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The role of dichotomous thinking and rigidity in perfectionism

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Abstract

Perfectionism is a complex psychological construct that has been defined in many different ways. Recent conceptualisations of perfectionism have involved dividing the construct into positive and negative components. Negative perfectionism is associated with high emotional distress whereas positive perfectionism is associated with positive affect and lower levels of distress. Although these distinctions have been made it remains unclear as to how distinct the two aspects of perfectionism are particularly in terms of their cognitive profiles. This study investigated two cognitive constructs that have been theoretically linked to perfectionism. Dichotomous thinking and rigidity were examined in three samples (40 clinical participants, 111 athletes, 101 students). As hypothesised, the clinical sample had the highest score on negative perfectionism, however, no differences were observed between groups on positive perfectionism. Dichotomous thinking emerged as the variable most predictive of negative perfectionism, and was less strongly related to positive perfectionism. These results highlight the importance of dichotomous thinking as a cognitive construct worthy of further research to understand negative perfectionism. Implications for the development of cognitive therapy interventions for negative perfectionism are discussed.

Keywords: Perfectionism; Dichotomous; Thinking; Rigidity

Perfectionism has been discussed in the literature for many years with various definitions being proposed. Definitions of perfectionism have typically focused on negative aspects, as perfectionism has been found to be elevated in individuals diagnosed with depression, social phobia, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and personality disorders compared to controls (for a review see Shafran & Mansell, 2001).

In addition to the negative aspects of perfectionism there is also evidence that it may include a positive side. In an attempt to understand perfectionism some authors have divided the construct into two aspects; positive and negative perfectionism (Terry-Short, Owens, Slade, & Dewey, 1995). Numerous studies utilising two different Multidimensional Perfectionism Scales (MPS-F; Frost, Marten, Lahart, & Rosenblate, 1990; MPS-H; Hewitt & Flett, 1991) have provided evidence for this with reliable associations between items measuring positive aspects of perfectionism and positive affect as well as items measuring negative

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perfectionism and negative affect. In samples of students and athletes, the MPS-F subscales Concern over Mistakes and Doubts about Actions and MPS-H *other-oriented* and *socially prescribed* perfectionism, have been positively correlated with anxiety, depression and maladjustment. Conversely, the MPS-F subscales Personal Standards and MPS-H *self-oriented* perfectionism have been negatively correlated with anxiety and depression and positively correlated with positive affect (Bieling & Smith, 2001; Enns, Cox, & Clara, 2002; Frost & Henderson, 1991; Frost et al., 1990; Hall, Kerr, & Matthews, 1998; Koivula, Hassmen, & Fallby, 2002; Rice & Dellwo, 2002). Terry-Short et al. (1995) compared individuals with eating disorders, depression, athletes and controls using the Positive and Negative Perfectionism Scale (PANPS). Further evidence was provided for the two categories of perfectionism, with athletes scoring highest on positive perfectionism, and an eating disordered group scoring highest on negative perfectionism. The depressed individuals scored significantly higher on negative perfectionism than controls or athletes, however not as high as the eating disordered group.

Positive perfectionism (or achievement striving as defined by Frost and colleagues) consists of high personal standards without the self-criticism that is associated with negative perfectionism. Although the two aspects of perfectionism are different there is evidence that much overlap exists between the two. For example, an individual may have moderate levels of positive perfectionism and high levels of negative perfectionism at the same time. Clearly it would be desirable to have higher levels of positive perfectionism and lower levels of negative perfectionism. More information is required regarding the differences between positive and negative perfectionism. In particular, understanding the cognitive profiles of each of these types of perfectionism may assist in the development of interventions aimed at reducing negative perfectionism.

Rigidity has been defined as a pattern of resisting "…the acquisition of new behaviour patterns by holding onto previous and non-adaptive styles of performance" (Schaie & Parham, 1975, p. 1). It is regarded as "…an essential component of dysfunctional perfectionism" (Shafran & Mansell, 2001, p. 896), yet only one study has investigated its relationship with perfectionism. Ferrari and Mautz (1997) administered to students a cognitive measure of attitude flexibility which is one part of the Test of Behavioural Rigidity (Schaie & Parham, 1975). They observed significant correlations between attitude flexibility and *self-oriented* perfectionism ($r = -.43$), *socially-prescribed* perfectionism ($r = -.19$) and *other-oriented* perfectionism ($r = -.19$). Essentially, they found that individuals who were more rigid in their thinking were also more perfectionistic. However, no study has yet examined relationships between rigidity and positive or negative perfectionism in a clinical sample.

Dichotomous thinking is another variable that has been linked to perfectionism. Shafran, Cooper, and Fairburn (2002) have developed a model of clinical perfectionism, which they define as "the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences" (p. 778). In their model of clinical perfectionism, Shafran and colleagues propose that dichotomous thinking is a central factor that maintains perfectionism. They suggest that individuals make decisions in a dichotomous way as to whether they have met their high personal standard (either as a complete success or a complete failure). Riley and Shafran (2005) found that dichotomous thinking was present in most individuals qualitatively judged as having clinical perfectionism. Burns and Fedewa (2005) investigated "categorical thinking" and positive and negative perfectionism, using the PANPS in undergraduate students. Categorical thinking had a significant correlation with negative perfectionism ($r = .36$), but no relationship with positive perfectionism ($r = .01$). These results suggest dichotomous thinking is related to negative rather than positive perfectionism. However, there were problems with the study, including poor internal consistency of the categorical thinking scale. Furthermore, the scale also assessed distrust of others and intolerance, which we argue are outside the construct of dichotomous thinking. These components make it difficult to interpret the results. No study to date has directly investigated dichotomous thinking and positive and negative perfectionism in a clinical sample.

Whatever term is used, there is evidence that perfectionism in some cases is associated with positive affect and adjustment and not only with psychopathology. Understanding why this is the case could help further our understanding of the construct. We aimed to understand differences between positive and negative perfectionism by examining their relationships with dichotomous thinking and rigidity. There were two main aims of this research. The first was to compare positive and negative perfectionism between three different