Eating Behaviors 15 (2014) 532–539

Contents lists available at ScienceDirect

Eating Behaviors

Marital conflict in early childhood and adolescent disordered eating: Emotional insecurity about the marital relationship as an explanatory mechanism

Melissa W. George [a,*], Amanda J. Fairchild [a], E. Mark Cummings [b], Patrick T. Davies [c]

[a] Department of Psychology, University of South Carolina, Columbia, SC, USA
[b] Department of Psychology, University of Notre Dame, Notre Dame, IN, USA
[c] Clinical and Social Sciences in Psychology, University of Rochester, Rochester, NY, USA

ARTICLE INFO

Article history:
Received 24 October 2013
Received in revised form 30 April 2014
Accepted 12 June 2014
Available online 20 June 2014

Keywords:
Marital conflict
Emotional security
Adolescence
Disordered eating behaviors

ABSTRACT

Disordered eating behaviors, including frequent dieting, unhealthy weight control behaviors (e.g., vomiting and skipping meals for weight loss) and binge eating are prevalent among adolescents. While negative, conflict-ridden family environments have long been implicated as problematic and a contributing factor to the development of disordered eating, few studies have examined the influence of marital conflict exposure in childhood to understand the development of these behaviors in adolescence. The current study investigates the impact of marital conflict, children's emotional insecurity about the marital relationship, and disordered eating behaviors in early adolescence in a prospective, longitudinal study of a community sample of 236 families in Midwest and Northeast regions of the U.S. Full structural mediation analyses utilizing robust latent constructs of marital conflict and emotional insecurity about the marital relationship, support children's emotional insecurity as an explanatory mechanism for the influence of marital conflict on adolescent disordered eating behaviors. Findings are discussed with important implications for the long-term impact of marital conflict and the development of disordered eating in adolescence.

1. Introduction

Although estimates for eating disorders are relatively low with 2–3% of adolescents meeting criteria for diagnosis (Merikangas et al., 2010), sub-threshold levels of eating disorders, including frequent dieting, unhealthy weight control behaviors (e.g., vomiting and skipping meals for weight loss) and binge eating are prevalent among adolescents (Ackard & Neumark-Sztainer, 2003). Indeed, a disturbing proportion of adolescents report engaging in unhealthy eating behaviors that are clinically severe but do not meet full DSM-IV diagnostic criteria for an eating disorder. A recent survey of a representative national sample suggests that one in five healthy or underweight adolescents in the U.S. report trying to lose weight (Eaton et al., 2012). Another ethnically-diverse population-based sample reported that 33% of U.S. adolescents presented with body image disturbances, 11% conveyed recurrent purging behaviors (e.g., vomiting, use of laxatives, and excessive exercise), and 7% indicated out of control binge-eating (Ackard, Fulkerson, & Neumark-Sztainer, 2007). Though such sub-clinical disordered eating behaviors appear prevalent, few studies have examined the development of these behaviors in community samples (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011).

The study of disordered eating may be particularly relevant as it is often associated with other health-compromising behaviors in adolescence, including smoking, alcohol and drug use, and suicide. Moreover, disordered eating is linked to the development of other physical and psychological problems, including anxiety (Granillo, Grogan-Kaylor, Delva, & Castillo, 2011), depressive symptoms (Johnson, Cohen, Kotler, Kasen, & Brook, 2002), and obesity (Field et al., 2003; Stice, Presnell, Shaw, & Rohde, 2005). Indeed, some youth who engage in disordered eating will worsen over time and eventually develop eating disorders (Patton, Slezer, Coffey, Carlin, & Wolfe, 1999; Santonastaso, Friederici, & Favaro, 1999). Given the high cost of treatment, significant impairment in functioning, and impact of these conditions on morbidity and mortality, disordered eating is a significant public health concern that merits further research (Agras, 2001). Yet, as with many mental health problems there is a considerable gap between *the need for* and *the availability of* effective treatment (Burns et al., 1995); few adolescents with disordered eating symptoms receive any support specifically for their unhealthy weight control behaviors (Merikangas et al., 2010). Understanding the developmental processes associated with the disordered eating in adolescence is crucial for identifying targets for prevention and early intervention,

