



How perfectionism and ineffectiveness influence growth of eating disorder risk in young adolescent girls



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ABSTRACT

While perfectionism is widely considered to influence risk for eating disorders, results of longitudinal studies are mixed. The goal of the current study was to investigate a more complex model of how baseline perfectionism (both high personal standards and self-critical evaluative concerns) might influence change in risk status for eating disorders in young adolescent girls, through its influence on ineffectiveness. The study was conducted with 926 girls (mean age of 13 years), and involved three waves of data (baseline, 6- and 12-month follow-up). Latent growth curve modelling, incorporating the average rate at which risk changed over time, the intercept (initial status) of ineffectiveness, and baseline perfectionism, was used to explore longitudinal mediation. Personal standards was not supported as contributing to risk but results indicated that the higher mean scores on ineffectiveness over the three waves mediated the relationship between higher baseline self-critical evaluative concerns and both measures of eating disorder risk. The relationship between concern over mistakes and change in risk was small and negative. These results suggest the usefulness of interventions related to self-criticism and ineffectiveness for decreasing risk for developing an eating disorder in young adolescent girls.

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Systematic reviews suggest that perfectionism is a risk factor for eating disorders (Bardone-Cone et al., 2007; Egan, Wade, & Shafran, 2011; Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Shafran & Mansell, 2001; Stice, 2002). Factor analysis of the most common multidimensional perfectionism measures, the Frost Multidimensional Perfectionism Scale (FMPS; Frost, Marten, Lahart, & Rosenblate, 1990) and the Hewitt and Flett Multidimensional Perfectionism Scale (1991), distinguishes two higher-order factors: high personal standards, or the pursuit of high standards and goals; and self-critical evaluative concerns, involving critical self-evaluations and over-concern of others' expectations when high standards are not met (Bieling, Israeli, & Antony, 2004; Cox, Enns, & Clara, 2002). Both dimensions are considered to be of relevance to eating disorders (Bardone-Cone et al., 2007).

Currently the majority of the evidence for the relationship between perfectionism and disordered eating rests on cross-sectional studies. Correlational studies have demonstrated that individuals with bulimia nervosa (BN) have significantly higher levels of perfectionism than healthy controls (Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2004). Retrospective case control studies have also reported significantly higher rates of childhood perfectionism in both individuals with BN and anorexia nervosa (AN) compared to healthy controls (Fairburn, Cooper, Doll, & Welch, 1999; Fairburn, Welch, Doll, Davies, & O'Connor, 1997). Individuals with AN also have higher levels of childhood perfectionism compared to psychiatric controls (Machado, Gonçalves, Martins, Hoek, & Machado, 2014). Elevated concern over mistakes, a subscale of the FMPS that loads on the self-critical evaluative concerns construct, is associated with retrospectively reported AN and BN but not with other psychiatric disorders (Bulik et al., 2003). Individuals who have recovered from AN continue to evidence significantly higher levels of perfectionism than healthy controls (Bastiani, Rao, Weltzin, & Kaye, 1995; Srinivasagam et al., 1995). Females with a self-

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reported lifetime history of fasting or purging (i.e., self-induced vomiting, or abuse of laxatives or diuretics) exhibit significantly higher levels of perfectionism than healthy controls (Forbush, Heatherton, & Keel, 2007), with fasting mediating the relationship between perfectionism and binge eating.

While some longitudinal studies have found that perfectionism is related to increases in eating disorder symptoms over time (e.g., Boone, Soenens, & Braet, 2011; Mackinnon et al., 2011), other studies have failed to confirm these findings (e.g., Gustafsson, Edlund, Kjellin, & Norring, 2009; Leon, Fulkerson, Perry, Keel, & Klump, 1999; Vohs, Bardone, Joiner, Abramson, & Heatherton, 1999). It has been suggested that more complex multivariate models will be required to properly understand the postulated effect of perfectionism on risk for disordered eating (Bardone-Cone et al., 2007; Stice, 2002). For example, several models involving moderation of perfectionism and growth of disordered eating have received support. Perfectionism has been shown to predict the growth of bulimic symptoms (both binge eating and self-induced vomiting) through a three-way interaction with self-efficacy and weight and shape concern (Bardone-Cone, Abramson, Vohs, Heatherton, & Joiner, 2006). Young women showing the greatest increase in symptoms had higher levels of perfectionism and weight and shape concern accompanied by lower self-efficacy. Replication of this model using self-efficacy has been successful (Bardone-Cone et al., 2008) but attempts to replicate it using self-esteem in the place of self-efficacy have persistently failed (Shaw, Stice, & Springer, 2004; Steele, Corsini, & Wade, 2007; Watson, Steele, Bergin, Fursland, & Wade, 2011). More recently, in a sample of young adolescent girls, body dissatisfaction was found to moderate the effect of perfectionism on changes in importance of weight and shape (Boone, Soenens, & Luyten, 2014). Higher levels of both concern over mistakes and personal standards perfectionism interacted with higher levels of body dissatisfaction at baseline leading to significantly higher levels of importance of shape and weight at 12-month follow-up.

