



# Does your child's weight influence how you judge yourself as a parent? A cross-sectional study to define and examine parental overvaluation of weight/shape



Janet A. Lydecker\*, Carlos M. Grilo

Department of Psychiatry, Yale School of Medicine, United States

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## ABSTRACT

Parents are integral stakeholders in children's health and development, and yet there is a dearth of research on parental attitudes and parents' personal weight and eating psychopathology, which have the potential to influence pediatric obesity and eating disorder treatments meaningfully. Overvaluation of weight/shape is a core concept in eating-disorder assessment and treatment defined as self-evaluation excessively based on weight/shape, which research has demonstrated to be clinically important psychopathology. A novel and related concept, parental overvaluation of weight/shape, could be defined as parents' self-evaluation unduly based on their child's weight/shape, yet this concept has not been studied and its clinical importance is unknown. The aim of this study was to examine the distinctiveness of parental overvaluation of weight/shape from personal overvaluation of weight/shape, and to examine associations of parental overvaluation with parents' psychopathology and children's weight and eating behaviors. The current study examined differences among parents with ( $n = 134$ ) and without ( $n = 872$ ) parental overvaluation using a cross-sectional design. Parental overvaluation was more common among parents with binge-eating disorder and bulimia than obesity and healthy-weight. Parental overvaluation was modestly associated with personal overvaluation. Parents with and without parental overvaluation differed on personal eating-disorder psychopathology and children's weight and eating behaviors. Importantly, differences remained after adjusting for personal overvaluation and child BMI. This study highlights a novel construct—parental overvaluation—associated with, but distinct from, parental eating disorders and personal overvaluation. Parental overvaluation may warrant clinical attention among parents seeking pediatric obesity or eating-disorder treatment, or treatment for personal eating disorders.

## 1. Introduction

Anorexia nervosa and bulimia nervosa (BN) have diagnostic requirements of significant disturbance in body image. This cognitive body-image criterion can include overvaluation of weight/shape, or self-evaluation excessively based on weight or shape (American Psychiatric Association, 2013). If individuals' self-evaluation is *unduly* influenced by their body weight or shape, this means that among the many potential influences on self-evaluation (e.g., work performance, quality of relationships), weight/shape take priority when individuals judge their self-worth. Although not required for the diagnosis of binge-eating disorder (BED), overvaluation has received empirical support as a severity specifier (Grilo et al., 2009; Grilo et al., 2008; Grilo et al., 2010a; Goldschmidt et al., 2010). Grilo (2013), in his review, summarized the clinical distinction and empirical support for the distinctiveness of overvaluation from the general concept of body

dissatisfaction. While body dissatisfaction is quite common and many individuals experience varying degrees of dissatisfaction with weight or appearance, few define themselves or their self-worth primarily based on their weight/shape (Grilo, 2013).

Overvaluation is measured in interview and questionnaire versions of the Eating Disorder Examination (Fairburn and Beglin, 1994). Earlier work on overvaluation using these instruments has shown similarities between adult patients with BN and BED (Grilo et al., 2009), and distinctions between patients with eating disorders from those with obesity alone (Grilo et al., 2008; Grilo et al., 2010a). Across these studies, a clinically significant level of overvaluation has been consistently related to eating-disorder psychopathology and depressive symptoms. Overvaluation has been consistently *unrelated* to BMI and binge-eating episode frequency (Grilo et al., 2009; Grilo et al., 2008; Grilo et al., 2010a; Goldschmidt et al., 2010). Thus, overvaluation does not merely reflect concern commensurate with excess weight or frequency of binge

\* Corresponding author at: Yale School of Medicine, 301 Cedar Street, New Haven, CT 06519, United States.  
E-mail address: [janet.lydecker@yale.edu](mailto:janet.lydecker@yale.edu) (J.A. Lydecker).

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eating, but is reliably related to the severity of eating-disorder psychopathology and these associations persist even after adjusting for depression (Grilo et al., 2008; Grilo et al., 2010a).

When problems arise that challenge or threaten a valued aspect of identity, this can create significant distress (Simon, 1992). This can be true for patients with psychological disorders, and this can also be true during the course of fulfilling normal developmental roles, including parenting (Simon, 1992). Parents for whom the parent role is particularly central to their identity are vulnerable to feeling distress when this role is strained (Simon, 1992) and those with more mature parental identities tend to have the highest psychosocial functioning (Fadjukoff et al., 2016). The prominent role of overvaluation in eating-disorder psychopathology (which we refer to as “personal overvaluation”), and the salience of the parent role (Simon, 1992), suggest a related question of clinical importance for parents: does their *child's* weight or shape influence how they judge themselves as parents? Parents may feel significant distress if they believe their child's weight/shape reflects poorly on themselves as parents, but this has not been examined empirically. Parents have key roles in the eating attitudes and behaviors of youth [e.g., 10], and parents' feeding practices and attitudes appear associated with their personal attitudes and psychopathology (Saltzman et al., 2016; Agras et al., 1999; Sadeh-Sharvit et al., 2015). Research suggests that some parents over-identify by their child's successes and failures (Fadjukoff et al., 2016). Work concerning parents with eating disorders indicates that some parents have strong concerns about their child's weight/shape (Cimino et al., 2016), even to the point of feeling preoccupied by it (Agras et al., 1999; Sadeh-Sharvit et al., 2015; Fowler and Bulik, 1997). Parents describe having a desire to help their children have a healthy weight and maintain control of their eating, but they also describe feeling unable and unsure how to do so (Palmberg et al., 2014). This incongruence between parenting desire and ability may threaten parental identity, and create distress.

