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Disordered Eating Patterns And Parenting Styles Among Female College Students

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DISORDERED EATING PATTERNS AND PARENTING STYLES AMONG FEMALE COLLEGE STUDENTS

SIMMS

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Disordered Eating Patterns and Parenting Styles

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Jennifer E. Simms

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Running head: EATING DISORDERS

Abstract

This study examined the relationship between parenting styles and the presence of a disordered eating pattern. It was expected that women displaying a disordered eating pattern would perceive their parents as more overprotective and less caring (a parenting style defined as affectionless control). One hundred and one female college students between the ages of 17 and 25 completed the 26-item Eating Attitudes Test (EAT) and the Parental Bonding Instrument (PBI) for both parents. The original hypothesis could not be tested using a Chi Square analysis due to small (< 5) frequencies in some of the cells of the disordered eating group by parenting style contingency tables. However, an analysis of variance revealed that women with a disordered eating pattern perceived their mothers as less caring than comparison women ($p < .05$, 1-tailed test). The results agree with previous findings that, although family factors may influence or may be influenced by an eating disorder, they do not have a consistent pattern. The limitations of this study and the instruments used are discussed.

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Several converging lines of research suggest a relationship between family variables and eating disorders (Humphrey, 1989; Scalf-McIver & Thompson, 1989; Bailey, 1991; Stern, Dixon, Jones, Lake, Nemzer & Sansone, 1989). Research examining the causal relationships between these family influences and eating disorders is, however, minimal. The literature suggests two types of causal relationships between these variables: dysfunctional family characteristics contribute to the development of eating disorders and development of eating disorders contributes to dysfunctional family characteristics.

Stern et al. (1989) found that five of the ten subscales on the Family Environment Scale (FES) differentiated among families of anorexics, bulimics, and controls. These subscales were cohesion, expressiveness, conflict, achievement motivation, and active-recreational orientation. These authors found a tendency for families to rate themselves as having less support for each other, less encouragement for the open expression of feelings, more interactions that were

conflict based, and less expressive. However, as the authors point out, these dysfunctional family characteristics are just as likely to be partly a consequence of the eating disorder as well as part of the cause. These characteristics may also be general properties of distressed families.

Anderson (1987) suggests that "family systems that do not allow patients to grow, to develop, to become more autonomous lead to lowered self-esteem" (p. 537). This author suggests that anorexic patients assume high levels of responsibility for their parent's mood early in their childhood and therefore do not take into account their own needs. Pike and Rodin (1991) suggested that the difference between disordered eaters and comparisons was the attitude their mothers held toward their weight and appearance. These authors felt that in order to express these attitudes to their daughters, the mothers of disordered eaters placed direct pressure on their daughters to be thin. The daughter then is more likely to accept her mother's attitudes and develop a disordered eating pattern. In addition, research by Bailey (1991) suggests that in a society that places unrealistic expectations on young

women, the family may increase the risk of the development of bulimia. This author looked at the relationship between bulimic-like symptoms, as measured by the Continuous Bulimia Scale, and the Family Environment Scale. This author also used some demographic control variables in portions of the analysis, such as race, highest level of education of the father and mother, the occupation of the father, and the occupation of the mother. Findings suggested that "those with bulimia or bulimic-like symptoms reported that their families are lacking in commitment, help, and support and are filled with anger, aggression, and conflict. Within these families, members were not allowed to express themselves and act openly and freely" (Bailey, 1991, p. 266).

