



Short Communication

A new look at the links between perceived parenting, socially-prescribed perfectionism, and disordered eating

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ABSTRACT

Perfectionism mediates the relation between parental psychological control and disordered eating, but it is unclear whether it functions similarly within associations between other parenting characteristics and eating pathology. The current study tested socially-prescribed perfectionism (SPP) as a mediator of the relations between two facets of perceived parenting style—autonomy support and psychological control—with disordered eating. Undergraduates ($N = 333$, 100% female) completed self-report measurement of study variables. Results indicated that psychological control and autonomy support were moderately correlated. Additionally, the indirect effect of parenting variables on disordered eating through SPP was significant across reports for both mother and father. When the directionality of variables was reversed, no indirect effects were significant, supporting the hypothesized relations between study variables. Findings reinforce prior work highlighting perfectionism as an important mechanism in the etiology of disordered eating.

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1. Introduction

The past decades have seen a resurgence of interest in the relation between perfectionism and eating disorders, prompting inquiry into the link between the constructs (e.g., [Bardone-Cone et al., 2007](#)). The current study aimed to identify whether socially-prescribed perfectionism (SPP) accounts for the effects of social variables highlighted as relevant to disordered eating. Specifically, we evaluated whether SPP explained the relation between two perceived parenting characteristics – parental autonomy support and psychological control – and disordered eating.

1.1. Perfectionism and eating disorders

Research has implicated perfectionism as important in the etiology of eating pathology (e.g., [Wade, Wilksch, Paxton, Byrne, & Austin, 2015](#)) and has suggested that maladaptive perfectionism may account for how other variables relate to disordered eating ([Bardone-Cone et al., 2007](#)). Although certain types of perfectionism may be adaptive, SPP, or expectations that individuals in one's social environment expect perfection ([Hewitt & Flett, 1991](#)), has been denoted as a particularly important facet of “maladaptive perfectionism” ([Bieling, Israeli, & Antony, 2004](#); [Klibert, Langhinrichsen-Rohling, & Saito, 2005](#)). Specific to eating

disorders, research indicates that SPP mediates links between social variables, such as parenting, and the development of eating pathology (e.g., [Sassaroli et al., 2011](#)).

1.2. The family environment, perfectionism, and disordered eating

A long tradition of work within eating disorders has emphasized that parenting plays some role in the emergence and maintenance of eating pathology ([Polivy & Herman, 2002](#)). Moreover, research based in theories such as the social expectation model of perfectionism ([Flett, Hewitt, Oliver, & Macdonald, 2002](#)) has emphasized that parental characteristics have an influence on how perfectionism develops ([Flett et al., 2002](#)). Therefore, associations between specific perceived parenting characteristics and later disordered eating may be explained by maladaptive perfectionism. Psychological control, or use of manipulative tactics to control how children feel, think, and behave ([Barber, 1996](#)), is one particular parental characteristic linked with disordered eating ([Soenens et al., 2008](#)). Research has found that maladaptive perfectionism accounts for the documented associations of psychological control with eating pathology ([Soenens et al., 2008](#)), suggesting that perfectionism seems to have an impact on the link between psychological control and disordered eating. However, it is unclear whether perfectionism plays a similarly relevant role in the link between other parental characteristics, such as autonomy support, and eating pathology.

Parental autonomy support, related to psychological control, describes a process through which parents encourage their children to engage in autonomous behavior. Although psychological control and autonomy support were once thought to represent two poles of the

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same construct, later work established that the two are negatively related, but distinct (Silk, Morris, Kanaya, & Steinberg, 2003). High levels of autonomy are linked to effective levels of performance, adaptive perfectionism, and psychological well-being, whereas actions that are highly controlled are associated with maladaptive perfectionism (Vansteenkiste et al., 2010). Within work on disordered eating, individuals with eating disorders consistently report lower levels of autonomy (Frederick & Grow, 1996); parents low in autonomy support are likely to parent their children in an over-controlled way, with low tolerance for independent thinking. Overall, autonomy support is a construct that relates conceptually to both perfectionism and disordered eating within the literature. Thus, perfectionism may account for both the effects of autonomy support and psychological control on disordered eating; however, this possibility has not been tested.

1.3. The current study

The present investigation evaluated SPP as a mediator of the links between psychological control/autonomy support and disordered eating in a sample of undergraduate females. We chose to pursue these analyses within an all-female sample due to the fact that previous work (e.g., Soenens et al., 2008) had been conducted primarily with females. Similar to prior research, we hypothesized that SPP would mediate the relation between psychological control and disordered eating. Additionally, we hypothesized that SPP would also mediate the relation between autonomy support and disordered eating behaviors, such that lower levels of parental autonomy support would be associated with higher SPP, which would relate to higher disordered eating.

2. Materials and methods

2.1. Participants

Participants were female undergraduates ($N = 333$, $M_{age} = 19.63$ years, $SD_{age} = 1.13$) at a medium-sized university in the Midwestern United States. The sample was comprised of 38.4% freshmen, 24% sophomores, 11.4% juniors, and 11.4% seniors. Although ethnic/racial background was not measured in the study, the university is comprised primarily of white students.

