Personality and Individual Differences 107 (2017) 126–130

Contents lists available at ScienceDirect

Personality and Individual Differences

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

An investigation of vulnerability factors for depression

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ARTICLE INFO

Article history:
Received 15 November 2016
Received in revised form 19 November 2016
Accepted 21 November 2016
Available online 24 November 2016

Keywords:
Depression
Perfectionism
Shame
Anxiety
Ego integrity
Personality

ABSTRACT

Previous studies have found that difficulty accepting the past mediates the predictive relationship between depression and socially prescribed perfectionism. This relationship inspired the present study to examine relations between a variety of personality traits - shame, anxiety, perfectionism and difficulty accepting the past - which pose as vulnerability factors for depressive symptoms. A single multi-faceted questionnaire was administered to 163 university students and 119 general public participants. Supporting predictions, socially prescribed perfectionism yielded a weaker relationship with depression than did anxiety, shame, and accepting the past.

1. Introduction

Mood disturbances typically affect individuals negatively, often to the point of being disruptive to everyday functioning. In particular, depression—a state defined by a negative or low mood and an aversion to activity—is frequently accompanied by a propensity toward misery, anguish, anhedonia and guilt (e.g., Fox, 1999; Kim, Thibodeau, & Jorgensen, 2011; Willner, Muscat, & Papp, 1992). It has also been associated with various negative effects on wellbeing (Blumenfield, Suojanen, & Weiss, 2012). When exhibited in an intense or prolonged manner, depression may be a symptom of a clinical mood disorder, namely major depressive disorder (MDD) or bipolar disorder (BD). In these more extreme manifestations of depression, the condition is typically prefaced by stressful life events (Kendler, Karkowski, & Prescott, 1999). Depression can often be treated successfully if diagnosed effectively, and available treatments can often mitigate symptoms and allow individuals to live less disrupted and more functional lives. Left untreated, however, depression is invariably tied to behaviour that can be damaging to one's health, wellbeing, and interpersonal relationships (Hays, Wells, Sherbourne, Rogers, & Spritzer, 1995; Papakostas et al., 2004).

A substantial and continuously growing body of clinical research has recognized the significance of personality factors in the development and maintenance of depressive symptoms (Blatt, 2004; Hawley, Ho, Zuroff, & Blatt, 2006). In particular, this area of research has found that depression is predicted by higher-order personality factors, namely Neuroticism and low Conscientiousness (Kotov, Gamez, Schmidt, & Watson, 2010), as well as by specific maladaptive traits that include perfectionism, self-esteem, shame, guilt-proneness, anxiety, reminiscing, and ego-despair (e.g., Cheng & Furnham, 2003; Hawley et al., 2006; Rylands & Rickwood, 2001; Tangney, Wagner, & Gramzow, 1992; Warner, Wickramaratne, & Weissman, 2008). Given the documented relevance of personality in our understanding of depression, it is imperative to continue to assess the individual difference variables that contribute to the development and maintenance of depression, in order to develop multi-faceted assessment tools to aid in the more effective recognition and treatment of depressive symptoms. In the present investigation, we compare a variety of personality traits—shame, anxiety, perfectionism and difficulty accepting the past—as vulnerability factors of depressive symptoms in order to determine which of these constructs are most highly predictive of depression.

1.1. Perfectionism

A potential personality risk factor for the onset of depression is the trait of perfectionism, which is typically understood in terms of two styles: normal perfectionism and neurotic perfectionism (Hamachek, 1978). Individuals who have a propensity toward either style of perfectionism maintain very high standards of performance and achievement for themselves. However, while those high on normal perfectionism are relatively forgiving and flexible when errors occur and are able to celebrate their successes, those high on neurotic perfectionism tend to be inflexible in their standards, and find it difficult to view any achievement as worthy of satisfaction or celebration. Although both normal and neurotic perfectionists experience some negative outcomes associated with their demanding expectations, including guilt, shame, and diminished self-esteem, those high on neurotic perfectionism experience them for longer durations and with greater intensity (Hamachek, 1978; Hewitt & Flett, 1991b).

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http://dx.doi.org/10.1016/j.paid.2016.11.049
0191-8869/

Beyond differentiating between adaptive versus maladaptive forms of perfectionism, Hewitt and Flett (1991b) further identified three major uses of perfectionism: self-oriented, other-oriented, and socially prescribed perfectionism. Self-oriented perfectionism refers to one's tendency to set high standards for oneself and to focus on failure rather than on success. Consequently, this type of perfectionism is most in line with neurotic perfectionism. Other-oriented perfectionism is characterized by a tendency to set unrealistically high standard for others, and to experience frustration if they are not met. Socially prescribed perfectionism occurs when individuals believe that others have set high standards for them, and they strive to meet these standards for fear disappointing others. These three uses of perfectionism are typically measured using the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991b).

