



Primary and secondary control over eating behaviors

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ABSTRACT

The relationships between subjective control, body image, and eating behaviors were examined within the framework of the Optimization in Primary and Secondary Control model (OPS model; Heckhausen, 1999). This model characterizes control as an adaptive and strategic process in which the target of control includes internal as well as external states, and in which the purpose is either to facilitate goal pursuit by engaging with the goal or managing the consequences of goal failure by disengaging from the goal. A convenience sample of 180 Australian women (age: $M = 26.49$, $SD = 5.03$) completed the Optimization of Primary and Secondary Control Scale (OPS scale Heckhausen, 1999), as well as measures of attitudinal and behavioral factors comprising Stice's (1994) dual-pathway model of bulimia. A series of path analyses revealed that the control strategies involved in goal engagement are directly associated with increased dietary restraint and purging, whereas the control strategies involved in goal disengagement are indirectly associated with these factors, and with negative affect, by way of reduced body dissatisfaction and reduced frequency of appearance comparisons. These results suggest that goal engagement strategies, which are typically adaptive in other contexts, are associated with potentially hazardous attitudes and behaviors in the context of the body. The results also suggest that an ability to disengage from body weight goals is associated with a reduced likelihood of developing disordered eating.

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1. Introduction

Significant numbers of women engage in potentially unhealthy behaviors aimed at reducing or controlling their body weight. These behaviors include fasting or severe dietary restraint, purging, compensatory exercise, and the use of diet pills, laxatives, and diuretics (Grigg, Bowman, & Redman, 1996; McCabe & Ricciardelli, 2004; Tylka & Subich, 2002). In a proportion of these women, the severity of these behaviors and the degree of resultant weight loss may warrant diagnosis of an eating disorder (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006). The dissatisfaction with appearance that underlies eating disorders and unhealthy body change behaviors is thought to stem from sociocultural factors that encourage internalisation of an unrealistically thin body ideal and self-comparisons against this ideal (cf. the Tripartite Influence model; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). The aim of this article is to examine subjective control in the context of physical appearance, eating behaviors, and the experience of these sociocultural factors.

1.1. Subjective control and eating behavior

The term 'subjective control' typically is used to describe an individual's beliefs relating to their ability to influence an outcome, behavior, or process. In psychological research perhaps the most popular and influential dimension of control is *locus of control* (Rotter, 1966) which reflects the extent to which an individual attributes control over outcomes to the self (internal locus) or other factors such as fate, powerful others or chance (external locus). An individual's control beliefs, particularly their locus of control attributions, are thought to have important health implications, as there is an established empirical relationship between attributions of control and health-promoting and health-risk behaviors (Norman, Bennett, Smith, & Murphy, 1998; Reich, Erdal, & Zautra, 1997; Steptoe & Wardle, 2001).

In this section we briefly review research on subjective control in the context of eating behaviors. We also consider conceptualizations of control that go beyond static attributions over overt behaviors such as eating. This includes control *strategies* that are flexible and applied in an adaptive manner to both external and internal states in order to facilitate goal pursuit, and also control strategies that are applied to internal states only in order to manage the individual's internal response to goal failure.

It has been suggested that women diagnosed with an eating disorder may experience a deficit in subjective control (i.e., an external locus of control), either within particular domains of life (e.g. relationships, their

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body), or of the self as a whole (e.g. Bruch, 1973; Crisp, 1995; Orbach, 1978). There is evidence to support this proposition, with disordered eating symptomatology associated with an external locus of control (Garner, Garfinkel, & O'Shaughnessy, 1985; King, 1989; Rogers & Petrie, 2001), both in clinical and sub-clinical populations (Lugli-Rivero & Vivas, 2001; Rogers & Petrie, 2001; Shisslak, Pazda, & Crago, 1990; Williams et al., 1993; Williams, Spencer, & Edelman, 1987). However, it has also been pointed out that the behaviors characteristic of restrained eaters and those diagnosed with anorexia nervosa appear to indicate an over-control, or extreme 'internal locus' of control, in the context of food, hunger, and body weight (Hood, Moore, & Garner, 1982). It has also been suggested that the binge eating episodes which are typically attributed by sufferers to the controlling influence of external factors, appear to be used by these individuals to indirectly control negative affect in other aspects of their life (Stice & Shaw, 2002). These apparent contradictions suggest that the role of subjective control in disordered eating is more complex than suggested by a locus of control conceptualization.

The dichotomy of internal and external control is now over 40 years old and many other forms of classification have since been devised. Perhaps foremost among these has been the idea that individuals seek control in a variety of ways – that they seek not only to exert control over the environment (primary control) but also over their own internal responses to the environment (secondary control). One of the earliest proponents of this was Wallston, Wallston, Smith, and Dobbins (1987), who include in their definition of control the "belief that one can determine one's own internal states and behavior, influence one's environment, and/or bring about desired outcomes" (p. 5). In relation to body weight, the apparently complex relationship between control beliefs and disordered eating may include the desire to control body weight as a *strategy* to compensate for deficiencies in control over other domains, and/or as a *strategy* to manage one's internal emotional/cognitive responses to successes or failures at controlling body weight (e.g., Rezek & Leary, 1991). In these dynamic conceptualizations of control, it is common to refer to 'control strategies' rather than 'control beliefs'. This idea is incorporated into the Optimization in Primary and Secondary Control model (OPS model; Heckhausen, 1999).

