Journal of Integrated Social Sciences
www.JISS.org, 2025 - 15(1): 43-60

**Original Article:**

# INVESTIGATING RELATIONSHIPS AMONG COLLEGE WOMEN'S AUTONOMY, MATERNAL INFLUENCE, AND EATING BEHAVIORS

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## Abstract

Disordered eating is a multifaceted public health issue, and more research is needed to understand its contributing factors. Self-Determination Theory emphasizes the need for autonomy in fostering healthy behaviors in everyday life, such as eating. Importantly, maternal influence also shapes daughters' body satisfaction and food perception. During emerging adulthood, young adults gain autonomy but may still be vulnerable to maternal influence. This study investigated how varying levels of autonomy and maternal influence related to disordered eating patterns among women ages 18-25 at a southeastern university. Participants were recruited through an introductory psychology subject pool and completed an online survey. Results showed first-year women did not differ significantly from women in later years of college on autonomy, maternal influence, or disordered eating. Correlational analyses indicated that women who reported lower autonomy also reported more disordered eating and a more negative maternal influence. In addition, women who reported more negative maternal influence also reported more disordered eating behaviors. These findings highlight the importance of fostering autonomy and addressing maternal influence to support healthy eating behaviors among emerging adult women. Further research is needed to fully understand and address this important issue.

**Keywords:** disordered eating behaviors, Self-Determination Theory, autonomy, emerging adulthood, maternal influence

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## INTRODUCTION

According to the National Eating Disorders Association (NEDA, 2023), approximately 20 million women in the United States will develop a clinically diagnosable eating disorder. Disordered eating, or "the full spectrum of eating-related problems from simple dieting to clinical eating disorders" (Pereira & Alvarenga, 2007, p. 142), includes harmful eating habits such as overeating, restricting food intake, purging and compensatory actions, and other approaches to attempt to lose or maintain body weight. While these behaviors can occur outside the context of a clinically diagnosable eating disorder, even in subclinical cases they are extremely important to identify due to the negative impact on the overall health of the individual. These behaviors can negatively affect cardiovascular, gastrointestinal, and skeletal health, contribute to the development of various medical conditions, and are associated with mental health challenges such as depression and suicidal ideation (Mayo Clinic, 2023). Disordered eating behaviors among women represent a complex, pervasive, and prevalent public health concern with significant implications for psychological and physical well-being (Breines et al., 2013), which suggests there is an immediate need for effective interventions (NEDA, 2023).

### Self-Determination Theory

One way to understand the complex issue of eating disorders is to consider the variables conceptualized within the psychological framework of Self-Determination Theory (SDT). This theory proposes autonomy, competence, and relatedness as fundamental psychological needs that are essential for an individual's optimal functioning towards growth and integration, as well as for fostering constructive social development and personal well-being (Ryan et al., 1997). Understanding the interplay between disordered eating behaviors and SDT is crucial in developing more efficient strategies to address psychological needs and ultimately support women's healthy relationships with food. For example, competence, which pertains to one's own perception of their ability to make informed and effective decisions, has been linked to body image concerns and maladaptive eating behaviors (Vansteenkiste et al., 2005). Relatedness, defined as the sense of connection and belonging, plays a significant role in the development of problematic eating behaviors, with feelings of social isolation and struggling relationships associated with an increased likelihood of disordered eating (Schaumberg et al., 2016).

In the current study, our primary focus is the factor of autonomy as it relates to women's relationships with food. Deci and Ryan (1985) define autonomy as a perceived sense of control over one's actions, and it likely plays a role in shaping eating behaviors. Indeed, disordered eating symptomology has been linked to a wide spectrum of social, psychological, and biological factors, particularly "the psychological concept of personal control" (Watt et al., 2002, p. 2503). Specifically, autonomy represents the ability to make self-directed and informed choices about food consumption. For individuals with less

perceived autonomy, there is an increased risk of engaging in restrictive eating, leading to a loss of control over one's eating habits and feelings of guilt associated with food intake (Teixeira et al., 2012). Understanding the role of autonomy in shaping eating behaviors is vital for evaluating the psychological relationship women may have with food and improving interventions for women with disordered eating.

