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Original article

Adolescents' Level of Eating Psychopathology Is Related to Perceptions of Their Parents' Current Feeding Practices

Emma Haycraft, Ph.D. *, Huw Goodwin, Ph.D., and Caroline Meyer, Ph.D.

Loughborough University Centre for Research into Eating Disorders, Loughborough University, Loughborough, UK

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A B S T R A C T

Purpose: This study aimed to examine the relationships between adolescents' eating disorder attitudes and their perceptions of the feeding practices that their parents/caregivers currently use.
Methods: Boys and girls (N = 528) aged 13–15 completed self-report measures of their levels of eating psychopathology and their parents' current feeding practices and reported their own height and weight.
Results: For girls, greater perceived pressure from parents to eat food and lower perceived parental responsibility for food were significantly related to more unhealthy eating-related attitudes. Similar to girls, lower perceived parental responsibility for food was significantly related to greater levels of eating psychopathology in boys. Greater perceived parental restriction of foods was also significantly related to greater eating psychopathology in boys.
Conclusions: These results suggest that adolescents' perceptions of their parents' use of more controlling feeding practices are related to greater prevalence of unhealthy eating-related attitudes. Such findings have potentially important implications for the prevention of disordered eating in adolescents.

IMPLICATIONS AND CONTRIBUTION

Adolescents' perceptions of their parents' food- and mealtime-related practices are related to their own unhealthy eating-related attitudes. Advising parents/caregivers to avoid using controlling feeding practices with their teens is recommended for promoting more positive eating behaviors and sustained behavior changes within adolescents and their families.

Parental use of controlling feeding practices has been shown to be related to children's inability to regulate their own food intake [1–3], to children's weight status [2,4,5], and to the later development of disordered eating behaviors [6]. Specifically, the use of restrictive feeding practices has been found to relate to children's restrained eating [7] and pressure to eat has been associated with young girls' later dietary restraint and disinhibited eating [8]. In addition, parental monitoring of their children's food intake has been associated with increased child weight [9], but also with children's food choices and with children making healthier food selections when they know that their parents are monitoring them [10]. The degree of control exerted by parents with regard to child feeding provides a potential behavioral mechanism via which parental attitudes and beliefs may be transmitted to their children [9].

Although research has tended to focus on parents' feeding practices with young children, when eating and feeding is primarily under parental control, parents/caregivers still maintain a degree of responsibility for feeding their child throughout childhood and into adolescence [11]. Adolescence is a key time for the onset of eating disorders [12] and identifying modifiable factors associated with the development of eating psychopathology is a primary aim for health professionals. Engaging in family mealtimes, prioritizing eating as a family and having more

Conflicts of Interest: The authors report no conflict of interest with this manuscript.

* Address correspondence to: Emma Haycraft, Ph.D., Loughborough University Centre for Research into Eating Disorders, School of Sport, Exercise & Health Sciences, Loughborough University, Loughborough, Leicestershire LE11 3TU, UK.
E-mail address: E.Haycraft@lboro.ac.uk (E. Haycraft).

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positive mealtimes have all been shown to be associated with lower levels of [13], and to be protective against [14], eating-disordered behaviors among adolescents. However, given the established associations between parental control around feeding with both disruptions in children's appetite regulation [1–3] and with the development of disordered eating [6–8], it follows that parents' feeding practices may be linked to the eating attitudes and behaviors of their adolescent offspring. Indeed, previous work has begun to examine early adolescents' perceptions of parental feeding control, finding that perceived parental restriction of food was related to adolescents' dietary restraint [7]. However, the impact of parental use of pressure, monitoring of food intake, and responsibility for food/meals has not been assessed previously in adolescents.

Much of the research into feeding practices has focused on parental reports, which have been shown to be valid and reliable indicators of parents' feeding practices [15,16], but adults and adolescents living in the same household have been found to differ in their perceptions of the family mealtime environment and adolescent eating patterns [17]. Therefore, there is value in obtaining adolescents' views of their parents' feeding practices, given that these perceptions might be related to, or have an effect on, their eating attitudes and behaviors.

