



“I can’t stop thinking about my child's flaws”: An investigation of parental preoccupation with their children's perceived flaws



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ABSTRACT

Parent-child obsessive-compulsive (OC) symptoms involve obsessive preoccupation on perceived flaws in one's child. Such preoccupation is often accompanied by compulsive behaviors aimed at alleviating the resulting distress. Parent-child OC symptoms can be construed as an additional presentation of Relationship Obsessive Compulsive Disorder (ROCD), a presentation of obsessive compulsive disorder (OCD) in which symptoms are centered on a significant other. In this study, a self-report scale for assessing parent-child ROCD symptoms (the PROCISI-PC) was created on the bases of an existing partner-focused ROCD scale. Confirmatory Factor Analysis conducted on a sample of 350 parents supported a five factor solution of the PROCISI-PC corresponding to five perceived-flaw domains: appearance, intelligence, competence, morality, and sociability-stability. The PROCISI-PC total score was associated with parental OCD and mood symptoms, and with parental stress. Moreover, the PROCISI-PC was associated with greater depression above and beyond the effect of parental OCD symptoms, and with greater parental stress above and beyond the effects of OCD symptoms and depression. Finally, the PROCISI-PC was linked to self-reported disability resulting from obsessive preoccupation of parents on their child's perceived flaws. The results indicate the parent-child OC symptoms may be a prevalent source of unique distress that is especially challenging for parents.

1. Introduction

Many parents consider their children's happiness and success as their main endeavor (Ablard & Parker, 1997). They attempt to increase their children's positive experiences and to prevent their children from enduring hardship and distress. For some parents, such attempts to avoid potential sources of future harm to their children may inadvertently lead to over-identification, preoccupation, and focus on particular attributes of their child that might endanger these goals. For instance, parents may be preoccupied with their child's intelligence, fearing the child would otherwise not be able to achieve economic security in the future. Similarly, parents wanting their child to avoid social exclusion may be over-concerned with the child's appearance or social skills.

In some cases, such common parental concerns may evolve into severe parental preoccupation focused on perceived physical, personality, or behavioral flaws of their children (Doron, Derby & Szepeswol, 2014). Such parental obsessive preoccupations may be understood as an additional form of Relationship Obsessive Compulsive Disorder (ROCD). ROCD is a presentation of obsessive compulsive disorder

(OCD) including obsessive compulsive (OC) symptoms centering on close or intimate relationships (Doron, Derby et al., 2014). In the context of romantic relationships, ROCD symptoms have been shown to be associated with significant disability and interference in personal and dyadic functioning (Doron, Mizrahi, Szepeswol, & Derby, 2014; Doron, Derby, Szepeswol, Nahaloni, & Moulding, 2016).

ROCD symptoms often involves obsessive doubts and preoccupations focusing on perceived physical, social, or personality flaws of the relationship partner (partner-focused symptoms; Doron, Derby, Szepeswol, & Talmor, 2012a). ROCD may also comprise doubts and preoccupations relating to the relationship itself including doubts regarding one's feelings towards the partner, the feel of the relationship (does it feel right), and/or the nature of the feelings of one's partner towards oneself (relationship-centered symptoms; Doron, Derby, Szepeswol, & Talmor, 2012b).

The principles governing the form and influence of ROCD symptoms in the romantic domain have been suggested to generalize to other important relational domains, including the relationship between parents and their children (Doron, Derby et al., 2014). Hence, obsessive preoccupation of parents with their children's flaws may take a similar

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form to obsessive preoccupation of individuals with their romantic partner's flaws, and involve similar distress. Indeed, our clinical experience suggests that individuals showing partner-focused ROCD symptoms in a specific domain (e.g., intelligence) may later demonstrate similar preoccupations towards their children's perceived flaws. In this paper, we investigate ROCD symptoms within the parent-child context. More specifically, we assess links between parental preoccupation with the child's perceived flaws (parent-child ROCD symptoms), negative parental mood, OCD symptoms, and parental distress.

1.1. Cognitive and behavioral characteristics of ROCD

ROCD symptoms may come in the form of thoughts (e.g., "Is she smart enough?"), images (e.g., memory of a specific act) and urges (e.g., to leave one's current partner; Doron, Derby et al., 2014). Such intrusions are generally ego-dystonic, as they contradict individuals' personal values (e.g., "appearance should not be important in selecting a partner") and/or subjective experience of the relationship (e.g., "I know she is not stupid, but I can't stop questioning her intelligence"; Doron & Derby, in press). These intrusions, therefore, are perceived as unacceptable and unwanted, and often bring about feelings of guilt and shame regarding their occurrence and/or content. ROCD symptoms also involve a wide range of compulsions. These compulsions may include repeated comparisons to other potential partners, checking of the partner's behaviors, and reassurance seeking. These compulsions are aimed at alleviating the distress caused by the unwanted intrusion (Doron, Derby et al., 2014).

