

# Depression and Perfectionism

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## Abstract

**Objectives:** This review article examined the relationship between types of perfectionism, and whether perfectionism is associated with attachment, maladaptive tendencies, and depression. Three dimensions of perfectionism are described: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. **Results:** The quality of parent – child relations has been implicated as a precursor to the development of perfectionism. Parents of maladaptive perfectionists have been characterized as being critical and demanding with unreasonably high standards and expectations of their children. Conversely, parents of adaptive perfectionists have been characterized as having high standards, but also being supportive and encouraging. Attachment predicted type of perfectionism, with adaptive perfectionists having more secure attachments than maladaptive perfectionists. **Conclusions:** In order to limit the development of perfectionism in children, it is crucial for parents to be appropriately responsive to their infant’s needs. Should depression develop, it may be in the best interest of the individual to seek a tailored therapeutic intervention targeting specific underlying personality vulnerabilities.

## Introduction

Depression is a common and growing problem in many modern societies. Depression, which is more than passing sadness or grief, is an illness that affects the body as well as the mind. It may cause an individual to feel sad, anxious, irritable, hopeless, helpless, shameful, excessively fatigued, and even suicidal (National Institute of Mental Health [NIMH], 2007). It is estimated that in a one year period, 9.5 percent of the population, or about 20.9 million American adults suffer from a depressive illness (NIMH, 2007). Recently, researchers have been extensively exploring key psychological processes that may be involved in the vulnerability to, and development of, depressive symptoms. One such process has involved people’s perfectionistic standards and strivings (Hewitt & Flett, 1991a). Perfectionism, which is described as “striving for flawlessness,” has generally been associated with a number of negative outcomes as well as severe psychopathologies (Flett & Hewitt, 2002). Specifically, perfectionism has been shown to be a significant vulnerability factor in the development of depression (Adler, 1956; Beck, 1967).

Although perfectionism has generally been believed to be a predisposing factor in the development of depression, controversy remains about the operational definitions as well as conceptualizations of the construct (Cox, Enns, & Clara, 2002; Enns & Cox, 2002; Flett & Hewitt, 2002). One such

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conceptualization asserts that perfectionism is invariably maladaptive (Blatt, 1995; Flett & Hewitt, 2002). Accordingly, the maladaptive form of perfectionism emphasizes unrealistically stringent standards of performance and flawlessness, self-criticism, and self-punitive reactions to perceived inadequacies (Blatt, 1995; Flett & Hewitt, 2002, Slaney, Rice, & Ashby, 2002). Maladaptive perfectionists seem to excessively anticipate failure, discount their successes, perceive mistakes as devastating, and have strong feelings of inferiority and low self-esteem (Ashby & Kottman, 1996; Rice & Dellwo, 2002; Rice & Slaney, 2002). In general, this form of perfectionism has been consistently associated with psychological pathologies and impairments, including, but not limited to depression, suicidal ideation and tendencies, anxiety, and eating disorders (Blatt, 1995; Flett & Hewitt, 2002; Rice, Leever, Noggle, & Lapsley, 2007). Conversely, the adaptive form of perfectionism has been conceptualized as having very high personal standards or expectations, conscientiousness to performance, preference for organization, and persistence in striving for excellence, all of which occur in the absence of excessive negativity, self-criticism, and chronic dissatisfaction (Ashby & Rice, 2002; Rice et al., 2007; Slaney et al., 2002). Further, the self-esteem of adaptive perfectionists has tended to be high and relatively immune to long-term detrimental effects of perceived failures (Rice & Ashby, 2007).

Some investigators have considered perfectionism as a one-dimensional trait that is inherently maladaptive and dysfunctional (Blatt, Quinlan, Pilokonis, & Shea, 1995), whereas others have conceptualized perfectionism as a multidimensional trait with personal as well as interpersonal aspects (Frost, Martin, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b). The Hewitt and Flett multidimensional model includes three dimensions of perfectionism based on the source of perfectionistic motivation. These dimensions include self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism (Hewitt & Flett, 1991b).

