Challenging Stereotypes of Eating and Body Image Concerns Among College Students: Implications for Diagnosis and Treatment of Diverse Populations

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The authors describe a study that was conducted to provide better understanding of eating and body image concerns among clients in university counseling centers. First, they explored the prevalence of such concerns among stereotype-congruent (White, heterosexual, female) and stereotype-incongruent groups (e.g., ethnic/sexual minorities, men). Then, because some groups may use compensatory behaviors not adequately captured by current definitions of eating disorders, they specifically examined body image disturbance among these groups.

National, population-based studies have suggested that eating disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000) affect between 1% and 3% of women and less than .5% of men (e.g., Hudson, Hiripi, Pope, & Kessler, 2007). In their severe forms, eating disorders can cause debilitating medical problems (e.g., heart and kidney failure, electrolyte imbalance, osteoporosis, reproductive problems) and can even be fatal. What is more, these disorders often are associated with other serious psychological problems: They have been found to be correlated with most other *DSM-IV-TR* diagnoses as well as social role impairment (Hudson et al., 2007).

Eating disorders as well as eating and body image concerns more generally are notoriously present in college student populations (Hill, 2002). Additionally, given that individuals suffering from eating and body image disturbance often experience a great deal of shame, these concerns can go underreported (Costin, 2006), making it all the more important for clinicians who work with college student populations to assess for eating and body image concerns and to follow up on any indications that a client may be experiencing such difficulties.

Stereotypes and Assumptions About Who Is at Risk

The stereotypical individual suffering from an eating disorder is a young (mid- to late teens, early 20s), White, heterosexual female. In fact, eating disorders

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have been referred to as "a Western culture-bound syndrome" and linked to an emphasis on the thin female beauty ideal (Smolak & Striegel-Moore, 2001). Women are thought to internalize the thin ideal, compare themselves with it, and experience dissatisfaction with their bodies, thus placing them at risk for eating disorders (e.g., Stice, 2002). In support of this theory, the authors of one study found a dose–response relationship between sociocultural emphasis on thinness and the incidence of eating pathology within a population (Anderson & DiDomenico, 1992). Others have found that, on an individual level, women who adhered to the European American standards of female beauty were at greater risk for disordered eating (e.g., Hooper & Garner, 1986).

Individuals who do not fit this stereotype (men, sexual minority women, women of color) have traditionally been seen as "immune" to (or at least at far lower risk for) eating disorders. Within Western culture, the ideal of male attractiveness has not involved thinness, so the thin ideal is thought not to apply to men. Furthermore, there has been less emphasis traditionally on men's appearance as compared to that of women; therefore, it has been assumed that men are less susceptible to body image disturbance associated with eating disorders. It also has been assumed that lesbians do not share the same standards of beauty as heterosexual women do, placing them at lower risk for eating pathology (Feldman & Meyer, 2007). Women of color have also been thought to be at lower risk for eating disorders for several reasons. First, many non-Western societies traditionally have not valued thinness and instead have valued plumpness (associated with fertility and economic security), so women from these cultural backgrounds may have received different messages about what constitutes female beauty (Harris & Kuba, 1997). Women of color also may be less likely to identify with the women portrayed in the media (most of whom are White) and may, therefore, be at lower risk for the aforementioned eating and body image concerns (e.g., Rucker & Cash, 1992).

How Accurate Are These Assumptions?

Men

Most studies have demonstrated that heterosexual men are significantly less likely to have eating disorders than are other groups (see Feldman & Meyer, 2007). However, as we will discuss later in this article, it has been suggested that current ways of defining eating disorders may not apply as well to men and may, therefore, lead clinicians to miss significant body image disturbance and unhealthy compensatory behaviors in this population (e.g., Harvey & Robinson, 2003).

Most of the aforementioned studies also demonstrated that the incidence of eating and body image concerns among gay men was comparable to that of heterosexual women, leading some to speculate that being attracted to men may be a risk factor for the development of eating disorders (see Feldman &

Meyer, 2007). Although less research has been done involving bisexual men, findings also seemed to indicate that rates of eating and body image disturbance in this population was significantly higher than those in the heterosexual male population (Feldman & Meyer, 2007).

