Adlerian Theory and Eating Disorders in the LGBT Community

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

Angela M. Adams (Segner)

May, 2012
Abstract

This literature review discusses current and major findings regarding the mental health of individuals who identify as sexual minorities. Research regarding eating disorders in particular within this population will be highlighted as well as correlations and possible causes and the evidence supporting the relationship between identifying LGBT members and having eating disorders. As a whole the review will look at causes of eating disorders within the gay, lesbian, bisexual, and transgender (LGBT) community through an Adlerian lens. Major conclusions drawn include the effects of gender roles, media, prejudices against the gay community and the mental health of its members. Additionally, the researcher discusses the facts surrounding the increase of eating disorders in gay men due to the possible effects of attracting other men. The review will discuss the research supporting these findings, giving mental health clinicians greater insight into how Adlerian theory explains eating disorders in the LGBT community.
# Table of Contents

Eating Disorders..................................................................................................................4
  Anorexia Nervosa.................................................................5
  Bulimia Nervosa.................................................................7
  Eating Disorder Not Otherwise Specified.............................................8
  Diagnosing Eating Disorders.....................................................10
    Personality Characteristics.................................................13
    Biological Factors............................................................15

Lesbian, Gay, Bisexual and Transgender Community.................................16
  Definitions: Lesbian, Gay, Bisexual and Transgender/Queer..................18
  Mental Health Issues in the LGBT Community....................................19
    Discrimination.................................................................21
    Trauma.............................................................................22
    Common Mental Health Issues.............................................23
  Eating Disorders in the LGBT Community...........................................24

Adlerian Theory, Eating Disorders and LGBT Community..........................30
  Inferiority Feelings/Striving for Superiority.......................................32
  Early Recollections...................................................................34
  Early Influences.......................................................................35
  Style of Life............................................................................37

Treatment & Prevention.................................................................................40

Author Reflection.........................................................................................44

References.................................................................................................48
Adlerian Theory, Eating Disorders and the LGBT Community

Despite growing research, questions still remain regarding the connection between sexual identity and eating disorders. Additional research is necessary on this topic due to the growing size of the LGBT community and the overall need for acceptance of this population into society. More attention needs to be focused on the LGBT community, in particular mental health concerns so that ethically, mental health providers have the knowledge to address the issue of eating disorders within this community. It is the hope of this researcher to work towards solving this problem by looking at Adlerian theory and how it can be used to explain the etiology of eating disorders as well as prevention and treatment measures. This review will begin to look at the root issue of the causes that lead to eating disorders in the LGBT population. The review will also define eating disorders, discuss the background of the LGBT community, describe the current research in the mental health that affects this population, and finally to discuss from an Adlerian perspective what may lead to eating disorders and how clinicians can best approach these issues with members of the LGBT community.

Eating Disorders

Eating disorders are seemingly breaking away from long held stereotype of only afflicting female, upper-middle class adolescents and are quickly becoming recognized by the general public. Approximately 8.7% of people in the United States will suffer from an eating disorder at some point during their lifetime, 10% to 15% of these individuals will be men (Blashill & Wal, 2009). The number of men with eating disorders may be increasing as more recent research is starting to suggest that as many as nearly one in six cases of eating disorders may be men (Anderson, Cohn, & Holbrook, 2000). Due to the shame and stigma that accompany mental illness and eating disorders in particular, it can be assumed that many cases will go
completely unreported. Many individuals also struggle with sub-clinical disordered behaviors and body dissatisfaction. Individuals with body image issues experience the same distortions, which can include selective attention, dichotomous thinking, making comparisons, scapegoating, projection, predicting the future and emotional reasoning (Eating Disorder Coalition, 2009). Due to lack of public education and availability of treatment, the majority of people with severe eating disorders do not receive specialized care. Eating disorders often occur in individuals that experience high levels of stress, loneliness, and parental neglect (http://www.clevelandclinicmeded.com). According to the National Eating Disorder Association (http://nationaleatingdisorders.org) eating disorders are slowly becoming recognized as much more than a white, adolescent, and female mental disorder as they have been viewed historically, but rather someone of any age, gender, or background can develop these issues.

Eating disorders can be described as “pathological eating behaviors combined with abnormal thoughts and beliefs about food and weight, including overvaluation of thinness, distorted body image, or obsessive rumination about food or weight” (Craighead, Miklowitz & Craighead, 2008, p. 467). According to the American Psychiatric Association (2000) there are three main diagnoses in the area of eating disorders.

**Anorexia Nervosa**

Anorexia Nervosa is classified and mostly known as the refusal of an individual to maintain a healthy or “normal” body weight and affects approximately 0.1 to 0.9% of the United States population (Craighead et al., 2008). Other criteria for this diagnosis include an intense fear of gaining weight as well as an unrealistic perception of personal body image. In females, the criterion for Anorexia Nervosa also requires amenorrhea, or the absence of menses. Other factors include an extremely restrictive eating pattern, excessive exercise, and at times purging
behaviors. Often times these behaviors start small and usually go unnoticed by others in the environment; however, they grow and evolve in the individual over time. Due to the extreme physical demands of this disorder, anorexia nervosa has the highest premature fatality rate of any mental illness (Sullivan, 1995). While 40% of all cases of anorexia nervosa are within females ages 15-19 years, this disorder is also subject to all races, ages, and genders (Hoek & Van Hoken, 2003). When it comes to treatment, 40% completely recover, 30% recover considerably, 20% are severely impaired, and 5-10% percent are killed from physiological complications associated with anorexia nervosa (Sperry & Carlson, 1996). According to Sperry and Carlson (1996), some of the personality characteristics of a person with anorexia include being dependent, introverted, shy, stubborn and compulsive. Sperry and Carlson (1996) also stated that children who develop anorexia in adulthood were described as having been very well-behaved and played an integral role in keeping the family at peace. Additionally, individuals with anorexia are often described as dependent, introverted, compulsive, stubborn, perfectionistic, and asexual (Sperry & Carlson, 1996).

Within this diagnosis are two different sub-types. Some individuals with anorexia strictly regulate their food intake to lose and/or maintain a low body weight. Other individuals with the diagnosis follow a binge and purge cycle (binge/purge less than the criterion for bulimia nervosa). Bingeing qualifies as the consumption of larger than normal amounts of food while feeling a loss of control. The purging that follows can come in many forms and differs for individuals. These behaviors can include the use of laxatives and diuretics, excessive exercise, and vomiting. Anorexia Nervosa can lead to physical symptoms such as brittle bones, extreme dehydration, and is the deadliest of the three classified eating disorders.
Bulimia Nervosa

The second eating disorder listed in the DSM-IV (American Psychiatric Association, 2000) is Bulimia Nervosa and prevalence ranges within 1 to 3% of the United States population (Craighead et al., 2008). This diagnosis is characterized by recurrent episodes of binge eating accompanied by recurrent episodes of compensatory behaviors in order to prevent weight gain. This diagnosis is stereotypically recognized by the purging behavior of vomiting that many with this diagnosis use to compensate for their binges and does not require weight minimums or maximums for diagnosis. These bingeing episodes often take place later in the day and tend to be influenced by changes in mood, stress, hunger, and unstructured time (Sperry & Carlson, 1996). Individuals with bulimia often develop a chipmunk like appearance caused by swelling of the face due to extreme water retention (Sperry & Carlson, 1996). Sufferers of this diagnosis typically present with a more chaotic lifestyle than those who develop anorexia (Craighead, et al., 2008). Sperry and Carlson (1996) describe the bulimic individual as “anxious, depressed, self-critical, socially inhibited, secretive and ashamed of their bulimia” (p. 516). These individuals often have conflicted emotions regarding relationships and sex, often feel angry and powerless, and have difficulty processing pain, loss, and conflict. Bulimia Nervosa is also qualified by the individual’s preoccupation with body shape and weight, and also their self-worth as it ties in to these factors.

This diagnosis again has two sub-types; purging and non-purging types. Individuals with bulimia will also show signs of over-concern with their weight and shape. The binge episodes are defined as eating more than most people would eat in a similar situation and within a discerned period of time. The binge is also described as being out of control however many clinicians find these descriptors ambiguous and often use the gauge of three times the typical portion size as a
guideline. Bulimia nervosa can lead to rotting of the teeth due to frequent vomiting, extreme water retention, and even heart failure.

