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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

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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.

Keywords

Binge eating; Body image; Childhood Obesity; Pediatrics; Parents

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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 [1]. 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 [2–5]. Grilo [6], 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 [6].

Overvaluation is measured in interview and questionnaire versions of the Eating Disorder Examination [7]. Earlier work on overvaluation using these instruments has shown similarities between adult patients with BN and BED [2], and distinctions between patients with eating disorders from those with obesity alone [3, 4]. 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 [2–5]. Thus, overvaluation does not merely reflect concern commensurate with excess weight or frequency of binge eating, but is reliably related to the severity of eating-disorder psychopathology and these associations persist even after adjusting for depression [3, 4].

When problems arise that challenge or threaten a valued aspect of identity, this can create significant distress [8]. 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 [8]. Parents for whom the parent role is particularly central to their identity are vulnerable to feeling distress when this role is strained [8] and those with more mature parental identities tend to have the highest psychosocial functioning [9]. The prominent role of overvaluation in eating-disorder psychopathology (which we refer to as “personal overvaluation”), and the salience of the parent role [8], 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 [11–13]. Research suggests that some parents over-identify by their child's successes and failures [9]. Work concerning parents with eating disorders indicates that some parents have strong concerns about their child's weight/shape [14], even to the point of feeling preoccupied by it [12, 13, 15]. 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 [16]. This incongruence between parenting desire and ability may threaten parental identity, and create distress.

Although related [17], parents' personal weight concerns appear to be distinct from their concerns about their children's weight [18]. 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 [10, 19, 20] 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.

Methods

Participants

Participants ($N=1,007$) 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 [21], is an increasingly used for psychological [22] and behavioral-medicine research [23], including research on prevention [24, 25], and parenting [26]. 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 [21, 27], but is not meant to replace nationally-representative epidemiological samples [28]. 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 ($n=658$)¹, 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/m² ($SD=7.91$)². 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

¹ $n=3$ 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

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

($n=97$) or healthy-weight ($n=183$)³. 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 ($SD=32.56$).

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.

Eating Disorder Examination Questionnaire (EDE-Q) [7]—EDE-Q assesses eating-disorder psychopathology and eating behaviors in the past 28 days. This study used a brief empirically-supported EDE-Q version [29, 30] 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 ($\alpha=.89-.92$).

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 scores ($\alpha=.66-.95$).

Patient Health Questionnaire (PHQ) [31]—PHQ is a 9-item measure of depression. Scores range from 0 through 27, with higher scores signifying greater depressive psychopathology. In this study, items yielded an internally consistent total score ($\alpha=.89$).

Questionnaire for Weight and Eating Patterns-Revised (QWEP-R) [32]—QWEP-R, used in *DSM-IV* field trials, assesses eating behaviors (e.g., binge eating, vomiting) and their frequencies that correspond to diagnostic criteria for BED and BN.

Creation of Study Groups

Parental overvaluation—The overvaluation items from the EDE-Q were adapted to refer to parental overvaluation on the EDE-Q-PV: “Over the past 28 days, has your child’s weight influenced how you think about (judge) yourself as a parent?” and “Over the past 28 days,

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

has your child's shape influenced how you think about (judge) yourself as a parent?". These items, as in the original EDE-Q, were scored on a scale from 0 (*Not at all*) through 6 (*Markedly*). Parents who endorsed a score of 4 (*Moderately*) or higher on either the weight or the shape item were included in the "parental overvaluation" group. This corresponds to the criteria used in examinations of personal overvaluation [e.g., 3].

