Dimensions of Perfectionism in Unipolar Depression

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We tested the hypothesis that self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism are related differentially to unipolar depression. The Multidimensional Perfectionism Scale was administered along with measures of depression and anxiety to 22 depressed patients, 22 matched normal control subjects, and 13 anxiety patients. It was found that the depressed patients had higher levels of self-oriented perfectionism than did either the psychiatric or normal control subjects. In addition, depressed patients and anxious patients reported higher levels of socially prescribed perfectionism than did the normal control subjects. The results suggest that various dimensions of perfectionism may play an important role in clinical depression.

Recently there has been renewed interest in personality factors related to depression (see Carson, 1989). Perfectionism is a construct that has been described as a potential vulnerability factor in depression by both psychoanalytic (Bibring, 1953) and cognitive theorists (Beck, 1967; Kanfer & Hagerman, 1981). For example, Kanfer and Hagerman contended that excessive self-standards serve to increase the frequency and magnitude of failure experiences. Perfectionistic self-standards and attendant failure experiences combine with self-blame or distress to produce depression.

Investigations have confirmed the presence of an association between perfectionism and subclinical depression (Hewitt & Dyck, 1986; Hewitt & Flett, 1990); however, these studies are limited in several respects. For example, there have been no direct examinations of perfectionism in clinically depressed patients, so it is not known whether past findings generalize to the experience of clinical depression. The need for direct research is further indicated by the equivocal findings of previous studies that have examined clinical depression and certain components of the perfectionism construct, including high self-standards and discrepancies between the actual and ideal self (Carver, LaVoie, Kuhl, & Ganellen, 1988; Ganellen, 1988; Strauman, 1989).

Finally, most previous research has been limited by a tendency to view the perfectionism construct from a unidimensional perspective (Hewitt, 1989). Recent studies have shown that the perfectionism construct is multidimensional and has both personal and social aspects (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, in press). For instance, factor analyses of our Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1989, in press) have identified three components of perfectionism: Self-Oriented, Other-Oriented, and Socially Prescribed Perfectionism. According to Hewitt and Flett (in press), self-oriented perfectionism is an intrapersonal dimension characterized by a strong motivation to be perfect, setting and striving for unrealistic self-standards, focusing on flaws, and generalization of self-standards. Self-oriented perfectionism may also involve a well-articulated ideal self-schema (see Hewitt & Genest, 1990). Other-oriented perfectionism involves similar behaviors, but these behaviors are directed toward others instead of toward the self. Finally, socially prescribed perfectionism entails the belief that others have perfectionistic expectations and motives for oneself.

The need for a multidimensional approach is indicated by research with college students that has shown that both self-oriented and socially prescribed perfectionism are correlated positively with subclinical depression (Flett, Hewitt, Blankstein, & O'Brien, in press; Hewitt & Flett, in press). These findings notwithstanding, it remains to be established whether the various perfectionism dimensions are involved in clinical depression. Thus, the primary goal of this study was to use a multidimensional perspective to examine whether clinically depressed persons are characterized by high levels of perfectionism.

Although our main purpose was to examine perfectionism and clinical depression, we felt it was also important to examine perfectionism and other forms of psychopathology, such as anxiety disorders. A link with anxiety is suggested by past research that has shown an association between self-oriented perfectionistic attitudes and trait anxiety in college students (Flett, Hewitt, & Dyck, 1989). An association between socially prescribed perfectionism and anxiety is particularly likely given that a fear of negative social evaluation is an important element of both constructs (Endler & Okada, 1975), as well as the fact...
that the discrepancy between the actual self and the ought self has been related to greater anxiety (Higgins, Bond, Klein, & Strauman, 1986; Strauman, 1989). Consequently, a second goal of this study was to determine if differences in perfectionism were specific to depression or generalize to anxiety. This was addressed by comparing perfectionism levels in depressed patients, anxious patients, and normal control subjects.

Method

Subjects

The depressed group consisted of 22 patients (6 men and 16 women) admitted to an acute-care psychiatric unit. These patients were interviewed by a psychiatrist and were diagnosed as having unipolar depression on the basis of criteria from the Diagnostic and Statistical Manual of Mental Disorders (rev. 3rd ed.; DSM-III-R; American Psychiatric Association, 1987). Each patient also had a probable or definite diagnosis of major depression on the basis of Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978) and Beck Depression Inventory scores (BDI; Beck, Rush, Shaw, & Emery, 1979) greater than 9. Patients were excluded from the depressed group if they had a concurrent anxiety disorder. The depressed patients had a mean age of 35.64 years (SD = 11.38), mean years of education of 11.27 (SD = 2.39), and mean number of previous admissions of 0.35 (SD = 0.59).

In addition, 13 patients (4 men and 9 women) diagnosed with an anxiety disorder on the basis of DSM-III-R (American Psychiatric Association, 1987) criteria (4 simple phobia, 4 generalized anxiety, 3 obsessive–compulsive, and 2 panic disorder) were recruited from the acute unit. Their mean age was 32.15 years (SD = 9.42), mean years of education, 11.54 (SD = 1.13), and mean number of previous admissions, 0.08 (SD = 0.28). Patients with a concurrent diagnosis of depression were excluded.

