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Perfectionism and clinical disorders among employees

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ABSTRACT

We examined differences in perfectionism between burned-out employees ($n = 77$), depressed employees ($n = 29$), anxiety-disordered employees ($n = 31$), employees with comorbid disorders, that is, a combination of clinical burnout, depression, or anxiety disorder ($n = 28$), and individuals without clinical burnout, depression disorder, or anxiety disorder (clinical control group; $n = 110$). The results suggest that setting high personal standards per se is not associated with clinical disorders. In contrast, maladaptive aspects of perfectionism, including perceived discrepancy between standards and performance and socially prescribed perfectionism, were related to clinical disorders, and in particular to comorbidity.

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1. Introduction

Although no definition of perfectionism has been formally agreed upon, the centrality of high personal standards is evident (Flett & Hewitt, 2002; Slaney, Rice, & Ashby, 2002). Several researchers have demonstrated that setting high personal standards (Slaney et al., 2002) or self-oriented perfectionism (Flett & Hewitt, 2002), was positively associated with positively valenced variables such as self-esteem, problem-focused coping, career satisfaction, and physical health (e.g., Bieling, Israeli, & Antony, 2004; Enns & Cox, 2002; Slaney et al., 2002; Stoeber, Feast, & Hayward, 2009). Similarly, in goal-setting research, high standards of performance have typically been found to be associated with focused attention, effort, and persistence, all of which are likely to enhance work motivation and job performance (Locke & Latham, 1990). Therefore, we argue and will demonstrate that, relative to their occurrence in a clinical control group, only *maladaptive* characteristics of perfectionism are prevalent among employees diagnosed with clinical disorders, and in particular among individuals with comorbid disorders.

Specifically, not high standards per se, but individuals' perceptions that they consistently fail to meet their personal standards,

henceforth referred to as *perceived discrepancy* (Slaney et al., 2002), may elevate levels of distress, and lead to the development of clinical disorders. Several studies consistently report that perceived discrepancy is associated with negative adjustment indicators such as lack of self-esteem, worry, and psychological distress (e.g., Slaney, Rice, Mobley, Trippi, & Ashby, 2001; Van Yperen & Hagedoorn, 2008). A perceived discrepancy between standards and criteria of success in meeting those standards is distressing because it interferes with people's basic need for competence and the need to actually succeed in getting what they want (Ellis, 2002; Ryan & Deci, 2002).

Similarly, the perception that others are imposing high standards on the self (i.e., *socially prescribed perfectionism*) has typically been found to be associated with a variety of negative outcomes, including depressive symptomatology, fear of negative evaluation, and negative affect (e.g., Flett & Hewitt, 2002; Stoeber et al., 2009). In contrast to personally adopted high standards, socially imposed high standards create concerns about others' criticism and expectations (Clara, Cox, & Enns, 2007; O'Connor, O'Connor, & Marshall, 2007). Focusing on others' high standards tends to raise a want to a necessity which is irrational and self-defeating, and accordingly, may decrease one's sense of self-efficacy and self-esteem, increase psychological distress, and, ultimately, leads to clinical disorders (cf., Ellis, 2002).

The assumed links between clinical disorders, including comorbidity, on the one hand, and maladaptive characteristics of perfectionism, on the other, are discussed below.

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1.1. Burnout

From the beginning, burnout (for the five common elements of burnout, see Table 1) was associated with perfectionism (Freudenberger, 1974). However, to our knowledge, there are no studies among employees that link dimensions of perfectionism to *clinical burnout*. Maladaptive aspects of perfectionism, including the perception of consistently failing to meet one's own standards and a chronic concern about others' criticism and expectations, may however lead to the development of severe burnout symptoms (Clara et al., 2007; Stoeber & Otto, 2006). Employees with a clinical burnout meet the criteria of the ICD-10 (i.e., the 10th revision of the International Statistical Classification of Diseases and Related Health Problems) equivalent of job- or work-related neurasthenia (Schaufeli, Bakker, Schaap, Kladler, & Hoogduin, 2001). That is, for the diagnosis clinical burnout, the listed symptoms (see Table 1) have to be present each day for at least 6 months. Table 1 also shows that the elements of burnout are very similar to the criteria for neurasthenia in ICD-10 and those for an undifferentiated somatoform disorder. In the DSM-IV (i.e., Diagnostic and Statistical Manual of Mental Disorders, 4th edition), undifferentiated somatoform disorder includes neurasthenia, which was abandoned as a separate category (Hickie, Hadzi-Pavlovic, & Ricci, 1997).

