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Perfectionism in the Self and Social Contexts: Conceptualization, Assessment, and Association With Psychopathology

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This article attempted to demonstrate that the perfectionism construct is multidimensional, comprising both personal and social components, and that these components contribute to severe levels of psychopathology. We describe three dimensions of perfectionism: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. Four studies confirm the multidimensionality of the construct and show that these dimensions can be assessed in a reliable and valid manner. Finally, a study with 77 psychiatric patients shows that self-oriented, other-oriented, and socially prescribed perfectionism relate differentially to indices of personality disorders and other psychological maladjustment. A multidimensional approach to the study of perfectionism is warranted, particularly in terms of the association between perfectionism and maladjustment.

Historically, the concept of perfectionism has been a topic of widespread interest (e.g., Adler, 1956; Hollender, 1965; Horney, 1950; Missildine, 1963; Pacht, 1984). Related constructs, such as level of aspiration, need achievement, and Type A behavior, have been the focus of extensive research; however, there have been few systematic attempts to examine the perfectionistic personality style. Indeed, only a few investigators have operationalized perfectionism (Burns, 1980; Jones, 1968) or suggested how it might develop as a personality style (Hamachek, 1978; Hollender, 1965).

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Copies of the Multidimensional Perfectionism Scale may be obtained from Paul L. Hewitt and Gordon L. Flett.

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Although perfectionistic behavior has been described as a positive factor in adjustment or achievement (Hamachek, 1978), it has been viewed typically as a pervasive neurotic style (e.g., Flett, Hewitt, & Dyck, 1989; Pacht, 1984; Weisinger & Lobsenz, 1981). Perfectionism has been linked to various negative outcomes including characterological feelings of failure, guilt, indecisiveness, procrastination, shame, and low self-esteem (Hamachek, 1978; Hollender, 1965; Pacht, 1984; Solomon & Rothblum, 1984; Sorotzkin, 1985), as well as more serious forms of psychopathology such as alcoholism, anorexia, depression, and personality disorders (e.g., American Psychiatric Association, 1987; Burns & Beck, 1978; Pacht, 1984). These adjustment difficulties are believed to arise from the perfectionist's tendency to engage in the following: setting unrealistic standards and striving to attain these standards, selective attention to and overgeneralization of failure, stringent self-evaluations, and a tendency to engage in all-or-none thinking whereby *only* total success or total failure exist as outcomes (Burns, 1980; Hamachek, 1978; Hollender, 1965; Pacht, 1984). These characteristics are believed to stem, in part, from the cognitive operations inherent in the ideal self-schema (see Hewitt & Genest, 1990).

Extant conceptualizations of perfectionism are unidimensional in that they focus exclusively on self-directed cognitions (e.g., Burns, 1980), with only implicit references to other dimensions (e.g., Hollender, 1965). Although perfectionism for the self is an essential component of the construct, it is our contention that perfectionism also has its interpersonal aspects and that these aspects are important in adjustment difficulties. The possibility that perfectionism has both personal and social components is consistent with research on the private versus public aspects of the self (Cheek & Briggs, 1982; Fenigstein, Scheier, & Buss, 1975; Greenwald & Breckler, 1985; Schlenker, 1980) and with suggestions that both intraindividual and interindividual personality components are important in the classification and etiology of psychiatric disorders (Kiesler, 1982; McLemore &

Benjamin, 1979; Millon, 1981). Descriptions of the personal and social dimensions of perfectionism are presented later.

The present work focused on three perfectionism components: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. The primary difference among these dimensions is not the behavior pattern per se, but the object to whom the perfectionistic behavior is directed (e.g., self-oriented vs. other-oriented) or to whom the perfectionistic behavior is attributed (e.g., socially prescribed perfectionism). We believe that each of these dimensions is an essential component of overall perfectionistic behavior.

Self-Oriented Perfectionism

Self-oriented perfectionism involves the self-directed perfectionistic behaviors described earlier. Thus, self-oriented perfectionism includes behaviors such as setting exacting standards for oneself and stringently evaluating and censuring one's own behavior. In contrast to past formulations (e.g., Burns, 1980), we believe that self-oriented perfectionism also includes a salient motivational component. This motivation is reflected primarily by striving to attain perfection in one's endeavors as well as striving to avoid failures.

By definition, self-oriented perfectionism should be related to similar forms of self-directed behavior such as level of aspiration and self-blame (Hewitt, Mittelstaedt, & Wollert, 1989). In addition, self-oriented perfectionism has been associated with various indices of maladjustment, including anxiety (e.g., Flett et al., 1989), anorexia nervosa (Cooper, Cooper, & Fairburn, 1985; Garner, Olmstead, & Polivy, 1983), and subclinical depression (Hewitt & Dyck, 1986; Hewitt & Flett, 1990a; Hewitt, Mittelstaedt, & Flett, 1990; Pirot, 1986). One component of self-oriented perfectionism, a discrepancy between actual self and ideal self, has been associated with depressive affect (Higgins, Bond, Klein, & Strauman, 1986; Strauman, 1989) and low self-regard (Hoge & McCarthy, 1983; Lazzari, Fioravanti, & Gough, 1978).

Other-Oriented Perfectionism

Another important dimension of perfectionism involves beliefs and expectations about the capabilities of others. Hollender (1965), for example, suggested that certain individuals engage in interpersonal perfectionistic behavior. The other-oriented perfectionist is believed to have unrealistic standards for significant others, places importance on other people being perfect, and stringently evaluates others' performance. This behavior is essentially the same as self-oriented perfectionism; however, the perfectionistic behavior is directed outward.