Finally, 22 normal control subjects (6 men and 16 women) were matched on age and gender with the depressed group. Subjects were excluded if they had BDI scores above 8 or if they had had any psychological treatment in the previous 2 years. Their mean age was 36.68 years (SD = 12.36), and they had a mean of 14.23 (SD = 1.60) years of education.

Materials

Multidimensional Perfectionism Scale. The MPS (Hewitt & Flett, 1989, in press) has three subscales of 15 items each. Respondents make 7-point ratings (1 = strongly disagree to 7 = strongly agree) of statements that reflect Self-Oriented Perfectionism (e.g., One of my goals is to be perfect in everything I do), Other-Oriented Perfectionism (e.g., I have high expectations for the people who are important to me), and Socially Prescribed Perfectionism (e.g., My family expects me to be perfect). Coefficient alphas were reported as .88 for Self-Oriented, .74 for Other-Oriented, and .81 for Socially Prescribed Perfectionism (Hewitt & Flett, in press), and test–retest reliabilities over 3 months in 39 patients were .75, .65, and .78 for these subscales, respectively. Intercorrelations of the subscales range between .25 and .40 for students and between .28 and .53 for patients. Additional evidence indicates that the MPS subscales have adequate concurrent validity in clinical samples (Hewitt & Flett, in press; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1990).

Beck Depression Inventory. The BDI is a 21-item scale designed to measure the severity of depressive symptomatology (Beck et al., 1979). Several studies have demonstrated its reliability and validity (Beck, Steer, & Garbin, 1988).

Endler Multidimensional Anxiety Scales—State (EMAS–S; Endler, Edwards, Vitelli, & Parker, 1989). The EMAS–S is a 20-item self-report measure of the autonomic-emotional and cognitive-worry components of state anxiety. Extensive validity and reliability evidence has been provided by Endler et al. (1989).

Procedure

Depressed and anxious patients with a minimum Grade 8 education and no history of mania, psychosis, organic impairment, or alcohol abuse were asked to volunteer in a study of personality factors and depression. Patients were interviewed by Paul L. Hewitt to confirm the DSM-III-R diagnoses from the Research Diagnostic Criteria (Spitzer et al., 1978) and to assess inclusion and exclusion criteria. Initially, three potential subjects, two with diagnoses of depression and one of anxiety, chose not to participate in the study. The normal control subjects were recruited from hospital staff and the community and were selected initially on the basis of matches with the depressed patients. These subjects were interviewed to assess inclusion and exclusion criteria. Questionnaires were administered in a random order and all subjects were paid $20 Canadian for their participation.

Results

Initially, several one-way analyses of variance were done to compare groups on age and education. The three groups did not differ on age, F(2, 54) = 0.67, ns, but did differ on education, F(2, 54) = 15.74, p < .001. The normal control subjects had had more education than had either the depressed or anxious patients. The patient groups did not differ from one another. All of the analyses herein used education level as a covariate.

The means and standard deviations of the measures are presented in Table 1. An analysis of covariance with BDI scores as the dependent variable was conducted to compare depression scores among the groups. This analysis was significant, F(2, 53) = 30.73, p < .001, and multiple comparisons showed that depressed patients had higher BDI scores than did either the anxiety patients or the normal control subjects. In addition, the anxiety patients had higher BDI scores than did the normal control subjects. Anxiety levels were also compared among the groups in a one-way analysis of covariance. This analysis was significant, F(2, 53) = 17.88, p < .001, wherein both the depressed and anxious patients had higher EMAS–S scores than did the normal control subjects but did not differ from one another.

Group differences on the perfectionism dimensions were examined by conducting a multivariate analysis of covariance with group status as the independent variable and the MPS subscale scores as the dependent variables. The multivariate effect of group status was significant, F(6, 104) = 3.28, p < .01. Univariate tests indicated that the three groups differed on Self-Oriented Perfectionism, F(2, 53) = 3.87, p < .05, and on Socially Prescribed Perfectionism, F(2, 53) = 7.04, p < .001, but not on Other-Oriented Perfectionism, F(2, 53) = 0.01, ns. Multiple comparisons revealed that depressed patients had higher mean levels of Self-Oriented Perfectionism than did the other two groups, but the anxiety patients and normal control subjects did not differ from one another. Finally, depressed and anxious patients had higher levels of Socially Prescribed Perfectionism than did the normal control subjects. The depressed and anxious patients did not differ from one another on Socially Prescribed Perfectionism.
Means and Standard Deviations of Depression, Anxiety, and Perfectionism Measures for Depressed, Anxious, and Control Subjects

| Measure | Depressed | | | | Anxious | | | | Control | | | | Total | | |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| M      | SD        | M         | SD        | M         | SD        | M         | SD        | M         | SD        | M         | SD        | M         | SD        |
| BDI     | 25.32     | 9.59      | 18.76     | 11.18     | 2.96      | 0.63      | 15.12     | 12.98     |           |           |           |           |           |
| EMAS-S  | 54.09     | 18.03     | 50.39     | 16.19     | 22.05     | 2.42      | 40.87     | 20.23     |           |           |           |           |           |
| MPS     |           |           |           |           |           |           |           |           |           |           |           |           |           |
| Self    | 76.05     | 17.46     | 64.39     | 15.61     | 63.50     | 15.70     | 68.54     | 17.17     |           |           |           |           |           |
| Other   | 52.00     | 15.81     | 52.31     | 13.60     | 55.46     | 11.55     | 53.40     | 13.64     |           |           |           |           |           |
| Social  | 60.50     | 20.10     | 58.39     | 13.11     | 42.64     | 12.68     | 53.12     | 17.88     |           |           |           |           |           |