1.2. Depression

According to the criteria of the DSM-IV, the symptoms of a major depressive episode include persistent sad mood, feelings of hopelessness or worthlessness, loss of interest in activities that were once enjoyed, and thoughts of death or suicide. Individuals may be more likely to develop depressive symptomatology, and in the long term, clinical depression when they are high in perceived discrepancy (e.g., Bieling, Israeli, & Antony, 2004; Clara et al., 2007). Such individuals are too critical of their own achievements, making them vulnerable to experiences of failure and the development of depressive symptomatology. Also, individuals who consistently feel that others are imposing high standards on them develop these symptoms because externally imposed stan-

dards are typically perceived as uncontrollable (Blatt, 1995; O'Connor et al., 2007).

1.3. Anxiety

Several researchers have reported a robust link between perceived discrepancy and anxiety, suggesting that people's perceptions that they consistently fail to meet their personal standards lead to the development of an anxiety disorder (Slaney et al., 2001). Similarly, the perception that one must meet others' high expectations may be perceived as being excessive and uncontrollable, and ultimately, lead to the development of an anxiety disorder. For example, Hewitt and Flett (1991) found higher levels of socially prescribed perfectionism in a group of patients with anxiety disorders than in healthy respondents.

Hence, *Hypothesis 1* was that, relative to the individuals in the control group, burned-out individuals, depressed individuals, and anxiety-disordered individuals would be higher in perceived discrepancy and socially prescribed perfectionism.

Comorbidity may be associated with even higher levels of perceived discrepancy and socially prescribed perfectionism; this is discussed in the following paragraph.

1.4. Comorbidity

In the present research, *comorbidity* refers to the co-occurrence of clinical burnout, depression, or anxiety disorders within the same individual. Assuming that socially prescribed perfectionism and perceived discrepancy are related to one of these mental disorders (see *Hypothesis 1*), the most severe and maladaptive forms of perfectionism may be associated with comorbidity (cf., Bieling, Summerfeldt, Israeli, & Antony, 2004). For example, individuals who score high on socially prescribed perfectionism and perceived discrepancy feel chronically anxious because they feel that they typically do not meet others' high standards and their own high standards, respectively. This may make them feel depressed and less energetic, making it difficult for them to work harder. In turn, this increases their feeling of falling short of the socially imposed or personally adopted standards, which is likely to elevate anxiety

Table 1

Comparison of the five common burnout elements as identified by Maslach and Schaufeli (1993), the criteria for neurasthenia (ICD-10), and the criteria for an undifferentiated somatoform disorder (DSM-IV).

Common elements of burnout as identified by Maslach and Schaufeli (1993)	Job or work-related neurasthenia (ICD-10)	Undifferentiated somatoform disorder (DSM-IV)
1. A predominance of fatigue symptoms such as mental or emotional exhaustion, tiredness, and depression	The feeling of either mental or physical fatigue or weakness and exhaustion after minimal effort	The presence of one or more physical complaints persisting for 6 months or longer. The most frequent complaints are chronic fatigue, loss of appetite, or gastrointestinal or genito-urinary symptoms
2. Various atypical physical symptoms of distress may occur	At least two out of seven symptoms should be present: i.e., muscular aches and pain, dizziness, tension headaches, sleep disturbance, inability to relax, irritability, and dyspepsia	
3. These symptoms are work-related	The life-management difficulty criterion put forward in ICD-10's definition of burnout corresponds to work-relatedness	
4. The symptoms manifest themselves in 'normal' persons who did not suffer from psychopathology before	These symptoms should not better be accounted for by the presence of a depression or anxiety disorder, or any other of the more specific disorders in the ICD-10 classification	The complaints are not better accounted for by another mental disorder, or are not intentionally produced or feigned
5. Decreased effectiveness and impaired work performance occurs because of negative attitudes and behaviors	In the clarification of neurasthenia the association of the disorder with impaired occupational performance or reduced coping efficiency in daily tasks is made explicitly	The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning The complaints cannot be fully explained by a known general medical condition or by the direct effects of a substance. When there is a related general medical condition the physical complaints or resultant impairment are grossly in excess of what could be expected from the history, physical examination, or laboratory findings

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