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Effects of childhood family dynamics on body dissatisfaction in adulthood

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EFFECTS OF CHILDHOOD FAMILY DYNAMICS ON BODY DISSATISFACTION
IN ADULTHOOD

A Thesis
Presented To
Eastern Washington University
Cheney, Washington

In Partial Fulfillment of the Requirements
for the Degree
Master of Science

By
Adrienne F. Kerbs
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MASTER'S THESIS

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Abstract

Past research has identified many singular components of family dynamics that affect body dissatisfaction in adulthood, but have not studied the effects of many different family factors simultaneously. The aim of the current study was to investigate the effects of multiple early family dynamics on body dissatisfaction in adulthood using a sample of female college students. It was expected that the nature of parental bonding, parental comments, and lack of parental acceptance during childhood would have negative effects on body image in adulthood. A sample of female college students completed self-report questionnaires about their parents from the perspective of when they were a child and questionnaires regarding their current body dissatisfaction. Results found that all parenting variables collectively had a significant impact on body image. Negative comments were the most consistent significant predictor of body dissatisfaction, even when controlling for BMI and self-esteem. The results of the current study can give researchers a better idea of which family dynamics to focus on when studying factors contributing to body dissatisfaction in adulthood.

Keywords: body dissatisfaction, parent child relations

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Table 1: Family Dynamics Variables' Correlations with Body Image Dissatisfaction

Effects of Childhood Family Dynamics on Body Dissatisfaction in Adulthood

The poet Khalil Gibran once said, “Beauty is not in the face; beauty is a light in the heart.” However, numerous indicators in the world suggest that people do not live by those words. There is so much more emphasis put on how one *looks* on the outside than on how one *is* on the inside. This is evident in the growing numbers of people having cosmetic plastic surgery. The American Society for Aesthetic Plastic Surgery (2010) reported that in 2010, the number of surgical and nonsurgical cosmetic procedures in the United States totaled 9,336,814, with over 1.6 million of those being actual surgical procedures. Cosmetic surgeons and dermatologists report that of those patients who receive plastic surgery, between 6% and 15% meet diagnostic criteria for body dysmorphic disorder (American Psychiatric Association, 2000), which includes “preoccupation with an imagined defect in appearance.”

Secondly, the growing emphasis of what one’s body looks like is evidenced in the prevalence of eating disorders. The prevalence of anorexia nervosa is 0.5% and the prevalence of bulimia nervosa is 1% to 3% (American Psychiatric Association, 2000). The growing number of extremes people are willing to go in order to achieve some kind of ideal body implies that it is becoming increasingly important to investigate where such behaviors and feelings stem from.

Research has identified many different factors that contribute to the development of body dissatisfaction in adulthood, one of which is family dynamics during childhood. According to Erik Erikson’s (1950) theory of development, a child’s parents are the first people she looks to for truth. They are the ones who teach a child how to interact with others, how to have relationships, and how to feel about themselves and the world. Thus,

it is within reason that the parents may impact the way a child feels about their body as well. The aim of the current study is to investigate the effects of various family dynamics during childhood on body dissatisfaction in adulthood. Parental bonding (including trust, communication, alienation, separation anxiety, care, and control), childhood teasing from parents, parental comments, and parental acceptance/rejection were measured to examine their relative contributions to body dissatisfaction. For the purposes of this report, the word “parent” or any variation thereof will refer to whomever served as primary caregiver or caregivers to the individual as a child. The phrase “family dynamics” in this report refers specifically to parent-child dynamics.