Within the romantic context, ROCD symptoms have been associated with significant personal and relational consequences (Doron, Mizrahi et al., 2014; Doron et al., 2016). For instance, ROCD symptoms were linked with other OCD symptoms, negative affect, low self-esteem, low relationship satisfaction, attachment insecurities, and impaired sexual functioning (Doron et al., 2012a, 2012b, 2016; Doron, Mizrahi et al., 2014). ROCD symptoms also significantly predicted relationship dissatisfaction and depression over-and-above common OCD symptoms and other mental health and relationship insecurity measures (Doron et al., 2012a, 2012b; Szepeswol, Shahar, & Doron, 2016). In a recent study comparing OCD, ROCD, and community controls, Doron et al. (2016) found similar levels of interference in functioning, distress, resistance attempts and degree of perceived control in both clinical groups.

1.2. Parent-child ROCD symptoms

Parent-child ROCD symptoms may take a similar form to partner-focused ROCD symptoms (Doron et al., 2012a). Namely, parents may experience unwanted thoughts (e.g., "Is my child smart enough?") and images (e.g., memory of a specific instance where the child "failed") pertaining to their child's perceived flaws. These thoughts and images may contradict the parent's own values (e.g., "All children should be accepted no matter their flaws) and/or subjective experience (e.g., "I know my child is doing well in school, but I can't stop questioning his/her intelligence"), thereby causing feelings of guilt and shame. Parent-child ROCD symptoms may also involve compulsions, including repeated comparisons of the child to other children, including siblings, checking of the child's behaviors, and reassurance seeking regarding the child's competencies and perceived flaws.

Parent-child ROCD symptoms focused on children's physical appearance have been previously described in the context of BDD by proxy (Greenberg et al., 2013). For instance, Josephson and Hollander (1997) described a 39 year-old married individual preoccupied with his children's facial and body hair. This individual described frequent, intrusive, anxiety provoking thoughts and urge to check his children's faces and sometimes their bodies. Bakhla, Prakriti, and Kumar (2012) reported a case of a 28-year-old woman diagnosed with BDD that attempted abortion fearing her baby would share her perceived ugliness.

Following her daughter's birth, she sought continuous reassurance and compulsively checked her daughter's perceived facial deformity, reporting significant guilt and distress for passing her own ugliness to her daughter. In fact, most reports are consistent with our clinical experience suggesting parent-child ROCD symptoms may be associated with significant reported parental distress. Thus, preoccupation with one's child alleged faults may be associated with disabling personal distress that interferes with the individual's parenting and with dyadic, social, and occupational functioning. Although similar in some ways to BDD by proxy, parent-child ROCD symptoms refer to obsessional preoccupation with a wider variety of the child's flaws (e.g., intelligence, sociality, morality, etc.).

1.3. The current research

Although parent-child OC symptoms have been observed in clinical settings (Doron, Mizrahi et al., 2014), systematic research has been hampered by the lack of measurement tools. In this study we examined the factor structure of the Partner Related Obsessive Compulsive Symptoms Inventory Parent-Child version (PROCSI-PC), a new measure of parent-child OC symptoms. In addition, we examined the construct and incremental predictive validity of the PROCSI-PC, and its relation to self-reported interference in functioning.

In accordance with common practice in studies of OCD (Abramowitz et al., 2014), the sample used in the present research consisted of non-clinical participants. Similarly to individuals who are clinically diagnosed with OCD, non-clinical participants tend to engage in compulsive behaviors to alleviate distress (e.g., Muris, Merckelbach, & Clavan, 1997). Furthermore, taxometric studies of OCD (e.g., Haslam, Williams, Kyrios, McKay, & Taylor, 2005) have found that OCD symptoms and OC-related beliefs are best conceptualized as continuous dimensional rather than categorical.

This study had four aims. First, we examined the factor structure of the PROCSI-PC using confirmatory factor analysis (CFA). Second, we evaluated the construct validity of the PROCSI-PC by examining its relation with general OCD symptoms (e.g., checking and obsessions), mood (e.g., depression, anxiety, and stress), and parenting stress. Third, we examined the incremental contribution of the PROCSI-PC to the prediction of parenting stress and mood beyond the contribution of more common OCD symptoms and mood. Finally, we investigated self-reported functional disability including time spent, distress and interference with functioning due to parent-child ROCD symptoms.

2. Method

2.1. Participants

The sample consisted of 350 individual American parents from the general population (243 mothers ranging in age from 30 to 63 years, $M = 39.09$; and 107 fathers ranging in age from 30 to 56, $M = 40.79$). In order to facilitate parental reporting, parent-child ROCD symptoms focused on their eldest child (168 daughters and 182 sons ranging in age from 12 to 18, $M = 14.68$). Parents in the sample had an average of 2.36 children. About half of parents had at least a 4-year university degree.

2.2. Materials and procedure

Participants were recruited via *MTurk.com*, an Amazon.com online survey platform. Following the completion of an online informed consent form, participants completed several online questionnaires. The order of the questionnaires was randomized. When answering questionnaires relating to parent-child ROCD symptoms, participants were asked to refer to their first born only. Participants were requested to complete the study in one session and were reimbursed for their time.

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