

Perfectionism and chronic insomnia

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Abstract

The relationship between chronic insomnia and perfectionism was investigated using a sample of 32 adults with chronic insomnia and 26 healthy controls. Different aspects of perfectionism were measured using two Multi-Dimensional Perfectionism Scales [1–3]. Using a univariate approach, results indicated that those with chronic insomnia were more likely to endorse features of “maladaptive” perfectionism relative to healthy controls. Further, those with chronic insomnia were more likely to report doubts

about action, frequent parental criticism, and concern over mistakes. Although those with chronic insomnia were found to be more perfectionistic in these areas, only perception of heightened parental criticism was associated with the reporting of delayed sleep-onset latency. No other aspect of perfectionism was associated with sleep-onset latency, total sleep time, or sleep quality. Implications for theories of the development of insomnia are discussed. © 2000 Elsevier Science Inc. All rights reserved.

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Introduction

Perfectionism is a complex, multi-dimensional construct that has generated considerable research interest over the years [4–6]. Currently there are differing conceptualizations of this construct. For example, several investigators emphasize that perfectionism entails the setting of and striving for unrealistic personal standards, coupled with a tendency to engage in critical self-evaluation when one falls short of such standards [6,7]. Frost et al. [8] suggest that perfectionism is characterized by excessively high standards, excessive concern over mistakes in performance, doubts about the quality of personal performance, perceptions of heightened expectation and evaluation by one's parents, and an exaggerated emphasis on precision, order, and organization. Recently, the interpersonal aspects of perfectionism have been highlighted. Hewitt and Flett [2,3] define “socially-prescribed perfectionism” as the need to meet standards and expectations prescribed by significant others, “other-oriented perfectionism” as the expectation

that others can and should meet high unrealistic standards, and “self-prescribed perfectionism” as the setting of excessively high standards for oneself. Research shows that “socially-prescribed perfectionism” is associated with elevated fear of negative evaluation, need for approval, and external locus of control, “other-oriented perfectionism” is associated with authoritarianism, dominance, and a tendency to blame others, and “self-oriented perfectionism” is associated with general distress, self-criticism, and self-blame [3].

The aspects of perfectionism measured by Frost et al. [1] and Hewitt and Flett [2,3] appear to be inter-related [9]. For example, “socially-prescribed perfectionism” is most strongly related to Frost et al.'s [1] “parental expectations” and “parental criticism” sub-scales, and “other-oriented perfectionism” is most strongly related to Frost et al.'s “concern over mistakes” and “personal standards” sub-scales. It is generally recognized that many of these beliefs and traits can be highly adaptive in the right circumstances and to the appropriate degree. In support of this idea, research has identified an adaptive and maladaptive type of perfectionism. Adaptive perfectionism is associated with good work habits, high need for order and organization, and pleasure gleaned from working towards a goal [5,7]. These qualities are asso-

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ciated with the constructive striving for achievement and self-actualization [5]. In contrast, maladaptive perfectionism is associated with the belief that others have unrealistic expectations of you (i.e., socially-prescribed perfectionism), heightened concern about making mistakes, tendency to doubt oneself, and low self-esteem. Maladaptive perfectionism is associated with a variety of health problems such as depression and suicidal ideation [5,8,10], eating disorders [11], panic disorder [12], sexual dysfunction [13], Type A behavior [14], migraines [15], and recently insomnia [16].