Sexual Minority Women

Although a number of studies have been conducted to explore the incidence of eating disorders in sexual minority women, the results of these studies have been far more inconclusive. Some have shown that the incidence in lesbians and bisexual women was lower than that reported for heterosexual women (e.g., Strong, Williamson, Netemeyer, & Geer, 2000). Other researchers found no difference in incidence between these groups (e.g., Share & Mintz, 2002). One study demonstrated higher rates among lesbians as compared with heterosexual women (Wichstrom, 2006). Finally, another study suggested that bisexual and "mainly heterosexual" women may be at higher risk for these disorders than are both "exclusively heterosexual" women and lesbians (Polimeni, Austin, & Kavanagh, 2009). In response to the discrepancies among these findings, some researchers have suggested that involvement in the lesbian/bisexual community may moderate the relationship between sexual minority status and eating and body image disturbance, with greater identification and involvement in the community associated with lower rates of eating pathology (Ludwig & Brownell, 1999). Regardless of the discrepancies, however, it is important to note that no studies have shown an absence of eating disorders in sexual minority women.

Ethnic Minority Women

The results of studies that examined the rates of eating and body image concerns among ethnic minority women have also been inconclusive. A number of studies have indicated that ethnic minority women in Western countries are at lower risk for eating pathology than White women are (e.g., Altabe, 1998; Lake, Staiger, & Glowinski, 2000). Others have demonstrated comparable rates between groups (e.g., French et al., 1997). Some have shown comparable rates between White, Latina, and Asian women but lower rates for Black women (Bay-Cheng, Zucker, Stewart, & Pomerleau, 2002). Still others have shown higher rates among ethnic minority women, especially when looking at subthreshold eating disturbance (e.g., McCourt & Waller, 1995). Explanations for these discrepancies have been proposed; for instance, it has been suggested that racial/ethnic identity development may moderate the relationship between racial/ethnic identity and eating and body image disturbance (Harris & Kuba, 1997). However, again, despite these inconclusive results, it is notable that no studies have shown an absence of eating pathology among ethnic minority women, and studies consistently show higher rates than may have been assumed previously.

Why Is It Important to Question This Stereotype?

Given that clients may underreport symptoms because of shame or ambivalence around wanting to change unhealthy compensatory behaviors, it is important that clinicians recognize and follow up on any signs of eating and body image disturbance. However, when a client is a member of a stereotype-incongruent group, clinicians may be less able to recognize symptoms for what they are. (Social psychologists call this phenomenon "counter-factual thinking"; e.g., see Mandel, Hilton, & Catellani, 2005). Gordon, Perez, and Joiner (2002) found that undergraduate students were more likely to recognize an eating disorder in a description of a peer when the peer was described as Caucasian rather than African American or Hispanic. Other studies have demonstrated such a bias among clinicians as well. For example, among women who had taken part in the 1996 National Eating Disorders Screening Program, Becker, Franko, Speck, and Herzog (2003) found that Latina and Native American women were significantly less likely than White women to have received a referral for further evaluation or care, despite reporting comparable symptoms. They also found that even when women of color self-acknowledged eating concerns, they were less likely than White participants to have been asked by a doctor about such symptoms. Additionally, Hermes (2007) conducted a study with physicians, asking them to read a fictional student diary and indicate what problems they thought the student was experiencing. The sex and race of the fictional student were experimentally manipulated, and results demonstrated that eating disorder symptoms in Black men and women and in White men often went unrecognized by physicians, whereas the same symptoms in White women were seen as indicators of pathology. These findings suggest that, even among health professionals, symptoms of eating disturbance displayed by a stereotype-incongruent individual may not elicit the same concern as these same symptoms do in a stereotype-congruent individual.

Furthermore, members of stereotype-incongruent groups may be less likely to seek help for eating and body image concerns than are other groups. They may be less likely to view their symptoms as problematic until they are more severe (Silber, 1986), and stigma may make them hesitate to seek treatment. A man, for example, may hesitate to seek treatment for what he sees and expects others to see as a woman's problem (Harvey & Robinson, 2003). Therefore, the possibility that clinicians might miss signs of eating disturbance in these individuals is even more concerning.

The present study is aimed at better understanding eating and body image concerns among clients seeking services at university counseling centers. First, we explored the prevalence of such concerns among both stereotype-congruent and stereotype-incongruent groups. Then, using evidence that current ways of defining eating disorders may cause clinicians to miss significant problems, especially in men, we conducted a close examination of body image disturbance in this group.

The Present Study: Part 1

The first goal of this study was to describe the population of students presenting with eating and body image concerns at university counseling centers in order to test and potentially challenge stereotypes and to raise awareness about prevalence in stereotype-incongruent groups.

