Personality and Individual Differences 70 (2014) 1–6

Contents lists available at ScienceDirect

Personality and Individual Differences

journal homepage: www.elsevier.com/locate/paid

Parent perfectionism and psychopathology symptoms and child perfectionism

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ARTICLE INFO

Article history:
Received 14 March 2014
Received in revised form 9 June 2014
Accepted 11 June 2014
Available online 30 June 2014

Keywords:
Parent psychopathology
Child
Perfectionism

ABSTRACT

Perfectionism is a multidimensional construct associated with various psychological problems. Studies regarding risk factors for perfectionism are scarce but evidence suggests that parents may be highly involved in their child's perfectionism. The present study included 160 children aged 8–17 years (67 males, 93 females) and their parents. Relationships between parent and child perfectionism and between parent psychopathology and child perfectionism were examined across 5 age groups (8–9 years, 10–11 years, 12–13 years, 14–15 years, 16–17 years). Self-oriented perfectionism was highest among children aged 16–17 years. Maternal perfectionism and maternal psychopathology predicted child self-oriented and socially prescribed perfectionism. Maternal anxiety mediated the relationship between maternal other-oriented perfectionism and socially prescribed perfectionism in children aged 8–12 years. Maternal perfectionism and psychopathology may constitute risk factors for child perfectionism. Findings are discussed in terms of their implications for theories of perfectionism.

1. Introduction

Perfectionism refers to a strong need to perform at a flawless level and to adhere to excessively high standards (Flett & Hewitt, 2002). Perfectionism is generally viewed as a multifaceted construct. Self-oriented perfectionism refers to high standards of achievement for oneself and a desire to attain perfection. Socially prescribed perfectionism refers to the belief that unrealistically high expectations are imposed on oneself by significant others. Other-oriented perfectionism refers to having excessively high standards for others (Hewitt & Flett, 1991).

Perfectionism has also been deemed as adaptive/healthy (e.g., high personal expectations or standards) or maladaptive/unhealthy (e.g., discrepancy between personal expectations and performance self-evaluations) (Rice, Ashby, & Slaney, 2007). Adaptive perfectionism is associated with positive attributes such as conscientiousness, achievement striving, order, self-discipline, organization, life satisfaction, positive affect, and academic success (Hill, Huelsman, & Araujo, 2010). Conversely, maladaptive perfectionism is related to suicidality as well as anxiety, mood, eating, and other psychological disorders in adults and youth (Boone, Soenens, Braet, & Goossens, 2012; DiBartolo & Varner, 2012; Flett, Panico, & Hewitt, 2011; Roxborough et al., 2012). Maladaptive perfectionism also erodes positive treatment outcomes for various disorders (Egan, Wade, & Shafran, 2011). Self-oriented perfectionism in the absence of socially prescribed perfectionism can be adaptive, though socially prescribed perfectionism itself is often maladaptive (Klibert, Langhinrichsen-Rohling, & Saito, 2005).

The study of the development of perfectionism in general is thus important, and several risk factors have been postulated or identified. Key internal risk factors include temperament, genetics, effortful control, and intolerance of uncertainty (Affrunti & Woodruff-Borden, in press). Parents may also have a crucial role in perfectionism development, so methods of transmission, parent psychopathology, and parenting style have also been examined (Hutchinson & Yates, 2008; McArdle & Duda, 2008; Rice, Tucker, & Desmond, 2008). Methods of transmission may include modeling, information transfer, and reinforcement (Fisak & Grills-Taquechel, 2007).

Several investigators have found associations between parent and child self-oriented, socially prescribed, and other-oriented perfectionism (e.g., Appleton, Hall, & Hill, 2010). Flett and Hewitt (2002) described perfectionism as a response to social expectations held by parents and significant others and suggested that anxious childrearing may contribute to perfectionism. These paths are expected to be more ingrained over time, so older children may be more likely to exhibit higher levels of perfectionism. Longitudinal work supports this notion (Stoeber, Otto, & Dalbert, 2009).

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http://dx.doi.org/10.1016/j.paid.2014.06.020
0191-8869/

Researchers have begun to examine family and parent characteristics related to child perfectionism utilizing juvenile samples as opposed to adult retrospective reports. DiPrima, Ashby, Gnilka, and Noble (2011) found that adolescents who were adaptive perfectionists generally perceived their family environment as more positive, cohesive, flexible, and adaptable than adolescents who were maladaptive perfectionists or nonperfectionists. Maladaptive perfectionism was associated more with negative self-worth and less parental nurturance. In addition, Sapieja, Dunn, and Holt (2011) found that authoritative parenting was related more to healthy than unhealthy perfectionism in young adolescent males. Flett, Druckman, Hewitt, and Wekerle (2012) also found that maltreated adolescents displayed depression, socially prescribed perfectionism, and low family support.

Other researchers have focused more specifically on the maternal role regarding child perfectionism. Clark and Coker (2009) found greater dysfunctional perfectionism among children whose mothers modeled heightened self-criticism. Hutchinson and Yates (2008) found higher levels of socially prescribed perfectionism among children whose mothers expressed their goals in a controlling and manipulative manner. Damian, Stoeber, Negru, and Baban (2013) found that adolescents who perceived that their parents had high expectations of them showed increased socially prescribed perfectionism over 7–9 months. Tong and Lam (2011) found that maternal performance goals for their children were associated with child self-oriented perfectionism.

