GENDER ROLE AND RISK PATTERNS FOR EATING DISORDERS IN MEN AND WOMEN

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The relationship between gender role and at-risk patterns for eating dysfunction was examined in this study of 206 men and women. The Bem Sex Role Inventory (Bem, 1974) and the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983) were the measures used. In accordance with the psychocultural model, it was expected that gender role and gender would interact across the risk factors. An interaction between gender and gender role was found across factors associated with eating disorders: different gender role identities contributed differentially to specific risk factors. The data contribute to a growing body of literature that suggests that the relationship between gender role and eating dysfunction is complex and requires multidimensional conceptualizations.

Medical and psychological research on eating disorders has burgeoned within the past 10 years. Reportedly, the incidence of eating disorders such as anorexia nervosa and bulimia is increasing steadily in adolescent and adult female populations (Strober, 1986) to as high as 20% of women who are "at risk" for these disorders due to subclinical symptomatology (Van Thorre & Vogel, 1985). The most prominent psychosocial theoretical views suggest psychodynamic or psychocultural etiology.

The psychocultural view maintains that social pressures directly put women at risk for eating disorders because of overemphasis on thinness as a primary component of female sexuality and identity. Additionally, the traditional stereotypic sex role identity for women, with its emphasis on submissiveness and indirect expression of autonomy, may increase risk for psychological problems, such as eating disorders, that are associated with poor self-concept. Published clinical reports often have supported these psychocultural views to the extent that female anorexic and bulimic patients are reported to represent the prototype of a traditional gender role orientation and to be adhering to self-views that are stereotypically feminine. In fact, these patients have been described as "prime examples of Bem's feminine women" (Boskind-White & White, 1986, p. 359). However, systematic empirical investigations have yielded results that fail to support the "hyperfeminine" hypothesis because they found less endorsement of feminine role identities in eating disorder subjects than in normals (Heilbrun & Putter, 1986; Lewis & Johnson, 1985). These findings can be interpreted in terms of the psychocultural perspective if it is expanded to include social pressures experienced by women whose identities are masculine or androgynous (van Strein, 1989). Recent research also suggests that an understanding of the relationship between disordered eating and gender role may need to go beyond undimensional conceptualizations to include related self-concept and social appraisals (Timko, Streigel-Moore, Silberstein, & Rodin, 1987).

Despite reported clinical case studies to the contrary (Ellis & Cantrell, 1985; Mitchell & Goff, 1984; Vandereycken & Van den Broucke, 1984), anorexia and bulimia often are considered to be exclusively feminine disorders. Indeed, these disorders have been

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referred to as "two uniquely feminine disorders" (Boskind-White & White, 1986, p. 362). However, as noted, clinical evidence suggests that the syndromes of anorexia and bulimia do occur in men with a very similar symptom picture and course as in women. Though it generally is agreed that the incidence of these eating disorders in men is significantly lower than in women, most of the research literature is confounded by a complete exclusion of male subjects. The male to female incidence has been estimated as between 1:10 and 1:16 (Vandereycken & Van den Broucke, 1984).

Not surprisingly given the low incidence rates, theoretical explanations for men with eating disorders are significantly rare in the literature. Some theorists (Mintz, 1983) view men as struggling with similar psychodynamic conflicts as their female counterparts. To date, male anorexic or bulimic patients have been ignored by psychocultural explanations. Intuitively, however, men may be subject to psychocultural conflicts that concern gender roles as are women, though such conflicts may be related less clearly to eating patterns.

The present study proposes to add to the database on factors related to risk patterns for disordered eating in both men and women and to investigate the relationship between gender role identification and factors associated with eating disorders. In view of previous research recommendations (Timko et al., 1987), both gender role and eating patterns will be treated as multidimensional rather than unitary concepts. Consistent with the psychocultural view as summarized by van Strein (1989), it is hypothesized that gender role will be related to dysfunctional eating as well as to psychosocial factors related to eating dysfunction.

Method

Subjects

Two hundred thirty-seven undergraduate students at a southeastern state university, 134 women and 103 men, served as volunteer participants. Ages ranged from 17 to 33 years with a modal age of 18.0 years. The majority (92.2%) were Caucasian and single (85.9%).

Measures

The Bem Sex Role Inventory (BSRI), developed by Bem in 1974, contains independent scales of Masculinity and Femininity so as to allow separate scores for each of these scales as well as a score that reflects the combination of Masculinity and Femininity scores (Undifferentiated and Androgynous). The classifications and score cut-offs used in this study were derived from median-splits using medians from the normative college group presented by the author (Bem, 1981).

The Eating Disorders Inventory (EDI), a paper-and-pencil self-report inventory, contains a number of psychological and behavioral traits often found in patients with eating disorders (Garner et al., 1983). The 64-item inventory is composed of eight factor analytically derived subscales: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears (Garner & Olmsted, 1984). The EDI was chosen because it allows measurement of self-concept and social adjustment factors that have been found to be related to eating dysfunction and because reliability and validity data are adequate (Garner & Olmsted, 1984).

Procedure

Subjects participated in groups with the general purpose of the study explained as part of the initial informed consent procedure. Each participant received a packet of materials that contained an informed consent form, a demographic data sheet, the BSRI, and the EDI. Subjects completed the materials individually.

Although data were collected from 237 subjects, data from 103 women were selected randomly from the larger pool of women to create a balanced design for data analysis. Thus, a group of 206 subjects, composed of equal numbers of men and women, was used for data analysis.

