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Body Image Concerns of Gay Men: The Roles of Minority Stress and Conformity to Masculine Norms

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The authors hypothesized that gay men's experiences of minority stress and their conformity to masculine norms would be associated with increased body image dissatisfaction and masculine body ideal distress. For this cross-sectional study, 357 gay males completed a Web-based survey, and 2 multiple regression analyses indicated that minority stress factors (i.e., internalized homophobia, expected stigma for being gay, and experiences of physical attack) were associated with body image dissatisfaction and masculine body ideal distress, accounting for 5% and 13% of the variance, respectively. Gay men's conformity to masculine norms was not associated with body image dissatisfaction but did uniquely explain an additional 3% of variance in masculine body ideal distress scores. The utility of the minority stress model, how traditional masculinity may contribute to gender-related presenting concerns, suggestions for developing and evaluating remedial and preventive interventions, limitations, and future research issues are discussed.

Keywords: minority stress, gay men, body image, masculinity

Gay men tend to report greater body dissatisfaction, body-related distress, eating-disordered behavior, and poorer body image than do heterosexual men (Beren, Hayden, Wilfley, & Grilo, 1996; French, Story, Remafedi, & Resnick, 1996; Lakkis, Ricciardelli, & Williams, 1999; Russell & Keel, 2002; Siever, 1994). One theoretical framework that might be useful in explaining body dissatisfaction in gay men is Meyer's (1995) minority stress model. The model posits that, "gay people, like members of other minority groups, are subjected to chronic stress related to this stigmatization" (p. 38), and describes internalized homophobia, expectations of stigma, and prejudicial events such as violence as distal and proximal sources of stress. Internalized homophobia is the degree to which a gay man internalizes the antigay sentiments of the larger heterosexual society and represents an internal form of stress (Gonsiorek, 1993; Meyer, 1995, 2003). Expectations of stigma represent the gay man's anticipation that he will be rejected and discriminated against by society because of his sexual orientation (Meyer, 1995, 2003). Experiencing prejudicial events such as antigay attacks is another factor contributing to minority stress affecting gay men. Such victimization is seen as interfering with the perception of the world as meaningful and orderly and leading to victims' sense of the world as insecure and of themselves as vulnerable (Garnets, Herek, & Levy, 1990). Research supports that these factors predict mental health distress for lesbian, gay and bisexual men and women (Cochran & Mays, 1994; D'Augelli & Hershberger, 1993; Diaz, Ayala, Bein, Jenne, & Marin, 2001; Herek, Gillis, & Cogan, 1999; Meyer, 1995; Waldo, 1999).

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One of our purposes in this study was to determine whether the minority stress model may be useful in explaining gay men's body image concerns. Supporting this idea, some scholars speculate that gay men who internalize homophobic attitudes and have greater expectations of being stigmatized for being gay may desire a powerful physique as a form of defense against the experience of prejudice from others or may develop a negative body image as a result of their own internalized shame (Williamson, 1999). Being a victim of an antigay attack may also lead to a greater desire for a more powerful physique as a mechanism through which gay men can feel safer from and more powerful against future antigay attacks and discrimination, as has been speculated to be true for some lesbians (Crowder, 1998). In this way, experiences of minority stress may put gay men at greater risk for body image concerns.

Because gay men's experiences reflect both being gay and being men, the second purpose of our study was to examine whether the model should incorporate gay men's conformity to masculine norms as a factor contributing to mental health concerns for gay men. Support for the idea of incorporating masculinity into understanding gay men's body image concerns comes from scholars who suggest that gay men may seek ways to compensate for perceptions that they are less masculine. These scholars suggest that desiring a powerful masculine physique is often a defensive reaction to the dominant society's stigmatization of them as "unmanly" (Pope, Phillips, & Olivardia, 2000; Signorile, 1997). From a gender role discrepancy strain perspective (Pleck, 1995), perceiving oneself as violating gender role norms is stressful for traditional men. Thus, we posited that traditionally masculine gay men are more likely to overconform to cultural norms to be physically powerful, leading to body image concerns, generally, as well as to masculine body ideal distress, defined as stress from failing to meet the ideal of muscular masculine body (Kimmel & Mahalik, 2004). We hypothesized that gay men who experience

greater minority stress comprising higher levels of internalized homophobia, perceived stigma, and experience of antigay physical attacks, and who report higher levels of conformity to masculine norms, will report increased body image dissatisfaction and masculine body ideal distress. We examined both general body image dissatisfaction as well as distress associated with not meeting the masculine body ideal to represent more adequately the construct of body image concerns for gay men.