Parental eating disorder—As described elsewhere [33], parent groups were formed using items from the EDE-Q and the QEWP-R. The "parent BED" group criteria required binge-eating at least weekly for three months, no weekly purging, and at least moderate distress. The "parent BN" group criteria required binge-eating at least weekly for three months, purging at least weekly for three months, at least moderate personal overvaluation, and BMI > 18.5 kg/m². The "subthreshold eating disorder" (sED) group had some eating-disorder psychopathology that did not meet criteria for BN or BED as described above. The "no eating disorder" groups had no weekly binge-eating, no weekly purging, BMI > 18.5 kg/m², subclinical distress about binge-eating, and subclinical personal overvaluation of weight and shape. The "no eating disorder" group were divided into obesity (BMI ≥ 30 kg/m²), overweight (BMI 25–30 kg/m²) and healthy-weight (BMI < 25 kg/m²).

Statistical analyses

To explore parental overvaluation, we first examined whether parents endorsed moderate or greater parental overvaluation, and the extent to which parental overvaluation was distinct from personal overvaluation, parental eating disorders, and parental obesity. Next, to extend earlier work on personal overvaluation, multivariate logistic regression analysis compared parents with and without parental overvaluation on demographic and clinical characteristics of themselves. Finally, ANOVAs also compared parents with and without parental overvaluation on child clinical characteristics. Partial η^2 was calculated as an effect size measure; these values represent the proportion of variation in the criterion measures accounted for by group (i.e., parental overvaluation) membership. Parallel ANCOVAs compared parents with and without parental overvaluation after adjusting for (1) child BMI z-score; (2) personal overvaluation; and (3) child age to determine if differences would persist. These ANCOVAs were conducted because child weight status could be expected to potentially influence parents' experience of children's weight and eating problems, because of an expected overlap between personal and parental overvaluation, and because child age was significantly different when demographic characteristics were compared between groups. Normality of variables was examined; two variables that did not have a normal distribution (child overeating episodes and child binge-eating episodes), were transformed using a square-root transformation for ANOVAs/ANCOVAs and correlations of these variables with parental overvaluation were assessed using Kendall's tau-b.

Results

Parental Overvaluation

Of the 1,007 participants, 134 parents reported at least moderate influence of child weight or shape on their judgment of themselves as parents ("parental overvaluation"; 13.3%), and 872 parents reported less than moderate parental overvaluation (86.6%); 1 parent did not

complete the overvaluation items. Table 1 summarizes correlations of clinical characteristics with parental overvaluation. Parental overvaluation was significantly, though only modestly, correlated with personal overvaluation ($r=.185$, $p<.001$). Parental overvaluation was also correlated significantly, yet modestly, with child BMI z -scores ($r=.187$, $p<.001$), and with restraint of the child's diet, dissatisfaction with the child's body shape/weight, and child binge-eating episodes.

Multivariate logistic regression analysis examined the relations of demographic variables with parental overvaluation. When all variables (parent sex, child sex, parent age, child age, parent BMI, child BMI z -score, parent education level, and parent race) were entered into the model, child BMI z -score had the strongest association with whether or not a parent had parental overvaluation, Wald(1)=18.76, $p<.001$, odds ratio (OR)=1.48 (95% CI 1.24–1.76). Parents of heavier children were more likely to have parental overvaluation. Child age was also significant, Wald(1)=14.02, $p<.001$, OR 1.15 (CI 1.07–1.24). Parents of older children were more likely to have parental overvaluation. No other variables reliably distinguished parents with parental overvaluation from parents without parental overvaluation.

Parental overvaluation differed by parent eating-disorder status, $\chi^2(5)=30.99$, $p<.001$, $\Phi=.176$: significantly more parents with BED ($n=16$ of 63; 25.4%) and BN ($n=13$ of 45; 28.9%) endorsed parental overvaluation compared to parents with sED ($n=79$ of 530; 14.9%, $p<.05$). Significantly more parents with BED, BN, and sED endorsed parental overvaluation compared to parents with non-eating-disordered obesity ($n=5$ of 85; 5.9%, $p<.05$), overweight ($n=6$ of 97; 6.2%, $p<.05$) and healthy-weight ($n=15$ of 183; 8.2%, $p<.05$).

