Parenting Perfectionism and New Parents’ Mental Health

Thesis

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Abstract

Parenting Perfectionism is the degree to which an individual strives to reach excessively high standards for parenting. I examined how parenting perfectionism may impact new parents’ mental health, as measured by depression, anxiety, and subjective well-being, using two dimensions of parenting perfectionism: self-oriented, or personal standards for perfection, and societal-oriented, or perceptions of societal expectations for perfection. Analysis included data collected from 182 couples during the third trimester of pregnancy, and at 3 months postpartum. I used Structural Equation Modeling (SEM) to determine change in parental mental health (depression, anxiety, and subjective well-being) across the transition to parenthood and to determine if self-oriented and societal-oriented parenting perfectionism were significant predictors of change in mental health. Structural models suggested that mothers’ societal-oriented parenting perfectionism was marginally associated with an increase in anxiety across the transition to parenthood. Also, fathers’ societal-oriented parenting perfectionism was marginally associated with an increase in anxiety, whereas fathers’ self-oriented parenting perfectionism was marginally associated with a decrease in anxiety. All reported findings were marginally significant, however, and when Neuroticism was included as a control all associations became nonsignificant. Thus, Neuroticism emerged as a predictor of the change in fathers’ depression and anxiety across the transition to parenthood.
Dedication

Dedicated to my mentors Dr. Schoppe-Sullivan and Dr. Kamp Dush
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Parenting Perfectionism and New Parents’ Mental Health

The transition to parenthood is a monumental life course transition that influences and shapes family roles; during this time new parents are faced with pressures and expectations held by both themselves and society to be a successful or even “perfect” parent. Because the parental role is thought to be one of the most gratifying and rewarding roles in life (Russell, 1974), increased importance and expectations may be placed on this role. Parenting perfectionism is defined as the degree to which individuals hold excessively high standards for themselves specific to the parenting role (Snell, Overbey, & Brewer, 2005). Subscribing to excessively high standards for parenting may have an impact on the psychological resources of the parent.

The current study aimed to examine the consequences of holding excessively high standards for parenting on new parents’ mental health across the initial transition to parenthood. Because parenting perfectionism is a fairly new construct it is vastly understudied, providing little indication of what implications high standards may have for psychological adjustment to parenthood. Belsky’s (1984) process model of parenting deemed parental psychological functioning, including mental health, as the most important determinant of parenting quality; thus, understanding the cognitive constructs such a parenting perfectionism that may impact parental depression, anxiety, and well-being is important for children as well as for parents themselves.
The New Parents Project is a longitudinal study that examined the experiences of 182 couples undergoing the transition to parenthood from the third trimester of pregnancy through nine months postpartum. Parenting perfectionism was measured during the third trimester prior to the birth of the infant. Parental mental health variables (depression, anxiety, and subjective well-being) were measured during the third trimester, 3, 6, and 9 months postpartum. The design of The New Parents Project allowed for the examination of parenting perfectionism cognitions as predictors of the change in mental health across the transition to parenthood and no prior study has explored how parenting perfectionism is associated with parental mental health during the first few intensive months of being a parent.

The Transition to Parenthood and Mental Health

The transition to parenthood is a common life course transition that presents unique stressors to new parents. Specifically, for first-time parents, adjustment to this role may be especially stressful (Russell, 1974). Common issues experienced during this transition may include: the physical burden of caring for an infant, strain on intimate relationships, and emotional costs (Belsky, 1986). Further documented struggles for parents during the transition to parenthood include a decline in relationship satisfaction for couples (Doss, Rhoades, Stanley, & Markman, 2009), and issues with mental health, most commonly postpartum depression.

Postpartum depression is characterized by a non-psychotic depressive episode that begins in or extends into the postpartum period (Cox, Murray, & Chapman, 1993) and is experienced by approximately 13% of new mothers (O’hara & Swain, 1996). The
repercussions of postpartum depression extend beyond the individual and may present negative outcomes for the cognitive and emotional development of children (Murray, Fiori-Crowley, Hooper, & Cooper, 1996). Depressed mothers interact in a distinct way with their infants either in a controlling over-stimulating style, or a withdrawn and under-stimulating style (Malphurs, Raag, Field, Pickens & Palaez-Nogueras, 1996). Because the first year of an infant’s life is a crucial time when parental sensitivity is necessary for fostering secure attachment styles (Ainsworth, Blehar, Waters, & Wall, 1978), depressed mothers may have more difficulty in providing warmth and security for healthy infant development. Due to the possible adverse outcomes children of depressed mothers may experience, it is important to further determine what predicts parental depression and other mental health issues.

Because depression and anxiety are among the most prevalent mental health issues diagnosed in adults and are considered largely comorbid (Reiger, Rae, Narrow, Kaelber, & Schatzberg, 1998), parental mental health research has focused extensively on how depressed and anxious parents may impact the development of their children (Gerlsma, Emmelkamp, & Arrindell, 1990). Specifically, research suggests stressful life events such as the transition to parenthood were associated with a decline in mental health (Leavy, 1983). One observational study found that mothers with anxiety disorders exhibited less warmth and positivity during interactions with their children than other mothers (Whaley, Pinto, & Sigman, 1999). It has been suggested that approximately 80 percent of infants of highly anxious mothers were classified as having an insecure attachment style when the infant was 18 months old (Manassis, Bradley, Goldberg, Hood,
& Swinson, 1995). Further documenting the association between maternal anxiety and infant attachment, one study of 52 first-time mothers across the transition to parenthood found that high levels of prebirth maternal anxiety and anxiety at 3 months postpartum predicted insecure infant attachment at one year (Del Carmen, Pederson, Huffman, & Bryan, 1993). Research on both maternal depression and anxiety emphasize the importance of parental psychological resources for healthy infant development.

