Recollections of Pressure to Eat During Childhood, But Not Picky Eating, Predict Young Adult Eating Behavior

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Picky eating is a childhood behavior that vexes many parents and is a symptom in the newer diagnosis of Avoidant/Restrictive Food Intake Disorder (ARFID) in adults. Pressure to eat, a parental controlling feeding practice aimed at encouraging a child to eat more, is associated with picky eating and a number of other childhood eating concerns. Low intuitive eating, an insensitivity to internal hunger and satiety cues, is also associated with a number of problem eating behaviors in adulthood. Whether picky eating and pressure to eat are predictive of young adult eating behavior is relatively unstudied. Current adult intuitive eating and disordered eating behaviors were self-reported by 170 college students, along with childhood picky eating and pressure through retrospective self- and parent reports. Hierarchical regression analyses revealed that childhood parental pressure to eat, but not picky eating, predicted intuitive eating and disordered eating symptoms in college students. These findings suggest that parental pressure in childhood is associated with problematic eating patterns in young adulthood. Additional research is needed to understand the extent to which parental pressure is a reaction to or perhaps compounds the development of problematic eating behavior.

Keywords: Picky Eating, Avoidant Eating, Intuitive Eating, Eating Behavior, Pressure, Disordered Eating
Recollections of Pressure to Eat During Childhood, But Not Picky Eating, Predict Young Adult Eating Behaviors

Childhood picky eating is a behavior that vexes many parents due to its associations with poor diet quality, frequent constipation, and low body weight (Dovey & Staples, Gibson, & Halford, 2008; Tharner et al., 2015). In childhood, picky eaters are more likely to be pressured to eat by their parents, which may have counterproductive consequences (Ventura & Birch, 2008). Research on picky eating has traditionally been limited to childhood, but an emerging literature is now exploring the presence of picky eating behaviors in adults (Kauer, Pelchat, Rozin, & Zickgraf, 2015; Wildes, Zucker, & Marcus, 2012). However, very little is known about how childhood picky eating and parental pressure to eat could affect future relationships with food, health, eating behaviors, and psychological well-being in young adulthood. Interestingly, the DSM-5 now allows for food avoidance with the presence of psychosocial impairment to be diagnosed as Avoidant/Restrictive Food Intake Disorder (ARFID) in adults, and yet there is only one empirical study supporting this diagnosis in adults (Wildes et al., 2012).

Therefore, it is necessary to examine how childhood picky eating and related negative feeding practices may lead to psychological impairment associated with eating in adulthood. The purpose of this study was to examine whether retrospective reports of parental pressure to eat and childhood picky eating predict current positive and negative eating behaviors in college students.

Picky eaters are individuals who consume a very limited variety of food through the rejection of both unfamiliar and familiar foods (Dovey et al., 2008). Children are typically thought to grow out of picky eating behaviors, but evidence suggests picky
eating prevalence remains stable across childhood and can take a chronic course, sometimes persisting into adulthood (Kaur et al., 2015; Marchi & Cohen, 1990; Mascola, Bryson, & Agras, 2010; Wildes et al., 2012). Picky eating and disordered eating in adults appear to be separate but often comorbid conditions, with disordered eating groups showing a higher level of clinical impairment and picky eating groups displaying higher levels of social eating anxiety (Wildes et al., 2012). Longitudinal research has partially supported the notion that childhood picky eating is predictive of disordered eating psychopathology in young adulthood (Kotler, Choen, Davies, Pine, & Walsh, 2001; Marchi & Cohen). Adults who identify as picky eaters have poor quality dietary intake, and qualitative research indicates that these adults feel “unique” in their eating behaviors and are often criticized for their “odd” eating choices (Blake, Bell, Freedman, Colabianchi, & Liese, 2013; Blake & Bisogni, 2003). Furthermore, these adults often attribute their pickiness to aversive childhood events and are frequently dissatisfied with their picky eating (Blake & Bisogni, 2003).