Comparisons of Parents with and without Parental Overvaluation

Table 2 summarizes ANOVA results comparing parents with and without parental overvaluation on clinical characteristics. Parents with parental overvaluation did not differ significantly from parents without parental overvaluation on BMI, but reported higher levels of depression and personal eating-disorder psychopathology than parents without parental overvaluation. Children of parents with parental overvaluation were reported to be significantly heavier and have more episodes of both overeating and binge-eating compared with the children of parents without parental overvaluation.

Table 2 also summarizes ANCOVAs, which parallel the initial ANOVAs; these assessed whether the parental overvaluation group findings persisted after adjusting for child BMI z -scores. Findings followed the same pattern of significance as ANOVAs, suggesting parental overvaluation is not merely commensurate with or reflecting child weight-status. Because of the conceptual overlap between personal and parental overvaluation (correlated at $r=.185$), we also calculated ANCOVAs paralleling the initial ANOVAs adjusting for personal overvaluation. As summarized in Table 2, these results followed the same pattern as ANOVA results, except that personal restraint and personal body dissatisfaction were no longer significantly different between parents with and without parental overvaluation after adjusting for personal overvaluation. Finally, because child age was significantly different in demographic analyses, we also calculated ANCOVAs paralleling the initial ANOVAs and adjusting for child age; these results follow the same pattern as ANOVA results (Table 2).

Discussion

This study represents the first examination and initial validation of a novel construct—parental overvaluation—posed by the question for parents: is their judgment of themselves as parents influenced by their child’s weight or shape? Our findings suggest that some parents consider their children’s weight/shape to be at least moderately important in how they judge themselves as parents. Parental overvaluation is associated with parental eating disorders and with personal overvaluation, albeit only modestly. Parents with and without parental overvaluation differed significantly on personal eating-disorder psychopathology, attitudes about child eating and body satisfaction, and child eating behaviors and weight. Importantly, most observed findings associated with parental overvaluation remained significant even after adjusting for child BMI z-score, and even after adjusting for personal overvaluation. Thus, parents’ increased psychopathology and concerns associated with parental overvaluation were not merely reflective of their child’s BMI or their own personal overvaluation.

Our findings that parental overvaluation is related to child eating behaviors and weight, but not parent weight, parallels work on adult patients’ personal overvaluation, in which overvaluation was related to eating-disorder psychopathology and broader distress but unrelated to weight [2–4]. Relations with child eating behaviors and weight highlight the importance of attending to both parents *and* children when treating pediatric obesity and when providing feedback on child weight generally (such as well-child pediatrician visits or school-based obesity prevention programs). Indeed, children of parents with parental overvaluation weighed, on average, within the healthy-weight range. The persistence of differences between parents with and without parental overvaluation after adjusting for child BMI z-score indicates that parents’ judgment of themselves as parents based on their child’s weight/shape may not reflect the child’s actual weight status, but the importance of child weight/shape to parents.

Additionally, the association between parental eating disorders (but not parental obesity) and parental overvaluation suggests that individuals with eating disorders may benefit from addressing parenting and the parent role during their treatment. The association of parental overvaluation with BN and BED, and to a lesser extent with sED, points to the pervasiveness of eating disorders into valued roles, including parenting, and future work should examine whether parental overvaluation impairs the parent-child relationship. Previous research suggests that parents for whom the parent role is highly salient are more vulnerable to threats to that aspect of their identity [8] and associated distress and impairment [8, 9]. Future research on parental overvaluation should explore if salience of the parent role is a mediating factor for eating-disorder psychopathology and child eating behaviors and may also examine whether parents’ weight influences their evaluation of themselves as parents.

