

**THE INTERGENERATIONAL TRANSMISSION OF DIET CULTURE:
A MODEL OF CHILDREN'S
DISORDERED EATING AND BODY IMAGE**

A Dissertation presented to
the faculty of the Graduate School
of the University of Missouri

In partial fulfilment of the requirements for the degree of
Doctor of Philosophy

by

Ellen Jordan

Dissertation Supervisor: Colleen Colaner, Ph.D.

May 2023

The undersigned, appointed by the dean of the Graduate School, have examined the dissertation titled,

THE INTERGENERATIONAL TRANSMISSION OF DIET CULTURE: A MODEL
OF CHILDREN'S DISORDERED EATING AND BODY IMAGE

presented by Ellen Jordan, a candidate for the degree of Doctor of Philosophy,
and hereby certify that, in their opinion, it is worthy of acceptance.

Colleen Colaner, Ph. D.

Haley Horstman, Ph. D.

Yerina Ranjit, Ph. D.

Kale Monk, Ph. D.

DEDICATION

For M. For B. For E. For L. May this work help create the world that you needed.

ACKNOWLEDGEMENTS

This dissertation fully encompasses who I have grown to be as a scholar. Without the mentorship, insights, guidance, and support of many individuals, this work would not have been possible. The following individuals have played an important role in shaping my scholarly identity and supporting my growth during the completion of this dissertation and throughout my time at the University of Missouri.

First, I would like to acknowledge the mentorship of my advisor, Dr. Colleen Colaner. Colleen has been a steady support system in my life throughout my time as a doctoral student and candidate, providing both an enthusiastic “cheer-you-on” presence and rational, expert guidance. I have appreciated Colleen’s dedication to pushing boundaries and helping me step outside of my comfort zone; without this tenacity, I may not have arrived at this topic for my dissertation. Colleen’s willingness to learn about eating disorders, body image, and diet culture alongside me has demonstrated her commitment to dedicated mentorship, and has empowered me to become the scholar I am today. Finally, Colleen’s clear and expeditious feedback on my dissertation drafts is very much appreciated, and her support has aided in ensuring my graduation this semester. Colleen, thank you for being who you are and for setting an example of what it means to be a dedicated and successful scholar, mother, mentor, and person. I hope to parallel your enthusiasm, intellect, and patience in my own career.

Next, I would like to thank Dr. Haley Horstman for her support and guidance throughout my time in the Department of Communication. As the first faculty member I contacted prior to applying to the doctoral program, Haley is the person who connected me with Colleen, expressing a strong belief in my capabilities as a doctoral student. I am

ever thankful for Haley's unwavering belief in my potential for success; her continuous guidance, reliable advice, and persistent support have been an overwhelmingly positive influence on my trajectory as a scholar. Haley, I hope to emulate your positivity and support for others throughout my lifetime.

I would further like to acknowledge the remaining members of my committee: Dr. Yerina Ranjit and Dr. Kale Monk. Yerina, your insights have prominently shaped my identity as a health and family communication scholar. Your guidance during my comprehensive exams process has thoroughly informed my perspective on the health communication discipline, and has invigorated in me a love of a discipline I had not originally intended to pursue upon beginning my scholarly journey at Mizzou. I appreciate your efforts toward helping me develop this critical component of my scholarly identity. Kale, I appreciate your presence on my committee as a human development and family science scholar. Family science is a love of mine and an important part of my professional background. Your perspective on the family environment, as well as knowledge of Family Life Education, have allowed me to continue pursuing this aspect of my background in tandem with my doctoral degree in communication. Thank you for helping me bridge my two disciplinary loves.

I would also like to thank Dr. Rebecca Meisenbach, who served on my committee throughout my comprehensive exams process. Rebecca, I am so thankful for your expertise on stigma and your presence on my committee. Your stigma class opened my eyes to a topic closely related (albeit a bit unexpectedly) to my content area of eating disorder prevention. Your expertise and guidance throughout the comprehensive exams process encouraged me to think more critically about the way in which societal weight

stigma plays a role in eating disorder development, and for that, I am truly grateful. This encouragement helped me gain perspective on diet culture in relation to family communication, and without this guidance, this dissertation would not have been possible.

In addition to my committee, I would like to acknowledge Dr. Ben Warner as a significant influence on my time in the Department of Communication. Ben's unwavering support has continuously made me feel valued as a member of the Mizzou Comm community. In particular, Ben has been instrumental in my knowledge of and comfort with structural equation modeling, offering time and effort graciously and without reservation. Additionally, Ben's support during my initial pursuits on the academic job market helped me to confidently pursue jobs and participate in interviews. Ben, I hope to emulate your attentiveness and care for others throughout my lifetime.

I would importantly like to acknowledge the support of my family and friends in my pursuit of a doctoral education. To my friends both near and far: Thank you for your kindness, friendship, and interest in my passions. You make me feel seen, cared for, and surrounded by love. I am grateful for your presence in my life. To Ian, my better half: You have been the most incredible support system during my time in graduate school. Your enthusiasm for my success and positive attitude have kept me motivated and helped me feel empowered in times of stress and doubt. I will never be able to express the depths of my gratitude for your listening ear, your continuous patience, and your steady supportive presence. I am eternally grateful to you for all that you are. To Mina: I am so excited to meet you this summer, and I hope my knowledge of family and health communication can help me pursue your own well-being, happiness, and sense of

belonging in our family. I am so honored to be your mom and look forward to supporting and loving you for the rest of my life.

Finally, I would like to thank the parents and children who participated in my study. Your time and efforts are valued and very much appreciated. This work would not have been possible without your generosity. Because of you, we are one step closer to eating disorder prevention.

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ABSTRACT

Eating disorder prevention efforts are needed. When considering prevention, three common and concerning precursors to eating disorder development must be addressed: diet culture, disordered eating behavior, and body image (Harrison, 2019; Levine & Piran, 2004; Levine & Smolak, 2021; Rohde et al., 2015; Seitz, 2019). Given that family communication can influence children's well-being (Arroyo et al., 2017; Baiocchi-Wagner & Talley, 2013; Jones & Young, 2021), the current study sought to investigate the intergenerational transmission of diet culture. 199 parent-child dyads completed an online survey, and data were analyzed using structural equation modeling. Results provide support for the transmission of diet culture beliefs from parent to child, suggesting that children's perceptions of parental weight talk may be more meaningful in the transmission of diet culture beliefs than parents' self-reported weight talk. Implications for theory, future research, and prevention efforts are discussed.

CHAPTER ONE

INTRODUCTION

Eating disorders are a health concern threatening children's wellbeing. The Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED) reports that in the United States alone, 28.8 million people alive today will experience an eating disorder during their lifetimes (Deloitte Access Economics, 2020). Eating disorders are harmful illnesses, causing deterioration of individuals' mental and physical health and affecting their social and relational wellbeing. For example, eating disorders often result in poorer quality of life (de la Rie et al., 2005) and those who experience eating disorders may be at risk for depressive and anxiety disorders (Berkman et al., 2007), pregnancy complications (Kimmel et al., 2016), and marital dissatisfaction (Whisman et al., 2012). Additionally, eating disorders have one of the highest mortality rates of any mental illness (Jones & Brown, 2016), further illuminating this issue. Although eating disorder onset typically occurs within adolescence to young adulthood (Levine & Smolak, 2021), children and adolescents face challenges with body image, thin idealization, weight stigma, and disordered eating behavior that contribute to eating disorder diagnoses every day. Given the pervasiveness and severity of eating disorders, prevention efforts are needed to mitigate this health concern.

When discussing eating disorder prevention, it is necessary to consider how eating disorders develop in the first place. Existing models of eating disorder development have taken a psychological approach, focusing on individual psychological processes and societal-level influences, such as female body ideals (Brytek-Matera & Czepczor, 2017; Stice & Van Ryzen, 2019). What seems to be missing is a direct and specific

consideration of family communication as a context through which onset may occur or be influenced. Family communication plays a key role in children's social, cognitive, and physical development. The family environment is a critical context in which human development takes place, and parent-child communication is a primary channel through which children learn about values, health, and appropriate behaviors (Baiocchi-Wagner & Talley, 2013; Bronfenbrenner, 1986; Medved et al., 2006). Through parent-child communication, children's beliefs and behaviors may be established that contribute to eating disorder onset. Consequently, family communication is an appropriate and necessary avenue through which eating disorder prevention may be facilitated, and as such, work is needed to better understand eating disorder development from a family communication perspective.

Although myriad factors can influence an individual's eating disorder, the extant literature has revealed three common and concerning precursors to eating disorder development and prevention: diet culture, disordered eating behavior, and body image (Harrison, 2019; Levine & Piran, 2004; Levine & Smolak, 2021; Rohde et al., 2015; Seitz, 2019). As will be explicated later in this chapter, diet culture facilitates beauty ideals and food moralization, contributing to negative body image and disordered eating across society (Harrison, 2019). Furthermore, as is described in chapter 2, disordered eating behaviors and body image can be communicatively transmitted within the family environment (Arroyo et al., 2017; Jones & Young, 2021). Therefore, the current study seeks to investigate the intergenerational transmission of diet culture within the family, while subsequently examining its influence on children's disordered eating and body image. By facilitating this understanding, effective prevention efforts may be informed.

To this end, the following goals are proposed for the current study: (a) to determine the influence of parents' diet culture-informed beliefs on their communication, (b) to understand how parent-child communication influences children's own diet culture beliefs, and (c) to understand how children's diet culture beliefs may predict their disordered eating and body image. The remainder of this chapter will serve as an introduction to and brief rationale for this study. First, three critical eating disorder precursors, diet culture, disordered eating behavior, and body image, will be defined and the need for prevention efforts for each will be discussed. Lastly, an argument will be presented for family communication as an important and necessary context through which such precursors are developed and, consequently, may be prevented, alongside a discussion of the need for children's perspectives in family communication research.

Precursors to Eating Disorders

Diet Culture

Diet culture can be thought of as a communicative societal environment of stigmatizing messages about body size, fatness, and the thin ideal. It pervades families' daily lives and influences how individuals feel about themselves and others. Defined by Harrison (2019), *diet culture* more specifically refers to,

a system of beliefs that equates thinness, muscularity, and particular body shapes with health and moral virtue; promotes weight loss and body reshaping as a means of attaining higher status; demonizes certain foods and food groups while elevating others; and oppresses people who don't match its supposed picture of "health" (p. 7).

Because diet culture's messages of fatphobia, weight stigma, and thin idealization are prevalent throughout society, it is nearly impossible to avoid its influence. These messages affect families and individuals in various ways. For example, exposure to thin-ideal messages within the media may predict children's eating disorders (Harrison, 2000). Additionally, parents' weight-stigmatizing experiences have been shown to affect their feeding practices with children (Gold & Vander Weg, 2020). Furthermore, parents who engage in dieting are more likely to have weight-focused conversations with their children (Winkler et al., 2018) and tease their children for their weight (Lessard et al., 2021).

With roots in fatphobia and weight stigma, diet culture has allowed for unfair treatment of fat people in areas such as healthcare, interpersonal relationships, and education. Fat individuals, disproportionately women, are often improperly diagnosed in healthcare settings, overlooked in educational environments, and stigmatized in romantic relationships (Fikkan & Rothblum, 2012). Individuals who experience weight stigma are at greater risk for disordered eating behavior (Chen et al., 2020; Wellman et al., 2018), suicidal thoughts (Hunger et al., 2020a), and weight bias internalization (Pudney et al., 2019). Diet culture's environment of extreme fatphobia has given way to mental health challenges for individuals who expect to be stigmatized for their weight, as anticipation of weight stigma has been connected with disordered eating as well as weight and body concerns (Hunger et al., 2020b). These findings thus point to a world in which fat people are treated as unwelcome guests.

Diet culture is notably comprised of messages emphasizing the importance of and requirements for being attractive, as well as moralizing food choices and eating

behaviors. These messages prescribe a moral value to eating habits and food choices under the guise of health and wellness. For example, diet programs often push dieters to take control of their eating habits, suggesting that weight loss would happen if they had enough willpower (Harrison, 2019). Within the family, research shows that parents often communicate messages of the thin ideal, suggesting that their children should lose weight for reasons of health, attractiveness, or social acceptance (Rubinsky et al., 2019). Parents may not realize they are sending such messages (Liechty et al., 2016), indicating the ever-present nature of diet culture's influence. Though not always intentional, these messages reinforce a notion often preceding an eating disorder: the idea that one can actively control their weight if they engage willpower enough to control their eating, and furthermore that this control is necessary to be healthy, attractive, and socially accepted (Harrison, 2019). Given diet culture's ever-presence, it is difficult to avoid its influence. Parents subjected to diet culture messages may unintentionally reinforce such ideals in communication with their children, as research has shown parents' weight stigmatizing experiences to predict their feeding practices (Gold & Vander Weg, 2020) and parents' dieting to influence the conversations they have with their children (Winkler et al., 2018). Ultimately, diet culture poses a considerable threat to society as a whole, but particularly to children and families. Therefore, it is important to understand how diet culture beliefs may be transmitted within the family, with the intention of informing prevention efforts.

Disordered Eating

Disordered eating behavior is a mental health challenge facing many children, adolescents, and adults. Defined by Harrison (2019), *disordered eating behavior* refers to,

using behaviors such as fasting, chronic restrained eating, restricting major food groups, vomiting, or laxatives to try to lose weight, and/or bingeing... all without engaging in any of those behaviors frequently or consistently enough to meet the criteria for a full-blown eating disorder (p. 6).

Disordered eating behavior, often simply referred to as *disordered eating* (DE), may include a variety of actions, including binge eating, food restriction, and/or unhealthy/extreme weight control behaviors. Additionally, Levine and Smolak (2021) contend that disordered eating is frequently accompanied by a sense of self based in unrealistic standards of beauty and fitness, behaviors such as body-checking and social comparison, and an “irrational fear and loathing of body fat and fat people” (p. 28).

Recent research on disordered eating has investigated the prevalence of disordered eating in different populations (e.g., Chatterton & Petrie, 2013; Sparti et al., 2019; Voelker et al., 2014) as well as protective or risk factors (e.g., Davis & Smith, 2018; Watson et al., 2017), including mediated and family communication (e.g., Arroyo et al., 2017; Holland & Tiggeman, 2017; Miller-Day & Marks, 2006).

While those who engage in disordered eating may not be diagnosed with a clinical eating disorder, disordered eating is in no way less harmful or concerning. Disordered eating has been associated with decreased emotion regulation abilities (Farstad & von Ranson, 2021; Haynos et al., 2018), problems with executive function (Ciszewski et al., 2020), menstrual irregularity (Barrack et al., 2021), and, when used as a coping mechanism for weight stigma experiences, poor physical health (Himmelstein et al., 2018). Those who engage in disordered eating behavior may be at risk for decreased relationship satisfaction as well (Blais et al., 2019). In addition to these concerning

outcomes, research shows that men and women who begin dieting in adolescence tend to see a continuous increase in dieting behavior over time (Goldschmidt et al., 2018). The same is true for men and women who engage in unhealthy weight control behaviors such as skipping meals, purging, and taking diet pills, although for women, the increase over time may depend on weight trajectory (Goldschmidt et al., 2018). Overall, these findings suggest that once individuals begin to engage in disordered eating, it may be challenging to stop. Given the adverse outcomes associated with disordered eating, and considering that it is often a precursor to a clinical eating disorder diagnosis (Seitz, 2019), it is clear that eating disorder prevention efforts need to address disordered eating as a severe and serious problem.

Body Image

Body image is another issue of concern relevant to eating disorder prevention, and can be thought of as a perception of one's body that individuals live with throughout their lifetimes. Defined simply, *body image* refers to one's feelings about and perceptions of their body (Kite & Kite, 2021). Individuals may have a positive or negative body image, and a person's body image tends to fluctuate over time. A positive body image deems a body valuable; for one to have a positive body image, they must have an appreciation of their body's abilities, characteristics, and/or worth. As Kite and Kite (2021) contend, "Positive body image... is knowing your body is good, regardless of how it looks" (p. 7). Conversely, a negative body image entails feelings of shame, embarrassment, or disappointment over one's body. Individuals who experience negative body image often feel badly about one or multiple characteristics of their body, often focusing on its appearance relative to societal beauty ideals. Research on body image often uses the term

body dissatisfaction and has most often focused on women's body image (e.g., Arroyo et al., 2020; Rubinsky et al., 2019), although some recent work has begun to investigate men's body image as well. Additional research has examined risk and protective factors associated with body image (e.g., Arroyo et al., 2020; Littleton & Ollendick, 2003; Rodgers et al., 2020), as well as related outcomes such as disordered eating, depression, and anxiety (e.g., Hartley et al., 2018; Kluck, 2010; Kogure et al., 2019).

Negative body image is a concern relevant to eating disorder prevention efforts. Not only does negative body image play a role in eating disorder onset (Levine & Piran, 2004; Rohde et al., 2015), but it has also been linked to a variety of other damaging outcomes. Individuals with negative body image may be at risk for depressive symptoms, particularly if they have a low level of physical activity (van Mierlo et al., 2021). Additionally, negative body image has been linked with low self-esteem (Verplanken & Velsvik, 2008) and emotional eating (Shriver et al., 2021). Individuals with negative body image may furthermore be at risk for symptoms of anxious, depressive, or somatic disorders (Carter et al., 2014). Taken together, these findings indicate that children who experience negative body image may be at risk for a variety of serious mental and physical health problems. As such, it is important that scholars seek to understand how diet culture and parent-child communication may influence children's body image with eating disorder prevention in mind.

Rationale for Current Study

Role of Family Communication

Diet culture, disordered eating, and body image are critical precursors to eating disorders, and the processes that comprise their development must be further examined to

aid in prevention efforts. A necessary next step, then, for eating disorder development and prevention research is the consideration of family communication as a critical and specific facilitator of – or preventative process against – such efforts. While the existing literature has identified parent-child communication as relating to diet culture beliefs, disordered eating, and body image (Arroyo et al., 2020; Holub et al., 2011; Jones & Young, 2021; Miller-Day & Marks, 2006), more work is needed to fully understand communication within the family as both a context for and process facilitating the development and prevention of such issues. Research is needed that connects parent-child communication with the ways in which diet culture beliefs, disordered eating, and body image come together toward eating disorders fully. To this end, the current study's consideration of parent-child communication as both a relevant context for and influential process toward the development of children's disordered eating, body image, and diet culture beliefs presents a useful and novel contribution to the field.

Family systems theory conceptualizes the family as an interconnected system, and posits that one family member's experiences will influence the entire family (Galvin et al., 2015). In this way, diet culture works as an ever-present influence, and when one family member experiences weight stigma or is exposed to fatphobic messages, their behavior and verbal communication will be affected. Thus, the entire family is exposed to diet culture's influence. It is through communication that diet culture weaves throughout family systems, and thus, research needs explicit attention on the communication processes through which such influence is passed between family members. Better understanding such processes may help inform prevention efforts. Thus, the current study aims to address this need by investigating how parents' verbal and nonverbal

communication may influence children's diet culture beliefs, which may subsequently predict children's disordered eating and body image.

Children's Perspectives and Prevention

Research investigating children's outcomes related to parent-child communication necessitates the use of children's perspectives. Though much of the existing research on parent-child communication claims to address child outcomes, very few studies adequately represent children's perspectives. In their review of family communication research, Miller-Day and colleagues (2013) found that less than 4% of the literature engaged child participants as communicators. Considering the breadth of parent-child communication research that addresses child outcomes, this is concerning. Research that does engage "children" as participants tends to use young adult children rather than adolescents or younger children (e.g. Arroyo et al., 2017; Jones & Young, 2021; Schrodtt et al., 2007). While this may be more convenient than obtaining a child sample, using a young adult sample limits the applicability of the research, as the findings will convey the young adult perspective. As such, a study's sample has important implications for how the research is understood and applied, and consequently, work that aims to address child outcomes should engage a sample that is relevant to the outcomes it seeks to address.

Finally, family communication research that does not engage a child or young adult child sample often uses parent perception to measure child outcomes. The problem with this lies again in what the study truly is measuring. Instead of measuring children's true outcomes, research that obtains parental perception is measuring just that. It is important for scholars to consider the implications of doing this when their intent is to measure child outcomes, and this becomes especially important for scholars researching

parent-child communication and disordered eating/body image outcomes, as it is possible that parents may misunderstand or not be aware of any mental health challenges their child is facing. Disordered eating is often enacted in secret, as detailed in Gay's (2017) and Tovar's (2018) memoirs, and mental health struggles are not always outwardly displayed. Parental perception may be even less accurate when specifically considering children's and adolescents' communication. As children get older, they seek more autonomy. Adolescents may not tell their parents about mental health challenges they face, instead choosing to address these problems on their own. Because of this, research assessing child outcomes through parent perception is not always likely to be accurate. With this in mind, the current study seeks to address this gap in the literature by obtaining child data when measuring children's diet culture beliefs, disordered eating, and body image, as well as children's perception of parents' weight talk and modeling of dieting behaviors.

Concerning eating disorder prevention, research engaging children's perspectives should seek participants within an appropriate age range for findings to truly be considered to inform prevention. Eating disorders typically occur in late adolescence to early adulthood (Jones & Brown, 2016); therefore, prevention efforts should seek to reach children younger than this age range. The Centers for Disease Control and Prevention (CDC) defines middle childhood as the age range of 9-11 years old (CDC, 2021a), and additionally defines young teens as the age range of 12-14 years old (CDC, 2021b). Furthermore, adolescence as a whole is typically defined as the age range of 10-19 years old (World Health Organization, 2021; WHO). As such, children aged 9-14 years old are an appropriate target population for this study.

Conclusion

The purpose of this research is to investigate a model in which children's disordered eating, body image, and diet culture beliefs are communicatively developed within the family. Through this investigation, an understanding of eating disorder development via family communication may emerge, lending itself toward family-based prevention efforts. To this end, three primary goals are asserted for this study: (a) to determine the influence of parents' diet culture-informed beliefs on their communication, (b) to understand how parent-child communication influences children's own diet culture beliefs, and (c) how children's diet culture beliefs may predict their disordered eating behavior and body image. Thus, the current study considers communication within and surrounding the family as being critical for the development of children's disordered eating, body image, and diet culture beliefs, such that family communication acts as a necessary context for and process influencing these outcomes. The following chapter will detail the extant literature relevant to the proposed model. Research pertaining to family communication, disordered eating behavior, body image formation, and diet culture will be discussed. Relevant theorizing will additionally be detailed. Finally, the proposed model and hypotheses will be presented.