**Eating Disorder Not Otherwise Specified**

The symptoms for Eating Disorder Not Otherwise Specified vary greatly as they capture elements of Bulimia Nervosa, Anorexia Nervosa, and compulsive overeating and binge eating (which many argue should have their own diagnoses). The DMS-IV-TR states that the diagnosis Eating Disorder Not Otherwise Specified is reserved for eating disorder diagnoses that do not meet the full criteria for another eating disorder which at this time mainly include Bulimia Nervosa and Anorexia Nervosa (American Psychiatric Association, 2000). This diagnosis, often listed as EDNOS, in addition to having tendencies towards Bulimia Nervosa or Anorexia Nervosa, also captures obscure symptoms such as chewing large amounts of food and spitting instead of ingesting and also binge eating or compulsive overeating as well (American Psychiatric Association, 2000). The term eating disorder in this context refers to notable disturbances in eating behaviors and/or intense preoccupation with food, weight, and body image (http://www.clevelandclinicmeded.com). For example, the DSM-IV-TR (American Psychiatric Association, 2000) states that an EDNOS diagnosis can be given to a female who meets all other criteria for Anorexia Nervosa however still maintains a regular menses (American Psychiatric Association, 2000). The same diagnosis could be given to a morbidly obese individual who could be described as a compulsive over eater or binge eater who consumes copious amounts of food without regular use of purging methods needed to be classified for a diagnosis of Bulimia Nervosa. According to the Eating Disorder Coalition (2009), individuals labeled with the Eating Disorder Not Otherwise Specified diagnosis often express feelings of not being “sick enough” for the other diagnoses, which is only exemplified by the decision of many insurance companies
to deny insurance coverage for such a diagnosis. Such labeling of these individuals leads to a hindrance of treatment and in many cases can lead to even more serious mental health issues (Nolen-Hoeksema, 2008).

The National Eating Disorder Association website also touches on the specific diagnosis of Eating Disorder Not Otherwise Specified and the false beliefs of many that it may not be as serious or damaging as Anorexia Nervosa or Bulimia Nervosa. As stated earlier, such thoughts are reflected in many insurance companies’ decisions to deny insurance benefits for the EDNOS diagnosis. According to the American Psychiatric Association’s website there is currently a proposed revision in the DSM-V development which calls for a separate diagnosis for Binge Eating Disorder (http://www.dsm5.org). The proposed change is due to the overuse of the diagnosis Eating Disorder Not Otherwise Specified in clinical settings and the broad range of symptoms that it encompasses.

Binge-eating disorder is the most common eating disorder in the United States with an estimated eight to nine million people suffering with this issue, many of which are untreated (BEDA, 2012). Anderson and colleagues (2000) state that just as many men as women suffer from binge eating disorder. This diagnosis is a newly termed eating disorder that may be a new addition in the upcoming release of the DSM. The diagnostic criterion are also outlined in the current DSM-IV TR (American Psychiatric Association, 2000) and are characterized by different behavioral and emotional signs which may include one or more of the following: Recurrent episodes of binge eating occurring at least twice a week for six months, eating a larger amount of food than normal during a short time frame (any two-hour period) or lack of control with eating during the binge episode (e.g. unable stop eating or loss of control with eating) (Sperry & Carlson, 1996). Furthermore, “Binge-eating is when overeating crosses the line and it becomes
a regular occurrence, shrouded in secrecy. When you have binge-eating disorder, you may be deeply embarrassed about gorging and vow to stop. But you feel such a compulsion that you can't resist the urges and continue binge eating.” (Mayo Clinic, 2012). Due to the recent acknowledgement of this complex disorder, there is much less research and general common knowledge around treatment. Additionally, studies revolving around individuals suffering from binge eating and compulsive overeating also have a high tendency for chemical dependency (http://www.clevelandclinicmeded.com). The act of eating for these individuals stimulates the brain’s reward centers, the way most drugs function, giving more of an explanation as to why these individuals simply cannot stop consuming food without undergoing treatment. There may also be impactful environmental factors. “Modern Western culture often cultivates and reinforces a desire for thinness. Most people who have binge-eating disorder are overweight; they are probably acutely aware of their appearance and may get angry with themselves after eating binges” (Mayo Clinic, 2012).

**Diagnosing Eating Disorders**

When diagnosing a client with an eating disorder, proper testing such as the Eating Disorder Inventory (EDI-3) can be used to help classify symptoms. Anderson and colleagues (2000) however point out that psychological testing for eating disorders is more commonly geared towards heterosexual females, making the tests sometimes invalid for other populations. Further symptoms to look for during assessment include reluctance to eat in public or with family, hoarding food, use of specific food rituals, dramatic weight loss or gain when medical complications have been ruled out, and the obvious reporting of binging, purging, restriction or excessive exercise (http://www.nationaleatingdisorderassociation.org). In certain cases where permission is given by the client, information from secondary sources is also helpful for
diagnosis as those with eating disorders are known to under-report symptom usage. Extreme body dissatisfaction or attitudes toward body dysmorphic reasoning should also be surveyed when assessing individuals. Many individuals with eating disorders and body image issues engage in appearance-preoccupied rituals which are repetitive efforts at body image control (Cash, 2008). These rituals include appearance checking and appearance fixing. While managing physical appearance is somewhat of a necessity, an individual should be able to recognize when control is lost.

Studies have shown that genetic factors can play a part in contracting an eating disorder (Craighead, et al., 2008). According to the Cleveland Clinic’s Center for Continuing Education website, eating disorders have been proven to follow genetic patterns in families (this research is mainly focused on Anorexia Nervosa and Bulimia Nervosa) and have found that children of eating disorder patients have tenfold the risk of developing an eating disorder over the general population (http://www.clevelandclinicmeded.com). While an individual may be genetically predisposed for the disorder, the environment must also be looked at as a factor, for example parenting styles, traumas, or birth order. Psychological aspects of eating disorders can include different personality traits that can contribute to the disorders. In many instances, the influences from family can also cause internalization of the thin-ideal. Instances such as critical comments, teasing due to appearances, modeling disordered eating habits, discussion of dieting, and other feeding behaviors can become factors in the etiology of an eating disorder (Craighead, et al., 2008).

Variables that exist within an eating disorder can also include body dissatisfaction, dieting, interoceptive awareness, body mass, and childhood sexual abuse (Craighead, et al., 2008). Body dissatisfaction is both a risk factor in the development of an eating disorder as well
as a maintaining cause for the disorder. Body dissatisfaction leads to dieting behaviors and lowered self-worth, increasing eating disordered symptoms. Body dissatisfaction is also linked to the cultural ideal of thinness, again increasing eating disorder symptoms. Along with body dissatisfaction would be body image distortion which is often the overestimation of true body size. This focus is sometimes on the whole body or at times specific areas of focus that causes excess concern for the individual (such as the thighs, upper arms, or stomach). These distortions often become more excessive overtime and lead to constant body checking and increased body dissatisfaction. Body image distortions are often a large part of treatment avoidance and medical issues in individuals as they can lead to distortions in logical thinking around the physical consequences of an eating disorder (Craighead et al., 2008). Some clinicians would go so far as to describe these distortions as delusions in their clients. Concurrently, denial and deception are often used by the struggling individual and become roadblocks to recovery. Individuals are often deceitful towards loved ones regarding the amount of food they have eaten or their recent exercise habits. Parents, friends, and significant others often find this characteristic one of the most alarming as the individual in most instances is usually an honest and trusting person (Craighead et al., 2008). Deceptive strategies and techniques used by those with eating disorders can include using weights to increase the number on the scale, hiding of food, using background noise to cover purging noises, and claiming they have already eaten.

Dieting and/or restricting can both add to the cyclical pathology of bingeing and purging as well as a maintaining factor in anorexia. Interoceptive awareness is known as “the ability to identify internal sensations, with regard to both physiological and emotional states” (Craighead et al., 2008, p. 451). Individuals with eating disorders will report poor interoceptive awareness and will have difficulty identifying sensations that should predict the oncoming of eating
disordered symptoms. Research also stated that individuals will often struggle after recovery to identify internal sensations however certain therapeutic approaches are often used to help such clients work on identifying hunger cues and other internal sensations. Another factor, childhood sexual abuse, is also an increased risk factor for those who develop eating disorders. This factor also increases pathology for anxiety, depression, and overall increased stress in an individual (Craighead et al., 2008). Clinicians should also look for isolation tendencies within the individual and withdrawal from previous activities that brought pleasure. Time will become consumed with symptom use and excessive planning of meals and counting of calories as well as exercise regimes and body checking.