In addition, Scalf-McIver and Thompson (1989) investigated the relationship between bulimic behavior, family social environment, consistency in parent-child relationships, cognitive distortion, satisfaction with appearance, and depression. Bulimic behavior was measured by the Bulimia Test, the family social environment was measured by the cohesion, conflict and control subscales of the Family Environment Scale, and

consistency in parent-child relationships was measured using the Parental Inconsistency of Love Scale. Results suggested that eating disturbances are more likely to be seen with an inconsistency of love in either mothers or fathers and less family cohesion. Finally, Humphrey (1989) observed the interactions within anorexic, bulimic, and normal families. Results suggested that in anorexic families, the parents are too nurturing, which keeps the daughter dependent, and also too neglectful of the daughter's developmental and expressive needs. The anorexic daughter then reciprocates these mixed messages through her uncertainty of expressing her feelings and obeying her parents' expectation. Bulimic families were more hostilely enmeshed, mutually controlling, and the daughter's separation is prevented by hostile submission. Thus, the causal relationship between family variables and the development of an eating disorder remains in need of clarification.

One family variable that may possibly have an effect on, or be affected by, the development of an eating disorder is parenting style. Using the Parental Bonding Instrument (PBI), Paris and Frank (1989) found

the parents of borderline patients to be less caring than the parents of nonborderline patients. These authors failed to find any evidence that parents of borderline patients differed from nonborderline patients in terms of perceived overprotectiveness. In another study using the Parental Bonding Instrument among borderline patients, Zweig-Frank and Paris (1991) found that both parents of borderline patients were perceived as low in caring and high in overprotectiveness as compared to nonborderline patients. Parental behaviors, also measured by the Parental Bonding Instrument (PBI), were found to contribute to a DSM-III-R diagnosis of an Axis II disorder and were also able to differentially predict a diagnosis of clusters A, B or C personality disorder but not GAF (Global Assessment of Functioning) scores (Paris, Frank, Buonvino & Bond, 1991). The authors suggested that the severity of the personality disorder is affected by the child's experiences but not actual functioning.

According to a study by Steinberg, Mounts, Lamborn and Dornbusch (1991), a parenting style characterized by both high responding and high demanding is

considered authoritative. Adolescents of parents who use an authoritative parenting style are more likely to "do better in school, are more self-reliant, report less psychological distress, and engage in less delinquent activity" (p. 31). Another study investigated the combination of psychological separation and parental attachment and its relationship with the combination of college student development and adjustment (Palladino Schultheiss & Blustein, 1994). These authors found that women who were both attitudinally dependent on and strongly emotionally attached to both parents were more "likely to have progressed effectively in developing purpose and academic autonomy" (p. 253). Kandel (1990) investigated whether lack of monitoring, low warmth, and high parental conflict would be associated with an increase in acting-out and control problems in the child. This author found that parents that are punitive report having children that are more aggressive, display behavior control problems, and are more unmanageable. Parenting style has also been found to be related to substance use. According to Coombs and Landsverk (1988), adolescents that abstain from

drugs or alcohol have "an emotionally close relationship with their fathers, receive advice and guidance from their mothers, and are expected to comply with conduct rules" (p. 480). Another study found a relationship between the self-concepts of young adults and the level of warmth and restrictiveness of their parents (Parish & McCluskey, 1992). College students were asked to evaluate themselves using the Personal Attribute Inventory which requires the subject to check adjectives for themselves. Higher scores reflect more negativity. The students were also asked to rate their parents on restrictiveness and warmth along a seven point scale. Results indicated that the college students' self-concepts were related to parental warmth but not parental restrictiveness.

Baumrind (1991) suggested a relationship between authoritarian parenting styles and adolescent development. She describes authoritarian control as "status-oriented, nonnegotiated, and constraining" (p. 752). Such parents are not responsive and instead expect their children to follow their demands without asking for an explanation. Baumrind (1991) suggests that an authoritarian-directive home is more likely to

have children, particularly girls, who use drugs and display behaviors reflective of internalizing difficulties.

Parental behaviors have also been found to differentiate neurotic depressives and anxiety neurotics (Lamont, Fischoff, & Gottlieb, 1976). Neurotic depressives reported their mothers as more rejecting and depriving and their fathers as more rejecting or depriving as compared to anxiety neurotics. A study by Parker (1983a) found that parental "affectionless control" as measured by the Parental Bonding Instrument may be related to depression. According to this author, neurotic depressives are more likely to perceive their parents as lacking in care and being overprotective. Finally, Cook, Kenny, and Goldstein (1991) investigated the relationship between the parent's affective style and severe psychopathology in the child. These authors suggested that negative parental affective styles and severe psychopathology in the child may have a reciprocal effect in disturbed families. These findings suggest that the relationship between parenting style and eating disorders should be studied

further.