**The Role of The Primary Maternal Figure**

As discussed above, disordered eating can be partially conceptualized through the lens of SDT. Disordered eating behaviors might also be shaped by the influential role of the primary maternal figure, particularly in terms of her body satisfaction. Perez and colleagues (2016) conducted a social learning experiment wherein mother-daughter dyads were placed in front of a mirror both together and individually to identify verbal statements about their overall body satisfaction. Daughters, who were ages 5-7, witnessed their mothers' responses and later changed their positive or negative body statements to conform with their mother's positive or negative self-talk (Perez et al., 2016). The mother-daughter relationship is crucial in terms of how the mother's self-talk and overall body satisfaction affect the daughter. During early childhood and adolescence, mothers generally spend more time with their children than fathers, underscoring their influence (Nelson-Coffey, 2019, p. 1378). A young woman's perception and verbal responses to her own body are shaped from a young age. Previous research has found that when young girls perceive a lack of autonomy in relation to their choices about food and body image, it may contribute to the internalization of environmental standards, leading to body dissatisfaction and disordered eating patterns (Rodgers et al., 2011). As a result, young women may continue to experience difficulties with disordered eating, low self-esteem, and poor body image as they grow up and separate from their parents.

**Emerging Adulthood**

Although autonomy and maternal influence are impactful for disordered eating among young women, it is not well understood how these factors relate to young women's developmental experiences during emerging adulthood. During this stage of development, it is expected that young people will adjust their social relationships and residential status, usually moving out of their parents' homes to pursue college or work (Arnett, 2000). Over 95% of American teenagers ages 12-17 reside at home with at least one parent while over 98% are unmarried, fewer than 10% have a child, and over 95% attend school. By age 30, new demographic norms have been established: about 75% of 30-year-olds are married, about 75% have become parents, and fewer than 10% are enrolled in school (Arnett, 2000). Emerging adulthood offers a wide spectrum of potential opportunities and directions without the constraints of role obligations traditionally seen in adulthood. In making this transition away from home and gaining more independence, it is important to investigate how the mother-daughter dynamic affects the development of autonomy in every area,

including eating behaviors. As women leave their parents' home or go away to college, there emerges an abrupt new freedom to make autonomous eating choices. It is important for research to consider these developmental changes when working with a population of emerging adult women.

Arnett (2000) also describes emerging adulthood as reflecting a state of "semi-autonomy," stating that "emerging adults do not see themselves as adolescents, but many of them do not see themselves entirely as adults" (p. 471). They take on some responsibilities associated with independent living (e.g., paying rent, doing chores) while depending on others, including their parents, college faculty and staff, or other adults, to help fulfill other needs and complete tasks (e.g., helping with large purchases or key decisions; Arnett, 2000). For example, a new college student might feel a sense of being "in between" childhood and adulthood within the context of eating. This might be due to their new freedom to choose what foods to eat, what quantity and portion size to consume, when to eat, and with whom they eat. College students may experience this "in between" feeling when choosing between restaurant options of varying nutritional content and when grocery shopping; these decisions can be further complicated by the fact that some are still relying on their parents to help fund food purchases. Students may also choose to begin eating on a new schedule based on their class times and new routine at college while still adhering to their parents' habits and routines in other ways. In this transitional phase, their experience of "semi-autonomy" may still be informed by parental beliefs and routines around food, so it is plausible that first-year women will report significantly less autonomy and significantly more disordered eating than second-, third-, and fourth/fifth-year students. Furthermore, it is plausible that from the first year to the fourth/fifth year of college, there may be significant growth in reported autonomy and decreases in disordered eating.

Limited attention has been directed towards understanding the connections between perceived autonomy, maternal influence, and disordered eating behaviors in the population of college women. Investigating these specific factors in an emerging adult sample is imperative for developing more informed, targeted support mechanisms tailored to the unique challenges faced by emerging adult, college-enrolled women who struggle with disordered eating.