Cross-sectional and longitudinal studies report that parental pressure to eat is correlated with higher levels of childhood picky eating, lower levels of food intake, and lower weight in children (Farrow & Blissett, 2008; Ventura & Birch, 2008). Using an experimental approach, researchers showed that even mild encouragement to eat resulted in increased negative affective responses, lowered preference for the target food, and a reduced rate of targeted food intake over time (Galloway, Fiorito, Francis, & Birch, 2006; Galloway, Fiorito, Lee, & Birch, 2005). Research has shown that children who received higher levels of parental pressure to eat were more likely to limit their food intake, eat in response to external factors such as emotion, and lack attention to hunger and satiety cues
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(Carper, Fisher, & Birch, 2000; Strein & Bazelier, 2007). More recently, it has been
documented that negative feeding practices appear to have a direct influence on
children’s eating behavior, rather than simply being a reaction to eating behavior that
parents perceive to be undesirable (Kiefner-Burnmeister, Hoffmann, Meers, Koball, &
Musher-Eizenman, 2014). Research on the outcomes of childhood parental pressure is
limited, but a retrospective study found that 70% of college students recalled a forced
consumption episode during their lifetime (Batsell, Brown, Ansfield, & Pashall, 2002).
Moreover, students who did so were more likely to be picky eaters in adulthood and were
more likely to be restrictive in their current eating behaviors than those who did not recall
a forced consumption episode.

Intuitive eating is an innate adaptive eating style characterized by eating in
response to internal cues of hunger and satiety. It is theorized that individuals who are
conscious of these internal cues will satisfy their internal hunger cravings in a natural,
nutritious, and non-restrictive way (Smith & Hawks, 2006; Tylka, 2006). Intuitive eaters
have higher psychological health indicators and physical health indicators including
improved dietary intake and healthy eating behaviors (e.g., eating breakfast; Dyke &
Drinkwater, 2013; Tylka, 2006). Intuitive eating may become disrupted by poor parental
feeding practices and individual dietary restraint (Herbert, Blechert, Hautzinger,
Matthias, & Herbert, 2013; Tylka, 2006). Retrospective accounts of parental food
monitoring and restriction in childhood has been linked to low intuitive eating in young
adults, and intuitive eating appears to be inversely related to disordered eating behaviors
(Denny, Loth, Eisenberg, & Neumark-Sztainer, 2013; Galloway, Farrow, & Martz, 2010;
Tylka, 2006).
The relationship among picky eating (as a symptom of the new diagnosis of ARFID), parental pressure to eat, intuitive eating, and more historically-identified aspects of disordered eating has not been examined in the literature previously. It is important to understand whether eating and feeding behaviors in childhood are associated with future young adult eating behaviors and how these early experiences may be related to positive and healthy eating behaviors and choices later in life. For the current study, we hypothesized that higher levels of parental recollections of their child’s pickiness and parents’ use of pressure would predict lower levels of intuitive eating and higher levels of disordered eating as self-reported by college students.

Methods

Participants

Participants included 170 college students (121 women; 49 men) and one parent, self-selected by the student, for each. Participants selected for the study were from the United States (US) and the United Kingdom (UK). Ninety-eight students volunteered from an undergraduate psychology research pool at a large comprehensive university in the southern United States, and 72 undergraduate students volunteered from a research pool at a large university in the UK. Student age ranged from 16 to 25 years old. Approximately, 96.6% of the sample identified as Caucasian, 2.3% identified as Black, and 1.1% identified as Asian. A previous study reported on a broader range of parental feeding practices for the US participants only (Galloway et al., 2010).

Procedure

The Institutional Review Boards at each university approved the study’s procedure. Each of the 170 participants completed a questionnaire for the study and then...
mailed a questionnaire to a parent to complete and return to the researchers. Students from the US and UK received class research credit, and US parents were given the opportunity to win a $50 gift card to a hardware store. After completing the questionnaire, students in the US had their height and weight measured privately by a trained research assistant in a separate room. Participants from the UK self-reported height and weight measurements. After completing the questionnaires, the students addressed envelopes so the researchers could mail questionnaires to their parents.

