



Parent and youth perfectionism and internalizing psychopathology

L. Caitlin Cook, Christopher A. Kearney*

Department of Psychology, University of Nevada, Las Vegas, 4505 Maryland Parkway, Las Vegas, NV 89154-5030, United States

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ABSTRACT

Perfectionism is a multidimensional construct that has only recently received greater attention in parents and their children. Perfectionism is often shared among family members, and one developmental model indicates that anxious parents may help predispose perfectionism in youths. This study examined relationships between parent and youth perfectionism and between parent perfectionism and youth internalizing psychopathology among adolescents aged 11–17 years. Both relationships were examined for mediation by parent internalizing psychopathology. Maternal perfectionism was found related to sons' self-oriented perfectionism and internalizing psychopathology. Maternal self-oriented perfectionism was most closely related to sons' self-oriented perfectionism, but maternal socially prescribed perfectionism was most closely (and inversely) related to sons' internalizing psychopathology. Maternal obsessive compulsive symptoms also mediated the relationship between mothers' and sons' self-oriented perfectionism. Several possible pathways between parent and child perfectionism are discussed, including information transfer, modeling, and excessive control.

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1. Introduction

Perfectionism has been historically conceptualized as a strong need to perform at a flawless level in many aspects of one's life (Flett & Hewitt, 2002). Many components of perfectionism have been investigated in recent years, including excessive concern about making mistakes, doubting one's ability to achieve goals, and order and neatness. Multidimensional conceptualizations of perfectionism have also been proposed and empirically supported, including Hewitt and Flett's (1991) popular model of self-oriented, socially prescribed, and other-oriented perfectionism.

Self-oriented perfectionism refers to harsh self-criticism and placing exacting demands on oneself, so the source and subject of perfectionism are internal. Socially prescribed perfectionism refers to a belief that significant others expect one to be perfect, so the source of perfectionism is external but the subject is internal. Other-oriented perfectionism refers to high expectations for the performance of others, so the source of perfectionism is internal but the subject is external (Flett & Hewitt, 2002). Greater research attention has been paid to self-oriented and socially prescribed perfectionism, especially in youths, so the emphasis here will be on these constructs (McCreary, Joiner, Schmidt, & Ialongo, 2004).

Self-oriented perfectionism in adults has been linked to high expectations for success, well-developed organizational abilities, and strong achievement motivation but also depression, anxiety,

and eating disorders (Flett, Hewitt, & Dyck, 1989; Frost, Heimberg, Holt, Mattia, & Neubauer, 1993; Hewitt & Flett, 1990). Self-oriented perfectionism in children and adolescents has been linked to scholastic effort, intrinsic motivation, and strong desire to meet academic goals. However, such perfectionism has also been closely linked to body dissatisfaction and anorexia and bulimia in youths (Castro et al., 2004; Evans, Bowes, & Drewett, 2008; McVey, Pepler, Davis, Flett, & Abdolell, 2002; Nilsson, Sundbom, & Hagglof, 2008).

Socially prescribed perfectionism carries risks for adults and children as well. Adults high in socially prescribed perfectionism tend to fear negative evaluation, display social anxiety and hopelessness, desire much positive attention from others, procrastinate on tasks, feel overly self-conscious in public, and have Type A personalities (Alden, Ryder, & Mellings, 2002; Chang & Rand, 2000; Flett, Hewitt, Blankstein, & Koledin, 1991). As such, these adults are at risk for panic disorder, social phobia, obsessive compulsive disorder, and other areas of maladjustment (Antony, Purdon, Huta, & Swinson, 1998; Sherry, Hewitt, Flett, & Harvey, 2003). Socially prescribed perfectionism in youths is related to positive aspects such as greater effort in school but also negative aspects such as depression, suicidality, anxiety, low self-esteem, body image dissatisfaction, and dysfunctional eating attitudes (Donaldson, Spirito, & Farnett, 2000; Hewitt & Flett, 2002; Hewitt, Newton, Flett, & Calender, 1997).

Given similar effects of perfectionism on adults and children, researchers have considered transmissive links between the two parties. Earlier theorists proposed that child perfectionism develops from strong desires to derive approval and affection from potentially demanding, controlling, austere, or critical parents. Re-

* Corresponding author. Tel.: +1 702 895 3305; fax: +1 702 895 0195.

E-mail addresses: cook16@unlv.nevada.edu (L.C. Cook), chris.kearney@unlv.edu (C.A. Kearney).

cent evidence supports these claims. For example, Neumeister and Finch (2006) examined high-ability students and found that insecure attachment with parents was closely aligned with authoritarian and uninvolved parenting and child self-oriented or socially prescribed perfectionism. Soenens et al. (2005, 2008) and Soenens, Vansteenkiste, Duriez, and Goossens (2006) also found parental psychological control to be related to elevated maladaptive perfectionism in youth and that both variables could lead to adverse effects on adolescent eating patterns and well-being.

Genetic influences or social learning/modeling may also be key transmission factors given that several researchers have found parent and child perfectionism to be closely linked (Bachner-Melman et al., 2007; Tozzi et al., 2004). Such modeling may involve primary caregivers (mothers) or result from same-sex interactions (e.g., fathers and boys). “Youths” in these studies have generally been adult participants, however (Chang, 2000; Frost, Lahart, & Rosenblate, 1991; Vieth & Trull, 1999).