CHAPTER TWO

LITERATURE REVIEW

Eating disorders pose a considerable health risk for children and adolescents (Jones & Brown, 2016; Levine & Smolak, 2021). Thus, the current study aims to better understand how precursors to eating disorders are communicatively developed within the family. To do this, the current study proposes a model describing the development of children's disordered eating and body image via the intergenerational transmission of diet culture. The proposed model suggests that parents' diet culture beliefs inform children's diet culture beliefs through their communication. Furthermore, the model proposes that children's developed diet culture beliefs predict their disordered eating and body image outcomes. Ultimately, this model seeks to explain diet culture's influence within and surrounding the family toward children's eating disorder-related risk factors. To this end, this chapter details the relevant literature toward the proposed model, providing a rationale for the current study.

Toward this rationale, relevant theorizing is first discussed. Theories of human development and communication are presented both as salient backdrops in which the proposed study is situated as well as influential processes toward explaining the development of children's outcomes. Secondly, the way in which diet culture is communicated within the family is discussed. Family communication techniques are thirdly discussed as a means through which children learn about eating behaviors and body image. Next, implications for children's disordered eating and body image are explicated, and the relevant literature is ultimately brought together in a detailed discussion of the proposed model. A list of hypotheses will be provided (Table 2.1), as

well as a graphic depiction of the model. Ultimately, the need to investigate diet culture communication, parent-child communication, and children's outcomes in conjunction with one another will be presented in this chapter.

Relevant Theorizing

Family Systems Theory

Family systems theory is an appropriate lens from which to primarily approach the current study. The central premise of family systems theory states that a family is an interconnected system rather than a simple group of individuals (Bowen, 1978; Minuchin, 1985). Family systems furthermore maintain seven primary characteristics: *interdependence, wholeness, patterns/self-regulation, openness, hierarchy/subgroups, interactive complexity, and equifinality* (Galvin et al., 2015; Yoshimura & Galvin, 2018). The first characteristic that family systems hold is *interdependence*. This means that each family member is connected in such a way that “changes in one... result in changes in the others” (Galvin et al., 2015, p. 59). In other words, when something happens to one family member, the entire system is affected. With regard to diet culture, interdependence can be seen in a parent's dieting behavior, for example. When a parent frequently diets, their communication with their children is affected (Winkler et al., 2018); thus, one family member's actions affect the entire system.

Wholeness suggests that a family's collective identity is separate from the individual identities of each family member. Family systems are comprised of their individual members, and while each family member is an independent person, together they comprise the family identity. For example, although certain descriptors may be used to describe a family as a whole, these words may not apply to family members

individually (Yoshimura & Galvin, 2018). A family's identity, then, emerges from interactions between family members (Galvin et al., 2015). For example, a family may be described as "fitness-oriented" if the parents often work out with their children, or as "healthy eaters" if parents frequently teach their children to cook healthy meals. Although each family member may not individually be interested in working out or cooking healthy recipes, these family interactions comprise the system's defining qualities.

Family systems theory additionally posits that family systems regulate themselves through patterns in behavior (Yoshimura & Galvin, 2018). These patterns are comprised of coordinated interactions between family members, constituting families' routines and patterned communication. When families establish patterns to help regulate the family system, communication rules are typically used as a necessary kind of pattern (Galvin et al., 2015). Communication rules and feedback help maintain stability within a family by providing constant communication as well as a standard expectation for family behavior. Communication rules also indicate how to handle deviance from this norm (Galvin et al., 2015). In the context of the current study, a family may follow a communication rule of, "We don't discuss weight in this family" or "Don't complain about the dinner you are served." These rules, according to family systems theory, help keep stability in the system by providing standards to be met by each member of the family.

Openness is the next characteristic of family systems. Though a family is a unit in itself, it is not independent of outside influence. Thus, openness is necessary because families exist within larger systems and are "influenced by societal conditions and norms outside of the family system" (Yoshimura & Galvin, 2018, p. 166). Openness, then, is

what allows societal influences to seep into family communication. The current study contends that families exist within the larger influence of a societal diet culture; thus, families' openness allows diet culture's values of fatphobia and the thin ideal to permeate into parent-child communication.

Families also contain *hierarchies* and *subgroups*. The entire family system contains subsystems, such as parental subsystems and sibling subsystems. These subsystems constitute entire systems themselves, and also comprise the larger family system (Yoshimura & Galvin, 2018). In this way, subsystems make families unique and diverse. Often, family subsystems are organized by a hierarchy. The parental subsystem, for example, may stand at the top of the hierarchy if the parents take an authority position within the family. Over time, subsystems and their hierarchies can change, as they adapt to changes in family relationships (Yoshimura & Galvin, 2018).

Because family systems are complex, structured, and comprised of various communication rules, subsystems, and hierarchies, they characteristically develop an *interactive complexity*. Due to a family's complexity, the existing interactions and structures within it "may only be understood in relation to each other" (Galvin et al., 2015, p. 66). In other words, no two families are alike, and a family cannot be thoroughly understood when compared with other families; rather, a family system may more clearly be understood when closely analyzed as a multidimensional unit. Though diet culture is ever-present in society and its influence cannot be avoided, it does not affect every family in the same way. The way in which diet culture affects a family's communication will depend on the family's openness, subsystems, hierarchies, communication rules, and

interdependence, among other factors. Thus, interactive complexity serves to individuate each family system.

Lastly, family systems experience *equifinality*, meaning that a family's circumstances, goals, and/or relationships may be reached in differing ways (Galvin et al., 2015). For example, while many families may aim to maintain a healthy lifestyle, this may be accomplished in different ways: while one family may focus on eating nutritious foods and exercising often, another family may focus on weight loss. Though these families have the same goal, equifinality suggests that no two families' paths will be the same (Yoshimura & Galvin 2018).

Ecological Risk/Protective Theory

Ecological risk/protective theory (ERPT) was proposed by Karen Bogenschneider (1996), and this theory provides additional support for the current study. Though similar in name, Bogenschneider's (1996) ecological theory is markedly distinct from Bronfenbrenner's (1979) ecological systems theory of development. While Bronfenbrenner's (1979) theory maintains a grand, multi-layered approach to understanding human development, ERPT more specifically considers both risk and protective factors within one's developmental ecology and proposes the potential ways in which such factors may affect one's development. According to ERPT, human development is affected by a multitude of factors and nuanced perspectives, and as such, it may not be sufficient to focus on one model alone when investigating developmental processes. Consequently, in her theory, Bogenschneider (1996) aims to extend Bronfenbrenner's assertions and Lerner's (1991) model of developmental contextualism by combining key elements of these approaches as the bases of ERPT.

Primarily, ERPT builds upon these models by merging two existing approaches to human development and prevention research: a risk-focused approach by Hawkins et al. (1992) and a protection-focused approach. Hawkins and colleagues' (1992) risk-focused perspective was developed toward the prevention of substance abuse. This approach maintains that prevention is best performed when risks within one's environment are reduced or eradicated (Hawkins et al., 1992). Risks in this approach are posited to exist at one of two levels. Broader societal and/or cultural-level risks provide frames of reference for normative social behavior, which may place individuals at risk for dangerous actions. For example, normative expectations of alcohol consumption may place individuals at risk for developing alcoholism (Hawkins et al., 1992). Interpersonal-level risks exist within individual, family, school, and peer environments, and may influence individuals toward risky behavior. For example, psychological propensities such as sensation-seeking may play a role in risky alcohol consumption. Family factors such as parental alcohol use may additionally put one at risk for alcoholism (Hawkins et al., 1992). In the context of the current study, diet culture messages rampant throughout the media would constitute societal-level risk factors toward body image issues and disordered eating, and familial communication like weight talk and mealtime conversations may constitute interpersonal-level risks toward these issues.

The second perspective considered within ERPT is a protection-focused approach to prevention. Though she does not attribute this approach to any particular scholar, Bogenschneider (1996) indicates its use by Werner (1990) and Benard (1993). According to Bogenschneider (1996), the protection-focused approach decidedly highlights protective processes, rather than risk factors, as being influential toward human

development. The term *processes* is used over the term *factors* as a marked way of separating them from the individual context; that is, protective *processes* happen within, to, or surrounding the individual, rather than being solely based within the person (Bogenschneider, 1996). Overall, protective processes work to facilitate prevention of damaging issues through one's development, and taking a protection-focused approach to prevention allows for a consideration of what is "right" with the person, rather than what is "wrong" (Bogenschneider, 1996).

Ultimately, Bogenschneider (1996) merges the risk and protection approaches with Bronfenbrenner's ecological systems theory and Lerner's developmental contextualism to form ERPT. The theory's central premise maintains that "human development is shaped by a myriad of processes and that these processes must be identified in multiple levels of the human ecology" (Bogenschneider, 1996, p. 130). ERPT contends that risk factors and protective processes exist throughout one's developmental ecology, and that considering these elements at varying levels of ecology will allow for the most comprehensive understanding of human development. Furthermore, as life continues and circumstances change, influential processes toward human development may change as well (Bogenschneider, 1996). Given these assertions, ERPT provides clear support for the current study. As detailed later in this chapter, this study specifies a model in which diet culture communication at the societal level is a risk factor toward children's outcomes via parent-child communication. Further, parent-child communication is proposed as both a risk factor and protective process through which outcome prevention and development may occur. By viewing diet culture as an influential factor both within and surrounding the family, the current study considers both

societal-level and interpersonal-level risk factors toward the development of children's disordered eating, body image, and diet culture beliefs. Parent-child communication is conceptualized additionally as a protective process against such negative outcomes. As such, this study is based in ERPT to comprehensively understand the communicative development of children's disordered eating, body image, and diet culture beliefs.

Family Communication Patterns Theory

Existing communication theory may elucidate the ways in which communication is a key context for and process facilitating the development and prevention of children's disordered eating and body image within and surrounding the family. Family communication patterns theory (FCPT) is a general theory of family communication that identifies families' communication propensities and schemas, which relate to children's socialization and how family members view their relationships with one another (Koerner et al., 2018). FCPT asserts that families' communication exists among two dimensions: conversation orientation and conformity orientation. Conversation orientation is open and inclusive in nature; it encourages varying voices and perspectives, and allows individual family members to build their own viewpoint (Koerner et al., 2018). Alternatively, conformity orientation emphasizes uniform beliefs and responses among family members (Koerner et al., 2018). Though traditionally seen as being negative or inhibitive, recent research has highlighted the ways in which conformity oriented-communication may benefit children's development by facilitating shared values among the family, expanding upon the previous understanding of this communication orientation (Horstman et al., 2018). FCPT asserts that families' communication will take on a level of both

conversation orientation and conformity orientation; that is, families may demonstrate high or low levels of each orientation within their communication (Koerner et al., 2018).

FCPT proposes four distinct schemata in which families reside: *consensual*, *protective*, *pluralistic*, and *laissez-faire*. These schemata are determined by the family's levels of conversation and conformity orientation (Koerner et al., 2018). Families who are *consensual* display communication that is high in both conversation and conformity. Consensual families face the challenge of trying to maintain a uniform belief system while also recognizing and accepting each other's differing viewpoints. Koerner and colleagues (2018) state that this often manifests as parents seeking out their children's perspectives, but ultimately explaining their own views to the children in hopes of compliance. In *protective* families, communication is low in conversation and high in conformity. These families place emphasis on parents as the decision-makers and do not value open discussion. Parents in protective families see conflict as a threat to family wellbeing and expect their children to agree with their perspectives (Koerner et al., 2018). Families who are *pluralistic* demonstrate communication that is high in conversation and low in conformity. These families value open communication and encourage children to build their independent perspectives. Parents in pluralistic families do not feel the need to be the sole decision-makers, but rather, they aim to include children in family matters (Koerner et al., 2018). Lastly, *laissez-faire* families are low in both conversation and conformity. Their communication is minimal, as members in these families have limited interaction. Individuals in *laissez-faire* families tend to be highly independent, and due to this lack of support, children may question their ability to be strong decision-makers (Koerner et al., 2018).

The way a family orients its communication is highly influential toward children's upbringing. Research has connected a family's communication orientation and FCPT schema to children's development. With particular salience to the current study, a family's FCPT-based communication style and schema has been connected with children's mental health (Schrodt et al., 2007), disordered eating behavior (Miller-Day & Marks, 2006), and weight stigma (Asbury & Woszidlo, 2016). The relevant literature on FCPT and children's outcomes will be discussed later in this chapter. The remainder of this chapter will detail the extant literature related to diet culture, relevant parent-child communication techniques, disordered eating, and body image, and additionally detail the proposed model.

Transmission of Diet Culture

Diet culture exists within and surrounding the family; that is, diet culture's influence upon the family is ever-present. Because diet culture's influence is nearly impossible to avoid, it is important to consider the ways in which such values may be transmitted within the family. Research investigating diet culture has rarely labeled it by name; instead, the extant literature focuses on concepts of weight stigma, weight bias internalization, self-objectification, and body (dis)satisfaction. In doing this, researchers have created a breadth of work that, when pieced together, can illuminate the role of diet culture in parent-child communication.

The extant literature suggests that parents' diet culture-informed beliefs may communicatively be transmitted to children. Research indicates that mothers' fatphobic beliefs are associated with their daughters' fatphobic beliefs, such that mothers' fear of fat and blame of fat people indicated greater weight bias in daughters (Gagnon-Girouard

et al., 2020). Additionally, children's stereotyped beliefs about fatness increase when mothers hold fatphobic attitudes themselves, and when mothers hold authoritarian parenting beliefs (Holub et al., 2011). Lastly, research by Damiano and colleagues (2015) additionally indicates that fathers' weight-related beliefs can be transmitted to their sons. With child weight-based stigma beliefs being highly prevalent in parents (Lydecker et al., 2018a), it is unsurprising, but also unfortunate, that parents may inadvertently communicate such beliefs to their children through their words, actions, and parenting decisions. Thus, the following hypothesis is proposed:

H1: Parents' diet culture beliefs will predict children's diet culture beliefs.

Because Americans grow up in the fatphobic environment of diet culture, it is easy to overlook how these stigmatizing beliefs are ingrained in family communication. When parents experience weight stigma, they are more likely to internalize weight bias, which is in turn associated with increased weight-focused conversations with children (Pudney et al., 2019). This means that parents may be more likely to communicate messages about weight to their children when they experience weight stigma, due to their internalization of weight stigma beliefs. Parents who have dieted recently or who perceive their child to be underweight or overweight may be more likely to discuss their child's weight with the child (Winkler et al., 2018), and may be more likely to tease their child for their weight (Lessard et al., 2021). Additionally, parents who are concerned about their child's weight tend to engage in more restrictive feeding practices, such as preventing children from eating too many sweets or eating their favorite foods too often (Jaffe & Worobey, 2006; Loth et al., 2021), and may tease their child for their weight more often (Lessard et al., 2021). Similarly, parents' own weight stigmatizing experiences

have been found to predict restrictive feeding practices for children (Gold & Vander Weg, 2020), and parents' anti-fat beliefs are also associated with restrictive child feeding practices (Robertson et al., 2022). These results were significant for restrictive feeding practices rooted in both health intentions (i.e., hoping for their children to be healthier) as well as weight reasons (i.e., hoping for their child to lose weight; Gold & Vander Weg, 2020). These findings raise questions about the messages that such parenting practices may communicate to children. Being fed less food and/or less appealing food in the name of weight concerns may communicate a value placed on thinness, working to perpetuate the thin ideal proposed within diet culture. Thus, the following hypotheses are posited:

H2a: Parents' diet culture beliefs will predict weight talk with their children.

H2b: Parents' diet culture beliefs will predict modeling of dieting behavior in front of their children.

Family Communication

The extant literature has clearly indicated the importance of family communication to children's diet culture beliefs, disordered eating, and body image. Within this literature, two primary communication techniques have emerged as being particularly salient to these issues: weight talk and behavioral modeling. In addition, mealtime has emerged as a highly salient context in which such communication may occur. As such, the following section details the existing research the degree to which parent-child weight talk, mealtime communication, and behavioral modeling of weight- and eating-related practices may predict children's diet culture beliefs, disordered eating, and body image.

Parent-Child Talk

Weight Talk. Weight talk within the family has been detrimentally linked with children's diet culture beliefs, disordered eating, and body image outcomes. Defined simply, weight talk refers to weight-related communication, particularly between parents and their children (Gillison et al., 2016; Pudney et al., 2019). Examples of weight talk include parents' comments about their own bodies, parents' comments about their children's bodies, weight-related teasing, fat talk, and discussing weight of non-family members. Weight talk may be highly prevalent among families, particularly from mothers to daughters (Dahill et al., 2021); therefore, it stands as an important consideration for family communication research.

Weight talk has commonly been examined within the parent-child relationship alongside children's disordered eating outcomes. Findings indicate that children's perceptions of encouragement to diet and weight teasing from parents are linked with children's dieting and dysfunctional eating (Gillison et al., 2016), and that parents' engagement in fat talk (that is, weight talk specifically focused on the negative aspects of fatness) is linked with children's disordered eating (Lydecker et al., 2018b). Maternal weight- and eating-focused comments toward children may be associated with increases in disordered eating in both sons and daughters over time (Rodgers et al., 2020). Additionally, girls whose mothers frequently make comments about their own weight or body may be at greater risk for engaging in unhealthy or extreme weight control behaviors and binge eating (Neumark-Sztainer et al., 2010), as well as an increased desire to lose weight (Jones & Young, 2021). Fathers' encouragement to diet and weight-related comments about their own bodies have also been linked with increases in girls' unhealthy or extreme weight control behaviors (Neumark-Sztainer et al., 2010).

In today's fatphobic culture, weight talk within the family may play just as big of a role in the development of disordered eating as messages from the media. Research by Abraczinskas and colleagues (2012) suggests that parents' weight-focused communication with their children, including weight- and eating-related comments and encouragement to stay thin and/or lose weight, is associated with both children's bulimic symptoms (i.e., binge eating and purging) and children's drive for thinness. These findings were still significant after accounting for media influence, highlighting the salience of parent-child communication to this issue (Abraczinskas et al., 2012). Additionally, alongside the media as a significant predictor of both bingeing and purging behavior over time, families' communication and history with disordered eating have been shown to predict such behaviors; specifically, fathers' communicated weight expectations were a significant predictor for binge eating in women over time, and girls whose mothers had a history of purging were also more likely to purge over time (Field et al., 2008).

Research has identified weight talk as a communication practice that may also influence how children feel about their bodies. When mothers engage in fat talk, daughters may be at risk for body dissatisfaction, or a negative body image (Jones & Young, 2021). Furthermore, Arroyo and Andersen (2016a) found that daughters whose mothers engage in fat talk are more likely to do it themselves, and that self-fat-talk in daughters was associated with poorer body image outcomes. These findings reveal an interesting perspective on body image development; not only is parents' communication predictive of daughters' body image, but also of daughters' own self-communication.

Thus, it is critical that fat talk be investigated alongside parents' communication and children's subsequent body image outcomes.

Other weight-related communication, such as weight-specific comments and teasing, is also of importance to children's body image development. Parental weight-related comments toward children (e.g., suggesting a child should lose weight) have been linked with increased body dissatisfaction, as well as unhealthy/extreme weight control behaviors and binge eating (Neumark-Sztainer et al., 2010). Weight comments from parents have been found to be associated with body image in both sons and daughters (Smolak et al., 1999), and are linked with children's negative body image and concern about weight (Haines et al., 2008). Furthermore, parental encouragement to diet may predict children's negative body image over time (Berge et al., 2018). Weight teasing has also been found to be problematic; when children experience weight teasing from family members, they are put at greater risk for body dissatisfaction (Neumark-Sztainer et al., 2010). Findings from Keery and colleagues (2005) similarly suggest that when girls are teased for their weight, specifically by family members, they are more likely to experience negative body image. Taken together, these findings indicate that familial weight-related communication has important implications for children's body image development.

Existing literature has furthermore documented how weight messages are communicated from parents to children. Mothers' fat talk, thin ideal internalization, and extreme weight control behaviors are associated with greater body dissatisfaction and motivation to lose weight in daughters (Jones & Young, 2021). Mothers' fat talk is additionally associated with bulimic symptoms (i.e., binge eating and purging) in

daughters (Arroyo & Andersen, 2016a), and mothers' fat talk and weight-loss behaviors are furthermore associated with daughters' increased motivation to lose weight (Jones & Young, 2021). Mothers' self-objectification has also been linked with daughters' self-objectification (Arroyo & Andersen, 2016b). To this end, the following hypotheses are proposed:

H3a: Parents' weight talk will predict children's diet culture beliefs.

H4a: The relationship between parents' diet culture beliefs and children's diet culture beliefs will be mediated by parents' weight talk.

Protective Talk. Family mealtime is recognized as a key context through which influential and protective communication toward children's health outcomes may occur. Regularly gathering for family meals is associated with lower occurrence of disordered eating and unhealthy/extreme weight control behaviors in adolescent girls (Haines et al., 2010; Neumark-Sztainer et al., 2008), and research indicates that communication during mealtime, such as parental support and positively valenced interactions, may be associated with decreased disordered eating in children (Godfrey et al., 2013). Additionally, increased family meals are associated with higher-quality communication between family members, and both family meal frequency and duration are associated with overall mental and physical wellbeing of family members (Ho et al., 2018). Parent-child communication during family meals has furthermore been associated with decreased internalizing symptoms in adolescence (Elgar et al., 2012). Overall, the extant literature demonstrates that parent-child communication during mealtimes may be a useful protective factor against disordered eating and other mental health concerns for children.

Parental Modeling

Another influential communication practice is parental modeling of behaviors. When parents model body-related behaviors for children, they nonverbally communicate acceptable ways to react to one's body, further communicating a body's value or lack thereof. Research has found that when mothers model self-compassionate attitudes, daughters may also feel more self-compassionate and have a more positive body image (Carbonneau et al., 2020). Daughters may also have a more positive body image when mothers model healthy weight-related behaviors, such as support for physical activity, positive body talk, and healthy eating habits (Arroyo et al., 2020). Parental modeling of behaviors may also influence children's body image in a negative way. Parents' modeled behaviors supporting thin idealization and dieting are linked with children's increased body dissatisfaction and drive for thinness (Abraczinskas et al., 2012). Additionally, findings by Bardone-Cone and colleagues (2011) contend that parental modeling of dieting behavior is significantly associated with body image for both white and black college-aged women. Jones and Young (2021) further found mothers' engagement in extreme weight loss behaviors to be predictive of daughters' body dissatisfaction. Together, these findings indicate that parents' nonverbal weight-related communication may be just as important as their verbal weight-related communication with regard to children's body image development.

Parents' behavioral modeling has also been connected to children's disordered eating. Research shows that parents' own dieting is associated with daughters' unhealthy/extreme weight control behaviors (Neumark-Sztainer et al., 2010), and furthermore, that parental modeling may predict children's bulimic symptoms

(Abraczinskas et al., 2012). Research additionally contends that parental modeling is an important consideration for eating disorder prevention (Loth et al., 2009). Maternal modeling of weight-related behaviors, communication, and attitudes furthermore allows disordered eating behaviors to persist across generations, from grandmothers to mothers to daughters (Arroyo et al., 2017). Taken together, this literature indicates a clear influence of parental modeling on children's body- and eating-related beliefs and behaviors. With this in mind, the following hypotheses are proposed:

H3b: Parents' behavioral modeling will predict children's diet culture beliefs.