The OPS model emphasises both the importance of selecting appropriate control strategies, and the target of control. This can include overt behavioral control over external states (primary control) as well as cognitive control over internal states (secondary control) such as emotions and motivations. And the purpose of these control strategies can include facilitating the pursuit of a goal as well as maintaining a positive psychological outcome in the event of a failed goal (Heckhausen & Schulz, 1998). *Selective primary control* is involved in efforts to control external states that are directly linked to a particular goal. This form of control is analogous to an internal locus of control, in which the control belief translates into behavioral self efficacy, which in turn contributes to the application of time, effort, skill, to achieve the goal. *Compensatory primary control* is involved in efforts to control external states that are indirectly linked to a particular goal. These indirect external states include technical aids, others' help or advice, or the acquisition of new skills, to promote goal pursuit particularly when direct behavioral resources are found to be inadequate. *Selective secondary control* is involved in efforts to control one's own internal states in order to remain engaged in goal pursuit, even in the face of obstacles or distracting alternative goals. As a cognitive strategy, this may include bolstering the value of the goal, enhancing perceptions of self-efficacy, etc. *Compensatory secondary control* is involved in efforts to manage the internal consequences of failed efforts at control, both direct and indirect. This form of control is thought to be important when the goal is perceived as unattainable or perhaps even detrimental. As a cognitive strategy, it involves disengaging from the goal, as well as the use of self-protective strategies. Collectively, the two types of primary control and selective secondary control are thought to be directly or indirectly relevant to goal

engagement, whereas compensatory secondary control is thought to be relevant to disengaging from unattainable goals in order to maintain self esteem, self efficacy, and perceived loss of control (Wrosch, Heckhausen, & Lachman, 2004).

1.2. Primary and secondary control and the development of disordered eating

The dual-pathway model of bulimia, proposed by Stice (1994), provides a framework for examining the role of primary and secondary control in the development of eating disordered behaviors. In the present study, the model was used as the basis for selecting variables to test as potential mediators of the relationships between control and disordered eating symptomatology.

The model posits three sociocultural factors that contribute to disordered eating in women: (i) a cultural ideal for female body shape that emphasises thinness or slenderness (the 'thin-ideal'), (ii) the centrality of appearance in the female gender role, and (iii) the perceived association between a woman's appearance and her success and social status. These pressures to be thin are reinforced by the over-representation of thin models and celebrities in the mass media, direct pressures to lose weight (e.g. weight-related teasing) from peers and family, and more indirectly by association with friends who obsess about weight (Stice & Shaw, 2002). Despite the pervasive, almost ubiquitous nature of these sources of sociocultural pressure in western societies, there are substantial individual differences in the extent to which women respond to these pressures (Tylka, 2004). To account for this, the model proposes that internalisation of the thin ideal serves as an important mediator of these pressures.

Internalisation refers to an individual's acceptance, and perceived importance, of cultural ideals regarding beauty, and research suggests that it is in fact the acceptance of, rather than mere exposure to sociocultural pressures, that leads to disordered eating (Griffiths et al., 1999, 2000). Individuals who internalise the thin ideal are known to be experience body dissatisfaction and negative affect (Dittmar & Howard, 2004; Stice & Whitenton, 2002), and the dual-pathway model posits that this can lead to dietary restraint and a range of potentially hazardous behaviors such as fasting, excessive/obligatory exercise, and extreme weight loss. Paradoxically, this may encourage episodes of uncontrolled binge eating that are initiated by extreme hunger, transgressions of strict dietary rules, or used as a means of alleviating negative affect associated with body dissatisfaction or dissatisfaction with diet progress. Binge eating may, in turn, promote compensatory behaviors such as purging, excessive/obligatory exercise, and laxative abuse aimed at minimizing any post-binge weight gain and/or as a form of emotional catharsis.

1.3. Aim and hypotheses

In addition to confirming the general relevance of the dual-pathway model to an Australian sample of women, we sought to examine the direct (unmediated) and indirect (mediated) relationships between goal engagement/disengagement and the components of the dual-pathway model. Our general rationale was that individuals' predisposition towards goal engagement and goal disengagement control in the context of the body should differentially influence the psychological processes, emotional reactions, and weight-control behaviors proposed in the dual-pathway model.

Goal engagement is characterized by the selection of direct and/or indirect strategies aimed at attaining goals. In the context of the body appearance domain, goal engagement should be associated with increased efforts to achieve one's weight goals through dieting, and increased attempts to compensate for lapses in dieting by purging. On this basis we hypothesize that goal engagement will be directly and positively associated with increased dietary restraint and purging.

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