Method

Participants

Participants were 357 gay men who were mostly White ($n = 312$, 87%; Latino $n = 20$, 6%; Asian American $n = 8$, 2%; multiracial $n = 7$, 2%; African American or Black $n = 4$, 1%; Native American $n = 2$, 0.6%; and Other $n = 4$, 1%) and averaged 34.85 years of age ($SD = 12.38$, *range* = 18 – 74). Participants averaged being "out" about their sexual orientation for 11.31 years ($SD = 9.84$, range = 0 months to 50 years). Most reported being single ($n = 191$, 54%; partnered and living together $n = 79$, 22%; partnered but not living together $n = 49$, 14%; or married, civil union or ceremonially committed $n = 37$, 10%) and having a graduate degree ($n = 131$, 37%; college degree $n = 116$, 33%; some college $n = 92$, 26%; high school degree $n = 13$, 4%; or no high school degree $n = 3$, 1%). Participants' median income was $35,000.

Measures

The Body Image Ideals Questionnaire (BIQ; Cash & Szymanski, 1995) assesses one's degree of body image satisfaction by measuring the degree of discrepancy between self-perceived physical attributes and idealized physical attributes, while also considering the importance of each of these physical ideals to the person. The measure consists of 22 items assessing 11 physical attributes (e.g., weight, facial features, muscle tone/definition, overall appearance). For 11 items, participants rate how much they resemble their personal physical ideal on a 4-point scale ranging from 1 (*exactly as I am*) to 4 (*very unlike me*) and then rate how important that personal ideal is to them on a 4-point scale ranging from 1 (*not important*) to 4 (*very important*). A multiplicative composite score is derived by determining the mean of the 10 Discrepancy × Importance cross-products (Cash & Szymanski, 1995). Composite scores can range from −3, indicating congruence across physical attributes, to 9, indicating discrepancies across physical attributes. Evidence for validity includes significant correlations with the Body Areas Satisfaction Scale, the Situational Inventory of Body-Image Dysphoria, the Appearance Schemas Inventory, the Bulimia Test Revised, and the Eating Attitudes Test (Cash & Szymanski, 1995; Szymanski & Cash, 1995). Reported α for the BIQ was .81 for men (Cash & Szymanski, 1995). In the current study, α was .87.

The Masculine Body Ideal Distress Scale (MBIDS; Kimmel & Mahalik, 2004) is an 8-item scale that measures the amount of distress one associates with failing to meet the ideal of having a muscular masculine body. The person rates how much distress they would experience if the items described their current physical appearance, using a 4-point scale ranging from 1 = *not distressing at all* to 4 = *very distressing* (e.g., "How much distress would you experience if your pectoral muscles were flabby?"). Scores can range from 8 to 32. Research reports the MBIDS to be composed of one factor with scores related to greater general body dissatisfaction and greater conformity to traditional masculine norms, with a coefficient alpha of .80 (Kimmel & Mahalik, 2004). In the current study, coefficient α was .89.

The Internalized Homophobia Scale (IHP; Martin & Dean, 1987) is a 9-item scale assessing the extent to which gay men are uneasy about their homosexuality and seek to avoid homosexual feelings. Items include "How often have you wished you weren't gay?" and are answered on a 5-point Likert-type scale ranging from 1 (*never*) to 4 (*often*). Scores can range from 9 to 36. The IHP scale has adequate internal consistency ratings ($\alpha = .79$) and was significantly correlated negatively with collective self-esteem, importance attached to community involvements, disclosure of sexual orientation to heterosexual friends, and satisfaction with the local gay/bisexual community; men scored significantly higher than women, and bisexuals scored significantly higher than homosexuals (Herek & Glunt, 1995). Higher IHP scores also significantly relate to demoralization, guilt, sex problems, suicidal ideation/behavior and AIDS-related traumatic stress response for gay men (Meyer, 1995). In the present study, α was .86.

The Stigma Scale (SS; Martin & Dean, 1987) assesses expectations of rejection and discrimination regarding homosexuality by using 11 items (e.g., "Most people would willingly accept a gay man as a close friend") answered on a 6-point Likert-type scale (1 = *strongly disagree*, 6 = *strongly agree*). Scores can range from 11 to 66. Higher scores on the SS relate significantly (a) to psychological distress for gay men, including demoralization, guilt, suicidal ideation, and behavior- and AIDS-related traumatic stress response and (b) to the degree to which gay men disclose their homosexuality to others (Meyer, 1995). Martin and Dean (1987) reported α as .86. In the present study, α was .89.