There have been numerous studies examining the effects of family dynamics on body dissatisfaction during adolescence and childhood, but there is a limited body of literature studying the lingering effects in adulthood. The literature that does focus on adulthood includes only one component of family life (e.g., family influence, parental bonding, or parental feedback; Cheng & Mallinckrodt, 2009; Green & Pritchard, 2003; Markham, Thompson, & Bowling, 2004; Rodgers, Paxton, & Chabrol, 2009; Sheldon, 2010; Young, McFatter, & Clopton, 2001). To date, there have not been studies that combine several components of family dynamics in a single study with an adult population. The findings from this study will shed more light on what aspects of parental behavior may contribute the most to body dissatisfaction in adulthood. This is important information to have because by identifying which family dynamics during childhood have the most effect on body dissatisfaction during adulthood, interventions in parenting may be developed to assist in prevention of body dissatisfaction and possibly eating disorders or excessive cosmetic surgeries.

A review of the relevant literature regarding parental bonding, comments made by parents, acceptance/rejection by parents, and their individual effects on body dissatisfaction will be helpful in developing a picture of what factors play a part in the development of this seemingly epidemical issue.

Parental Bonding

Research has shown a strong relationship between the way a parent bonds with their child and how those children end up feeling about their bodies as adults. Ecological theory holds that an individual's development is impacted by several different factors, including family relationship factors (Sira & White, 2010). For example, daughters whose mothers are over-controlling may be more likely to develop eating disorders, disorders which have a lot to do with control over food intake. On the other side of the spectrum, adult women whose parents treated them with warmth and expressed enough affection may be more likely to treat themselves with that same kind of warmth and affection. In one study, high parental care significantly predicted body satisfaction in females (Cheng & Mallinckrodt, 2009). In contrast, Markham et al. (2004) did not find parental care and control to be significantly related to the development of body-image shame in their adult sample. However, this difference may just be due to the fact that the former study by Markham et al. (2004) measured body dissatisfaction and the latter by Cheng and Mallinckrodt (2009) measured body shame, two potentially different constructs. An individual who is simply dissatisfied with her body may isolate that dissatisfaction to their body only, whereas "an individual who experiences shame tends to generalize shortcomings to a core defect in the entire self" (Markham, Thompson, & Bowling, 2005, p. 1530). Simply put, an overcontrolling parent may not have a big

enough impact to translate into a daughter experiencing something as deep as shame about her body.

In addition, constructs such as separation anxiety (anxiety a child experiences when he/she does not feel safe or secure being out of proximity from a parent) and insecure attachment style of the parents also have significant negative effects on body satisfaction, as was found by Troisi et al. (2006). A girl who grows up not feeling safe, heard, or being able to trust and rely on her parents may not develop the adequate confidence to gain a sense of mastery and competence during her childhood. This could translate into a general sense of not feeling safe in the world and not being able to look inward to know that she is okay and good enough. This sense of not feeling as though she is good enough may infiltrate many parts of her self, including her body image. Although the results from these studies are somewhat mixed, there is a general trend that indicates that healthy parental bonding is negatively correlated with body dissatisfaction.

Parental Comments

Along with how a young girl's parents bonded with her, the remarks that were made to her as a child may have an impact on her as an adult. As mentioned earlier, Erikson maintained that the girl's parents are the first ones she looks to for truth. Therefore, if lots of negative things are said to her about herself, it stands to reason that she would accept those statements as truth and carry them into adulthood. Thus, the voice of a parent consistently telling their daughter that she needs to lose weight or are not thin enough may be likely to become the internal voice of her as an adult.

The research on parental comments is somewhat limited but a negative relationship between certain types of comments and body dissatisfaction in adulthood has

been established. In a study by Rodgers, Paxton, and Chabrol (2009), adult participants were asked about different types of comments regarding body and fitness that may have been made to them as children by their parents. With and without controlling for body mass index (BMI), positive comments (i.e., “You always look wonderful”) were negatively correlated with body dissatisfaction, and negative/comparison (i.e., Commented on the shape or weight of friends) comments were positively correlated with body dissatisfaction.