**Personality characteristics.** Craighead and colleagues (2008) suggest common traits in eating disordered individuals include impulsivity, compulsivity/obessionality, perfectionism, sensation seeking, harm avoidance, and self-directedness. Impulsivity is more often reported in individuals with bulimia; however, it has been reported in higher rates within all eating disorder diagnoses. This impulsivity is often linked to purging behaviors and is linked with more serious symptomology of eating disorders (Craighead et al., 2008). Additionally, increased impulsivity negatively impacts recovery, alluding to the fact that impulsiveness is highly linked with symptom use. Obsessive/compulsive trends are also common in those with eating disorders according to Craighead and colleagues (2008). These traits tend to stay with the individual past recovery stages suggesting they are not linked to symptoms however are linked to the overall etiology of the disorders. Perfectionism is also an important factor present among individuals with eating disorders, which includes “high expectations of one’s own performance, self-criticism, beliefs that others critically evaluate one, fear of failure, and excessive concern over mistakes” (Craighead et al., 2008, p. 448). Perfectionism has long been looked at as a risk
factor for eating disorders and stays present with the individuals after recovery, often taking on a new form.

Emotion regulation, or intense mood states and increased mood instability are often present within eating disordered individuals. Studies suggest that when skills are lacking in an individual to readily regulate his/her emotions that food is often used in its stead (Craighead et al., 2008). Many individuals with eating disorders report having difficulties identifying their emotions and are unable to cope with their feelings and are intolerant of extreme mood states (Craighead et al., 2008). Emotion regulation also seems to go hand-in-hand with cognitive dysfunctions which include ideas around appearance, overvaluation, internalization of the thin ideal, cognitive biases and rigid and obsessive thinking patterns (Craighead et al., 2008). When diagnosing an individual it is important to evaluate if self-worth is affected by physical traits such as weight and body shape. Control over the body and appearance becomes a link to increasing worth in the eyes of an individual with an eating disorder. Higher occurrences of appearance overvaluation is linked with later onset eating disordered symptoms and remains one of the most common occurrences in individuals with eating disorders. Craighead and colleagues (2008) postulate that this linkage could be due in part of the cultural ideal for thin bodies in women and muscular, low body fat appearances in men. These ideals are often internalized and are possibly the cause of increased body dissatisfaction. Research has found that internalized societal ideals of thinness lead to greater occurrences of body dissatisfaction, dieting, and overall negative effect. Cognitive biases are exhibited in eating disordered individuals when information is processed related to food and to body shape and weight (Craighead et al., 2008). Research exists showing that these biases influence attention and memory processes and that these individuals pay more attention to stimuli that are food, shape, or weight related. They become
better related to recall information involving these topics in comparison to other categories of information. Other cognitive biases include the overestimation of body shape, size and weight which leads to continued desire to control weight and increased body dissatisfaction. Craighead and colleagues (2008) stated that these biases are most likely a result of an eating disorder rather than a cause. Other cognitive dysfunctions present in eating disorders include obsessive thinking or dichotomous thinking. Obsessive thoughts and patterns revolve around eating, weight, and shape while dichotomous thinking often involves the categorization of food as good or bad and includes the creation of rigid eating “rules” (Craighead, et al., 2008).

**Biological factors.** Biological factors of eating disorders can in some context be explained through neurobiology, although more research is needed in this area. Current research has begun investigating the link between neurotransmitters and appetite. According to Craighead and colleagues (2008) research is also leading investigators towards using a neuroimaging technique to look at the structural and functional brain influences on eating disordered clients. Studies point to serotonin as the neurotransmitter linked mostly with mood, appetite, and impulse control and has been found at lower levels than normal in individuals with anorexia. Further research will be needed in order to make assumptions regarding the linkage as well as the implications towards prevention and treatment. Additional neuroimaging research has shown decreased brain mass in malnourished individuals with eating disorders and can fortunately be reversed with weight restoration. Again, further research is needed in order to calculate the lasting effects of brain shrinkage and the exact cause. Such advanced research is necessary in order to continue to explain the biological causes and effects of eating disorders in order to improve treatment and prevention in the future.
Lesbian, Gay, Bisexual and Transgender Community

The Williams Institute at the UCLA School of Law, a sexual orientation law and public policy organization, states that 9 million (about 3.8%) of Americans identify as gay, lesbian, bisexual or transgender (2011). The institute also states that bisexuals make up 1.8% of the population, while 1.7% are gay or lesbian. Transgender adults roughly make up 0.3% of the population. Between 2000 and 2005 another survey of same-sex couples in the U.S. reported that the number of individuals in same-sex relationships increased by 30%, or to put in perspective, five times the rate of population growth in the United States. The study attributed the jump to people being more comfortable self-identifying as homosexual to the federal government (http://www.NORC.org, 2011). According to the American Psychological Association (2011) sexual orientation "describes the pattern of sexual attraction, behavior and identity e.g. homosexual (aka gay, lesbian), bisexual and heterosexual (aka straight)". It also states, "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles" (American Psychological Association, 2011, p. 12).

There is no agreement among researchers regarding the reasons that an individual develops a heterosexual, bisexual or homosexual orientation. Hypothesized possibilities include a combination of genetic factors and environmental factors including birth order, prenatal hormone exposure and fetal treatment (Siever, 1994). The American Academy of Pediatrics website (http://www.AAP.org) states that "sexual orientation probably is not determined by any
one factor but by a combination of genetic, hormonal, and environmental influences." The American Psychological Association (2012a) states that "there are probably many reasons for a person's sexual orientation and the reasons may be different for different people" (p. 3). Additional information from the American Psychological Association states that usually sexual orientation is determined at an early age. The American Psychiatric Association states that "to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality. Similarly, no specific psychosocial or family dynamic cause for homosexuality has been identified, including histories of childhood sexual abuse" (2000, p. 14). Research continues regarding sexual orientations and what prenatal or genetic factors are related, which has recently been brought to light through political debates regarding homosexuality, causing concern over the future possibilities of what this could mean for the LGBT community.

When understanding sexual orientation, the American Psychological Association points out that "sexual orientation falls along a continuum. In other words, someone does not have to be exclusively homosexual or heterosexual, but one can feel varying degrees of both. Sexual orientation develops across a person's lifetime—different people realize at different points in their lives that they are heterosexual, bisexual or homosexual" (2011, p. 3). It is also important to note that sexual attraction, behavior and identity may also be incongruent and sexual attraction or behavior may not necessarily be consistent with identity. Some individuals identify with the LGBT population without ever having sexual experience in this area. Then of course there are others who have had homosexual experiences but would not consider themselves to be gay, lesbian, or bisexual (Mireshghi, Martinez & Navarro, 2010). And on the other hand, gay or lesbian individuals may occasionally sexually interact with members of the opposite sex but do not necessarily identify as bisexual.
As evidenced by the aforementioned information regarding this community, the term “LGBT” while sounding compact and organized is realistically a large group of many different sexual minorities with unique qualities. In order to further discuss these individuals some basic term definitions will be given.

**Definitions**

**Lesbian.** The term “lesbian” is used to describe a woman who is attracted to some other women (American Psychological Association, 2011). Lesbians in American culture in particular often classify themselves as having an identity that defines their individual sexuality, as well as their membership to a group that shares common traits. Lesbians in the United States are estimated to be about 2.6% of the population, according to a survey completed in 2000 by National Opinion Research Center on sexually active adults who had had same-sex experiences within the past year (http://www.NORC.org, 2011).

**Gay.** Gay is the term used to describe homosexuality among men and is also used to describe a man attracted to some other men (American Psychological Association, 2011). Some reject the label homosexual due to the history of its use and the clinical connotations which are reminiscent of the time when homosexuality was considered a mental illness. On the other hand, some reject the term “gay” as a label because of the negative cultural connotations and its use of a derogative meaning. The term “gay” is also sometimes used to describe both males and females who identify as being attracted to same-sex persons.

**Bisexual.** Bisexuality is a sexual orientation or behavior including physical and/or romantic attraction regardless of gender (this definition is also loosely used for the term “pansexual”). Individuals who have a distinct but not exclusive preference for one sex over the other may also identify themselves as bisexual. Bisexuals often find themselves discriminated
against within the LGBT community due to their failure to adhere to a strict label. Bisexual men can be accused of being too afraid to come out as fully gay and well as lesbian women who face the same stigma (American Psychological Association, 2011).

Transgender/Queer. Transgender or queer are the umbrella terms used to define a large grouping of individuals who do not necessarily fit into socially constructed categories of bi-polar genders. Society has taught us that one is born into one of two possible genders (male and female) which will be expressed through characteristic qualities such as interests, dress, and choice of sexual partners. The term transgender describes those who do not fit into the conservative definitions of a given gender. The term transgender may also be used for individuals who consider conventional sexual orientation labels inadequate or inapplicable to them or others. It is also important to note that transgender also encompasses individuals who identify with the following labels: cross-dresser, transvestite, androgynes, genderqueer, people who live cross-gender, drag kings, drag queens, and transsexual (American Psychological Association, 2012b).