The weak longitudinal relationship between perfectionism and eating disorder risk may also be explained by a suppressor effect, where the addition of a mediator can strengthen the effect of perfectionism on eating disorder outcomes, or increase the overall variance explained in the outcome variable. One such model has previously been tested (Boone et al., 2014) but there was no support for a longitudinal mediational model where body dissatisfaction at 6-month follow-up was postulated to mediate the relationship between baseline perfectionism and over-evaluation of weight and shape at 12-month follow-up. One potentially important mediator of the relationship between perfectionism and disordered eating is suggested by the functional analysis of AN and BN (Slade, 1982). This model describes how perfectionism, allied with life dissatisfaction (e.g., stress and failure experiences), impacts on an increased need to exert control over life situations, including control of nutritional intake. The role of perfectionism and life dissatisfaction in the context of early adolescent developmental challenges had previously been suggested as a pivotal trigger for eating disorders by Hilde Bruch (1974). Several other theoretical models also implicate both high levels of perfectionism and ineffectiveness (low self-efficacy or difficulties with managing life and strong emotion), as being critical to the development of eating disorders (Bardone-Cone et al., 2006; Fairburn, Cooper, & Shafran, 2003; Schmidt & Treasure, 2006). Qualitative research (Serpell, Treasure, Teasdale, & Sullivan, 1999) suggests AN plays a powerful role in tackling a sense of ineffectiveness, making the person feel safe, helping them to communicate distress, and stifling emotions. The most endorsed worries of women with AN do not relate to aspects of eating or weight, but to issues that increase a sense of ineffectiveness: rejection and abandonment, negative perceptions

of self, and experience of negative emotions (Sternheim et al., 2012). Ineffectiveness has previously been shown to predict the growth of importance of weight and shape (Wilksch & Wade, 2010).

When examining mediational relationships with disordered eating in adolescents, who have yet to express behavioural symptoms of an eating disorder, it is more useful to examine risk of developing disordered eating rather than disordered eating *per se*. Two empirically validated constructs of risk exist, both of which are adopted in the current investigation. The first is importance of weight and shape, used previously in studies of adolescents to indicate risk (Boone et al., 2014; Wilksch & Wade, 2010). Importance of shape and weight, which forms part of the diagnostic criteria for both AN and BN, has been described as the “core psychopathology” of eating disorders (Cooper & Fairburn, 1993) and has been found to predict the growth of disordered eating behaviours in young adolescent girls (Wilksch & Wade, 2010). A second “omnibus” construct of risk includes the presence of high levels of weight and shape concern in addition to either a history of depression and/or negative comments from others about eating, weight or shape (Jacobi et al., 2011). Where depression and/or negative comments were present at baseline in addition to weight and shape concern, the development of full or subthreshold eating disorders was significantly increased in college women i.e., 35% compared to 4% where only elevated weight and shape concern was present.

Therefore, the aim of the current study was to longitudinally test the hypothesis that the intercept of ineffectiveness (modelled to allow change over time) mediates the relationship between baseline perfectionism (both high personal standards and self-critical evaluative concerns) and changes in the slope of eating disorder risk status in young adolescents. It was hypothesized that ineffectiveness would mediate the relationship between both types of perfectionism and eating disorder risk, with the latter indicated by both (i) importance of weight and shape, and (ii) higher levels of weight and shape concern, depression and negative comments about weight.

Methods

Participants

All girls who had completed baseline observations as part of participation in a prevention study across three states of Australia were included in the current study ($n = 926$). The girls were from Grades 7 and 8 across 12 schools; ten schools were co-educational, while two were girls-only. The schools were public ($n = 3$); private ($n = 4$) and Catholic ($n = 5$), and were composed typically of Caucasian students. An indicator of socioeconomic status was obtained from the Australian government's Index of Community Socio-Educational Advantage (ICSEA) whereby 1000 represents the mean, with a standard deviation of 100 (ACARA, 2011). The variables used in calculating a value on the ICSEA scale include student-level data on the occupation and education level of parents/carers, and/or socio-economic characteristics of the areas where students live, whether a school is in a metropolitan, regional or remote area, proportion of students from a language background other than English, as well as the proportion of Indigenous students enrolled at the school. The twelve participating schools from the present study had ICSEA ratings between 972 and 1183 with an average of 1104, indicating a slightly above average socio-economic advantage. The mean age of the girls was 13.00 years ($SD = 0.75$), with a mean body mass index (BMI) of 20.43 ($SD = 3.82$) and a mean BMI percentile of 49.51 ($SD = 29.23$). Approval for this research was

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