Whereas self-oriented perfectionism should engender self-criticism and self-punishment, other-oriented perfectionism should lead to other-directed blame, lack of trust, and feelings of hostility toward others. Furthermore, this dimension should be related to interpersonal frustrations such as cynicism and loneliness and to marital or family problems (Burns, 1983; Hollender, 1965). On a more positive note, other-oriented perfectionism may be associated with desirable attributes such as leadership ability or facilitating others' motivation.

Perfectionism has seldom been studied from a social perspective; however, Hewitt and Flett (1990a) found that other-oriented perfectionism may be distinct from self-oriented perfectionism. Specifically, 150 subjects completed a variety of questionnaires including measures of self-oriented perfectionism and other-oriented perfectionism. In this particular study, the measure of other-oriented perfectionism was created by rewording items on the Burns (1983) measure of perfectionism (e.g., "An average performance by someone I know is unsatisfactory"). Analyses confirmed that both self-oriented perfectionism and other-oriented perfectionism predicted unique variance in depression scores.

Related research on other-directed behavior has indicated that individuals have different sanctioning styles, either characteristically blaming themselves or others for misfortunes (Wollert, Heinrich, Wood, & Werner, 1983), and that each style may contribute to negative emotional states. In addition, research on irrational beliefs has shown that "other-oriented should" statements can be important determinants of interpersonal functioning (Demaria, Kassinove, & Dill, 1989; Kassinove, 1986). Finally, research on the familial aspects of levels of aspiration suggests that parents of asthmatic children are characterized by the perfectionistic standards they have for their children (Morris, 1961). Thus, there is indirect support for the notion that other-oriented perfectionism is a relevant dimension of human behavior and is an important aspect of maladjustment.

Socially Prescribed Perfectionism

The third proposed perfectionism dimension involves the perceived need to attain standards and expectations prescribed by significant others. Socially prescribed perfectionism entails people's belief or perception that significant others have unrealistic standards for them, evaluate them stringently, and exert pressure on them to be perfect.

Intuitively, socially prescribed perfectionism should result in a variety of negative consequences. Because the standards imposed by significant others are perceived as being excessive and uncontrollable, failure experiences and emotional states, such as anger, anxiety, and depression, should be relatively common. These negative emotions could result from a perceived inability to please others, the belief that others are being unrealistic in their expectations, or both. Because individuals with high levels of socially prescribed perfectionism are concerned with meeting others' standards, they should exhibit a greater fear of negative evaluation and place greater importance on obtaining the attention but avoiding the disapproval of others.

At present, there have been no systematic investigations of socially prescribed perfectionism. However, research on expressed emotion has confirmed that people's perception that significant others have overly high expectations for them is related to relapse in schizophrenia (Vaughn & Leff, 1983). Similarly, a recent study by Hooley and Teasdale (1989) on psychosocial predictors of relapse to depression found that the best predictor of relapse was the patients' view of the criticalness exhibited by the spouse.

More general evidence of the importance of socially prescribed standards is provided by experimental work on intrinsic motivation. Research has shown that controlling feedback, which involves the perception that one must meet someone

else's expectations, leads to reduced levels of intrinsic motivation and negative affect (Deci & Ryan, 1985; Ryan, 1982). Finally, discrepancies between the real self and the "ought" self (what others expect of the individual) can result in agitation-related emotions (Higgins et al., 1986; Strauman, 1989).

Assessment of Perfectionism

Before issues related to the significance of self-oriented, other-oriented, and socially prescribed perfectionism can be assessed, it is necessary to develop a reliable and valid instrument for the measurement of each perfectionism dimension. The advent of such a measure would allow models of psychopathology and maladjustment to be tested (Hewitt & Dyck, 1986) and therapy approaches used to treat negative aspects of perfectionistic behavior to be assessed (e.g., Barrow & Moore, 1983; Burns, 1980; Hollender, 1965; Pacht, 1984).

Although several measures of perfectionism have been developed (e.g., Burns, 1983; Hewitt & Flett, 1990a; Jones, 1968), these measures are limited because there have been few attempts to assess their reliability, validity, and possible response biases. Perhaps most important, the tendency to focus narrowly on the nonsocial aspects of perfectionism has probably obscured some potentially important findings involving other-oriented perfectionism and socially prescribed perfectionism.

In the present research, it is shown that perfectionism is multidimensional and that these dimensions can be assessed with an adequate degree of reliability and validity. Moreover, the importance of the multidimensional approach is demonstrated in a study that examines dimensions of perfectionism and pervasive maladjustment in a psychiatric sample.

Study 1

The initial steps in developing a measure of a psychological construct involve explication of the construct in question, rational generation of a large pool of items, and selection of the best items (Jackson, 1970). The purpose of Study 1 was to develop a reliable set of items, derived from psychological theory, tapping the three dimensions of perfectionism, while at the same time controlling for the response bias of social desirability.

Method

Subjects

The subjects were 156 psychology students (52 men and 104 women) at York University. The mean age of the sample was 21 years.

Materials and Procedure

Descriptive passages reflecting the three perfectionism dimensions were derived from case descriptions and theoretical discussions (e.g., Burns & Beck, 1978; Hollender, 1965). These descriptions were presented to a graduate student and three undergraduate students who were asked to generate items (Angleitner, John, & Lohr, 1986) that could be rated for agreement. The resulting 162 items were corrected for clarity, duplicates were deleted, and some items were rephrased to ensure that half were reversed. This resulted in a total of 122 potential items that could be rated for agreement on a 7-point scale.

Subjects were administered the items, with instructions to rate them on a 7-point Likert scale. Subjects also completed the Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960). An item was selected if it had a mean score between 2.5 and 5.5, a correlation of greater than .40 with its respective subscale, and a correlation of less than .25 with the other subscales. Items were retained only if they had a correlation of less than .25 with social desirability. These criteria resulted in the 45-item Multidimensional Perfectionism Scale (MPS), with three subscales of 15 items each for the self-oriented, other-oriented, and socially prescribed dimensions. Representative items are listed in the Appendix.