* Corresponding author at: 1512 Pendleton Street. Department of Psychology University of South Carolina Columbia, SC 29201.
E-mail addresses: georgemr@mailbox.sc.edu (M.W. George), amandajfairchld@gmail.com (A.J. Fairchild), ecumming@nd.edu (E. Mark Cummings), patrick.davies@rochester.edu (P.T. Davies).

http://dx.doi.org/10.1016/j.eatbeh.2014.06.006
1471-0153/

and can ultimately contribute to the development of effective treatment options yielding both individual and societal benefits (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000).

The current study explores a putative developmental process underlying disordered eating in adolescence. Specifically, we examine the role of early marital conflict exposure to inform how disordered eating manifests. We posit that emotional insecurity about the marital relationship plays a mediating role in the influence of marital conflict on disordered eating in adolescence, such that insecurity is the vehicle through which the impact of conflict on disordered eating is conveyed. We develop our argument for this model in the following sections, describe our sample and procedures before testing the hypothesis via mediation analysis within a structural equation modeling framework.

Family functioning is often implicated in the development of child and adolescent mental health problems (Cummings, Davies, & Campbell, 2000), and eating disorders are not an exception. Negative family relationships have long been a focus of eating disorders theory, research, and practice (Ackard & Neumark-Sztainer, 2001; Hodges, Cochrane, & Brewerton, 1998; Minuchin, Rosman, & Baker, 1978). Negative, conflict-ridden environments that demonstrate low levels of cohesion and expressiveness are often characteristic of families of youth with disordered eating symptoms (Archibald, Linver, Graber, & Brooks-Gunn, 2002; Benninghoven, Tetsch, Kunzendorf, & Jantschek, 2007). Conflict in the parent–child relationship has often been implicated (e.g., Bowen, 1978; Bruch, 1985; Minuchin et al., 1978) with high control, restrictiveness and rejection associated with greater maladaptive eating behaviors (Berge et al., 2012; Boensch, Raml, Seiwald, & Rathner, 1993; Enten & Golan, 2009; Kichler & Crowther, 2001; McKinley, 1999; Ogden & Steward, 2000). Indeed, retrospective, concurrent, and short-term longitudinal examinations in adolescence suggest harmonious parent–child relationships are linked to lower levels of dieting behaviors (Archibald, Graber, & Brooks-Gunn, 1999; Salafia, Gondoli, Corning, McEnerny, & Grundy, 2007), and less body dissatisfaction (Barker & Galambos, 2003; Bearman, Presnell, Martinez, & Stice, 2006), and preoccupation with weight and engagement in bulimic behaviors (Kenny & Hart, 1992). However, parent–child relationships and disordered eating have not been supported in longitudinal studies over longer periods of time (e.g., Blodgett Salafia & Gondoli, 2011; Ferguson, Munoz, Winegard, & Winegard, 2012) and while parenting is critically important for healthy socio-emotional development in children (Cummings et al., 2000), children are influenced by other conflict in other family relationships (Cox & Paley, 2003).

The marital relationship is critically important for understanding the influence of the family on child development (Cummings & Davies, 2010); children's exposure to destructive marital conflict, characterized by frequent, verbal and physical aggression, hostility, and lack of resolution, increases risk for the development of depressive and anxious symptoms, aggression, delinquency, and conduct problems (Buehler, Lange, & Franck, 2007; El-Sheikh, Buckhalt, Mize, & Acebo, 2006), social difficulties (McCoy, Cummings, & Davies, 2009; McCoy, George, Cummings, & Davies, 2013) and school adjustment problems (George, Koss, McCoy, Cummings, & Davies, 2010). Yet few studies have examined marital conflict in relation to the development of disordered eating behaviors. For example, Latzer, Lavee, and Gal (2009) found higher levels of marital distress in families of adolescents with eating disorders in comparison to a community sample of families. Considering the influence of marital conflict is imperative as the detrimental impact of interparental discord on child adjustment problems is well-established (Cummings & Davies, 2002; Cummings & Davies, 2010).