Mental Health Issues in the LGBT Community

According to Rosario, Schrimshaw, Hunter, and Braun (2006), "the development of a lesbian, gay, or bisexual (LGB) sexual identity is a complex and often difficult process. Unlike members of other minority groups (e.g., ethnic and racial minorities), most LGB individuals are not raised in a community of similar others from whom they learn about their identity and who reinforce and support that identity. Rather, LGB individuals are often raised in communities that are either ignorant of or openly hostile toward homosexuality" (p. 26). The stigma and inequalities that lesbian, gay, bisexual, and transgender people face on a daily basis can increase their stress level and affect their well-being. In 1975, the American Psychological Association
accepted homosexuality as a healthy form of sexual identity and urged all mental health professionals to adopt the same beliefs; that it should not be treated as a mental health illness (American Psychological Association, 2011). The belief that homosexuality is a mental disorder, or that any deviant from sexual attraction norms are abnormal, has no support from conventional professional mental health organizations. Before the endorsement of this identity, homosexuality was commonly pathologized and largely treated as a mental health disorder. Dubbed “reorientation” or “conversion therapy,” lesbian women and gay men who did not identify with “normal” sexual orientations were historically urged to become heterosexual (Rothblum, 1994). Presently, some religious and political organizations still take efforts to change sexual orientation in these individuals through therapy, which at times have become heated debates in our country. Such negative propaganda about a minority group is sure to have negative effects on the members of the LGBT community.

Since medical literature was the first to describe homosexuality and lesbianism in particular, it has historically been thought that psychopathology was to blame, most likely influenced by works of Sigmund Freud. Although he believed bisexuality to be a natural occurrence, and said that most people will have phases of homosexual attraction or experimentation; exclusive same-sex attraction he attributed to stunted development resulting from trauma or parental conflicts (Blashill & Vander Wal, 2009). Additionally, literature exists on the mental health of lesbians which is centered on their depression, substance abuse, and suicide. Although these issues exist among lesbians, discussion about their causes shifted after homosexuality was removed from the Diagnostic and Statistical Manual in 1973. Instead, social ostracism, legal discrimination, internalization of negative stereotypes, and limited support structures indicate factors homosexuals face in Western societies that often adversely affect their
mental health. Women who identify as lesbian report feeling significantly different and isolated during adolescence; these emotions have been cited as appearing on average at 15 years old in lesbians and 18 years old in women who identify as bisexual. On the whole, women tend to work through developing a self-concept internally, or with other women with whom they are intimate. Women also limit who they divulge their sexual identities to, and more often see being lesbian as a choice, as opposed to gay men, who work more externally and see being gay as outside their control (Feldman & Meyer, 2007).

**Discrimination.** Currently, sexual minorities who look for mental health services seek help mainly for identity development, coming out to family and friends, legal issues, and coping with both external and internalized homophobia. Research shows that people of sexual minorities face more psychological issues than heterosexual people (Mireshghi, Martinez & Navarro, 2010). LGBT members continue to lose jobs, homes, and families because of their sexual identity status. Healthcare can even be withheld or inadequate care is given because of a provider’s discomfort with working amid this population. One of the main psychological factors that afflict members of this group is the individual’s degree of “outness” or the extent to which he or she has disclosed his or her sexual orientation. Another area of concern is internalized homonegativity, or the internalized negative attitudes and assumptions of sexual minorities. Homophobia refers to irrational fear or hatred of gay people. Sometimes, LGBT people turn society’s negative view about them inward and apply it to themselves, or in other words; internalize it. This can affect psychological well-being and can have consequences for healthy development, particularly among youth (Rosario, Schrimshaw, Hunter, & Braun, 2006). Again, mental health providers need to be aware of this issue and how it may affect mental health and well-being among their LGBT clients. Another important factor to consider stems from family-
of-origin variables, such as cultural beliefs and values regarding homosexuality (Mireshghi et al., 2010).

The United States overall has seen increases in the acceptance of the LGBT community, especially over the last decade. However, many LGBT members still face discrimination in U.S. society (Shelton & Delgado-Romero, 2011). Shelton and Delgado-Romero (2011) conducted research on present microaggressions, or “communications of prejudice and discrimination expressed through seemingly meaningless and harmful tactics” (p. 210) within society as well as within therapeutic relationships. These tactics included snide remarks or dismissive gestures, looks, and tones as opposed to fully blatant prejudice such as full-on discrimination. Furthermore, such acts should not be looked at as singular events, but the compounded result of many instances over a period of time, producing an environment of hostility and lack of acceptance. Shelton and Delegado-Romero (2011) also state that often the deliverers of these microaggressions are well-meaning individuals (even mental health workers can be susceptible) hiding biases and ignorance within nebulous verbal, nonverbal or environmental means, “microaggressions communicate that marginalized groups are not welcome, intellectually inferior, and deviants” (p. 211). This research acts as yet another reminder for clinicians to stay hyper-vigilant regarding their conduct when working with diverse populations such as the LGBT community. Additionally, society as a whole, even those who remain indifferent, or in support of, the LGBT populations should reevaluate their use of language and behavior when interacting or speaking of this population.

Trauma. The mental health of the LGBT community can often involve instances of trauma and abuse. Research has found that sexual minority individuals may be more likely than heterosexual individuals to have experienced childhood physical abuse (Gold, Feinstein,
Gold and colleagues (2011) stated that members of the LGBT community are over twice as likely to have experienced abuse in their childhood in comparison to their heterosexual counterparts. Childhood physical abuse is often accompanied by psychological symptoms such as anxiety, depression, and posttraumatic stress disorder in addition to dangerous behaviors such as self-harm and substance use (Gold et al., 2011). Gold and colleagues also found that lesbian women were more likely than gay men to report childhood physical abuse, although stated that contradicting research exists in which gay men were found to have reported childhood abuse at higher rates than lesbian women. Research from this study did however find that all sexual minorities did not differ on mental health outcomes.

**Common mental health issues.** Anxiety disorders and depression are the most common mental health issues for women. Depression is reported among lesbians at a rate similar to heterosexual women, although generalized anxiety disorder is more likely to appear among lesbian and bisexual women than heterosexual women (Gold et al., 2011). Depressions is a more significant problem among women who feel they must hide their sexual orientation from friends and family, experience compounded ethnic or religious discrimination, or endure relationship difficulties with no support system. Men's shaping of women's sexuality has proven to have an effect on how lesbians see their own bodies. Studies have shown that heterosexual men and lesbians have different standards for what they consider attractive in women. Lesbians who view themselves with male standards of female beauty may experience lower self-esteem, eating disorders, and higher incidence of depression. More than half the respondents to a 1994 survey of health issues in lesbians reported they had suicidal thoughts, and 18% had attempted suicide (Gold et al., 2011).
A population-based study completed by the National Alcohol Research Center found that women who identify as lesbian or bisexual are less likely to abstain from alcohol. Lesbians and bisexual women have a higher likelihood of reporting problems with alcohol, as well as not being satisfied with treatment for substance abuse programs. Many lesbian communities are centered in bars, and drinking is an activity that correlates to community participation for lesbians and bisexual women. Substance use is also connected to the gay male community, seemingly making this a trend among the LGBT community. Researchers suggest that as well as using substances to fit in with this community, substances are also used to lower inhibitions sexually and as a coping mechanism or for providing escape from mental health issues (Carroll, Gilroy, & Ryan, 2002). Mental health issues should be discussed and further researched with the LGBT community due to the growing need of this population.

**Eating Disorders in the LGBT Community**

Eating disorders and body image as it applies to the LGBT community is important to be aware of because of the popular belief that these issues are restricted to the population of Caucasian upper to middle class heterosexual women and girls. Sperry and Carlson (1996) state that Alfred Adler likened individuals with eating disorders to those with depression in that they are discouraged and perfectionistic. Additionally, children that develop eating disorders later in life were often used by their parents to become successful in areas they were never able to, adding further stress (Sperry & Carlson, 1996). From this perspective the individuals may be stuck in a never ending battle to be “good enough” and their goals can never be met as they are continuously setting the bar higher. Research has shown that compared to heterosexual men there are higher levels of disordered eating within the LGBT male community and that gay men present with higher rates of body dissatisfaction and fully diagnosable eating disorders (Carroll,
et al., 2002). In addition, although studies support the idea that heterosexual women follow more extreme body image ideals than lesbian women, women in the LGBT community are definitely not immune to body image dissatisfaction or eating disorder symptomology.