Similarly, weight-related teasing by a girl’s parents is correlated with body dissatisfaction (Schwartz, Phares, Tantleff-Dunn & Thompson, 1999). Hanna and Bond (2006) found that body dissatisfaction played a mediating role in the relationship between negative maternal comments and disturbed eating in their adolescent and adult participants. As with parental bonding, Markham, Thompson and Bowling (2004) did not find a significant relationship between weight-related teasing and body shame, but that again may be due to the construct differences mentioned earlier. All in all, there does seem to be a general relationship between comments of a negative nature and body dissatisfaction in most previous research.

Parental Acceptance and Rejection

Parental acceptance or rejection during childhood could also be an important contributor to body dissatisfaction. According to Carl Rogers’s theory, acceptance from a parent (e.g., unconditional positive regard) is essential to healthy mental development (Dwairy, 2010). Thus, a girl experiencing a feeling of rejection from her parents may in turn learn to reject herself as well. While a relationship between parental acceptance and parental rejection has not been studied in relation to body dissatisfaction, a relationship

can potentially be established through self-esteem. Parental acceptance has been shown to predict higher self-esteem in adulthood (Berenson, Crawford, Cohen, & Brook, 2004). Particularly, parental rejection is related to lower self-esteem in females (Conte, Plutchik, Picard, Buck, & Karasu, 1996). It is possible that high self-esteem contributes to lower body dissatisfaction. Though causation cannot be determined, the literature suggests that self-esteem is correlated with body dissatisfaction (Green & Pritchard, 2003; Sira & White, 2010). Thus, it stands to reason that there would be a relationship between parental acceptance or rejection and body dissatisfaction if it can be assumed that parental acceptance/rejection influences self-esteem, which influences body dissatisfaction.

My study examined the effects of various family dynamics during childhood on body dissatisfaction in adulthood using a sample of female college students. In particular, I examined parental bonding (including care, control, separation anxiety, communication, trust, and alienation), various types parental comments (including teasing and comparison to others), and parental acceptance/rejection, and how they individually and jointly affect body dissatisfaction in adulthood. The body fat percentage and BMI of the participants was also calculated so that variability in body size can be taken into account. Since the previous literature has relied predominantly on self-report measures, I also collected information through self-report measures. Participants answered questions from the perspective of how they perceived their primary caregiver(s) as a child and body-related questions from the perspective of how they feel currently. It was predicted that all of the aforementioned family dynamics components during childhood would significantly contribute body dissatisfaction during adulthood.

Method

Participants

Participants for the current study were 88 female undergraduate students from a state university in the northwest. The mean age of the participants was 20.95 years ($SD = 4.72$). The sample was composed of 70 Caucasian participants, 10 Latina participants, 4 Asian/Pacific Islander participants, 3 African American participants, and 1 Native American participant. Of the participants, 14 reported currently living with their identified primary caregiver(s) and 74 reported not. The participants who reported not living with their identified primary caregiver(s) reported having not lived with said identified primary caregiver(s) for an average of 2.9 years ($SD = 4.63$). Fifty-three participants identified their mother and father as their primary caregivers, 32 identified their mother only, 2 identified their father only, and 1 identified their aunt.

Procedure

Upon entering the lab, the Experimenter measured the participants' height to be used for calculating body mass index. The participants were then administered the questionnaires in electronic form using MediaLab software. Anonymity was assured to the individuals and they completed the study in private rooms. The questionnaires used in this study were amended so that the participants would be answering the questions about their parent(s)/primary caregiver(s) in retrospect. In other words, they would be answering the questions from the perspective of when they were children, not currently. However, they were instructed to answer questions about how they felt about their bodies from the perspective of how they felt currently. The questionnaires were presented to the participants beginning with the body-related measures (Body Dissatisfaction subscale of

the Eating Disorder Inventory [Garner, Olmstead, & Polivy, 1983] and Body Shape Questionnaire [Cooper, Taylor, Cooper, & Fairburn, 1987]) followed by the parental measures (Inventory of Parent and Peer Attachment [Armsden & Greenberg, 1987], Parental Bonding Instrument [Parker, Tuplig, & Brown, 1979], Parental Comments Scale [Rodgers, Faure, & Chabrol, 2009], Perception of Teasing Scale [Thompson, Cattarin, Fowler, & Fisher, 1995], Separation Anxiety Symptom Inventory [Silove, Manicavasagar, O'Connell, Blaszczynski, Wagner, & Henry, 1993], Parental Acceptance Rejection Questionnaire [Rohner & Khaleque, 2005], and Rosenberg Self-Esteem Scale [Rosenberg, 1965]).