Results

The means and standard deviations for the subscales are shown in Table 1. The only gender difference was in other-oriented perfectionism, with men scoring higher than women, $t(154) = 2.57$, $p < .01$. The respective means for men and women were 59.9 ($SD = 12.0$) and 54.6 ($SD = 12.7$).

Item-to-subscale total correlations were computed for each item and ranged between .51 and .73 for self-oriented items, .43 and .64 for other-oriented items, and .45 and .71 for socially prescribed items. The coefficient alphas (Cronbach, 1951) were .86 for self-oriented perfectionism, .82 for other-oriented perfectionism, and .87 for socially prescribed perfectionism. Finally, intercorrelations among the MPS subscales ranged between .25 and .40, thus indicating some degree of overlap.[1]

Additional analyses showed that self-oriented perfectionism was not correlated significantly with social desirability. However, small yet significant negative correlations were evident between social desirability and both other-oriented perfectionism, $r(154) = -.25$, $p < .05$, and socially prescribed perfectionism, $r(154) = -.39$, $p < .01$.

Discussion

The results of this study indicate that the perfectionism dimensions have adequate internal consistency and that the subscales share some variance. It is important to note that the subscale intercorrelations were relatively low compared with the magnitude of the subscale alpha coefficients. This difference indicates that the subscales are relatively distinct and are not simply alternate forms of the same dimension. Nunnally (1978) has observed that it is rare for there to be a large discrepancy between the correlation obtained for alternate forms of a test and the alpha coefficients if the alternate forms are measuring the same dimension.

With respect to social desirability, the results indicated that other-oriented and socially prescribed perfectionism are associated with less social desirability and are probably an accurate reflection of the perfectionism construct's association with social desirability. That is, endorsing the presence of unrealistic

[1] There are reasons to expect some degree of overlap among the three dimensions. All three dimensions measure perfectionism and have an implicit or explicit focus on the attainment of standards. Also, Hamachek (1978) has described a phenomenon known as "neurotic perfectionism" in which an individual is high on all forms of perfectionism. The presence of neurotic perfectionism would also contribute to the overlap among the subscales.

Table 1
Means and Standard Deviations of the MPS Subscales

	Self-oriented		Other-oriented		Socially prescribed	
Study	*M*	*SD*	*M*	*SD*	*M*	*SD*
Study 1	65.27	14.01	53.38	12.55	48.17	12.88
Study 2						
Students	68.00	14.95	57.94	11.74	53.62	13.85
Patients	69.90	18.03	55.23	13.45	58.18	15.53
Study 3						
Sample 1	64.65	15.43	56.23	13.48	45.92	13.51
Sample 2	66.72	15.99	55.59	11.66	50.67	14.06
Sample 3	65.87	14.74	55.53	13.16	49.18	13.12
Study 4	73.42	14.90	59.57	11.86	53.66	14.99
Study 5	70.66	18.21	58.07	12.26	60.32	12.58

Note. Higher scores reflect greater levels of self-oriented, other-oriented, and socially prescribed perfectionism. MPS = Multidimensional Perfectionism Scale.

standards for others and being unable to meet others' expectations may be undesirable.

Overall, the procedures used in Study 1 produced a multidimensional measure of individual differences in perfectionistic behavior. The three dimensions appeared to have adequate reliability and internal consistency. Additional research was then conducted to examine the validity of the three perfectionism dimensions.

Study 2

One way of determining an instrument's validity is to examine the underlying structure of the measure using factor-analytic techniques. Because we have proposed that the perfectionism construct assesses three dimensions of perfectionistic behavior, three corresponding factors should emerge from factor analyses of the instrument assessing these dimensions. In this study, we assessed the underlying factor structure in a sample of university students and a sample of psychiatric patients.

Another important step in assessing an instrument's validity is to establish a relation between self-ratings and observer ratings. This procedure provides evidence that individual differences in perfectionistic behavior are observable to others and do not simply reflect self-report biases. In this study, we assessed further the validity of the three dimensions by determining the degree to which others could rate the level of perfectionism in target individuals. A subset of target students completed the MPS and had a significant other use the scale to indicate the target's levels of self-oriented, other-oriented, and socially prescribed perfectionism. Similarly, clinicians provided observer ratings of perfectionism in a subset of psychiatric patients to provide additional evidence that perfectionism is a clinically relevant personality style.

Method

Subjects

The subjects were 1,106 university students (399 men and 707 women) from York University and 263 psychiatric patients (121 men and 142 women) from the Brockville Psychiatric Hospital. The patient sample included in- and out-patients with the most frequent diagnosis of affective disorder.

Materials and Procedure

The 45-item MPS was presented to subjects with instructions to rate their agreement with the statements on a 7-point scale ranging from *strongly disagree* (1) to *strongly agree* (7). The students were administered the MPS in groups of approximately 50. The patients were individually administered the MPS along with other clinical scales.

A subset of 25 target subjects from a fourth-year psychology class completed the MPS. They were then asked to have someone they knew well, such as a spouse or close friend, independently fill out the MPS. The MPS for the significant others had the instructions altered by asking respondents to answer each item as they believed the target person would respond.

Clinician ratings were obtained for a subset of 21 female and male psychiatric outpatients. Three clinical psychologists and one psychometrist were given rating forms and detailed descriptions of the three perfectionism dimensions. The clinicians were asked to rate a sample of their own therapy patients, whom they knew well, on the dimensions using the rating scales provided, then they were asked to administer the MPS to those patients. All ratings were done on an 11-point scale to enable fine discriminations.