Researchers have found that the ideal body image is becoming more rigid for both men and women, particularly within the LGBT community. Studies have shown that new trends within the LGBT community are leading gay men to strive for a thinner and more muscular ideal as well as an image of being young and hairless (Martins, Tiggemann, & Churchett, 2008). Also of note, there is a belief that women in the LGBT community do not have body image concerns, most likely because of the observable feminist preference for natural body shapes within this community. Although research exists supporting that lesbians reported feeling more free to reject mainstream female appearance norms and reported greater rates of body acceptance after coming out, the same population reported high ratings of eating disorders and weight concerns (Feldman & Meyer, 2007). These results may be explained in part by the internal struggle caused by the incongruence between the values of the lesbian community as it relates to the standards of self acceptance and the personal beliefs of women within the LGBT community. Research has yet to touch on the fact that there still remains differences between the beliefs of women within the LGBT community, and research indicating that feminine women report greater instances of lower body satisfaction than either masculine or androgynous females. Additionally, studies suggest that younger generations within the LGBT community have more idealized and rigid body images than older members within the community (Feldman & Meyer, 2007).

Feldman and Meyer (2007) found that symptoms of disordered eating occurred in gay and bisexual men ten times more than heterosexual men. This study suggests that the increased probability for gay or bisexual men to have an eating disorder can be best explained from a
sociocultural perspective. This perspective provided that the current social norms and cultural values have created an ideal body image that will remain unattainable for many. Wiseman and Moradi (2010) suggest that such sociocultural factors include sexual objectification and attractiveness standards. Blashill and Wal (2009) state that between 10% and 42% of men who suffer from eating disorders are gay or bisexual and this group also portrays a higher rate of body dissatisfaction. These researchers seem to be in agreement that eating disorders and related symptomology is on the rise especially for the males in the LGBT community.

Siever (1994) in particular points out that gay men are more likely to experience Bulimia Nervosa or Anorexia Nervosa as opposed to binge eating or compulsive overeating as encompassed under the diagnosis Eating Disorder Not Otherwise Specified. Siever (1994) also postulates that both gay men and heterosexual women are the two subgroups most prone to eating disorders due to their desire to attract men. Siever (1994) points out that men have been shown to assess possible partners on physical attractiveness more so than women. Therefore if gay men and heterosexual women have increased body dissatisfaction based on their desire to attract men, then heterosexual men and lesbian women are less likely to experience dissatisfaction with their image and consequently less prone to eating disorders compared to gay men. Although little research seems to be available regarding body dissatisfaction or eating disorders in general in lesbian women it could be assumed that because women are shown to make choices for their partner based more on personality that these occurrences are less probable (Siever, 1994). Siever (1994) also points out research showing that the lesbian subculture is known to rebel against current standards for beauty, yet again supporting the lower occurrence of eating disorders in this population.
Identity disturbances are yet another factor that could contribute to mental health issues including substance abuse and eating disorders (Tally, Tomko, Littlefield, Trull & Sher, 2011). Identity in this instance refers to an individual’s specific abilities and drives within the given environment or culture. The Diagnostic and Statistical Manual of Mental Disorders define identity disturbances as a clear and constant unstable sense of self (American Psychiatric Association, 2000). Tally and colleagues (2011) suggest that sexual minorities have a greater prominence of identity disturbances than their heterosexual counterparts. This study also suggests that individuals having experienced abuse during childhood are also more susceptible to identity disturbances. The same study also points out that “as a group, sexual minority individuals report a greater frequency of experiences with childhood abuse and victimization” (Tally, et al., 2011, p. 531).

Yet another factor, and a large one at that, is the role that media plays in beauty standards. Kane (2010) states that the ideal physical standard of gay men in the 1980s was a “thin and youthful image” (p. 311) which then morphed to a more muscular and strong image in the 2000s, which constituted for a small waist with lean muscle mass. Kane (2010) suggests that such factors as the role of the gay community, being effeminate and internalized homonegativity have added to increased body dissatisfaction. The newer muscular ideal has also been attributed to HIV and the consequent “wasted” body appearance many sufferers acquire with the disease (Kane, 2010). It appears that HIV, a slow and steady deadly disease often contracted by gay men due to unprotected sex, has become so intertwined with the LGBT community that gay men will take measures to outwardly reject the stigma associated with it. Furthermore, many gay men have come to endorse traditional masculinity above previous more effeminate appearances and behavior in other gay men (Sánchez, Westefeld, Ming Liu & Vilain, 2010). Sánchez and
colleagues (2010) suggest that “gay men who are overly concerned with masculinity are compensating for feelings of inferiority stemming from their sexual orientation” (p. 105).

According to Boisvert and Harrell (2009) gay men seem to have a higher prevalence of disordered eating than their heterosexual counterparts. This study hypothesizes that gay males “place greater emphasis on physical appearance when selecting a mate and are more dissatisfied with their current weight and their bodies” (Boisvert & Harrell, 2009, p. 211). The same study also states that homosexual males choose fitter and leaner body ideals when comparing drawings of bodies, show a greater discrepancy between their own actual body size and their ideal body size, report more eating disordered behaviors, have in general lower body mass indexes than heterosexual men, and report being on diets more frequently (Boisvert & Harrell, 2009).

Boisvert and Harrell (2009) stated that the gay culture has increased their standards of social norms especially in the area of physical appearances. The current physical trend for homosexual men can be described as “a muscular build characterized by a well-developed upper body and a slender lower body (Boisvert & Harrell, 2009, p. 211). Advertisements look to point out physical insecurities and provide the population with the messages that a standard must be met in order to be considered attractive in the culture. Boisvert and Harrell (2009) hypothesize that due to homosexual men’s already increased standard for physical appearances, coupled with the increased negative messages from the media they may be at greater risk for eating disorder tendencies. In addition, the standard for gay men to reach low body weights while maintaining a muscular physique adds to the already difficult to achieve appearance.

Women have been living with impossible media ideals for decades, whereas the ideal for men has seemed to become more prominent in only the last several years. This relatively new standard has seemingly caused men to become more aware or sensitive of their own physical
appearances and has led them to create comparisons between themselves and media images (Boisvert & Harrell, 2009). On the other hand, while for women it has become socially acceptable to discuss their own body image and the body images of women in general; men have not yet seemed to reach this level of comfort. Boisvert and Harrell (2009) hypothesize that such discussions could cause feelings of emasculation or shame at the thought of openly discussing body image. Compounding the problem is the need for gay men to constantly prove to society (and to themselves due to internalized homonegativity) that they are in fact “real men.” As the physical standard for “real men” has reached unattainable standards their tendencies to acquire an eating disorder increase (Boisvert & Harrell, 2009). Martins, Tiggemann and Churchett (2008) also looked at the increased pressure for males to acquire the ideal body: narrow waist, broad shoulders, and a well defined stomach. This study also looked at the increased pressure from media and examined Gender Role Strain Theory, which was defined as society’s view on how a gender should look, which is often contradictory, evolving, and inconsistent. The research goes on to describe that this paradigm, when violated, leads to “social condemnation, over-conformity to them, or, on an intrapersonal level, to negative psychological consequences (Martins, et al., 2008, p. 249). While the new ideal for men’s appearance is, for most men, unattainable, many men have not ended their pursuit. Martins and colleagues (2008) point out as evidence of Gender Role Strain the increase in gym memberships, money spent in the male beauty and grooming market, and the newly coined term for heterosexual men who practice meticulous grooming habits and heightened sense of appearance and lifestyle: “metrosexual.” It seems then, that one likely cause for gender role strain is the struggle or inability to meet the male body image ideals.
Schurr and O’Brien (2010) point out the significance of “naming the goal” for mental health psychotherapy within the LBGT community. In this sense, “naming the goal” could range from increasing self-acceptance, improving body image, and countless others being tied to the individual and their place in society. It can be assumed that individuals in this population reporting security in their identity and feelings of security with their role in society will also have higher rates of psychological well-being. It has become apparent that homosexual men have different relationships with their bodies than heterosexual men, at least in part due to the fact that the objects of their desire are of the same gender (Boisvert & Harrell, 2009). Additionally, many gay men constantly strive to prove to themselves and society that despite their sexual orientation, they are in fact “real men” and in doing so take great measure to meet the physical standard set for men (Boisvert & Harrell, 2009). On the contrary, other sexual minorities, such as lesbian women, do see larger psychological disturbances (Rothblum, 1994); however, they do not experience a higher prevalence of eating disorders in particular. While much attention has been given to LGBT men and eating disorders, this researcher believes that more studies are necessary for the existence or non-existence of eating disorders in all types of sexual minorities.