Perfectionism and insomnia

There has been little research in the area of perfectionism and insomnia (See Lundh et al. [16] for an exception), however, there is some indirect evidence that the two constructs are related. First, perfectionism has been associated with heightened distress and arousal [5,6], and heightened arousal has been associated with delayed sleep-onset latency and reduced overall sleep time [17,18] (see Chambers and Keller [19] for an alternative view). Second, a relationship between perfectionism and fatigue has been noted in healthy populations [20]. Third, in clinical settings, perfectionistic individuals with insomnia are reported to expect their sleep to be perfect and to become inordinately frustrated/anxious about any deviations from what is desirable [21]. Finally, Lundh et al. [16], in the single study conducted in this area, found that Swedish patients with insomnia were more perfectionistic (i.e., reported more concern about making mistakes, more doubts about personal action, and higher personal standards) than Swedish community controls. Unfortunately, the authors did not indicate the relationship between perfectionism and sleep parameters. The current study aimed to replicate previous findings with a North American sample and to explore the relationship between perfectionism and various aspects of sleep (e.g., sleep latency and sleep quality).

Method

Participants

Participants were 58 adult volunteers from the community; 32 with chronic insomnia and 26 healthy controls. Participants with insomnia responded to an advertisement placed in a community newspaper offering treatment for people with chronic insomnia. The healthy control sample was recruited with printed notices at grocery stores, libraries, swimming pools, and at a local hospital and paid a \$25 honorarium. Inclusion criteria for the chronic insomnia group were verified by using questionnaire and sleep diary data as well as a modified version of the Structured Clinical Interview for Diagnostic and Statistical

Manual of Mental Disorders (fourth edition) (DSM-IV) axis I disorders (SCID) [22]. Inclusion criteria were as follows: (a) total sleep time <6.5 h per night, (b) either delay in sleep onset >45 min, and/or wake after sleep onset >30 min (c) problems with sleep occurring on at least 4 of 7 nights per week for at least the previous 6 months, (d) at least two daytime effects that the participant attributed to sleep loss, and (e) sleep problem not exclusively due to the presence of a psychiatric disorder. None of the participants met the study's exclusion criteria which were as follows: (a) the presence of shift work, (b) the report of symptoms suggestive of another sleep disorder (e.g., sleep apnea, periodic limb movements) as determined by an interview, (c) presence of an organic mental disorder, bipolar disorder, schizophrenia, or alcohol dependency, (d) serious medical condition, and (e) concurrent psychological treatment. The inclusion criteria for the healthy control group was the absence of any current or past psychiatric diagnosis as obtained using a SCID-screening tool. Written informed consent was obtained from all participants after procedures had been fully explained to them.

Of the sample with insomnia, 72% (23) were female, 94% (30) were Caucasian, and the majority were married (56%). The groups were balanced with regards to education, racial background, and gender; however, the insomnia group was somewhat older (insomnia $M = 46.91$, $S.D. = 10.04$; controls $M = 39.65$, $S.D. = 11.49$) $t(56) = 2.30$, $P = .03$. Of the sample with insomnia, 39% had at least one secondary, co-morbid axis I diagnosis and these were as follows: generalized anxiety disorder (34%), social phobia (16%), hypochondriasis (3%), obsessive-compulsive disorder (3%), and major depression (3%). None of the participants met DSM-IV criteria for panic disorder. None of the healthy controls met criteria for any axis I anxiety or mood disorder.

For the insomnia group, the mean duration of insomnia was 14.37 years ($S.D. = 11.95$). The average total sleep time per night was 5.14 h ($S.D. = 0.89$), the average sleep onset latency was 1.00 h ($S.D. = 1.07$), the average number of awakenings per night was 2.46 ($S.D. = 1.63$), and the average number of hours awake at night was 0.53 ($S.D. = 0.39$). Using the Pittsburgh Sleep Quality Index score (PSQI) [23], the chronic insomnia group reported clinically significant problems with sleep, and their sleep was significantly more disturbed relative to the control group (insomnia $M = 14.14$, $S.D. = 2.99$; control $M = 4.24$, $S.D. = 2.67$) $t(55) = 12.94$, $P = .0001$. Of those in the insomnia group who were using medications for sleep, nine reported using Zopiclone and seven reported using a benzodiazepine. None of those in the healthy control group reported using medications for sleep.

Materials

Two Multi-Dimensional Perfectionism Scales (MPS) [1–3] were used to measure different aspects of perfectionism.

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