Results

Student Sample

The subscale means are presented in Table 1. There were no gender differences in mean subscale scores. Alpha coefficients were calculated to confirm the subscales' high internal consistency. The values were .89 for self-oriented perfectionism, .79 for other-oriented perfectionism, and .86 for socially prescribed perfectionism.

A principal-components factor analysis was performed on the item responses from the student sample.[2] Subsequently, a scree test (Cattell, 1966) confirmed that three factors should be retained, accounting for 36% of the variance. The first factor comprised all 15 items of the self-oriented scale, with factor loadings ranging between .45 and .66. The second factor included all 15 socially prescribed items, with factor loadings ranging between .39 and .63. Finally, the third factor was made up of 13 other-oriented items, with loadings ranging between .38 and .63. The other two items from the other-oriented subscale had factor loadings of .24 and .32 on this third factor but had slightly higher loadings on the second factor.

Patient Sample

The subscale means for this sample are also included in Table 1. Men had higher other-oriented perfectionism scores than women, $t(263) = 3.02$, $p < .01$; however, no other gender differences were found. The alpha coefficients in the patient sample were .88 for self-oriented perfectionism, .74 for other-oriented perfectionism, and .81 for socially prescribed perfectionism.

[2] Factor analyses were done on men and women separately. Because the results were highly similar for men and women, the data were collapsed across gender.

Identical factor-analytic procedures were used with these data, and again three factors emerged, accounting for 34% of the variance. Following rotation, 14 of the 15 self-oriented items loaded highest on the first factor (loadings ranged from .36 to .77), with the remaining item loading highest on the third factor. Fourteen items of the socially prescribed subscale loaded highest on the second factor (loadings ranged from .32 to .63), with one item loading higher on the third factor. Finally, 10 other-oriented items loaded highest on the third factor (loadings ranged from .33 to .60). Remaining items loaded complexly on the first and third factors.

The factor structures obtained with data from the two samples were quite similar with the exception of a few items measuring other-oriented perfectionism. It was expected that the student sample factor analysis would correspond closely to the three dimensions because the scale was developed originally on a sample of college students. In order to determine whether the factor structure was similar for the two samples, a stringent test of the factor structure's replicability was performed by computing the coefficient of congruence (Harman, 1976). The respective coefficients of congruence were .94 for the first factor (self-oriented perfectionism), .93 for the second factor (socially prescribed perfectionism), and .82 for the third factor (other-oriented perfectionism). The magnitude of these coefficients indicates that the factor structure is highly similar across the two samples (Harman, 1976).

Observer Ratings

Correlations were calculated between the student targets and the MPS scores supplied by observers. The correlation was significant for self-oriented perfectionism, $r(23) = .35$, $p < .05$. Similarly, significant correlations were obtained for ratings of other-oriented perfectionism, $r(23) = .47$, $p < .01$, and socially prescribed perfectionism, $r(23) = .49$, $p < .01$. Importantly, significant correlations were not obtained when correlations were computed between the measures not tapping the same dimension (e.g., the subjects' ratings of self-oriented perfectionism and the observers' ratings of other-oriented perfectionism).

Further analyses revealed that the correlations between clinician ratings and MPS scales were significant for self-oriented perfectionism, $r(19) = .61$, $p < .01$, other-oriented perfectionism, $r(19) = .43$, $p < .05$, and socially prescribed perfectionism, $r(19) = .52$, $p < .01$. Once again, significant correlations were not obtained between measures not tapping the same dimension.

Discussion

In addition to providing normative data, the results of this study show that there are few gender differences in mean levels of perfectionism, with the possible exception of other-oriented perfectionism being higher in men with severe adjustment problems. Moreover, this study demonstrated that the three MPS subscales have an adequate degree of internal consistency.

More important, the results of Study 2 provided support for the hypothesized dimensionality of the MPS. It was found that the MPS has three underlying factors that correspond to the three proposed dimensions of perfectionistic behavior in both clinical and nonclinical samples.

The results involving observer ratings confirmed that levels of self-oriented, other-oriented, and socially prescribed perfectionism are observable to others. These data constitute additional evidence for the view that perfectionism is salient in interpersonal contexts. Both clinicians and students' significant others appear to be able to observe the various dimensions of perfectionistic behavior in targets.

Study 3

There are certain requirements when developing a new measure of personality traits. For example, issues related to the scale's construct validity must be addressed. The essence of construct validation is to demonstrate that the scale in question measures only what it purports to measure (Campbell & Fiske, 1959; Cronbach & Meehl, 1955; Hogan & Nicholson, 1988; Wiggins, 1973).

In this study, convergent and discriminant validity were assessed by administering numerous measures related to self- and socially related behavior. It has been argued previously that self-oriented perfectionism is a self-directed personality pattern that is relatively distinct from the social aspects of perfectionism. Thus, self-oriented perfectionism should be related most highly to self-related constructs (e.g., self-criticism and high self-standards), other-oriented perfectionism should be related most highly to other-directed constructs (e.g., authoritarianism and other-blame), and, finally, socially prescribed perfectionism should be related most highly to perceptions of socially related information (e.g., fear of negative evaluation, concern with social approval, and external locus of control).

Subjects in this study also reported their academic standards and the academic standards imposed on them by significant others. Because perfectionism entails standard setting and motivation to attain standards, self-oriented perfectionism should be related to indices of self-standards. Socially prescribed perfectionism, on the other hand, should be related to indices of the standards expected by others.

Further evidence of the construct validity of the MPS was obtained by examining dimensions of perfectionism and dimensions of narcissism and general psychopathology. It has been observed that narcissists strive for perfection, both for themselves and for other people (Akhtar & Thompson, 1982; Emmons, 1987; Freud, 1957; Raskin & Terry, 1988). Thus, showing that only self-oriented and other-oriented perfectionism are associated with narcissism would support the validity of the three subscales.

