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Negative eating attitudes and behaviors among adolescents: The role of parental control and perceived peer support

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ABSTRACT

In the present study, we examined from a longitudinal perspective the relationship between parental (both maternal and paternal) psychological control, perceived peer support, and negative eating attitudes and behaviors, focusing on the moderating role that perceived peer support may play in the relationship between parental psychological control in early adolescence and negative eating attitudes and behaviors in late adolescence. In Wave 1, participants were 507 adolescents (249 boys and 258 girls) aged from 14 to 15 years (M = 14.76; SD = 0.63). Three years later (Wave 2), the same adolescents participated again in the study (M = 17.88 years; SD = 0.57). Regression analyses displayed that paternal, but not maternal, achievement-oriented psychological control during early adolescence positively predicted negative eating attitudes and behaviors in late adolescence, whereas perceived peer support negatively predicted negative eating attitudes and behaviors. Results also showed a moderator effect of perceived peer support in the relationship between father's psychological control and negative eating attitudes and behaviors, such that at higher levels of paternal achievement-oriented psychological control, negative eating attitudes and behaviors tended to be higher when perceived peer support was low and to be lower when perceived peer support was high.

1. Introduction

Negative eating attitudes and behaviors are typically frequent among adolescents (Eaton et al., 2010) and may include restrictive dieting or unsafe weight and shape control behaviors (e.g., fasting, self-induced vomiting, and skipping meals for weight loss). According to Jones, Bennett, Olmsted, Lawson, and Rodin (2001), the individuation of negative eating attitudes and behaviors among the nonclinical population, especially in adolescence, is very important to monitor trends and changes and to identify the factors most related to disordered eating habits. When these behaviors become unhealthy (e.g., an obsession with calories or ritual eating patterns such as cutting small pieces of food, eating alone, and/or hiding food), their presence can be a sign of significant psychological and medical risks and can be precursors of subsequent eating disorders, such as anorexia, bulimia, and binge eating (Fryer, Waller, & Stenfert Kroese, 1997; Jones et al., 2001). Data from the National Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 2013) showed that 1–3% of adolescents between the ages of 14 and 18 are anorexic and 1–5% are bulimic. The World Health Organization (WHO; 2014) recently reported anorexic and bulimic diseases are the second leading cause of death among adolescents, after road accidents. In line with other countries, in Italy about 3–4% of people, especially adolescents and young adults, have some kind of eating disorder (especially anorexia or bulimia). According to data from the Italian Ministry of Health, the incidence of eating disorders in Italy is at least 8 new cases per 100,000 people every year among female adolescents, while boys comprise between 0.02 and 1.4 new cases (Laghi, Pompili, Baumgartner, & Baiocco, 2015).

As underlined by the Primary Socialization Theory (PST), adolescent risk behaviors can be explained by understanding their social context (Oetting & Donnermeyer, 1998). Norms for many risk behaviors are predominantly developed in the context of interaction with family and peers (Francis & Thorpe, 2010; Lopez et al., 2001).

The family is the primary social agency influencing children (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000), thus, it is likely that many risk factors for childhood negative eating

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habits have substantial roots in the family context (Ventura & Birch, 2008). A great amount of research has focused on the role of parenting practices in children's eating attitudes and behaviors. Starting from the seminal work of Baumrind (1971, 1989, 1991) and Maccoby and Martin (1983), who identified responsiveness/nurturance and demandingness/control as the two global dimensions along which parents differed in their behaviors toward their children, research exploring the role of parenting practices and styles in the domain of childhood eating behaviors has found that demanding and controlling practices, such as restricting and monitoring, are associated with negative eating behaviors (Haycraft & Blisset, 2010; Hughes, Power, Orlet Fisher, Mueller, & Nicklas, 2005; Patrick, Hennessy, McSpadden, & Oh, 2013). It has been found that families with children and adolescents who have eating disorders are enmeshed, intrusive, hostile, and negative toward the child's emotional needs or excessively concerned with parenting (Hinrichsen, Sheffield, & Waller, 2007; Soenens et al., 2008). On the contrary, affective and warm parenting has been found to moderate children's poor food habits or maladaptive eating behaviors (Liang et al., 2016).

Some research has focused attention on the association between eating disorders in children and adolescents and parental psychological control, defined as a "particular parenting dimension characteristic of parents who pressure their children to comply with their own agenda through insidious and manipulative tactics" (Soenens, Vansteenkiste, & Luyten, 2010, pp. 217–218). Generally, psychologically controlling parenting engages in restriction of autonomy and independence, is empirically related to internalizing difficulties, and does not advance good interactions with others (Pace et al., 2014; Passanisi & Pace, 2017; Soenens & Beyers, 2012). Soenens et al. (2010) have identified two components of parental psychological control: dependency psychological control and achievement psychological control. Dependency psychological control can be defined as the use of psychological control in the domain of parent-child intimacy, where control is used as a means to keep children within close physical and emotional confines. Achievement psychological control can be explained as the use of psychological control in the domain of achievement, where psychological control is used as a way to make children comply with excessive parental standards for performance. Both constructs have been found to be related to maladaptive consequences, especially to internalizing difficulties, as well as disordered eating behaviors (Soenens et al., 2008).