A two-way (2 × 4) analysis of variance was conducted on an index of overall risk for eating disorders. This index was a sum of the eight EDI scale scores. The factors for the ANOVA included gender (male, female) and BSRI classification (Masculine, Feminine, Undifferentiated, Androgynous). Two-way ANOVAs on each EDI subscale then were conducted. ANOVAs rather than a single MANOVA were conducted because of low interscale correlations on the EDI and because the authors directly suggest that the subscales be analyzed independently (Garner & Olmsted, 1984).

Results

A significant main effect for gender was found in the analysis of the overall EDI score, $F(1,3) = 18.155$, $p < .01$. The interaction between the main factors of gender and gender role was also significant, $F(3,3) = 2.750$, $p < .05$. The Student Neuman-Keuls procedure was employed to analyze the interaction effect, and it was found that the overall significance was due to the fact that Masculine women had significantly higher EDI sums than any of the other groups.

On the scale that most directly assesses eating behaviors, Bulimia, a significant interaction was found, $F(3,3) = 2.716$, $p < .05$; Masculine women again had the highest score. Both gender and gender role were significant on the Drive for Thinness scale, a scale related to weight preoccupation, $F(1,3) = 44.111$, $p < .05$ and $F(3,3) = 2.072$, $p < .05$, respectively. Women and Androgynous and Masculine groups had significantly higher scores. Undifferentiated and Feminine role groups of both sexes scored significantly higher on the Ineffectiveness scale, $F(3,3) = 4.957$, $p < .05$, while, conversely, Androgynous and Masculine groups in both sexes scored higher on the Perfectionism scale, $F(3,3) = 2.997$, $p < .05$. The cell means for each scale by gender are included in Table 1.

Discussion

These results support the body of literature (Lewis & Johnson, 1985; Sitnick & Katz, 1984; Timko et al., 1987) that challenges those role theories that view eating dysfunction as involving only conventional stereotypic feminine identification. In fact, on four of the five EDI scales on which effects were found, Masculine women had the highest scores or shared that position.

A review of group means (Table 1) reveals that men consistently scored lower than women across the scales. However, also evident from review of Table 1 is the fact that the pattern of relationships between gender role and eating factors overlap for men and women in areas that pertain to self-concept. For both sexes, masculinity and androgyny were associated with weight preoccupation (Drive for Thinness) and compulsivity/self-criticism (Perfectionism). For women, femininity also was associated with weight preoccupation and feelings of low self-esteem/efficacy (Ineffectiveness). For both men and women, an undifferentiated role identity was associated with ineffectiveness.

The data also suggest that gender/gender role/eating pattern relationships differ in men and women. It is plausible to view the disproportionate number of eating disorder patients who are women not as a function of the inherent "femaleness" of the disorders, but of the complex transitions of the female role in our culture. Perhaps men are underrepresented in the eating disorders because of the point of evolution of their gender role. As men more often watch their role models endorsing diet colas, dieting products, and sveltness, one wonders whether they, too, will fall prey to the sociocultural expec-

Table 1
Cell Means for EDI Scales by Gender

	Female			
	Role			
	Undifferentiated	Masculine	Feminine	Androgynous
Scale				
Bulimia	.72	6.40*	1.95	2.21
Drive for Thinness	3.07	9.80*	6.27*	7.13*
Body Dissatisfaction	10.21	17.30	15.30	12.16
Perfectionism	5.00	5.80*	5.60	7.74*
Ineffectiveness	3.93*	3.00	3.72*	2.00
	Male			
	Role			
	Undifferentiated	Masculine	Feminine	Androgynous
Scale				
Bulimia	1.82	1.19	.40	1.54
Drive for Thinness	1.06	1.61*	1.00	2.76*
Body Dissatisfaction	8.06	5.26	4.00	5.26
Perfectionism	5.41	7.45*	4.60	7.52*
Ineffectiveness	4.06*	1.61	4.60	2.24

*$p < .05$.

tations with regard to thinness. The current status of gender role issues and eating dysfunction in men affords the opportunity for the development of prevention models.

The differences found across the factors measured by the EDI support the contention that an understanding of eating dysfunction must incorporate intrapsychic and interpersonal concepts as well as behavioral patterns. Additionally, the confounding empirical results across the literature may be due in part to the differential influence of gender role across these factors.

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SUICIDE IDEATION AND COMMUNITY SUPPORT: AN EVALUATION OF TWO PROGRAMS

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Thirty-one suicidal French-Canadian men and women participated in a study of the differential effect of two community-based support programs on levels of self-esteem, stress, and suicide ideation. Results indicate that subjects in both programs reported an increase in self-esteem and a decrease in life stress and suicide ideation. The two social support approaches reflected in the respective programs did not result in relative differences in suicide ideation.

De Man, Balkou, and Iglesias (1987b) suggested that community-based, suicide-prevention programs that are designed to improve clients' self-esteem and stress management skills in addition to providing social support may be more successful in lowering clients' levels of suicide ideation than are intervention systems that are limited to offering social support. The present study concerned the development, introduction, and evaluation of such a fortified support program in cooperation with a community-based, suicide-prevention center.

People in suicidal crises who contacted the center for help and met certain criteria were offered the opportunity to participate in one of two short-term (maximum 12 weeks) support programs; that is, either the center's standard program of assistance that consisted of social support by trained community volunteers, or a program that, in addition to social support, provided help in improving self-esteem and stress management skills.

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