While much of the research on parental mental health and its implications for children’s development has focused primarily on mothers, it is also important to examine fathers due to their increasing involvement with children (Pleck & Masciadrelli, 2004). Fewer studies have specifically examined fathers’ mental health characteristics across the transition to parenthood and the impact that fathers’ have on their newborns in comparison to the large body of research that exists on mothers’ characteristics. However, one study estimated that the rate of paternal depression during the early postpartum period may range from as many as 4.8-13% of men (Matthey, Barnett, Ungerer, & Waters, 2000). Similar to mothers, one study found that the rate of fathers’ depression increased over the first year postpartum (Areias, Kumar, Barros, & Figueiredo, 1996). Suggesting a slightly different trajectory, Matthey et al.’s study of 157 couples across the transition to parenthood, found that fathers’ rates of depression were highest during the prebirth period at 5.3%, after birth, fathers’ rates of depression decreased and gradually increased at each phase with 2.8% at 6 weeks, 3.2% at 4 months, and 4.7% at 12 months postpartum. In regards to anxiety, fathers experienced an increase in personal stress across the initial transition to parenthood (Miller & Sollie, 1980).
Although fewer studies have focused on fathers’ mental health across the transition to parenthood than mothers, it would be beneficial to determine what predicts changes in mental health for fathers, especially during the crucial period following the birth of a child.

Another measure that may be an important indicator of parental mental health is subjective well-being (Pavot & Diener, 1993). Subjective well-being is a more general assessment of life satisfaction. One study found that mothers’ and fathers’ well-being increased across the initial transition to parenthood and decreased again once the baby was 8 months old (Miller & Sollie, 1980). Few studies have utilized a measure of subjective well-being across the transition to parenthood, but rather focus on specific measures such as depression or anxiety. Because the measure of subjective well-being assesses a more general form of satisfaction, it may be a unique indicator of parental mental health.

**Perfectionism, Mental Health, and Parenting**

Belsky’s process model of parenting identified parental psychological resources as the most important determinant of parenting (1984), and one such psychological characteristic of parents that may be important is perfectionism, or the degree to which an individual strives to reach excessively high standards (Hamachek, 1978). Indeed, parents high on perfectionism are characterized as anxious, overprotective, and more harsh with their children (Flett, Hewitt, Oliver, & MacDonald, 2002). Perfectionism has typically been interpreted as negative due to its associations with mood problems and psychopathology (Pacht, 1984). Traditionally the construct was thought to be
unidimensional; however, Hamachek (1978) was among the first researchers to suggest two distinct types of perfectionism: normal/healthy, or a personal desire for excellence, and neurotic/unhealthy, or excessive concerns over mistakes and fear of failure. This monumental study laid the groundwork for future perfectionism research to examine multiple dimensions of this construct because it was the first to suggest a positive element to holding perfectionistic standards. One highly influential conceptualization of perfectionism comes from the work of Hewitt and Flett’s (1991a); they described perfectionism as consisting of three dimensions: self-oriented, societal-oriented, and other-oriented perfectionism. This conceptualization focuses on where perfectionistic standards originate from – in particular, whether standards stem from an internal or external source. Self-oriented perfectionism is defined as the setting of high standards for oneself, related to a perfectionistic motivation, whereas societal-oriented perfectionism is the belief that others hold the individual to exceptionally high standards. Lastly, other-oriented perfectionism is defined as holding unrealistic standards for significant others (Hewitt & Flett, 1991a). Together these three dimensions help conceptualize perfectionism and allow for investigations to determine if certain forms of perfectionism are adaptive or maladaptive.

In fact, a factor analysis of two multidimensional perfectionism scales found that two distinct factors emerged: a factor including organization, personal standards, self-oriented and other-oriented perfectionism, and a second factor including concern over mistakes, doubts about actions, parental expectations, parental criticism, and societal-oriented perfectionism (Stoeber & Otto, 2006). Researchers identified the first factor as
consisting of positive striving, whereas the second factor was identified as tapping maladaptive evaluation concerns. When compared to various measures of well-being the maladaptive evaluation concerns factor was associated with negative affect and depression, whereas the positive striving factor was associated with positive affect. Stoeberr and Otto’s (2006) study provided evidence that perfectionism is multidimensional in nature with both adaptive and maladaptive qualities.

However, the research evidence remains mixed regarding the positive or negative nature of the dimensions of perfectionism, especially with regard to their associations with mental health. Some research has found distinct differences between self-oriented and societal-oriented perfectionism. Consistently, societal-oriented perfectionism has been associated with negative affect (Stoeberr & Otto, 2006). Societal-oriented perfectionism has also been associated with various social interaction measures including the fear of negative evaluation from others, an external locus of control, and the need for approval from others (Hewitt & Flett, 1991b). While consistent evidence indicates that societal-oriented perfectionism is primarily maladaptive, the implications of self-oriented perfectionism are much less clear. One study found self-oriented perfectionism to be associated with a decrease in negative affect over time (Powers, Koestner, & Topciu, 2005), whereas other studies have found it to be associated with depressive symptomology and increased negative affect (Flett, Besser, & Hewitt, 2005).