H4b: The relationship between parents' diet culture beliefs and children's diet culture beliefs will be mediated by parents' behavioral modeling.

Family Communication Environment

The overall family communication environment may influence families' behavior, relationships, and well-being. Families' communication may be oriented toward conversation and/or conformity; that is, communication between family members tends to have a level of openness and frequency while also emphasizing a degree of similarity and likeness among individuals (Koerner et al., 2018). Research on family communication, disordered eating, and body image has found connections between conversation and conformity orientations and these outcomes in children.

Conversation Orientation. Families' conversation orientation has been linked with children's diet culture beliefs and disordered eating, both in a protective as well as developmental manner. Research suggests that children demonstrate less weight stigma belief when families' communication is oriented toward conversation, or greater openness in diversity of communicated beliefs (Asbury & Woszidlo, 2016). Fathers'

conversation orientation may be protective against disordered eating in children (Miller-Day & Marks, 2006). Similarly, Botta and Dumlao (2002) found that families' conversation orientation predicted anorexia symptoms in young women, such that greater conversation orientation predicted fewer anorexia symptoms. Results further revealed that pluralistic family types were protective against anorexia symptoms, and that laissez-faire family types were conducive to bulimic symptoms (Botta & Dumlao, 2002). Given these findings, it appears that a family's conversation orientation may play a role in the protection, as well as development, of children's disordered eating. Consequently, the following hypotheses are posited:

H5a: The relationship between parents' weight talk and children's diet culture beliefs will be moderated by the family's degree of conversation orientation, such that low conversation orientation will make the relationship stronger.

H5b: The relationship between parents' behavioral modeling and children's diet culture beliefs will be moderated by the family's degree of conversation orientation, such that low conversation orientation will make the relationship stronger.

Conformity Orientation. Families' conformity orientation has additionally been linked with children's weight stigma beliefs, disordered eating, and body image. Children may be more likely to develop weight stigma attitudes when families' communication is more conformity-oriented (Asbury & Woszidlo, 2016). Additionally, fathers' conformity orientation has been shown to predict children's disordered eating behavior (Miller-Day & Marks, 2006), such that greater conformity orientation has been linked with increased disordered eating in children. Conformity orientation is focused on uniformity in beliefs

among family members, as well as respecting parental authority (Horstman et al., 2018). Given that previous research has shown that disordered eating, weight stigma beliefs, and body image can be communicatively transmitted from parents to children (Arroyo et al., 2017; Holub et al., 2011; Jones & Young, 2021), children whose parents model diet culture-informed behavior and communication would reasonably be at risk for similar beliefs if parents' communication was highly conformity-oriented. To this end, the following hypotheses are posed:

H5c: The relationship between parents' weight talk and children's diet culture beliefs will be moderated by the family's degree of conformity orientation, such that high conformity orientation will make the relationship stronger.

H5d: The relationship between parents' behavioral modeling and children's diet culture beliefs will be moderated by the family's degree of conformity orientation, such that high conformity orientation will make the relationship stronger.

Implications for Children's Health

Given the apparent influence of diet culture on families' communication and children's beliefs, it is important to consider how such beliefs may impact children's mental and physical health. Disordered eating and negative body image pose threats to children's eating disorder risk, and as such, are salient health outcomes to be considered. Thus, this section addresses the extant findings related to diet culture and children's disordered eating and body image development.

Disordered Eating

Disordered eating in childhood seems to be closely connected to communication within the family and diet culture beliefs. Much research has examined family

communication processes and weight stigma/anti-fat beliefs alongside specific forms of disordered eating, such as binge eating, food restriction, and dieting. When viewed as a whole, the extant literature points to family communication and diet culture as having a considerable impact on children's disordered eating outcomes. Children whose parents encourage them to diet are at greater risk for unhealthy weight control behaviors, dieting, binge eating, and negative body image (Berge et al., 2018), and experienced weight stigma has been shown to put children at risk for disordered eating (Wellman et al., 2018), suicidal thoughts (Hunger et al., 2020a), and weight bias internalization (Pudney et al., 2019).

The influence of diet culture is notable for children's disordered eating. Research suggests that individuals with eating disorder diagnoses and individuals who frequently engage in binge eating (but who do not have a diagnosis) are significantly more likely to hold weight bias beliefs than those who do not engage in disordered eating (Najjar et al., 2018). Additionally, weight bias internalization has been linked with women's disordered eating (Marshall et al., 2020), and parental pressure to be thin may predict children's disordered eating as well (Larsen et al., 2015). Both mothers' and daughters' fatphobic beliefs are shown to predict daughters' restricted eating (Hart et al., 2021). Additionally, for white men, weight stigma beliefs predict their disordered eating, particularly their engagement in binge eating (Lydecker et al., 2019). Furthermore, research by Chen et al. (2020) indicates that adolescents' disordered eating is predicted by anti-fat beliefs, and this relationship is mediated by internalized weight stigma. Thus, the greater weight stigma beliefs that children hold, the more likely they are to engage in disordered eating.

Further, thin idealization has been found to influence women's disordered eating pathology (Chithambo, 2018). Consequently, the following hypothesis is proposed:

H6a: Children's diet culture beliefs will predict children's disordered eating.

Body Image

Body image is a key element of mental health and plays an instrumental role in the development and prevention of eating disorders. Although eating disorders are experienced differently and are not always rooted in body image concerns, research has indicated negative body image to be a predictor of both clinical eating disorders and disordered eating behavior (Cooley & Toray, 2001; Gardner et al., 2000; Kluck, 2010; Prnjak et al., 2021). In accordance with Bogenschneider's (1996) ecological risk/protective theory, communication at the family level may act as both a risk factor and protective process for children's body image. Therefore, parent-child communication is highly salient toward promotion and prevention efforts. Relevant to the current study, the extant literature has highlighted the ways in which diet culture and parent-child communication play a key role in children's body image development.

The way parents talk to their children can affect their children's body image. Mothers' body- and weight-related comments have been linked to daughters' motivation to lose weight and sons' drive to increase muscle mass (McCabe et al., 2007). Additionally, body-related memorable messages (such as messages about body size, body type, and body image) with a negative tone may be associated with decreased self-esteem and a more negative body image in young adult women (Rubinsky et al., 2019). As indicated previously, both weight talk and modeling of weight behaviors can influence children's feelings about their bodies (Abraczinskas et al., 2012; Arroyo et al., 2020;

Bardone-Cone et al., 2011; Haines et al., 2008; Smolak et al., 1999). Diet culture beliefs have also been shown to contribute to body image. Weight bias internalization may predict body image, which subsequently predicts disordered eating (Romano et al., 2021). Similarly, research by Durso and colleagues (2016) contends that weight bias internalization plays a role in body image and self-esteem. For white men specifically, greater negative attitudes toward fatness are linked with body dissatisfaction (Lydecker et al., 2019). In accordance with these findings, the following hypothesis is proposed:

H6b: Children’s diet culture beliefs will predict children’s body image.

Summary of Proposed Model

The purpose of the current study is to examine a model that illustrates the intergenerational transmission of diet culture. This model stems from the study’s hypotheses, which are presented in Table 2.1. Through this model, the communicative development of children’s diet culture beliefs, disordered eating, and body image can be discerned, giving way to needed family-based prevention efforts. The proposed hypotheses emerge from the extant literature on human development, parent-child communication, disordered eating, body image, and weight stigma. The resulting model introduces the notion of the intergenerational transmission of diet culture, which has previously not been investigated in communication research. Thus, the proposed model offers an innovative communication-centered approach to informing eating disorder prevention within the family. This model is depicted in Figure 2.1.

The proposed model, depicted in Figure 2.1, begins with the assertion that parents’ diet culture-informed beliefs will predict children’s own diet culture-informed beliefs. Next, it is hypothesized that this connection is mediated by two parent-child

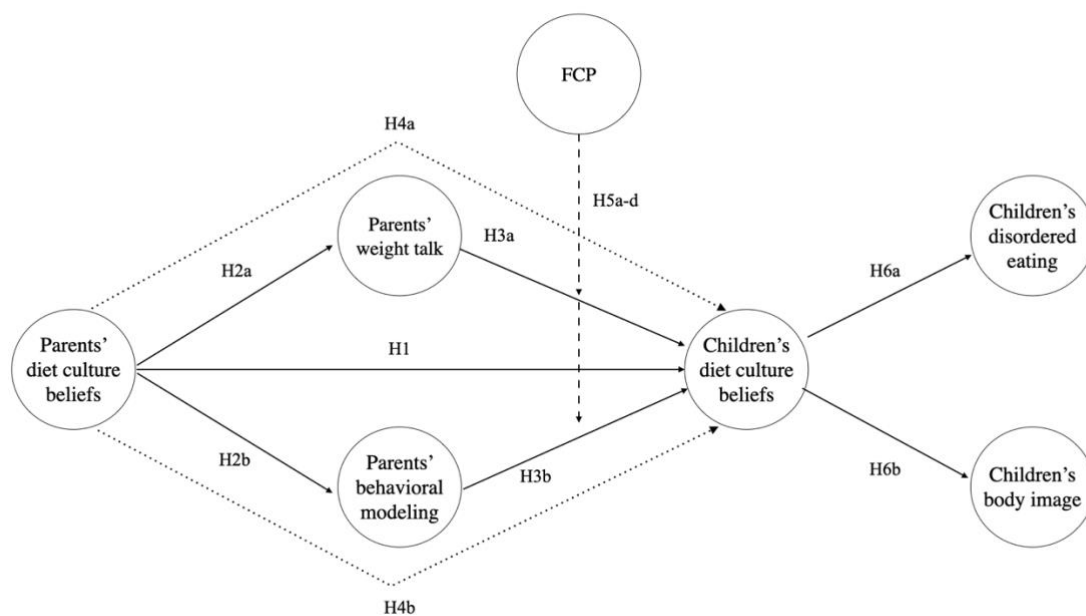
communication processes: weight talk and behavioral modeling. The model further indicates that children's diet culture beliefs will predict their disordered eating and body image. Lastly, it is hypothesized that a family's FCPT conversation and conformity orientations will moderate the relationship between parent-child communication processes and children's diet culture beliefs. This model takes into consideration Bogenschneider's (1996) ecological risk/protective theory, FCPT, and findings from the extant literature toward understanding how communication within and surrounding the family shapes children's beliefs and outcomes related to eating disorder development.

Conclusion

This chapter detailed a proposed model illustrating the intergenerational transmission of diet culture in accordance with the extant literature. In this model, parent-child communication is considered as the primary context through which diet culture beliefs, disordered eating, and body image are formed in children. In this chapter, the literature on relevant theorizing, parent-child communication, disordered eating, weight stigma, and body image has been detailed, forming the basis of the proposed model. In the following chapter, the study's methods will be explained. This study's participants, recruitment methods, procedure, and measures will be discussed.

Table 2.1*List of Hypotheses*

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- | | |
|-----|---|
| H1 | Parents' diet culture beliefs will predict children's diet culture beliefs. |
| H2a | Parents' diet culture beliefs will predict weight talk with their children. |
| H2b | Parents' diet culture beliefs will predict modeling of dieting behavior in front of their children. |
| H3a | Parents' weight talk will predict children's diet culture beliefs. |
| H3b | Parents' behavioral modeling will predict children's diet culture beliefs. |
| H4a | The relationship between parents' diet culture beliefs and children's diet culture beliefs will be mediated by parents' weight talk. |
| H4b | The relationship between parents' diet culture beliefs and children's diet culture beliefs will be mediated by parents' behavioral modeling. |
| H5a | The relationship between parents' weight talk and children's diet culture beliefs will be moderated by the family's degree of conversation orientation, such that low conversation orientation will make the relationship stronger. |
| H5b | The relationship between parents' behavioral modeling and children's diet culture beliefs will be moderated by the family's degree of conversation orientation, such that low conversation orientation will make the relationship stronger. |
| H5c | The relationship between parents' weight talk and children's diet culture beliefs will be moderated by the family's degree of conformity orientation, such that high conformity orientation will make the relationship stronger. |
| H5d | The relationship between parents' behavioral modeling and children's diet culture beliefs will be moderated by the family's degree of conformity orientation, such that high conformity orientation will make the relationship stronger. |
| H6a | Children's diet culture beliefs will predict children's disordered eating. |
| H6b | Children's diet culture beliefs will predict children's body image. |
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Figure 2.1*Hypothesized Model*

CHAPTER THREE

METHODS

The current study was approved by the University of Missouri IRB under project number 2091527. The purpose of this study is to investigate the intergenerational transmission of diet culture and its influence on children's disordered eating and body image outcomes. The first chapter offered a rationale for the importance of the current study and defined key terms. The second chapter outlined relevant theorizing and literature surrounding this topic, presenting the hypothesized model describing potential communicative pathways through which parental endorsement of diet culture may relate to children's own endorsement, as well as precursors of eating disorders. In this chapter, the methods for this study are discussed. First, recruitment efforts are detailed, and participant demographics are described. Next, the study's procedure is provided, and survey measures are detailed, with a following conclusion.

Participants and Recruitment

Participants

Data were obtained from a sample of 199 parent-child dyads in which children were aged 9-14 years old. An a priori power analysis was conducted in R using the *semPower* package (Moshagen & Erdfelder, 2016). Results indicated a required minimum sample size of 164 parent-child dyads to reach acceptable power; thus, 199 parent-child dyads is an appropriate sample size for the current study.

The mean age of parent participants was 55.91 years old, and the mean age of child participants was 11.14 years old. Most parents identified as cisgender women (62.31%, $n=124$), 53 parents identified as cisgender men (26.63%), six identified as

transgender women (3.02%), six identified as transgender men (3.02%), one identified as nonbinary (.50%), and nine did not provide their gender (4.52%). The majority of children were cisgender boys (53.27%, $n=106$); 81 children were cisgender girls (40.70%), six were transgender girls (3.02%), four were transgender boys (2.01%), and two were nonbinary (1%). Most parents identified as white (57.79%, $n=115$); 53 identified as black (26.63%), nine identified as Latino/a/x/é (4.52%), 12 identified as Native American/American Indian (6.03%), five identified as Asian (2.51%), two identified as multiracial (1.01%), and three did not provide their race (1.51%). The majority of children identified as white (57.79%, $n=115$), 52 children identified as black (26.13%), nine children identified as Latino/a/x/é (4.52%), 12 identified as Native American/ American Indian (6.03%), seven identified as Asian (3.52%), and four identified as multiracial (2.01%).

Most parents held a Bachelor's degree as their highest level of completed education (43.22%; $n=86$); five had completed a high school diploma or equivalent (2.51%), two parents reported completing some college (1%), 11 held a two-year degree (5.53%), 78 held a graduate degree (39.20%), 15 held a professional degree (7.54%), and two did not report their highest level of education (1%). The majority of parents reporting having experienced disordered eating (75.38%, $n=150$), while 45 reported not having experienced disordered eating (22.61%) and five did not express their history (or lack thereof) with disordered eating.

Recruitment

Recruitment for this study took place online and in the local Columbia, MO community. Online recruitment announcements were distributed via targeted Facebook

ads. Recruitment messages were posted on the author's personal social media accounts (Facebook, Twitter, and Instagram), as well as relevant Facebook groups, including groups centered on parenting and adolescent caregiving. Messages were also posted in the online CFLE forum facilitated by the National Council on Family Relations. The author additionally used Facebook advertising to recruit participants. To recruit local parent-child dyads in the Columbia, MO community, flyers were placed in relevant local organizations, such as coffee shops, and family-facing facilities. The recruitment flyer, social media image, and Facebook ads are displayed in Appendix A.

Recruitment messages contained information pertinent to participation in the study. First, materials stated that the study aimed to learn about parent-child communication and children's body image. This is a general statement about the study that served to adequately inform participants of the study's purpose without priming them toward eating disorder prevention. Recruitment messages additionally included information about a \$10 gift card compensation for each parent-child pair, and prompted participants to contact the author if they were interested in participating. Lastly, recruitment materials included the author's name and contact information.

Procedure

Parents who were interested in participating were prompted to contact the author, who shared a URL to the survey via email, along with PDF copies of the consent form (Appendix B) and child assent form (Appendix C). Upon accessing the URL, parents were directed to a Qualtrics survey (Appendix D), which began with the informed consent form. The consent form included the purpose of the study and explained that both the parent and their child were being asked to complete a survey. The consent form

additionally informed the parent that they will receive a \$10 gift card for participating in the study.

The survey was comprised of two portions: Part 1, which was meant to be completed by the parent, and Part 2, which was meant to be completed by the child. Upon consenting for themselves and their child to participate, each parent received a message explaining that they should complete Part 1, while their child would complete Part 2. In the first portion of the survey, each parent completed measures assessing their diet culture beliefs, their family's conversation orientation, their family's conformity orientation, their weight talk, and their behavioral modeling of dieting behavior. Lastly, parents were asked to provide demographic information about themselves and their child, as well as an email address to which their incentive could be sent.

Once each parent completed their portion of the survey, they were prompted to give the device on which they are completing the survey to their child. Each child was then provided an assent form, and once assent was given, children completed measures assessing their body image, disordered eating, and diet culture beliefs. Upon completion of Part 2, children were prompted to give the device back to their parent. This ensured that the data was submitted properly by allowing the parents the chance to ultimately submit the survey,

Once data was collected, the author ensured that the email addresses provided within the survey were deleted from the data and saved within a separate file to protect participants' anonymity. Once the email addresses were saved in a separate file, a \$10 gift card was sent to each email address in the file. Each parent-child dyad received a \$10 gift card to thank them for their time and efforts toward completing the study.

Measures

Diet Culture Beliefs

To assess diet culture beliefs, parents and children completed the Diet Culture Beliefs Scale (DCBS; Davidson, 2020) to indicate their diet culture beliefs. The DCBS contains nine items which participants respond to on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” The scale contains three subscales: Dieting and Status, Moralization of Food and Bodies, and Dieting and Health. From the first subscale, a sample item is, “I will only wear clothes that make me look thin.” From the second subscale, a sample item is, “Some foods are temptations to be resisted.” From the third subscale, a sample item is, “Fat people are unhealthy.” The DCBS demonstrated good reliability for parent diet culture beliefs ($\alpha=.873$) and child diet culture beliefs ($\alpha=.913$).

Disordered Eating

Children’s disordered eating was assessed with the Children’s Eating Attitude Test (ChEAT; Maloney et al., 1988). This scale was modified for child participants from the Eating Attitudes Test-26 (EAT-26). The ChEAT was validated with a sample of children in grades 3-6 (ages 8-13), making it appropriate for use in this study. Children responded to 26 items which participants respond to on a 6-point Likert scale ranging from “never” to “always.” Sample items include, “I stay away from eating when I am hungry” and “I feel very guilty after eating.” The scale demonstrated good reliability ($\alpha=.965$).

Body Image

Children’s body image was assessed using the Body Appreciation Scale-2 (BAS-2; Tylka & Wood-Barcalow, 2015). The BAS-2 is a 10-item scale assessing positive

body image, where higher scores indicate a more positive body image and lower scores indicate a more negative body image. Children responded to each item on a 5-point Likert scale ranging from “never” to “always.” Sample items include, “I feel good about my body,” and “I appreciate the different and unique characteristics of my body.” The BAS-2 demonstrated good reliability ($\alpha=.907$).

FCPT Conversation Orientation

Conversation orientation was measured using the 15-item conversation orientation subscale of the Revised Family Communication Patterns Instrument (RFCP; Ritchie & Fitzpatrick, 1990). Previous research has found this subscale to have acceptable reliability ($\alpha=.89$, Koerner & Fitzpatrick, 2002). Parents responded to each item on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” Sample items include, “My child can tell me almost anything,” and “I often ask my child’s opinion when the family is talking about something.” The RFCP demonstrated good reliability ($\alpha=.928$).

FCPT Conformity Orientation

Conformity orientation was measured using the 24-item Expanded Conformity Orientation Scale (ECOS; Horstman et al., 2018). Items were adapted for the parent perspective; for example, “I have clear expectations about how my child is supposed to behave” was used instead of, “My parents have clear expectations about how a child is supposed to behave.” Parents responded to each item on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” Sample items from the adapted scale include, “My child is expected to follow my wishes,” and “Our family has a particular way of seeing the world.” The ECOS demonstrated good reliability ($\alpha=.919$).

Weight Talk

In this study, weight talk is conceptualized as parents' talk about their own weight as well as their child's. This may include comments about parents' own bodies or weight, or that of their child, as well as negative talk about fatness. As such, weight talk was assessed using the self and child subscales from the adapted Fat Talk Questionnaire (FTQ; Royal et al., 2013) from Lydecker and colleagues' (2018b) study. These subscales contain items that address parents' communication about their own weight and that of their child, thereby encompassing the current study's conceptualization of weight talk.

Parents responded to each question on a 5-point Likert-style scale ranging from "never" to "always." Sample items from the self-weight talk subscale include, "When I'm with my child, I comment that my arms are too flabby," and "When I am with my child, I complain that I am fat." Sample items from the child weight talk subscale include, "When I'm with my child, I comment that my child's arms are too flabby," and "When I am with my child, I complain that my child is fat." The full scale demonstrated good reliability ($\alpha=.974$). Similarly, reliability estimates for the self subscale were good ($\alpha=.947$), as were reliability estimates for the child subscale ($\alpha=.959$).

Behavioral Modeling

Behavioral modeling in this study refers to parents' modeling of unhealthy behaviors related to dieting and weight loss. Consequently, behavioral modeling may entail such behaviors as dieting and unhealthy weight control behaviors, which are frequently seen in the extant literature. Both parent and child data were collected for behavioral modeling, to assess both parents' reported behavior and children's perceptions of parents' behavioral modeling.

This variable was measured using two brief assessments, in line with prominent work by Neumark-Sztainer et al. (2010). Parents were asked to respond to the following question: “How often have you gone on a diet in the last year? By ‘diet,’ we mean changing the way you eat so you can lose weight.” Parents chose one of the following responses: “never,” “1-4 times,” “5-10 times,” “more than 10 times,” or “I am always dieting.” Children were asked the same question, but in relation to their parents (“How often has your parent gone on a diet in the last year”).

Parents also responded to the following question to indicate unhealthy weight control behaviors: “In the last year, how many of the following things have you done in order to lose weight or keep from gaining weight?” Parents selected as many of the following behaviors as necessary: “fasted,” “ate very little food,” “used a food substitute (powder or a special drink),” “skipped meals,” “smoked more cigarettes,” “took diet pills,” “made myself vomit,” “used laxatives,” and “used diuretics.” To avoid priming children for unhealthy or extreme weight loss behaviors, children were asked to provide perception of parents’ weight control behaviors differently. Rather than asking child participants to select all that applied from a list of weight control behaviors, children instead were asked to respond to the following open-ended question: “Has your parent done anything else to lose weight? If so, please type the things they have done to lose weight in the box below. If they have not done anything to lose weight, please type “no” or leave the box below blank.”