Measures

Body Dissatisfaction

Body dissatisfaction was assessed with the Body Dissatisfaction subscale of the Eating Disorder Inventory (Garner, Olmstead, & Polivy, 1983) and the Body Shape Questionnaire (Cooper, Taylor, Cooper, & Fairburn, 1987). The Body Dissatisfaction subscale of the Eating Disorder Inventory contains 9 statements that respondents are supposed to rate on a 6-point scale ranging from 1 (*always*) to 6 (*never*). Statements include, "I think that my stomach is too big," and "I think that my thighs are just the right size." Garner, Olmstead, and Polivy (1983) found the BD-EDI to have a Cronbach's alpha of .90. The Body Shape Questionnaire asks a series of 34 questions about how an individual feels about their body and the impact it has on their daily life. Participants answer on a 6-point scale ranging from 1 (*never*), to 6 (*always*). Questions include such things as, "Have you avoided running because your flesh might wobble?" and "Has eating even a small amount of food made you feel fat?" Cronbach's alpha for the BSQ

has been found to be .97 in our study. The BSQ and the BD-EDI were found to be highly correlated, $r(86) = .79, p < .001$, so upon analysis, the two measures were analyzed individually and averaged together to be analyzed as a composite measure. The means, standard deviations, and Cronbach's alphas found for the BSQ and BD-EDI in the current study can be found on Table 1.

Primary Caregiver

After completing the body-related questionnaires, the participants were then asked to identify who they considered to be their primary caregiver(s) as a child from a list that included Mother and Father, Mother, Father, Grandparents, Grandma, Grandpa, Aunt, Uncle, Foster Parent(s), Older Sibling, and Other (specify).

Parental Bonding

Parental bonding was assessed using three questionnaires which focused on attachment style between child and parent, levels of parental care and concern, and separation anxiety from parents. The parent subscale of the Inventory of Parent and Peer Attachment (IPPA) is a 28-question self-report inventory about the nature of the relationship between child and parent (Armsden & Greenberg, 1987). The IPPA is divided into three domains: communication ("I told my parent(s)/primary caregiver(s) about my problems and troubles"), trust ("I didn't know whom I could depend on those days" [reversed]), and alienation ("I had to rely on myself when I had a problem to solve"). The scores range from 1 (*almost never or never true*) to 4 (*almost always or always true*). I determined which questions loaded onto each of the factors by running a factor analysis on the data. This measure had a Cronbach's alpha of .86 in past research

(Armsden & Greenberg, 1987). Refer to Table 1 for the descriptive statistics and internal consistency reliability of all parenting measures.

Secondly, the Parental Bonding Instrument (PBI) is a 25-item self-report questionnaire with a care subscale and control subscale (e.g., how authoritarian the caregiver is) that assesses the mother's and father's degree of care about the child and control over the child during the individual's childhood (Parker, Tuplig, & Brown, 1979). Typical administration of this instrument includes the participants answering the 25 questions twice, once about their mother and once about their father. However, since not all individuals were raised by their mother and father, the participants in the present study answered the questions about their parent(s)/caregiver(s) only for each of the parental measures. The questionnaire consists of questions such as "[My parent(s)/primary caretaker(s)] made me feel I wasn't wanted" (care; reversed) or "[My parent(s)/primary caretaker(s)] let me do those things I liked doing" (control; reversed) and participants responded on a 4-point scale from 1 (*very unlike*) to 4 (*very like*). The Cronbach's alpha for both care and concern constructs was between .73 and .89 (Parker, Tuplig, & Brown, 1979).

