Parenting style and the risk for eating disorders among teenage girls

PhD (C.) Semiramida Manaj
University of Tirana

Abstract

The aim of this study was to explore the role of parenting styles and the risk to develop an eating disordered behavior among teenage girls. This study was designed to test the hypotheses that parenting style are correlated with the risk to have an eating disordered behavior among female teenages. It was predicted that the teenage girls at risk for developing an eating disorder would report experiencing their parents style as high in control and low in warmth or low in control and high in warmth. Specifically, the permissive and the authoritarian parenting style will be positively correlated with the risk to develop an eating disordered behavior. The sample of this research was composed by 100 teenage girls 15-18 years old. The selection of the participant was totally random and they were selected on the schools they frequented. There were found significant correlations between daughters approach to eating and mothers parenting style. These results support the impact of mothers parenting style on the risk to have an eating disorder, but more research needs to be conducted in examining the relationship between parenting style and eating disordered behavior.

Keywords: Adolescence, eating disorders, parenting style, authoritarism, permissive.

Introduction

There has been an increasing number of eating disorders cases and five million Americans have an eating disorder (Becker, Keel, Anderson-Fye, & Thomas, 2004). Subsequently, a growing number of theories and treatments have been developed and researched to address and explain this phenomenon. Yet, there is much debate as to whether there is a singular origin or precipitating factor that contributes to the development of eating disorders. In the literature, there have been numerous theories proposed as to the root causes of eating disordered behavior, ranging from psychoanalytic explanations (e.g., Blitzer, Rollins, & Blackwell, 1961) to developmental, cognitive, and social influences (e.g., Vitousek & Manke, 1994). From a treatment perspective, one of the most successful therapeutic interventions for anorexia and bulimia is family therapy (e.g., Lock & le Grange, 2005; Lock, le Grange, Forsberg,& Hewell, 2006) highlighting an important role of the family in recovery as well as etiology.

The purpose of this study is to explore the role of parenting styles of mothers and the risk to develop an eating disorder omogn teenage girls. Specifically, the study is designed to test the hypotheses that permissive and authoritarian parenting styles of mothers is correlated with an increased risk of they doughters to develop an eating disordered behavior. Eating attitudes and behavior and parenting style were measured with a self-reported proclivity for eating disordered behavior among teenage girls. It is predicted that those at risk for developing an eating disorder will

report experiencing their mothers parenting style as high in control and low in warmth or low in control and high in warmth.

Eating Disorders

There are three diagnosable categories of eating disorders: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (APA, 2000a). Although the current DSM qualifies eating disorders into three categories, researchers question the efficacy and legitimacy of these categories. These diagnoses are further broken down into subtypes of anorexia and bulimia, but these have not added to the diagnostic usefulness of eating disorders. Some research suggests more similarities than differences between the different subtypes (Kaye, Frank, Bailer, & Henry, 2005). A common occurrence is the "switching" between the categories of eating disorders. Given the categorical problems associated with the eating disorder criteria, eating disorders may be better described as existing on a continuum between healthy eating behaviors and eating disordered. This would allow for a greater number of at-risk cases to be identified. Clinical cases seen in designated treatment facilities may only represent a small proportion of those that have an eating disorder (Williams, Schaefer, Shisslak, Gronwaldt, & Comerci, 1986). By examining only the clinical populations, there is a large portion of the spectrum of eating disorders that is being ignored. Aside from those who may meet criteria for an eating disorder, there is a population of individuals who may not meet criteria, but are clearly participating in disordered eating behavior. This "subclinical" population may be the best avenue for prevention research, and provide more understanding of the development of the disorder.

Parental Variables

There are numerous environmental influences on children◎s behavior and attitudes, much of which originates with parents. Parents often play the single largest role in the development of children prior to the introduction of peer influence. Although researchers discuss the importance of peers and teachers on children◎s adjustment to developmental and social milestones, it is the quality of the parent-child relationship prior to the initiation of school that allows them to relate appropriately to their classmates and become attached to school (National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2004). Even the quality of peer relationships originates with the development of a health family environment.