Ultimately, parents’ behavioral modeling was assessed with a combination of how often they reported dieting in the last year and the total number of indicated weight control behaviors. Children’s perception of behavioral modeling was assessed with a

combination of how often they reported parents dieting in the last year and the total number of weight control behaviors listed in the open-ended question.

Ethical Considerations and Quality Assurance

Ethical Considerations

When engaging children as participants, particularly in a study about such harmful mental health outcomes like disordered eating and negative body image, there are ethical considerations that need to be made. As such, the current study was thoughtfully designed to ensure the research was conducted as ethically as possible. When seeking children's perception of parental weight control behaviors, it would be risky to ask children to select all behaviors that apply from a provided list, as parents were asked to do. Given that children are a vulnerable population, and the participants' age range was particularly at risk for negative body image and disordered eating in childhood and adolescence (see section "Children's Perspectives and Prevention" in Chapter 1), it was important to the author not to present children with a list of unhealthy or extreme weight control behaviors. Therefore, children were instead asked to simply list any weight loss behaviors they noticed their parents using.

Additionally, children's body image was intentionally assessed using the Body Appreciation Scale-2 (BAS-2; Tylka & Wood-Barcalow, 2015). Rather than asking children possibly triggering questions about negative perceptions of their bodies, the author chose to obtain data about children's positive perceptions of their bodies. As mentioned earlier, lower scores on the scale would indicate a more negative body image, while higher scores would indicate a more positive body image. This served as an ethical

method of assessing children's body image without priming participants to feel negatively about their bodies, particularly during a developmentally vulnerable period.

A further ethical consideration for this study was asking children to report disordered eating behavior. It is challenging to assess disordered eating in a questionnaire without a scale specifically intended to do so; as such, to ensure data was collected as ethically as possible, the author chose to use a scale specifically made for children (the Children's Eating Attitude Test; ChEAT; Maloney et al., 1988). While the scale did ask participants about disordered eating behaviors like avoiding food when hungry, the language was understandable and appropriate for children in the intended age range. Although it was not possible to avoid asking children to report such behaviors for purposes of this study, the measure used helped ensure the research was conducted as ethically as possible.

Quality Assurance

When seeking parent-child data, particularly via an online survey and with an incentive, considerations need to be made to ensure the quality of the data. It is possible for participants to attempt to complete the survey multiple times to obtain multiple incentives. It is also possible that participants provided false data to obtain the incentive. Given these considerations, the survey was designed to mitigate data quality concerns, and the author removed responses that were incomplete or seemingly "mischievous responders" (Robinson-Cimpian, 2014).

To mitigate the concern of false data, recruitment efforts asked interested participants to contact the author for the survey link. This allowed the author to initially engage with potential participants and reasonably assess their authenticity. The author

received numerous emails seeking to participate, many of which appeared to be “bots” or “mischievous responders.” For example, many emails included the same word-for-word content expressing interest in the investigation. Such emails were not considered legitimate participants.

Additionally, child perception of parental weight control behaviors was assessed via an open-ended question. This served not only to ensure ethical data collection, but also as a measure of quality control. Qualitative responses that did not respond to the question (i.e., did not provide weight loss behaviors) or were comprised of jumbled letters were removed from the data. Finally, the author reviewed the final data file for any repeat email addresses. Participants were asked to provide an email address to which their gift card incentive could be sent. Entries which provided an email address already provided earlier in the data were removed as duplicates.

Method of Analysis

Upon completion of data collection, data were analyzed using structural equation modeling (SEM), using the *lavaan* package for R, an open-source statistics software (Rosseel, 2012). A correlation matrix was generated (Table 3.1). After conducting the initial confirmatory factor analysis, large variables were parceled to preserve just identification (Little et al., 2013). Engaging SEM in statistical analysis allows for reliable results, as this method accounts for measurement error and non-normality of the data (Kline, 2016). To perform the analysis, a

Table 3.1*Correlation Matrix*

	1	2	3	4	5	6	7	8	9	10	<i>M</i>	<i>sd</i>
1 PDCB	-										3.50	0.82
2 Weight Talk (P-Rep)	.62**	-									2.61	0.97
3 Weight Talk (C-Rep)	.61**	.91**	-								2.51	1.01
4 CDCB	.70**	.56**	.58**	-							3.28	1.02
5 Conversation	.31**	.00	.07	.20**	-						3.91	0.73
6 Conformity	.62**	.39**	.37**	.63**	.58**	-					3.67	0.64
7 Body Appreciation	-.03	-.16*	-.18*	-.12	.47**	.20**	-				3.74	0.79
8 Disordered Eating	.64**	.67**	.73**	.64**	.16*	.41**	.12	-			3.27	1.14
9 Parent DE History	-.34**	-.54**	-.49**	-.39**	.03	-.19**	.22**	-.37**	-		1.22	0.41
10 Parent Age	-.17*	-.16*	-.23**	-.14	-.18**	-.17*	-.22**	-.22**	-.01	-	55.92	5.83
11 Child Age	-.03	.07	.06	-.19**	-.11	-.28**	.01	.02	.04	.07	11.14	1.53

*p < .05, **p < .01

confirmatory factor analysis (CFA) was first conducted to assess the measurement model. Then, hypotheses were tested using SEM.

Conclusion

The purpose of this study was to better understand the intergenerational transmission of diet culture and its influence on the development of children's disordered eating and body image. This chapter described the current study's methods, including recruitment strategy, sample size, procedure, and measures. Ultimately, recruitment resulted in 199 parent-child dyads who completed an online Qualtrics survey, providing data to be analyzed via structural equation modeling (SEM). In the following chapter, data analysis and results will be detailed.

CHAPTER FOUR

RESULTS

Previous chapters have detailed the current study's purpose, theoretical backing, and methods. In this chapter, the current study's method of analysis and findings will be discussed. First, the method of analysis is detailed. Next, the findings from a confirmatory factor analysis (CFA) are presented, and finally, findings specific to each hypothesis are discussed.

Missing Data

Prior to conducting the analysis, missing data were handled using SPSS. A Missing Completely at Random (MCAR) test was conducted, and results suggested that the missing data were missing completely at random ($\chi^2=17923.055, p \leq .911$). Only a small percentage of data was missing, with each variable seeing between 0% and 4.5% missing data. This suggests acceptable conditions to perform a multiple imputation. Consequently, values were then imputed for all variables with missing data.

Confirmatory Factor Analysis (CFA)

Initial CFA

A confirmatory factor analysis (CFA) was conducted to assess the measurement model, using the *lavaan* package in R with a robust maximum likelihood estimator (MLR). The initial measurement model would not converge, likely due to the model's complexity and large number of indicators for some variables. Because of this, portions of the measurement model were tested across three CFAs until the entire measurement model was assessed.

The first portioned CFA (Table 4.1a) assessed variables from the first, second, third, and fourth hypotheses. This included the following variables: parental diet culture beliefs, weight talk, child perception of weight talk, behavioral modeling, and child perception of behavioral modeling. Results suggested acceptable model fit: $\chi^2(2449)=3918.302$, $p<.000$, $RMSEA=.055$, $CFI=.857$, $TLI=.850$, $SRMR=.053$. Loadings for the parental diet culture beliefs variable ranged from .462 to .835, with the majority ranging between .500 and .700, and the average loading being .577. The loadings for parent-reported weight talk ranged from .631 to .844, with an average loading of .762. Loadings for child perception of weight talk ranged from .705 to .837. The average loading was .788. Loadings for parent-reported behavioral modeling were largely unsatisfactory, ranged from .094 to .837. The majority ranged from .200 to .400, and the average loading was .309. Child perception of behavioral modeling was assessed using a single indicator (see section “Behavioral Modeling” in Chapter 3).

The second portioned CFA (Table 4.1b) included the conversation orientation variable and the conformity orientation variable. Results suggested poor model fit: $\chi^2(701)=1566.657$, $p<.000$, $RMSEA=.079$, $CFI=.741$, $TLI=.727$, $SRMR=.127$. Loadings for conversation orientation ranged from .459 to .750, with an average loading of .680. Loadings for conformity orientation ranged from .410 to .765, with the average loading being .564.

The third portioned CFA (Table 4.1c) included variables from the remaining hypotheses. This encompassed the following variables: child diet culture beliefs, child body appreciation, and child disordered eating. Results suggested acceptable model fit: $\chi^2(990)=6389.585$, $p<.000$, $RMSEA=.054$, $CFI=.898$, $TLI=.895$, $SRMR=.074$. Loadings

Table 4.1a*CFA Loadings: PDCB, Weight Talk, CDCB*

Item	Loading
Parental Diet Culture Beliefs (PDCB)	
1. I try to control my weight so that others will have a positive opinion of me.	.526
2. I only exercise to have a body that others find acceptable.	.850
3. I will only wear clothes that make me look thin.	.754
4. Some foods are temptations to be resisted.	.654
5. I put a lot of effort into resisting bad foods.	.685
6. There are some foods that I should never eat.	.575
7. Fat people are unhealthy.	.657
8. If I am thin, I will live longer.	.673
9. A person's health is largely determined by the types of food they eat.	.472
Self-Reported Parental Weight Talk	
<i>Parcel 1</i>	.952
1. When I'm with my child, I complain that my arms or legs are too flabby.	
2. When I'm with my child, I complain that my stomach is fat.	
3. When I'm with my child, I criticize my body compared to thin models in magazines.	
4. When I'm with my child, I complain that my body is out of proportion.	
14. When I'm with my child, I complain that my child's arms or legs are too flabby.	
15. When I'm with my child, I complain that my child's stomach is fat.	
16. When I'm with my child, I criticize my child's body compared to thin models in magazines.	
17. When I'm with my child, I complain that my child's body is out of proportion.	
<i>Parcel 2</i>	.961
5. When I'm with my child, I complain that I hate my whole body.	
6. When I'm with my child, I complain that I am fat.	
7. When I'm with my child, I complain that I should not be eating fattening foods.	
8. When I'm with my child, I complain that I've gained weight.	
18. When I'm with my child, I complain that I hate my child's whole body.	
19. When I'm with my child, I complain that my child is fat.	
20. When I'm with my child, I complain that my child should not be eating fattening foods.	
21. When I'm with my child, I complain that my child has gained weight.	

Parcel 3 .975

9. When I'm with my child, I complain that my clothes are too tight.
10. When I'm with my child, I complain that I need to stop eating so much.
11. When I'm with my child, I criticize my body compared to my friends' bodies.
12. When I'm with my child, I complain that my body is disgusting.
13. When I'm with my child, I complain that I'm not in shape.
22. When I'm with my child, I complain that my child's clothes are too tight.
23. When I'm with my child, I complain that my child needs to stop eating so much.
24. When I'm with my child, I criticize my child's body compared to their friends' bodies.
25. When I'm with my child, I complain that my child's body is disgusting.
26. When I'm with my child, I complain that my child is not in shape.

Child-Reported Parental Weight Talk*Parcel 1* .979

1. When I'm with my parent, they complain that their arms or legs are too flabby.
2. When I'm with my parent, they complain that their stomach is fat.
3. When I'm with my parent, they criticize their body compared to thin models in magazines.
4. When I'm with my parent, they complain that their body is out of proportion.
14. When I'm with my parent, they complain that my arms or legs are too flabby.
15. When I'm with my parent, they complain that my stomach is fat.
16. When I'm with my parent, they criticize my body compared to thin models in magazines.
17. When I'm with my parent, they complain that my body is out of proportion.

Parcel 2 .953

5. When I'm with my parent, they complain that they hate their whole body.
6. When I'm with my parent, they complain that they are fat.
7. When I'm with my parent, they complain that they should not be eating fattening foods.
8. When I'm with my parent, they complain that they've gained weight.
18. When I'm with my parent, they complain that they hate my whole body.
19. When I'm with my parent, they complain that I am fat.

20. When I'm with my parent, they complain that I should not be eating fattening foods.	
21. When I'm with my parent, they complain that I have gained weight.	
<i>Parcel 3</i>	.969
9. When I'm with my parent, they complain that their clothes are too tight.	
10. When I'm with my parent, they complain that they need to stop eating so much.	
11. When I'm with my parent, they criticize their body compared to their friends' bodies.	
12. When I'm with my parent, they complain that their body is disgusting.	
13. When I'm with my parent, they complain that they are not in shape.	
22. When I'm with my parent, they complain that my clothes are too tight.	
23. When I'm with my parent, they complain that I need to stop eating so much.	
24. When I'm with my parent, they criticize my body compared to my friends' bodies.	
25. When I'm with my parent, they complain that my body is disgusting.	
26. When I'm with my parent, they complain that I am not in shape.	
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Child Diet Culture Beliefs	
1. I try to control my weight so that others will have a positive opinion of me.	.821
2. I only exercise to have a body that others find acceptable.	.793
3. I will only wear clothes that make me look thin.	.818
4. Some foods are temptations to be resisted.	.749
5. I put a lot of effort into resisting bad foods.	.775
6. There are some foods that I should never eat.	.594
7. Fat people are unhealthy.	.727
8. If I am thin, I will live longer.	.707
9. A person's health is largely determined by the types of food they eat.	.611
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for child diet culture beliefs ranged from .625 to .842, with the average loading being .732. The loadings for body appreciation ranged from .638 to .752, with an average loading of .703. Finally, loadings for child disordered eating ranged from .264 to .837, with the majority ranging from .700 to .837. The average loading for child disordered eating was .715.

Removal of the Behavioral Modeling Variable. Based on the results of the initial CFA, both parent-report behavioral modeling and child perception of behavioral modeling were removed from the model, given their poor loadings. Loadings ranged from .153 to .667, with the majority ranging from .153 to .347. The average loading was .341. Regarding the parent-report data, it seems that the survey question structure for the item assessing parents' weight control behaviors was not suitable to conducting a CFA; the "select all that apply" structure results in what seems to be missing data for those items not selected. The remaining parent-report data for behavioral modeling included a single indicator; which, in the CFA, would leave the modeling variable under-identified.

The child perception data for behavioral modeling had similar problems. The item assessing perception of parents' weight control behaviors was not able to be included in the CFA, given its open-ended structure. Additionally, the remaining question was the same single-indicator measure asked of parents, but from the child's perspective. Consequently, this left child perception of behavioral modeling under-identified. Given these measurement concerns, behavioral modeling was removed from the model.

Parceled CFA

Upon completing the portioned CFAs, variables were parceled to simplify the measurement model and preserve just identification (Little et al., 2013). Given the

Table 4.1b*CFA Loadings: Conversation Orientation, Conformity Orientation*

Item	Loading
Conversation Orientation	
<i>Parcel 1</i>	.854
1. In our family, we often talk about topics like politics and religion where some persons disagree with others.	
2. In often say things like, "Every member of the family should have some say in family decisions."	
3. I often ask my child's opinion when the family is talking about something.	
4. I encourage my child to challenge my ideas and beliefs.	
5. I often say things like, "You should always look at both sides of an issue."	
<i>Parcel 2</i>	.883
6. My child usually tells me what s/he is thinking about things.	
7. My child can tell me almost anything.	
8. In our family, we often talk about our feelings and emotions.	
9. My child and I often have long, relaxed conversations about nothing in particular.	
10. I think my child really enjoys talking with me, even when we disagree.	
<i>Parcel 3</i>	.906
11. I encourage my child to express his/her feelings.	
12. I tend to be very open about my emotions.	
13. We often talk as a family about things we have done during the day.	
14. In our family, we often talk about our plans and hopes for the future.	
15. I like to hear my child's opinion, even when s/he doesn't agree with me.	
Conformity Orientation	
<i>Parcel 1</i>	.924
1. I expect my child/children to respect their elders.	
2. In our home, my child/children is/are expected to speak respectfully to me.	
3. I have clear expectations about how my child(ren) is/are supposed to behave.	
10. I feel it is important to be the boss.	
11. I become irritated with my child's views if they are different from mine.	
16. In my family, family members are expected to hold similar values.	
21. My child is expected to challenge my beliefs.	
<i>Parcel 2</i>	.929

- 4. When my child is home, they are expected to obey my rules.
- 5. I insist that my child respect those who have been placed in positions of authority.
- 6. I emphasize certain attitudes that I want the children in my family to adopt.
- 12. I try to persuade my child to view things the way I see them.
- 13. I say things like, "You'll know better when you grow up."
- 17. My child is expected to adopt my views.
- 18. I encourage my child to adopt my values.
- 22. In our home, children are allowed to question my authority.
- 23. I encourage open disagreement.

Parcel 3

.841

- 7. In our home, I have the last word.
 - 8. I expect my child to trust my judgment on important matters.
 - 9. My child is expected to follow my wishes.
 - 14. I say things like, "You may not understand why we are doing this right now, but some day you will."
 - 15. I say things like, "My ideas are right and you should not question them."
 - 19. Our family has a particular way of seeing the world.
 - 20. My child feels pressure to adopt my beliefs.
 - 24. In our home, children are encouraged to question my authority.
-

large number of indicators for the weight talk variables, both parent-reported weight talk and child perception of weight talk were parceled using domain-representative parcels (with each parcel including items measuring parental weight talk about the self and items measuring parental weight talk about the child). The conformity orientation variable was additionally parceled using domain-representative parcels, with each parcel containing items from each subscale. Because the conversation orientation scale did not contain subscales, this variable was parceled randomly. Finally, child disordered eating and body appreciation were also parceled randomly, given that their scales also did not include subscales.

A final CFA was run in R to assess the newly parceled measurement model. Items and loadings for each parcel are detailed in Table 4.1, along with loadings for variables not parceled. Model fit was good: $\chi^2(637)=1056.237$, $p<.000$, RMSEA=.060, CFI=.930, TLI=.923, SRMR=.064. The loadings for the parent-reported weight talk parcels were favorable, ranging from .952 to .975. The loadings for the child perception of weight talk parcels were also favorable, ranging from .953 to .979. Loadings for the conversation orientation parcels were good, ranging from .854 to .906. Loadings for the conformity orientation parcels ranged from .841 to .929. The loadings for the body appreciation parcels ranged from .788 to .904. Finally, loadings for the disordered eating parcels were good, ranging from .875 to .943.

Analysis of Hypotheses

After assessing the measurement model, hypotheses were analyzed by testing the structural model. Two models were ultimately tested: one including parent-reported weight talk (the “parent-report model”), and one including child-reported weight talk (the

“child-report model”). Research has shown the salience of perceived messages toward well-being and health outcomes (Holman & Koenig Kellas, 2018; Jordan, 2022). Thus, it was important to test a model in which parent-child communication was reported by the parents as well as a model in which parent-child communication was reported by children. This provided the opportunity to understand whether the hypothesized process differed by parents’ reported weight talk behavior and children’s perception of parental weight talk. Results from the assessment of each model are described below.

Parent-Report Model

In the parent-report model, weight talk was assessed using parent-reported data (that is, parent-reported data on frequency of weight talk). The hypothesized model is depicted in Figure 2.1. All hypotheses were tested via SEM analysis in R using the *lavaan* package. The model was tested using a robust maximum likelihood estimator (MLR). Observed results are depicted in Figure 4.1.

Initial results for the direct effects model yielded fair model fit: $\chi^2(371)=698.511$, $p<.000$, RMSEA=.070, CFI=.914, TLI=.906, SRMR=.074. The amount of variance accounted for in the structural model was 49% for self-reported parental weight talk, 66.9% for child diet culture beliefs, 3.7% for body appreciation, and 51.4% for children’s disordered eating. Regression estimates are detailed in Table 4.2.

Hypothesis 1 suggested that parents’ diet culture beliefs would predict children’s diet culture beliefs, and findings revealed support for this hypothesis. As depicted in Table 4.2, children whose parents reported high degrees of diet culture beliefs were more likely to also hold high degrees of diet culture beliefs. Hypothesis 2a stated that parents’ diet culture beliefs would predict weight talk with their children. This hypothesis was

Table 4.1c*CFA Loadings: Body Appreciation, Disordered Eating*

Item	Loading
Body Appreciation	
<i>Parcel 1</i>	.904
1. I respect my body.	
2. I feel good about my body.	
3. I feel that my body has at least some good qualities.	
4. I take a positive attitude towards my body.	
<i>Parcel 2</i>	.788
5. I am attentive to my body's needs.	
6. I feel love for my body.	
7. I appreciate the different and unique characteristics of my body.	
<i>Parcel 3</i>	.896
8. My behavior reveals my positive attitude toward my body; for example, I hold my head high and smile.	
9. I am comfortable in my body.	
10. I feel like I am beautiful even if I am different from media messages of attractive people (e.g., models, actresses/actors).	
Disordered Eating	
<i>Parcel 1</i>	.875
1. I am scared about being overweight.	
2. I stay away from eating when I am hungry.	
3. I think about food a lot of the time.	
4. I have gone on eating binges where I feel that I might not be able to stop.	
5. I cut my food into small pieces.	
<i>Parcel 2</i>	.915
6. I am aware of the energy (calorie) content in foods that I eat.	
7. I try to stay away from foods such as breads, potatoes, and rice.	
8. I feel that others would like me to eat more.	
9. I vomit after I have eaten.	
10. I feel very guilty after eating.	
<i>Parcel 3</i>	.907
11. I think a lot about wanting to be thinner.	
12. I think about burning up energy (calories) when I exercise.	
13. Other people think I am too thin.	
14. I think a lot about having fat on my body.	

15. I take longer than others to eat my meals.	
<i>Parcel 4</i>	.987
16. I stay away from foods with sugar in them.	
17. I eat diet foods.	
18. I think that food controls my life.	
19. I can show self-control around food.	
20. I feel that others pressure me to eat.	
<i>Parcel 5</i>	.943
21. I give too much time and thought to food.	
22. I feel uncomfortable after eating sweets.	
23. I have been dieting.	
24. I like my stomach to be empty.	
25. I enjoy trying new flavorful foods.	
26. I have the urge to vomit after eating.	

supported; a significant direct effect of parent diet culture beliefs on self-reported weight talk was found, such that parents who held high degrees of diet culture beliefs were likely to engage in more frequent weight talk.

Hypothesis 2b suggested that parents' diet culture beliefs would predict modeling of dieting behavior in front of their child. As the behavioral modeling variable was removed from the model (see section "Parceled CFA"), this hypothesis was not tested. Hypothesis 3a suggested that parents' weight talk would predict children's diet culture beliefs. This hypothesis was supported. As depicted in Table 4.2, a significant direct effect was found for parental self-reported weight talk on children's diet culture beliefs, such that children whose parents engaged in more frequent weight talk held higher degrees of diet culture beliefs. Hypothesis 3b stated that parents' behavioral modeling of dieting behavior would predict children's diet culture beliefs. Because the behavioral modeling variable was removed from the model (see section "Parceled CFA"), this hypothesis was not tested.