2.2. Measures

2.2.1. Eating attitudes test-26 (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982)

The EAT-26 is a 26-item measurement (in our sample, Cronbach's $\alpha = .90$) of disordered eating attitudes and behaviors (Garner et al., 1982). Items, such as "I am terrified about being overweight," are rated using a 6-point scale (3—Always, 2—Usually, 1—Often, 0—Sometimes, 0—Rarely, 0—Never).

2.2.2. Multidimensional perfectionism scale—socially prescribed subscale (MPS; Hewitt & Flett, 1991)

The MPS is a 45-item scale that measures various facets of perfectionism. The socially-prescribed subscale is thought to represent maladaptive perfectionism and was used in the current analyses (in our sample, Cronbach's $\alpha = .86$). Items are ranked using a 7-point Likert-type scale ranging from 1 (Strongly disagree) to 7 (Strongly agree).

2.2.3. Barber parental control scale, youth self-report (PCS-YSR; Barber, 1996)

Parental psychological control was measured using Barber's 16-item PCS-YSR (in our sample, Mother Cronbach's $\alpha = .80$; Father Cronbach's $\alpha = .80$). The scale asks the respondent to rate items such as "often interrupts me" on a 3-point Likert-type scale (1 = "Not like him/her"; 3 = "A lot like him/her").

2.2.4. Parental autonomy support

Autonomy support was measured using a 17-item scale (Soenens et al., 2007) that assesses various facets of parental autonomy support (in our sample, Mother Cronbach's $\alpha = .89$; Father Cronbach's $\alpha = .88$). Participants rated items (e.g., "My mother/father encourages me to be independent") using a 7-point Likert-type scale.

2.3. Procedure

A random pool of students from the university was sent information about the study via email. If individuals indicated interest, they were invited to complete the study on their own computer. Following informed consent, participants completed measures online and were mailed \$5 for their participation. The university Institutional Review Board approved all study procedures and materials.

2.4. Analytic plan

In screening for normality, EAT-26 and psychological control scores demonstrated positive skewness and were transformed in order to achieve acceptable normality (i.e., skew < 1.0); EAT-26 scores were transformed using a square-root transformation, maternal psychological control scores were transformed using a log transformation, and paternal psychological control scores were transformed using an inverse transformation. Hayes' PROCESS macro (Hayes, 2013), which uses bootstrapping to estimate indirect effects, was used for all mediation analyses. Due to limitations of conducting mediational analyses using cross-sectional data, we ran analyses that switched the order of hypothesized independent and mediator variables; doing so tests the possibility that psychological control and autonomy support mediated the relation between SPP and disordered eating.

3. Results

3.1. Descriptive statistics

Descriptive statistics and correlations between study variables are available in Table 1. The majority of the correlations were statistically significant; however, contrary to hypotheses, parental autonomy support was not significantly related to EAT-26 scores. Though autonomy support and psychological control were significantly negatively correlated, the small-to-medium negative correlations ($r = -.20$ – $-.49$) between the factors suggest that the two factors are distinct.

3.2. Primary analyses

3.2.1. Psychological control

Results of the regression analyses assessing direct and indirect effects of SPP and psychological control on EAT-26 scores are available in Table 2.

3.2.1.1. Maternal psychological control. The maternal psychological control model was significant, $F(2, 289) = 16.42$, $p < .01$, $R = .32$, $R^2 = .10$. The main effects of maternal control on SPP and SPP on disordered eating were positive and significant. Additionally, the indirect effect of maternal psychological control on disordered eating through SPP was positive and significant. When the order of the variables was reversed, the indirect effect of SPP on disordered eating was not significant (95% CI: $-.004$, $.01$), providing support for the hypothesized relations between variables.

3.2.1.2. Paternal psychological control. The paternal psychological control model was significant, $F(2, 289) = 16.57$, $p < .01$, $R = .32$, $R^2 = .10$. Positive, direct effects of paternal psychological control on SPP and SPP on disordered eating emerged. The model indicated a significant, positive indirect effect of paternal psychological control on disordered

Table 1
Summary of bivariate correlations.

	1. SPP	2. EAT-26	3. PCSm	4. PCSf	5. PASm	6. PASf	M	SD
1. Socially-prescribed perfectionism (SPP)	–						54.35	12.67
2. Eating disorder symptoms (EAT)	.30**	–					9.53	10.19
3. Maternal psychological control (PCSm)	.33**	.12*	–				11.16	3.11
4. Paternal psychological control (PCSF)	.39**	.12*	.42**	–			10.19	2.72
5. Maternal autonomy support (PASm)	–.31**	.01	–.49**	–.15*	–		86.10	14.63
6. Paternal autonomy support (PASf)	–.31**	–.02	–.22**	–.34**	.64**	–	86.49	14.32

* $p < .05$.
** $p < .01$.

eating. Follow-up analyses in which the independent and mediational variables were reversed revealed that paternal psychological control did not mediate the SPP-EAT-26 relation (95% CI: $-.003, .01$), providing support for the hypothesized relations between variables.

3.2.2. *Autonomy support*

Results assessing indirect and direct effects between parental autonomy support, SPP, and EAT-26 scores are available in Table 3.