Hilde Bruch (1978) also discussed the important role of the family in the development of anorexia. She stated that "all anorexics are involved with their families in such a way they have failed to achieve independence". Her cited case examples discussed themes of excessive closeness, passive mothering, paternal emotional underinvolvement, and the tendency to use the identified patient to mask underlying marital issues and personal emotional disturbances among parents.

Parenting Styles

Parenting styles describe parents in terms of warmth and level of control exerted toward their children (Baumrind, 1971). Previous research indicates that certain parenting styles are associated with psychologically adapted children (e.g., Buri, Louiselle, Misukanis, & Mueller, 1988). Assessment instruments such as the Parental Authority Questionnaire (PAQ; Buri, 1991) evaluate these degrees of warmth and control exhibited by parents. Those high in warmth and control are categorized as authoritative; their interactional style with their children comes off as firm and clear, but they allow for flexibility and use effective communication patterns with their children. Parents low in warmth and high in control are authoritarian, and they tend to rely on unquestioning obedience as the main disciplinary style with their children. Finally, those high in warmth and low in control are permissive. Permissive parents, while nurturing and noncontrolling, tend not to use punishment at all, which often leads to a lack of clear guidelines and expectations in the family (Baumrind, 1971). Although children often resent overcontrolled environments, lack of control frequently translates to confusion and boundary testing in adolescents. A fourth category, uninvolved parents, is sometimes used to describe those that are low in both warmth and control. Early messages children and adolescents receive from their parents about acceptable levels of warmth, acceptance and control may contribute to their internalized views of the level of control they should have over their own lives and degree to which they are worthy of acceptance. A balanced level of warmth and control (i.e., authoritative parenting) leads to higher likelihood of characteristics such as independence, self-reliance, and responsibility than offspring of parents utilizing another style (Baumrind, 1971). Perception of control and feelings of acceptance are concepts often linked with exacerbation of eating disordered behavior in the literature. Restricted eating associated with anorexia nervosa is related to desire for control and rigidity in routine and adherence to minimal caloric intake is perceived by some theorists as a means to maintain control. Binge eating associated with bulimia nervosa is characterized by a feeling of being out of control during the eating episode. Eating disorders have also been tied to desire for social acceptance. First experiences with love and acceptance start with primary caregivers and shape how one perceives other relationships; influences not only in direct acceptance but also in terms of values associated with social acceptance. If individuals have unclear messages about levels of control, either too much or too little, and feel little warmth at home, this could contribute to disordered eating patterns (Carter & Moss, 1984).

Parenting style has been shown to be directly related to levels of self-esteem in college students. Low self-esteem is often an accompaniment to a number of psychological disorders, especially eating disorders. Buri et al. (1988) found higher levels of self-esteem among students who reported having authoritative parents, especially if both mothers and father were congruent in their parenting style. This effect was twice as strong for girls as it was for boys. The authors found almost 37% of the variance in self-esteem among girls was explained by their parents◎ levels of authoritarianism and authoritativeness (Buri et al., 1988).

A number of parental characteristics have been linked with risk of developing anorexia. Shoebridge and Gowers (2000) found that mothers of anorexic adolescents were less likely to allow others to take care of their children when young, experienced anxiety at separation from their children, and did not allow daughters to stay away from home overnight until older than their peers, indicating a high level of overprotection similar to characteristics of an authoritarian level of parental control. In her experience with mothers of anorexic patients, Bruch (1973) found them unable to provide the necessary warmth to parent effectively because of their own neuroses.

Method

Design and Procedure. The design of this study is based on a quntitative aproacch. Participants of this research were recruited from public and private high school in Tirana and the selection process was totally random one to three form the list of their names. The sample was composed by 100 teenage girls, with a range of age 15-18 years old. All participants were asked to complete basic demographic questions. Students completed 3 questionnaires, including the 1) Eat Attitude Test (Garner et al., 1982), 2) Parental Authority Questionnaire (PAQ; Buri, 1991) and 3) The demografic questionnaire.