Literature on perfectionism has found associations between self-oriented and societal-oriented perfectionism and various measures of mental health, especially depression and anxiety. Beck suggested that depression was associated with two distinct
personality styles: sociotrophy, including the desire to please others, and autonomy, an achievement-related construct (1983). This suggests a connection between goal-striving and achievement-related characteristics and depression. In one study of college students, both self-oriented and societal-oriented perfectionism were associated with increased levels of depression (Hewitt & Flett, 1991a). Further, associations between self-oriented and societal-oriented perfectionism have been found in clinical as well as nonclinical populations. In one study of clinically depressed and anxious patients it was found that both groups had higher levels of societal-oriented perfectionism. Also, the depressed patient group had higher levels of self-oriented perfectionism, suggesting that self-oriented perfectionism may play a unique role in depression (Hewitt & Flett, 1991b). Another study sampled college students and found through regression analyses that self-oriented perfectionism and life stress events interact and are associated with an increase in depressive symptoms (Flett, Hewitt, Blankstein, & Mosher, 1995). Findings from this study suggest that perfectionists that encounter a stressful life event may experience a negative impact on their mental health.

Further research has also found connections between self- and societal-oriented perfectionism and anxiety. One study found that both self- and societal-oriented perfectionism were associated with worry prebirth and postbirth for parents (Hewitt & Flett, 2002). Another study used the perfectionism dimension of concern over parenting mistakes and found that this specific perfectionism dimension was associated with anxiety and depression in new parents (Flett, Hewitt, Endler, Puckering, & Berk, 2001). Because the transition to parenthood presents a stressful life event, it is possible that
studying perfectionism at this dynamic time may reveal valuable information on how this construct operates in various contexts.

**Parenting Perfectionism and the Transition to Parenthood**

Although some study perfectionism as a more general construct, consistent across situations, Hewitt and Flett (1991a.) suggested that the construct can be examined in a domain-specific manner. In support of this notion, one study found differences in the levels of perfectionism from respondents in the domains of work and home life (Mitchelson & Burns, 1998). Thus, perfectionism may not be as stable across situations as is often expected. Because perfectionistic strivings may vary depending on the domain or context, it may be beneficial to study perfectionism in specific contexts instead of general perfectionistic tendencies. Of these possible domains, one of the most commonly experienced during the lifecourse is the parental role (Russell, 1974). In order to better understand perfectionism in the parenting domain, Snell and colleagues created the first and only scale specifically intended to measure parenting perfectionism, the Multidimensional Parenting Perfectionism Questionnaire (Snell et al., 2005). Three of the eleven dimensions of this scale (self-oriented, societal-oriented, and other-oriented) were modeled off of the Multidimensional Perfectionism Scale (MPS) (Hewitt & Flett, 1991a.), with items created to reflect perfectionism specific to parenting behaviors and cognitions.

One reason why parenting perfectionism – especially societal-oriented parenting perfectionism – may be particularly damaging to new parents’ mental health is that perfectionists often participate in dichotomous thinking, or interpreting actions as either
complete successes or a complete failures (Egan, Piek, Dyck, & Rees, 2007). Because successes and failures in interpersonal domains such as parenting are not easily and immediately informed, with no direct evidence of a success or a failure, it is possible that these interpretations are especially difficult for perfectionists, and that such individuals are particularly likely to repeatedly interpret parenting experiences as failures without evidence to the contrary.

Moreover, because individuals high on both self-oriented and societal-oriented perfectionism desire more control over situations than nonperfectionists, stressful life events in which control is lost or diminished may be especially problematic (Hewitt & Flett, 1995). Burger (1984) found that individuals with high levels of control motivation were more likely to experience depression following a stressful life event. Also, Hewitt and Dyck found a connection between self-oriented perfectionism and stressful life events, depression, and anxiety (1986). Because of the relation of perfectionism to stressful life events and mental health issues, studies have supported a diathesis-stress model of perfectionism. The diathesis-stress model suggests that perfectionists exposed to stressful life events are especially vulnerable to mental health problems (Hewitt & Flett, 1995). Thus, examining a normative stressful life events that perfectionists are likely to encounter throughout the life course, such as the transition to parenthood, is important for understanding how perfectionism affects individuals’ mental health and responses to stress.

Hypotheses
It was hypothesized that parenting perfectionism would be a significant predictor of a maladaptive change in mental health across the transition to parenthood. Because previous perfectionism research has specifically focused on implications of self-oriented and societal-oriented perfectionism for mental health (Stoeber & Otto, 2000), I examined only the self- and societal-oriented dimensions and excluded the other-oriented dimension. Specifically, it was hypothesized that societal-oriented parenting perfectionism would be associated with an increase in anxiety and depression, and a decrease in subjective well-being across the initial transition to parenthood. Because of the adverse outcomes associated consistently with the dimension of societal-oriented perfectionism documented in the literature (Stoeber & Otto, 2000), it was hypothesized that societal-oriented parenting perfectionism will be a stronger predictor of maladaptive mental health across the transition to parenthood than the self-oriented dimension. Due to the mixed findings in the literature regarding self-oriented perfectionism (Hewitt & Flett, 1991a.; Hewitt & Dyck, 1986; Lee, Schoppe-Sullivan, & Kamp Dush, 2012) no specific hypotheses regarding self-oriented parenting perfectionism were formulated.