### **Orientations of Perfectionism**

Self-oriented perfectionism involves self-directed tendencies toward unrealistic standards, excessive striving to attain these standards, and engaging in 'all-or-nothing' thinking (Hewitt & Flett, 1991b). Self-oriented perfectionism also relates to self-criticism as well as self-blame due to the intense fixation on personal shortcomings and failures (Blatt et al., 1995; Hewitt, Mittelstaedt, & Wollert, 1989). Self-oriented perfectionism has been significantly related to a number of maladaptive tendencies including anorexia nervosa, anxiety, and depression (Hewitt & Flett, 1991b, 1993). A fundamental component in the development of depressive affect involves a perceived discrepancy between "ideal" and "actual" self (Hewitt & Flett 1991b; Strauman, 1989). Furthermore, individuals who set unrealistically exaggerated standards and encounter achievement-related disappointments are more likely to have ongoing, chronic depressive symptoms. Conversely, self-oriented perfectionists

may be able to avoid such adverse outcomes if they are able to meet their standards and avoid failure (Hewitt & Flett, 1993).

Other-oriented perfectionism represents setting unrealistic standards for others (Hewitt & Flett, 1991b). The other-oriented perfectionist places high demands of perfection on significant others and strictly evaluates their performance. Essentially, the other-oriented perfectionist is comparable to the self-oriented perfectionist, with the exception that the expectations of perfection are directed outward (Hewitt & Flett, 1991b). Other-oriented perfectionism is hypothesized to be unrelated to depression since the focus is on the shortcomings of others rather than on one's own failures (Hewitt & Flett, 1991b, 1993).

Socially oriented perfectionists believe that others hold unrealistically high standards of them, evaluate them critically, and exert excessive pressure on them to be perfect (Hewitt & Flett, 1991b). Thus, in order to meet the approval of and gain acceptance from significant others, they must achieve these standards. Because such standards are perceived as being exaggerated, excessive, and uncontrollable, socially oriented perfectionists may be prone to anxiety, anger, self-criticism, and depression resulting from an inability to attain such standards or the belief that others are excessively demanding (Hewitt & Flett, 1991b, 1993). These feelings may, in turn, be exaggerated by the fact that socially oriented perfectionists are more likely to internalize their true emotions in order to maintain an appearance of composure and social approval. Indeed, research has revealed that there is a significant positive association between socially prescribed perfectionism, self-silencing, and depression (Flett, Besser, Hewitt, & Davis, 2007).

### **Theoretical Origins**

Research suggests that differences in the quality of parent-child relations may account for the development of perfectionism (Hamachek, 1978; Sorotzkin, 1998). Parents of maladaptive perfectionists have been characterized as being critical and demanding with unreasonably high standards and expectations of their children (Hamachek, 1978). Such parents are generally never satisfied with their children's performance. Children of such parents, in turn, learn the importance of performance and tend to place a greater emphasis on performance over their own emotional well-being. Conversely, parents of adaptive perfectionists have been characterized as having high standards, but also being supportive and encouraging (Sorotzkin, 1998). Thus, children of such parents may be high achieving yet realistically aware of their shortcomings.

Attachment theory, as posited by John Bowlby, describes the framework of affectionate relationships between young children and their caretakers (Crain, 2005). In his theory, Bowlby illustrated how infants progressively develop strong, secure attachments from relatively weak, insecure

attachments. Although Bowlby's theory posited four phases of attachment in children, research supports two continuous dimensions to describe adult attachment (Fraley & Waller, 1998).

Adult attachment can be viewed as either anxious or avoidant (Brennan, Clark, & Shaver, 1998). Adult attachment anxiety is characterized by an intense fear of rejection or abandonment as well as by an excessive need for approval from others (Wei, Mallinckrodt, Russell, & Abraham, 2004). Adult attachment avoidance is characterized by a strong need for independence and self-reliance as well as a fear of closeness or dependence (Wei et al., 2004). Further, individuals with high levels of either dimension are considered to have an insecure attachment orientation and an inability to manage challenges whereas those with low levels of attachment anxiety and avoidance are assumed to have a secure attachment orientation and the ability to maintain supportive attachments (Mallinckrodt, 2000; Rice & Mirzadeh, 2000; Wei et al., 2004).

Research has suggested a strong relation between both levels of insecure attachments (anxious and avoidant) and psychological distress (Wei, Heppner, & Mallinckrodt, 2003; Wei et al., 2004). Individuals with insecure attachment report greater emotional intensity (Pietromonaco & Barrett, 1997), more depressive symptoms (Roberts, Gotlib, & Kassel, 1996), more emotional distress (Collins, 1996), and higher levels of perfectionism (Bartholomew & Horowitz, 1991; Hamachek, 1978) than individuals with secure attachment report. Such individuals generally find it difficult to manage and adjust to new challenges and situations (Crain, 2005).