Method

Participants. We used data from a pilot study conducted as part of the Center for Collegiate Mental Health, described in detail by Hayes, Locke, and Castonguay (2011; this issue). That article provides detailed information about participant characteristics. International students (comprising 4% of the sample) were not included in these analyses. Because meaningful differences in eating disturbance have been found between ethnic minority groups in the United States and individuals from other countries (e.g., between Asian Americans and Asians; Cummins, Simmons, & Zane, 2005), their inclusion would have added an additional layer of complexity that was beyond the scope of this article.

Measures. Each contributing counseling center collected standardized data using two instruments as part of their routine clinical procedure at intake. The first measure, the Standardized Data Set (SDS; see Hayes et al., 2011), contains demographic questions and questions about mental health history. Questions from the SDS that are relevant to this study included questions about gender (male, female, transgender, or prefer not to answer), sexual orientation (heterosexual, gay, lesbian, bisexual, questioning, or prefer not to answer), and race/ethnicity (African American/Black, American Indian or Alaska Native, Arab American, Asian American/Asian, East Indian, European American/White/Caucasian, Hispanic/Latino(a), Native Hawaiian/Pacific Islander, multiracial, prefer not to answer, or other).

The second measure, the Counseling Center Assessment of Psychological Symptoms (CCAPS; see Hayes et al., 2011), also was included in routine intake procedures by participating centers. This measure contains 70 items, and students are asked to respond by indicating how well each statement describes them within the past 2 weeks. Responses are made on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely well*). Subsequent factor analyses, retest reliability studies, focus group research, and other such studies revealed eight factors underlying 62 of the 70 items. These eight factors measure depression, generalized anxiety, eating concerns, substance use, hostility, family distress, social anxiety, and academic distress. For the purposes of these analyses, only the Eating Concerns subscale was used. It consists of the following items: (a) I think about food more than I would like to; (b) I feel out of control when I eat; (c) I eat too much; (d) When I start eating, I can't stop; (e) I diet frequently; (f) The less I eat, the better I feel about myself; (g) I am dissatisfied with my weight; (h) I am satisfied with my body

shape (reverse scored); and (i) I purge to control my weight. Each item is given a score between 0 and 4. Scores across items within the subscale are then averaged for a subscale score ranging from 0 to 4. The CCAPS Eating Concerns subscale has been found to have high internal consistency ($\alpha = .883$) and to be highly correlated with the Eating Attitudes Test (EAT-26; Mintz & O'Halloran, 2000), one of the most widely used self-report measures of eating problems ($r = 0.648$, $p \leq .001$; Locke et al., 2011).

Analyses. Analyses of these data were performed to test for rates of eating concerns among different demographic groups. Frequencies were conducted for students endorsing "moderate" levels of eating concerns (defined as ≥2 on the Eating Concerns subscale) or "high" levels of eating concerns (defined as ≥3 on the Eating Concerns subscale). The statistical significance of differences between groups was determined using the chi-square test of independence.

Results

Gender. First, we examined rates of moderate to high levels of eating and body image concerns by gender. Frequencies for each group can be seen in Table 1. Rates for women were significantly higher than those for men at both moderate, $\chi^2(1, N = 16{,}235) = 505.10$, $p < .001$, and high, $\chi^2(1, N = 16{,}235) = 112.43$, $p < .001$, levels. Numbers of transgender students were too low to determine whether differences between this group and the others were significant.

Gender and sexual orientation. Next, we divided gender groups on the basis of sexual orientation. Frequencies for each group can be seen in Table 1. Rates of eating concerns for heterosexual women were significantly higher than those of lesbian women at a moderate level, $\chi^2(1, N = 8{,}631) = 5.01$, $p = .025$, and at

TABLE 1

Prevalence Rates for Moderate and High Levels of Eating and Body Image Concerns by Gender and Sexual Orientation