Methods

Participants

Data were drawn from The New Parents Project, a longitudinal study of 182 couples who made the transition to parenthood in 2008-2010. The purpose of The New Parents Project was to examine family and child development across the first transition to parenthood. Criteria for inclusion in the study included the following: participants had to be over the age of 18, able to speak English, expecting their first child, married or
cohabiting, and both working outside the home and intending to return to work after the infant was born. Participants were recruited through childbirth education classes, newspaper ads, movie ads, and snowball sampling in a large Midwestern city.

Demographic analyses suggested that the most common self-reported races of mothers included: 88% white, 6% African American, 2% Asian, 3% some other race. For fathers, the most common self-reported races included: 85% white, 6% African American, 2% Asian, and 2% some other race. Eighty-six percent of the sample identified as married. Mothers on average were highly educated and included 75% with a bachelor’s degree or higher. Sixty-five percent of fathers reported having a bachelor’s degree or higher. The median household income for these dual earner couples was $81,000 a year.

**Procedure**

Data collection occurred at four phases: the third trimester of pregnancy, 3, 6, and 9 months postpartum. In the third trimester, 3, and 9 months postpartum participants completed questionnaire data and research assistants staffed two-hour in-home visits to collect interview and observational data. At 6 months postpartum, in order to reduce stress for the new parents, participants completed only the questionnaire data and a telephone interview. Due to lower participation rates at 6 and 9 months postpartum, the current study only utilized the first two phases. Also, studies suggest the most drastic change in parental mental health may occur across the initial transition to parenthood (O’hara & Swain, 1996); thus I examined how parents’ mental health changed from prebirth to 3 months postbirth.
Measures

During the third trimester, mothers and fathers completed questionnaires including a 12-item shortened version of the Multidimensional Parenting Perfectionism Questionnaire (Snell et al., 2005), a measure closely related to general perfectionism questionnaires but modified to assess perfectionism in the context of parenting. The responses were measured on a 5-point Likert scale (1= not at all characteristic of me and 5= very characteristic of me) and included two 4-item dimensions that were the focus of this study: self-oriented parenting perfectionism (i.e., “I set very high standards for myself as a parent”; $\alpha_m=.81$, $\alpha_f=.74$) and societal-oriented parenting perfectionism (i.e., “Only if I am a ‘perfect’ parent will society consider me to be a good parent”; $\alpha_m=.82$, $\alpha_f=.69$). Participants also completed the 60-item NEO- Five Factor Inventory (Costa & McCrae, 1992) which included 12-items that assessed Neuroticism on a 5-point Likert scale (1=strongly disagree and 5=strongly agree; i.e., “I worry about things”; $\alpha_m=.88$, $\alpha_f=.85$).

In the third trimester of pregnancy and at 3 and 9 months postpartum mothers and fathers completed measures to assess their mental health. For depression, participants completed the 5-item ($\alpha_m=.61$, $\alpha_m^2=.74$, $\alpha_f^1=.57$, $\alpha_f^2=.47$) Brief CES-D (Bonomi et al., 2008; Radloff, 1977) which uses a 4-point Likert scale (0= rarely or none of the time (<1 day) and 3= most or all of the time (5-7days)) to assess symptoms of depression (i.e., “In the past week I felt depressed”). To measure anxiety participants completed the 6-item ($\alpha_m=.83$, $\alpha_m^2=.85$, $\alpha_f^1=.78$, $\alpha_f^2=.84$) Brief STAI (Marteau & Bekker, 1992) which used a 4-point Likert scale (1=not at all and 4=very much) to assess anxiety.
symptoms (i.e., “Right now at this moment I am tense”). Participants also completed the 5-item ($\alpha_{m1} = .84, \alpha_{m2} = .84, \alpha_{f1} = .79, \alpha_{f2} = .83$) Satisfaction with Life Scale (Pavot & Diener, 1993) that assessed subjective well-being using a 7-point Likert scale (1 = strongly disagree and 7 = strongly agree) (i.e., “In most ways my life is close to ideal”).