Other researchers have begun to look at more specific parent variables to help explain the relationship with child perfectionism. Mitchell, Broeren, Newall, and Hudson (2013) asked parents to display high or non-perfectionistic rearing behaviors toward their children. Self-oriented perfectionism was significantly higher among clinically anxious children than controls following high perfectionistic rearing behaviors. In addition, Cook and Kearney (2009) found that maternal self-oriented and socially prescribed perfectionism and maternal psychopathology each predicted self-oriented perfectionism among sons. Maternal obsessive compulsive symptoms also mediated the relationship between mothers' and sons' self-oriented perfectionism.

The present study was designed to extend the specificity of these various findings. The first hypothesis was that older children would display higher levels of self-oriented and socially prescribed perfectionism than younger children, thus extending general findings in this area (Stoeber et al., 2009). The second hypothesis was that parent perfectionism and parent depression, anxiety, and obsessive compulsiveness would significantly predict child perfectionism. Depression, anxiety, and obsessive compulsiveness have been implicated but not fully evaluated in previous studies (Affrunti & Woodruff-Borden, in press). The third hypothesis was that parent psychopathology variables would mediate relationships between parent and child perfectionism, thus expanding on previous mediation work (Cook & Kearney, 2009).

2. Method

2.1. Participants

Participants were 160 children and their parents. Child participants were 93 females and 67 males aged 8–17 years (M = 12.29, SD = 2.92). Child participants were aged 8–9 years (n = 35, 21.9%), 10–11 years (n = 35, 21.9%), 12–13 years (n = 30, 18.8%), 14–15 years (n = 30, 18.8%), and 16–17 years (n = 30, 18.8%). Child participants were European American (n = 102; 63.7%), Hispanic American (n = 20; 12.5%), multiracial (n = 19; 11.9%), Asian American (n = 7; 4.4%), African American (n = 5; 3.1%), other (n = 5; 3.1%), or Native American (n = 2; 1.3%).

Parent participants included 112 mothers and 86 fathers. Parents were European American (n = 137; 69.2%), Hispanic American (n = 24; 12.1%), Asian American (n = 11; 5.6%), African American (n = 10; 5.1%), multiracial (n = 9; 4.5%), other (n = 6; 3.0%), or Native American (n = 1; 0.5%). Most families (93.1%) comprised biologically related parents and children. Some families (6.3%) comprised a stepparent and a biological parent. One family (0.6%) comprised 2 parents with an adopted child. Participating parents who were not biologically related to their participating child(ren) were required to have lived with the child for greater than 50% of the child's life.

Child participants came from 116 families. Some families (n = 44, 37.9%) had 2 children who were eligible and who participated in the study. Most families (70.7%) were dual-parent but other families (29.3%) were single-parent or had one parent who was unable to participate. Families reported an annual income of less than $20,000 (1.9%), $20,000–40,000 (5.6%), $40,000–60,000 (14.4%), $60,000–80,000 (14.4%), $80,000–100,000 (15.0%), and greater than $100,000 (32.5%; 16.3% unreported).

2.2. Parent measures

2.2.1. Multidimensional Perfectionism Scale (MPS)

The MPS (Hewitt & Flett, 1991) is a 45-item self-report measure of 3 perfectionism dimensions: self-oriented perfectionism (demanding perfection from oneself), socially prescribed perfectionism (perceiving others as expecting one to be perfect), and other-oriented perfectionism (having perfectionist expectations of others). Each dimension (subscale) was used in the present study. Individuals rate their level of agreement with each item on a 7-point scale, with some reverse scoring. Higher scores indicate greater perfectionism. The MPS takes approximately 15 min to complete and can be administered to persons aged 18+ years. The MPS subscales are internally consistent (coefficient α = .89, .86, and .79 for self-oriented, socially prescribed, and other-oriented perfectionism). Test–retest reliabilities are good for self-oriented (.88), socially prescribed (.75), and other-oriented (.85) perfectionism. Factor analyses indicate that the MPS has 3 factors consistent with its proposed structure (Hewitt & Flett, 1991). Cronbach's alpha for the present study was .70.

2.2.2. Symptom Checklist-90-Revised (SCL-90-R)

The SCL-90-R (Derogatis, 1994) is a 90-item self-report measure of 9 symptom dimensions: somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The obsessive compulsive, depression, and anxiety subscales were used for the present study. Item severity is rated on a scale of 0 (not at all) to 4 (extremely). The SCL-90-R takes 12–15 min to complete and can be administered to persons aged 13+ years. The 9 symptom dimensions are internally consistent among psychiatric outpatients (r = .79–.90) and symptomatic volunteers (r = .77–.90) (Derogatis, 1994). Test–retest reliability of the measure ranged from .78 to .90 over 1-week (Derogatis & Savitz, 1999). Cronbach's alpha for the present study was .94.

2.3. Child measure

2.3.1. Child and Adolescent Perfectionism Scale (CAPS)

The CAPS (Flett, Hewitt, Boucher, Davidson, & Munro, 1997) is a 22-item self-report measure of self-oriented and socially prescribed perfectionism in 7–18-year olds. Both subscales were used in the present study. CAPS items are rated on a 5-point scale with some reverse scoring. Twelve items reflect self-oriented perfectionism and 10 items reflect socially prescribed perfectionism. The CAPS takes approximately 15 min to complete. Internal