**Purpose of the Present Study**

To summarize, we were interested in examining the relationships among autonomy, disordered eating behaviors, and maternal influence, particularly in an emerging adult population experiencing the transition to college and life in college more generally. Previous literature shows that disordered eating relates to autonomy within the context of eating behaviors (Teixeira et al., 2012). Autonomy represents the ability to make self-directed and informed choices about food consumption. Additionally, previous research has indicated the importance of the mother-daughter relationship within the context of body

satisfaction and messaging (Rogers et al., 2011). This study specifically included emerging adult women because of their experience with "semi-autonomy" in making decisions about food.

In the present study, participants completed an online survey assessing autonomy, disordered eating behaviors, and maternal influence. To investigate group differences, we compared first-year to second-, third-, and fourth/fifth-year students on levels of reported autonomy, maternal influence, and disordered eating. We then conducted correlational analyses to examine the relationships between reported autonomy, maternal influence, and disordered eating. In addition, hierarchical regression analyses were conducted to determine the unique contributions of autonomy and maternal influence in predicting disordered eating behaviors. We proposed the following hypotheses:

Hypothesis 1: *When comparing first-year students to second, third, and fourth/fifth year students, first-year students will have a lower level of reported autonomy, more disordered eating, and a more negative maternal influence.*

Hypothesis 2: *Lower levels of reported autonomy will be correlated with higher levels of disordered eating behaviors and more negative maternal influence*.

Hypothesis 3: *Greater negative maternal influence will be correlated with more disordered eating behaviors.*

## METHOD

### Participants

The study sample was comprised of students at a multi-campus state university in the southeastern U.S. who identified as women (cisgender or transgender) or non-binary.[1] Based on a G*Power analysis (Faul et al., 2007), the target sample size was 100 participants. Eligibility criteria included being between the ages of 18-25, having computer access, and consenting to participate in an online survey. Participants reported their gender identity (to confirm eligibility), age, academic year, and racial identity. The age range was

[1]Based on existing research, transgender and non-binary people have similar experiences to cisgender people in the context of eating, and their inclusion in social science research will help promote beneficence for people of all genders (Bronet et al., 2023).

limited to 18-25 to capture the age group defined in the theory of emerging adulthood (Arnett, 2000).

A total of 114 individuals participated in the study. Eight were excluded because they identified as male, two because they exceeded the age limit of 25, and one because they did not complete the survey, resulting in a final sample size of 103 participants. The mean age of participants was 18.96 (*SD* = 1.28). Table 1 shows the demographic characteristics of the participants.

***Table 1. Demographic Characteristics of Participants***

| Demographic Characteristic | *n* | % |
|---|---|---|
| **Gender** | | |
| Female | 99 | 96.1 |
| Non-binary | 4 | 3.9 |
| **Academic year** | | |
| 1st year/Freshman | 73 | 70.9 |
| 2nd year/Sophomore | 17 | 16.5 |
| 3rd year/Junior | 7 | 6.8 |
| 4th or 5th year/Senior | 6 | 5.8 |
| **Race/Ethnicity** | | |
| White/Caucasian | 81 | 78.6 |
| American Indian or Alaskan Native | 3 | 2.9 |
| Asian/Asian American | 4 | 3.9 |
| Hispanic/Latino/a | 10 | 9.7 |
| Bi- or Multi-racial | 2 | 1.9 |
| Other | 1 | 1.0 |

## Measures

### *Physiological Measures*

The Basic Psychological Need Satisfaction Scale (BPNSS) contains 21 self-report questions that assess the participants' perceptions of how much their basic psychological

needs have been satisfied. This scale was developed by Deci and Ryan (2000) based on Self-Determination Theory. Respondents indicated on a scale from 1 (*not true at all*) to 7 (*definitely true*) the extent to which the psychological needs of autonomy (7 items, $\alpha = .69$), relatedness (6 items, $\alpha = .86$), and competence (8 items, $\alpha = .71$) were generally satisfied in their life. Examples of items are, "I feel like I can decide for myself how to live my life" (autonomy), "I really like the people I interact with" (relatedness), and "I often do not feel very capable" (competence, reversed). Although we were primarily interested in the autonomy subscale, we included the complete BPNSS in the self-report survey for exploratory purposes.

