Personality and Individual Differences 70 (2014) 66–71

Contents lists available at ScienceDirect

Personality and Individual Differences

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

The mediating influence of hope on multidimensional perfectionism and depression

Jaya Mathew, Claire Dunning, Charlotte Coats, Thomas Whelan *

ACU University, School of Psychology, Melbourne Campus, 115 Victoria Parade, Fitzroy, Victoria, 3065 Australia

ARTICLE INFO

Article history:
Received 4 April 2014
Received in revised form 3 June 2014
Accepted 6 June 2014
Available online 12 July 2014

Keywords:
Perfectionism
Maladaptive perfectionism
Adaptive perfectionism
Depression
Hope

ABSTRACT

This study investigated the relationship between perfectionism and depression, and the mediating effects of the components of hope – agency and pathways. Participants were 152 undergraduate students who completed an online survey that included measures of perfectionism, hope and depressive symptoms. It was hypothesised that adaptive perfectionists would have higher levels of agency and pathways, and lower levels of depression than maladaptive and non-perfectionists. Further, that agency and pathways would mediate the relationship between both adaptive and maladaptive perfectionism and depression. These hypotheses were supported, however, contrary to expectations maladaptive perfectionists demonstrated higher levels of agency than non-perfectionists. The results demonstrate that both components of hope are important to the psychological outcomes of perfectionists.

1. Introduction

Initially, perfectionism was understood to be a negative trait where the actions of striving for excessively high standards were thought to lead to emotional distress (Burns, 1980; Hollender, 1965). Over the past two decades, a multidimensional model of perfectionism has been established (Dunkley, Zuroff, & Blankstein, 2003; Slade & Owen, 1998). According to this view, not everyone who has high standards experiences distress. Rather, it is those who attach not achieving their high standards to failure, who are inclined to experience anxiety, worthlessness and depression. Therefore, maladaptive perfectionists are those who experience negative affect over discrepancy between desired high standards and achieved results. Adaptive perfectionists also have high standards for their set goals, however, they do not experience the same intensity of anxiety related to any perceived discrepancy. Finally, non-perfectionists are distinct from both of these perfectionist types as they lack the same desire for high standards (Rice & Mirzadeh, 2000).

Adaptive and maladaptive perfectionism have been found to correlate with a variety of behavioural and affective outcomes (Stoeber & Otto, 2006). Depression, in particular, has been an outcome of interest (e.g., Black & Reynolds, 2013; Gnilka, Ashby, & Noble, 2013). A strong positive relationship has been reported between maladaptive perfectionism and depression in both clinical and non-clinical samples (Argus & Thompson, 2008; Bieling, Israeli, Smith, & Antony, 2003). This has been explained in terms of the developmental environment of maladaptive perfectionism. According to Enns, Cox, and Clara (2002), typically maladaptive perfectionists have grown in settings where there is harsh and critical parenting. This can cause a dysfunctional belief that a person is worthless if they cannot achieve high standards, which in turn causes depression. In line with this, a maladaptive perfectionist may suffer from depression because they believe there is a large disparity between their 'actual self' (who they are) and their 'ought self' (who they believe they should be; Einstein, Lovibond, & Gaston, 2000).

The relationship between adaptive perfectionism and depression is not as clear. Adaptive perfectionists have been reported to have lower levels of depression than both maladaptive and non-perfectionists (Mobley, Slaney, & Rice, 2005; Rice & Mirzadeh, 2000). Conversely, there is some evidence that adaptive perfectionism positively correlates with depression (e.g., Bieling, Israeli, & Antony, 2004). One explanation for this inconsistency is that there is an overlap in variance between adaptive and maladaptive perfectionism in terms of depression. Indeed, when maladaptive perfectionism has been controlled for, a consistent negative relationship between adaptive perfectionism and depression has been reported (Stoeber & Otto, 2006; Stoeber & Rambow, 2007). Clearly, further studies would benefit from controlling for the effects of maladaptive perfectionism on adaptive perfectionism when examining associations with depression.

* Corresponding author. Address: School of Psychology, ACU University, Locked Bag 4115, Fitzroy MDC, Victoria 3065, Australia. Tel.: +61 399533127.
E-mail address: tom.whelan@acu.edu.au (T. Whelan).

http://dx.doi.org/10.1016/j.paid.2014.06.008
0191-8869/

Several investigators (e.g., Mobley et al., 2005; Rice, Ashby, & Slaney, 1998) have speculated that with adaptive perfectionism, a mediator might act as a buffer against depression. A potential mediator that has recently been examined is hope (Ashby, Dickenson, Gnilka, & Noble, 2011). Previously perfectionism had only been linked with hopelessness (Beevers & Miller, 2004). Given developments in the conceptualisation of positive aspects of perfectionism (Slade & Owen, 1998), it is prudent to investigate whether perfectionism can be related to a gain rather than a loss of hope. Also, the view of hope as a person's belief that they can meet their set goals (Snyder et al., 1991) appears to have relevance for perfectionists given their apparent mental schema concerning achieving their high standards.