Eating Attitudes Test. The EAT consists of 26-items designed to elicit eating disordered thinking. The original Eating Attitudes Test had 40 items (Garner & Garfinkel, 1979), but factor analyses of all items yielded a highly correlated (r = 0.98) and shorter version (Garner et al., 1982), which is commonly used in contemporary eating disorder research. For each item, respondents choose on a 6-point scale whether the statement describes them always, usually, often, sometimes, rarely, or never. The EAT-26 has been popular with researchers, due to its high internal consistency (a = 0.90; Garner et al., 1982), test-retest reliability (0.84; Carter & Moss, 1984), sensitivity, and specificity (Garfinkel & Newman, 2001). In addition, the EAT has been useful in cultures other than the North American population on which it was standardized (Garfinkel & Newman, 2001). The abbreviated version of the EAT yields three subscales: dieting, bulimia and food preoccupation, and oral control. The EAT has been useful in identifying abnormal concerns with weight in both clinical and non-clinical populations, although there is strong caution exerted in using self-report instruments such as the EAT as solitary diagnostic tools (Garner et al., 1982). A total score of 20 or higher suggests the presence of an eating disorder, but when used without other measures of eating disorders may generate a high false positive rate.

Parental Authority Questionnaire. The PAQ is a 30-item questionnaire used to appraise Baumrindes (1971) authoritative, authoritarian, and permissive parenting styles (Buri, 1991). Participants respond to each of the items using a 5-point Likert scale (strongly disagree (1) to strongly agree (5)). Students in this study filled out one questionnaire for each parent, and each parent filled out one questionnaire evaluating their perception of their own style. Each of the subscales has demonstrated moderate to high test-retest reliabilities (.77 to .92) and internal consistencies (.74 to .87) (Buri, 1991). Buri (1991) also provided evidence of discriminant and criterion-related validity when comparing overlap with each of the styles, and comparing the PAQ

to a measure of parental nurturance. Daughters completed the PAQ evaluating their perception of their mothers" approach to parenting.

Results

Descriptives. Descriptive characteristics were obtained for the demografic questionnaire, including percentle, valid percentle and cumulative percentle.. These are provided in Table 1.

Table 1

Age	*Percentle*	*Valid Percentle*	*Cumulative Percentle*
15 years old	24	24	24
16 years old	26	26	50
17 years old	27	27	77
18 years old	23	23	100
Total	100	100	

Descriptive characteristics were obtained for the EAT, and the Authoritarian and Permissive scales from the Parental Authority Questionnaire, including means, standard deviations and ranges. These are provided in Table 2.

Table 2.

Descriptive Characteristics			
	Mean	SD	Range
Eating Attitudes Test	10.5	9.9	0-57
Mother's Authoritarian Parenting	30.51	7.5	16-48
Mother's Permissive Parenting	24.3	6.3	12-43

Table 3.

Internal Consistencies		
	# items	α
Eating Attitudes Test	26	0.87
Mothers' Authoritarian Parenting	10	0.91
Mothers' Permissive Parenting	10	0.86

This table shows that all of the measures demonstrated high internal consistency (a = 0.86-0.91).

Table 4

Correlation Matrix			
	Eating disordered behaviors	Authoritarian	Permissive
Eating disordered behaviors	-	0.25*	-0.23*
Authoritarian	0.25*	-	-0.51***
Permissive	-0.23*	-0.51***	-
*p< .05. **p< .01. ***p < .001. (2-tailed test).			

These individual analyses revealed important information about the relationships between these variables.

It had been predicted that teenage girls with an authoritarian mother, highly permissive, or both would have a disordered approach to eating. Indeed, there was a significant correlation between mother's authoritarianism and daughter's approach to eating (r = .25, p< .05). However, contrary to what had been predicted, mother's permissiveness was significantly and negatively correlated with daughter's approach to eating (r = -.23, p< .05). Possible explanations as to the emergence of this unpredicted relationship will be discussed in the final section of this study. Notably, there was a strong negative correlation between mother's authoritarianism and permissiveness (r = - .51, p< .001).

Discussion

This study was designed to explore the relationship between mother parenting style and tennage doughters approach to eating. It was hypothesized that there would be a significant relationship between daughter's approach to eating disordered behavior and mother's parenting style. Several related analyses were conducted to explore the relationships between the variables and interesting and relevant findings emerged.