### *Eating Disorder Examination Questionnaire (EDE-Q)*

The Eating Disorder Examination Questionnaire (EDE-Q) from Fairburn and Beglin (2008) is a 28-item questionnaire that serves as a self-report version of the Eating Disorder Examination, an investigator-based interview (Fairburn & Cooper, 1993). The measure contains several subscales that target specific concerns related to eating, weight, and shape. The restraint subscale includes questions about rules and restrictions around food and eating. The eating concern subscale includes questions about feelings of worry and guilt surrounding eating behaviors. The shape concern subscale includes questions about physical appearance in relation to eating such as importance of shape and fear of weight gain. The weight concern subscale includes questions about overall perception of weight in terms of importance, preoccupation, and dissatisfaction. The internal reliabilities for the four EDE-Q subscales as assessed in the current study were acceptable; the Cronbach's alphas were .86 (eating concern), .87 (restraint), .87 (weight concern), and .90 (shape concern).

Notably, the EDE-Q has high convergent validity with the more recently developed ED-15 (Accurso & Waller, 2020). The EDE-Q was also found to be highly accurate in discriminating between individuals with and without an eating disorder (Aarrdoom et al., 2012; Mond et al., 2004) and moderately accurate in differentiating individuals with binge eating disorder from those with obesity (Aardoom et al., 2012). The questions focus on eating behaviors in the past four weeks (28 days). A sample item is: "On how many of the past 28 days have you had a strong desire to lose weight?" The last three questions, which ask respondents to provide their weight, height, and information on their menstrual cycle, were not used in this study due to their personal, sensitive nature. All questions were measured using a 7-point frequency scale that included: *no days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days,* and *every day*, with higher scores indicating more severely disordered eating behaviors.

### *Maternal Influence Questionnaire*

A self-report Maternal Influence Questionnaire (see Appendix) was designed and developed by the authors. We created this measure based on our desire to specifically

assess the interplay of maternal influence and body satisfaction, which was not fully captured by existing measures. The measure had an internal reliability of $\alpha = .72$. The questionnaire consisted of 10 questions about perceived maternal influence on daughters' body image, body satisfaction, and eating behaviors. The term "primary maternal figure" was used in parentheses after "my mother" at the beginning of each question for participants who were raised primarily by their grandmother, aunt, stepmother, foster mother, or another female guardian. Participants indicated their level of agreement with each statement on a 4-point Likert scale with a range of 1 (*strongly disagree*) to 4 (*strongly agree*). High scores indicated a stronger, more negative maternal influence. A sample item is: "My mother (or primary maternal figure) makes negative statements about her own body/her appearance several times per week."

One question that focuses on overall similarity between the mother's appearance and daughter's appearance was analyzed separately in the context of the trend in the other responses (i.e., primarily negative or primarily positive). This question states: "Based on my perception or how others have described us, my mother (or primary maternal figure) and I look similar physically." In other words, if a mother is perceived to have a primarily negative body image and the daughter perceives that she and her mother are physically similar, this implies that the daughter may be more likely to have a negative body image. This question aims to investigate the specific aspect of physical resemblance within maternal influence, as it relates to previous literature that emphasizes daughters internalizing their mothers' body image messaging (Rogers et al., 2011).

**Procedure**

This study was approved by an Institutional Review Board. Each participant accessed the online study through the online subject pool database. Each participant clicked on the survey link, read the consent form, and either agreed or refused to provide consent. Consenting participants then completed the demographic questions, BPNSS, EDE-Q, and Maternal Influence Questionnaire. Afterwards, they were taken to a page with a debriefing statement that included information about accessing student mental health resources if needed. Participants who completed the survey received research credit for their classes. Each response was recorded anonymously. Data collection was completed using Qualtrics.

**Data Analysis**

To test the first hypothesis, we conducted independent samples *t*-tests comparing first-year student participants to continuing college students (second, third, and fourth/fifth years) regarding reported autonomy, disordered eating, and maternal influence. Additionally, an independent samples *t*-test was conducted for each of the four subscales (eating concerns, shape concerns, weight concerns, and restraint) to compare the second, third, and fourth/fifth year participants' scores with first-year participants. For the remaining two hypotheses, we used Pearson correlation analyses to examine relationships

among autonomy, maternal influence, and disordered eating. Furthermore, exploratory regression analyses were conducted to investigate whether maternal influence and autonomy predicted disordered eating when accounting for each other.