Existing research pertaining to perfectionism has noted that the variable is predictive of depression (Hawley et al., 2006). Specifically, reports have suggested that perfectionist individuals engage in excessive self-criticism and self-scrutiny, often shunning the support of others, which may ultimately have a detrimental impact on their mood (e.g., Zuroff & Duncan, 1999). In particular, depression has been linked to neurotic perfectionism (Sumi & Kanda, 2002), self-oriented perfectionism, and socially prescribed perfectionism (Hewitt & Flett, 1991a).

1.2. Shame

Shame represents a state of distress that occurs when one feels embarrassed, often in response to an act that one has committed. It is conceptualized as an internally guided construct that is associated with withdrawal and avoidance—behaviors enacted to prevent emotional damage that may otherwise occur (Cohen, Wolf, Panter, & Insko, 2011). Shame-proneness, reflecting individual differences in one's tendency to feel shame in response to personal transgressions, has been shown to be positively associated with depressive symptoms (Tangney et al., 1992). Recent research aimed to create a measure that quantified previous cognitive attribution scales to effectively measure shame with two subscales oriented around negative-self evaluations and withdrawal. The results indicated that individuals with negative-self evaluating shame employed coping mechanisms that involved ruminating, which often led to further psychological distress, low self-esteem, and low self-compassion (Cohen et al., 2011). This study helped to pinpoint the origin of the growth of depressive symptomatology.

Previous inventories have focused on measuring non-specific states of shame. Accordingly, Andrews, Qian, and Valentine (2002) conducted research to develop a questionnaire designed to predict depressive symptoms through an extension of previous evidence indicating a strong association between depressive symptomatology and shame. This assessment purported to assess less transient, more persistent elements of shame, and was found to be more strongly correlated with depressive symptoms than more general assessments of shame as a transient negative emotional state.

1.3. Anxiety

Anxiety can be described as an adaptive fear which helps individuals deal with a potential threat. Once this fear becomes maladaptive, the resulting effects present in the form of threat responses which are inappropriate or disproportionate to the nature of the situations in which they are elicited. Anxiety can prevent individuals from coping effectively with threatening situations, causing a decrease in performance and functioning in everyday life. Many studies have found anxiety to be highly prevalent among patients with Major Depressive Disorder (MDD; Flint & Rifat, 1997; Wehry et al., 2015). Feske, Frank, Kupfer, Shear, and Weaver (1998) compared patient anxiety levels in a sample of individuals diagnosed with unipolar depression. Anxiety levels, especially in the form of a panic disorder, were found to be negatively predictive of treatment success.

Many personality traits share relationships with both anxiety and depression, two of which include the constructs of harm-avoidance (the tendency toward shy and inhibited social behaviour) and self-directedness (a measure of self-esteem and self-acceptance). While high harm-avoidance and low-self directedness can be predictive of individuals with depression and anxiety, anxiety and depression can also be related to a variety of constructs across several dimensions of personality. For example, high scores on measures of self-transcendence—where individuals may be characterized as patient, creative and spiritual—are often correlated with depressive symptoms, whereas low cooperativeness—the acceptance and tolerance of others—is more often correlated with anxiety (Tanaka, Sakamoto, Kijima, & Kitamura, 1998).

1.4. Difficulty accepting the past

Difficulty accepting the past involves an inability to view life experiences as meaningful and satisfying. Living with regret makes it difficult for individuals to focus on the present, often leading to a chronic dissatisfaction. Dissatisfaction with one's life experiences has been shown to correlate with depressive symptoms (Hayes, 2004). Sherry, Sherry, Hewitt, Mushquash, and Flett (2015) examined undergraduate participants' perfectionism, difficulty accepting the past, self-esteem and depression. In addition to testing a novel moderated meditation model, this study presented empirical evidence that people who experience high socially prescribed perfectionism often express depressive symptoms in part due to an increased difficulty in accepting the past. The present study intends to build on these findings by comparing the predictive qualities of multiple correlates of depression.

2. Method

2.1. Participants

The sample consisted of 282 participants. Of these, 163 were undergraduate students in an introductory psychology course, who were compensated with course credit, and 119 were adults recruited via Amazon Mechanical Turk (MTurk), who were compensated $1.00 USD for taking part in the investigation.

2.2. Materials

2.2.1. Beck Depression Inventory (BDI-II)

The BDI-II (Beck, Steer, & Brown, 1996) assesses thoughts, behaviors, feelings, and physical symptoms associated with major depressive disorder (MDD). This measure consists of 21 self-report items scored on a 4-point Likert scale ranging from 0 (*no symptoms of depression*) to 3 (*high symptoms of depression*). Higher scores on the BDI-II indicate a greater presence of depressive symptoms. The questionnaire has demonstrated good psychometric properties (e.g., Dozois, Dobson, & Ahnberg, 1998).

2.2.2. Multidimensional Perfectionism Scale (MPS)

The MPS (Hewitt & Flett, 1991b) was used to assess variability in self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. The MPS consists of 45 self-reflective items. To complete the questionnaire, participants respond to each item using a 7-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores on the measure reflect greater perfectionism. The MPS has demonstrated good psychometric properties overall (e.g., Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).