**Measurements**

**Background information.** Students provided demographic information and indicated with whom the student lived as a child and now while at college. Parents reported their height, weight, level of education, and occupation, in addition to answering questions regarding the child’s feeding history in middle childhood (ages 5-10). Body Mass Index (BMI) was calculated from either measured or self-reported height and weight.

**Pressure to eat.** Parents completed a retrospective version of the Child Feeding Questionnaire (CFQ; Birch et al., 2001) that assesses controlling feeding practices. The current study used only one of its three subscales: parental use of pressure to influence their child to eat. The CFQ was adapted from present to past tense to be used retrospectively. The 4-item pressure to eat subscale on the CFQ is scored using a 5-point Likert scale for each item, and a total score is calculated by taking the mean, with higher scores indicating higher levels of controlling feeding practices. Parents were encouraged to recall their feeding practices at the time when their child was 5-10 years old. Parents’
pressure to eat scores demonstrated internal consistency appropriate for research purposes 
($\alpha = .76$).

Students also completed a retrospective version of the Kids’ Feeding Questionnaire for Children (KFQC; Carper et al., 2000), which measured their recollections about their parents’ controlling feeding practices when they were younger. The current study used only one of its three subscales: parental pressure to eat, comprised of seven items. The KFQC uses 5-point response items that range from (1) never to (5) always, with higher scores indicating higher levels of parental control. The KFQC has shown predictive validity for restrained eating and emotional eating (Carper et al., 2000).

Because the original KFQC was designed for use with young children, it was modified for use with these college student participants. Students were prompted to “Think back to when you were a child and your experience with food and eating. Please complete the following questionnaire with the person in mind who was most often responsible for feeding you.” The KFQC pressure subscale demonstrated appropriate levels of reliability in this study ($\alpha = .76$).

An overall pressure to eat variable was created from the two retrospective reports of pressure described above. Students’ self-reports of pressure were averaged with parents’ reports of pressure to create a single aggregated measure of pressure to be used in the analyses for this study.

**Picky eating.** Parents completed a picky eating scale that has been used in previous studies on childhood picky eating and has acceptable internal consistency ($\alpha = .85$; Galloway et al., 2005; Galloway et al., 2003). The scale includes three items designed to capture the parent’s retrospective perceptions on their child’s willingness to
eat during mealtimes. The items include: (1) “My child’s diet consisted of only a few foods”; (2) “My child was unwilling to eat many of the foods that our family ate at mealtimes”; and (3) “My child was fussy or picky about what he/she ate.” Each item is measured on a 5-point Likert scale, with higher scores representing a higher level of pickiness. Parents were asked to retrospectively report on their college student’s eating behavior during middle childhood. The pickiness subscale in this study showed high internal consistency ($\alpha = .88$).

**Intuitive eating.** The Intuitive Eating Scale (IES, Tylka, 2006) is a 21-item questionnaire developed to serve as a measure for adaptive eating that consists of three subscales comprised of seven items each: unconditional permission to eat, eating for physical reasons, and reliance on signs of hunger/satiety. Total scores or subscale scores may be derived from this instrument, but only total scores are used in the present study, with higher scores indicating more intuitive eating and positive eating behaviors. The IES has demonstrated strong construct validity and test-retest reliability (Tylka, 2006). The IES was completed by the college student participants. The total IES score demonstrated strong internal consistency in this study ($\alpha = .90$).

**Disordered eating.** The Eating Disorder Inventory (EDI-2) is a questionnaire that measures psychological and behavioral traits historically associated with eating disorders. It has high test-retest reliability indicating an acceptable stability over time (Andreas & Thomas, 2006) and can be used as a screening tool for eating disorders (Nevonen & Broberg, 2001). The current study used two of its eight subscales: Drive for Thinness and Bulimia. College student participants responded to the two EDI-2 subscales on a 6-point Likert scale ranging from “always” to “never.” We used untransformed (6-point) scaling,
which has demonstrated increased stability and reliability of the measure when using the EDI-2 in nonclinical samples (Eklund, Paavonen, & Almqvist, 2005; Schoemaker, van Strien, & van der Staak, 1994). Both the mean item scores and the mean sum scores were calculated, with higher scores indicating more disordered eating. In this study, the EDI-2 demonstrated strong internal reliability on both the Bulimia (α = .80) and Drive for Thinness subscales (α = .91).