There were a number of interesting findings. It had been hypothesized that mothers's permissive parenting would be correlated with daughter's approach to eating. However, correlational analyses indicated a significant negative relationship between these factors, suggesting that mothers who have a higher level of permissive parenting have daughters with lower risk for disordered approach to eating. A possible reason for this may have to do with the two dimensions that comprise parenting style. According to Baumrind (1971), parenting style is based on levels of warmth and control. While authoritarian parenting is characterized by low warmth and high control, permissive parenting is the combination of high warmth and low control. A negative correlation between permissive parenting and approach to eating in this study may suggest that warmth is a stronger protective factor than control is a risk factor. Much of the literature discusses the role that control has in the development and exacerbation of eating disorders, especially with the concept of overcontrol with anorexia and lack of control with bulimia. The low control concept in permissive parenting was included in these hypotheses as it appeared to be congruent with the literature that it might create an environment that feels out of control, due to lack of structure (Bruch, 1978). However, with permissive parenting, there is an appropriate level of parental warmth that is absent with authoritarianism. This may contribute to a perceived level of support that emerges as stronger than the detrimental effects of low control. This is consistent with other findings of the predictive nature of maternal warmth in the development of eating disorders among children (Haudek et al., 1999).

It was found that mother's level of authoritarianism was significantly related to daughter's approach to eating. This might suggest that the main effect of mothers's authoritarianism on daughter's approach to eating may be more of a function that authoritarian parenting leads to overall poor adjustment and/or functioning, which would encompass disordered eating as well.

The findings from this study indicate a number of possible future directions. Some of these are related directly to the limitations of the study. As with other studies focusing on self-report measures, there is a risk of respondents answering in a way to exaggerate their symptoms, or to present themselves in a positive light. Some research suggests that a more detailed clinical interview would be best to assess for eating disordered thoughts and symptoms (Fairburn & Beglin, 1994). Given the nature of this study, it may be beneficial in future research in this area to consider other measures.

Another potential limitation was the age of the eating disorder measures. There are new trends in eating disorder patterns, such as binge eating, that may not be fully encapsulated by the EAT. Although there are subscales that assess for bulimia, these scales have only few items and are not as comprehensive as a 26 or 91 item full questionnaire. One of the benefits in using an older questionnaire, is the strong literature base that has provided support for its reliability and validity as a measure. Normally the use of an undergraduate population is a limitation, but this is a strength with this study. The majority of those with eating disorders, or those at-risk, fall in the adolescent and young adult age ranges. Previous research also has found increased incidence within college age populations, raising estimates from below 5% up to 20% (Robert-McComb, 2001). In addition, this time period would be an ideal time to intervene with eating disordered risk behavior.

The eating patterns were not separated into anorexia nervosa and bulimia nervosa symptoms, which would be an interesting distinction to explore in future research, especially given the differences with issues of control exhibited by those with anorexia versus those with bulimia. It is possible there might be a significant difference in the impact of parenting styles based on level of control when looking at different diagnoses. Traditionally, anorexia is often linked with struggling to find a sense of control in an overcontrolled environment, whereas previous research links bulimia with a sense of feeling out of control and desiring more control from their external environment (Evans & Street, 1995).

Future research would likely benefit from further examining the role of fathers in daughter's approach to eating. As of the time of this literature review, there was not much research that included fathers, although this may imply a lack of involvement or an ineffectual stance (Dalzell, 2000) worth further exploration. Interestingly, the only study found did not find any significant results related to father's emotional involvement (Haudek et al., 1999).

Conclusions

From this research resulted that mothers's permissive parenting was significatly correlated with daughter's approach to eating. Correlational analyses indicated a significant negative relationship between these factors, suggesting that mothers who have a higher level of permissive parenting have daughters with lower risk for disordered approach to eating. It was also found that mother's level of authoritarianism was significantly related to daughter's approach to eating. This might suggest that the main effect of mothers's authoritarianism on daughter's approach to eating may

be more of a function that authoritarian parenting leads to overall poor adjustment and/or functioning, which would encompass disordered eating as well. The findings from this study indicate a number of possible future directions focused on the examinnation of the role of fathers in daughter's approach to eating, or including also the parents self report instruments, not only the teenages self report measures, or considering other type of measures, for example a more detailed clinical interview to assess the eating disordered thoughts and symptoms.