**Adlerian Theory and Eating Disorders within the LGBT Community**

Adlerian Theory, or Individual Psychology, was pioneered by Alfred Adler (1870-1937). Alfred Adler, a physician turned historically influential psychiatrist and once a colleague of Sigmund Freud, began focusing on new ideas geared towards philosophy in the early 20th century. Adlerian counseling is characterized by the emphasis on childhood development, feelings of inferiority, family environment and holistic examinations of the individual. Adler’s approach “has a strong philosophical base that focuses on clients’ perceptions of the world (phenomenological) and is holistic and humanistic” (Seligman, 2004). Adler’s theories tend to
focus strongly on early influences during childhood years and look at how they play out in adult life. According to Adlerian theory, each individual is striving for significance, striving to be important in some way, and what is significant or important is different for each person (Ansbacher & Ansbacher, 1956). As individuals strive for both short-term and long-term goals, they may use methods to achieve the goals that are not as effective as one perceives they are or as effective as they used to be. Therapy from this view involves finding more effective and satisfying ways of meeting goals. Adlerian counseling involves the development of positive and socially responsible goals and ways of achieving them and the establishment of new ways of coping within the unique lifestyle (Seligman, 2004). Adler believed that it was imperative to become intimately familiar with a person’s social context by looking at factors such as birth order, unique life style, and parenting style with which he/she was raised. Adler was also one the first theorists to focus on the area of holistic theory on personality, psychotherapy and psychopathology and believed that a person will be more receptive and cooperative when he/she is encouraged (Ansbacher & Ansbacher, 1956). Adler also believed when a person is dissatisfied and discouraged, they will display counter-productive behaviors that present competition, defeat and withdrawal. When one is able to receive the positive influences of encouragement, one’s feelings of fulfillment and confidence increase. Adlerian theory places importance on a person’s ability to adapt to feelings of inadequacy and inferiority relative to others. These emotions may be a result of birth order, especially if the person experienced personal de-valuation and discouragement at an early age. Another cause may be due to the presence of a physical limitation (organ inferiority) or lack of social empathy (social interest) for other people. This theory also focuses attention to behavior patterns and belief systems that were developed in childhood. Therapists who use this form of therapy believe that these factors influence all
behavior and are directly related to how a person perceives the self and the world. By examining these early-life behaviors, clinicians can improve the tools needed to create a sense of self-worth, meaning, and ultimately create change that results in forward progress.

**Inferiority Feelings/Striving for Superiority**

From an Adlerian perspective on eating disorders within the LGBT community, one must consider biological, environmental, and personal choice factors (Ansbacher & Ansbacher, 1956). All of these factors will play a role in the etiology of the disorder. An Adlerian therapist would not look at these diagnoses as an illness but rather a “mistaken way of living” (Sperry & Carlson, 1996, p. 134). Additionally, the perception from an Adlerian viewpoint is not that the client is a victim of the symptoms. This viewpoint would look at the client as an active participant of the diagnosis and that the symptoms have been a factor of choice to achieve some unconscious goal (Sperry & Carlson, 1996). From the information discussed earlier regarding the existence and possible causes of mental health issues within the LGBT community it appears that both externalized and internalized homonegativity play a huge role in these particular pathologies. Both of these pressures are bound to make an individual feel inferior, or less than, their heterosexual counterparts. When taking into consideration the psychosocial aspects of eating disorders, one could theorize that perfectionism plays a major role in the etiology of the disorder. Being a minority person in the population, and a minority that is generally widely persecuted, it can be assumed that many of these individuals harbor feelings of discouragement and feel misplaced within society, and perhaps even within their families. Eating disorders in general could be looked at as a way for inferiority feelings to be expressed in an individual and the symptoms a result of the individual coping with feelings of failure (Belangee, 2006), a model that could easily be applied to an individual in the LGBT community. Adler stated that eating
disorders may be the expression of, or method of coping with, inferiority feelings, or striving for superiority (Sperry & Carlson, 1996). Adler also believed that “children have strong feelings of inferiority that they strive to overcome throughout their lives by seeking achievement, mastery, pleasure, and social acceptance” (Seligman, 2004). While normal feelings of inferiority begin at birth through a process of trial and error, difficulties with inferiority also begin to develop through childhood. The errors that develop throughout life are often those which form the notions of what life is. In this sense, the symptoms of eating disorders become a way of coping with feelings of failure, perhaps in the eyes of society or within the family of origin (or both). If an individual believes that achievement in the life tasks is not possible, they strive towards another goal, such as achieving the ideal body image, or being thinner (Sperry & Carlson, 1996). Belangee (2006) states that “eating disorders are examples of the methods or problem solving strategies a person could choose to cope with the inferiority complex” (p. 5). Belangee (2006) goes on to state that the symptoms of eating disorders are used as a way of blocking the uncomfortable inferiority feelings and though it may have served its purpose for a time, the symptoms can become out of control and turn cyclical in nature. It has been suggested that “the nearer we are to perfection, the stronger is the need to perform” (Ansbacher & Ansbacher, 1956, p. 105). According to Alfred Adler, all life is engaged in movement from a perceived minus situation to a perceived plus situation. Adler’s felt plus is more accurately understood as a fictional plus, that is, a subjectively-constructed (hence fictional) image of maturity, mastery, completion, fulfillment, or perfection which the individual strives to attain in his or her struggle to move away from the felt minus situation toward the fictional plus personality ideal (Griffith & Powers, 2007). The focus of this movement is to make the individuals feel better about themselves and to feel closer to perfection (Carlson & Sperry, 1996). The notion of striving for
perfection is a very pertinent idea to discuss when speaking about eating disorders. Adler makes a point to say that everyone strives for perfection and that it is a natural and innate quality (Ansbacher & Ansbacher, 1956). Striving for perfection is another way of stating that one is striving to evolve and conquer. It is a way to move one’s self from a position of a felt minus to a perceived plus. The problem with striving then becomes about the degree to which someone strives for perfection and through what means. When it comes to the LGBT community they are already treated with disrespect and it can be assumed that many experience feelings of discouragement due to environment. Turning to eating disorders for some may have become an alternate route to gain superiority through their image and control of their diet.

Adler also suggests that although all people strive for perfection, there are many ways in which to go about it; the ideal approach to perfection is through social interest (Ansbacher & Ansbacher, 1956). Usually when someone refers to another as a perfectionist, they are speaking of the person’s tendency to want to be and do everything perfect. This describes perfectionism as a striving for one’s own aim in efforts to gain control and safeguard the self-esteem. Carlson and Sperry (1996) state that “eating disorders are viewed as an expression of a combination of perfectionism and pessimism” (p. 518). Adler might reword this sentence to say that, like many forms of neurosis, the individual is striving for superiority (through the use of personal perfection of the body) and is discouraged.

**Early Recollections**

Early recollections are what Adler believed to be intentionally manipulated recalls from the past that represent ideas in support of an individual’s goals (Sperry & Carlson, 1996). Adlerian theory addresses the importance of early recollections (ERs) in the therapeutic process. Early recollections create a story of the individual's life, and reinforce goals and behaviors. Early
recollections, dreams, and goal examination can all be used throughout therapy as an indication of a client's underlying and current day issues. In a nutshell, early recollections “revealed people’s views of themselves, others, and the world around them and prepared them for their futures” (Mosak & DiPietro, 2006, p. 14). What is important to take into account is that individuals will act in accordance with their early recollections. Additionally, a therapist could actually gauge progress in a client by the way in which early recollection change over the course of therapy. In the case of an LGBT client with an eating disorder, recollections may involve (though are not limited to) memories of being left out, discriminated against, or being different from others. Furthermore, these memories could deal with physical attributes such as not being big enough, small enough, or the like. Using early recollections to explain pathologies would in most cases require a case study to illustrate, however their use in this context does highlight the belief that behaviors serve a long standing purpose. Furthermore, using early recollections in practice can lead to greater insight into the pathology and the person as a whole which is greatly encouraged in Adlerian practices (Mosak & DiPietro, 2006).