Note. The data are based on the responses of 22 depressed patients, 13 anxious patients, and 22 control subjects. Higher scores reflect greater depression, anxiety, and perfectionism. BDI = Beck Depression Inventory; EMAS-S = Endler Multidimensional Anxiety Scales-State; MPS = Multidimensional Perfectionism Scale; Self = Self-Oriented Perfectionism; Other = Other-Oriented Perfectionism; and Social = Socially Prescribed Perfectionism.

Table 2 presents the correlations among the measures collapsed across groups. It can be seen that both Self-Oriented and Socially Prescribed Perfectionism were associated significantly with depression and anxiety. Regression analyses were conducted to provide further information with regard to the unique contribution of the MPS dimensions to depression and anxiety. In this set of analyses, after anxiety scores were first entered, Self-Oriented Perfectionism contributed a significant amount of variance in depression scores (multiple $R = .82$, $R^2_{change} = .03$, $p < .05$). Similarly, again after anxiety scores were entered, Socially Prescribed Perfectionism contributed additional variance (multiple $R = .83$, $R^2_{change} = .04$, $p < .05$). Other-Oriented Perfectionism did not contribute significant unique variance. The analyses to predict anxiety found that none of the MPS subscales contributed significant variance after depression had been entered into the equation.

Discussion

The purpose of this study was to use a multidimensional approach to assess whether levels of perfectionism in clinically depressed patients differ from levels of perfectionism in clinically anxious and normal control subjects. The results showed that the depressed patients were differentiated from the other subjects by a higher level of self-oriented perfectionism. Thus, our results suggest that higher levels of self-oriented perfectionism may be specific to clinical depression and do not generalize to clinical anxiety.

Self-oriented perfectionism ought to be related to depression for several reasons. Self-oriented perfectionists' tendencies to set unrealistic standards and stringently evaluate their own performance increases not only the frequency of failure (Kanfer & Hagerman, 1981) but also the personal impact and meaning of failure experiences. Because self-oriented perfectionists tend to equate self-worth with performance (Pacht, 1984), falling short of self-imposed standards on a consistent basis may promote chronic deficits in self-esteem and self-evaluation. This suggests that these persons may generate their own failures and stressors, which make them particularly prone to depressive episodes.

Consistent with expectations, additional findings revealed that both the depressed and anxious patients had higher levels of socially prescribed perfectionism than did the normal control subjects. These data indicate that socially prescribed perfectionism is a feature of depression, but it is not necessarily specific to depression. This corroborates previous results with college students that indicated that socially prescribed perfectionism is related to several types of maladjustment (Hewitt & Flett, in press). It is also consistent with claims that a neurotic form of anxious depression exists and stems in part from perceived deprivation and lack of gratification from significant others (see Gersh & Fowles, 1979; Kiloh & Garside, 1963).

The analyses further revealed that other-oriented perfectionism was not related to depression in this study. Although this dimension was not associated with depression or with anxiety, other-oriented perfectionism has been shown to correlate with...
measures of antisocial, histrionic, and narcissistic personality disorders (see Hewitt & Flett, in press).

Certain limitations of the current study must be noted. First, no attempt was made to examine factors that may mediate the association between perfectionism and depression. Future research needs to examine possible mediating factors such as life stress (Hewitt & Dyck, 1986), self-critical attributional style, self-focused attention, and maladaptive coping styles (Flett et al., in press). A consideration of these factors will be in keeping with self-regulation models (e.g., Kanfer & Hagerman, 1981), which maintain that the manner in which perfectionists interpret and cope with failure is an important determinant of their experience of depression.

Second, it is apparent that our findings are based on self-report data and ought to be replicated with behavioral measures. Third, our results do not address causality or vulnerability issues. Although the findings indicated that perfectionism is associated with clinical depression and anxiety during the depressive or anxious episode, it remains for future research to establish whether the perfectionism dimensions are involved in susceptibility to these adjustment problems. Finally, it is essential that future research determines whether the various dimensions of perfectionism account for unique variance in depression over and above the variance accounted for by other personality factors involved in depression.

In summary, this study compared levels of perfectionism in depressed and anxious patients and normal control subjects. Depressed patients were differentiated from the other two groups by higher levels of self-oriented perfectionism. In addition, both depressed and anxious patients were characterized by elevated levels of socially prescribed perfectionism. These findings support the usefulness of further research of the role of perfectionism in clinical depression.

References