Parental overvaluation may be associated with the treatment-seeking behavior of parents, their perceptions of health professionals, their willingness to engage in treatment, or the type of treatment needed. Fear of being blamed by a health care provider may present a barrier to seeking or accessing treatment, such as has been seen with adults who perceive weight bias from their provider [34]. Assessing parental overvaluation may present a clinical opportunity

to tailor the treatment for the family. For example, parents with parental overvaluation may benefit from a parent-focused or family-focused treatment approach, which would allow the clinician to address the home environment, and the parent-child relationship along with the child's eating. As a parallel, we note here that a conceptually similar problem, body dysmorphic disorder by proxy, has the central feature of an individual's preoccupation with aspects of another person's appearance. This phenomenon had distress and impairment at similar levels to body dysmorphic disorder, had negative influence on the object of the preoccupation (e.g., child), but once identified seemed amenable to cognitive-behavioral treatment [35]. Investigation into whether a similar approach could improve the psychosocial well-being of parents and their children when parents have parental overvaluation of weight/shape is a key step. Research on parental overvaluation and response to treatments for pediatric obesity and eating disorders could also help clarify the scope of the clinical utility of this variable. Findings that personal overvaluation is a significant negative predictor of treatment outcomes for various treatments for adults with disordered eating and obesity [36, 37] highlights the need for further research on parental overvaluation, including its prognostic significance.

We note strengths and potential limitations as context for our findings. One potential limitation is the subjectivity of self-report and parent-report, including data for weight, height, and diagnostic criteria. Participants, however, were recruited from the Mechanical Turk online platform, which provides high-quality data from diverse, internally-motivated participants [21], and has been used extensively in research, including psychological [22] and prevention-oriented research [24]. In this study, child eating behaviors and weight were reported by parents, and it is not known whether their responses were influenced by their cognitive experiences such as personal overvaluation. Earlier work found that among adult patients, discrepancies between self-reported and measured weights were unrelated to eating-disorder psychopathology [38], but the relation of parent-reported values with parent psychopathology has not been studied. Alternatively, self-report measures can maintain a sense of privacy and potentially facilitate honest disclosure of sensitive information, including weight-related attitudes and behaviors [7] such as the extent to which parents experience personal or parental overvaluation. Finally, our work had a cross-sectional design, which precludes any speculation regarding causality. Moreover, our sample was predominantly White and did not use a nationally-representative sample; further research with samples with greater racial/ethnic diversity is needed to understand parental overvaluation in other groups and to characterize the prevalence of parental overvaluation. Despite these limitations, the study had notable strengths: inclusion of fathers and mothers with and without eating disorders and obesity, inclusion of parental attitudes and parent-reported child eating and weight behaviors, and use of a community sample (lessening treatment-seeking confounds).

To summarize, our study examined parental overvaluation, a novel construct based in part on the core cognitive element of eating disorders, that is, personal overvaluation of weight/shape. Our findings suggest that some parents consider their children's weight/shape to be of at least moderate importance in how they view themselves as parents. Parental overvaluation appears to be distinct from parental eating disorders and personal overvaluation, but associated significantly with concerns regarding child eating behaviors and weight though

not exclusively child BMI. Our findings suggest that parental overvaluation may warrant clinical attention among parents seeking pediatric obesity and eating disorder treatment, particularly in the context of weight stigma, and among parents seeking personal treatment for their own eating disorders. Further research is needed to replicate and to examine these issues prospectively.

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Highlights

- Overvaluation of weight/shape is self-evaluation excessively based on weight/shape
- Parental overvaluation is self-evaluation unduly based on a child's weight/shape
- Parental overvaluation was more common among parents with eating disorders
- Parental overvaluation was associated with child eating behaviors and weight
- Parental overvaluation is distinct from personal eating disorders and overvaluation

Table 1

Correlations of parent and child variables with the parental overvaluation of weight/shape composite score.