Data Analysis

Descriptive statistics were calculated for each of the variables included in the regression analysis along with other demographic information. A Total Pressure variable was created to gain a fuller perspective of pressure by combining the student and parent pressure scores and then calculating the mean. Preliminary Pearson correlations were then calculated to examine the relationships between picky eating, pressure to eat and BMI. Independent sample t-tests were used to explore whether there were significant gender differences between males and females on pressure to eat, picky eating and BMI.

Three hierarchical regression analyses examined whether pressure to eat and picky eating, as well as the personal characteristics of BMI and gender, were predictive of each of the three eating-related outcomes: intuitive eating, bulimia, and drive for thinness. The primary focus of this study is on the unique effects of childhood pressure and picky eating on eating-related outcomes in young adulthood; therefore, these two predictors were included first in the regression analyses. We were also interested in examining a possible moderating effect between these two related constructs, so a simple multiplicative interaction term was entered in the regression following the main effects of pressure and picky eating. However, because important demographic variables such as
BMI and gender are often related to both positive and negative eating behaviors, we sought to understand their role by entering BMI and gender as final steps in the hierarchical regressions to examine their effects on the resulting models. Therefore, each of the three regressions included five steps with the following variables added as predictors: 1) the main effect of pressure, 2) the main effect of picky eating, 3) the interaction between pressure and picky eating, 4) student BMI, and 5) student gender. Following the analysis for intuitive eating, the same hierarchical predictors were also analyzed to examine Bulimia and Drive for Thinness outcome variables. The mean item scores for the EDI subscales were used in the regression analysis. The proportion of variance explained and standardized regression coefficients (β) for each step of the hierarchical regression models are shown in Table 2.

A post-hoc power analysis was calculated using G*Power to determine the power of our current sample of 170 participants for a linear multiple regression. For an effect size of $R^2 = .18$, with five predictors, and error probability of $p < .05$, we were able to achieve a power of 0.99 with the current sample size (Faul, Erdfelder, Buchner, & Lang, 2010).

**Results**

Descriptive characteristics of the student-parent dyads (n = 170) are presented in Table 1. There were some missing data on the reporting of parent gender (n = 29) but the majority of reporting parents were mothers (132 mothers; 9 fathers). Correlations among the predictor variables revealed a significant positive relationship between childhood picky eating and recollections of pressure, $r (170) = .28$, $p < .01$. There was no significant relationship between current student BMI and childhood picky eating or pressure, $r (170)$...
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\[ r = .00, p = .99 \] and \[ r = -.12, p = .12 \] respectively. Independent samples \( t \)-tests indicated there were significant differences in the picky eating scores between men (\( M = 1.95, SD= 1.13 \)) and women (\( M = 2.36, SD = 1.26 \)); \( t(168) = 1.99, p < .05 \), indicating that parents were more likely to identify daughters as picky eaters. There was not a significant difference for pressure between men (\( M = 2.61, SD = 0.53 \)) women (\( M = 2.62, SD = 0.75 \)), \( t(168) = 0.09, p = .92 \), or for student BMI between men (\( M = 24.54, SD = 4.94 \)) and women (\( M = 23.71, SD = 4.53 \)), \( t(168) = 1.06, p = .29 \).