An earlier study by Humphrey (1986) suggested that both bulimics and classical anorexics, as compared to controls, perceive their relationship with their parents and their feelings toward themselves as more hostile and less supportive. More recent studies investigating the relationship between eating disorders and parenting styles in clinical populations have had inconsistent results.

Steiger, Van der Veen, Goldstein, and Leichner (1989) compared 58 women meeting DSM-III-R criteria for an eating disorder to 24 women who showed no history or symptomology of an eating disorder. Subjects were administered the Bond Defense Style Questionnaire, the Parental Bonding Instrument, and the 40-item Eating Attitudes Test. These authors found that eating disordered subjects percieved their father as less caring than control subjects (Steiger, et al., 1989). Steiger and his associates (1989) suggested that "serious psychopathology in women may thus often surround feelings of failure with fathers" (p. 138).

Palmer, Oppenheimer, and Marshall (1988) found that anorexic mothers, bulimic mothers, and bulimic

fathers were less caring (p. 104). They compared 72 female adult patients suffering from anorexia nervosa or bulimia on the Parental Bonding Instrument to one of Parker's (1983b) Australian general practice normative sample. These authors suggests that their results do not undermine the influence of family factors in eating disorders but fail to implicate a particular pattern (Palmer et al., 1988).

Calam, Waller, Slade, and Newton (1990) compared scores on the Parental Bonding Instrument from 98 anorexic and bulimic women to 242 female volunteers. The clinical group perceived both their mothers and fathers as less caring and also their fathers as more protective. In addition, they also compared anorexics, bulimics with a history of anorexia nervosa, and bulimics with no history of anorexia and found that bulimics with and without a history of anorexia perceived their fathers as less caring and bulimics with no history of anorexia also found their mothers as less caring. Calam and associates (1990) felt that their results "support the hypothesis that overprotection and low warmth would be associated with anorexia and bulimia" (p. 483). In addition, Kent and

Clopton (1992) investigated the relationship between bulimia and family variables in a nonclinical college population. These authors had subjects complete the Personal History Questionnaire, the Bulimia Test, the Eating Disorder Inventory, the Family Environment Scale, and the Parental Bonding Instruments. Their results suggested that symptom-free college females, bulimics, and subclinical bulimics did not differ in terms of parental overprotection or caring.

Newton, Butler, and Slade (1988) found that fathers of eating disordered subjects were more overprotective than controls while Rhodes and Kroger (1992) found that the mothers were more overprotective. In this study, sixty-six subjects who were clinically diagnosed as having an eating disorder were administered the Eating Attitudes Test (EAT). High-EAT scorers were compared to low-EAT scorers on the Setting Conditions for Anorexia Nervosa Scale (SCANS), the Body Satisfaction Scale (BSS), and the Parental Bonding Instrument (PBI). Results indicated that low-EAT scorers were more likely to be clinically diagnosed as anorexic and perceive their fathers as more overprotective.

Rhodes and Kroger (1992) studied 20 women with eating disorders as determined by a psychiatrist or clinical psychologist according to DSM-III-R criteria were compared to 20 student controls from a university. Subjects were administered the Eating Disorder Inventory (EDI), the Parental Bonding Instrument, and the Separation-Individuation Test of Adolescence (SITA). Although the results showed a trend in the direction of less parental care and more parental overprotection for the women with eating disorders, only maternal care differentiated the eating disordered women from the controls. Overall, previous studies investigating parental caring and protection and the presence of an eating disorder in women from a clinical population have produced inconsistent findings.