Although related (Gowers and Shore, 2001), parents' personal weight concerns appear to be distinct from their concerns about their children's weight (Lampard et al., 2008). Yet, the extent to which child weight or eating problems impact how parents judge themselves as parents is unknown. Understanding this facet of parental identity can help the development of parent-based interventions in general, and more specifically when interventions target pediatric obesity or eating behaviors. Furthermore, because of the potentially critical yet also potentially burdensome role parents must play in the treatment of pediatric obesity and eating disorders (Golan, 2006; Whitney et al., 2012; National Institute for Health and Care Excellence, 2017) and the understudied association of parental attitudes on risk for the development of pediatric weight/eating disorders, it is important to examine how parents' evaluation of themselves as parents is influenced by their children's weight/shape.

This study explored whether the novel construct of “parental overvaluation” of weight/shape—parents' evaluation of their self-worth as parents unduly influenced by their child's weight/shape—occurs among parents, and the associations of parental overvaluation with constructs known to be related to personal overvaluation. We hypothesized that parental overvaluation would be a distinct construct from personal overvaluation, yet have a similar pattern of associations with eating-disorder psychopathology as has been shown to occur with personal overvaluation.

## 2. Methods

### 2.1. Participants

Participants ( $N = 1007$ ) were parents who responded to an advertisement on Mechanical Turk to complete a single (cross-sectional) online survey about their opinions on weight and eating. Mechanical Turk, a website designed to recruit participants for various tasks including research studies (Buhrmester et al., 2011), is increasingly used

for psychological (Handley et al., 2015) and behavioral-medicine research (Kramer et al., 2017), including research on prevention (Leung et al., 2017; Berry et al., 2017), and parenting (Faria et al., 2017). Participants recruited from Mechanical Turk have greater diversity than college samples, and yield high-quality data with similar reliability and validity of measures as samples recruited using traditional sources (Buhrmester et al., 2011; Hauser and Schwarz, 2016), but is not meant to replace nationally-representative epidemiological samples (Yank et al., 2017). Eligibility criteria for the current study included being from the United States, at least 21 years old and the primary caregiver for a child 5–15 years old. Yale IRB approval was obtained and all participants provided informed consent.

Parents in this study included both fathers ( $n = 346$ ) and mothers ( $n = 658$ ),<sup>1</sup> most of whom were biological parents ( $n = 891$ ). Average parent age was 35.99 years ( $SD = 7.86$ ). Parents had an average BMI of 29.06 kg/m<sup>2</sup> ( $SD = 7.91$ ).<sup>2</sup> Most parents were non-Hispanic White ( $n = 812$ ; 80.6%) and well-educated (college degree or higher,  $n = 472$ , 46.9%, or some college,  $n = 395$ , 39.2%). For *a priori* planned subset of analyses, parents met criteria (see “Creation of study groups” for specific criteria) for BN ( $n = 45$ ), BED ( $n = 63$ ), subthreshold eating disorder (sED;  $n = 530$ ), and no eating disorder with obesity ( $n = 85$ ), overweight ( $n = 97$ ) or healthy-weight ( $n = 183$ ).<sup>3</sup> Parents were instructed to answer all questions about their child while thinking about one particular child. Children were sons ( $n = 497$ ) and daughters ( $n = 497$ ), and were, on average, 10.16 years old ( $SD = 3.02$ ). The average BMI z-score for children, based on CDC growth charts accounting for age and sex, was 0.59 ( $SD = 1.41$ ), or the 66.17th percentile ( $SD = 32.56$ ).

### 2.2. Measures

Parents reported demographic characteristics and health data including their height and weight, and completed established questionnaires. Parents also reported demographic and health characteristics of their children, including parent-reported child age, sex, eating behavior and weight. Self-reported height and weight were used to calculate parent BMI and weight status, and parent-reported child height and weight were used to calculate child BMI z-scores.

#### 2.2.1. Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn and Beglin, 1994)

The EDE-Q assesses eating-disorder psychopathology and eating behaviors in the past 28 days. This study used a brief empirically-supported EDE-Q version (Grilo et al., 2015; Grilo et al., 2010b) for parents to report personal eating-disorder psychopathology. This version has 7 items that comprise three subscales (Restraint [3 items], Overvaluation [2 items], Body Dissatisfaction [2 items]) in addition to behavioral items assessing binge eating and extreme weight control behaviors. The overvaluation subscale was used in ANCOVAs to account for variance explained by personal overvaluation. In this study, items yielded internally consistent scores for brief EDE-Q subscales ( $\alpha = 0.89–0.92$ ).

Parents also completed an adapted “parenting” version (EDE-Q-PV; adapted by changing “you” to “your child”) to assess parents' attitudes about their children's eating and weight, and to capture parent-report of child eating behaviors, including objective binge-eating episodes (OBES; eating objectively large quantities of food within a distinct time while experiencing subjective loss of control). The brief EDE-Q-PV also includes the parental overvaluation items used to create the parental overvaluation group. In this study, items yielded internally consistent

<sup>1</sup>  $n = 3$  participants had missing parent sex data,  $n = 13$  participants had missing child sex data;  $n = 1$  participant had missing brief EDE-Q data;  $n = 20$  participants had missing child height/weight data.

<sup>2</sup> In our sample, 65.0% of parents had overweight/obesity; in the United States, 70.7% of adults have overweight/obesity.

<sup>3</sup>  $n = 4$  participants had missing data that did not allow them to be classified.

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