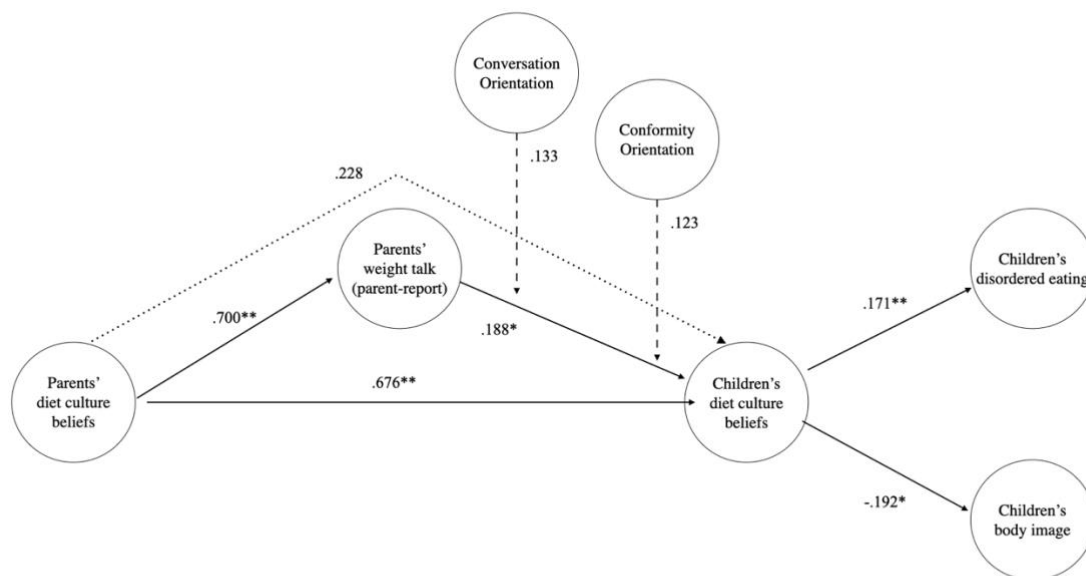
Results for the mediation model yielded the same global model fit as the direct effects model: $\chi^2(371)=698.511$, $p<.000$, $RMSEA=.070$, $CFI=.914$, $TLI=.906$, $SRMR=.074$. The amount of variance accounted for in the structural model was 49% for self-reported parental weight talk, 66.9% for child diet culture beliefs, 3.7% for body appreciation, and 51.4% for children's disordered eating. The unstandardized estimate, confidence interval, and p-value can be found in Table 4.3.

Hypothesis 4a posited that the relationship between parents' diet culture beliefs and children's diet culture beliefs would be mediated by parents' weight talk. Although a significant direct effect was found of parents' self-reported weight talk on children's diet

culture beliefs (coef.=.233, $p<.024$), the mediation was approaching significance, but was ultimately not significant. Hypothesis 4b predicted that the relationship between parents' diet culture beliefs and children's diet culture beliefs would also be mediated by parents' behavioral modeling. Because behavioral modeling was removed from the model (see section "Parceled CFA"), this hypothesis was not tested.

Results for the conditional effects model with conversation orientation as a moderator yielded fair model fit: $\chi^2(548)=998.418$ $p<.000$, RMSEA=.067, CFI=.901, TLI=.892, SRMR=.089. The amount of variance accounted for in the structural model was 48.5% for self-reported parental weight talk, 68.6% for child diet culture beliefs, 3.7% for body appreciation, and 52% for children's disordered eating. Similarly, results for the conditional effects model with conformity orientation as a moderator yielded fair model fit: $\chi^2(548)=995.250$ $p<.000$, RMSEA=.069, CFI=.906, TLI=.898, SRMR=.077. The amount of variance accounted for in the structural model was 48.8% for self-reported parental weight talk, 69.1% for child diet culture beliefs, 3.1% for body appreciation, and 50.8% for children's disordered eating. Regression estimates are detailed in Table 4.4.

Hypothesis 5a posited that the relationship between parents' weight talk and children's diet culture beliefs would be moderated by the family's degree of conversation orientation, such that low conversation orientation would make the relationship stronger. Although the interaction term had a positive relationship with children's diet culture beliefs, the moderation was not significant. Hypothesis 5b suggested the same moderation for the relationship between parents' behavioral modeling and children's diet culture beliefs; however, as behavioral modeling was removed from the model (see section "Parceled CFA"), this hypothesis was not tested.

Figure 4.1*Observed Relationships: Parent-Report*

Note. * $p < .05$, ** $p < .01$

Table 4.2*Parent-Report Model: Direct Effects*

IV	DV	Estimate	St. Estimate	S.E.	p-value
Parent DCB	Child DCB	1.175	.676	.298	.000**
Parent DCB	WT (Parent-Rep)	.980	.700	.175	.000**
WT (Parent-Rep)	Child DCB	.233	.188	.103	.024*
Child DCB	Body Appreciation	-.113	-.192	.055	.040*
Child DCB	Disordered Eating	.592	.717	.088	.000**

* $p < .05$, ** $p < .01$

Hypothesis 5c posited that the relationship between parents' weight talk and children's diet culture beliefs would be moderated by the family's degree of conformity orientation, such that high conversation orientation would make the relationship stronger. While results demonstrated a negative relationship between the interaction term and children's diet culture beliefs, the moderation was not significant. Hypothesis 5d suggested the same moderation for the relationship between parents' behavioral modeling and children's diet culture beliefs; however, as behavioral modeling was removed from the model (see section "Parceled CFA"), this hypothesis was not tested.

Hypothesis 6a stated that children's diet culture beliefs would predict children's disordered eating. As depicted in Table 4.2, this hypothesis was supported: children's diet culture beliefs had a significant predictive relationship to children's disordered eating, such that the higher degree of diet culture beliefs held by children, the greater their likelihood of engaging in disordered eating. Finally, hypothesis 6b posited that children's diet culture beliefs would predict children's body appreciation. As demonstrated in Table 4.2, support was found for this hypothesis. The higher degree of diet culture beliefs held by children, the lower their body appreciation was likely to be.

Child-Report Model

In the child-report model, weight talk was assessed using child perception data (that is, child-reported data on their parent's frequency of weight talk). The hypothesized model is depicted in Figure 2.1. All hypotheses were tested via SEM analysis in R using the *lavaan* package. The model was tested using a robust maximum likelihood estimator (MLR). Observed results are depicted in Figure 4.2.

Table 4.3*Parent-Report Model: Indirect Effects*

IV	Mediator	DV	Estimate	CI -		p-value
				Lower	Upper	
Parent DCB	WT (Parent-Rep)	Child DCB	.228	-.001	.457	.051

*p < .05, **p < .01

Table 4.4*Parent-Report Model: Conditional Effects*

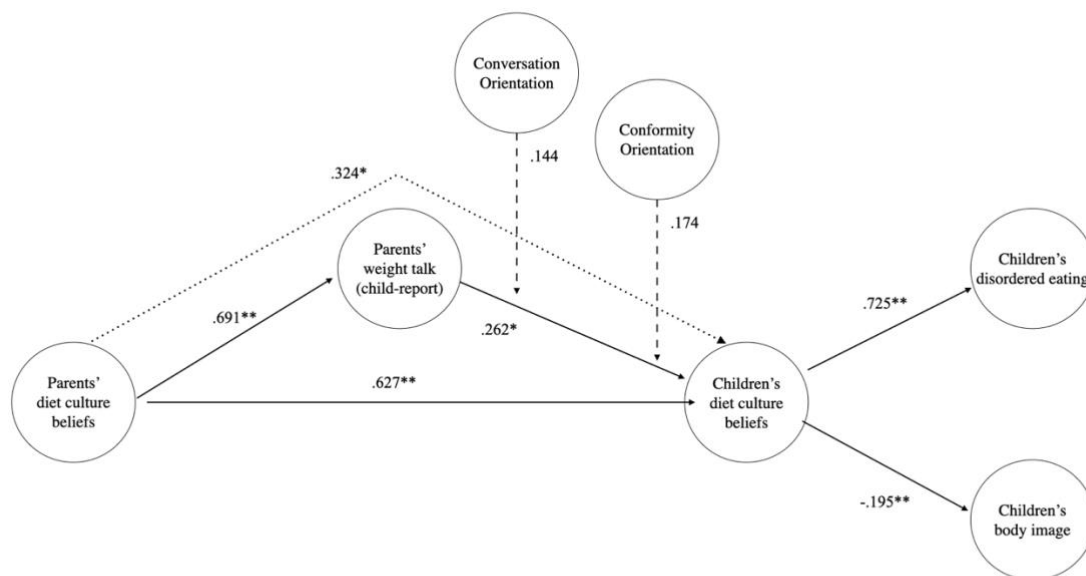
IV	Moderator	DV	Estimate	S.E.	p-value
WT (Parent- Rep)	Convo Orientation	Child DCB	.227	.133	.089
WT (Parent- Rep)	Conf Orientation	Child DCB	-.062	.123	.618

*p < .05, **p < .01

Results for the direct effects model yielded fair model fit: $\chi^2(371)=684.682$, $p<.000$, RMSEA=.068, CFI=.920, TLI=.913, SRMR=.077. The amount of variance accounted for in the structural model was 47.8% for child-reported parental weight talk, 68.8% for child diet culture beliefs, 3.8% for body appreciation, and 52.6% for children's disordered eating. Regression estimates are detailed in Table 4.5.

Hypothesis 1 suggested that parents' diet culture beliefs would predict children's diet culture beliefs, and findings revealed support for this hypothesis. Similar to the parent-report model, children whose parents held high degrees of diet culture beliefs were more likely to hold high degrees of diet culture beliefs themselves (Table 4.5). Further support was found for hypothesis 2a, which suggested that parents' diet culture beliefs would predict their weight talk with their children. As Table 4.5 demonstrates, parents' diet culture beliefs had a significant positive predictive relationship with child-reported parental weight talk; when parents held higher degrees of diet culture beliefs, children were more likely to report parental weight talk.

As the behavioral modeling variable was removed from the model (see section "Parceled CFA"), hypothesis 2b was not tested. Hypothesis 3a posited that parents' weight talk would predict children's diet culture beliefs. This hypothesis was supported. A significant positive predictive relationship was found between child-reported parental weight talk and children's diet culture beliefs, such that when children reported greater parental weight talk, they also reported higher degrees of diet culture beliefs. Because the behavioral modeling variable was removed from the model (see section "Parceled CFA"), hypothesis 3b was not tested.

Figure 4.2*Observed Relationships: Child-Report*

Note. * $p < .05$, ** $p < .01$

Table 4.5*Child-Report Model: Direct Effects*

IV	DV	Estimate	St. Estimate	S.E.	p-value
Parent DCB	Child DCB	1.121	.627	.293	.000**
Parent DCB	WT (Child Rep)	.957	.691	.170	.000**
WT (Child-Rep)	Child DCB	.338	.262	.134	.012*
Child DCB	Body Appreciation	-.111	-.195	.053	.037**
Child DCB	Disordered Eating	.589	.725	.082	.000**

** $p < .05$, ** $p < .01$

Results for the mediation model yielded the same global model fit as the direct effects model: $\chi^2(371)=684.682$, $p<.000$, $RMSEA=.068$, $CFI=.920$, $TLI=.913$, $SRMR=.077$. The amount of variance accounted for in the structural model was 47.8% for child-reported parental weight talk, 68.8% for child diet culture beliefs, 3.8% for body appreciation, and 52.6% for children's disordered eating. The unstandardized estimate, confidence interval, and p-value can be found in Table 4.6.

Hypothesis 4a posited that the relationship between parents' diet culture beliefs and children's diet culture beliefs would be mediated by parents' weight talk. In contrast to the parent-report model, support was found for this hypothesis with the child-report model. Specifically, child-reported parental weight talk significantly mediated the relationship between parents' diet culture beliefs and children's diet culture beliefs (Table 4.6). Hypothesis 4b was not tested, as the behavioral modeling variable was removed from the model.

Results for the conditional effects model with conversation orientation as a moderator yielded fair model fit: $\chi^2(548)=990.938$ $p<.000$, $RMSEA=.067$, $CFI=.902$, $TLI=.894$, $SRMR=.092$. The amount of variance accounted for in the structural model was 47.6% for child-reported parental weight talk, 69.1% for child diet culture beliefs, 3.9% for body appreciation, and 52.6% for children's disordered eating. Further, results for the conditional effects model with conformity orientation as a moderator yielded fair model fit: $\chi^2(548)=967.989$ $p<.000$, $RMSEA=.065$, $CFI=.917$, $TLI=.910$, $SRMR=.080$. The amount of variance accounted for in the structural model was 47.5% for child-reported parental weight talk, 70.9% for child diet culture beliefs, 3.1% for body

appreciation, and 52.1% for children's disordered eating. Regression estimates are detailed in Table 4.7.

Hypothesis 5a stated that the relationship between parents' weight talk and children's diet culture beliefs would be moderated by the family's degree of conversation orientation, such that low conversation orientation would make the relationship stronger. As with the parent-report model, this hypothesis was not supported; the moderation was not found to be significant in the child-report model. Hypothesis 5b was not tested, as the behavioral modeling variable was removed from the model.

Hypothesis 5c suggested that the relationship between parents' weight talk and children's diet culture beliefs would be moderated by the family's degree of conformity orientation, such that high conformity orientation would make the relationship stronger. Similar to the parent-report model, this hypothesis was not supported; the moderation was not significant (Table 4.7). Hypothesis 5d was not tested, as the behavioral modeling variable was removed from the model.

Hypothesis 6a stated that children's diet culture beliefs would predict children's disordered eating. As demonstrated in Table 4.5, this hypothesis was supported, such that higher degrees of diet culture beliefs significantly predicted greater levels of disordered eating in children. Further, support was found for hypothesis 6b, which suggested that children's diet culture beliefs would predict children's body appreciation. As demonstrated in Table 4.5, higher degrees of diet culture beliefs were found to significantly reduce children's body appreciation.

Table 4.6*Child-Report Model: Indirect Effects*

IV	Mediator	DV	Estimate	CI -		p-value
				Lower	Upper	
Parent DCB	WT (Child-Rep)	Child DCB	.324	.024	.623	.034*

*p < .05, **p < .01

Table 4.7*Child-Report Model: Conditional Effects*

IV	Moderator	DV	Estimate	S.E.	p-value
WT (Child- Rep)	Convo Orientation	Child DCB	-.026	.144	.818
WT (Child- Rep)	Conf Orientation	Child DCB	-.033	.174	.852

*p < .05, **p < .01

Conclusion

In this chapter, the results of the current study have been detailed. A structural equation modeling (SEM) analysis was conducted in R using the *lavaan* package (Rosseel, 2012). After the initial CFA was conducted to assess the measurement model, large variables were parceled to preserve just identification. After inspecting results of the subsequent CFA, parental behavioral modeling was removed from the structural model, given its indicators' poor loadings in the CFA. Finally, SEM analyses were run for the structural model, first with parent-reported weight talk data and then with child-reported parental weight talk data.

In conclusion, results provide support for the paramount role of children's perception of parental weight talk in children's propensity for diet culture beliefs, subsequently predicting children's likelihood of engaging in disordered eating and experiencing body image concerns. Additionally, although parent-reported weight talk was not found to significantly mediate the relationship between parents' diet culture beliefs and those of children, it was extremely close to being significant ($p < .051$). This suggests that while child perception may play a more prominent role in children's diet culture beliefs, parent's self-reported weight talk may still be important. Finally, the hypothesized moderations of conversation orientation and conformity orientation on the relationship between weight talk and children's diet culture beliefs were not found to be statistically significant for either model. In the following chapter, I discuss these findings and their meaning for continued research as well as practical application.

CHAPTER FIVE

DISCUSSION

Eating disorder prevention is of the utmost importance. Eating disorders have one of the highest mortality rates of any mental illness (Jones & Brown, 2016), and can detrimentally impair the lives of those affected (Berkman et al., 2007; de la Rie et al., 2005; Whisman et al., 2012). Communication within the family has the potential to play a key role in eating disorder prevention, and thus, the current study sought to investigate the role of parent-child communication in the development of three precursors to eating disorders: children's diet culture beliefs, disordered eating, and body image. In this chapter, the current study's results will be summarized, implications for prevention will be discussed, and the study's limitations will be acknowledged. Ultimately, this dissertation will conclude with an important discussion of the current study's contributions to the extant literature and implications for practical efforts that may contribute to eating disorder prevention.

Contributions to the Literature

This study examined a model depicting the intergenerational transmission of diet culture, considering communication both from the parent's perspective and from the child's perspective. The current findings lend credence to a process at play in which parents' diet culture beliefs inform their own weight talk (and perceived weight talk by children), as well as children's diet culture beliefs, which furthermore predict children's eating disorder-related outcomes of body image and disordered eating behavior. Thus, results from both models provide support for the transmission of diet culture beliefs from parent to child.

Notably, weight talk was found to significantly mediate the relationship between parents' diet culture beliefs and children's diet culture beliefs only in the child-report model, suggesting that children's perceptions of parental weight talk may have a greater impact on the development of children's diet culture beliefs than parent-reported weight talk. These results suggest that it may be through such perceived parental weight talk that children form diet culture beliefs, highlighting the paramount role of children's experiences in the formation of their beliefs.

Interestingly, the proposed moderations of conversation and conformity orientations were not found to be significant in either model. Furthermore, in some cases, the observed relationships differed in direction from the hypotheses. Possible explanations for this, as well as the non-significant weight talk mediation in the parent-report model, are discussed below. Ultimately, the current findings have implications for research by way of theory, acknowledgement of diet culture, and the inclusion of children's perspectives.

Theory

Results from this dissertation hold implications for theory that should be discussed. As mentioned, the proposed effects of conversation and conformity orientations on the relationship between weight talk and children's diet culture beliefs were not found to be significant for either model. Previous research has connected conversation orientation with such outcomes as weight stigma beliefs (Asbury & Woszidlo, 2016) and anorexia symptoms (Botta & Dumlao, 2002), suggesting that higher degrees of conversation orientation may be protective against such beliefs and behaviors. Further, conformity orientation has been linked with increased weight stigma beliefs and

increased disordered eating in the extant literature (Asbury & Woszidlo, 2016; Miller-Day & Marks, 2006). It would seem plausible, given such findings, that conversation orientation and conformity orientation may moderate the relationship between weight talk and children's diet culture beliefs, such that lower degrees of conversation orientation, and higher degrees of conformity orientation, may make the relationship stronger. Despite this, there are reasonable explanations for not having found support for these hypotheses.

A possible explanation for these findings differing from the hypotheses lies in data collection. Data regarding the family's conversation and conformity orientation were collected via parent report. Thus, the data collected on each family's degree of conversation and conformity orientation relied on the perspective of the parent taking the survey. Research has shown that parents' and children's perspectives of a family's FCP orientations can differ (Saphir & Chaffee, 2002). As with weight talk, it is possible that results may have been different if FCP orientations had been measured both from the perspective of the parent and the perspective of the child. Given the differences in parent-reported weight talk and children's perceptions of parental weight talk in the current study, it is possible that other differences in perceived communication exist – including FCP. While a parent may have believed the family's communication environment to be high in conversation orientation, for example, their child may have felt the environment to be low in conversation orientation.

Although FCPT does not specifically state a family's communication patterns to originate from the parent alone, much of the extant literature engages solely parent report, child report, or retrospective adult child report to measure such qualities (e.g., Ledbetter,

2015; Miller-Day & Marks, 2006; Schrodt et al., 2007; Schrodt, 2020). It may be important for continued work in the realm of FCPT to engage both child and parent data, to better understand not only differences in perception, but also the way in which such differences may operate in parent-child communication and children's developmental outcomes. Then, a stronger understanding of the effect of both parents' and children's understandings of the family's FCP on children's outcomes may be discerned.

An additional explanation for such differing findings may lie in FCP's position within the proposed model. Although previous literature has engaged conversation orientation and conformity orientation as moderators (e.g., Jiao, 2021; Schrodt & Scruggs, 2021), much work related to parent-child communication, disordered eating, and weight stigma has investigated direct relationships (e.g., Asbury & Woszidlo, 2016; Miller-Day & Marks, 2006). It is possible that conceptualizing FCP's place within the proposed model as direct relationships rather than moderators may have resulted in a clearer and more accurate picture of conversation and conformity orientations' roles in the intergenerational transmission of diet culture.

This poses interesting considerations for FCPT theorizing. Koerner and colleagues (2018) contend that FCPT "claims to describe what family communication is and how it functions" (p. 142). A wide breadth of research has examined conversation and conformity orientations in relation to specific communication strategies and outcomes, but despite this work, no clear articulation has been offered for the way in which such patterns function to facilitate specific strategies and outcomes. Scholars have engaged FCPs in examinations of direct, indirect, and conditional effects relationships (e.g., Abdullah & Salim, 2020; Asbury & Woszidlo, 2016; Jiao, 2021; Schrodt &

Scruggs, 2021), and an understanding of the significance of families' conversation and conformity orientations in family and developmental outcomes has become clear. What is needed is an explicit discussion of the way families' conversation and conformity orientations are understood to function toward facilitating such outcomes. For example, does the family's communication environment necessarily play a role in such outcomes more prominently as a direct relationship? Are conversation and conformity orientations more influential as moderators or mediators, rather than having a direct effect? Theorists may consider answering these questions by reviewing the extant FCPT-informed literature to draw conclusions about the way FCPs function toward facilitating family and developmental outcomes, and in doing this, a clearer picture of conversation and conformity orientations' functionality in such outcomes may be explicated, leading to more concrete suggestions for research design and implementation.

Diet Culture

Diet culture as a distinct concept has notably been left out of the extant literature. While existing work has investigated concepts of weight stigma, self-objectification, weight bias internalization, and body dissatisfaction (e.g., Gagnon-Girouard et al., 2020; Holub et al., 2011; Jones & Young, 2021; Lydecker et al., 2018a), very little research has specifically called diet culture by name. This has detrimental implications for existing work; when individual components of diet culture (like weight stigma, thin idealization, and food moralization) are examined in research, such work paves the way for continued investigations which are incomplete. This, then, creates a breadth of work that only partially illuminates the full reality of diet culture's influence, preventing diet culture

from wholly being recognized as a distinct and destructive influence on family interactions.

The current study sought to begin rectifying this concern by specifically investigating diet culture beliefs, rather than individual components of diet culture, to more holistically address the oppressive societal environment affecting parent-child communication and individual development. This constitutes an important contribution to family and health communication research, particularly with regard to eating disorder prevention. For work to adequately inform prevention efforts, findings need to be comprehensive and applicable to eating disorder development. Further cementing this contribution is the current study's findings, which clearly indicate a process in which diet culture-informed beliefs may work to facilitate harmful weight communication, which in turn may inform children's own beliefs and behavior related to eating disorder onset.