Finally, the Separation Anxiety Symptom Inventory (SASI) is a 15-item questionnaire that assesses things like the individual's fears about leaving home and being away from parents at one point in their lives (Silove, Manicavasagar, O'Connell, Blaszczynski, Wagner, & Henry, 1993). Examples of statements are, "I was very unhappy if I was separated from my family" or "I was afraid of being harmed or kidnapped when I was alone." Participants responded on a 4-point scale, ranging from 1 (*I never had this feeling*) to 4 (*this feeling occurred very often*). The SASI has been

found to have a Cronbach's alpha of over .80 (Silove, Manicavasagar, O'Connell, Blaszczynski, Wagner, & Henry, 1993).

Parental Comments

Parental comments were measured by the Parental Comments Scale (PCS; Rodgers, Faure, & Chabrol, 2009) and the Perception of Teasing Scale (POTS; Thompson, Cattarin, Fowler, & Fisher, 1995). The Parental Comments Scale is a self-report questionnaire that assesses the nature of comments made to a child by her parents. The types of comments assessed are classified as positive (i.e., "It's okay if you put on some weight, don't worry about it), negative (i.e., "You look great, you must have lost weight!" [implying one can only look good if she is thinner]), and importance/comparison (i.e., "My parent(s)/primary caretaker(s) commented on the shape or weight of my friends"). The Cronbach's alphas for the positive, negative, and importance/comparison sections have been reported as .87-.91, .84-.85, and .83-.79, respectively (Rodgers, Paxton, & Chabrol, 2009). Participants respond on a 5-point scale ranging from 1 (*never*) to 5 (*always*). The Perception of Teasing Scale measures weight-related teasing. The scale consists of 6 weight-related items (i.e., "Made fun of you because you were heavy") and 5 competency-related items (i.e., "Made fun of you because you were afraid to do something") in which participants rated the frequency of teasing-related scenarios on a 5-point scale ranging from 1 (*never*) to 5 (*very often*). The scale customarily asks the participant to rate how upset they were by the teasing, but this element was omitted for the current study because how upset they were by the teasing was not relevant to the current focus.

Parental Acceptance

Parental acceptance of the participants was measured with the short form of the Parental Acceptance-Rejection Questionnaire (PARQ; Rohner & Khaleque, 2005). This scale contains 29 items falling into four domains (Warmth, Hostility/Aggression, Indifference/Neglect, Undifferentiated Rejection), requiring the individuals to respond on a 4-point Likert-type scale ranging from 1 (*almost never true*) to 4 (*almost always true*). Example items include, “[My parent(s)/primary caregiver(s)] said nice things about me” (warmth subscale), “[My parent(s)/primary caregiver(s)] hits me, even when I do not deserve it” (hostility/aggression subscale), “[My parent(s)/primary caregiver(s)] paid no attention to me” (indifference/neglect subscale), and “[My parent(s)/primary caregiver(s)] sees me as a big nuisance” (undifferentiated rejection). The Cronbach’s alpha for the PARQ has been found to be .75 for the father portion and .77 for the mother portion. The questionnaire was modified so that participants answered the questions one time in regards to whomever they identified as their primary caregiver(s).

Self-Esteem

Participants’ self-esteem was measured using the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES is a 10-item questionnaire for which participants responded to such items as “I am able to do things as well as most other people” and “I certainly feel useless at times” (reversed) on a 4-point scale ranging from 1 (*strongly disagree*), to 4 (*strongly agree*). The Cronbach’s alpha for the RSES was .87 the current study ($M = 3.26$, $SD = 0.54$).

Following the questionnaires, the participants were given the option to have the experimenter configure a body fat scale so that it would measure their weight and pounds

of body fat, which the participant would then enter into the computer privately and anonymously. If the participant did not feel comfortable using the scale, she was still given the option to simply enter her weight if she knew it and not enter pounds of body fat.