The purpose of this study was to clarify the relationship between parenting styles and the presence of a disordered eating pattern. Due to the frequency with which researchers have found disordered eating among college women in nonclinical populations (Mintz & Betz, 1988; Klemchuk, Hutchinson & Frank, 1990; Clark & Palmer, 1983), this study focused on women in a nonclinical college population. A segment of the

college women was expected to display a disordered eating pattern. It was hypothesized that the group with a disordered eating pattern would perceive their parents as more overprotective and less caring. These parenting styles are classified by the PBI as affectionless control which is characterized by parents that are overprotective, controlling, emotionally cold, and neglectful. Parental-child interactions that are characterized in this manner were predicted to be related to the presence of a disordered eating pattern. The alpha level was set at .05.

Method

Subjects

Subjects were 101 undergraduate females between the ages of 17 and 25 and in psychology courses at Eastern Illinois University.

Measures

The Eating Attitudes Test, EAT-26, (Garner, Olmsted, Bohr, & Garfinkel, 1982) is a 26-item self-report measure of attitudes and behaviors related to eating disorders. The EAT-26 was determined to be reliable, valid and economical. Subjects respond to items on 6-point scales. The cutoff score for

determining a potential eating disorder was 20, as suggested by Garner et al. (1982).

The Parental Bonding Instrument, PBI, (Parker, Tupling, & Brown, 1979) is a 25-item self-report measure of the individual's first 16 years that is filled out by the subject twice: once for the mother and once for the father. The PBI has demonstrated test-retest and split-half reliability and in terms of validity it appears to be an acceptable measure of perceived and actual parental characteristics (Parker, 1983b). Subjects respond on 4-point Likert scales which are scored from 0 to 3. The PBI yields two subscales: care and overprotection. The care subscale assesses parental affection on one extreme and neglect on the other; the overprotection subscale assesses parental behaviors from control and infantilization to the allowance of independence and autonomy.

Procedure

Students were informed prior to administration that their participation was voluntary and that they could discontinue at any time during the study. Subjects were tested in groups using a questionnaire

which took approximately 15 minutes to complete. All subjects were contacted through the psychology department. They were asked to fill out the questionnaires completely and honestly. Confidentiality was discussed and the subjects were assured that their identity whould not be revealed in any reports of the research. Both the EAT and the PBI were administered. The entire questionnaire took about 15 minutes to complete. After the questionnaire was completed, an informational sheet concerning the purposes of the study and a list of available resources in the area for eating disorder concerns was provided.

Results

Subjects were categorized as eating disordered and non-eating disordered based on their scores on the EAT using a cut-off point of 20 (Garner et al., 1982); 19 subjects were classified as having a disordered eating pattern and the remaining 82 subjects were considered as showing no symptoms of a disordered eating pattern. Parental bonding, as assessed using the PBI, was classified as high care-low overprotection (optimal

bonding), low care-low overprotection (absent or weak bonding), high care-high overprotection (affectionate constraint), or low care-high overprotection (affectionless control). Mothers were considered high or low on caring based on a cutoff score of 27.0 and high or low on overprotection based on a cutoff score of 13.5 (Parker, 1983b). On the other hand, fathers were considered high or low on caring based on a cutoff score of 24.0 and high or low on overprotection based on a cutoff score of 12.5 (Parker, 1983b).

Insert Table 1 Here

As seen in Table 1, several of the cells had frequencies of less than five; the small sizes of these cells precludes testing the original hypothesis.

Insert Table 2 Here

The data was analyzed using a one-tailed one-way analyses of variance with the between-groups variable as the care and overprotection subscales of the PBI and the within-subjects variable as disordered eating

group. As shown in Table 2, the two disordered eating groups did not differ on maternal protection or on either paternal scale; however, women with a disordered eating pattern had mothers who were perceived as less caring, F (1,99) = 3.5941, $p < .05$, 1-tail test.