	Parental Overvaluation				
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>r</i>	<i>p</i>
<i>Parent Characteristics and Attitudes</i>					
BMI	29.06	7.91	1003	.063	.045
PHQ	2.49	3.90	996	.222	<.001
EDE-Q Personal Restraint	2.88	2.19	1005	.122	<.001
EDE-Q Personal Body Dissatisfaction	3.62	2.02	1006	.126	<.001
EDE-Q Personal Overvaluation	3.29	2.02	1006	.185	<.001
EDE-Q-PV Child Restraint	0.59	1.13	1006	.521	<.001
EDE-Q-PV Child Body Dissatisfaction	0.78	1.46	1006	.716	<.001
EDE-Q-PV Parental Overvaluation	0.94	1.59	1006	n/a	n/a
<i>Child Characteristics and Behaviors</i>					
BMI z-score	0.59	1.41	986	.187	<.001
OOEs ^a	2.34	6.10	1006	.330 ^a	<.001
OBEs ^a	1.24	4.53	1006	.425 ^a	<.001

Note. BMI=Body Mass Index; PHQ=Patient Health Questionnaire; EDE-Q=brief Eating Disorder Examination Questionnaire; EDE-Q-PV=brief Eating Disorder Examination Questionnaire-Parenting Version; OOE=Objective Overeating Episode; OBE=Objective Binge-Eating Episode. Correlations examined associations with a composite parental overvaluation score (average parent overvaluation by child weight and overvaluation by child shape).

^aKendall's tau-b evaluated the association of OOE's and OBE's with parental overvaluation because they were not normally distributed.

Comparisons of parents with ($n=134$) and without ($n=872$) parental overvaluation of weight/shape.

Table 2

	No Parental Overvaluation				ANOVA			ANCOVA adj. Child BMI z-score			ANCOVA adj. Personal Overvaluation			ANCOVA adj. Child Age		
	M	SD	M	SD	F	p	η^2	F	p	η^2	F	p	η^2	F	p	η^2
Parent Characteristics and Attitudes																
BMI	28.96	7.70	29.75	9.19	1.13	.288	.001	0.18	.670	<.001	0.04	.839	<.001	0.59	.444	.001
PHQ	2.16	3.53	4.53	5.15	45.00	<.001	.043	39.65	<.001	.039	34.00	<.001	.033	42.74	<.001	.041
EDE-Q Personal Restraint	2.78	2.20	3.51	2.00	13.26	<.001	.013	11.82	.001	.012	3.08	.079	.003	12.28	<.001	.012
EDE-Q Personal Body Dissatisfaction	3.56	2.03	4.00	1.91	5.30	.022	.005	4.77	.029	.005	2.41	.121	.002	5.19	.023	.005
EDE-Q Personal Overvaluation	3.18	2.02	4.03	1.85	21.11	<.001	.021	19.54	<.001	.020	n/a	n/a	n/a	22.19	<.001	.022
EDE-Q-PV Child Restraint	0.39	0.88	1.87	1.59	251.02	<.001	.200	214.18	<.001	.179	241.64	<.001	.194	239.53	<.001	.193
EDE-Q-PV Child Body Dissatisfaction	0.44	1.00	3.00	1.96	550.83	<.001	.354	514.31	<.001	.344	540.69	<.001	.350	527.51	<.001	.345
Child Characteristics and Behaviors																
BMI z-score	0.51	1.39	1.12	1.44	22.33	<.001	.022	n/a	n/a	n/a	20.53	<.001	.020	22.42	<.001	.022
OOEs	1.52	3.99	7.62	12.03	149.64	<.001	.130	127.97	<.001	.115	140.86	<.001	.123	137.47	<.001	.121
OBEs	0.53	2.34	5.85	9.71	260.65	<.001	.206	229.47	<.001	.189	245.61	<.001	.197	247.29	<.001	.198

Note. BMI=Body Mass Index; PHQ=Patient Health Questionnaire; EDE-Q=brief Eating Disorder Examination Questionnaire; EDE-Q-PV=brief Eating Disorder Examination Questionnaire-Parenting Version; OOE=Objective Overeating Episode; OBE=Objective Binge-Eating Episode. ANOVAs examined mean differences between parents with and without parental overvaluation; ANCOVAs examined mean differences between parents with and without parental overvaluation after adjusting for child BMI z-score, personal overvaluation, or child age. Conventions for interpretation of effect size are: small $\eta^2 < .09$; medium $\eta^2 = .10-.24$; large $\eta^2 \geq .25$.