Body Fat Percentage/Body Mass Index

For females between the ages of 20-40, the healthy range of body fat is between 21% and 33%. Any percentage under 21% is considered underweight, between 33-39% is considered overweight, and anything over 39% is considered obese. Body mass index is an indicator of an individual's body fat based on height and weight. According to the U.S. Department of Health and Human Services (2012), an individual is considered to have a normal weight if their BMI is between 18.5 and 24.9 and anything under 18.4 is considered underweight. A BMI from 25 to 29.9 is considered overweight and over 30 is considered obese. Only 14 participants opted to weigh themselves and record their pounds of body fat, so BMI was used in the final data analyses. The mean BMI for my sample was 25.10 ($SD = 6.68$).

The participants were asked to provide their age and ethnicity, and to answer some general questions about their relationship with their primary caregiver(s) (i.e., if they are currently living with them, how long it has been since they lived with them, how often they speak, how close they consider themselves to be with them). Finally, the participants were asked to write what they thought was the purpose of the study, were given credit for their participation in the study, and were thanked for their time.

Results

Based on previous literature, it was predicted that all of the different family dynamics assessed would significantly contribute to body dissatisfaction. This prediction was primarily supported by the data collected. The means, standard deviations, Cronbach's alphas and correlations of all the parenting variables with the body-related dependent variables is presented in Table 1. Of all the variables listed, the only one that was not significantly correlated with either body-related variable individually or averaged together was the Separation Anxiety Symptom Inventory (SASI), but even that measure was marginally significantly correlated with the BSQ, $r(86) = .21, p = .055$. Eleven of the 15 variables were significantly correlated with at least two of the three body-related measures. Only three variables were significantly correlated with only one of the measures (BSQ); the Control subscale of the Parental Bonding Instrument (PBI), the Competence Teasing subscale of the Perception of Teasing Scale (POTS), and the Undifferentiated Rejection subscale of the Parental Acceptance Rejection Questionnaire (PARQ).

Regarding the individual body-related measures themselves, the Body Shape Questionnaire appeared to have the most consistent relationships with the parental variables as the measure was significantly correlated with every parental variable except for the SASI. The strongest relationship between the body-related measures was the Negative Comments subscale of the Parental Comments Scale (PCS). It was very highly correlated with the BSQ, $r(86) = .63, p < .001$, the BD-EDI, $r(86) = .52, p < .001$, and the BSQ and BD-EDI averaged together, $r(86) = .61, p < .001$.

To further explore my hypotheses, three different multiple regression analyses were conducted to predict participants' body dissatisfaction based on their early childhood family dynamics (e.g., all the parenting variables listed in Table 1). Each of the three body-related dependent measures were analyzed separately. Regarding the BSQ, this model was found to be significant, $F(15,72) = 5.57, p < .001 (R^2 = .44)$. The significant predictors in this model were the Positive Comments subscale of the PCS, $t = -2.81, p = .006, \beta = -.30$, and the Negative Comments subscale of the PCS, $t = 2.86, p = .006, \beta = .36$. The BD-EDI model was also found to be significant, $F(15,72) = 3.2, p < .001 (R^2 = .40)$, with the Negative Comments subscale of the PCS being the sole significant predictor, $t = 2.78, p = .007, \beta = .44$. Finally, the model was significant when the BSQ and BD-EDI were averaged together, $F(15,72) = 4.54, p < .001 (R^2 = .49)$. As with the BSQ, the Positive Comments subscale of the PCS, $t = -2.45, p = .017, \beta = -.28$, and the Negative Comments subscale of the PCS, $t = 3.03, p = .003, \beta = .40$, were the significant predictors.