3.2.2.1. *Maternal autonomy support.* The maternal autonomy support model was significant, $F(2, 224) = 12.31, p < .01, R = .31, R^2 = .10$. The model revealed a significant, negative direct relation between maternal autonomy support and SPP and a positive relation between SPP and EAT-26 scores. Results also indicated that the indirect effect from maternal autonomy support to EAT-26 scores through SPP was significant. Providing support for the hypothesized relations of variables, follow-up analyses indicated that maternal autonomy support did not mediate the link between SPP and disordered eating (95% CI: $-.01, .001$).

3.2.2.2. *Paternal autonomy support.* The model for paternal autonomy support, $F(2, 217) = 15.94, p < .01, R^2 = .13$, indicated that the negative, indirect effect of paternal autonomy support on EAT-26 scores through SPP was significant. Within the model, paternal autonomy support had a significant, negative direct effect on SPP, and SPP had a significant, positive direct effect on EAT scores. In follow-up analyses, paternal autonomy support failed to mediate the relation between SPP and EAT-26 scores (95% CI: $-.01, .002$).

4. Discussion

The current study investigated SPP as a mediator of the relation between elements of perceived parenting style—psychological control and autonomy support—and disordered eating. Findings indicate that while autonomy support and psychological control seem to represent two distinct elements of parenting, SPP plays a role in explaining how both of these facets of parenting exert their influence.

Our investigation yielded three main findings. First, though past work posited that autonomy support and psychological control represented

two poles of one construct, the small-to-medium size correlations between the two facets of parenting are consistent with more recent work indicating that the two are distinct (e.g., Silk et al., 2003). Second, bootstrapping analyses confirmed prior work suggesting that SPP accounts for the link between psychological control and eating pathology. Last, we found that the indirect, negative relation between autonomy support and disordered eating was also accounted for by SPP. Our results suggest that individuals who perceive their parents as granting low levels of autonomy also possess high levels of SPP, which is associated with higher risk for disordered eating.

Although perfectionism has already been incorporated into treatment protocols (e.g., Egan, Wade, Shafran, & Antony, 2014), results emphasize the need to consider the construct within a family context. Clinicians who treat eating disorders with family-based treatment may benefit from integrating discussion of how parenting can give rise to expectations of perfection and facilitate more adaptive forms of parenting.

Future research should assess variables longitudinally in order to better determine the directionality of the relations; it is possible that the development of maladaptive perfectionism may arise in conjunction with, rather than a result of, certain parenting characteristics. However, although the causality of the studied relations cannot be asserted due to the cross-sectional nature of the data, results from follow-up analyses that reversed the order of independent and mediational variables supported the hypothesized links between parental variables and SPP. Further, it is necessary to examine whether SPP functions similarly within clinical populations. Finally, future work must examine the constructs of interest within male populations, as our female sample represents a limit to the external validity of the study.

4.1. Conclusions

Overall, the current investigation found that perceived psychological control and autonomy support had indirect effects on disordered eating through SPP. Our findings confirm the notion that SPP represents an important etiological factor in disordered eating (Bardone-Cone et al., 2007) and highlight the need to target SPP in the prevention and treatment of eating disorders.

Table 2
Direct and Indirect effects of socially-prescribed perfectionism on the relation between (a) maternal psychological control and EAT-26 scores and (b) paternal psychological control and EAT-26 scores.

Regression paths	b	se	t	p
PCSm→SPP	37.51	6.43	5.83	<.01
SPP→EAT	.04	.01	5.22	<.01
Direct effect, PCSm→EAT	.46	.84	.55	.58
Indirect effect, PCSm→EAT	1.41	.40		95% CI: [.76, 2.33]
PCSF→SPP	–183.77	32.41	–5.67	<.01
SPP→EAT	.04	.01	5.18	<.01
Direct effect, PCSf→EAT	–3.16	4.20	–.75	.45
Indirect effect, PCSf→EAT	–6.87	1.96		95% CI: [–11.23, –3.66]

Note. PCSm—Psychological control, mother; PCSf—Psychological control, father; SPP—Socially-prescribed perfectionism; EAT—Eating attitudes test-26.

Table 3
Direct and indirect effects of socially-prescribed perfectionism on the relation between (a) maternal autonomy support and EAT-26 Scores and (b) paternal autonomy support and EAT-26 scores.

Regression paths	b	se	t	p
PASm→MPS	–.29	.06	–5.19	<.01
MPS→EAT	.04	.01	4.95	<.01
Direct effect, PASm→EAT	.01	.01	1.27	.10
Indirect effect, PASf→EAT	–.01	.003		95% CI: [–.02, –.006]
PASf→MPS	–.26	.05	–4.84	<.01
MPS→EAT	.05	.01	5.53	<.01
Direct effect, PASf→EAT	.01	.01	1.16	.25
Indirect effect, PASf→EAT	–.01	.003		95% CI: [–.02, –.01]

Note. PASm—Autonomy granting, mother; PASf—Autonomy granting, father; SPP—Socially-prescribed perfectionism; EAT—Eating attitudes test-26.

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