Results

Preliminary Analyses

Descriptive statistics (see Table 2) suggested that on average mothers scored slightly higher on societal-oriented parenting perfectionism than fathers ($M_m = 9.68, SD_m = 3.60; M_f = 9.09, SD_f = 2.98$); conversely, on average fathers scored higher than mothers on self-oriented parenting perfectionism ($M_m = 12.87, SD_m = 3.43; M_f = 13.47, SD_f = 3.32$). The difference in self-oriented perfectionism was statistically significant (see Lee et al., 2012). There were no significant differences between mothers’ and fathers’ reports of depression and anxiety. However, mothers’ and fathers’ reports of depression decreased significantly across the transition to parenthood ($t(170) = -.63, p < .01$). For subjective well-being, mothers reported higher well-being than fathers during the third trimester ($M_m = 28.89, SD_m = 5.13; M_f = 25.86, SD_f = 6.43; t(167) = 5.26, p < .01$), as well as at 3 months postpartum ($M_m = 28.45, SD_m = 5.29; M_f = 26.86, SD_f = 5.57; t(170) = 3.10, p < .01$). Whereas mothers’ subjective well-being did not change across the transition, fathers’ subjective well-being increased ($t(159) = -2.21, p < .01$). While there was a range in the variability of mothers’ and fathers’ reports of parenting perfectionism dimensions and mental health measures, the distributions for some mental health
variables were highly skewed. For example, the distributions of depression during the third trimester were highly skewed ($M_{\text{skew}} = 1.70, F_{\text{skew}} = 1.40$).

Correlations among variables (see Table 1) suggested some associations between societal-oriented parenting perfectionism and the measures of mental health; however, no associations existed between self-oriented parenting perfectionism and depression, anxiety, and subjective well-being. Specifically, mothers’ societal-oriented parenting perfectionism was positively correlated with depression during the third trimester, and anxiety both pre- and post-birth. Neuroticism was positively correlated with self- and societal-oriented parenting perfectionism for mothers and with societal-oriented parenting perfectionism for fathers. Also, Neuroticism was highly correlated with depression and anxiety, and lower levels of subjective well-being for both mothers and fathers. Depression, anxiety, and subjective well-being were all highly correlated with each other for both parents.

Structural equation modeling in AMOS 19.0 was utilized to create measurement models in order to confirm that scale items were accurate indicators of the constructs studied and these models were tested for fit to the data. Preliminary analysis included six measurement models: mother’s depression, anxiety, and subjective well-being at both time points (3rd trimester, and 9 months postpartum), and father’s depression, anxiety, and subjective well-being at each respective time point. The measurement models also included the independent variables: self- and societal-oriented parenting perfectionism. Model fit was assessed using several indices (Bollen & Curran, 2006): the chi-square test, the root-mean-square error of approximation (RMSEA; values < .08 are acceptable), and
the Comparative Fit Index (values ≥ .90 are acceptable). Full information maximum likelihood (FIML) estimation was used to estimate parameters without replacing missing data by using all available information from each case (Schafer, 1997).

The measurement models for mothers’ and fathers’ depression were not admissible because the covariance matrices were not positive definite according to AMOS output. This can happen when the data are highly skewed. Inspection of descriptive statistics for maternal and paternal depression revealed that data from the depression inventory were highly skewed for both mothers and fathers. Because data were not normally distributed, no measurement model could be created. However, summing across the depression items for mothers and fathers resulted in less skewed variables. Thus, I used summary depression scores as observed variables in structural models (see below).

Although the chi-square test was significant, according to other fit indices, the measurement model for mothers’ anxiety had an adequate fit: $\chi^2(124) = 222.347, p < .01$, RMSEA = .066, CFI = .933. All factor loadings were statistically significant at $p < .01$ and ranged from .463-.850, except one item ("I feel upset") was found to have a low factor loading and was dropped at all time points. The measurement model for fathers’ anxiety also showed adequate fit even though the chi-square test was significant, $\chi^2(124) = 232.007, p < .01$, RMSEA = .069, CFI = .903. All factor loadings were significant at $p < .01$ and ranged from .371-.907, except one item had a low factor loading ("I am worried") and was dropped at all time points.
The chi-square for the measurement model for mothers’ subjective well-being was significant, $\chi^2(124) = 213.690$ at $p < .01$, but the other fit indices indicated adequate model fit: RMSEA = .063, CFI = .952. All factor loadings were significant at $p < .01$ and ranged from .463-.895. Also, the chi-square for the measurement model for fathers’ subjective well-being was significant: $\chi^2(124)= 218.946$ at $p < .01$. But, the RMSEA (.065) and CFI (.934) indicated adequate fit. Factor loadings were all statistically significant and ranged from .373 -.866.

**Structural Models**

Next, structural models were created in AMOS 19.0 that included self-and societal-oriented parenting perfectionism during the third trimester as predictors of the change in mental health from prebirth to three months postpartum. All covariances between independent variables for each individual were estimated. Because the literature on perfectionism indicated a correlation between Neuroticism and perfectionism, I then conducted structural models including the control variable of Neuroticism to determine if the parenting perfectionism dimensions held connections with the change in mental health above and beyond the influence of Neuroticism.

Due to the difficulty of constructing a measurement model for depression, I created a structural model using summary scores as observed variables. The model for mothers’ depression without controlling for Neuroticism was significant $\chi^2 (31) = 87.163$ at $p < .01$, but other indices suggested marginally adequate fit: RMSEA = .100 and CFI = .922 (see Figure 1). Next, I calculated the model including Neuroticism as a control variable and found that the model fit adequately, $\chi^2 (226) = 409.26$ at $p < .01$, RMSEA =
.067 and CFI = .908. No significant paths were found in either model; thus, mothers’ self- and societal-oriented parenting perfectionism and Neuroticism were not significant predictors of the change in mothers’ depression across the transition to parenthood. However, both models suggested that mothers’ depression was stable across time.