Additionally, I conducted partial correlation tests with the BSQ and BD-EDI individually and averaged together to determine whether any of the parental variables would remain significantly correlated with body dissatisfaction after controlling for BMI and self-esteem. The one variable to remain significant in all three tests was the Negative Comments subscale of the PCS, $r(84) = .41, p < .001$ (BSQ), $r(84) = .24, p = .025$ (BD-EDI), $r(84) = .36, p = .001$ (BSQ & BD-EDI). The Comparison Comments subscale of the PCS, $r(84) = .31, p = .003$, and the Weight-related Teasing subscale of the POTS, $r(84) = .28, p = .009$, were also significantly correlated with the BSQ after controlling for self-esteem and BMI.

Discussion

The aim of the current study was to investigate the role of family dynamics from childhood in the development of body dissatisfaction in adult women. Based on previous literature, it was predicted that all of the family dynamics variables included in the study would have a significant impact on body dissatisfaction. The hypothesis was primarily supported by the data, which showed that collectively, the family dynamics variables studied were significantly related to body dissatisfaction. All parenting variables were related to at least one measure of body dissatisfaction except for the Separation Anxiety Symptom Inventory (SASI), which was still marginally significant.

The present study added a family dynamics variable that to date had not been studied in relation to body dissatisfaction (parental acceptance/rejection). All four subscales of the Parental Acceptance Rejection Questionnaire (PARQ; Warmth, Hostility/Aggression, Indifference/Neglect, and Undifferentiated Rejection) were significantly correlated with the Body Shape Questionnaire (BSQ; see Table 1). Additionally, the Warmth subscale of the PARQ was significantly correlated with all three body-related dependent measures.

To date, the current study was the first to simultaneously analyze numerous family dynamics during childhood simultaneously and their effect on body dissatisfaction in adulthood. Only a few variables were correlated with body dissatisfaction after controlling for BMI and self-esteem, or while examining all parenting variables simultaneously in a regression. Throughout all analyses conducted, the one variable to remain significantly related to body dissatisfaction was the Negative Comments subscale of the Parental Comments Scale.

The results of the study indicated that negative comments made by one's primary caregiver(s) during childhood may have the biggest impact among the other variables analyzed on the development of body dissatisfaction in adulthood for women. One possible explanation for this finding is the direct, verbal, and thus more explicit nature of negative comments towards the child's weight. In accordance with Erik Erikson's theory the primary caregiver in a child's life serves as a mirror for the child's feelings. The primary caregiver communicates to the child if a situation warrants feelings of safety or concern, and the child looks to the parent for indicators of how she should feel about herself. Therefore, being told things such as, "If you eat that, you'll get fat," or "If you want to look good you need to work out more" may communicate a message that stays with the child until she becomes an adult. This may also account for why the Weight-Related Teasing subscale of the POTS also remained significantly correlated with the BSQ after controlling for self-esteem and BMI. This is in contrast to the more subtle messages possibly contained within the other parental variables that tapped into the nature of the parent/child relationship.

The previous literature found significant correlations between the Separation Anxiety Symptom Inventory and body dissatisfaction. However, in all analyses conducted, the SASI was only marginally correlated with body dissatisfaction. Regarding this finding, my results may have turned out differently because the previous literature used a sample of women who were all diagnosed with anorexia nervosa or bulimia nervosa (Troisi et al., 2006) and my sample was made up of college students who may or may not have met diagnostic criteria for such disorders. The sample with anorexia nervosa and bulimia nervosa may have been higher in situational or trait anxiety

than my sample, and those disorders are often accompanied by high amounts of anxiety. However, the results of the current study fit generally well with other work that tends to indicate a parental component having a significant relationship with body dissatisfaction.

Additionally, the parental-related variables had more significant correlations with the BSQ than the BD-EDI. This may be explained by comparing the two body-related measures and what exactly they assess regarding body dissatisfaction. The BD-EDI assessed how the individual felt about specific parts of her body, whereas the BSQ addressed those body part-specific concerns as well as the impact the body dissatisfaction had on her daily functioning and interactions with others.