In summary, parental use of controlling feeding practices has been associated with disruptions in their offspring's ability to regulate their food intake and with the development of eating-disordered attitudes and behaviors. These findings are primarily based on data provided by parents, meaning that adolescents' perceptions of their parents' mealtime practices have not been thoroughly explored. Moreover, although eating disorders are more prevalent in females, males experience eating disorder symptoms too and thus it is important that research considers both adolescent girls and boys [18]. To date, research has not examined the relationships between adolescents' perceptions of a wide variety of their parents' feeding practices with reports of their eating psychopathology. This study aimed to address this gap. Based on previous findings [6–8], it was predicted that perceptions of more controlling feeding practices (more pressure to eat and restriction of foods) would be related to significantly greater eating disorder symptoms in both girls and boys.

Method

Participants

Adolescents (N = 828) aged 13–15 years were recruited via schools within the United Kingdom as part of an ongoing study into eating and exercise. Participants completed self-report measures (see the following section) and reported their age, gender, height, and weight. Many participants did not know their height and/or weight, resulting in a significant amount of missing data. Because body mass index (BMI) is frequently associated with eating disorder symptoms [19] and feeding practices [20], and therefore needed to be controlled for in our analyses, only participants for whom complete BMI data were available were retained[1]. This left a final sample of 528 adolescents (275 females and 253 males). BMI z scores (BMIz), accounting for age and gender [21], were calculated for the sample. The average BMIz score for girls was −.00 (SD = 1.13) and for boys was .37 (SD = 1.37), indicating generally healthy weights.

Measures and procedure

Following Institutional Review Board ethical approval, five schools were recruited to take part in this study. After providing written informed consent, participants completed two self-report measures during a designated lesson at school. Class teachers in each school administered the survey and were provided with a "script" in order to standardize the procedure. No incentives were provided to pupils for taking part in this study and participants not wishing to take part completed an alternative task.

Child feeding questionnaire-adolescents (CFQ-A). The CFQ [20,22] assesses parents' reports of their child feeding practices. It was adapted by Kaur and colleagues [20] for use by parents of adolescents and we made further minor modifications to those adapted questions so that they were suitable for adolescents to complete about their perceptions of their parents' feeding practices. For example, "How often do you keep track of the high fat food that your teen eats?" was rephrased to "How often do your parents keep track of the high fat foods that you eat?". The 5-point Likert scale response options and scoring remained the same. Four of the CFQ subscales were of relevance to this study, namely those that tap feeding practices and responsibility: perceived feeding responsibility (e.g., "How often are your parents responsible for deciding if you have eaten the right kind of foods?"); monitoring (e.g., "How often do your parents keep track of the sugary beverages that you drink?"); pressure to eat (e.g., "If you say 'I'm not hungry,' your parents try to get you to eat anyway"); and restriction (e.g., "If my parents did not guide or regulate my eating, I would eat too many junk foods"). Average scores are calculated for each subscale and higher scores indicate greater use of each feeding practice. The CFQ has been widely used as a measure of feeding practices and both versions have demonstrated adequate reliability [20,22]. The Cronbach's alphas for the CFQ-A in this sample were satisfactory (perceived responsibility α .68; monitoring α .90; pressure to eat α .63; restriction α .85).

Eating disorder inventory-II (EDI). Questions from the three eating-related subscales of the EDI [23], which assess drive for thinness, bulimic symptoms, and body dissatisfaction, were included in this study. Participants responded to each of the 23 items on a 6-point Likert scale and responses were summed to create a total EDI score in which higher scores correspond to greater eating disorder symptoms (score range 0–66). The EDI is valid for use with adolescents [24] and has been used successfully with nonclinical adolescent samples [25]. In the current sample, the Cronbach's alpha for the EDI total was .92.

Data analysis

Kolmogorov-Smirnov tests identified the data to be non-normally distributed and therefore nonparametric tests were used where possible. Preliminary Mann Whitney U tests confirmed significant differences between boys and girls on

[1] In comparison to individuals who provided BMI data and were retained in the sample, individuals for whom BMI data were not available did not differ significantly on any of the CFQ-A subscales but had significantly higher EDI total scores ($z = -2.53$, $p = .011$).