It has also been argued that perfectionism plays an important role in maladjustment. The validity of the perfectionism dimensions in relation to adjustment problems was assessed by having subjects complete a multidimensional measure of general psychopathology.

Another requirement in test construction is evidence of the instrument's stability over time. This is important not only to support the reliability of the scale but also to provide evidence that the scale measures a personality trait that is stable.

Method

Subjects

Three separate samples of subjects participated in this study. The subjects in Sample 1 were 104 students (33 men and 71 women) with a mean age of 22.1 years who completed the MPS, personality, and psychopathology measures. Thirty-four randomly selected subjects from this sample completed the MPS at Time 1 and 3 months later at Time 2 to assess test–retest reliability. A second sample of 93 students (29 men and 64 women) completed the MPS and a measure of narcissism. Finally, a third sample of 45 female students completed the MPS and measures of authoritarianism and dominance.

Materials and Procedure

The subjects were recruited from several classes at York University. They completed the MPS and the following personality measures:

Attitudes Toward Self. This scale assesses high self-standards, self-criticism, and overgeneralization of failure (see Carver, LaVoie, Kuhl, & Ganellen, 1988).

Self- and Other-Blame. The Self- and Other-Blame Scale (Mittelstaedt, 1989) is a 32-item measure of the degree of blame or criticism that is directed toward the self and blame directed toward others. Mittelstaedt (1989) has provided evidence of the scale's reliability and validity.

The Authoritarianism Scale. The Authoritarianism Scale is a 35-item measure of individual differences in authoritarian behavior (Heaven, 1985).

The General Population Dominance Scale. This scale was developed to assess dominance behavior directed toward others that is distinct from authoritarianism (Ray, 1981).

Fear of Negative Evaluation. The brief Fear of Negative Evaluation Scale is a measure of the degree to which people experience apprehension at the prospect of being evaluated negatively (Leary, 1983).

Irrational Beliefs Test. The Demand for Approval of Others subscale from the Irrational Beliefs Test (Jones, 1968) measures the need to be approved by every significant person.

Locus of Control Scale. The Locus of Control Scale (Rotter, 1966) is a well-known measure of the extent to which an individual perceives that rewards are due to an internal versus an external cause.

Academic standards. Two questions assessed minimum grades: "What is the lowest letter grade you could get that you would be satisfied with?" (minimum self-standard) and "What is the lowest letter grade you could get that some person who is important to you would be satisfied with?" (minimum social standard). Two questions also assessed ideal grades: "What letter grade would you ideally like to get in a course?" (ideal self-standard) and "What letter grade would some person who is important to you ideally like you to get in a course?" (ideal social standard). The responses were converted to a 15-point scale, with higher scores representing higher standards.

Performance importance was also assessed: "How important is it to you to do well in your courses?" (self-importance of performance), "How important is it to you to live up to your own goals and standards?" (self-importance of goal attainment), and "How important is it to you to live up to other people's goals and standards?" (social importance of goal attainment). Ratings were made on 11-point scales; higher ratings reflected greater importance.

The Narcissistic Personality Inventory. This is a 40-item forced-choice inventory that provides a total score of narcissistic tendencies and subscale measures of authority, self-sufficiency, superiority, exhibitionism, exploitativeness, vanity, and entitlement (Raskin & Terry, 1988).

Symptom Checklist 90–Revised. The Symptom Checklist 90–Revised (SCL-90; Derogatis, 1983) is a measure of general maladjustment with general distress and symptom indices such as anxiety, depression, and paranoia.

Results

The correlations between self-oriented perfectionism and the personality variables are presented in Table 2. Self-oriented perfectionism was correlated significantly with such self-related measures as high standards, self-criticism, and self-blame. Self-oriented perfectionism was not correlated with demand for approval of others, fear of negative evaluation, locus of control, authoritarianism, dominance, or other-directed blame, supporting the discriminant validity of this subscale.

The correlations between perfectionism dimensions and academic standards are also presented in Table 2. The self-oriented subscale was not correlated significantly with the measures of minimum or ideal self-standards; however, a gender difference was evident in that self-oriented perfectionism and minimum self-standards were correlated for women, $r(69) = .30$, $p < .01$, but not for men, $r(31) = -.17$, *ns.* Additionally, self-oriented perfectionism was correlated significantly with both self-importance of performance and self-importance of goal attainment. Finally, more evidence of discriminant validity was provided by the finding that there were no significant correlations between these self-measures and either other-oriented perfectionism or socially prescribed perfectionism.

Table 2 also presents the correlations involving other-oriented perfectionism. As expected, a positive correlation was obtained between other-oriented perfectionism and other-blame, as well as between other-oriented perfectionism and both authoritarianism and dominance. Although this subscale was not correlated with measures such as demand for approval of others, fear of negative evaluation, and locus of control, thus supporting its discriminant validity, there were significant correlations between other-oriented perfectionism and high standards and self-criticism.

As predicted, socially prescribed perfectionism correlated significantly with measures of demand for approval of others, fear of negative evaluation, and locus of control (see Table 2). Although socially prescribed perfectionism was associated significantly with some self-related measures, such as self-criticism, overgeneralization of failure, self-blame, and other-blame, it was not correlated significantly with high self-standards, authoritarianism, or dominance.

The correlations involving socially prescribed perfectionism and academic standards showed that, as expected, socially prescribed perfectionism was correlated significantly with minimum social standards, ideal social standards, and the social importance of goal attainment. As a further indication of the discriminant validity of the socially prescribed perfectionism subscale, this subscale was not correlated with any of the self-standard or self-importance measures.