One limitation of my study is that I used an all-female sample. Therefore, the results of the study can not apply to men. However, body-related issues in women appear to be more relevant than ever with the extreme measures women go to in order to achieve a thin ideal, so studying women is increasingly important. Additionally, the body-related measures used in the study, which are both widely used in the literature, are composed of items more appropriately worded for women's body issues.

Another limitation in the study could be the use of BMI as a control variable as opposed to body fat percentage. It was the initial intent to use body fat percentage instead of BMI, but since there were not enough participants who opted to measure their pounds of body fat, BMI was used.

Thirdly comes the limitation inherent with this type of study: correlation does not imply causation. Even though I conducted analyses to control for BMI and self-esteem, there may be another variable not measured that accounts for the body dissatisfaction in

my sample. For example, the current study did not look at variables such as sibling dynamics, media influence, or personality variables such as neuroticism.

The present study opens the door to exploring further the impact of negative parental comments on body dissatisfaction. The results indicate that what happens to an individual during childhood—particularly what is said to an individual as a child—seems to linger through to at least early adulthood. Since the mean age of my sample was just barely 20 years, it would be of interest to see if negative comments made by the primary caregiver(s) during childhood would correlate with body dissatisfaction in older samples. Another future direction for this research could be to investigate whether there is a bigger impact of hearing negative comments from a child's primary caregiver or from a child's siblings, friends, teachers, coaches, etc. Based on Erik Erikson's theory, it would stand to reason that the child's primary caregiver(s) would have the most influence on the child's identity and esteem formation, but there is a possibility that this may not always be the case if a child grows to become very close with a teacher, for example, and therefore looks to the teacher instead for that mirroring of feelings.

With the knowledge gained from this study, we can begin to educate parents and other primary caregivers about the impact that negative weight-related comments have on children and their lasting effects. While it may be important to teach a child to be cognizant of her weight for health-related reasons, it also appears to be important to be aware of the ways in which that message is presented to a child. Instead of making statements that may be construed as critical in nature, parents and primary caregivers may need to be educated in reinforcing positive behaviors children do to manage their weight.

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Table 1

Family Dynamics Variables' Correlations with Body Image Dissatisfaction

Scale	<i>M</i>	<i>SD</i>	α	BSQ	BD-EDI	BSQ&BD-EDI
PBI Care	3.33	0.73	.94	-.23*	-.19	-.22*
PBI Control	2.28	1.79	.83	.22*	.13	.18
SASI	1.83	0.51	.86	.21	.05	.13
IPPA Communication	2.88	0.80	.91	-.27*	-.29**	-.30**
IPPA Trust	3.24	0.71	.92	-.29**	-.31**	-.32**
IPPA Alienation	1.86	0.70	.86	.26*	.16	.22*
PCS Positive	3.13	0.59	.75	-.50**	-.47**	-.52**
PCS Negative	1.95	0.94	.88	.63**	.52**	.60**
PCS Comparison	2.14	1.08	.91	.54**	.33**	.45**
POTS Weight	1.14	0.32	.78	.51**	.38**	.47**
POTS Competence	1.81	1.03	.92	.23*	.04	.14
PARQ Warmth	3.46	0.65	.94	-.31**	-.27*	-.30**
PARQ Hostility/Aggression	1.41	0.69	.91	.25*	.18	.22*
PARQ Indifference/Neglect	1.69	0.76	.91	.26*	.21	.25*
PARQ Rejection	1.39	0.64	.85	.23*	.12	.18
BMI	25.1	6.68	--	.52**	.49**	.54**
RSES	3.26	0.54	.87	-.49**	-.47**	-.51**
BD-EDI	3.39	1.05	.89	.79**	--	.95**
BSQ	2.81	0.95	.97	--	.79**	.94**

* $p < .05$, two-tailed. ** $p < .01$, two-tailed

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