	Moderate Levels of Eating Concerns		High Levels of Eating Concerns	
Variable	***n***	**%**	***n***	**%**
Gender				
Women (*N* = 10,562)	1,811	17.1	315	3.0
Men (*N* = 5,673)	271	4.8	27	0.5
Transgender (*N* = 27)	2	7.4	0	0.0
Gender and sexual orientation				
Heterosexual women (*N* = 8,454)	1,447	17.1	262	3.1
Lesbian women (*N* = 177)	19	10.7	0	0.0
Bisexual women (*N* = 346)	57	16.5	10	2.9
Questioning women (*N* = 124)	32	25.8	6	4.8
Heterosexual men (*N* = 4,548)	170	3.7	15	0.3
Gay men (*N* = 290)	51	17.6	6	2.1
Bisexual men (*N* = 69)	2	2.9	1	1.4
Questioning men (*N* = 47)	5	10.6	0	0.0

Note. Moderate and high are defined as ≥2 and ≥3, respectively, on the Eating Concerns subscale of the Counseling Career Assessment of Psychological Symptoms.

a high level, $\chi^2(1, N = 8{,}631) = 5.66$, $p = .017$, but did not differ significantly from those of bisexual women at either level. Rates for questioning women were significantly higher than those for heterosexual women at a moderate level, $\chi^2(1, N = 8{,}578) = 6.47$, $p = .011$, but not at a high level. Rates for questioning women were also significantly higher than those for bisexual women at a moderate level, $\chi^2(1, N = 470) = 5.18$, $p = .023$, but not at a high level and were higher than they were for lesbians at both moderate, $\chi^2(1, N = 301) = 11.77$, $p = .001$, and high levels, $\chi^2(1, N = 301) = 8.74$, $p = .003$. Rates for bisexual women were also significantly higher than those for lesbians at high levels, $\chi^2(1, N = 523) = 5.22$, $p = .022$, but not at moderate levels.

Rates of eating concerns for gay men were significantly higher than those for heterosexual men at both moderate levels, $\chi^2(1, N = 4{,}838) = 119.93$, $p < .001$, and high levels, $\chi^2(1, N = 4{,}838) = 19.08$, $p < .001$. They were also significantly higher than those for bisexual men at moderate levels, $\chi^2(1, N = 359) = 9.56$, $p = .002$, but not at high levels. Bisexual and heterosexual men did not differ significantly at either level. Rates for questioning men did not differ significantly from the rates for either bisexual or gay men at either level but were significantly higher than those for heterosexual men only at the moderate level, $\chi^2(1, N = 4{,}595) = 6.05$, $p = .014$.

Rates of eating concerns for heterosexual women were significantly higher than the rates for heterosexual men at both a moderate level, $\chi^2(1, N = 13{,}002) = 486.01$, $p < .001$, and at a high level, $\chi^2(1, N = 13{,}002) = 108.77$, $p < .001$. The rates were also significantly higher than those for bisexual men at a moderate level, $\chi^2(1, N = 8{,}523) = 9.80$, $p = .002$, although not at a high level. Rates for heterosexual women did not differ significantly from those for either gay men or questioning men at either level. Rates for lesbian women were significantly higher than those of heterosexual men at a moderate level, $\chi^2(1, N = 4{,}725) = 21.72$, $p < .001$, although not at a high level.

Race/ethnicity within heterosexual women. Next, heterosexual women were analyzed on the basis of race/ethnicity. (Only White, Black, Latina, and Asian American women were included because of inadequate sample size in other groups.) Frequencies for each group can be seen in Table 2. White women reported higher rates than did participants in all other groups at both moderate and high levels. However, differences in these rates at the moderate level were only significant for White women and Black women, $\chi^2(1, N = 6{,}780) = 11.08$, $p = .001$, and White women and Asian women, $\chi^2(1, N = 6{,}504) = 4.95$, $p = .026$. Differences in these rates at the high level were significant only for White women and Black women, $\chi^2(1, N = 6{,}780) = 5.45$, $p = .020$. The difference was also close to significant at the high level for White women and Latina women, $\chi^2(1, N = 6{,}548) = 3.63$, $p = .057$. No other between-group differences were significant.

Discussion: Part 1

As found in previous studies (e.g., see Feldman & Meyer, 2007) heterosexual women and gay men in this study reported comparable levels of eating concerns.

TABLE 2

Prevalence Rates for Moderate and High Levels of Eating and Body Image Concerns for Heterosexual Women by Ethnic Group

	Moderate Levels of Eating Concerns		High Levels of Eating Concerns	
Variable	***n***	**%**	***n***	**%**
Women				
White/Caucasian (*N* = 6,172)	1,114	18.0	210	3.4
Black/African American (*N* = 608)	77	12.7	10	1.6
Hispanic/Latina (*N* = 376)	56	14.9	6	1.6
Asian/Asian American (*N* = 332)	44	13.3	8	2.4
Multiracial (*N* = 261)	41	15.7	7	2.7

Note. Moderate and high are defined as ≥2 and ≥3, respectively, on the Eating Concerns subscale of the Counseling Career Assessment of Psychological Symptoms.