Discussion

The results of this study do not support the hypothesis that a particular type of parenting style is related to a disordered eating pattern. Women who had a disordered eating pattern were more likely to perceive their mothers as less caring. One possible explaination for this finding is that women with a disordered eating pattern feel that their mothers are less caring because they are not responding to their apparent eating problem. Another possibility is that women with a disordered eating pattern may not only have a disorted view of thier own bodies but also a distorted view of their environment. Their mothers may be perceived as less caring as a result of this distortion they possess. A final possibility is that these women may have a genetic predisposition towards a disordered eating pattern. If their mothers are less

caring, they are more likely to develop this pattern of disordered eating.

In this study, paternal caring, paternal overprotection, and maternal overprotection were not related to the presence of a disordered eating pattern. The findings--or lack thereof, reported here are quite likely the result of certain limitations discussed below.

The results of this study may have been limited by the small sample size; indeed, the original hypothesis could not be tested due to the small number of probands. Another limitation is the measures used in the study. Both the Parental Bonding Instrument and the Eating Attitudes Test lack the ability to detect the truthfulness of the subjects' responses. A possibility exists that individuals may have made themselves (or their parents) look good or they may have denied their symptoms (or their parents' behavior). Another possible limitation is that an identified clinically diagnosed sample of eating disordered women was not also administered the EAT. By comparing this sample's scores with the nonclinical sample's scores, high risk nonclinical individuals can

be discriminated from nonclinical individuals with a disordered eating pattern. High risk individuals may perceive their parents differently than those with a disordered eating pattern.

Implications

When compared to previous research on parental care and overprotection, the results of this study do not further the view that a particular type of parenting style is related to a disordered eating pattern. The results do, however, support the view that family factors may influence or be influenced by an eating disorder. The use of the PBI and different eating scales used in different studies has failed to find a consistent pattern of family factors.

Future Directions

In view of the discordant findings regarding the relationship between eating disorders and parenting styles, future research should focus on the reasons for the inconsistency. One area of focus could be the sample size. Based on the findings here (see Table 1), studies that classify subjects' parents according to their parenting style should use sample sizes of at least 300. Sample sizes of this magnitude would ensure

sufficient probands with the different parenting styles.

Another area of focus for future research is the measures used in the studies. The Parental Bonding Instrument used in most of the studies to identify perceived parenting styles was normed using an Autralian sample; it may be sensitive to cultural differences. As a result of potential cultural sensitivity, investigators using this instrument should develop local norms. As already discussed, the PBI is a measure of perceived parenting style and lacks the ability to determine the truthfulness of responses. Future research may benefit from multiple instruments to determine parenting style or from sibling concordance.

The EAT may also be a focus for future research. As previously stated by Newton et al. (1988), individuals clinically diagnosed as anorexic were more likely to score low on the EAT. A possible explaination is that these women may deny their sypmotoms of a disordered eating pattern. The EAT also has no method of identifying the truthfulness of the subjects' responses. Therefore, further research may

need to use several measures (for example, the EAT, a clinical interview, and parental reports) for classifying individuals as having a disordered eating pattern.

Finally, future studies may benefit from including a clinically diagnosed sample of eating disordered women in order to discriminate high risk individuals from disordered eating individuals within the nonclinical population. The high risk individuals may perceive their parents differently than those with a disordered eating pattern.

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Table 1

Disordered Eating Group By Parenting Styles.

Parenting Style	Mothers		Fathers	
	No Symptoms	Disordered Eating	No Symptoms	Disordered Eating
Absent bonding	9	2*	9	5
Affectionless control	8	3*	17	4*
Affectionate constraint	19	5	13	2*
Optimal bonding	46	9	43	8

* cell size < 5

Table 2

Means and Standard Deviations of PBI Scores for Women By Disordered Eating Group.

	Group			
	Disordered Eating		Comparison	
PBI	M	SD	M	SD
Maternal				
Care*	27.05	10.96	30.51	6.01
Protection	12.58	7.54	11.44	6.22
Paternal				
Care	24.68	7.90	25.61	9.10
Protection	10.37	6.47	11.63	6.94

* $p < .05$