## RESULTS

### Group Comparisons

#### *Disordered Eating Behaviors*

To test Hypothesis 1, which predicted that first-year students would report lower autonomy, significantly more disordered eating behaviors, and a more negative maternal influence compared to second, third, and fourth/fifth-year students, we conducted an independent samples *t*-test for each of the four EDE-Q subscales, which showed no significant group differences for eating concerns ($t(102) = 0.28$, $p = 0.61$, $d = -0.11$), shape concerns ($t(102) = 0.10$, $p = 0.91$, $d = -0.02$), weight concerns ($t(102) = 0.52$, $p = 0.41$, $d = -0.18$), or restraint ($t(102) = -0.38$, $p = 0.71$, $d = -0.08$). These findings did not support Hypothesis 1, as first-year students did not report significant differences among disordered eating across subscales. Please refer to Figure 1 for a visual comparison of group means on these subscales. Although the EDE-Q subscales were highly correlated, we reported the results for each subscale to permit a more nuanced examination of specific domains of disordered eating behaviors. In subsequent correlational and regression analyses, a composite, global EDE-Q score was utilized for simplicity.

#### *Maternal Influence*

Next, we evaluated participants' perceptions of their mothers' behaviors related to eating, weight, and shape and compared these based on their year in college. An independent samples *t*-test was conducted to determine whether a more negative maternal influence was associated with the first-year student status. Results indicated no significant difference in perceived maternal influence among year in college, $t(102) = 0.11$, $p = 0.83$, $d = -0.05$.

One item from the maternal influence questionnaire stated, "Based on my perception or how others have described us, my mother (or primary maternal figure) and I look similar physically." As described above, this question was considered separately in the context of the participant's overall response pattern. Descriptive analyses provided insight into how participants perceived their physical similarities with their maternal figure in a positive or negative way, depending on the overall positive or negative response pattern. For example, if most responses indicated a negative overall maternal influence, the physical similarity question would be coded as negative. Responses showed that 16.5% of participants strongly disagreed, 34.0% disagreed, 32.0% agreed, and 16.5% strongly

agreed with this question, suggesting that participants across the sample perceived varying levels of similarity with their maternal figures.