Early Influences

Researchers point out that it appears that eating disorders do have a genetic component to them (Costin, 2007), but even with genetic components there must be environmental influences such as parenting styles that also add to the etiology. An Adlerian view of eating disorders could be closely aligned with that of depression (Sperry & Carlson, 1996). Eating disorders will often stem from over-controlled behavior usually through family systems. “Evaluations of family atmosphere are the background for judgments made about life in early childhood when the individual's basic convictions about self, others, and the world were being formed” (Griffith & Powers, 2007, p. 36). Family atmosphere also employs meteorological imagery to convey a
sense of the ambience in which values are planted and cultivated (Griffith & Powers, 2007). Adler found that there were two parenting styles that could cause problems in adulthood: pampering and neglect. The first, pampering, includes overprotecting or spoiling a child. The grown child will consequently be ill-equipped to deal with reality and may doubt his/her own abilities. The second, neglect describes a child who is not protected from the world and is forced to face life's struggles alone. Such children may grow up to fear the world, have a strong sense of mistrust for others, and have a difficult time forming intimate relationships. As stated earlier, eating disorders take different forms in different individuals. A child that was very controlled and not given the chance to gain confidence will often turn to extreme constriction or control of their diet, leading to anorexic-like symptoms (Sperry & Carlson, 1996). On the other hand, a child who was raised in a chaotic household with little encouragement or attention given will usually turn to more chaotic symptomology such as those seen in binge eating or bulimia (Sperry & Carlson, 1996). Sperry and Carlson (1996) state that more often, Adlerians are likely to see eating disorders as situations in which the child is overprotected, overindulged, or over-controlled by his or her parents or environment. Many parents pamper their children, while several others neglect their children, both groups of parents not fully knowing to what extent their acts would influence the lives of their children. In the case of the LGBT community it is easy to postulate how a parent could fall on either side of the spectrum. Some parents may pull away from a child that acts different or not how they would prefer while other parents could take the opposite route and tend to overprotect their children from a prejudiced society. Since it is common for LGBT individuals to know they are different from an early age it can be assumed that their parents also had a reaction to these differences, affecting their behavior as adults (Gold, Feinstein, Skidmore, & Marx, 2011). Those raised as pampered children develop selfish
demands which become their primary motivating force (Lundin, 1989). Because they were spoiled as children, they may have little or no self-control as adults, which could lead them to eating disordered behavior. As pampered individuals, they often present with unrealistic demands, and when unmet, that could lead them to bursts of symptom usage because they are excessively concerned with approval from others and are highly sensitive to rejection. In this regard, they may become addicted to seeking ways to enhance their self-esteem by placing excessive importance on being physically attractive, leading to stress, drug and alcohol use, and eating disorders (Crocker & Park, 2004). Furthermore, there may be members of the LGBT community who suffer from eating disorders because they were former neglected children. As Shives (2008) notes, those people develop an eating disorder because they believe that their parents have never responded adequately to their initiatives or recognized individualities. Although many parents love their children, they never feel comfortable showing their affection, which could later have devastating results for the children.

**Style of Life**

Eating disorders could be explained through other various psychological theories that exist, all of which could be integrated with Adlerian theory. These approaches also explain the use of maladaptive behaviors to achieve a certain goal. A popular approach currently used among eating disorder therapists revolves around cognitive theories (http://www.nationaleatingdisorders.org). Cognitive theories are based around the notion that “thoughts and beliefs shape our behaviors and the emotions we experience” (Nolen-Hoeksema, 2008, p. 56). An example of a client’s thoughts in this situation may be the cognition that they are overweight when in reality they are normal or even underweight. When these cognitions start to take over an eating disorder can form and symptoms could range from food restriction, to
bingeing and purging, and a plethora of other symptoms. The goal then in therapy using this approach would be to start at the source and alter the client’s maladaptive thoughts in hopes of changing the behaviors. From an Adlerian perspective, ideals about life appear in an individual as a goal toward which he/she strives to move (Davidson, 1991). These ideals are formed for the self and become unreachable due to the set “ideal” or perfection. The goal could also be looked at as an end goal, constantly being pushed to unreachable levels (for example, “If everyone loved me, I would be good”). Sperry and Carlson (1996) state that Adler considered individuals with eating disorders similar to those with depression in that they are both discouraged and perfectionistic. Additionally, children that develop eating disorders later in life were often used by their parents to become successful in areas they were never able to, adding additional stress (Sperry & Carlson, 1996). Belangee (2006) proposes that individuals with eating disorders attempt to hide what they feel are their failures from others due to feelings of inadequacy. From this perspective the individuals may be stuck in a never ending battle to be “good enough” and their goals can never be met as they are continuously setting the bar higher.

Eating disorders are often a more passive form of rebellion combined with an exaggerated acceptance of society’s idealized “perfect” image (Sperry & Carlson, 1996). For many people experiencing eating disorders, their need for perfection does not allow them to admit they have a problem. Denial and deception are very common features of patients with eating disorders, anorexia nervosa in particular (Craighead, et al., 2008). In instances in the LGBT population these individuals are not what society would categorize as ideal because of their sexual identity. They would however, have control over the way they looked. Craighead and colleagues (2008) note that “the individual (with an eating disorder) must …highly value body shape and weight” and “common triggers for binges/purges include… feeling like a dieting
rule has been broken” (p. 436-7). This kind of private logic and standards one has set for oneself could very likely play into what Adler would say: “The continuous striving for security urges toward the overcoming of the present reality in favor of a better one” (Ansbacher & Ansbacher, 1956, p. 107). This is also the concept of a perceived minus to a felt plus. If the individual believes the symptoms of this disorder can bring them from a place of imperfection to their perception of perfection (an ideal body shape or weight; possibly represented by outside influences such as media or family history) then it will continue until it ultimately kills or proves useless and working against the perceived goal of perfection. It is at this point in an individual’s life when he or she is trying to establish an identity as an adult, separate from the identity as a child. The life task of love/relationships is beginning to (if it has not already) become a part of the individual’s life. Based on convictions established in childhood, a perception of an ideal partner may have already been set and striving for this idea of perfection is conducted through maintaining this physical figure by an exercise of control and letting go (Craighead et al., 2008).

Eating disorder symptoms in the LGBT community, if looked at through the lens of purpose-driven behavior in Adlerian terms, give great insight. The symptoms themselves lay out the issue – the person feels a lack of control in some part of life or in many, which makes him/her control his/her eating habits to try to fill this void or feel as though he/she has control, which then reiterates the feeling of lack of control, hence creating a cycle. From an Adlerian point of view this feeling of lack of control could be the goal-oriented behavior driven by the beliefs. Through lifestyle Adler would then help the client to see his/her mistaken beliefs (e.g. believing self is worthless or weak), which drove him/her to try to compensate through eating disordered behavior.
Treatment & Prevention

A reported half of individuals treated for eating disorders report full recovery from their core eating disordered symptoms (Craighead et al., 2008). Many individuals who have overcome the brunt of their disorder will often continue to display preoccupation with food and appearance, albeit at lower levels. Both psychological and pharmacological treatments are now becoming more widely available for eating disordered individuals. Treatment for eating disorders from an Adlerian approach requires the clinician to remain patient and supportive in order to aid the client in making difficult and significant changes in behavior. Creating a safe environment and a strong relationship with the client is also crucial in making progress in therapy for an eating disorder (Sperry & Carlson, 1996). Additionally, eating disordered clients have often been denied their individuality within their family and this should be recognized and avoided in therapy. According to Sperry and Carlson (1996), eating disordered clients should be “heard, encouraged, and helped to develop a separate identity” (p.521). For clients displaying dependent personality types, as are often seen within eating disorder populations, the clinician should encourage independence and self-worth. Due to the sometimes serious nature of eating disorders, clinicians will often be forced to take a firm stance with their clients if a higher level of care, such as hospitalization, is required.

Clinicians working with minority populations, such as the LGBT community, need to take the initiative to educate themselves about working with such populations and become familiar with their struggles as a community. For many mental health workers “views about transsexuals, transvestites, or cross-dressers, and others with transgender status have not been informed by objective empirical research. Consequently, counselors are ill-prepared to meet the needs of such clients” (Carroll, et al., 2002, p. 132). Such areas recommended to be familiar with
include evolving definitions within the LGBT community, the politics involved with the community, clinical issues and interventions for use with such clients, and the observation of an actual case and the progression through therapy that occurs (Carroll et al., 2002). Additionally, clinicians must be sensitive to the fact that the “medical and psychiatric establishments have long histories of pathologizing LGBT individuals” (Carroll et al., 2002, p. 133). Furthermore, clinicians must also be aware to not generalize within this population and to remain sensitive to each individual’s life experiences and past and present needs. Adlerian psychology offers clinicians a coherent structure that emphasizes the unique, indivisible, social, decision-making nature of human beings.

