079	-1.516	.130	-.079	

Note: Superscripts of differing values denote significant differences between groups

of sexual orientation for men in their 30s and 40s only, such that BG men had greater bulimic symptoms than heterosexual men ($F(1, 337) = 19.924, p < .001$, partial eta² = .056). There was also a main effect of relationship status in men in their 30s and 40s, with single men having greater bulimic symptoms than men in relationships ($F(1, 337) = 4.318, p = .038$, partial eta² = .013). Similar to analyses across age groups, the interaction between sexual orientation and relationship status for men in their 30s and 40s was not significant.

Regression analyses examining sexual orientation and relationship satisfaction revealed that the overall model was significant ($R^2 = .032, F(4,368) = 3.067, p = .017$). There were no observed main effects for sexual orientation or relationship satisfaction on bulimic symptoms. However, the interaction between sexual orientation and relationship satisfaction was significant. Follow-up tests revealed that, at high levels of relationship satisfaction, BG and heterosexual men did not differ on bulimic symptoms ($b = -1.293, t(372) = -1.221, p = .223$, partial $r = -.064$). However, at low levels of relationship satisfaction, BG men had increased bulimic symptoms compared to heterosexual men ($b = 1.816, t(372) = 2.290, p = .023$, partial $r = .119$).

Dieting Frequency

Table 3 presents associations between sexual orientation, relationship status, relationship satisfaction, and dieting frequency. There was a significant main effect of sexual orientation, such that BG men dieted more frequently than heterosexual men ($F(1, 571) = 10.205, p = .001$, partial eta² = .018). There was no significant main effect of relationship status or significant interaction between sexual orientation and relationship status (both p -values $>.40$). As with men in all age groups, there was a

significant main effect of sexual orientation for men in their 30s and 40s ($F(1, 339) = 18.411, p < .001$, partial eta² = .052). There was also a significant main effect of relationship status, such that single men dieted more frequently than those in a relationship ($F(1, 339) = 4.524, p = .034$, partial eta² = .013). Further, there was a significant sexual orientation by relationship status interaction for men in their 30s and 40s only, such that single BG men dieted more frequently than single heterosexual men ($F(1, 339) = 17.625, p < .001$, partial eta² = .049), while there were no differences in dieting frequency between BG men and heterosexual men in a relationship ($F(1, 339) = 2.173, p = .141$, partial eta² = .006).

Regression analyses examining sexual orientation and romantic relationship satisfaction revealed that the overall model significantly predicted dieting frequency ($R^2 = .041, F(4,370) = 3.932, p = .004$). However, neither sexual orientation, relationship satisfaction, nor their interaction significantly predicted dieting frequency.

Discussion

Results from the current study replicated previous findings that BG men have increased disordered eating compared to heterosexual men. Results further show that relationship status moderated the effect on disordered eating in men in their 30s and 40s. However, this effect depended upon the measure of disordered eating, with predicted effects evident for drive for thinness and dieting frequency, but not bulimic symptoms. In contrast, satisfaction with romantic relationships moderated the association between sexual orientation and bulimic symptoms but did not impact drive for thinness or

TABLE 3. Associations between sexual orientation, relationship status, relationship satisfaction, and dieting

Sample	BG Men				Heterosexual Men				F	p	Part eta ²
	Single		Relationship		Single		Relationship				
	M	SD	M	SD	M	SD	M	SD			
20s 30s and 40s	2.10	1.30	1.95	1.20	1.54	.86	1.60	.85	.509	.476	.001
30s and 40s	3.00 ^a	1.60	2.00 ^c	1.31	1.54 ^c	.94	1.65 ^c	.85	6.827	.009	.020
Dieting Frequency N = 375											
Variable	Beta	t	p	Partial r	R square						
Relationship satisfaction	-.055	-1.062	.289	-.055	.041						
Orientation	.096	1.802	.072	.093							
Satisfaction × orientation	-.003	-.055	.956	-.003							
Age	.160	3.100	.002	.159							

Note: Superscripts of differing values denote significant differences between groups.

dieting frequency. Consistent with previous research that romantic relationships for men in their 20s may be defined differently than relationships in adulthood,^{22,24} relationship status did not moderate the effect of sexual orientation on disordered eating when analyses included late adolescent/young adult men.

Results for relationship status in men in their 30s and 40s are consistent with Siever's theory that BG men may have increased risk for eating pathology due to pressure to attract a male partner. Findings for BG men parallel those found in the literature for predominantly heterosexual women; further, the lack of effect of relationship status in heterosexual men replicates and extends previous findings examining the effect of marital status on disordered eating in men.²¹

While the above pattern was observed across restrictive disordered eating variables, contrary to study hypotheses, there was no moderating effect of relationship status on bulimic symptoms. One possible explanation for this null result is that the EDI Bulimia subscale is primarily a measure of tendency toward binge eating, which by nature is inconsistent with the goal of weight reduction. As the gay male subculture emphasizes a thin ideal, it would follow that men subjected to these pressures would attempt to maximize behaviors leading to thinness and minimize behaviors incompatible with this ideal. Thus, perhaps being single for BG men specifically increases risk for eating behaviors related to restriction (i.e., drive for thinness, dieting frequency).