The correlations between perfectionism dimensions and narcissism dimensions are also presented in Table 2. As expected, only the self-oriented and other-oriented perfectionism subscales correlated with narcissism. Self-oriented perfectionism was correlated with overall narcissism, authority, and entitle-

Table 2
Correlations Between the MPS Subscales and the Personality Measures, Performance Standards, and SCL-90 Subscales

Measure	Self-oriented	Other-oriented	Socially prescribed
Personality measures			
High self-standards	.46***	.22*	.16
Self-criticism	.46***	.25**	.48***
Overgeneralization	.19	.10	.42***
Self-blame	.21*	.12	.49***
Other-blame	.15	.43***	.35***
Authoritarianism	.24	.32*	.01
Dominance	.20	.30*	−.21
Fear of negative evaluation	.04	.17	.46***
Approval of others	−.03	.19	.27**
Locus of control	−.11	.12	.20*
Total narcissism	.21*	.29**	−.02
Authority	.26*	.24*	−.05
Self-sufficiency	.20	.13	.00
Superiority	.09	.15	−.15
Exhibitionism	−.01	.15	.03
Exploitativeness	.07	.23*	.06
Vanity	.08	.07	−.01
Entitlement	.23*	.34**	.18
Performance standards			
Minimum self-standard	.13	.11	−.02
Ideal self-standard	.12	.04	.04
Self-importance—performance	.57***	.16	.09
Self-importance—goals	.53***	.19	.06
Minimum social standard	.10	.29**	.31*
Ideal social standard	.03	.11	.25*
Social importance goals	.29**	.30**	.36***
SCL-90 subscales			
Somatization	.21*	.07	.38***
Obsessive–Compulsive	.23*	.19	.49***
Interpersonal Sensitivity	.23*	.15	.45***
Depression	.28**	−.05	.48***
Anxiety	.30**	.16	.30**
Hostility	.30**	.16	.30**
Phobias	.23*	.21*	.38***
Paranoia	.23*	.23*	.52***
Psychoticism	.23*	.06	.37***

Note. Correlations are based on responses of 104 students, except the authoritarianism and dominance measures, which are based on 45 students, and the narcissism measures, which are based on 91 students. MPS = Multidimensional Perfectionism Scale. SCL-90 = Symptom Checklist 90–Revised.
* $p < .05$, ** $p < .01$, *** $p < .001$.

ment. Significant associations were also found between other-oriented perfectionism and various measures of narcissism, including overall narcissism, authority, exploitativeness, and entitlement. Finally, as expected, socially prescribed perfectionism was not correlated with any of the narcissism measures.

The correlations between self-oriented perfectionism and the SCL-90 show that all of the symptom scales were correlated significantly with self-oriented perfectionism, indicating that self-oriented perfectionism is related broadly to psychological distress and specific symptom patterns in college students.

Other-oriented perfectionism was correlated significantly only with the SCL-90 phobic anxiety and paranoia subscales. A pattern of gender differences emerged, with other-oriented perfectionism in men correlating with obsessive compulsiveness, $r(31) = .38$, $p < .05$; interpersonal sensitivity, $r(31) = .45$, $p < .01$; anxiety, $r(31) = .47$, $p < .01$; hostility, $r(31) = .43$, $p < .05$; phobic anxiety, $r(31) = .43$, $p < .05$; and paranoia, $r(31) = .40$, $p < .01$. There were no significant correlations between other-oriented perfectionism and SCL-90 measures for women.

Consistent with the view that socially prescribed perfectionism is closely linked with maladjustment, the socially prescribed subscale was also correlated moderately with all of the SCL-90 subscales.

Strong evidence of the temporal stability of the dimensions was obtained. The test–retest reliabilities were .88 for self-oriented perfectionism, .85 for other-oriented perfectionism, and .75 for socially prescribed perfectionism.

Discussion

The results of this study provide extensive evidence for the validity of the MPS subscales. Self-oriented perfectionism was correlated significantly with several self-related constructs, supporting the notion that this subscale measures a self-related personality pattern. Similarly, it was found that other-oriented perfectionism was most highly correlated with a tendency to blame others and with other-directed patterns such as authoritarianism and dominance. Finally, the socially prescribed perfectionism subscale was found to relate significantly with measures of social behaviors such as fear of negative social evaluation, a need for approval from others, and an external locus of control.

Further evidence for the validity of the subscales was provided by the correlations involving the measures of academic standards and the importance of actual academic performance. It was found that significant positive correlations were present between self-oriented perfectionism and self-ratings of performance importance and the importance of attaining one's goals. Likewise, socially prescribed perfectionism was correlated significantly with such measures as the importance of meeting other people's performance expectations and the ideal standards prescribed by others.

Mixed support was found for the discriminant validity of our subscales in this study. Clearly, there were some indications of discriminant validity. Self-oriented perfectionism was the only MPS dimension correlated with the self-ratings of the importance of performance and goal attainment. However, certain other measures were correlated with more than one perfectionism dimension. Self-criticism, for example, was associated positively with all three perfectionism dimensions. These findings may signify problems with discriminant validity due to overlap. Alternatively, this may be a true reflection of the nomological network comprising the perfectionism construct. It is possible, for instance, that self-criticism is a response common to all forms of perfectionism, but the reasons for the self-criticism may stem from different sources (i.e., failures of the self, failures of others, and being criticized by others). Whatever the case, it appears that additional evidence of the instrument's discriminant validity is required.

The pattern of correlations with the perfectionism measures provides support that the significant relations were not due simply to method variance. If method variance was responsible for the correlations, all correlations between measures using the same format should be significant and positive. This was clearly not the case with the present data.