A growing evidence base focuses on a process-oriented approach that addresses the mechanisms by which marital conflict impacts development rather than simply documenting associations (Cummings, Goeke-morey, & Papp, 2003; Grych, Harold, & Miles, 2003; Kerig, 2001). Indeed, child and adolescent emotional insecurity about the marital relationship has been shown to mediate the harmful influence of marital conflict on emotional, behavioral, and social development (Cummings, Schermerhorn, Davies, Goeke-Morey, & Cummings, 2006; Davies et al., 2002; Harold, Shelton, Goeke-Morey, & Cummings, 2004) including sleep disturbances, academic achievement, and health-related outcomes (El-Sheikh, Buckhalt, Cummings, & Keller, 2007; El-Sheikh, Buckhalt, Keller, Cummings, & Acebo, 2007) and differences in the functioning of physiological, behavioral and emotional regulatory systems (Koss, George, Bergman, Cummings, & Davies, 2011; Koss et al., 2013). It is posited that emotional insecurity about the marital relationship is harmful because it undermines children's sense of security about the stability of the family system having short-term and long-term consequences for children's regulation and adjustment over time (Cummings, George, McCoy, & Davies, 2012; Cummings et al., 2006; Davies, Harold, et al., 2002).

Despite the considerable implications of emotional insecurity about the marital relationship for subsequent difficulties in social, emotional, and behavioral functioning across development (e.g., Cummings & Davies, 2010) there are no prospective longitudinal studies examining the influence on adolescent disordered eating behaviors. The current study fills this needed gap examining marital conflict, emotional insecurity about the marital relationship, and disordered eating across early childhood to adolescence to advance understanding of developmental pathways resulting from children's exposure to marital conflict (Cummings & Davies, 1996) and process-oriented investigations for these relations are notably lacking (Ingoldsby, Shaw, Owens, & Winslow, 1999; Neighbors, Forehand, & Bau, 1997). Consistent with recent research suggesting the long-term consequences of marital conflict (Cummings et al., 2012), the current study hypothesizes that marital conflict exposure in kindergarten will have lasting effects by contributing to children's emotional insecurity which will in turn be associated with disordered eating behaviors in adolescence.

2. Material and methods

2.1. Sample

Participants in the current study were families from a multi-site longitudinal project investigating family processes, marital conflict and children's psychological adjustment in a representative community sample of 235 primarily middle-class families located in areas of the Midwest and Northeast, United States. This study is based on data collection from three longitudinal time points when children (106 boys, 129 girls) were in: (a) kindergarten (i.e., T1; *M* age = 6.00; *SD* = .45), (b) second grade (i.e., T2; *M* age = 8.02; SD = .49), and (c) seventh grade (i.e., T3; *M* age = 12.62; *SD* = .56). Eighty-nine percent of couples were married and families were representative of the areas they resided (76.5% Caucasian, 16.7% African American, 3.8% Hispanic, 2.1% indicated being of another race). Data collection at T1 began in 2000; the median annual family income range reported was between $40,000 and $54,999. Mothers' *M* age was 35.0 years (*SD* = 5.57) and fathers' *M* age was 38.6 years old (*SD* = 6.09). Assessments at T3 were collected 7 years after the initial assessment and were completed by 194 (83%) of the families. Thirty-six couples separated or divorced between T1 and T3; two fathers passed away during the study. Families were retained in the sample if willing to participate, regardless of separation, divorce or loss of family member. As reported in detail in other manuscripts reporting results from this study (e.g., Cummings et al., 2012), comparisons of families that were retained in the study versus those who withdrew from participating did not suggest differences based on demographic variables, including family income, parent education, marital and relationship status, parent relationship with child, and time spent living together.

2.2. Procedure

Participants were recruited through distributing flyers and postcards in the local communities. Flyers were also sent home with children through schools, placed in daycare agencies, and distributed via booths