Parental, Temperament, & Peer Influences on Disordered Eating Symptoms
Kaija M. Muhich, Alyssa Collura, Jessica Hick and Jennifer J. Muehlenkamp

Psychology Department, University of Wisconsin-Eau Claire

Introduction

Previous research has investigated the psychopathology in eating disordered behavior through family and peer-related learning experiences as well as temperament. The reliable differentiation of bingeing/purging (BN) and restricting (AN) ED groups is important clinically, as distinct etiological factors may underlie different symptom patterns and in turn call for different intervention strategies (Tchanturia, Davies, & Campbell, 2007; Westen & Hamden-Fischer, 2001). Additional research has also shown that scores on behavioral inhibition portray eating disorder behavior more reliably than behavioral activation in a non-clinical sample (Smits & Boeck, 2006). According to this prior study, identification of ED subtypes using the behavioral inhibition and activation scales (BIS/BAS) is critical because recognizing triggers to symptomology can be systematically trained whereas inheritable genes remain intact. Becerra Garcia (2010) found that the BIS/BAS was able to differentiate between healthy and populations at risk making it a clinically relevant to test BIS/BAS activity in subclinical populations. However, to our knowledge, there are no current studies that have assessed the ability to distinguish between eating disorder subtypes using primarily the BIS/BAS.

Past research has also extensively looked at parental bonding and peer influence on the etiology of disordered eating. Anrus et al. (2007) found that family teasing history was related to thinness and eating expectancies. Another study conducted by Swanson et al. (2010) found that AN participants rated parental care lower and parental control higher than individuals in the non-clinical sample. Implications for the past research is that multiple variables have been assessed, but not all in the same study to account for differences between groups. Thus, the present study assessed all major variables influencing ED symptomology to determine which of these variables best differentiated potential ED subtypes. The purpose of this study was to replicate past findings and analyze how all of these variables relate to differentiating between AN and BN symptoms groups.

HYPOTHESES

H1: Scores on the BIS/BAS will differentiate between AN and BN symptomatology.
H2: The BN symptom group subtypes will have lower BIS scores than the AN symptom group, replicating prior research.
H3: Perceived parental bonding scores (subscates) will differentiate between AN and BN symptoms, with AN groups reporting more parental overprotection and less care.
H4: Peer views on eating and weight will have a stronger association with BN symptoms than AN symptoms, which will be more strongly associated with parental views on weight and eating.

Method

• A sample of 124 Females completed an online survey assessing disordered eating symptoms, parental bonding, temperament, and parent/peer views on attractiveness.

• Age range was 18-53 years (M = 20.69; SD = 4.57)

• The total sample was taken from the University of Wisconsin- Eau Claire and selected eating disorder websites.

• No clinical diagnoses were known or required as a part of the study. Individuals were grouped into AN and BN groups based on their EDI scores on Drive for Thinness and Bulimia.

• The scores resulted in 30 individuals in the AN group and 40 in the BN group. Because the study focused on discriminating between the two eating disorder subtypes, only these 70 participants were used in analyses.

Results

A MANOVA was conducted to examine potential mean differences between AN and BN groups on parental bonding, temperament, parent and peer views on attractiveness. Figures 1 and 2 display the results. Binary Logistic Regression was run to examine which variables best predicted AN and BN group membership.

Discussion

This study provides a non-clinical analysis of how AN and BN symptomology differ across temperament, parent, and peer views of attractiveness. Results indicate that sub-clinical AN and BN behavior can be best differentiated through scores on parental care, behavioral inhibition (punishment sensitivity), and peers view on importance of attractiveness.

* Findings from this study confirm past research in that AN and BN individuals score differently on parental bonding, namely parental care. Consistent with prior research (Canetti et al., 2008), individuals within the AN group indicated greater parental care than those in the BN group. In addition, results confirm that individuals who display disordered eating behavior score higher on behavioral inhibition than behavioral activation, suggesting that individuals with disordered eating may be more prone to avoiding aversive experiences than they are to pursue goal-oriented or rewarding experiences. However, in contrast to past studies, AN participants did not score higher on behavioral inhibition than BN participants. In fact, the BN group scored significantly higher than the AN group, indicating they were more likely to report avoiding any potential aversive events versus seeking positive events. This finding may be due to the sub-clinical sample comprising the BN group or the type of behavior found in BN symptoms. Perhaps individuals that are more likely to use BN symptoms are also more likely to act on impulsive pain avoiding behavior, indicating higher scores on BIS.

* Our results also show that peer views on attractiveness have a very strong association to BN behavior versus AN behavior, which replicates other research as well. Based upon our data, it appears that having peers who value thinness along with being a person who is sensitive to and wants to avoid aversive experiences significantly increases the likelihood of developing BN-related symptoms, whereas perceiving higher levels of parental care are linked to AN symptoms.

* The data from the current study is useful in considering the multiple variables that influence the etiology and maintenance of disordered eating behavior. Our data, combined with past research, suggests that it may be more useful to target behaviors linked to BIS/BAS temperament, improve parental bonding, and decrease peers’ endorsement of thinness in efforts to prevent the development of disordered eating.

* A limitation to the current study was the relatively small samples that represented each ED group and the inability to obtain a clinically diagnosed sample. Further research should be conducted to analyze how a clinically diagnosed sample of AN and BN individuals would vary across these same scales.

Thank you to the research team and UWEC ORSP for funding aspects of this research.