This is notable to consider for future research. Ecological risk/protective theory (ERPT) contends that both risk factors and protective processes within one's developmental ecology will influence development, and furthermore, that such factors and processes exist at varying levels within one's developmental ecology (Bogenschneider, 1996). Harmful diet culture messages at a societal level can inform communication at the family level, which, as found in this study, may inform children's outcomes. In this way, diet culture acts as a risk factor within one's developmental ecology, working as "processes that can potentially mitigate youth development" (Bogenschneider, 1996, p. 130). Diet culture's detrimental influence on weight stigma, thin idealization, and the moralization of food and bodies poses immense threat to developmental well-being, and the results of this study further support this claim. As

such, this dissertation contributes much to communication and eating disorder prevention literature. Beyond the current study, future work should continue acknowledging diet culture as a complete and inescapable systemic environment affecting families' and communities' communication. Doing so can build upon the beginning rectification presented in this dissertation, bolstering the scope and applicability of communication research toward eating disorder prevention.

Children's Perspectives

Another prominent contribution this study presents to the extant literature is its use of children's data to assess children's outcomes. Notably, the proposed mediation of parental weight talk on the relationship between parents' diet culture beliefs and children's diet culture beliefs was only found to be significant in the child-report model, indicating that children's perception of parental weight talk fully facilitates the effect of parents' beliefs on those of children. This suggests the possibility that children's perceptions may be more impactful in the intergenerational transmission of diet culture than parent-reported weight talk. Previous research indicates that parents may not realize they are sending messages about beauty ideals to children (Liechty et al., 2016), suggesting that parent-report data may not always present an accurate reflection of parents' weight- and appearance-related communication. Considering this, it would be plausible for children's perceptions to have a greater impact than parent-reported communication. Additionally, children's perceptions of parent behaviors are known to play a role in children's developmental outcomes (e.g., Gaylord et al., 2003; Korelitz & Garber, 2016). Therefore, it seems reasonable that while parent-reported weight talk had a direct effect on children's diet culture beliefs, it may not have fully mediated the

relationship between parents' and children's diet culture beliefs. In other words, parent-reported weight talk may be an important piece of the diet culture transmission process, but it may not fully facilitate the transmission of beliefs from parent to child.

Family systems theory suggests that families maintain interconnected relational webs, with seven defining characteristics as systems: interdependence, wholeness, patterns/self-regulation, openness, hierarchy/subgroups, interactive complexity, and equifinality (see "Family Systems Theory" section in Chapter 2). From this, families are demonstrated as being highly complex and distinct from other interpersonal relationships. Family communication research often relies on parent perspective to assess parent-child communication in relation to children's outcomes, functionally suggesting the family communication environment to solely be informed by the parent. This notion is clearly flawed, as previous research has cemented the role of children in developing families' relational culture and communication environments (e.g., Saphir & Chafee, 2002).

As noted in Chapter 1, research by Miller-Day and colleagues (2013) suggests that less than 4% of family communication research has engaged child participants as communicators; thus, family communication research has suffered from its lack of sufficient representation of children's perspectives. This is critically important when considering the purpose of such work. If research is meant to increase an understanding of the way in which parent-child communication affects children's outcomes, for example, then it cannot be assumed that using a young adult sample will adequately convey such an effect. While researchers can attempt to obtain data from young adults by asking about their childhood, this data cannot be a reliable substitute for data from child participants, as it relies on an accurate memory. What is largely absent is an

acknowledgement of the bi-directional nature of socialization within the family. When work engages solely the parent perspective, there is an underlying assumption that parents' perspectives are not only representative of the family as a whole, but also the most valuable perception of families' communication patterns, interactions, and outcomes.

Previous work has supported the importance of child perceptions of family interaction on their own development (e.g., Gaylord et al., 2003; Korelitz & Garber, 2016), thereby demonstrating the significance of children's perceptions, along with parent's perceptions, in the socialization process. With regard to the current study, when research assumes the parent to be the sole influence on children's development, such work cannot adequately provide an understanding of communicative eating disorder development. Furthermore, if research is meant to inform practice, then practitioners must ensure that such work is applicable to the practice they aim to inform. Practitioners interested in children's outcomes may use young adult-informed research as a starting point (e.g., "Now that we know that disordered eating can be communicatively transmitted, let's look at research on adolescents to find specific, helpful communication techniques for your family to prevent this issue,"), but it would be important for the practitioner to find research specific to the issues they aim to inform, so that they can engage data that speaks to that context. Scholars should take care to approach future family communication research from a family systems perspective, considering the complexity at play in the relationships being studied. Studies should be informed by the bidirectional nature of parent-child socialization and the significance of children's behaviors and beliefs in the family communication environment.

By engaging children as participants, the current study intentionally allows for an understanding of the way in which diet culture beliefs play a role in the development of children's disordered eating and body image, and thus can be applicable to eating disorder prevention work aimed at an appropriate population (see "Participants" in Chapter 3). Taken together, the current study's intentional use of children's data represents a prominent contribution to family and health communication research.

Communication-Based Process

A final contribution this study makes to the literature is its consideration of the communicative transmission of diet culture beliefs from parents to children. By examining a model of the intergenerational transmission of diet culture, the current study has pieced together current understandings related to parent-child communication, children's body image, children's disordered eating, and eating disorder development. In doing so, the current study has proposed, and largely found support for, a process by which children's eating disorder risk factors are facilitated; a process which places communication at the centerfold. As mentioned in Chapter 1, existing models of eating disorder development have typically engaged a psychological approach, emphasizing individual-level psychological processes and societal-level influences, like female body ideals (Brytek-Matera & Czepczor, 2017; Stice & Van Ryzen, 2019). While a psychological perspective is undoubtedly needed to prevent mental illness, a consideration of surrounding communicative environments seems equally as critical.

Viewing the current study through the lens of ERPT (Bogenschneider, 1996) can illuminate the significance of this contribution. As articulated earlier, diet culture can be seen as a dominant risk factor in children's developmental ecologies. What seems clear

from the extant literature, and what is supported by the current findings, is the notion that parent-child communication may act as either a risk factor and/or a protective process toward children's development. As suggested by the current findings, parental weight talk may significantly predict children's diet culture beliefs, suggesting that when parents talk about their own weight or that of their child, children may be at greater risk for developing beliefs related to weight stigma and thin idealization. Furthermore, the current findings support the notion that children's perceived parental weight talk may facilitate the connection between parents' own diet culture beliefs and those of children. In this way, parent-child weight communication can be considered as a risk factor in children's developmental ecologies. Previous work has additionally posited that parents' weight-related communication may be protective; for example, Arroyo and colleagues (2020) contend that mothers' modeling of healthy behaviors and discussions of female beauty ideals may help prevent against daughters' negative body image. Considering the current findings alongside existing literature, it is clear that parent-child communication is critical context which needs to be considered in the development and prevention of eating disorders and related outcomes. Thus, the current study's consideration of communication as a central component in the development of eating disorder risk factors presents a useful and important contribution to family and health communication literature, and to prevention work in particular.

Implications for Prevention

A discussion of the current study's implications for prevention in practice is warranted. While this dissertation presents implications for future research, its findings may also be interpreted to inform eating disorder prevention work. Practitioners working

to create mid-level or large-scale prevention programs, as well as practitioners working one-on-one with families, such as family life educators (FLEs) or parent educators, may especially gain insight from the current findings.

Practitioners working to develop mid-level or large-scale prevention programs may interpret the current study's findings to inform educational efforts within such programs. As findings support the intergenerational transmission of diet culture beliefs, particularly via child-perceived weight talk, practitioners may consider incorporating curriculum related to this communicative process within their programs. For programs aimed primarily at parents, practitioners may consider curriculum centered on eliminating or reducing weight talk, particularly around children. Curriculum should engage parents with specific, actionable tips and individual activities so parents can confidently leave the program feeling empowered to make behavioral change, especially when such diet culture-informed behaviors are deeply ingrained. For example, practitioners may suggest that parents seek to recognize when they talk about their own weight and that of their child. Practitioners may suggest language of which to be aware, which might help parents identify their own weight talk. An additional actionable tip may include engaging children in conversations about their own perception of parents' beliefs. Parents may be prompted to ask their kids what they think their parents believe about weight, bodies, and appearances. Parents may benefit from such conversations, as being aware of children's perceptions may allow parents to intervene before children's own destructive diet culture beliefs are solidified, or before disordered eating and body image challenges arise.

For programs aimed primarily at children, practitioners may choose to emphasize coping strategies. Given that children's perception of parental weight talk significantly

mediated the relationship between parents' diet culture beliefs and children's diet culture beliefs in the current study, it seems especially important for children experiencing parental weight talk to learn clear, understandable coping strategies for mitigating the effects of such weight talk on their mental and physical well-being. This, then, may additionally act as an intervention point to reach children before eating disorder precursors do.

Practitioners working one-on-one with families may additionally engage the current findings to inform their practice. As the study's recruitment methods and sample size do not allow the findings to be generalizable, findings should be interpreted as a communicative process by which children's eating disorder risk factors may be facilitated. As such, practitioners working one-on-one with families may engage the current study's findings to educate parents on the importance of recognizing and reducing weight talk within the home. In a one-on-one setting, practitioners can more closely get to know their clients, and thus can provide personalized guidance toward this end. In particular, practitioners working with parents should take care to communicate that parents are not at fault for any body image challenges or disordered eating their child may face; rather, their words can play a powerful role in shaping kids' experiences and beliefs. Practitioners working directly with children may additionally consider helping clients express their experiences with their parents. Facilitating more open communication in the parent-child relationship may help parents to recognize their own weight talk and learn how their comments are being perceived by their children. Such efforts may help families to make needed to change to work toward reducing the transmission of diet culture beliefs in the home.

Limitations

While the current study presents useful contributions to family and health communication research, and to eating disorder prevention practice, its limitations must be discussed. The first limitation that should be acknowledged is the potential for self-selection bias. Recruitment methods included posting study information both in the author's local community and online to social media groups focused specifically on parenting. Parents who were interested in participating with their child were prompted to contact the author. Given this recruitment strategy, it is possible that the members of such online groups may have been particularly interested in participating, given their existing participation in a group discussing parenting challenges. It is also possible that given the study's subject, participants may have been particularly motivated to participate in a study about body image if they have personally experienced a history of negative body image or food-related challenges. As noted in Chapter 3, 75.38% ($n=150$) of parent participants reported a history of disordered eating, and while it is possible this may be common, it is also possible that participants' personal histories of disordered eating may have influenced them to participate in the study. Considering the possible self-selection bias, the results of this study should not be interpreted as generalizable to all parent-child pairs, but rather, should be seen as a process composed of predictive relationships between parent-child communication, diet culture beliefs, and children's disordered eating and body image.

Additionally, given the author's use of online data collection methods, it is not possible to be absolutely certain that parents did not complete Part 2 of the survey for their children. Although measures were put into place to ensure data quality (see section

“Ethical Considerations and Quality Assurance” in Chapter 3), it is possible that parents still completed the survey in place of their children. Given this possibility, the results should be interpreted with data collection methods in mind.

Finally, because this study’s findings cannot be generalized to the public, results cannot be interpreted to be universally applicable. Practitioners aiming to engage this study’s findings toward eating disorder prevention should consider the findings to be indicative of a communicative process through which diet culture beliefs may be transmitted from parent to child, consequently facilitating children’s body image and disordered eating. As mentioned above, practitioners may consider referencing the current findings to educate families on the importance of reducing weight talk and acknowledging children’s perspectives of such communication within the home.

Conclusion

This chapter has presented a discussion of the current study’s findings, its implications for future research and eating disorder prevention practice, and its limitations. Ultimately, this dissertation presents a novel and considerable contribution to the extant literature surrounding parent-child communication, eating disorder development, and children’s perspectives. Through analysis of dyadic data via structural equation modeling, the current study supports the intergenerational transmission of diet culture, noting the significance of communication within and surrounding families toward children’s health-related outcomes.

Eating disorder prevention can only be facilitated if such work is continued. More research is needed to better understand how diet culture informs family interactions and children’s perception of parents’ beliefs and behaviors. Furthermore, work is critically

needed which centers children's experiences and perceptions by engaging children and adolescents as valuable participants. While more work is needed, this dissertation makes an important step in advancing this call. Overall, the current study highlights the role of diet culture beliefs and both parent-reported and child perception of parents' weight talk in the development of children's eating disorder-related outcomes, with notable implications for both future research and much-needed prevention practice.

References

- Abdullah, S. H. & Salim, R. M. A. (2020). Parenting style and empathy in children: The mediating role of family communication patterns. *Humanitas Indonesian Psychological Journal*, 17(1), 34-45.
<https://doi.org/10.26555/humanitas.v17i1.13126>
- Abraczinskas, M., Fisak Jr., B., & Barnes, R. D. (2012). The relation between parental influence, body image, and eating behaviors in a nonclinical female sample. *Body Image*, 9, 93-100. <https://doi.org/10.1016/j.bodyim.2011.10.005>
- Arroyo, A., & Andersen, K. K. (2016a). Appearance-related communication and body image outcomes: Fat talk and old talk among mothers and daughters. *Journal of Family Communication*, 16(2), 95-110.
<https://doi.org/10.1080/15267431.2016.1144604>
- Arroyo, A., & Andersen, K. K. (2016b). The relationship between mother-daughter self-objectification: Identifying direct, indirect, and conditional direct effects. *Sex Roles*, 74(5-6), 231-241. <https://doi.org/10.1007/s11199-015-0554-1>
- Arroyo, A., Segrin, C., & Andersen, K. K. (2017). Intergenerational transmission of disordered eating: Direct and indirect maternal communication among grandmothers, mothers, and daughters. *Body Image*, 20, 107-115.
<https://doi.org/10.1016/j.bodyim.2017.01.001>
- Arroyo, A., Stillion Southard, B. A., Cohen, H., & Caban, S. (2020). Maternal communication strategies that promote body image in daughters. *Communication Research*, 47(3), 402-427. <https://doi.org/10.1177%2F0093650218781737>

- Asbury, M. B. & Woszidlo, A. (2016). Understanding the relationship between family communication and the development of weight stigma. *Health Psychology Report*, 4(3), 213-223. <https://doi.org/10.5114/hpr.2016.57682>
- Baiocchi-Wagner, E. A. & Talley, A. E. (2013). The role of family communication in individual health attitudes and behaviors concerning diet and physical activity. *Health Communication*, 28, 193-205. <https://doi.org/10.1080/10410236.2012.674911>
- Bardone-Cone, A. M., Harney, M. B., & Sayen, L. (2011). Perceptions of parental attitudes toward body and eating: Associations with body image among Black and White college women. *Body Image*, 8(2), 186-189. <https://doi.org/10.1016/j.bodyim.2010.12.001>
- Barrack, M. T., Van Loan, M. D., Rauh, M., & Nichols, J. F. (2021). Disordered eating, development of menstrual irregularity, and reduced bone mass change after a 3-year follow-up in female adolescent endurance runners. *International Journal of Sport Nutrition & Exercise Metabolism*, 31(4), 337–344. <https://doi.org/10.1123/ijsnem.2021-0011>
- Benard, B. (1993). Fostering resiliency in kids. *Educational Leadership*, 51(3), 44-48.
- Berge, J. M., MacLehose, R., Loth, K. A., Eisenberg, M., Bucchianeri, M. M., & Neumark-Sztainer, D. (2013). Parent conversations about healthful eating and weight: Associations with adolescent disordered eating behavior. *JAMA Pediatrics*, 167(8), 746-753. <https://doi.org/10.1001/jamapediatrics.2013.78>
- Berge, J. M., Winkler, M. R., Larson, N., Miller, J., Haynos, A. F., Neumark-Sztainer, D. (2018). Intergenerational transmission of parent encouragement to diet from

adolescence into adulthood. *Pediatrics*, 141(4), <https://doi.org/10.1542/peds.2017-2955>

Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders*, 40(4), 293-309. <https://doi.org/10.1002/eat.20369>

Blais, R. K., Monson, C. M., Livingston, W. S., & Maguen, S. (2019). The association of disordered eating and sexual health with relationship satisfaction in female service members/veterans. *Journal of Family Psychology*, 33(2), 176-182.
<http://dx.doi.org/10.1037/fam0000493>

Bogenschneider, K. (1996). An ecological risk protective theory for building prevention programs, policies, and community capacity to support youth. *Family Relations*, 45(2), 127-138. <https://doi.org/585283>

Botta, R. A. & Dumlao, R. (2002). How do conflict and communication patterns between fathers and daughters contribute to or offset eating disorders? *Health Communication*, 14(2), 199-219. https://doi.org/10.1207/s15327027hc1402_3

Bowen, M. (1978). Family therapy in clinical practice. Aronson.

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723-742.
<https://doi.org/10.1037/0012-1649.22.6.723>

Brytek-Matera, A. & Czepczor, K. (2017). Models of eating disorders: a theoretical investigation of abnormal eating patterns and body image disturbance. *Archives of Psychiatry and Psychotherapy*, 19(1), 16-26. <https://doi.org/10.12740/APP/68422>

- Carbonneau, N., Goodman, L. C., Roberts, L. T., Bégin, C., Lussier, Y., & Musher-Eizenman, D. R. (2020). A look at the intergenerational associations between self-compassion, body esteem, and emotional eating within dyads of mothers and their adult daughters. *Body Image, 33*, 106-114.
<https://doi.org/10.1016/j.bodyim.2020.02.007>
- Carter, J., Smith, S., Bostick, S., & Grant, K. E. (2014). Mediating effects of parent-child relationships and body image in the prediction of internalizing symptoms in urban youth. *Journal of Youth and Adolescence, 43*, 554-567.
<https://doi.org/10.1007/s10964-013-9985-6>
- Centers for Disease Control and Prevention. (2021a). *Middle childhood (9-11 years of age)*. U.S. Department of Health and Human Services.
<https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html>
- Centers for Disease Control and Prevention. (2021b). *Young teens (12-14 years of age)*. U.S. Department of Health and Human Services.
<https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence.html>
- Chatterton, J. M., Petrie, T. A. (2013). Prevalence of disordered eating and pathogenic weight control behaviors among male collegiate athletes. *Eating Disorders, 21*(4), 328-341. <https://doi.org/10.1080/10640266.2013.797822>
- Chen, H., Ye, Y., & Guo, J. (2020). Impact of weight stigma on preadolescents' and adolescents' disordered eating behaviors: Testing two mediation models. *Social Behavior & Personality: an international journal, 48*(10), 1-15.
<https://doi.org/10.2224/sbp.9392>

- Chithambo, T. P. (2018). The role of thin-idealization in associations between body dissatisfaction, dieting, and eating pathology: A moderated mediation analysis. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*, 39(2), 550–555. <https://doi.org/10.1007/s12144-017-9776-4>
- Ciszewski, S., Flood, K. E., Proctor, C. J., & Best, L. A. (2020). Exploring the relationship between disordered eating and executive function in a non-clinical sample. *Perceptual and Motor Skills*, 127(6), 1033-1050. <https://doi.org/10.1177/0031512520937569>
- Cooley, E. & Toray, T. (2001). Body image and personality predictors of eating disorder symptoms during the college years. *International Journal of Eating Disorders*, 30(1), 28-36. <https://doi.org/10.1002/eat.1051>
- Dahill, L., Mitchison, D., Morrison, N. M. V., Touyz, S., Bussey, K., Trompeter, N., Lonergan, A., & Hay, P. (2021). Prevalence of parental comments on weight/shape/eating amongst sons and daughters in an adolescent sample. *Nutrients*, 13(1), 158. <https://dx.doi.org/10.3390/n13010158>
- Damiano, S. R., Gregg, K. J., Spiel, E. C., McLean, S. A., Wertheim, E. H., & Paxton, S. J. (2015). Relationships between body size attitudes and body image of 4-year-old boys and girls, and attitudes of their fathers and mothers. *Journal of Eating Disorders*, 3(16), 1-10. <https://doi.org/10.1186/s40337-015-0048-0>
- Davidson, K. (2020). *The development of a scale to measure diet-culture beliefs*. (Publication No. 27744893) [Master's thesis, Colorado State University]. ProQuest.

- Davis, H. A., & Smith, G. T. (2018). An integrative model of risk for high school disordered eating. *Journal of Abnormal Psychology, 127*(6), 559–570.
<https://doi.org/10.1037/abn0000365>
- de la Rie, S. M., Noordenbos, G., & van Furth, E. F. (2005). Quality of life and eating disorders. *Quality of Life Research, 14*, 1511-1521.
<https://doi.org/10.1007/s11136-005-0585-0>
- Deloitte Access Economics (2020). *The social and economic costs of eating disorders in the United States of America: A report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders*.
<https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders>
- Durso, L. E., Latner, J. D., & Ciao, A. C. (2016). Weight bias internalization in treatment-seeking overweight adults: Psychometric validation and associations with self-esteem, body image, and mood symptoms. *Eating Behaviors, 21*, 104-108. <https://doi.org/10.1016/j.eatbeh.2016.01.011>
- Elgar, F. J., Craig, W., & Trites, S. J. (2012). Family dinners, communication, and mental health in Canadian adolescents. *Journal of Adolescent Health, 52*(4), 1-6.
<https://doi.org/10.1016/j.jadohealth.2012.07.012>
- Farstad, S. M. & von Ranson, K. M. (2021). Binge eating and problem gambling are prospectively associated with common and distinct deficits in emotion regulation among community women. *Canadian Journal of Behavioural Science, 53*(1), 36-47. <http://dx.doi.org/10.1037/cbs0000239>
- Field, A. E., Javaras, K. M., Aneja, P., Kitos, N., Camargo Jr., C. A., Taylor, C. B., & Laird, N. M. (2008). Family, peer, and media predictors of becoming eating

disordered. *Archives of Pediatrics and Adolescent Medicine*, 162(6), 574-579.

<https://doi.org/10.1001/archpedi.162.6.574>

Fikkan, J., & Rothblum, E. (2012). Is fat a feminist issue? Exploring the gendered nature of weight bias. *Sex Roles*, 66(9-10), 575-592. <https://doi.org/10.1007/s11199-011-0022-5>

Fitzpatrick, M. A. & Ritchie, L. D. (1994). Communication schemata within the family: Multiple perspectives on family interaction. *Human Communication Research*, 20(3), 275–301. <https://doi.org/10.1111/j.1468-2958.1994.tb00324.x>

Fowler, C. & Zorn, A. (2020). Age identity and intergenerational relationships in the family. In J. Soliz & C.W. Colaner (Eds.), *Navigating relationships in the modern family: Communication, identity, and difference* (pp. 1-18). Peter Lang.