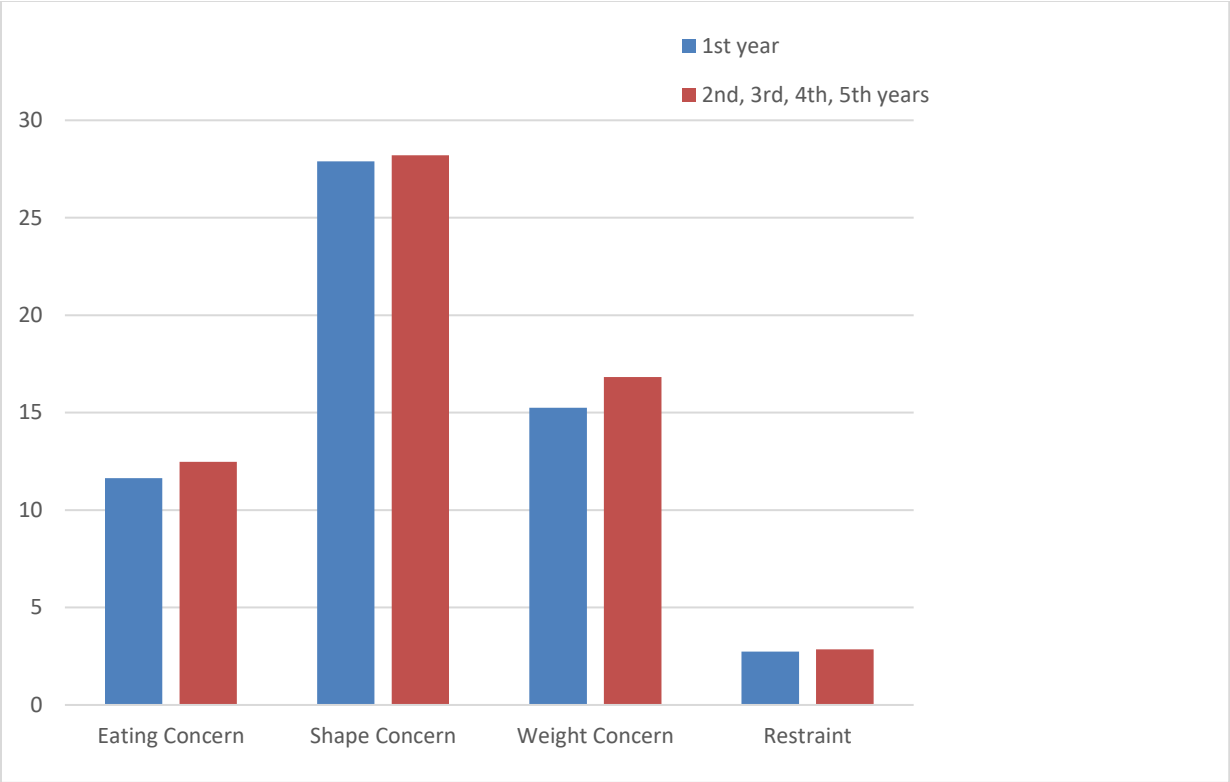


***Figure 1.*** *EDE-Q Disordered Eating Scores in First Year and Continuing College Students*
Note: No significant group differences emerged.

### *Autonomy and Related Variables*

An independent samples *t*-test was conducted to compare perceived autonomy scores between the first-year and second, third, and fourth/fifth-year students. Consistent with the findings described above, results from this test did not support Hypothesis 1, as autonomy scores did not show a significant difference between groups, $t(102) = 1.18$, $p = 0.24$, $d = 0.26$. Exploratory analyses for competence, $t(102) = 0.98$, $p = 0.47$, $d = 0.16$ and relatedness, $t(102) = 0.01$, $p = 0.49$, $d = 0.15$ also yielded nonsignificant findings.

### Correlational Analyses

To test Hypotheses 2 and 3, we conducted correlational analyses to examine the interplay among autonomy, maternal influence, and disordered eating. As Hypothesis 2 predicted, autonomy was negatively correlated with disordered eating and with maternal influence, indicating that participants who reported lower autonomy also reported more disordered eating and a more negative maternal influence. Consistent with Hypothesis 3,

maternal influence was negatively correlated with autonomy and positively correlated with disordered eating, indicating that participants who reported a negative maternal influence also reported lower autonomy and more disordered eating. These findings fully support the hypothesized relationships among the key study variables. Please refer to Table 2 for more detailed correlational findings.

***Table 2. Descriptive Statistics and Correlations for Autonomy, Maternal Influence, and Disordered Eating***

| Variable | *M* | *SD* | 1 | 2 | 3 |
|---|---|---|---|---|---|
| 1. Maternal Influence | 20.73 | 4.51 | — | | |
| 2. EDE-Q | 66.86 | 32.35 | .443** | — | |
| 3. Autonomy | 4.60 | .76 | -.26** | -.24* | — |

Note: *Correlation is significant at the 0.05 level (2-tailed) **Correlation is significant at the 0.01 level (2-tailed)

**Regression Analyses**

A hierarchical linear regression was conducted to further explore whether maternal influence and autonomy predict disordered eating when accounting for each other. When they were both included in the model, autonomy and maternal influence significantly predicted EDE-Q global score, $F(2, 99) = 13.18$, $p < 0.001$, $R^2 = 0.210$), reflecting a significant improvement from the model with only autonomy included ($\Delta R^2 = 0.159$). Maternal influence was a significant predictor of EDE-Q global score ($B = 2.71$, SE = 0.61, $\beta = .413$, $t = 4.46$, $p < .001$), indicating that a more negative maternal influence was associated with increased eating disorder symptoms. This finding supports Hypothesis 3, which posited a significant relationship between a negative overall maternal influence, lower levels of reported autonomy and more disordered eating behaviors. Autonomy initially predicted disordered eating in the first step of the model ($B = –9.02$, $SE = 3.88$, $\beta = –.227$, $t = -2.33$, $p = .022$), but this variance was fully accounted for by maternal influence in the second step ($B = –4.81$, $SE = 3.68$, $\beta = –.121$, $t = -1.31$, $p = .194$). See Table 3 below for more detailed results.