The structural model for fathers’ depression was conducted the same way as mothers’, using summary scores as observed variables. The model for fathers’ depression without controlling for Neuroticism was significant \( \chi^2 (31) = 79.922 \) at \( p < .01 \) and did not fit the data adequately (see Figure 2). No significant paths emerged, however, depression was stable over time. Next, the model controlling for fathers’ Neuroticism suggested a marginally adequate fit: \( \chi^2 (37) = 89.359 \) at \( p < .01 \), RMSEA = .088 and CFI = .899. In this model, depression was stable across time and fathers’ Neuroticism emerged as a significant predictor of the change in mental health for fathers across the transition to parenthood \( (\beta = .378, p < .01) \). Specifically, fathers high on the trait of Neuroticism experienced a significant increase in depression from the third trimester to 3 months postpartum.

The structural model for mothers’ anxiety was significant, \( \chi^2 (124) = 222.347 \) at \( p < .01 \), but other indices suggested adequate fit: RMSEA = .066 and CFI = .933 (see Figure 3). In this model, societal-oriented parenting perfectionism was a marginally significant predictor of the change in mothers’ anxiety from the third trimester to 3 months postpartum. Specifically, mothers’ high on societal-oriented parenting perfectionism experienced an increase in anxiety across the transition to parenthood. Also, mothers’ anxiety was stable across time. Next, I computed the model that included
Neuroticism as a control variable and found that when Neuroticism was included, societal-oriented parenting perfectionism was no longer a marginally significant predictor of mothers’ change in anxiety. The model including Neuroticism had an adequate fit: $\chi^2 (138) = 261.670$ at $p < .01$, RMSEA = .070 and CFI = .920.

The structural model for fathers’ anxiety was significant, $\chi^2 (124) = 232.007$ at $p < .01$, but other indices suggested adequate fit: RMSEA = .069 and CFI = .903 (see Figure 4). Fathers’ societal-oriented parenting perfectionism emerged as a marginally significant predictor of change in anxiety so that fathers that scored high on societal-oriented parenting perfectionism experienced an increase in anxiety across the transition. Self-oriented parenting perfectionism also emerged as a marginally significant predictor of the change in fathers’ anxiety. Specifically, fathers that scored high on self-oriented parenting perfectionism experienced a decrease in anxiety from the third trimester to 3 months postpartum. The model that controlled for fathers’ Neuroticism fit adequately: $\chi^2 (138) = 261.176$ at $p < .01$, RMSEA = .070 and CFI = .897. In this model the marginal associations between parenting perfectionism and change in anxiety became nonsignificant; however, Neuroticism was a strong predictor of change in fathers’ anxiety ($\beta = .368$, $p < .01$). Specifically, fathers’ that scored high on Neuroticism experienced more anxiety across the transition to parenthood.

The structural model for mothers’ subjective well-being was significant, $\chi^2 (124) = 213.690$ at $p < .01$, but other indices suggested adequate fit: RMSEA = .063 and CFI = .952 (see Figure 5). No significant associations emerged between parenting perfectionism and mothers’ change in subjective well-being; however, subjective well-being was stable
over time. The model that included Neuroticism as a control variable fit adequately $\chi^2 (138) = 239.486$ at $p < .01$, RMSEA = .064 and CFI = .947; however, no significant associations were found. The structural model for fathers’ subjective well-being suggested an adequate fit: $\chi^2 (124) = 218.946$ at $p < .01$, RMSEA = .065 and CFI = .934. No significant associations emerged; however, subjective well-being was stable over time. When fathers’ Neuroticism was added into the model the model fit adequately: $\chi^2 (138) = 248.746$ at $p < .01$, RMSEA = .067 and CFI = .926; however, no new associations emerged.

**Discussion**

Results from this study indicate that parenting perfectionism had no significant associations with change in parental mental health across the transition to parenthood, especially when controlling for Neuroticism. Although there were significant mean changes in parental mental health across the transition to parenthood, only few marginal associations emerged. Correlations between variables suggested that there may be some association between societal-oriented parenting perfectionism and mental health for mothers. While the parenting perfectionism dimensions appeared marginally significant predictors in the change in mothers’ and fathers’ anxiety, these findings became nonsignificant once the personality trait of Neuroticism was included in the SEM models. Because Neuroticism was highly correlated with societal- and self-oriented parenting perfectionism for both mothers and fathers, as well as with all three indicators of mental health, there were no unique effects of parenting perfectionism on change in parental mental health beyond Neuroticism. Thus, parenting perfectionism was determined to
have no significant associations with change in parental mental health across the transition to parenthood for mothers or fathers.

While the current study revealed no robust associations between parenting perfectionism cognitions and change in new parents’ mental health, the study contained various strengths. First, no prior study had used Snell’s Multidimensional Parenting Perfectionism Questionnaire to specifically examine associations between parenting perfectionism and mental health. Prior to this examination, little was known regarding perfectionism in the social context of parenting and especially for parental mental health. Also, this study measured a range of variables reflecting mental health rather than one specific measure, possibly capturing a more accurate experience for first-time parents. Because mental health may be measured in a multitude of ways, the measures of depression, anxiety, and well-being were used despite comorbidity (Reiger et al., 1998) and possible overlap between variables. Another strength of the study was the longitudinal design. Because data were collected both pre- and post-birth it was possible to examine the initial transition to parenthood in which the most dramatic transition into parenthood occurred. Also, the measurement of parenting perfectionism occurred prior to the birth of the infant, thus capturing parents’ expectations for perfection. This method permitted the examination of holding excessively high standards for parenting and the possible mental health issues that may or may not accompany perfectionism specific to the parenting role. Because no associations between parenting perfectionism and mental health were found, it is possible that parenting perfectionists were able to cope with their
excessively high standards in a positive way (Van Yperen & Hagedoorn, 2008); thus having no significant impact on their mental health.