Gagnon-Girouard, M. P., Carbonneau, N., Gendron, M., Lussier, Y., & Bégin, C. (2020). Like mother like daughter: Association of maternal negative attitudes toward people of higher weight with adult daughters' weight bias. *Body Image*, 34, 277-281. <https://doi.org/10.1016/j.bodyim.2020.07.004>

Galvin, K. M., Braithwaite, D. O., & Bylund, C. L. (2015). *Family communication: Cohesion and change* (9th ed.) Routledge.

Gardner, R. M., Stark, K., Friedman, B. N., & Jackson, N. A. (2000). Like mother, like daughter: Association of maternal negative attitudes towards people of higher weight with adult daughters' weight bias. *Journal of Psychosomatic Research*, 49(3), 199-205. [https://doi.org/10.1016/s0022-3999\(00\)00172-0](https://doi.org/10.1016/s0022-3999(00)00172-0)

Gay, R. (2017). *Hunger: A memoir of (my) body*. Harper.

- Gaylord, N. K., Kitzmann, K. M., & Coleman, J. K. (2003). Parents' and children's perceptions of parental behavior: Associations with children's psychosocial adjustment in the classroom. *Parenting, 3*(1), 23-47.
https://doi.org/10.1207/S15327922PAR0301_02
- Gillison, F. B., Lorenc, A. B., Sleddens, E. F. C., Williams, S. L., & Atkinson, L. (2016). Can it be harmful for parents to talk to their child about their weight? A meta-analysis. *Preventive Medicine, 93*, 135-146.
<http://dx.doi.org/10.1016/j.ypmed.2016.10.010>
- Godfrey, K., Rhodes, P., & Hunt, C., (2013). The relationship between family mealtime interactions and eating disorder in childhood and adolescence: A systematic review. *Australian and New Zealand Journal of Family Therapy, 34*(1), 54-74.
<https://doi.org/10.1002/anf.1005>
- Gold, J. M., & Vander Weg, M. W. (2020). Investigating the relationship between parental weight stigma and feeding practices. *Appetite, 149*, 104635.
<https://doi.org/10.1016/j.appet.2020.104635>
- Goldschmidt, A. B., Wall, M. M., Choo, T.-H. J., Evans, E. W., Jelalian, E., Larson, N., & Neumark-Sztainer, D. (2018). Fifteen-year weight and disordered eating patterns among community-based adolescents. *American Journal of Preventive Medicine, 54*(1), e21-e29. <https://doi.org/10.1016/j.amepre.2017.09.005>
- Haines, J., Gillman, M. W., Rifas-Shiman, S., Field, A. E., & Austin, S. B. (2010). Family dinner and disordered eating behaviors in a large cohort of adolescents. *Eating Disorders, 18*(1), 10-24.
<https://dx.doi.org/10.1080%2F10640260903439516>

- Haines, J., Neumark-Sztainer, D., Hannan, P., & Robinson-O'Brien, R. (2008). Child versus parent report of parental influences on children's weight-related attitudes and behaviors. *Journal of Pediatric Psychology, 33*(7), 783-788.
<https://doi.org/10.1093/jpepsy/jsn016>
- Harrison, C. (2019). *Anti-Diet: Reclaim your time, money, well-being, and happiness through intuitive eating*. Little, Brown Spark.
- Harrison, K. (2000). The body electric: Thin-ideal media and eating disorders in adolescents. *Journal of Communication, 50*(3), 119-143.
<https://doi.org/10.1111/j.1460-2466.2000.tb02856.x>
- Hart, E., Tan, C. C., & Chow, C. M. (2021). Anti-fat attitudes and dietary restraint within mother-daughter dyads: an Actor-Partner Interdependence Model (APIM) analysis. *Eating and Weight Disorders, 26*, 1417-1426.
<https://doi.org/10.1007/s40519-020-00949-w>
- Hartley, E., Hill, B., McPhie, S., Skouteris, H. (2018). The associations between depressive and anxiety symptoms, body image, and weight in the first year postpartum: a rapid systematic review. *Journal of Reproductive and Infant Psychology, 36*(1), 81-101. <https://doi.org/10.1080/02646838.2017.1396301>
- Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64-105.
<https://doi.org/10.1037/0033-2909.112.1.64>

- Haynos, A. F., Wang, S. B., & Fruzzetti, A. E. (2018). Restrictive eating is associated with emotion regulation difficulties in a non-clinical sample. *Eating Disorders*, 26(1), 5-12. <https://dx.doi.org/10.1080/2F10640266.2018.1418264>
- Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2018). Weight stigma and health: The mediating role of coping responses. *Health Psychology*, 37(2), 139-147. <https://doi.org/10.1037/hea0000575>
- Ho, H. C. Y., Mui, M., Wan, A., Yew, C., Lam, T. H., Chan, S. S., & Stewart, S. M. (2018). Family meal practices and well-being in Hong Kong: The mediating effect of family communication. *Journal of Family Issues*, 39(16), 3835–3856. <https://doi.org/10.1177/2F0192513X18800787>
- Holland, G. & Tiggeman, M. (2017). “Strong beats skinny every time”: Disordered eating and compulsive exercise in women who post fitspiration on Instagram. *International Journal of Eating Disorders*, 50, 76-79. <https://doi.org/10.1002/eat.22559>
- Holman, A. & Koenig Kellas, J. (2018). “Say something instead of nothing”: Adolescents’ perceptions of memorable conversations about sex-related topics with their parents. *Communication Monographs*, 85(3), 357-379. <https://doi.org/10.1080/03637751.2018.1426870>
- Holub, S. C., Tan, C. C., & Patel, S. L. (2011). Factors associated with mothers' obesity stigma and young children's weight stereotypes. *Journal of Applied Developmental Psychology*, 32(3), 118-126. <https://doi.org/10.1016/j.appdev.2011.02.006>

- Horstman, H. K., Schrodt, P., Warner, B., Koerner, A., Maliski, R., Hays, A., & Colaner, C. W. (2018). Expanding the conceptual and empirical boundaries of family communication patterns: The development and validation of an Expanded Conformity Orientation Scale. *Communication Monographs*, 85(2), 157–180. <https://doi.org/10.1080/03637751.2018.1428354>
- Hunger, J. M., Dodd, D. R., & Smith, A. R. (2020a). Weight-based discrimination, interpersonal needs, and suicidal ideation. *Stigma and Health*, 5(2), 217–224. <http://dx.doi.org/10.1037/sah0000188>
- Hunger, J. M., Dodd, D. R., & Smith, A. R. (2020b). Weight discrimination, anticipated weight stigma, and disordered eating. *Eating Behaviors*, 37, 1-5. <https://doi.org/10.1016/j.eatbeh.2020.101383>
- Jaffe, K. & Worobey, J. (2006). Mothers' attitudes toward fat, weight, and dieting in themselves and their children. *Body Image*, 3(2), 113-120. <https://doi.org/10.1016/j.bodyim.2006.03.003>
- Jiao, J. (2021). Family communication patterns and emerging adults' attachment with parents and romantic partners. *Communication Research Reports*, 38(4), 229–240. <https://doi.org/10.1080/08824096.2021.1922373>
- Jones, C. C., & Young, S. L. (2021). The mother-daughter body image connection: The perceived role of mothers' thoughts, words, and actions. *Journal of Family Communication*, 21(2), 118-126. <https://doi.org/10.1080/15267431.2021.1908294>
- Jones, M., & Brown, T. (2016). *Why early intervention for eating disorders is essential*. National Eating Disorders Association.

<https://www.nationaleatingdisorders.org/blog/why-early-intervention-eating-disorders-essential>

Jordan, E. (2022). “If you don’t lose weight, the government will take you away”: An analysis of memorable messages and eating disorders in the LGBTQ+ community. *Health Communication*.

<https://doi.org/10.1080/10410236.2022.2126695>

Keery, H., Boutelle, K., van den Berg, P., & Thompson, J. K. (2005). The impact of appearance-related teasing by family members. *Journal of Adolescent Health, 37*, 120-127. <https://doi.org/10.1016/j.jadohealth.2004.08.015>

Kimmel, M. C., Ferguson, E. H., Zerwas, S., Bulik, C. M., & Meltzer-Brody, S. (2016). Obstetric and gynecologic problems associated with eating disorders.

International Journal of Eating Disorders, 49(3), 260-275.

<https://doi.org/10.1002/eat.22483>

Kite, L. & Kite, L. (2021). *More than a body: Your body is an instrument, not an ornament*. HarperCollins.

Kline, R. B. (2016). *Principles and practice of structural equation modeling* (4th ed.). New York, NY: Guilford.

Kluck, A. S. (2010). Family influence on disordered eating: The mediating role of body image dissatisfaction. *Body Image, 7*, 8-14.

<https://doi.org/10.1016/j.bodyim.2009.09.009>

Koerner, A. F. & Fitzpatrick, M. A. (2002). Understanding family communication patterns and family functioning: The roles of conversation orientation and

- conformity orientation. *Annals of the International Communication Association*, 26(1), 36-65. <https://doi.org/10.1080/23808985.2002.11679010>
- Koerner, A. F., Schrodt, P., & Fitzpatrick, M. A. (2018). Family communication patterns theory: A grand theory of family communication. In D. O. Braithwaite, E. A. Suter, & K. Floyd (Eds.), *Engaging theories in family communication: Multiple perspectives* (2nd ed., pp. 142-153). Routledge.
- Kogure, G. S., Ribeiro, V. B., Lopes, I. P., Furtado, C. L. M., Kodato, S., de Sá, M. F. S., Ferriani, R. A., da Silva Lara, L. A., & dos Reis, R. M. (2019). Body image and its relationships with sexual functioning, anxiety, and depression in women with polycystic ovary syndrome. *Journal of Affective Disorders*, 253, 385-393. <https://doi.org/10.1016/j.jad.2019.05.006>
- Korelitz, K. E. & Garber, J. (2016). Congruence of parents' and children's perceptions of parenting: A meta-analysis. *Journal of Youth and Adolescence*, 45(10), 1973-1995. <https://doi.org/10.1007/s10964-016-0524-0>
- Larsen, P. S., Strandberg-Larsen, K., Micali, N., & Nybo-Andersen, A. (2015). Parental and child characteristics related to early-onset disordered eating: A systematic review. *Harvard Review of Psychiatry*, 23(6), 395-412. <https://doi.org/10.1097/hrp.0000000000000073>
- Ledbetter, A. (2015). Political philosophy as a (partial) mediator of the association between family communication patterns and perception of candidate credibility in the 2012 U.S. presidential election. *Journal of Family Communication*, 15(3), 214-231. <https://doi.org/10.1080/15267431.2015.1043432>

- Lerner, R. M. (1991). Changing organism-context relations as the basic process of development: A developmental contextual perspective. *Developmental Psychology*, 27(1), 27–32. <https://doi.org/10.1037/0012-1649.27.1.27>
- Lessard, L. M., Puhl, R. M., Larson, N., Simone, M., Eisenberg, M. E., & Neumark-Sztainer, D. (2021). Parental contributors to the prevalence and long-term health risks of family weight teasing in adolescence. *Journal of Adolescent Health*, 69(1), 74-81. <https://doi.org/10.1016/j.jadohealth.2020.09.034>
- Levine, M. P. & Piran, N. (2004). The role of body image in the prevention of eating disorders. *Body Image*, 1(1), 57-70. [https://doi.org/10.1016/S1740-1445\(03\)00006-8](https://doi.org/10.1016/S1740-1445(03)00006-8)
- Levine, M. P. & Smolak, L. (2021). *The prevention of eating problems and eating disorders: Theory, research, and applications* (2nd ed.). Routledge.
- Liechty, J. M., Clarke, S., Birky, J P., Harrison, K., & STRONG Kids Team (2016). Perceptions of body image socialization in families: Exploring knowledge, beliefs, and strategies among mothers of preschoolers. *Body Image*, 19, 68-78. <http://dx.doi.org/10.1016/j.bodyim.2016.08.010>
- Little, T. D., Rhemtulla, M., Gibson, K., & Schoemann, A. M. (2013). Why the items versus parcels controversy needn't be one. *Psychological Methods*, 18(3), 285-300. <http://dx.doi.org/10.1037/a0033266>
- Littleton, H. L. & Ollendick, T. (2003). Negative body image and disordered eating behavior in children and adolescents: What places youth at risk and how can these problems be prevented? *Clinical Child and Family Psychology Review*, 6(1), 51-66. <https://doi.org/10.1023/a:1022266017046>

- Loth, K. A., Mohamed, N., Trofholz, A., Tate, A., & Berge, J. M. (2021). Associations between parental perception of- and concern about-child weight and use of specific food-related parenting practices. *Appetite, 160*.
<https://doi.org/10.1016/j.appet.2020.105068>
- Loth, K. A., Neumark-Sztainer, D., & Croll, J. K. (2009). Informing family approaches to eating disorder prevention: perspectives of those who have been there. *International Journal of Eating Disorders, 42*(2), 146-152.
<https://doi.org/10.1002/eat.20586>
- Lydecker, J. A., O'Brien, E., Grilo, C. M. (2018a). Parents have both implicit and explicit biases against children with obesity. *Journal of Behavioral Medicine, 41*, 784-791. <https://doi.org/10.1007/s10865-018-9929-4>
- Lydecker, J. A., Riley, K. E., & Grilo, C. M. (2018b). Associations of parents' self, child, and other "fat talk" with child eating behaviors and weight. *International Journal of Eating Disorders, 51*(6), 527-534. <https://dx.doi.org/10.1002%2Feat.22858>
- Lydecker, J. A., Cotter, E., & Grilo, C. M. (2019). Associations of weight bias with disordered eating among Latino and white men. *Obesity, 27*(12), 1982–1987.
<https://doi.org/10.1002/oby.22632>
- Maftai, A., Holman, A.-C., & Cârlig, E.-R. (2020). Does your child think you're happy? Exploring the associations between children's happiness and parenting styles. *Children and Youth Services Review, 115*.
<https://doi.org/10.1016/j.childyouth.2020.105074>
- Maloney, M. J., McGuire, J. B., & Daniels, S. R. (1988). Reliability testing of a children's version of the Eating Attitude Test. *Journal of the American Academy of Child*

and *Adolescent Psychiatry*. 27(5), 541-543. <https://doi.org/10.1097/00004583-198809000-00004>

- Marshall, R. D., Latner, J. D., & Masuda, A. (2020). Internalized weight bias and disordered eating: The mediating role of body image avoidance and drive for thinness. *Frontiers in Psychology*, 10, <https://doi.org/10.3389/fpsyg.2019.02999>
- McCabe, M. P., Ricciardelli, L. A., Stanford, J., Holt, K., Keegan, S., & Miller, L. (2007). Where is all the pressure coming from? Messages from mothers and teachers about preschool children's appearance, diet, and exercise. *European Eating Disorders Review*, 15, 221-230. <https://doi.org/10.1002/erv.717>
- Medved, C. E., Brogan, S. M., McClanahan, A. M., Morris, J. F., & Shepherd, G. J. (2006). Family and work socializing communication: Messages, gender, and ideological implications. *Journal of Family Communication*, 6(3), 161-180. https://doi.org/10.1207/s15327698jfc0603_1
- Miller-Day, M., & Marks, J. D. (2006). Perceptions of parental communication orientation, perfectionism, and disordered eating behaviors of sons and daughters. *Health Communication*, 153-163. https://doi.org/10.1207/s15327027hc1902_7
- Miller-Day, M., Pezalla, A., & Chesnut, R. (2013). Children are in families too! The presence of children in communication research. *Journal of Family Communication*, 13(2), 150-165. <https://doi.org/10.1080/15267431.2013.768251>
- Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development*, 56(2), 289-302. <https://doi.org/10.2307/1129720>

- Moshagen, M. & Erdfelder, E. (2016). A new strategy for testing structural equation models. *Structural Equation Modeling*, 23, 54–60.
<https://doi.org/10.1080/10705511.2014.950896>
- Najjar, R. H., Jacob, E., & Evangelista, L. (2018). Eating behaviors, weight bias, and psychological functioning in multi-ethnic low-income adolescents. *Journal of Pediatric Nursing*, 38, 81–87. <https://doi.org/10.1016/j.pedn.2017.11.008>
- Neumark-Sztainer, D., Bauer, K. W., Friend, S., Hannan, P. J., Story, M., & Berge, J. M. (2010). Family weight talk and dieting: How much do they matter for body dissatisfaction and disordered eating behaviors in adolescent girls? *Journal of Adolescent Health*, 47, 270-276. <https://doi.org/10.1016/j.jadohealth.2010.02.001>
- Prnjak, K., Hay, P., Mond, J., Bussey, K., Trompeter, N., Lonergan, A., & Mitchison, D. (2021). The distinct role of body image aspects in predicting eating disorder onset in adolescents after one year. *Journal of Abnormal Psychology*, 130(3), 236-247.
<https://doi.org/10.1037/abn0000537>
- Pudney, E. V., Himmelstein, M. S., & Puhl, R. M. (2019). The role of weight stigma in parental weight talk. *Pediatric Obesity*, 14(10), <https://doi.org/10.1111/ijpo.12534>
- Ritchie, L. D., & Fitzpatrick, M. A. (1990). Family communication patterns: Measuring intrapersonal perceptions of interpersonal relationships. *Communication Research*, 17, 523–544. <http://dx.doi.org/10.1177/009365090017004007>
- Robertson, M. D. A., Dempster, S., Doherty, L., & Sharpe, H. (2022). Exploring the association between parental anti-fat attitudes and restrictive feeding practices in a British and Irish sample. *Appetite*, 168,
<https://doi.org/10.1016/j.appet.2021.105755>

- Robinson-Cimpian, J. P. (2014). Inaccurate estimation of disparities due to mischievous responders: Several suggestions to assess conclusions. *Educational Researcher*, 43(4), 171–185. <https://doi.org/10.3102/0013189X14534297>
- Rodgers, R. F., Wertheim, E. H., Damiano, S. R., & Paxton, S. J. (2020). Maternal influences on body image and eating concerns among 7- and 8-year-old boys and girls: cross-sectional and prospective relations. *International Journal of Eating Disorders*, 53(1), 79-84. <https://doi.org/10.1002/eat.23166>
- Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: implications for prevention efforts. *International Journal of Eating Disorders*, 48(2), 187-198. <https://dx.doi.org/10.1002%2Feat.22270>
- Romano, K. A., Heron, K. E., & Henson, J. M. (2021). Examining associations among weight stigma, weight bias internalization, body dissatisfaction, and eating disorder symptoms: Does weight status matter? *Body Image*, 37, 38–49. <https://doi.org/10.1016/j.bodyim.2021.01.006>
- Rosseel, Y. (2012). lavaan: An R package for structural equation modeling. *Journal of Statistical Software*, 48, 1-36. Retrieved from <http://www.jstatsoft.org/v48/i02/>
- Royal, S., MacDonald, D. E., & Dionne, M. M. (2013). Development and validation of the Fat Talk Questionnaire. *Body Image*, 10, 62-69. <http://dx.doi.org/10.1016/j.bodyim.2012.10.003>
- Rubinsky, V., Hosek, A. M., & Hudak, N. (2019). “It’s better to be depressed skinny than happy fat:” College women’s memorable body messages and their impact on

- body image, self-esteem, and rape myth acceptance. *Health Communication*, 34(13), 1555-1563. <https://doi.org/10.1080/10410236.2018.1504659>
- Saphir, M. N. & Chaffee, S H. (2002). Adolescents' contributions to family communication patterns. *Human Communication Research*, 28(1), 86-108. <https://doi.org/10.1111/j.1468-2958.2002.tb00799.x>
- Schrodt, P. (2020). Emotion labor as a mediator of family communication patterns and young adult children's mental well-being. *Journal of Family Communication*, 20(1), 66-81. <https://doi.org/10.1080/15267431.2019.1661250>
- Schrodt, P., Ledbetter, A. M., & Ohrt, J. K. (2007). Parental confirmation and affection as mediators of family communication patterns and children's mental health. *Journal of Family Communication*, 7(1), 23-46. <https://doi.org/10.1080/15267430709336667>
- Schrodt, P., & Scruggs, X. (2021). Young adults' shared family identity with parents as a function of family communication patterns. *Communication Reports*, 34(1), 14–25. <https://doi.org/10.1080/08934215.2020.1859573>
- Seitz, S. (2019). *Disordered eating as a precursor to eating disorders*. National Eating Disorders Association (NEDA). <https://www.nationaleatingdisorders.org/blog/disordered-eating-precursor-eating-disorders>
- Shriver, L. H., Dollar, J. M., Calkins, S. D., Keane, S. P., Shanahan, L., & Wideman, L. (2021). Emotional eating in adolescence: Effects on emotion regulation, weight status, and negative body image. *Nutrients*, 13(79), 1-12. <https://doi.org/10.3390/nu13010079>

- Smolak, L. & Levine, M. P. (1994). Psychometric properties of the children's eating attitudes test. *International Journal of Eating Disorders*, 16(3), 275-282.
[https://doi.org/10.1002/1098-108X\(199411\)16:3%3C275::AID-EAT2260160308%3E3.0.CO;2-U](https://doi.org/10.1002/1098-108X(199411)16:3%3C275::AID-EAT2260160308%3E3.0.CO;2-U)
- Smolak, L., Levine, M. P., & Schermer, F. (1999). Parental input and weight concerns among elementary school children. *International Journal of Eating Disorders*, 25(3), 263-271. [https://doi.org/10.1002/\(SICI\)1098-108X\(199904\)25:3%3C263::AID-EAT3%3E3.0.CO;2-V](https://doi.org/10.1002/(SICI)1098-108X(199904)25:3%3C263::AID-EAT3%3E3.0.CO;2-V)
- Sparti, C., Santomauro, D., Cruwys, T., Burgess, P., & Harris, M. (2019). Disordered eating among Australian adolescents: Prevalence, functioning, and help received. *International Journal of Eating Disorders*, 52(3), 246-254.
<https://doi.org/10.1002/eat.23032>
- Stice, E., & Van Ryzin, M. J. (2019). A prospective test of the temporal sequencing of risk factor emergence in the dual pathway model of eating disorders. *Journal of Abnormal Psychology*, 128(2), 119–128. <http://dx.doi.org/10.1037/abn0000400>
- Tovar, V. (2018). *You have the right to remain fat*. Feminist Press.
- Tylka, T. L. & Wood-Barcalow, N. L. (2015). The Body Appreciation Scale-2: Item refinement a psychometric evaluation. *Body Image*, 12, 53-67.
<https://doi.org/10.1016/j.bodyim.2014.09.006>
- van Mierlo, L. A., Scheffers, M., & Koning, I. (2021). The relative relation between body satisfaction, body investment, and depression in Dutch emerging adults. *Journal of Affective Disorders*, 278, 252-258. <https://doi.org/10.1016/j.jad.2020.09.034>

- Verplanken, B. & Velsvik, R. (2008). Habitual negative body image thinking as psychological risk factor in adolescents. *Body Image*, 5, 133-140.
<https://doi.org/10.1016/j.bodyim.2007.11.001>
- Voelker, D. R., Gould, D. & Reel, J. J. (2014). Prevalence and correlates of disordered eating in female figure skaters. *Psychology of Sport and Exercise*, 15(6), 696-704.
<https://doi.org/10.1016/j.psychsport.2013.12.002>
- Watson, R. J., Veale, J.F., & Saewyc, E. M. (2017). Disordered eating behaviors among transgender youth: Probability profiles from risk and protective factors. *International Journal of Eating Disorders*, 50(5), 515-522.
<https://doi.org/10.1002/eat.22627>
- Wei, C., & Kendall, P. C. (2014). Child perceived parenting behavior: Childhood anxiety and related symptoms. *Child & Family Behavior Therapy*, 36(1), 1–18.
<https://doi.org/10.1080/07317107.2014.878175>
- Wellman, J. D., Araiza, A. M., Newell, E. E., & McCoy, S. K. (2018). Weight stigma facilitates unhealthy eating and weight gain via fear of fat. *Stigma Health*, 3(3), 186-194. <https://doi.org/10.1037/sah0000088>
- Werner, E. E. (1990). Protective factors and individual resilience. In S. J. Meisels & J. P. Shonkoff (Eds.), *Handbook of early childhood intervention* (pp. 97-116). Cambridge University Press.
- Whisman, M. A., Dementyeva, A., Baucom, D. H., & Bulik, C. M. (2012). Marital functioning and binge eating disorder in married women. *International Journal of Eating Disorders*, 45(3), 385-389. <https://doi.org/10.1002/eat.20935>

Winkler, M. R., Berge, J. M., Larson, N., Loth, K. A., Wall, M., & Neumark-Sztainer, D.