In particular, adolescents with eating disorders, in comparison to a control group (adolescents without eating disorders), have been found to perceive their parents, and particularly their fathers, as more controlling (Passanisi, Craparo, & Pace, 2017; Soenens et al., 2008). The quality of the relationship with one's father has been found to be an important factor in the development of eating disorders: girls with anorexia described their fathers as intrusive and overprotective and as turning often to their daughters for nurturance and support (Pace, Cacioppo, & Schimmenti, 2012; Rowa, Kerig, & Geller, 2001).

Besides family, peers are adolescents' other fundamental context for socialization (Francis & Thorpe, 2010; Lopez et al., 2001; Oetting & Donnermeyer, 1998) that influences more and more of their behaviors and consumption decisions in different fields (John, 1999), including food consumption (Moreno, Pigeot, & Ahrens, 2011). Adolescents become more peer-oriented as reliance on friends for support and approval increases significantly during puberty. In this sense, the perception of support from peers may serve a protective role, primarily during times of stress, by enhancing adaptive coping behaviors (Pace, Zappulla, & Di Maggio, 2016). Perceived peer support plays a buffering role against the consequences of stressful life events such as anxiety, depression, and behavioral distress during adolescence (Lo Cascio, Guzzo, Pace, & Pace, 2013; Zappulla, Pace, Lo Cascio, Guzzo, & Huebner, 2013) as well as against the impact of stress eating on male adolescents' weight (Darling, Fahrenkamp, Wilson, Karazsia, & Sato, 2017). Some research has underlined how perceived peer support is an important variable connected to eating behaviors in adolescence, suggesting that the perception of a good level of peer support may be related to body satisfaction (Kwan & Gordon, 2016), which in turn may play a protective role against maladaptive eating behaviors such as restrictive dieting, binge eating, and purging (Fitzsimmons & Bardone-Cone, 2011). In the same way, adolescents who perceive low peer support are more likely to experience body dissatisfaction; from this perspective, low levels of peer support may be a significant risk factor influencing negative attitudes and values about their own bodies (Stice & Whitenton, 2002). Peer support may have compensatory effects on adolescents' negative eating attitudes and behaviors, especially when it is expressed as acceptance and not as pressure (Ata, Ludden, & Lally, 2007). From this perspective, adequate perceived peer support may serve a protective function against eating disorders in adolescents (Wonderlich-Tierney & Vander Wal, 2010).

In the present study, we examined from a longitudinal perspective the relationship between parental (both maternal and paternal) psychological control, perceived peer support, and negative eating attitudes and behaviors, focusing on the moderating role that perceived peer support may play in the relationship between parental psychological control in early adolescence and negative eating attitudes and behaviors in late adolescence. We examined the following hypotheses. H1: Parental psychological control (especially fathers' psychological control) is expected to be positively associated with negative eating attitudes and behaviors. H2: Perceived peer support is expected to be negatively associated with negative eating attitudes and behaviors. H3: Perceived peer support is expected to moderate the relationship between parental psychological control and negative eating attitudes and behaviors, so that at higher levels of parental psychological control, negative eating attitudes and behaviors are expected to be lower when perceived peer support is high.

2. Material and methods

2.1. Participants

Participants in this study are drawn from a larger longitudinal study on adolescent development, peer relationships and adjustment. In Wave 1, participants were 507 adolescents (249 boys and 258 girls) aged from 14 to 15 years ($M = 14.76$; $SD = 0.63$), attending the second classes of two public high schools situated in two big Italian cities. Three years later (Wave 2), the same adolescents participated again in the study when they attended the fifth classes of high school (mean age = 17.88 years; $SD = 0.57$). Of the entire group, at Wave 2 only 482 adolescents (245 boys and 237 girls) participated, because some of them ($N = 25$) had abandoned school or moved. All the participants were Caucasian and, based on demographic information, were mostly of middle class backgrounds. Most of the participants (85%) came from intact two-parent families. At both Waves, a written informed consent was obtained for all by sending letters to their parents in order to inform them of the study. No parents objected to their child's involvement in the study. We also obtained assent from all the adolescents involved in the study.

2.2. Procedure

This study is part of a larger longitudinal study on the role played by individual and relational characteristics during early