Another goal of this study was to provide some initial data on the extent to which the perfectionism dimensions are related to general psychopathology in college students. In this regard, the results showed that self-oriented perfectionism was correlated significantly with scores on all indices of poor adjustment. These data corroborate the results of past studies using different perfectionism measures showing a relation between perfectionistic standards for the self and adjustment difficulties (Flett et al., 1989; Hewitt & Dyck, 1986; Hewitt et al., 1989, 1990). These data extended past findings by showing that other-oriented perfectionism in men, and socially prescribed perfectionism in both men and women, may also play a role in personal adjustment. The fact that the strongest correlations involved the socially prescribed perfectionism dimension suggests that this dimension may be central to the experience of poor adjustment.

The final goal of this study was to examine the temporal stability of the three dimensions. Evidence of the stability of the subscales was obtained. Although these findings must be replicated, they constitute important evidence that perfectionism is a trait that remains relatively stable over time.

Study 4

In Study 4, we sought to extend the evidence of the measure's validity by examining predictions regarding the link between perfectionism and the experience of one aspect of maladjustment, negative emotion. Hamachek (1978), for instance, hypothesized that guilt arises from the inability of the perfectionist to attain his or her standards. Thus, whereas self-oriented perfectionism may be related to guilt and disappointment, socially prescribed perfectionism should be related to emotions such as anger. Anger is typically conceptualized as a "social" emotion that arises from the perception of intentional misdeeds on the part of others (Averill, 1983). In this instance, anger would stem from the perceived tendency for other people to endorse unfair expectations.

As noted earlier, it is important to demonstrate the concurrent validity of new measures of personality traits. In this study, additional validity evidence was obtained by comparing scores on the MPS to another measure of perfectionism described as measuring self-oriented perfectionistic attitudes (Burns, 1983). It was expected that the largest positive correlation would be between the Burns scale and the MPS self-oriented perfectionism subscale.

The final goal of this study was to investigate further the role of response biases in perfectionism. A broader assessment of the possible role of response bias was obtained in this study by having the subjects complete a measure of impression management (Gur & Sackeim, 1979).

Method

Subjects

A total of 91 undergraduate students (34 men and 57 women) from York University were the subjects. The mean age of the sample was 25.4 years.

Materials and Procedure

In addition to the MPS, subjects completed the following measures in groups of approximately 30 people:

Multidimensional Anger Inventory. The Multidimensional Anger Inventory (Siegel, 1986) is a measure of the frequency, magnitude, duration, range, and expression of anger.

Problem Situation Questionnaire. This scale was designed as a situation-specific measure of guilt; it also provides measures of regret, shame, and disappointment. Klass (1987) has provided preliminary evidence of the scale's reliability and validity.

Burns Perfectionism Scale. This is a 10-item measure of irrational beliefs related to self-oriented perfectionism (Burns, 1983).

Other-Deception Questionnaire. This is a measure of impression management that has been used to assess levels of desirable responding (Gur & Sackeim, 1979).

Results

The correlations between the MPS subscales and the other measures are displayed in Table 3. The analyses involving the emotion measures obtained significant correlations between self-oriented perfectionism and guilt, disappointment, and anger. Other-oriented perfectionism was not correlated significantly with the emotion measures; however, socially prescribed perfectionism was correlated significantly with anger. Marginally significant correlations were obtained between this perfectionism subscale and both shame, $r(89) = .17$, $p < .06$, and guilt, $r(89) = .15$, $p < .10$. With respect to gender differences in the correlations, women tended to show slightly higher positive correlations between socially prescribed perfectionism and regret, disappointment, and guilt. These differences were not significant.

As expected, the Burns scale correlated most strongly with the self-oriented perfectionism scale; however, it also correlated with other-oriented perfectionism and socially prescribed perfectionism. The correlation between the two self-oriented perfectionism measures was not significantly greater than the correlation between the Burns scale and other-oriented perfectionism, $z = 0.22$, $p > .05$, but it was significantly greater than the correlation between the Burns scale and socially prescribed perfectionism, $z = 2.52$, $p < .05$.

The correlations between the MPS subscales and the measure of impression management are also shown in Table 3. The only correlation approaching significance involved socially prescribed perfectionism, but, as was shown in Study 1, greater socially prescribed perfectionism was associated with less impression management. Thus, the three perfectionism dimensions do not appear to be influenced strongly by this response bias.

Discussion

Overall, these findings provide additional evidence suggesting that the three perfectionism dimensions have an adequate degree of validity. There were many significant correlations between the perfectionism and emotion measures. Consistent with the results of Study 3, self-oriented and socially prescribed perfectionism were the dimensions most closely associated with these negative emotions. Although the significant correlations tended to be small in magnitude, this is not surprising in that these emotion measures did not involve the assessment of emotional responses following a specific stressor in a naturalistic setting. The measure of guilt (Klass, 1987), for instance, involves imagined responses to hypothetical situations.

Evidence of concurrent validity was obtained in that all three dimensions were correlated significantly with scores on the Burns scale of self-oriented perfectionism, but the largest correlation was obtained with our measure of self-oriented perfectionism. Finally, results indicated that scores on the various subscales are not influenced strongly by attempts to create a favorable impression of oneself.

Table 3
Correlations Between MPS Subscales and Emotion Measures

Measure	Self-oriented	Other-oriented	Socially prescribed
Guilt	.18*	.12	.15
Self-disappointment	.27**	.17	.13
Regret	.15	.13	.15
Shame	.14	.17	.17
Anger	.20*	.08	.44**
Burns perfectionism	.57**	.40**	.39**
Other deception	.13	.02	−.17

Note. Correlations are based on the responses of 91 university students. MPS = Multidimensional Perfectionism Scale.
* $p < .05$. ** $p < .01$.