For a history of antigay physical attack, we used a single-item question to assess whether participants had been physically attacked because of their perceived sexual orientation: "Have you ever been physically attacked because of your sexual orientation?" Meyer (1995) used a similar single item question to determine gay men's experiences of prejudice in his research on minority stress and mental health in gay men. History of an antigay physical attack was scored as 2 for participants who had experienced an act of physical violence because of their sexual orientation and as 1 for those who had not. Previous research reported that experience of prejudicial events within the past year significantly predicted four measures of psychological distress including demoralization, guilt, suicidal ideation and behavior, and AIDS related traumatic stress response (Meyer, 1995).

The Conformity to Masculine Norms Inventory (CMNI; Mahalik et al., 2003) was used to measure conformity to traditional masculine norms in the dominant culture in U.S. society. The CMNI consists of 94 items answered on a 4-point scale (0 = *strongly disagree*, 3 = *strongly agree*) with factor analysis indicating that the CMNI has 11 distinct factors labeled as Winning, Emotional Control, Risk-Taking, Violence, Dominance, Playboy, Self-Reliance, Primacy of Work, Power Over Women, Disdain for Homosexuals, and Pursuit of Status (Mahalik et al., 2003). Scores on the CMNI range from 0 to 282. In this study, only the CMNI total score was used after we subtracted the Disdain for Homosexuals subscale score from the total to correct for the overlap in content between the CMNI total score and the score for for the Internalized Homophobia scale described earlier. Mahalik et al. (2003) reported that α was .94 for the CMNI total score with a test–retest coefficient over a 2- to 3-week period of .96. Mahalik et al., (2003) reported that CMNI scores significantly related positively to other masculinity related measures, as well as to psychological distress, social dominance, and aggression. In the present study, $\alpha = .91$ for the CMNI total score (corrected).

Procedure

Moderators of 33 gay Web-based discussion groups were contacted to ask permission to post a description of the study. Of these, 12 never responded, but 21 gave permission to post a description of the study, as well as the Internet address of the survey. The study's main purpose was described as examining body image issues in the gay community. Participants were not reimbursed for their participation.

Four hundred seventy-four respondents logged onto the Internet address. Of those, 117 (25%) were eliminated: 4 (1%) because they identified their gender as female; 10 (2%) because they logged onto the survey but did not complete any of the survey information; 60 (13%) because they filled out

only the demographics portion of the survey; and 43 (9%) because they identified their sexual orientation as bisexual, questioning, or "other." The 357 retained for the analyses identified themselves as gay males and completed the demographics section of the survey and the four structured questionnaires.

Results

A comparison of means and standard deviations with other samples using the measures in our study (see Table 1) indicated that our sample was (a) within one half a standard deviation of heterosexual men on the BIQ (Cash & Szymanski, 1995) and MBIDS (Kimmel & Mahalik, 2004), (b) within half a standard deviation of gay men on the IHP scale, (c) within one standard deviation of gay men on the SS (Meyer, 1995), and (d) lower but within one standard deviation of heterosexual men on the corrected CMNI total (Mahalik et al., 2003).

To determine whether the variables met the assumption of normality for general linear model analyses, all continuous variables were examined for skewness and kurtosis. Only IHP scores were non-normal, but skewness was corrected from 1.57 to −.60, and kurtosis was corrected from 2.19 to −.85 after we transformed the original scores by using the inverse as suggested by Tabachnick and Fidell (2001). Because the inverse of the score was taken in making the transformation, the directionality of the scores was also inverted. Therefore, higher IHP scores now indicated lower internalized homophobia as a result of the transformation.

We examined the demographic variables next to determine if they covaried in relation to the criterion variables. Because Caucasians constituted most of the sample and five of the seven racial groups contained fewer than 10 members, race was transformed into a dichotomous variable (i.e., 1 = White, 2 = non-White). Correlational analyses indicated that race, income, and education were unrelated to the criterion variables but that age was negatively related to MBIDS scores ($r = -.16$, $p = .001$), with younger gay men reporting more distress from failing to meet the masculine body ideal.

Main Analyses

Two hierarchical regression analyses were conducted examining BIQ and MBIDS scores, respectively (see Table 2). For both analyses, age was entered in the first step, and the minority stress model variables and the CMNI total score (corrected) were entered in the second step. Examining body image dissatisfaction (BIQ scores) indicated that age was not significant in the first step but that the three minority stress model variables were significant in the second step—internalized homophobia ($\beta = -.12$, $p < .05$), stigma ($\beta = .15$, $p < .01$), and physical attack ($\beta = .11$, $p < .05$)—accounting for 6.1% of the variance in the full model. Gay men who reported more body image dissatisfaction were more likely to report greater internalized homophobia, greater expectations of stigma from others for being gay, and suffered an antigay physical attack.