Table 1

Descriptive Statistics for the Measures Used

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Age (years)</td>
<td>19.75 (1.99)</td>
</tr>
<tr>
<td>Parent Age (years)</td>
<td>48.26 (5.87)</td>
</tr>
<tr>
<td>Parent BMI (kg/m^2)</td>
<td>27.71 (8.87)</td>
</tr>
<tr>
<td>Student BMI (kg/m^2)</td>
<td>23.95 (4.66)</td>
</tr>
<tr>
<td>Underweight</td>
<td>(1.2%)</td>
</tr>
<tr>
<td>Normal Range</td>
<td>(68.6%)</td>
</tr>
<tr>
<td>Overweight</td>
<td>(21.9%)</td>
</tr>
<tr>
<td>Obese</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Picky Eating</td>
<td>2.25 (1.24)</td>
</tr>
<tr>
<td>Parent Recollected Pressure</td>
<td>2.75 (0.73)</td>
</tr>
<tr>
<td>Student Recollected Pressure</td>
<td>2.49 (1.01)</td>
</tr>
<tr>
<td>Total Pressure Composite</td>
<td>2.62 (0.69)</td>
</tr>
</tbody>
</table>
Intuitive Eating 3.36 (0.61)
EDI Bulimia 2.02 (0.77)
EDI Drive for Thinness 3.08 (1.30)

Note. Picky eating, pressure, and intuitive eating were scored on a 5-point scale, and EDI bulimia and EDI drive for thinness were scored on a 6-point scale, and mean item scores are presented in the table. Mean sum scores were also calculated (EDI bulimia = 12.51, \(SD = 4.82\); EDI drive = 21.52, \(SD = 9.03\)). BMI classification cutoff points were < 18.50 = underweight; 18.50-24.99 = normal weight; 25.00-29.99 = overweight; \(\geq 30\) = obese.

**Intuitive Eating**

As outlined in Table 2, in the first step, pressure was a statistically significant predictor of intuitive eating, but neither pressure nor picky eating were statistically significant when they were used together in Step 2. However, once BMI was entered as a predictor in Step 4, pressure was again a significant predictor of intuitive eating. Furthermore, pressure, BMI, and gender remained statistically significant predictors in the final model, which explained 24% of the variance in intuitive eating. Female college students who had higher BMIs and reported higher levels of pressure to eat during childhood were likely to be low intuitive eaters.

**Bulimia**

The findings for the regression predicting bulimia mirrored that for intuitive eating (see Table 2). In the first step, pressure was a statistically significant predictor of EDI bulimia scores, but neither pressure nor picky eating were significant in Step 2. In Step 4, pressure again emerged as a predictor and remained significant in Step 5, along with BMI and gender, demonstrating that female students with higher BMI and more
childhood pressure to eat had higher bulimia scores. The final model explained 19% of
the variance in bulimia.

**Drive for Thinness**

Neither pressure nor picky eating were statistically significant predictors of EDI
drive for thinness scores (see Table 2); however, the interaction between pressure and
picky eating was in Step 3. This interaction remained significant in Step 4 with the
addition of BMI, which also emerged as a predictor. However, only BMI and gender
remained statistically significant in the final model, demonstrating that women with
higher BMI reported a higher drive for thinness. The final model explained 27% of the
variance in drive for thinness.
Table 2