Many different treatment approaches have been used with eating disorders, and many can easily be intertwined with Adlerian theory. For example, Sperry and Carlson (1996) suggest both cognitive and behavioral interventions to help with symptom interruption. Due to the effects these disorders can have on the body, psycho-educational pieces are also recommended to add to the logical decision making being introduced to the client and to create a greater understanding of the effects the disorder has on the whole person. Working from an Adlerian model, maladaptive thinking and mistaken beliefs should be added as another layer to treatment for an eating disorder. The clinician and client must work together to diminish negative thoughts about the self and body image in order to begin to establish healthy thoughts (Sperry & Carlson, 1996). By looking at the individual’s unique style of life and private logic work can start to be done around understanding the etiology of the disorder. The hope from this perspective is to guide the client towards a greater understanding of self and behaviors. By creating this greater sense of insight and self-understanding the individuals will be better equipped to create new behaviors and start progress towards recovery.
Counseling an LGBT individual with an eating disorder from an Adlerian approach should include empowerment and encouragement and helping the client to focus on efforts as opposed to accomplishments (Seligman, 2004). Additionally, therapists using this approach will focus on the strong establishment of a therapeutic alliance in order to increase collaboration and further forward progress. Many modalities and approaches to psychotherapy have a variation of the same goal, and that is to replace unhealthy ways of living with healthy ways of living.

Recollecting and reconstructing early stories have been shown to be useful for clients in recovery from eating disorders. Within an Adlerian perspective that emphasizes encouragement, social contribution, and a goal-oriented approach (Ansbacher & Ansbacher, 1956), rehearsing the new stories allows individuals to consider their thoughts and actions from a healthier perspective and promotes long-term changes in behavior. A clinician should work with the client on interpretations of early memories via hunches and intuitive guesses in order to continue to encourage insight and awareness of patterns (Seligman, 2004). When working with the LGBT population, especially in the context of eating disorders, it would be important to consider the environment they were raised in. Things to consider include their relationship with their parents and siblings, their own coming out process, and creating a lifestyle to better understand their private logic and life goals.

Adler viewed people with neurosis as people who believed themselves to be drowning and were completely focused on saving themselves. Using this metaphor, the individual is unable to take in the scenery around them and often drag down those who try to save them. If they were to cooperate with those offering aid they could be saved (Sperry & Carlson, 1996). This metaphor illustrates their disconnect from society (lack of social interest) and inability to see a way out. Adler was known for his support of outreach programs and social reform which was
often based on educational principals (Mosak & Maniaci, 1999). Due to the stigma surrounding the LGBT community this author suggests that to increase mental health throughout this population an effort for maximized social interest would greatly improve their current mental health state. Social interest is translated from the German word “Gemeinschaftsgefühl” roughly meaning “community feeling” (Kronmyer, 2011). According to Adler, social interest is a necessary part of human development and exists in an individual only if his/her style of life is healthy or well developed (Sperry & Carlson, 1996). From the author’s understanding, social interest is displayed when one is able to view the self as part of a social system and is able to contribute positively to the whole as opposed to someone who remains internally focused and self-concerned. Using social interest as a gauge for one’s mental health status can be complicated, although helpful, in understanding psychopathologies. It could cause false conclusions as a neurotic person may still care for his/her community (family, co-workers, the planet, etc.) even if he/she is not caring for him/herself. The key is to first interpret the lifestyle then determine the existence of social interest. Using social interest as an indicator for a given psychopathology is also complicated in that it does not seem to be an all or nothing characteristic. It may, however, give the clinician an idea of the severity of a neurosis. For example, an individual with mild anxiety may be somewhat internally focused yet somewhat able to act with social interest whereas an individual with severe anxiety may remain constantly self-concerned (Kronmyer, 2011).

Research suggests that in prevention of eating disorders both education and social support were helpful in preventative programs (Craighead et al., 2008). Using social interest as a tool in therapy, especially in terms of social advocacy would be encouraged for this population for both the treatment and prevention of eating disorders. Mental health professionals should be prepared
to give clients proper resources to connect with their local LGBT community to hopefully find a niche and feel a sense of belonging with others who have perhaps shared common struggles. Belonging to such a community would hopefully create empowerment within the individual and increase self-esteem. The hope in connecting them with their community is also part of Adler’s theory of striving for perfection. If individuals are working on a horizontal plane towards a common, healthy, cause, they will in turn be more mentally healthy and content with themselves. Adler states that in order to be considered healthy a connection to social interest will be present (Adler, 1938). Adler also believed that a neurotic individual was a discouraged individual (Sperry & Carlson, 1996). Introducing positive supportive relationships into the individual’s life would be another helpful aspect to treatment and would create an encouraging environment. This could be possible through setting up mentoring programs within the LGBT community where established mentally stable members are connected with perhaps struggling or newly “out” members of the group for support on topics of need. Creating peer led groups would be another option on this same line of thought which could offer support and camaraderie to its members. Many large cities also hold “Gay Pride Weeks” which include fairs, parades, and outreach programming based on topics such as legislature on equal rights. Becoming involved with these programs may instill feelings of belonging, purpose, and self-sufficiency. These activities will most likely bring about encouraging experiences for a struggling individual and would be a helpful addition to individual therapy.

Author Reflection

Living with a mental illness is a frustrating, confusing, and moreover a lonely place to be. Both eating disorder awareness and the LBGT community are passions for the author; both needing community involvement and advocacy in order to progress and become accepted into
today’s society. While more research on these topics has led to greater understanding in recent decades, the author believes there is much work to continue, especially in the field of mental health. In the LGBT community in particular, the author is often taken aback at the amount of hate and prejudice this population must tolerate on a day-to-day basis, making it very likely that they must struggle with internal battles as well. As mentioned in this essay, social interest can improve these individuals’ perceptions and overall wellbeing. However, this population will continue to suffer until the whole of society also partakes in social interest and is mutually accepting of their fellow beings. As mentioned in the essay, well-meaning individuals may still be susceptible to “micro-aggressions” towards LGBT individuals, furthering the damage done to this population by society. Additionally, mental health workers must also take initiative in educating themselves on this community in order to continue to improve the care they provide. As a clinician, it is a requirement to remain open and helpful during the therapeutic process. However, the author feels that it is important to realize when a referral may be necessary if a clinician’s competence is not sufficient to adequately treat the client.

It is this author’s belief that the images given out to society through varying media outlets have set an unreachable standard on one’s physical appearance, somehow linking appearances to one’s worth as a human being. In this current society of extreme dieting, fast food, and mixed messages from the media, it is to no surprise that one’s body, what one presents to the world, is on the forefront of one’s mind. What better way to take one’s feelings out on the single outlet that will forever be with him/her? Human bodies have become a battle ground for emotions to play out, and with the increasing reports of eating disorders this is becoming a losing battle. Additionally, the author has learned through her experiences that many individuals look at their eating disorder as a companion in life (albeit an unhealthy one). For individuals experiencing
loneliness and discrimination perhaps an eating disorder can give new meaning to life, or at least something to offer distraction from the real problems at hand. The author believes that the longer one has become attached to the eating disorder that it could possibly be more difficult to become healthy and independent from its grasp.

With the growing number of eating disorders occurring within the LGBT community more awareness regarding this issue is necessary. While some people with eating disorders feel attacked by society, those with eating disorders in the LGBT community could feel doubly attacked. The United States culture is still seemingly a homophobic-transphobic-trans-sexist-homosexist society where more and more measures are being taken to ensure that bigotry and inequality continue against the LGBT community in particular. It seems to this author that truth will win out only if society continues advocating and educating. When there is a significant portion of society who openly and hatefully opposes one’s sexual identity as well as the added stress of being accepted into such a small and sometimes intimidating group of people (LGBT community) this can definitely influence an individual’s environment enough to harbor a mental illness such as an eating disorder. The author suggests that future clinicians work to educate themselves on the existence of eating disorders within the LGBT population and to show social interest themselves through their support in society.

The LGBT movement seems to be at turning point in the current political state of the United States. In the 40 years since the Stonewall Riots, LGBT awareness and acceptance has changed dramatically. There are currently gay-straight alliances in schools across the country, gay characters in movies and on television, affirming communities of faith, and even recently openly gay public officials. However, there are still inequalities for LGBT individuals as
working people, as equal members of the military, as families, as immigrants, as students, as taxpayers, and as United States citizens.

All across the country, LGBT people remain the victims of hate crimes and discrimination. More than 30 states have banned same-sex marriage, including some states (California and Maine) that had previously affirmed marriage rights. Several states have banned LGBT individuals and couples from adopting children, and in the majority of states it remains legal to fire people because of their sexual orientation or gender identity. Maybe most discouraging, there has been little movement on federal legislative priorities: the Employment Non-Discrimination Act (ENDA) is held up in delays and the Defense of Marriage Act (DOMA) still ensures that discrimination remains the law of the land. All the while, supposedly progressive leaders openly refuse to prioritize civil rights. It is of this author’s belief that the time has come to say unequivocally that this is more than a political movement but rather a civil rights movement.
References


