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Brief Report

Self-critical perfectionism is a vulnerability factor for depression but not anxiety: A 12-month, 3-wave longitudinal study

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ABSTRACT

It is unclear whether perfectionism is an antecedent of depressive symptoms, a consequence of depressive symptoms, or both. Furthermore, no study has tested reciprocal relations between perfectionism and anxiety symptoms, despite theory suggesting perfectionism both leads to, and results from, anxiety symptoms. We recruited 302 undergraduates and tested reciprocal relations between self-critical perfectionism and depressive and anxiety symptoms using a 12-month, 3-wave longitudinal design. Self-critical perfectionism predicted increases in depressive symptoms; depressive symptoms did not predict changes in self-critical perfectionism. Self-critical perfectionism was also a concomitant of, but not an antecedent or consequence of, anxiety symptoms. Results complement theory suggesting self-critical perfectionism is a vulnerability factor for depressive symptoms.

1. Introduction

Depression and anxiety are commonly co-occurring problems with symptoms that may be conceptualized on a continuum from mild to severe. Given the common, impairing, and costly nature of these symptoms (McGrath et al., 2012), it is important to understand if personality traits, such as perfectionism, are important contributors to depressive and anxiety symptoms. Identification of such traits will point toward assessment and treatment targets.

Perfectionism is linked to many problems, including depressive and anxiety symptoms (Hewitt & Flett, 1991). Evidence suggests there is a distinction between perfectionistic strivings (rigidly and ceaselessly demanding perfection of oneself) and self-critical perfectionism (nagging doubts about performance abilities, negative reactions to perceived failures, excessive concern of others' evaluations, and intense self-rebuke; Dunkley, Zuroff, & Blankstein, 2003). Because perfectionistic strivings are generally unrelated to depressive and anxiety symptoms (Graham et al., 2010), we focus on self-critical perfectionism here. Research (Dunkley et al., 2003) indicates self-critical perfectionism involves four constructs: self-criticism (Blatt, D'Afflitti, & Quinlan, 1976), socially prescribed perfectionism (Hewitt & Flett, 1991), concern over mistakes, and doubts about actions (Frost, Marten, Lahart, & Rosenblate, 1990).

One potential explanation for the link between self-critical perfectionism and depressive or anxiety symptoms is the vulnerability model, which asserts self-critical perfectionism predicts increased depressive and anxiety symptoms over time. This model is tested with longitudinal designs, with evidence suggesting people high in self-critical perfectionism are vulnerable to increased depressive symptoms (McGrath et al., 2012; Sherry, Mackinnon, Macneil, & Fitzpatrick, 2013). Less is known about perfectionism as a vulnerability factor for anxiety symptoms. Among the very few studies in this area, results are mixed, with studies both confirming (Einstein, Lovibond, & Gaston, 2000) and failing to confirm (Vohs et al., 2001) the vulnerability model of perfectionism predicting anxiety symptoms. These inconsistencies may arise from studying different age groups or using different measures of perfectionism.

Another possible explanation for the association between self-critical perfectionism and depressive or anxiety symptoms is the complication/scar model, which maintains depressive or anxiety symptoms contribute to either permanent changes in personality (i.e., scar effects) or transient changes in personality (i.e., complication effects; McGrath et al., 2012). Our study used a 12-month longitudinal design, and therefore tests complication effects. There is support for the complication model of perfectionism and depressive symptoms (McGrath et al., 2012), but not all studies support this model (Hawley, Ho, Zuroff, & Blatt, 2006). Tests of this model

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involve diverse samples, timeframes, and measures, which may account for inconsistencies. Additional research is needed to confidently (dis)confirm the complication model. Many cross-sectional studies reveal correlations between perfectionism and anxiety symptoms (Kawamura, Hunt, Frost, & DiBartolo, 2001). However, these studies do not illuminate questions of temporal precedence or directionality. To our knowledge, there are no longitudinal studies testing the complication/scar model of perfectionism and anxiety symptoms.

One other potential explanation for the association between self-critical perfectionism and depressive or anxiety symptoms is the reciprocal relations model, which integrates both the vulnerability and complication models. This model posits changes in self-critical perfectionism contribute to increases in depressive or anxiety symptoms and vice versa (Fig. 1). Despite some preliminary support for the reciprocal relations model of perfectionism and depressive symptoms (McGrath et al., 2012), very few studies test this model. Of these studies, our research improves on their methods. Unlike McGrath et al.'s (2012) 1-week measurement intervals, our study uses 6-month measurement intervals to allow more time for personality change. Whereas most studies in this area analyze two waves of data (Vohs et al., 2001), we analyze three waves, thereby capturing a broader and potentially more representative slice of change. Our study will also be the first (we know of) to test reciprocal relations between perfectionism and anxiety symptoms, a surprising omission given numerous calls to clarify questions of directional influence between these variables (Bieling, Summerfeldt, Israeli, & Antony, 2004).

