



Multidimensional perfectionism, depression and relational health in women with eating disturbances

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ABSTRACT

Objective: This study investigated multidimensional perfectionism, depression, and relational health and quality across varying severities of eating disorders. The Questionnaire for Eating Disorder Diagnoses (Mintz, O'Halloran, Mulholland, & Schneider, 1997) was used to distinguish clinical, subclinical, and asymptomatic groupings.

Method: The sample included 212 women recruited from a university and an eating disorder treatment center. **Results:** Results indicated significant differences across all the three groups on perfectionistic discrepancy. All three groups also differed on their level of depressive mood. However, there were no significant group differences on relational health and quality.

Discussion: This study contributes to the understanding of intrapersonal and interpersonal correlates of eating disorders and subclinical eating disturbances. This understanding allows for better identification of vulnerability to eating disorders and offers the potential to design more specialized and effective treatments.

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1. Introduction

The incidence of clinical eating disorders is relatively small, yet they are one of the most life-threatening of all psychological syndromes. Lifetime prevalence rates of anorexia nervosa and bulimia nervosa range from 0.3% to 4.2% (American Psychiatric Association [APA] Work Group on Eating Disorders, 2006). Mortality rates among women with eating disorders, and particularly with anorexia, are higher than for any other psychological disorder. The suicide rate for women with anorexia is reported to be twelve times than that of women of matched age in the larger population (APA Work Group on Eating Disorders, 2006). The prevalence of subclinical eating concerns is potentially more far-reaching and while more difficult to estimate, it is thought to affect anywhere from 20% to 60% of college aged women (Maine, 2001; Mintz & Betz, 1988). Over 50% of female college students report a history of chronic dieting, and 40% use diet aids such as drinks or pills to aid in weight loss efforts suggesting that preoccupation with body image and eating is widespread (APA Work Group on Eating Disorders, 2006). These subclinical behaviors are risk factors for the development of full syndrome eating disorders (Lowe et al., 1996).

Theories of eating disorders from psychodynamic and cognitive behavioral traditions point to the importance of identifying the factors in both personality and environment that may hinder recovery.

Psychodynamic theorists have conceptualized eating disorders as related, in part, to a disruption of self-concept often referred to as the false self (Goodsitt, 1983, Strober, 1991). The false self-construct involves having an idealized public self that results from alienation from or disavowal of aspects of the true self that are considered unacceptable (such as rage, vulnerability, trauma). The public false self then cultivates idealized relationships with others which may ultimately feel lonely and disappointing. In this conceptualization, distress is linked to the effort to project a more perfect self, alienation from one's true self, and alienation from genuine connection with others.

From the cognitive behavioral perspective, Fairburn, Cooper, and Shafran (2003) identified four "maintaining mechanisms" that they believe serve as underpinnings of the most treatment-resistant eating disorders. These are (a) "clinical perfectionism" which is the holding of excessively high standards for oneself, (b) interpersonal difficulties, such as conflictual family dynamics, or a pattern of failed relationships, (c) "mood intolerance," or difficulty in managing and regulating mood swings, and, (d) pervasive low self-esteem. These maintaining mechanisms are conceptually related to the construct of the false self, particularly the mechanisms of "clinical perfectionism" (in which the authors are emphasizing that there is a pathological and distressing aspect to the perfectionism) and interpersonal difficulties. Difficulty in tolerating negative affect and the experience of low self-esteem appear to be internal states that may be related to maladaptive perfectionism and interpersonal problems.

There is already a great deal of evidence linking perfectionism with eating disorders (see Bardone-Cone et al., 2007 for a review). However,

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the measures of perfectionism vary widely and measure everything from a fairly simple, unidimensional construct (EDI; Garner, Olmsted & Polivy, 1983), to multidimensional constructs measuring, among other things, expectations from parents (Frost, Marten, Lahart and Rosenblate, 1990), perfectionism directed toward others (Hewitt & Flett, 1991), and both adaptive and maladaptive intrapsychic dimensions of perfectionism (Slaney, Mobley, Trippi, Ashby, & Johnson, 1996). It is important to isolate the way in which perfectionism is problematic for this particular population.

Slaney et al. (1996) developed the Almost Perfect Scale-Revised (APS-R) based on dictionary definitions of perfectionism as “extreme or excessive striving for perfection” and “a disposition to regard anything short of perfection as unacceptable” (p. 131). Two higher-order factors emerged through factor analytic studies (Frost, Heimberg, Holt, & Mattia, 1993). The APS-R measures a positive dimension represented by holding high standards for one self and a negative dimension represented by a perceived discrepancy between high standards and performance. This perceived discrepancy seems to conceptually reflect both the construct of the false self and eating disorder symptomatology in which the individual's desired body image is never attained. Along with discrepancy, perfectionistic concerns around self-image also appear to be conceptually associated with eating disorders. In particular, Hewitt et al.'s (2003) conceptualization of perfectionistic self-presentation (perfectionistic self-promotion, non-display of imperfection, and non-disclosure of imperfection) could have implications for one's body image.