***Table 3. Hierarchical Linear Regression Predicting EDE-Q Global Score***

| Predictor | B | Beta | 95% CI | | *p* |
|---|---|---|---|---|---|
| | | | *LL* | *UL* | |
| (Constant) | 107.87 | | -14.47 | 79.10 | <.001 |
| Autonomy | -4.811 | -.121 | -12.11 | 2.50 | .194 |
| Maternal Influence | 2.713 | .413 | .012 | .023 | <.001 |

Note: $R^2 = .210$, $\Delta R^2 = .159$, $F(2, 99) = 13.18$, $p < .001$.

## DISCUSSION

We evaluated how autonomy, maternal influence, and disordered eating behaviors related to one another in an emerging adult sample of 103 women. Specifically, we analyzed the relationships among autonomy, disordered eating, and maternal influence between two groups (first-year college students and second, third, and fourth/fifth-year college students). We also explored correlational relationships among these three variables. Our findings indicated that women who reported having less autonomy also experienced more negative maternal influence and disordered eating behaviors. Hierarchical regression analyses further indicated that maternal influence accounted for unique variance in disordered eating, even when controlling for autonomy. This emphasizes that, while autonomy is important, maternal influence may play a particularly strong role in predicting disordered eating behaviors among emerging adult women. On the other hand, the findings did not indicate significant differences in scores when comparing first-year students to those with more college experience. This was true for all three variables: autonomy, maternal influence, and disordered eating behaviors. Arnett's (2000) Theory of Emerging Adulthood shaped this study's hypotheses, which suggested that the first year of residential change is a period of "semi-autonomy". However, our results suggest that the phase of "semi-autonomy" persists past the first year of residential change at age 18.

There are several important theoretical and practical implications of these findings. Women who reported having less autonomy also experienced more negative maternal influence, and it is important to consider that they may feel less empowered to make autonomous decisions in everyday life and within the context of eating. This finding suggests that it may be important to specifically address autonomy when working with individuals who wish to improve their overall mother-daughter relationship. The role of autonomy within the mother-daughter relationship is important because it directly impacts

eating decisions. Additionally, the finding that women who reported having a negative maternal influence experienced more disordered eating behaviors supports previous research that shows the significant impact of perceived maternal body satisfaction on young girls (Perez et al., 2018). If the mother maintains an unhealthy relationship with food and a negative body image, the daughter will likely be negatively influenced. The findings also support Self-Determination Theory by showing the importance of autonomy in behavioral decisions (Ryan & Deci, 2000). The women who reported having more control (autonomy) over their eating choices reported fewer disordered eating behaviors. This highlights the vital role of autonomy in cultivating healthy eating behaviors. Now, it is important to further investigate why there were no significant group differences when comparing first-year students to second, third, and fourth/fifth-year students. It is possible that this study could not capture the third and fourth/fifth year students' experiences accurately due to the small proportions they represented in the sample. It might also be due to how significant maternal influences were in the context of body satisfaction for our sample. Maternal influence, as indicated from the study's results, may persist beyond the first year of college.

**Limitations, Implications, and Future Directions**

It is important to consider the current study's limitations, as they may affect the generalizability of the results. First, our sample was limited to students within the psychology subject pool at one southeastern university. Although our use of an online survey permitted us to recruit from a multi-campus community, it still constitutes a convenience sample. The population included in the subject pool is predominantly white and female, and it mostly encompasses first and second year students. Thus, the use of this sample may limit the generalizability of our results to more diverse populations. Second, the maternal influence measure we developed had a slightly lower reliability score than the other measures ($\alpha = .72$). The BPNSS also had a low reliability score for the autonomy subscale that could be considered a limitation, as autonomy was a key factor. Third, there were problems with careless responding as some participants seemed to rush through the survey, failed to follow instructions for some items, and failed to complete the survey in its entirety. Unfortunately, this is a common pattern of behavior among subject pool participants. Furthermore, even though the survey was conducted anonymously, there was some potential for underreporting given that questions about sensitive topics such as disordered eating and body image were included. Lastly, due to the use of a correlational design, causal relationships among the variables could not be fully assessed. While significant relationships were found, future research that uses a longitudinal approach or other methods that could evaluate directionality would be valuable.