Results provided partial support for the second hypothesis, that relationship satisfaction would moderate the effect of sexual orientation on disordered eating. Relationship satisfaction did moderate the association between sexual orientation and bulimic symptoms, while it did not moderate the association for drive for thinness or dieting fre-

quency. Low satisfaction with romantic relationships is an indicator of poor psychosocial functioning, a factor that has been robustly associated with eating disorders, particularly bulimia nervosa, concurrently^{34,35} and prospectively.³⁶ This association between poor psychosocial functioning and bulimia nervosa may extend to nonclinical bulimic symptoms as well. Perhaps BG men who lack satisfying support from their partners are less able to cope effectively with stress, which leads them to engage in bingeing behaviors in an effort to improve and/or regulate their emotions. This effect would be more pronounced in BG men compared to heterosexual men, as intense focus within the gay community on eating related issues may leave BG men more vulnerable to food-specific coping strategies, as opposed to other maladaptive coping strategies (i.e., alcohol use). Alternatively, the reverse may be true, greater bulimic symptoms in BG men may contribute to difficulty developing or sustaining satisfying romantic relationships.

There are several possible explanations for the lack of significant association between relationship satisfaction and sexual orientation for restrictive eating attitude and behaviors. First, given the significant moderating effect of being in a relationship on the association between sexual orientation and drive for thinness and dieting frequency, differences between BG men and heterosexual men were greatly reduced for men in relationships. This may have significantly reduced power to detect the moderating effect of relationship satisfaction in men with partners. Second, Siever's theory may have been better assessed by relationship commitment rather than relationship satisfaction, given that it is possible to remain committed to a relationship despite dissatisfaction, and only BG men not committed to remaining in their relationship might feel pressure to attain the thin ideal.

However, relationship commitment was not measured within the parent study. Third, given that relationship status only moderated associations for men in their 30s and 40s, it may be that the moderating effect of relationship satisfaction would only be seen in these men. While age was included as a covariate in regression analyses, this does not account for whether age differentially influences the association between relationship satisfaction and disordered eating. Finally, findings may represent a true null effect; relationship satisfaction may not impact increased pressure to attain the thin ideal in BG men compared to straight men in relationships.

The present study had several notable strengths. Data came from a randomly selected college-based sample, spanning across men from late adolescence to mid-life. The use of multiple age groups was particularly important, as convenience samples of college-aged men would not have revealed the moderating effect of relationship status. Additionally, there was no evidence of biased attrition, which increases the likelihood that the men sampled in the present study were representative of the college population from which they were originally sampled. The use of self-report measures was advantageous due to the stigmatized nature of the topics of sexual orientation and disordered eating. Previous studies have found that self-report assessments are associated with greater candor as compared to interview-based assessments.^{37,38} The present study also included measures with strong psychometric properties, including the EDI Drive for Thinness and Bulimia subscales. Finally, there was adequate power to detect moderate effects.

While the present study had several strengths, there were also weaknesses that merit discussion. First, participants for the present study were drawn from a selective northeastern university. Thus, the sample of BG and heterosexual men may not be representative of men within the population at large. Additionally, the sample for the current study was nonclinical, and thus results may not extend to men with formal eating disorders. Future research will be needed to determine whether results replicate within clinical populations of men. Of note, nonclinical samples provide better models for understanding risk as the presence of an eating disorder likely impacts satisfaction with relationships and other life domains. The present study also utilized a cross-sectional design, which limits any causal or temporal inferences that can be made. It may be that being single leads BG men to develop increased drive for thinness and diet more often, or alternatively, it may be that increased drive for

thinness and dieting frequency in BG men decreases their ability to maintain a relationship. Similarly, it may be that low satisfaction with romantic relationships leads BG men to develop bulimic symptoms, or alternatively, it may be that bulimic symptoms in BG men leads to decreased satisfaction with romantic relationships. Prospective designs are needed to determine whether entering a committed relationship predicts decreases in disordered eating in BG men or vice versa. Finally, sexual orientation, relationship satisfaction, and dieting frequency were measured with single-item assessments, which reduce reliability given unmeasured sources of error variance.

In sum, results from the present study have important theoretical implications for understanding why BG men are at increased risk for eating pathology. Results from the present study provide partial support for Siever's theory, in that single BG men have increased risk for restrictive disordered eating attitudes and behaviors (e.g., drive for thinness and dieting frequency), but not for bulimic symptoms. Thus, Siever's theory may better apply to restrictive disordered eating attitudes and behaviors, than to bulimic symptoms. Indeed, results imply that among BG men in relationships, bulimic symptoms may be more related to psychosocial functioning rather than increased pressure to be thin. In addition to informing theory, results from the present study also may have implications for prevention and treatment. Given that single BG men are at increased risk for restrictive disordered eating attitudes and behaviors, this group may benefit from a cognitive dissonance-based intervention that challenges cultural pressures to be thin. For BG men in relationships, it may be advantageous to use therapeutic techniques that focus on improving interpersonal relationships, such as Interpersonal Psychotherapy, as these may help reduce bulimic symptoms in this group. Future studies would benefit from examining how relationships may affect the longitudinal trajectory of disordered eating in BG men to help better understand risk over time for this group.

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