(2018). Parent-child health- and weight-focused conversations: who is saying

what and to whom? *Appetite*, *126*, 114-120.

<https://doi.org/10.1016/j.appet.2018.03.023>

World Health Organization. (2021, November 17). *Adolescent mental health*.

<https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

Yoshimura, C. G. & Galvin, K. M. (2018). General systems theory: A compelling view

of family life. In D. O. Braithwaite, E. A. Suter, & K. Floyd (Eds.), *Engaging*

theories in family communication: Multiple perspectives (2nd ed., pp. 164-174).

Routledge.

Appendix A

Recruitment Materials

Recruitment Flyer/Social Media Image

Calling all parents!

Is your child 9-14 years old?

Researchers at the University of Missouri are interested in learning about **parent-child communication and body image** and would love for you and your child to participate in this study!

Participation involves completing an online survey, which should take approximately 30 minutes.

Each parent-child pair will receive a \$10 gift card for their time and effort.

Parents must be 18+ and kids must be age 9-14. Must speak English and have access to Internet to take the online survey.

For more information, or if you are interested in participating, please contact Ellen Jordan.

Ellen Jordan
ellenjordan@mail.missouri.edu

Facebook Ads

A Facebook advertisement with a purple and teal background. The text is centered in a white box. The title 'Participate in Research!' is in a large, bold, blue font. Below it, the text describes a study by the University of Missouri seeking parent-child pairs. It mentions that participation involves an online survey taking about 30 minutes. Eligibility criteria are listed: parents must be 18+ and kids 9-14, and they must speak English and have internet access. Contact information for Ellen Jordan is provided at the bottom in a teal box.

Participate in Research!

Researchers at the University of Missouri are seeking **parent-child pairs** to participate in a study about **parent-child communication & body image**

Participation involves completing an online survey, which should take approximately 30 minutes.

Parents must be 18+ and kids must be age 9-14.
Must speak English and have access to Internet to take the online survey.

If you are interested in participating, please contact Ellen Jordan.

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Participate in Research!

Researchers at the University of Missouri are seeking **parent-child pairs** to participate in a study about **parent-child communication & body image**

Participation involves doing an online survey, which should take about 30 minutes.

Parents must be 18+ and kids must be age 9-14.
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Participate in Research!

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Participation involves doing an online survey, which should take about 30 minutes.

Parents must be 18+ and kids must be age 9-14.
Must speak English & have access to Internet to take the survey.

If you are interested in participating, please contact Ellen Jordan.

ellenjordan@mail.missouri.edu

Appendix B

Consent Form

Parental/Guardian Consent Form

Project Title: The Intergenerational Transmission of Diet Culture: Associations with Children's Disordered Eating and Body Image

Principal Investigator Name: Ellen Jordan

Principle Investigator's Advisor: Colleen Colaner, Ph.D.

IRB Assigned Project Number: 2091527

Key Information About the Study

You and your child are being asked to participate in a research study. The purpose of this research project is to better understand parent-child relationships and children's mental health outcomes. You and your child are being asked to complete an online survey. Possible benefits include receiving a \$10 digital gift card for your time and effort. Risks are minimal, but some possible risks may include feeling uncomfortable providing responses to the survey questions.

Please read this form carefully and take your time. Let us know if you have any questions before consenting to participate and/or giving your child permission to participate. The researcher is happy to explain words or information that you do not understand.

Participating in this research is voluntary and you can choose not to participate. You may also choose not to have your child participate. If you do not want yourself or your child to participate, or if you choose to start the study and then stop later, there will be no penalty or loss of benefits to which you and your child are otherwise entitled.

Purpose of the Research

You and your child are being asked to participate in this study because you are over the age of 18 years old and your child is between 9 and 14 years old. The purpose of this research project is to better understand parent-child relationships and children's mental health.

What will happen during the study?

You and your child are being asked to complete an online survey, which should take approximately 30 minutes. You will be asked to complete the first half of the survey, and your child will be asked to complete the second half of the survey.

There will be about 150-200 parent-child pairs participating in this study.

What are the expected benefits of the study?

There are no direct benefits to participating in this study. However, the results of this study may have the potential to inform mental health prevention efforts, which would benefit society as a whole.

What are the possible risks of participating in this study?

There are minimal risks expected when taking part in this study. There are some that we know about and some may not know about yet. Some possible risks include feeling uncomfortable or embarrassed about providing responses to some of the questions in the survey.

To help lower these possible risks, we will ensure that the information you provide is confidential. Your information will not be shared with anyone. Only the research team will have access to the information you provide.

We will tell you about any new important information we learn that may affect your decision to participate and/or allow your child to participate in this study.

What other choices do I have if I don't want to be in the study and/or my child to be in this study?

You and your child are not required to be in this study. You can simply choose not to participate. You can look for other research projects you and your child may be interested in instead of this study.

Will my child and I receive compensation for taking part in this study?

You and your child will be compensated for taking part in this study. For their time and effort, you and your child will receive one digital \$10 gift card. The gift card will be sent to your email address that you provide in the survey. Gift cards will be sent out after data has been collected for this study.

Are there any costs for participating in this study?

You should not expect any additional costs by participating and/or letting your child participate in this study.

Will information about myself and my child be kept private?

The research team is committed to respecting your and your child's privacy and keeping your and your child's personal information confidential. We will make every effort to protect your and your child's information to the extent allowed by law.

When the results of this research are published, we will remove all identifying information so it will not be known who provided the information. Your and your child's information will be kept as secure as possible to prevent your identities from being disclosed. The data we collect from you and your child as part of this research will not be used or shared for future research studies. It will only be used for purposes of this study.

Who do I contact if I have questions or concerns?

If you have questions about this study, you can contact Ellen Jordan, the University of Missouri researcher, at ellenjordan@mail.missouri.edu. You may also contact Colleen Colaner, Ph.D., the advisor for this research study, at colanerc@missouri.edu.

If you have questions about your or your child's rights as a research participant, please contact the University of Missouri Institutional Review Board (IRB) at 573-882-3181 or muresearchirb@missouri.edu. The IRB is a group of people who review research studies to make sure the rights and welfare of participants are protected.

If you want to talk privately about any concerns or issues related to your or your child's participation, you may contact the Research Participant Advocacy at 888-280-5002 (a free call) or email muresearchrpa@missouri.edu.

Do I get a copy of this consent form?

You will receive a copy of this consent form for your records.

We appreciate your consideration for your child to participate in this study.

Consent to Participate - Signatures

Parent/Guardian Signature	Date

Child's Name

Relationship to Child

Appendix C

Child Assent Form

Child Assent

Research Title: The Intergenerational Transmission of Diet Culture: Associations with Children's Disordered Eating and Body Image

Researcher's Name: Ellen Jordan

IRB Project Number: 2091527

Information about the Study

You are being asked to be in a research study.

Please read this form carefully and take your time. Let us know if you have any questions before you decide if you want to be in the study. The research team can explain words that you do not understand. Your parents can also help explain the study to you.

If you do not want to be in the study, that is okay. You can also choose to start the study then stop later. It will not be a problem at all.

You are being asked to be in this study because you are between the ages of 9 years old and 14 years old. We are doing the study because we want to learn about relationships between parents and children. What you tell us will only be used for this study. It will not be used for other studies or shared with anyone besides the researcher.

What will happen during the study?

You are being asked to do an online survey. It will take about 30 minutes. The information you share will be private. Only the researcher will know what you said. They will not tell anyone what you say.

What are the good things that can happen in this study?

You may or may not have good things happen to you by being in the study. We may learn something from the study that may help other people in the future.

What are the bad things that can happen in this study?

We do not expect anything bad to happen to you.

What other choices do I have if I don't want to be in this study?

You do not have to be in this study. You can stop at any time and the researcher won't be upset.

Will I be paid for being in this study?

You and your parent will receive one \$10 gift card for participating in this study. The gift card will be sent to your parent in an email. The gift card will be sent once the researcher has collected her data.

Will my information be kept private?

We will do everything we can to keep your information private. Only the researcher will know what you shared.

What if I have questions or problems?

You and your parent can contact the researcher at any time at ellenjordan@mail.missouri.edu. The researcher's name is Ellen, and she is happy to answer any questions you have.

Assent Signature

Child's Signature	Date

Appendix D

Questionnaire

[Consent Form]

Part 1: Parents

Welcome to Part 1 of the study! This survey has two parts. The parent should complete Part 1, and the child should complete Part 2. You will get a similar alert to this one when Part 1 has ended and Part 2 is coming up.

Because this survey needs information from both you and your child, please complete your part of the survey with your child nearby, so when it is your child's turn to complete Part 2, you can hand them the device so they can do Part 2 of the survey.

The parent should complete the following questions. While answering each question, please answer honestly. Remember, only the research team will see your responses. Thank you very much for your participation.

Conversation Orientation

Please indicate the degree to which you agree with each statement, ranging from "Strongly Disagree" to "Strongly Agree."

In our family, we often talk about topics like politics and religion where some persons disagree with others.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In often say things like, "Every member of the family should have some say in family decisions."

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I often ask my child's opinion when the family is talking about something.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I encourage my child to challenge my ideas and beliefs.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I often say things like, "You should always look at both sides of an issue."

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My child usually tells me what s/he is thinking about things.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My child can tell me almost anything.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In our family, we often talk about our feelings and emotions.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My child and I often have long, relaxed conversations about nothing in particular.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I think my child really enjoys talking with me, even when we disagree.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I encourage my child to express his/her feelings.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I tend to be very open about my emotions.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

We often talk as a family about things we have done during the day.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In our family, we often talk about our plans and hopes for the future.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I like to hear my child's opinion, even when s/he doesn't agree with me.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Conformity Orientation

Please indicate the degree to which you agree with each statement, ranging from "Strongly Disagree" to "Strongly Agree."

I expect my child/children to respect their elders.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In our home, my child/children is/are expected to speak respectfully to me.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I have clear expectations about how my child(ren) is/are supposed to behave.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When my child is home, they are expected to obey my rules.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I insist that my child respect those who have been placed in positions of authority.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I emphasize certain attitudes that I want the children in my family to adopt.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In our home, I have the last word.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I expect my child to trust my judgment on important matters.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My child is expected to follow my wishes.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel it is important to be the boss.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I become irritated with my child's views if they are different from mine.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I try to persuade my child to view things the way I see them.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I say things like, "You'll know better when you grow up."

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I say things like, "You may not understand why we are doing this right now, but some day you will."

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I say things like, "My ideas are right and you should not question them."

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In my family, family members are expected to hold similar values.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
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My child is expected to adopt my views.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

I encourage my child to adopt my values.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

Our family has a particular way of seeing the world.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

My child feels pressure to adopt my beliefs.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

My child is expected to challenge my beliefs.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

In our home, children are allowed to question my authority.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

I encourage open disagreement.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

In our home, children are encouraged to question my authority.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

Parental Diet Culture Beliefs

Please indicate the degree to which you agree with each statement, ranging from "Strongly Disagree" to "Strongly Agree".

I try to control my weight so that others will have a positive opinion of me.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

I only exercise to have a body that others find acceptable.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

I will only wear clothes that make me look thin.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

Some foods are temptations to be resisted.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

I put a lot of effort into resisting bad foods.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree

There are some foods that I should never eat.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fat people are unhealthy.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If I am thin, I will live longer.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A person's health is largely determined by the types of food they eat.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Almost there! Thank you for answering these questions. It is very much appreciated! Just a few more left.

Parental Self-Weight Talk

We are interested in the comments you make. Please answer honestly. For each statement, you may choose between the following options: "Never," "Rarely," "Sometimes," "Often," and "Always."

When I'm with my child, I complain that my arms or legs are too flabby.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my stomach is fat.

Never	Rarely	Sometimes	Often	Always
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When I'm with my child, I criticize my body compared to thin models in magazines.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my body is out of proportion.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I hate my whole body.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I am fat.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I should not be eating fattening foods.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I've gained weight.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my clothes are too tight.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I need to stop eating so much.

Never Rarely Sometimes Often Always

When I'm with my child, I criticize my body compared to my friends' bodies.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my body is disgusting.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I'm not in shape.

Never Rarely Sometimes Often Always

Parental Child-Weight Talk

We are interested in the comments you make. Please answer honestly. For each statement, you may choose between the following options: "Never," "Rarely," "Sometimes," "Often," and "Always."

When I'm with my child, I complain that my child's arms or legs are too flabby.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my child's stomach is fat.

Never Rarely Sometimes Often Always

When I'm with my child, I criticize my child's body compared to thin models in magazines.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my child's body is out of proportion.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that I hate my child's whole body.

Never Rarely Sometimes Often Always

When I'm with my child, I complain that my child is fat.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child should not be eating fattening foods.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child has gained weight.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child's clothes are too tight.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child needs to stop eating so much.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I criticize my child's body compared to their friends' bodies.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child's body is disgusting.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my child, I complain that my child is not in shape.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Parental Dieting

How often have you gone on a diet in the last year? By "diet," we mean changing the way you eat so you can lose weight.

Never	1-4 times	5-10 times	More than 10 times	I am always dieting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Parental Weight Loss Behaviors

In the last year, how many of the following things have you done in order to lose weight or keep from gaining weight? Choose all that apply.

- Fasted
- Ate very little food
- Used a food substitute (such as a powder or special drink)
- Skipped meals
- Smoked more cigarettes and/or vaped more often
- Took diet pills
- Made myself vomit
- Used laxatives
- Used diuretics

You're doing great! This is the final section of Part 1 (your part) of the survey. The following questions ask you to provide demographic information about yourself and your child. For the questions asking about your child, please refer to the child who is participating in the study with you. Please answer honestly.

Demographics

Please indicate your age in years.

18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75

Please indicate your gender.

- Cisgender woman
- Cisgender man
- Transgender woman
- Transgender man
- Nonbinary

Please indicate your race.

- Black
- Latino/a/x
- Asian
- Native American/American Indian
- White/Caucasian
- Multiracial
- Other race not listed

Please indicate your highest level of completed education.

- High school diploma
- Some college
- Two-year college degree (Associate's)
- Four-year college degree (Bachelor's)
- Graduate degree (Master's, Doctorate)
- Professional degree (law, medical, etc.)

Please indicate whether you have ever experienced disordered eating. Disordered eating is any eating behavior that is abnormal or unhealthy. Examples of disordered eating include binge eating, restricting food intake, dieting, and/or purging food after eating.

- Yes, I have personally experienced disordered eating.
- No, I have never experienced disordered eating.

Please indicate your child's age in years. If you have multiple children, provide the age of the child who is completing this study with you.

- Younger than 9 years old
- 9
- 10
- 11
- 12
- 13
- 14
- Older than 14 years old

Please indicate your child's gender. If you have multiple children, provide the gender of the child who is completing this study with you.

- Cisgender girl
- Cisgender boy
- Transgender girl
- Transgender boy
- Nonbinary

Please indicate your child's race. If you have multiple children, provide the race of the child who is completing this study with you.

- Black
- Latino/a/x
- Asian
- Native American/American Indian
- White/Caucasian
- Multiracial
- Other race not listed

Email As a way to thank you for participating in this study, we would like to give you a \$10 gift card. Please indicate an email address to which we can send a virtual gift card.

Part 1 has ended. Your child will now need to complete Part 2. Please hand this device to your child so that they can complete Part 2. Remember, your child should complete Part 2 of the survey on their own.

Once your child is done with Part 2, they will be prompted to give this device back to you so you can make sure the information is submitted completely. This step will only take a few seconds.

You may click the "next" button below and hand the device to your child. Thank you very much!

Welcome to Part 2 of the study! Your parent already did Part 1 of the survey, and you are being asked to complete Part 2.

Before completing Part 2, you will need to consent to participate in the study (This means you need to agree to do the study before you can do Part 2 of this survey). Please review the consent form below. If you agree to participate, you may click the "next" button below to begin answering the questions.

[Child Assent Form]

Thank you for agreeing to participate! You will be asked several questions. Please answer as honestly as possible. We will not be upset with you or your answers, and we are really thankful for you answering these questions!

Body Appreciation

This section will ask you how you feel about your body. Please choose how often each statement is true about you. You can choose "Never," "Seldom (Rarely)," "Sometimes," "Often," or "Always."

I respect my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel good about my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel that my body has at least some good qualities.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I take a positive attitude towards my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I am attentive to my body's needs.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel love for my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I appreciate the different and unique characteristics of my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My behavior reveals my positive attitude toward my body; for example, I hold my head high and smile.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I am comfortable in my body.

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel like I am beautiful even if I am different from media messages of attractive people (e.g., models, actresses/actors).

Never	Seldom (Rarely)	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel that others would like me to eat more.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I vomit after I have eaten.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel very guilty after eating.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I think a lot about wanting to be thinner.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I think about burning up energy (calories) when I exercise.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other people think I am too thin.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I think a lot about having fat on my body.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I take longer than others to eat my meals.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I stay away from foods with sugar in them.

Never	Rarely	Sometimes	Often	Very Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I eat diet foods.

Never	Rarely	Sometimes	Often	Very Often	Always
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You're doing great! Just a few more questions. Thank you for your participation so far!

Parental Self-Weight Talk (Child Perception)

For this section, please think about your parent who did the first part of this survey before you. We want to know what you think about how they talk to you.

For each statement below, please choose how often you think it is true. You may choose between the following options: "Never," "Rarely," "Sometimes," "Often," and "Always." If you don't know, please choose the option that you think is most true.

When I'm with my parent, they complain that their arms or legs are too flabby.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that their stomach is fat.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they criticize their body compared to thin models in magazines.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that their body is out of proportion.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they hate their whole body.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they are fat.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they should not be eating fattening foods.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they've gained weight.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that their clothes are too tight.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they need to stop eating so much.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they criticize their body compared to their friends' bodies.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that their body is disgusting.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they're not in shape.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Parental Child-Weight Talk (Child Perception)

One more time! These questions are similar to the ones you just did.

Think about your parent who did the first part of this survey before you. We want to know what you think about how they talk to you. For each statement below, please choose how often you think it is true. You may choose between the following options: "Never," "Rarely," "Sometimes," "Often," and "Always."

Again, if you don't know, please choose the option you think is most true.

When I'm with my parent, they complain that my arms or legs are too flabby.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that my stomach is fat.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they criticize my body compared to thin models in magazines.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that my body is out of proportion.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that they hate my whole body.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that I am fat.

Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I'm with my parent, they complain that I should not be eating fattening foods.

Never	Rarely	Sometimes	Often	Always
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When I'm with my parent, they complain that I have gained weight.

Never Rarely Sometimes Often Always

When I'm with my parent, they complain that my clothes are too tight.

Never Rarely Sometimes Often Always

When I'm with my parent, they complain that I need to stop eating so much.

Never Rarely Sometimes Often Always

When I'm with my parent, they criticize my body compared to my friends' bodies.

Never Rarely Sometimes Often Always

When I'm with my parent, they complain that my body is disgusting.

Never Rarely Sometimes Often Always

When I'm with my parent, they complain that I am not in shape.

Never Rarely Sometimes Often Always

Parental Dieting (Child Perception)

How often do you think your parent has gone on a diet in the last year? By 'diet,' we mean changing the way they eat so they can lose weight. If you don't know, please choose the option that you think is most likely true.

Never 1-4 times 5-10 times More than 10 times I am always dieting

Parental Weight Loss Behaviors

Has your parent done anything else to lose weight? If so, please type the things they have done to lose weight in the box below.

If they have not done anything to lose weight, please type "no" or leave the box below blank.

Child Diet Culture Beliefs

This is the last question!

Please choose how much you agree with each statement, ranging from "Strongly Disagree" to "Strongly Agree".

I try to control my weight so that others will have a positive opinion of me.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I only exercise to have a body that others find acceptable.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I will only wear clothes that make me look thin.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Some foods are temptations to be resisted.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I put a lot of effort into resisting bad foods.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

There are some foods that I should never eat.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fat people are unhealthy.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If I am thin, I will live longer.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A person's health is largely determined by the types of food they eat.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you so much for participating! Please click the arrow button below. This will complete the survey. Then, hand the device back to your parent.

VITA

Ellen Jordan is a family and health communication scholar, examining the communicative development and prevention of children's eating disorders and related outcomes. Ellen received her Bachelor of Arts degree in Communication and Journalism from the University of St. Thomas in St. Paul, Minnesota, and her Master of Arts degree in Family Science from Concordia University St. Paul in St. Paul, Minnesota. Ellen is a provisionally certified Family Life Educator, and she uses this training to inform not only her research, but also family- and community-focused outreach efforts.

Ellen was raised in St. Paul, Minnesota and grew up in a family of five, including her father, Mitch Martin; her mother, Kristy Martin; and her siblings, Beth and Lulu Martin. Ellen credits her family's relationship dynamics, along with Dr. Carol Bruess' family communication class at the University of St. Thomas, with igniting her interest in studying family communication. In her lifetime, Ellen hopes to engage her education in family and health communication, Family Life Education, and human development to inform and facilitate family- and community-based eating disorder prevention efforts.