References

American Psychiatric Association. (2000a). *Diagnostic and Statistical Manual of Mental Disorders, (4th ed., Text revision)*. American Psychiatric Association: Washington, DC.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs, 4(1, Pt. 2)*, 1-103

Becker, A. E., Keel, P., Anderson-Fye, E. P., & Thomas, J. J. (2004). Genes and/or jeans?: Genetic and socio-cultural contributions to risk for eating disorders. *Journal of Addictive Diseases, 23*, 81-103.

Blitzer, J. R., Rollins, N., & Blackwell, A. (1961). Children who starve themselves: Anorexia nervosa. *Psychosomatic Medicine, 23*, 369-383.

Bruch, H. (1973). *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within.* New York: Basic Books, Inc.

Bruch, H. (1978). *The Golden Cage: The Enigma of Anorexia Nervosa.* Cambridge, MA: Harvard University Press.

Buri, J. R., Louiselle, P. A., Misukanis, T. M., & Mueller, R. A. (1988). Effects of parental authoritarianism and authoritativeness on self-esteem. *Personality and Social Psychology Bulletin, 14*, 271-282.

Buri, J. R. (1991). Parental authority questionnaire. *Journal of Personality Assessment, 57*, 110-119.

Carter, P. I., & Moss, R. A. (1984).Screening for anorexia and bulimia nervosa in a college population: Problems and limitations. *Addictive Behaviors, 9*, 417-419.

Dalzell, H. J. (2000). Whispers: The role of family secrets in eating disorders. *Eating Disorders, 8*, 43-61.

Evans, C., & Street, E. (1995). Possible differences in family patterns in anorexia nervosa and bulimia nervosa. *Journal of Family Therapy, 17*, 115-131.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or selfreport questionnaire? *International Journal of Eating Disorders, 16*, 363-370.

Garfinkel, P. E., & Newman, A. (2001).The eating attitudes test: Twenty-five years later. *Eating and Weight Disorders,* 1-24.

Garner, D. M., & Garfinkel, P. E. (1979). The eating attitudes test: an index of the symptoms of anorexia nervosa. *Psychological Medicine, 9*, 273-279.

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: psychometric features and clinical correlates. *Psychological Medicine, 12*, 871- 878.

Haudek, C., Rorty, M., & Henker, B. (1999). The role of ethnicity and parental bonding in the eating and weight concerns of Asian-American and Caucasian college women. *International Journal of Eating Disorders, 25*, 425-433.

Kaye, W. H., Frank, G. K., Bailer, U. F., & Henry, S. E. (2005). Neurobiology of anorexia nervosa: Clinical implications of alterations of the function of serotonin and other neuronal systems. *International Journal of Eating Disorders, 37*, S15- S19.

Lock, J., & le Grange, D. (2005). Family-based treatment of eating disorders. *International Journal of Eating Disorders, 37*, S64-S67.

Lock, J., le Grange, D., Forsberg, S., & Hewell, K. (2006). Is family therapy useful for treating children with anorexia nervosa? Results of a case series. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*, 1323-1328.

National Institute of Child Health and Human Development Early Child Care Research Network. (2004). Fathers' and mothers' parenting behavior and beliefs as predictors of children's social adjustment in the transition to school. *Journal of Family Psychology, 18*, 628-638.

Robert-McComb, J. J. (Ed.) (2001). *Eating disorders in women and children: Prevention, stress management, and treatment.* Boca Raton, FL: CRC Press.

Shoebridge, P., & Gowers, S. G. (2000). Familial transmission of risk for bulimia and anorexia nervosa. *Eating Disorders Review, 11*, 3.

Vitousek, K., & Manke, F. (1994). Personality variables and disorders in anorexia nervosa and bulimia nervosa. *Journal of Abnormal Psychology, 103*, 137-147.

Williams, R. L., Schaefer, C. A., Shisslak, C. M., Gronwaldt, V. H., & Comerci, G. D. (1986). Eating attitudes and behaviors in adolescent women: Discrimination of normals, dieters, and suspected bulimics using the eating attitudes test and eating disorder inventory. *International Journal of Eating Disorders, 5*, 879-894.