Heterosexual women reported significantly higher levels of eating concerns than did lesbian women. Bisexual women reported levels of eating concerns that did not differ significantly from those of heterosexual women and were significantly higher than those of lesbians at the high level. It is interesting that questioning women reported levels that were significantly higher than those of heterosexual women (and every other group) at the moderate level. This finding is consistent with research suggesting that identity confusion or conflict may be a risk factor for eating concerns (e.g., Hooper & Garner, 1986) and is also in line with the research that we discussed earlier in this article, which suggests that identification with the lesbian, gay, bisexual, and transgender community may serve as a protective factor, assuming that questioning women are less identified with this community than lesbian or bisexual women are.

Also consistent with previous research, gay men reported significantly higher levels of eating concerns than did heterosexual men. As in the case of bisexual women, bisexual men appeared to be more similar to heterosexual men than to gay men in their levels of eating concerns. Bisexual men did not differ significantly from heterosexual men in their reported levels of eating concerns at the moderate level, although they did report significantly higher rates at the high level, where they did not differ significantly from gay men. Questioning men also seemed to be at greater risk than at least heterosexual and bisexual men, although still at significantly lower risk than were gay men. Across these findings, female gender, attraction to men, and questioning one's sexual orientation were prominent as significant risk factors for eating and body image disturbance.

For heterosexual women, somewhat higher levels of eating and body image concerns were found among White women than among Asian American and Black women; however, the levels of concern for Asian American and Black women were not significantly higher than they were for Latina or multiracial women, and no other significant differences were found between ethnic groups.

Implications for Practice

As discussed earlier in this article, stereotypes about clients with eating and body image concerns have the potential to have an impact on clinicians' interpretation of clients' presentation and their likelihood of asking or following up on significant problem areas. These stereotypes may also affect stereotype-incongruent clients' likelihood of seeking help or reporting their concerns, making it all the more important for clinicians to be vigilant in assessing for them. Although the results of the present study confirmed that there were meaningful differences between groups with regard to these concerns, they also demonstrated that no group was immune to such difficulties, and many stereotype-incongruent groups experienced these concerns at higher levels than has been assumed previously. Furthermore, some stereotype-incongruent groups (notably, gay men, questioning women and men, ethnic minority women) demonstrated levels of eating concerns that were comparable to or even higher than those for the stereotype-congruent group.

The Present Study: Part 2

Consistent with previous findings (e.g., see Feldman & Meyer, 2007), heterosexual men in the present study reported significantly lower levels of eating and body image disturbance than did participants in almost all other groups. However, as previously mentioned, there is some evidence to suggest that current methods of defining eating pathology may be less applicable to men and, therefore, may result in clinicians missing significant body image disturbance and unhealthy compensatory behaviors in men. During the past 25 years, changes in media depictions of men, which focus on a muscular ideal, have been associated with increasing the rate of body dissatisfaction among men (e.g., see Harvey & Robinson, 2003). However, men are less likely to be concerned with losing weight or becoming thin (characteristics often thought to be necessary for the diagnosis of an eating disorder) and may instead be more concerned with building muscle (Harvey & Robinson, 2003). Men, therefore, may be less likely to endorse symptoms of wanting to lose weight or being overly concerned with body weight and may be more likely to express concern about body shape or muscle mass.

Several studies have demonstrated that men at risk for eating disorders are less likely than women to engage in oral control or oral compensatory behaviors (e.g., restricting food intake, vomiting) and more likely to engage in excessive exercise to control their body weight or shape (e.g., see Gadalla, 2009). Furthermore, a number of studies have suggested that rigid commitment to physical exercise may be a predictor, risk factor, and/or symptom of eating pathology in men (e.g., McLaren, Gauvin, & White, 2001). Men may also be more likely to abuse steroids or other dietary supplements in an attempt to build muscle (Harvey & Robinson, 2003). Nonetheless, many self-report measures of eating concerns, including the Eating Concerns subscale of the

CCAPS (and the EAT-26), do not include questions about excessive exercise or steroid/supplement use and thus may miss important aspects of such disturbance in the male population.