One area that may link parent and child perfectionism but that has received little direct attention in the literature is parent psychopathology. Flett and Hewitt (2002) proposed an anxious rearing model of perfectionism in that children exposed to parents who continually worry about being perfect or who are generally anxious will become perfectionistic to avoid making mistakes and minimize associated threats. Researchers have found that anxious youths generally have anxious parents, and that parent perfectionism is related to child test anxiety, but little information is available about aspects of child perfectionism and parent psychopathology such as anxiety, depression, or obsessive compulsiveness (Besharat, 2003; Fisak and Grills-Taquechel, 2007).

The purpose of this study was thus to investigate, using standardized measures, two specific hypotheses about perfectionism in adults and youths aged 11–17 years. The first hypothesis was that parent perfectionism would predict youth perfectionism and that this relationship would be mediated by parent psychopathology. The second hypothesis was that parent perfectionism would predict youth psychopathology and that this relationship would be mediated by parent psychopathology. In line with extant literature, hypotheses concentrated on parent and child internalizing psychopathology as well as parent self-oriented and socially prescribed perfectionism and adolescent self-oriented perfectionism.

2. Method

2.1. Participants

Participants were 97 youths aged 11–17 years ($M = 14.3$, $SD = 2.0$) and their parents. Youths were primarily female (54.6%); parents included 89 mothers and 63 fathers. Several families (19.6%) had two children who participated in the study. Most families were dual-parent (57.7%). Family members were primarily European-American (75.9%) but also Hispanic (9.2%), Asian-American (6.0%), multiracial (4.0%), African-American (3.2%), or other (1.6%). Families spoke English as their primary language. Family annual income was largely split between those earning more (53.6%) or less (41.2%) than \$80,000 (no report = 5.2%). Some families included data from a stepparent (5.2%) or adoptive parent (7.2%). Non-biological parents were included only if their children resided with them for at least 50% of the child’s lifespan.

2.2. Child measures

Child-Adolescent Perfectionism Scale (CAPS) (Flett, Hewitt, Boucher, Davidson, & Munro, 1997). The CAPS is a 22-item self-report measure of self-oriented and socially prescribed perfectionism in youths. CAPS items are rated on a 1–5 scale from “false” to “very

true.” Item examples include “I want to be the best at everything I do” and “There are people in my life who expect me to be perfect”. The scale has been extensively used with persons aged 11–18 years in clinical and nonclinical populations (Donaldson et al., 2000; Enns, Cox, & Inayatulla, 2003; Hewitt et al., 1997, 2002; McVey et al., 2002). Internal consistency and test–retest reliability for the self-oriented (.85/.74) and socially prescribed (.81/.66) factors are good (Flett et al., 1997). To limit number of variables and maintain comparability with the extant literature, a focus was made only on adolescent self-oriented perfectionism.

Youth Self-Report (YSR) (Achenbach & Rescorla, 2001). The YSR is a 112-item self-report measure for youths aged 11–18 years. Items surround several broadband internalizing, mixed, and externalizing factors of child behavior problems: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. Items are rated on a 0–2 scale from “not true” to “very true or often true”. Internal consistency (.71–.95) and mean test–retest reliability (.82) for the problem scales are good. To limit number of variables and maintain comparability with the extant literature, a focus was made only on adolescent anxious/depressed, withdrawn/depressed, and total internalizing behaviors. Cronbach’s alpha calculated across the four child dependent measures was .78 ($p < .01$).

2.3. Parent measures

Multidimensional Perfectionism Scale (MPS) (Hewitt & Flett, 1991). The MPS is a 45-item measure in which 15 items are devoted each to three perfectionism subscales: self-oriented, socially prescribed, and other-oriented. Items are rated on a seven-point scale with some reverse scoring. Item examples include “One of my goals is to be perfect in everything I do” and “My family expects me to be perfect”. The subscales have respectively demonstrated good internal consistency (.89/.79/.86) and test–retest reliability (.88/.85/.75). The MPS’s three-factor composition has been supported in clinical and nonclinical populations, and subscale scores correlate significantly with other measures of constructs comprising respective perfectionism dimensions (Hewitt & Flett, 1991). To limit number of variables and maintain comparability with the extant literature, a focus was made only on parent self-oriented and socially prescribed perfectionism.

Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1994). The SCL-90-R is a 90-item measure of nine symptom groups: somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Items are rated on a 0–4 severity scale from “not at all” to “extremely”. Internal consistency (.77–.90) and test–retest reliability (.78–.90) for the subscales are good. The SCL-90-R has converged as expected with scores from the Minnesota Multiphasic Personality Inventory and General Health Questionnaire (Derogatis, 1994; Derogatis & Savitz, 1999; Schmitz, Kruse, Heckrath, Alberti, & Tress, 1999). To limit number of variables and maintain comparability with the extant literature, a focus was made only on parent anxiety, depression, and obsessive compulsive symptoms. Cronbach’s alpha calculated across the five adult dependent measures was .77 ($p < .01$) for mothers and .72 ($p < .01$) for fathers.

2.4. Procedure

Following Institutional Review Board approval, administrators for private schools, religious facilities, after-school activity groups, and community centers were contacted and informed of the nature and purpose of the current study. Permission was secured to provide information to prospective participants about the study; participants were also recruited via referral from previous

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