Although this study provided further understanding of what may or may not impact new parents’ mental health, various limitations were present. One possible limitation of this study was the difficulty in accurately measuring mental health, specifically for fathers. Men may experience different symptoms of depression than those described in general depression inventories or may have poorer recall of depressive symptoms (Wilhelm & Parker, 1994), thereby underreporting the occurrence and severity of depression. Due to this measurement issue, it was difficult to capture exactly how common or severe depression was for men with the shortened measure of depression I used. It is possible that using other measures that capture male symptoms of depression may help researchers understand how men cope with mental health issues. Another problem with the measure of depression was that there was low variability in the sample. Because the sample appeared especially high functioning, with few self-reports of poor mental health, it was difficult to create adequate models to further examine how parenting perfectionism related to mental health.

Even though findings from Lee et al., suggested that societal- and self-oriented parenting perfectionism dimensions were related to parental cognitions including: parenting self-efficacy, parenting stress, and parenting satisfaction (2012), it is possible that these dimensions relate more to parenting cognitions than general mental health. It could be that mental health is more strongly associated with longstanding individual characteristics such as personality rather than standards held specifically for the domain.
of parenting. Specifically, trait Neuroticism emerged as a highly significant predictor of an increase in anxiety and depression for fathers, and an increase in anxiety for mothers. While parenting perfectionism failed to be an important factor in parental mental health, Neuroticism - a related construct, was identified as a predictor in the change in mental health for parents. Because the personality trait Neuroticism was shown to be important for what Belsky deemed the most important determinant of parenting (1984), mental health, it may be beneficial to continue studying related constructs that may also impact parental mental health.

Due to the noted difficulties in measuring mental health, especially for fathers, future studies should utilize multiple measures in order to capture depressive symptoms and better represent mental health. Also, the current sample consisted mostly of white, highly educated, high income, married couples; future studies should examine a more generalizable sample that better represents the population of new parents. While the high functioning nature of the sample provided a range of parenting perfectionists, the sample provided little variability in parental mental health. Investigations of populations that have more diversity in mental health would be beneficial to study. Also, because the sample consisted of primarily married couples, examination of cohabiting couples is warranted due to the increase in nonmarital childbearing in the United States, with roughly half of births occurring to unmarried parents (Bumpass & Lu, 2000).

Because studies have consistently suggested the importance of parental mental state in child development (Whaley, Pinto, & Sigman, 1999), determining which parental characteristics impact mental health may help target interventions for new parents.
making the difficult transition to parenthood. Even though no negative mental health implications were found for parenting perfectionists, perhaps holding excessively high standards for parenting impacts parents in a different way. Further investigations of parenting perfectionism and the potential benefits or drawbacks for both parents and children are recommended.
References


Figure 1. *Structural model of mothers’ depression*

Third Trimester

- Societal-oriented perfectionism
- Self-oriented perfectionism

3 Months

- Depression

\[
\chi^2 (31) = 87.163 \\
\text{RMSEA} = .100 \\
\text{CFI} = .922
\]

**p < .05, *p < .01, +p < .10**
Figure 2. *Structural model of fathers' depression*

Societal-oriented perfectionism → Depression
Self-oriented perfectionism → Depression

-third trimester-

Societal-oriented perfectionism
Self-oriented perfectionism

-third trimester-

Depression

-3 months-

χ² (31) = 79.922
RMSEA = .093
CFI = .886

** ** p < .05, * p < .01, + p < .10
Figure 3. Structural model of mothers’ anxiety

Third Trimester

Societal-oriented perfectionism

Self-oriented perfectionism

Anxiety

3 Months

\[ \chi^2 (124) = 222.347 \]
\[ \text{RMSEA}= .066 \]
\[ \text{CFI}= .933 \]

** \[ p < .05 \], * \[ p < .01 \], + \[ p < .10 \]

** \[ p < .05 \], * \[ p < .01 \], + \[ p < .10 \]
Figure 4. *Structural model of fathers’ anxiety*

**Third Trimester**

- Societal-oriented perfectionism

**3 Months**

- Self-oriented perfectionism

\[ \chi^2 (124) = 232.007 \]
\[ \text{RMSEA} = .069 \]
\[ \text{CFI} = .903 \]

- Anxiety

**Paths and Significance**

- \( .58^+ \)
- \( -.62^+ \)
- \( .27^* \)

**Significance Levels**

\( ** p < .05, * p < .01, ^+ p < .10 \)
Figure 5. *Structural model of mothers’ subjective well-being*

Third Trimester

Societal-oriented perfectionism

Self-oriented perfectionism

Well-being

Three Months

Well-being

\[ \chi^2 (124) = 213.690 \]