Despite these limitations, the study's results suggest that universities should allocate more resources to health and eating education and promote opportunities that allow students to take practical steps in improving their physical and mental wellness. Key

stakeholders in this effort include dining services, residence life, and student counseling services. For example, it is important to educate university staff and resident assistants about eating behaviors (which are relevant to student mental health and overall well-being) and how to recognize signs and symptoms of disordered eating. Counseling offices should also offer support groups for students who struggle with disordered eating, and the broader university community should prioritize learning about healthy eating and providing options that support students' well-being. Our results indicate that some college students may have lower autonomy than expected, and this may not change substantially throughout their time in school. This highlights a critical need for more effective resources to support students' transition from high school through graduation. Initiatives for emerging adult women must meet both the collective and individual needs of each campus's unique population. Resident assistants who are educated about negative parenting styles and the role of independence in eating decisions can help foster a culture in which students feel comfortable openly and safely discussing their experiences.

Further, the correlation between negative maternal influence and disordered eating suggests a need for interventions that involve both parent and student components. For instance, counseling offices could host outreach events or workshops for parents of prospective and new students to support them in navigating the transition to college and fostering their children's autonomy. Additionally, departments such as nursing or psychology could offer community-based training focused on body satisfaction and healthy eating behaviors, providing support for families with children of various ages. Such preventative interventions may help address problematic patterns and behaviors before the college transition even begins.

In the future, there is a need to continue gathering data from diverse populations. This will aid in understanding how varied campus and local cultures may impact eating behaviors, autonomy, and maternal influence. Additionally, future research should augment the information provided by the BPNSS and EDE-Q with questionnaires that address college-specific factors such as perceived autonomy in academic decision-making, campus-based food choices, and residence life. In continuing to develop and improve the Maternal Influence Questionnaire, it would be beneficial to add more questions and consider adding more specific subscales similar to those used in the EDE-Q. For example, it would be helpful to specifically assess perceived autonomy in the family home in relation to meal planning and coordination. Furthermore, future research should explore how autonomy and eating behaviors are shaped by overall family dynamics, cultural narratives around body image messaging, and institutional policies on mental health and wellness in higher education.

Overall, it is vital to promote education and awareness about disordered eating to college women and develop more resources for them on campus and beyond. In addition, college women would benefit from having greater support from their families and the university community as they work on adjusting to new stressors, increasing their

independence, and developing their own identities. The findings from this study should be shared with campus stakeholders to better serve the individual needs of emerging adult women. This study underscores the importance of considering how individual psychological constructs such as autonomy impact and are influenced by relational and institutional systems.

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## APPENDIX

### Maternal Influence Questionnaire

Please indicate your level of agreement with each statement. The term "primary maternal figure" is included in each question for individuals who were raised primarily by their grandmother, aunt, stepmother, foster mother, or other primary female guardian.

The response options: 1 = *strongly disagree*, 2 = *disagree*, 3 = *agree*, or 4 = *strongly agree.*

1) My mother (or primary maternal figure) has high self-esteem.

2) My mother (or primary maternal figure) makes negative statements about her own body/her appearance several times per week.

3) My mother (or primary maternal figure) talks about being concerned with her weight on the scale.

4) My mother (or primary maternal figure) makes negative statements about my appearance several times per week.

5) My mother (or primary maternal figure) makes positive statements about my appearance several times per week.

6) Based on my perception or how others have described us, my mother (or primary maternal figure) and I look similar physically.

7) Throughout my childhood, my mother (or primary maternal figure) would limit the amount of food I could eat during a meal.

8) Throughout my childhood, my mother (or primary maternal figure) would pressure me to finish all the food on my plate, even if I expressed to her that I was full.

9) Throughout my childhood, my mother (or primary maternal figure) would allow me to choose what I ate and drank at a restaurant.

10) My mother (or primary maternal figure) refers to food as "good" or "bad".