The link between perfectionism and depression has been soundly established (see Shafran & Mansell, 2001 for a review) and women with eating disorders have higher incidences of depressive disorders than the general population (Lewinsohn, Striegel Moore & Seeley, 2000). Wonderlich et al. (2005) found 3 clusters of bulimics: low comorbidity, affective/perfectionistic, and impulsive. Participants in the affective/perfectionistic cluster had high depression, anxiety, and perfectionism and reported the greatest severity of eating disorder symptoms. Thus, higher levels of depression and perfectionism were associated with severity of eating disorder symptoms.

There is also a significant body of research related to eating disorders and interpersonal difficulties. Various studies implicate dysfunctional attachment styles (Cole-DeTke & Kobak, 1996), perceptions of poor social support (Grissett & Norvell, 1992; Rorty, Yager, Buckwalter & Rossotto, 1999), and diminished relationship quality (Grissett & Norvell, 1992, Striegel-Moore, Silberstein, & Rodin, 1986) as co-occurrences with eating disorders. In many of these investigations, social support is measured in a general way (the number of people in a social support network, or the individual's “perceived social support”) that asks the individual to assess his or her overall interpersonal network or support. This does not address the quality of specific relationships. Given the relational bind and the potential for idealization presented by the false self-construct, it may be difficult for those with eating disorders to provide an accurate picture of their overall network. A theory of psychological development that emphasizes relational health suggests another approach.

The relational/cultural theory of psychological development (Jordan, 2002) emphasizes affirming and growth-promoting interpersonal relationships as central to healthy human development. The focus on the quality of specific relationships provided by relational/cultural theory encourages a more detailed account of the important relationships that exist in an individual's life. It also invites an understanding of the depth of these relationships and of what “support” actually means in the context of a particular relationship. In a review of 23 studies of individuals recovered from eating disorders, empathic understanding, and supportive relationships were identified as “critically important” (Bell, 2003).

Although there is an established knowledge base addressing women with eating disorders, those who have disturbed eating but do not meet the criteria for a formal diagnosis deserve attention. Using the Questionnaire for Eating Disorders Diagnoses (Q-EDD; Mintz, O'Halloran, Mulholland, & Schneider, 1997) to conceptualize eating

disturbances may provide a better understanding of individuals at risk of developing eating disorders. The Q-EDD classifies women into three ordered categories of eating disturbances—clinical, subclinical, and asymptomatic. The subclinical group is characterized by a preoccupation with body image and eating and some disordered eating patterns but does not meet the criteria for bulimia, anorexia, or eating disorder not otherwise specified (ED NOS). The asymptomatic group represents individuals with no eating disturbances. Using the Q-EDD, women have been found to differ across groups on various eating related symptoms, such as body dissatisfaction, maturity fears, impulse regulation, and asceticism (Tylka & Subich, 1999). However, data on whether perfectionism levels differ across these three groups are inconsistent. Perfectionism levels measured by the Eating Disorders Inventory-2 (EDI-2; Garner, 1991) did not differ across the three eating disorder groups (Tylka & Subich, 1999), but perfectionism measured by a composite score from the Frost's Multidimensional Perfectionism Scale (Frost et al., 1990) differed based on the severity of the three groups (Peck & Lightsey, 2008). However, in both studies perfectionism was measured as a single variable without taking into account its multidimensionality.

This study aims to examine differences on perfectionism, depression, and interpersonal dimensions across groups with varying levels of eating disturbances. The overall research question for this study was: How do the presence and severity of eating concerns relate to adaptive and maladaptive perfectionism, depression, and having authentic and supportive interpersonal relationships? We hypothesized that the clinical group would have significantly higher mean scores than the subclinical and asymptomatic groups on measures of perfectionistic discrepancy, self-promotion, non-display and non-disclosure of imperfection, depression, and relational health. Similarly, we also predicted that the subclinical group would have significantly higher mean scores on these measures than the asymptomatic group.

2. Method

2.1. Participants

Two hundred and eight women from a Mid-Atlantic public university and 38 women at a Northeast eating disorder treatment center participated in this study. Thirty-four participants were excluded due to missing data leaving 180 college students and 32 clinic participants. The total sample of 212 women included 81.6% Caucasian women, 7.5% African-American women, 3.8% Hispanic women, 3.8% Asian-American/Pacific Islander women, 0.5% Native American women, and 2.8% self-identified as another ethnicity. Ages ranged from 18 to 55 with 91% of the participants between the ages of 18 and 23.

2.2. Measures

2.2.1. Questionnaire for Eating Disorder Diagnoses (Q-EDD; Mintz et al., 1997)

The Q-EDD was used to assess eating disorders. The Q-EDD is a 50-item self-report questionnaire that has been shown to effectively differentiate DSM-IV diagnosed eating disorder, symptomatic (subclinical), and asymptomatic groups. The Q-EDD includes items assessing actual body height/weight and perceptions, such as “How afraid are you of becoming fat/gaining weight”. The symptomatic (subclinical) group is defined as having some features of eating disorders but not meeting the criteria for any of the DSM-IV designated categories. The asymptomatic group has no features of clinical or subclinical eating disorders. Good convergent validity was found between the Q-EDD and the Eating Attitudes Test (EAT; Garner & Garfinkel, 1997), a self-report measure of eating disorder symptoms, and the Bulimia Test-Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991), a self-report measure of DSM-IV bulimia symptoms.

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