The second aim of this study was to take a closer look at men's (and women's) responses to specific questions on the CCAPS Eating Concerns subscale. Because this subscale primarily comprises items related to eating (e.g., "I think about food more than I would like to" or "I eat too much") or oral compensatory behaviors (e.g., "I purge to control my weight" or "The less I eat, the better I feel about myself"), individuals with significant body image disturbance who engage in compensatory behaviors not identified in these items (e.g., excessive exercise, steroid use) may have lower scores on this subscale than the significance of their disturbance would warrant. We hypothesized that looking only at those items having to do with body dissatisfaction ("I am dissatisfied with my weight" and "I am satisfied with my body shape") might provide a better sense of rates of these types of difficulties in the male population.

Method

Participants and measures were the same as those described in The Present Study: Part 1 section of this article. Frequencies were conducted for students endorsing individual items at moderate levels (i.e., ≥2) or high levels (i.e., ≥3). The statistical significance of differences between groups was determined using a chi-square test of independence.

Results

Weight dissatisfaction. First, we looked at the specific item, "I am dissatisfied with my weight," at moderate and high levels for men, broken down by sexual orientation. For a comparison, we also completed the same analyses for women. Frequencies for each group can be seen in Table 3. Rates of weight dissatisfaction were significantly lower for heterosexual men than they were for gay men at both a moderate level, $\chi^2(1, N = 4{,}821) = 50.59$, $p < .001$, and a high level, $\chi^2(1, N = 4{,}821) = 58.58$, $p < .001$. Rates for heterosexual men were also significantly lower than they were for questioning men at a moderate level, $\chi^2(1, N = 4{,}579) = 7.08$, $p = .008$, but not at a high level. No significant differences were found between heterosexual and bisexual men at either level. Gay men reported significantly higher rates than did bisexual men at both a moderate level, $\chi^2(1, N = 358) = 7.52$, $p = .006$, and a high level, $\chi^2(1, N = 358) = 6.37$, $p = .012$. Rates for heterosexual women were significantly higher than they were for heterosexual men at both a moderate level, $\chi^2(1, N = 12{,}964) = 570.06$, $p < .001$, and a high level, $\chi^2(1, N = 12{,}964) = 476.63$, $p < .001$. No significant differences were found between heterosexual women and gay men at either level.

Body shape dissatisfaction. Next, we looked at the specific item, "I am satisfied with my body shape" (reverse scored), at moderate and high levels for men, analyzed by sexual orientation. Again, for comparison, we then completed the

TABLE 3

Prevalence Rates for Moderate and High Levels of Weight and Body Shape Dissatisfaction by Gender and Sexual Orientation

	Moderate Levels of Dissatisfaction		High Levels of Dissatisfaction	
Variable	***n***	**%**	***n***	**%**
Weight dissatisfaction				
Heterosexual men (*N* = 4,532)	1,655	36.5	923	20.4
Gay men (*N* = 289)	166	57.4	114	39.4
Bisexual men (*N* = 69)	27	39.1	16	23.2
Questioning men (*N* = 47)	26	55.3	14	29.8
Heterosexual women (*N* = 8,432)	4,933	58.5	3,307	39.2
Lesbian women (*N* = 177)	100	56.5	62	35.0
Bisexual women (*N* = 344)	197	57.3	141	41.0
Questioning women (*N* = 124)	84	67.7	67	54.0
Body shape dissatisfaction				
Heterosexual men (*N* = 4,532)	2,427	53.5	1,286	28.4
Gay men (*N* = 290)	224	77.2	158	54.5
Bisexual men (*N* = 69)	40	58.0	25	36.2
Questioning men (*N* = 47)	33	70.2	25	53.2
Heterosexual women (*N* = 8,437)	5,701	67.6	3,558	42.2
Lesbian women (*N* = 177)	144	64.4	68	38.4
Bisexual women (*N* = 346)	220	63.6	139	40.2
Questioning women (*N* = 124)	90	72.6	63	50.8

Note. Moderate and high are defined as ≥2 and ≥3, respectively, on the Eating Concerns subscale of the Counseling Career Assessment of Psychological Symptoms.