RMSEA = .063

CFI = .952

** p < .05, * p < .01, + p < .10
Figure 6. Structural model of fathers’ subjective well-being

Third Trimester

Societal-oriented perfectionism

Self-oriented perfectionism

Well-being

Three Months

Well-being

$\chi^2 (124)= 218.946$
RMSEA= .065
CFI= .934

** $p < .05$, * $p < .01$, + $p < .10$
Table 1. *Descriptive Statistics*

<table>
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<th>Max</th>
<th>M</th>
<th>SD</th>
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<td>169</td>
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Table 2. Correlations

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<th></th>
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<tr>
<td>1.</td>
<td>.062</td>
<td>.205**</td>
<td>.148*</td>
<td>.539**</td>
<td>.450**</td>
<td>.492**</td>
<td>.375**</td>
<td>-.335**</td>
</tr>
<tr>
<td>2. Societal-oriented parenting perfectionism</td>
<td>.201*</td>
<td>.176*</td>
<td>.736**</td>
<td>.166*</td>
<td>.145+</td>
<td>.156*</td>
<td>.229**</td>
<td>-.051</td>
</tr>
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<td>.065</td>
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<td>.140</td>
<td>.075</td>
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<td>4. Depression 1</td>
<td>.510**</td>
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<td>.071</td>
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<td>.064</td>
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<td>.172*</td>
<td>.308**</td>
<td>.536**</td>
<td>-.344**</td>
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<tr>
<td>6. Anxiety 1</td>
<td>.500**</td>
<td>.085</td>
<td>.116</td>
<td>.243**</td>
<td>.382**</td>
<td>.137</td>
<td>.400**</td>
<td>-.278**</td>
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<tr>
<td>7. Anxiety 2</td>
<td>.476**</td>
<td>.106</td>
<td>-.065</td>
<td>.243**</td>
<td>.433**</td>
<td>.363**</td>
<td>.180*</td>
<td>-.191*</td>
</tr>
<tr>
<td>8. Subjective Well-being 1</td>
<td>-.359**</td>
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<td>-.136</td>
<td>-.260**</td>
<td>-.303**</td>
<td>-.198*</td>
<td>-.146+</td>
<td>.242**</td>
</tr>
<tr>
<td>9. Subjective Well-being 2</td>
<td>-.261**</td>
<td>-.039</td>
<td>-.006</td>
<td>-.209**</td>
<td>-.425**</td>
<td>-.184*</td>
<td>-.299**</td>
<td>.506**</td>
</tr>
</tbody>
</table>

Note: Highlighted correlations show the intersection of mothers’ and fathers’ reports. Correlations above the highlighted numbers represent mothers and correlations below the highlighted numbers represent fathers. Also, 1=third trimester and 2=three months post partum. ** $p < .05$, * $p < .01$
Appendix

*Listed below are several statements that concern the topic of parenting. Please read each item carefully and decide to what extent it is characteristic of you. Although you are not yet a parent, answer in terms of what you think your responses would most likely be after your child is born. Then, for each statement circle the response that indicates how much it applies to you:*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all characteristic of me</th>
<th>Somewhat Characteristic of me</th>
<th>Very Characteristic of me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I set very high standards for myself as a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Only if I am a “perfect” parent will society consider me to be a good parent</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I expect my partner to always be a top-notch and competent parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I must always be a successful parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. My partner should never let me down when it comes to being a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. One of my goals is to be a “perfect” parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Most people expect me to always be an excellent parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I always pressure myself to be the best parent in the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
9. In order for people to accept me, I have to be the greatest parent in the world.

10. I will appreciate my partner, but only if she/he is a perfect parent.

11. Most people expect me to be perfectionistic when it comes to being a parent.

12. I expect my partner to try to be perfectionistic when it comes to parenting behavior.
### NEO-FFI

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am not a worrier</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I often feel inferior to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. When I’m under a great deal of stress sometimes I feel like I’m going to pieces</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I rarely feel lonely or blue</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I often feel tense or jittery</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Sometimes I feel completely worthless</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I rarely feel fearful or anxious</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I often get angry at the way people treat me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Too often, when things go wrong, I get discouraged and feel like giving up</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>10. I am seldom sad or depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I often feel helpless and want someone else to solve my problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. At times I have been so ashamed I just want to hide</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

42
Please circle the number that most closely resembles the way you feel. Be open and honest in your responses.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Neither agree or disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
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</thead>
<tbody>
<tr>
<td>1. In most ways my life is close to my ideal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. The conditions of my life are excellent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. I am satisfied with my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. So far I have gotten the important things I want in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. If I could live my life over, I would change almost nothing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

**In the past WEEK:**

<table>
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<th></th>
<th>Rarely or none of the time (&lt; 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or a moderate amount of the time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
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<tr>
<td>6. I felt depressed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. I had crying spells.</td>
<td></td>
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<tr>
<td>8. I felt hopeful about the future.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. I was happy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I felt that people disliked me.</td>
<td></td>
<td></td>
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</table>

**Right now, at this MOMENT:**

<table>
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<th></th>
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<th>Somewhat</th>
<th>Moderately</th>
<th>Very Much</th>
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<tr>
<td>11. I feel calm.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I am tense.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I feel upset.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I feel content.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I am worried.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>