We conducted a 12-month, 3-wave longitudinal study (with 6-month measurement intervals) that tested reciprocal relations between self-critical perfectionism and depressive and anxiety symptoms (Fig. 1). Self-critical perfectionism is strongly stable over time, more than depressive and anxiety symptoms (McGrath et al., 2012). Based on past evidence (Graham et al., 2010; Sherry et al., 2013), we hypothesized first-order autoregressive paths for self-critical perfectionism (capturing rank-order interindividual stability) would show the highest stability, and first-order autoregressive paths for depressive and anxiety symptoms would show somewhat lower stability (vs. self-critical perfectionism). First-order autoregressive paths are immediately adjacent paths (e.g., depressive symptoms at Wave 1 → depressive symptoms at Wave 2).

Building on earlier theory and evidence (Bieling et al., 2004; McGrath et al., 2012), we hypothesized reciprocal relations between self-critical perfectionism and depressive and anxiety symptoms as seen in Fig. 1 (i.e., self-critical perfectionism will predict changes in depressive and anxiety symptoms and vice versa). Self-critical perfectionism involves traits, such as harsh self-rebuke and nagging doubts about performance abilities, which are believed to be part of the personality of people vulnerable to depressive and anxiety symptoms (McGrath et al., 2012). Depressive and anxiety symptoms may also complicate self-critical perfectionism, with the affect, cognition, and behavior comprising depressive and anxiety symptoms exacerbating self-critical perfectionism (McGrath et al., 2012). For example, behavioral avoidance (e.g., skipping class) is a hallmark of depressive and anxiety symptoms, which may contribute to self-critical perfectionists' feelings of failure and imperfection.

2. Method

2.1. Participants

We recruited 302 undergraduates (219 women) from the Department of Psychology at Dalhousie University. Perfectionism, depression, and anxiety are common problems among undergraduates (Johnson & Hayes, 2003). Most participants identified as Caucasian (90.1%). At Wave 1, participants averaged 20.84 years of

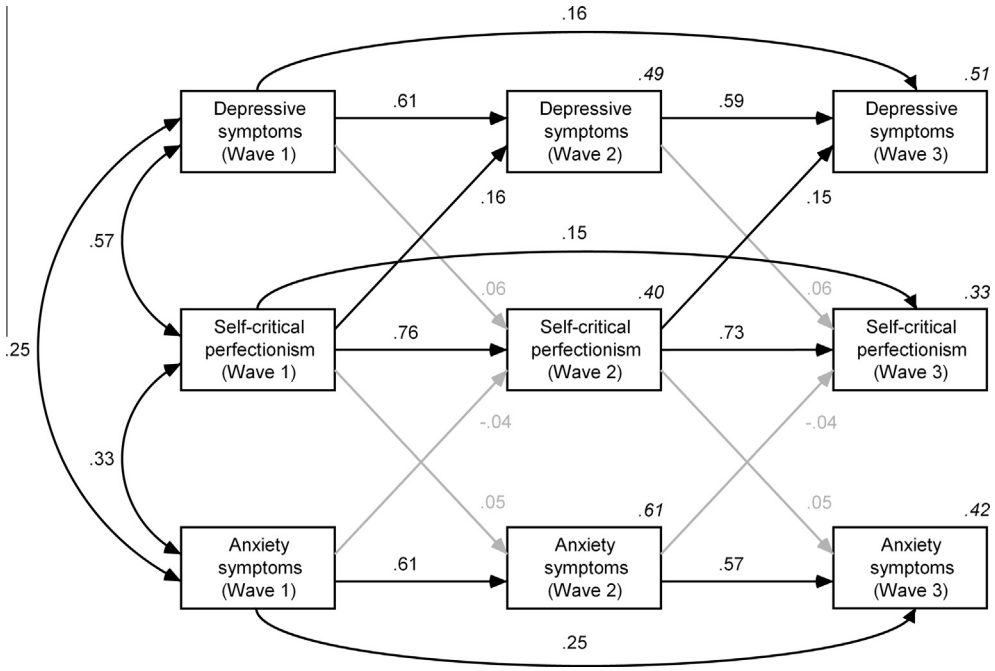

Fig. 1. Hypothesized reciprocal relations model showing cross-lagged path analyses with paths constrained to equality across waves. Rectangles represent measured variables. Double-headed black arrows represent significant correlations ($p < .05$); single-headed black arrows represent significant paths ($p < .05$); single-headed gray arrows represent nonsignificant paths ($p > .05$). Path coefficients are standardized. Italicized numbers in the upper right corner of rectangles (e.g., .51 for Depressive symptoms at Wave 3) represent the amount of variance explained by associated exogenous variables (i.e., R^2 values). Unstandardized path coefficients were constrained to equality; however, standardized path coefficients may vary slightly. Cross-wave correlated errors (e.g., error for self-critical perfectionism at Wave 2 correlated with error for self-critical perfectionism at Wave 3) were specified a priori. Error terms are not displayed.