Hierarchical Regression of Eating Behavior Outcomes in College Students

<table>
<thead>
<tr>
<th></th>
<th>Intuitive Eating Scale</th>
<th>EDI(^a) Bulimia Scale</th>
<th>EDI Drive for Thinness Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( R^2 ) or ( \Delta R^2 )</td>
<td>( \beta )</td>
<td>( R^2 ) or ( \Delta R^2 )</td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td>( R^2 = .029^* )</td>
<td>-.17*</td>
<td>( R^2 = .029^* )</td>
</tr>
<tr>
<td>Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td>( \Delta R^2 = .039^* )</td>
<td>-.17*</td>
<td>( \Delta R^2 = .042^* )</td>
</tr>
<tr>
<td>Pressure</td>
<td>-.142</td>
<td>.130</td>
<td></td>
</tr>
<tr>
<td>Picky Eating</td>
<td>-.103</td>
<td>.126</td>
<td></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td>( \Delta R^2 = .004 )</td>
<td>-.128</td>
<td>( \Delta R^2 = .016 )</td>
</tr>
<tr>
<td>Pressure</td>
<td>-.128</td>
<td>.104</td>
<td></td>
</tr>
<tr>
<td>Picky Eating</td>
<td>-.103</td>
<td>.127</td>
<td></td>
</tr>
<tr>
<td>Interaction (PRxPE)(^b)</td>
<td>-.068</td>
<td>.130</td>
<td></td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td>( \Delta R^2 = .069^{**} )</td>
<td>-.167*</td>
<td>( \Delta R^2 = .107^{**} )</td>
</tr>
<tr>
<td>Pressure</td>
<td>-.167*</td>
<td>.152*</td>
<td></td>
</tr>
<tr>
<td>Picky Eating</td>
<td>-.093</td>
<td>.115</td>
<td></td>
</tr>
<tr>
<td>Interaction (PRxPE)</td>
<td>-.050</td>
<td>.107</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>-.265^{***}</td>
<td>.331^{***}</td>
<td></td>
</tr>
<tr>
<td><strong>Step 5</strong></td>
<td>( \Delta R^2 = .132^{**} )</td>
<td>-.198^{**}</td>
<td>( \Delta R^2 = .024^{*} )</td>
</tr>
<tr>
<td>Pressure</td>
<td>-.198^{**}</td>
<td>.165*</td>
<td></td>
</tr>
<tr>
<td>Picky Eating</td>
<td>-.030</td>
<td>.088</td>
<td></td>
</tr>
<tr>
<td>Interaction (PRxPE)</td>
<td>.012</td>
<td>.081</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.302^{***}</td>
<td>.347^{***}</td>
<td></td>
</tr>
<tr>
<td>Gender(^c)</td>
<td>.375^{***}</td>
<td>-.160^*</td>
<td></td>
</tr>
</tbody>
</table>

**Final Model**

\( R^2 = .244^{***} \) \( R^2 = .189^{***} \) \( R^2 = .273^{***} \)

\(^a\) EDI = Eating Disorder Inventory. \(^b\) PRxPE = Interaction between picky eating and pressure scores. \(^c\) Gender = Female (0). Male (1).
Discussion

The limited research supporting the DSM-5’s inclusion of the newer diagnosis of Avoidant-Restrictive Food Intake Disorder (ARFID) in adult populations calls for further study into the stability of picky eating beyond childhood and how picky eating and parental feeding practices in childhood may predict eating behaviors in young adulthood (American Psychiatric Association, 2013; Wildes et al., 2012). The purpose of this study was to examine the recollections of pressure to eat and picky eating in middle childhood as predictors of positive and negative eating behaviors in young adults. We found parental pressure to eat in childhood predicted lower levels of intuitive eating and higher levels of disordered eating behaviors associated with bulimia, but not drive for thinness, in college students. However, childhood picky eating did not predict intuitive or disordered eating.

Our findings for pressure support previous research indicating that parental pressure to eat is associated with external, emotional, restrained eating, and disordered eating (Batsell et al., 2002; Carper et al., 2000; Galloway et al., 2006), which is important because parental pressure may have the unintended consequence of disrupting the development of intuitive and adaptive eating styles. These results converge with Loth et al.’s (2014) large correlational study that found a predictive relationship between other parental controlling feeding practices (restriction & pressure) and extreme weight control behaviors in adolescents using parent-child dyads. However, the cross-sectional nature of our findings do not rule out the possibility that problematic eating behaviors prompt parents to use more pressure and that the problematic eating continues into young adulthood.
Although the literature has been inconclusive, there is some evidence that childhood picky eaters tend to be of lower weight compared to non-picky eaters (Dovey et al., 2008; Marchi & Cohen, 1990). We found no significant relationship between picky eating in childhood and BMI in young adulthood; however, adult picky eaters have been shown to have weight statuses that are comparable to low pathology eaters (Wildes et al., 2012). This lack of relationship could indicate that college students who were picky eaters in childhood and of lower weight tend to reach weight levels more comparable to their peers by young adulthood. Although a lack of variety in their diet may continue to exist, their caloric intake becomes sufficient, which could be accounted for by having the freedom to eat what they want without being confined to the foods prepared by their adult family members.