From the standpoint of attachment anxiety, maladaptive perfectionism results when a child's needs for parental nurturance and acceptance are not met (Hamachek, 1978). Likewise, Ainsworth suggested that if caregivers (i.e., parents) are inconsistent or otherwise unreliable in responding to the general needs of young children, insecure anxious attachment is likely to result (Crain, 2005). Subsequently, such children may strive to be "perfect" in order to earn parental love and acceptance. This maladaptive pattern of gaining acceptance tends to persist into adulthood and may result in the development of depressive mood or major depression.

In terms of attachment avoidance, research suggests that individuals tend to strive for perfection to avoid rejection from others (Robbins & Patton, 1985; Wei et al., 2004). Although these individuals may already describe themselves as perfect, they strive to attain this perfection in order to manage their hidden imperfections (Wei et al., 2004). This is believed to be a defense mechanism that hides a wounded sense of self resulting from inadequate parent or caregiver emotional responsiveness in early development (Robbins & Patton, 1985).

Secure attachments develop in children of parents who have been emotionally available, nurturing, supportive, positive, responsive, and realistically demanding (Crain, 2005; Rice & Mirzadeh, 2000). Such attachments provide the child with a “secure-base” from which the child may confidently explore and approach rather than avoid new challenges and situations (Crain, 2005). In turn, securely attached children come to view themselves as worthy and strong; they are able to strive for high standards, but are nonetheless accepting of their shortcomings. Thus, although adaptive perfectionists have very high personal standards they are not excessively self-punitive; their self-esteem and self-efficacy allow them to avoid chronic disappointment and other such detrimental effects of perceived failures because they are able to accept that they are, indeed, “less than perfect” (Rice & Ashby, 2007; Rice & Mirzadeh, 2000).

### **Implications for Clinical Practice and Prevention**

In a society which upholds the highest of standards, individuals are constantly bombarded with expectations of and demands for high performance. Adults and children alike may strive endlessly to reach such demands of perfection. While some may understand and accept their limitations, others are reluctant to settle for anything but the best. Unwilling to accept their shortcomings, these individuals may experience pervasive feelings of failure, guilt, low-self esteem, and helplessness. This, more often than not, results in serious forms of psychopathology including disordered eating, alcoholism, anxiety, depression, and even suicidal ideation and tendencies (Blatt, 1995; Flett & Hewitt, 2002). Given such daunting realities, it is clear that treatment, as well as prevention, are of the utmost importance.

In order to prevent the development of perfectionism in children, parents must provide their children with “good enough” parenting (Winnicott, 1992). The notion of parenting which is “good enough” entails being appropriately responsive to an infant’s needs, thus ensuring that the infant does not experience too much distress. Should the infant experience parenting that is less than good enough, he or she will, theoretically, aim to increase the responsiveness of the parents by whatever means possible. The infant may come to learn that if “perfect”, it may be more likely to gain parental love and attention. Such perfectionistic tendencies may, as previously illustrated, continue into adulthood and manifest into full-blown perfectionism which, in turn, may lead to psychological pathologies such as depression.

In the event that clinical depression arises due to perfectionism, it may be in the best interest of the individual to seek a tailored therapeutic intervention targeting specific underlying personality vulnerabilities (Hawley, Ho, Zuroff, & Blatt, 2006). Such an intervention may entail a therapeutic alliance between client and therapist in which maladaptive schemata are challenged while attempting to develop a more realistic system of thinking. Given the perfectionistic belief that others will be overly critical of their

behavior, an environment that allows a patient to challenge the maladaptive belief system would foster acceptance and support without the fear of being judged, criticized, or rejected. In accordance with the multidimensional model of perfectionism, therapists should target specific vulnerabilities of each perfectionistic orientation. For example, in treating patients who are self-oriented perfectionists, mental health practitioners should target the “all-or-none” thinking exhibited by such individuals. In treating clients who are socially oriented perfectionists, treatment may address the reasons why the client believes he or she so desperately needs the approval of others, and why this approval is so heavily dependent on their “perfection.” Essentially, perfectionists may be best served by therapists who assist them in understanding and dealing with feelings of insecurity, anxiety, avoidance, or other such problematic attachment orientations.

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