same analyses for women. Frequencies for each group can be seen in Table 3. Rates of body shape dissatisfaction were significantly lower for heterosexual men than they were for gay men at both a moderate level, $\chi^2(1, N = 4{,}821) = 62.03$, $p < .001$, and a high level, $\chi^2(1, N = 4{,}821) = 88.77$, $p < .001$. Rates were also significantly lower for heterosexual men than they were for questioning men at both a moderate level, $\chi^2(1, N = 4{,}583) = 5.22$, $p = .022$, and a high level, $\chi^2(1, N = 4{,}583) = 14.06$, $p < .001$. No significant differences were found between heterosexual and bisexual men at either level. Gay men reported significantly higher rates of eating and body concerns than did bisexual men at both a moderate level, $\chi^2(1, N = 359) = 10.64$, $p = .001$, and a high level, $\chi^2(1, N = 359) = 7.43$, $p = .006$. Rates for heterosexual women were significantly higher than those for heterosexual men at both a moderate, $\chi^2(1, N = 12{,}973) = 249.44$, $p < .001$, and a high level, $\chi^2(1, N = 12{,}973) = 240.83$, $p < .001$. Finally, rates for gay men were significantly higher than those for heterosexual women at a moderate level, $\chi^2(1, N = 8{,}727) = 12.03$, $p = .001$, and a high level, $\chi^2(1, N = 8{,}727) = 17.38$, $p < .001$.

Discussion: Part 2

Again, the results confirmed that there were meaningful differences in body weight and shape dissatisfaction between groups. Heterosexual men reported

lower rates of body weight and shape dissatisfaction than did all groups of women. They also reported lower rates than did both gay and questioning men. However, these findings also highlight the fact that all groups have rather high rates of serious body image disturbance. More than half the heterosexual men endorsed body shape dissatisfaction at a moderate level, and more than a quarter endorsed it at a high level.

Consistent with previous research, more men endorsed dissatisfaction with their body shape than with their weight. Although this was also true for women, differences between ratings of shape and weight dissatisfaction were larger for men than they were for women. In fact, gay men and heterosexual women did not differ significantly in weight dissatisfaction; however, gay men reported significantly higher rates of body shape dissatisfaction than did heterosexual women. This emphasis on shape over weight seems consistent with assertions that men may be less likely to engage in oral compensatory behaviors to alter their weight and more likely to engage in body building or other behaviors intended to alter body shape.

Implications for Practice

Although heterosexual men in this population were less likely than other groups to report eating and body image concerns overall (as assessed by the CCAPS Eating Concerns subscale), their levels of body image dissatisfaction should be cause for some concern, especially in light of evidence that they may be more likely to engage in compensatory methods not adequately captured by the CCAPS. Body image dissatisfaction alone does not necessarily mean that an individual will engage in unhealthy compensatory behaviors; however, it is a significant risk factor (McLaren et al., 2001). Thus, in the absence of information about other types of compensatory behaviors, clinicians should be concerned that eating and body image disturbance may be a more significant problem for a larger proportion of this population than previously assumed. This provides further evidence that therapists should be vigilant in assessing for such disturbances with all clients, not just those who fit the aforementioned stereotype.

Limitations and Directions for Future Research

The studies presented here do have several limitations. A primary limitation is the fact that the CCAPS does not currently include items that would allow for the exploration of other forms of compensatory behavior (e.g., excessive exercise), as discussed in Part 2. Findings from this study suggest that the inclusion of such items in future versions of the CCAPS may improve its utility in assessing eating and body image disturbance, especially in men.

The fact that cutoff scores for moderate and high levels of eating and body image disturbance used in this study are not linked to known levels of pathology is an additional limitation. Future work to determine cutoff scores associated with such levels of pathology would improve understanding of the significance of the disturbance reported in this population.

However, we believe that these cutoffs—the top half and top quarter of the scale—give reasonable approximations for how significant a role these concerns play in a student's life and, therefore, how much they may warrant clinical attention.

Additional limitations include the fact that we were unable to compare prevalence rates for some groups for whom we did not have an adequate sample size, including transgender individuals and those from several ethnic groups. Also, for reasons discussed earlier, we also did not include data for international students in these analyses, so the applicability of these findings to international students is currently unknown.

Future studies should be conducted to explore other types of compensatory behaviors that may better represent eating disorders (although they may have less to do with eating) in men and other nonstereotypical populations. Such studies will help researchers and clinicians better understand the phenomenology of these types of disturbances across the full range of students seeking services in university counseling centers. It would also be beneficial to explore how the use of instruments like the CCAPS may assist clinicians in more comprehensively assessing for eating and body image concerns among stereotype-incongruent clients.

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