Examination of masculine body ideal distress (MBIDS scores) indicated that age was significant in the first step ($\beta = -.16$, $p < .01$), accounting for 2.5% of the variance. In the second step, each of the minority stress variables was significant—internalized homophobia ($\beta = -.18$, $p < .001$), stigma ($\beta = .21$, $p < .001$), and physical attack ($\beta = .14$, $p < .01$)—along with conformity to masculine norms ($\beta = .18$, $p < .001$) accounting for 16% of the variance in MBIDS scores. Gay men were more likely to report distress from failing to achieve an ideal masculine body if they were younger, reported greater internalized homophobia, greater expectations of stigma for being gay, had suffered an antigay physical attack, and were more conforming to traditional masculine norms. For both analyses, no multicollinearity was evident because none of the dimensions had more than one variance proportion greater than .50 (see Tabachnick & Fidell, 2001).

Discussion

Results from this cross-sectional study indicated that all three minority stress factors (i.e., internalized homophobia, stigma, and an antigay physical attack) were significantly associated with both body image dissatisfaction and masculine body ideal distress. These findings support previous research documenting that minority stress helps to explain lesbian, gay and bisexual individuals' mental health problems such as suicidal ideation, depression, anxiety, and substance use (e.g., Cochran & Mays, 1994; D'Augelli & Hershberger, 1993; Diaz, Ayala, Bein, Jenne, & Marin, 2001; Herek, Gillis, & Cogan, 1999; Meyer, 1995; Waldo, 1999). Results also extend the applicability of the minority stress model to body image concerns for gay men by supporting earlier scholars' speculations that experiences of prejudice, internalized shame, and the

Table 1
Means, Standard Deviations, and Intercorrelations of Variables

	M	*SD*	1	2	3	4	5
1. BIQ	1.85	1.51	—				
2. MBIDS	19.92	5.27	.47***	—			
3. IHP	12.46	2.48	−.13*	−.30***	—		
4. Stigma	3.31	0.94	.20***	.27***	−.30***	—	
5. Attack	1.24	0.43	.10	.12*	.09	−.01	—
6. CMNI	98.32	20.43	−.04	.24**	−.25***	−.01	.06

Note. $N = 357$. BIQ = Body Image Ideals Questionnaire (Cash & Szymanski, 1995); MBIDS = Masculine Body Ideal Distress Scale (Kimmel & Mahalik, 2004); IHP = Internalized Homophobia Scale (Martin & Dean, 1987); Stigma = Stigma Scale (Martin & Dean, 1987); Attack = history of an antigay physical attack; CMNI = total score of the Conformity to Masculine Norms Inventory (Mahalik et al., 2003) minus the Disdain for Homosexuals subscale. Lower transformed IHP scores reflect higher levels of internalized homophobia.
* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed). *** $p < .001$ (two-tailed).

Table 2
Hierarchical Regression Analysis of the BIQ and MBIDS Scores

	BIQ scores			MBIDS scores		
Variable	ΔR^2	β^a	sR^2	ΔR^2	β^a	sR^2
Step 1	.002			.03**		
Age		.04	.001		−.17**	.027
Step 2	.065***			.16***		
IHP		−.12*	.012		−.18***	.030
Stigma Scale		.17**	.026		.22***	.049
Attack		.11	.012		.15**	.025
CMNI		−.07	.004		.17***	.031
Full model						
Multiple R	.26			.43		
Multiple ΔR^2	.05			.18		
F (5, 330)	4.56***			15.34***		

Note. $N = 357$. $\beta^a = \beta$ for full, five-variable model evaluated at one-tail level. BIQ = Body Image Ideals Questionnaire (Cash & Szymanski, 1995); MBIDS = Masculine Body Ideal Distress Scale (Kimmel & Mahalik, 2004); IHP = Internalized Homophobia Scale (Martin & Dean, 1987); Attack = history of an antigay physical attack; CMNI = Total score of Conformity to Masculine Norms Inventory (Mahalik et al., 2003) minus the Disdain for Homosexuals subscale. Lower transformed IHP scoresreflect higher levels of internalized homophobia.
* $p < .05$. ** $p < .01$. *** $p < .001$.