Both BMI and gender were strong predictors of intuitive eating and disordered eating behaviors, with lower versus higher BMIs and being male rather than female associated with more positive outcomes. These results are consistent with previous research in young adults that report similar associations between both gender and BMI and the measures of drive for thinness and bulimia used in the present study (Lewisohn, Seeley, Moerk, & Striegel-Moore, 2002). Considering their strong associations with problematic eating, we included BMI and gender in the model to determine if picky eating and pressure to eat would still predict positive and negative eating behaviors after considering BMI and gender’s contribution.

Picky eating in childhood did not predict disordered eating behaviors in young adulthood, but recent research indicates that picky eating’s long-term implications may have greater pathological impact on social impairment (Wildes et al., 2012). Our findings
contradict previous research indicating links between childhood picky eating and young adult disordered eating (Marchi & Cohen, 1990). Some picky eaters’ effort to control their food and eating environment or to follow certain food rules that govern what they will eat may contribute to problematic social interactions. This “control” or regulatory issue would also align with our finding that picky eating was not a significant predictor of intuitive eating, considering low intuitive eating is associated with a disrupted ability to internally regulate a response to hunger or satiety (Tylka, 2006). These findings, if replicated, may be useful for practitioners to reassure parents that childhood picky eating is not necessarily a predictor of long-term disordered eating behavior.

This study is unique in that it assessed the predictive quality of the interaction between childhood picky eating and parental pressure to eat, and also looked at the previously unexplored relationship between picky eating and intuitive eating. Most eating behavior research focuses on negative outcomes associated with eating behavior; however, understanding the predictors of positive eating behaviors, such as intuitive eating, is important to inform the development of healthy lifestyles.

Although it is important to confirm these findings within additional adult populations and utilize longitudinal designs, these data provide evidence that children pressured to eat by their parents may be more likely to develop disordered eating patterns in young adulthood. Due to the cross-sectional design of this study, it may also be possible that children who evoke pressure from their parents tend to go on to engage problematic eating behaviors due to reasons unrelated to parental pressure. Although recent research supports the belief that controlling feeding practices can directly
influence child eating behavior, more research is needed to confirm the directionality of this relationship (Kiefner-Burnmeister et al., 2014).

Despite these strengths, there are several limitations of the current study. The retrospective nature of the study does not allow us to determine if college students were accurately reporting their experience of being pressured to eat in childhood; however, parental pressure is more overt than other negative parental practices, such as restriction and monitoring, and family members show high reliability when reporting on pressure (Pulley, Galloway, Webb, & Payne, 2014). The retrospective methodology also limits our ability to determine if parental reporting on picky eating and pressure could be a reaction to their child’s current eating behaviors. This study utilized self-reported BMI for a subset of participants, and although this approach has shown inaccuracies in comparison to measured BMI in the general population, some research supports its validity in college student samples (Quick et al., 2011; Rowland, 1990). Also, we did not directly obtain the college students’ recollection of picky eating and instead relied only on the parental report of picky eating. The generalizability of our study is a further limitation, as our sample was primarily white, female, and in the normal weight range. We do not know if our findings would persist within more diverse populations.

While future research may be needed to confirm whether the development of interventions for childhood picky eating is warranted, we believe that the literature supports the need to develop interventions aimed at the reduction of parents’ use of pressure as a feeding practice. Recently, more evidence-based strategies are available for parents and practitioners to prevent and treat common non-clinical feeding problems in children. (Holley, Haycraft & Farrow, 2014; Mitchell, Farrow, Haycraft, & Meyer, 2012;
Wardle et al., 2003; Wolfenden et al., 2012). Straightforward strategies, such as merely presenting a variety of fruits and vegetables for snacks (Roe, Meengs, Birch, & Rolls, 2013) may increase acceptance of fruits and vegetables and could, in turn, reduce mealtime struggles and the use of coercive feeding strategies.
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Highlights

- Examined recollected predictors of adult eating behaviors.
- Parental pressure to eat associated with low intuitive eating in adulthood.
- Parental pressure to eat associated with disordered eating in adulthood.
- Picky eating in childhood did not predict adult eating behavior.
- Results support the need for interventions that promote positive feeding interactions.