Ashby et al. (2011) conducted a study of hope and perfectionism using a sample of 153 middle school students. The students completed self-report measures that included the Children's Hope Scale (Snyder et al., 1997). It was found that compared to maladaptive and non-perfectionists, the adaptive perfectionists had higher levels of hope. Hope mediated the relationship between maladaptive perfectionism and depression, and a significant indirect effect of hope was found between adaptive perfectionism and depression, where adaptive perfectionism was related to depression only through hope. Ashby and colleagues posited that the reason hope had an effect on this relationship was because of an aspect of hope, known as agency.

According to Snyder (2002), *agency* is one of the two key components that constitute hope, the other being *pathways*. Snyder conceptualised hope as a cognitive process that revolves around achieving goals. The first component of hope, *pathways,* refers to the ability a person has in identifying and developing new ways of attaining their goals. The second component, *agency,* relates to the ability a person believes they have to act on or follow their pathways to attain their goal.

Ashby et al. (2011) suggested that maladaptive perfectionists place their standards so high that they do not have the agency to attain their goal and that this can result in depression. However, there has been contrasting evidence regarding whether agency or pathways is the main contributing factor to depression (Arnau, Rosen, Finch, Rhudy, & Fortunato, 2007; Chang, 2003; Elliot, Witty, Herrick, & Hoffman, 1991). Unfortunately, Ashby et al. (2011) did not examine the components of hope separately. An investigation of the separate components of hope would be worthwhile to clarify if one component has a greater influence on the relationship.

The current study aims to expand upon previous research regarding the relationship between perfectionism, hope and depression. In particular, it will investigate the mediating effects of hope in terms of its two components, agency and pathways.

It is hypothesised that adaptive perfectionists will report lower levels of depression, and higher hope scores (i.e., agency and pathways) than both maladaptive and non-perfectionists. Furthermore, it is hypothesised that maladaptive perfectionists will report higher levels of depression than non-perfectionists, but that non-perfectionists will report higher hope scores (i.e., agency and pathways). Finally, hope scores (i.e., agency and pathways) are expected to mediate the relationship between perfectionism (i.e., adaptive and maladaptive) and depression.

2. Method

2.1. Participants

This study was conducted over a 2-year period. The total data set included 171 participants, with 85 from the first and 86 from the second year of the study. All respondents were undergraduate students from ACU University and were recruited from a single unit (Lifespan Development). Participants completed the study for course credit. Recruitment was conducted across three campuses, Brisbane ($n = 37$), Sydney ($n = 28$) and Melbourne ($n = 106$), constituting a response rate of 29.27%. Ages ranged from 18–54 years ($M = 23.31$; $SD = 7.30$).

2.2. Measures

2.2.1. Demographics survey

Initially, participants were asked demographic questions. This included items about their age, gender and course of study.

2.2.2. Almost perfect scale-revised

Perfectionism was measured using the Almost Perfect Scale-Revised (APS-R: Slaney, Rice, Mobley, Trippi, & Ashby, 2001). This is a 23-item self-report measure and is designed to assess multidimensional perfectionism (Slaney et al., 2001). The measure has three subscales, although only two are used to discriminate between perfectionist groups (Gilman & Ashby, 2003; Rice & Ashby, 2007). The *standards* subscale assesses the level of striving one has for high personal performance (adaptive perfectionism), while the *discrepancy* subscale represents the levels of distress a person experiences in regards to achieving their standards (maladaptive perfectionism). The APS-R has sound psychometrics (Mobley et al., 2005; Rice & Ashby, 2007) with good internal consistency (Accordino, Accordino, & Slaney, 2000; Nounopoulos, Ashby, & Gilman, 2006). Slaney et al. (2001) demonstrated that the APS-R has both convergent and construct validity by correlating it with other multidimensional perfectionism scales and related constructs (i.e., self-esteem, anxiety). The internal consistency for the current sample was sound with the standards scale at .83 and .94 for discrepancy.

2.2.3. The hope scale

Hope was measured using the Hope Scale (Snyder et al., 1991), a 12-item self-report measure. The scale consists of two subscales: agency and pathways. The *pathways* items measure the ability to develop goal achieving strategies. The *agency* items assess the extent to which a person believes that they can achieve their goals through their pathways. Agency and pathways have been demonstrated to be separate but related constructs (Babyak, Snyder, & Yoshinobu, 1993). The Hope Scale has shown good test–retest reliability and high internal consistency has been observed for both subscales (Snyder et al., 2002). The internal consistency for the current sample was .77 for pathways and .76 for agency.

2.2.4. Centre for epidemiological studies depression scale

Participants' level of depressive symptoms was measured using the Centre for Epidemiologic Studies Depression Scale (CES-D: Radloff, 1977). This is a 20-item self-report measure that assesses the presence of depressive symptoms over the previous week. Although the CES-D is not a diagnostic tool it demonstrates good construct validity by accurately discriminating between clinical and non-clinical populations (Radloff, 1977, 1991). Test–retest reliability has been shown to be moderate with higher correlations occurring over shorter periods. The CES-D has demonstrated high internal consistency for both clinical and non-clinical populations (Radloff, 1977), and for the current sample was .93.

2.3. Procedure

Permission was granted for data collection by the ACU University Ethics Committee. Participants were advised of the study by flyers distributed in their classes and were able to access the surveys online via the university's participant recruitment site. First,