desire to feel more powerful against antigay attacks may contribute to gay men's desire for a powerful physique (Crowder, 1998; Williamson, 1999). Conformity to masculine norms did not correlate with body image dissatisfaction but was associated with gay men's distress if their body did not meet the physically powerful masculine ideal, as we hypothesized. This difference may be due to the general nature of body image dissatisfaction assessed by the BIQ, in which physical characteristics such as facial characteristics were part of the overall score, whereas the MBIDS had a specifically masculine focus. This finding also suggests that future explorations about incorporating gay men's conformity to masculine norms into the minority stress model for gay men's mental health concerns should be limited to presenting concerns with a strong gendered component (e.g., masculine body ideal distress). The finding that conformity to masculine norms was associated with masculine body ideal distress also (a) supports previous findings that conformity to masculine norms related to the drive for muscularity and masculine body ideal distress in heterosexual samples (Kimmel & Mahalik, 2004; Mahalik et al., 2003); and (b) extends research finding traditional masculinity to relate to an array of physical and psychological health problems for gay men (Carlson & Steuer, 1985; Simonsen, Blazina, & Watkins, 2000). In addition, the finding gives some support to those who suggest that gay men may seek ways to compensate physically for perceptions that they are less masculine (Pope et al., 2000; Signorile, 1997) or to fight against the stereotype that to be gay is to be effeminate (Kurtz, 1999).

We believe the findings from this study have potential clinical implications for both prevention and treatment efforts. Meyer (2003) suggested that interventions for minority stress might aim to change how situations are appraised and to developing strategies to cope with stressful and adverse conditions such as discrimination and physical attacks. The focus of our study may enable clinicians to help gay men to reduce their negative self-perceptions and attitudes (i.e., internalized homophobia) and anticipations of rejection and discrimination (i.e., expectations of stigma) and to find coping strategies for prejudicial events such as antigay attacks. This might take place in individual or group sessions or might be a part of outreach programming to educate the gay community about the potential connection between minority related stress and body image concerns. Understanding the connection between minority stress factors and body image concerns may provide valuable insight and empowerment for gay men in treatment for body image distress. Meyer (2003) also challenged clinicians to work to change the objective properties of the stressors by altering the stress-inducing environment and reducing exposure to stress. Such interventions would work to reduce homophobia and stigma toward gays in society and to make antigay violence a thing of the past. "The former [strategy] places greater burden on the individual, the latter, on society" (Meyer, 2003, p. 692).

The finding that conformity to traditional masculine norms related to gay men's masculine body ideal distress suggests to us that gender issues may also be useful to explore with gay men. Specifically, clinicians might explore directly with gay men their range of feelings about being masculine in a heterosexist society. For some gay men, being masculine may be important because it makes them feel more accepted within the dominant heterosexual society.

We note several limitations in the current study. First, the sample was predominantly White and did not include bisexual men, making it difficult to generalize these findings to gay men of color or to bisexuals. Second, the sample was recruited online, and some consideration must be given to how online data collection may limit generalizability. However, a recent empirical analysis of online research concluded that "the data provided by Internet methods are of at least as good quality as those provided through traditional paper and pencil measures" (Gosling, Vazire, Srivastava & John, 2004, p. 102) and that findings from Web-based research "generalize across presentation formats, do not appear to be tainted by false data or repeat responders, and are, so far,

consistent with results from traditional methods" (p. 102). Also, our sample of gay men reported levels of body image concerns similar to that of heterosexual samples, unlike other studies (e.g., Siever, 1994). This difference in findings may have occurred because our measures and sampling method were different than these studies (Beren et al., 1996; French et al., 1996; Lakkis et al., 1999; Siever, 1994), but it also suggests that future research should continue to examine prevalence of body image concerns in gay samples. In addition, because of the small amount of the variance accounted for in this study, future research might also investigate other factors thought to relate to gay men's body image, such as, the gay community's emphasis on slimness and youthfulness (Williamson, 1999).

Existing research indicates that minority stress relates to an array of psychological health problems for gay men and that traditional masculinity is associated with physical and psychological health concerns (Meyer, 1995, 2003; Mahalik et al., 2003). We extended these lines of inquiry to examine the problem of gay men's body image, and suggest that other mental and physical health variables may also be influenced by minority stress and masculinity. Research could examine how presenting concerns such as gay men's alcohol and drug use including anabolic steroid use, unsafe sexual practices or other risk-taking behaviors, or gay partner abuse may have their source in gay men's experiences of minority stress and their constructions of masculinity.

In conclusion, in this study, we sought to contextualize gay men's body image concerns by examining minority stress as an explanatory model and to determine whether traditional masculinity could explain unique variance in body image dissatisfaction and masculine body ideal distress along with the minority stress factors. Our findings supported the utility of the minority stress model, examining both body image constructs, and traditional masculinity for explaining unique variance for masculine body ideal distress. We encourage researchers to continue to examine other presenting concerns for gay men and to develop and evaluate empirically informed remedial and preventive interventions to improve the health of members of the gay community.

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