Study 5

Overall, the results of the first four studies indicate that individual differences in self-oriented, other-oriented, and socially prescribed perfectionism can be assessed in a reliable, valid manner in both college students and psychiatric patients and that these three perfectionism dimensions are associated with theoretically similar constructs. However, as noted in a recent article (Frese, Stewart, & Hannover, 1987), it is not enough to demonstrate that a new conceptualization of a construct exists. The practical importance of the new conceptualization must also be demonstrated.

Perhaps one of the most important means of demonstrating the usefulness of a multidimensional approach to perfectionism is to establish that these dimensions are associated differentially with severe psychopathology. Although the previous studies indicated that perfectionism is related to indices of negative affect and adjustment difficulties in college students, it is important to show that perfectionism plays a role in the lives of individuals who have been affected seriously by psychopathology. Consequently, the primary purpose of Study 5 was to test the hypothesis that perfectionism is correlated significantly with the experience of certain personality disorders in psychiatric patients.

The link between perfectionism and personality disorders is suggested both by clinical observations (Millon, 1981) and by past research (Broday, 1988; Lohr, Hamberger, & Bonge, 1988). Broday (1988) administered the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983) and two measures of self-oriented perfectionistic beliefs to a sample of student clients at a university counseling center. It was found that perfectionism was correlated positively with measures of avoidant, dependent, passive–aggressive, and schizoid personality disorders and was correlated negatively with histrionic and obsessive–compulsive personality disorders.

Likewise, a study of spouse abusers by Lohr et al. (1988) also indicated a link between perfectionism and various personality disorders. Lohr et al. (1988) used the MCMI to identify a group of spouse abusers that was distinguished by perfectionism in the form of high self-expectations. These individuals were characterized by passive aggressiveness and avoidant tendencies along with borderline and paranoid features.

These studies suggest an association between perfectionism and certain personality disorders; however, the role of the various perfectionism dimensions is unclear because social aspects of the construct have not been taken into account. The importance of considering social factors is revealed by an examination of relevant literature on obsessive–compulsive personality disorders (e.g., American Psychiatric Association, 1987; Millon, 1981). Perfectionism demanded from the self is recognized as a diagnostic feature of individuals with an obsessive–compulsive personality disorder (American Psychiatric Association, 1987). Although this may indeed be true, Ingram (1982) has stated that the obsessive–compulsive personality disorder is characterized by the tendency to impose unrealistic demands on others, in conjunction with a tendency to adopt standards imposed by parents. From Ingram's perspective, only other-oriented and socially prescribed perfectionism should be important in obsessive–compulsive personality disorders (also see Millon, 1981).

The social aspects of perfectionism have been implicated as possible contributing factors in several other personality disorders. For instance, it has been suggested that individuals with a narcissistic personality disorder have highly unrealistic expectations for others and are quick to criticize the behavior of others (e.g., Kernberg, 1975; Kohut, 1971). Indeed, a link between other-oriented perfectionism and elements of narcissism in college students was found in Study 3. Thus, individuals with a narcissistic personality disorder should exhibit high levels of other-oriented perfectionism. Finally, Millon (1969) has observed that a central feature of both the schizoid and avoidant personality disorders is people's perception that other individuals have unrealistic expectations for them and are critical in their evaluations (e.g., Millon, 1969). Thus, socially prescribed perfectionism should be correlated highly with measures of these two personality disorders. These various observations were examined empirically in Study 5 by having a clinical sample of psychiatric patients complete the MCMI (Millon, 1983) along with our perfectionism measure.

A second goal of this study was to examine how individual differences in perfectionism relate to Axis I disorders as espoused in the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, Revised) (*DSM-III-R;* American Psychiatric Association, 1987). As noted earlier, perfectionism has long been associated with a variety of psychological difficulties; however, most of this research has used student samples. In fact, it was demonstrated in Study 3 that self-oriented and socially prescribed perfectionism were associated with several measures of adjustment problems in college students. It is clearly important to examine the generalizability of these findings in clinical samples. Because the MCMI also provides measures of clinical symptom syndromes (e.g., alcohol abuse, anxiety, and psychotic thinking), its inclusion in the present study enabled us to obtain some initial data on the association between dimensions of perfectionism and symptoms indicating the presence of Axis I disorders.

Method

Subjects

The subjects were 77 adult psychiatric patients (39 men and 38 women) from the Brockville Psychiatric Hospital. The sample comprised 31 inpatients and 46 outpatients. The most frequent primary diagnoses, according to the *DSM-III-R*, were schizophrenia (33.8%), affective disorder (19.5%), alcohol/drug dependency (11.7%), marital/family problems (11.7%), personality disorder (9.1%), and adjustment disorder (6.5%). Subjects with less than a Grade 8 education, over the age of 65 years, with organic impairment, or with active psychosis were excluded. The mean age of the sample was 35.86 years.

Materials and Procedure

Initially, the names of patients were provided by clinicians at the Brockville Psychiatric Hospital. The subjects were contacted and asked to participate in a study of personality and distress. All subjects were paid $10 for their participation and were administered the MPS and the MCMI in a random order in small groups. They were encouraged to ask for help if there were any problems in understanding the tasks.

The MCMI (Millon, 1983) is a 175-item true–false instrument that contains 20 scales relevant to the *DSM-III*. It has subscales of moderate personality disorders (e.g., avoidant, dependent, and histrionic) as well as severe personality disorders (i.e., schizotypal, borderline, and paranoid). It also has symptom-related subscales (e.g., alcohol abuse, anxiety, and psychotic depression). There is evidence of the MCMI's validity (McMahon & Davidson, 1986; Millon, 1983) and stability (McMahon, Flynn, & Davidson, 1985; Piersma, 1986) in a variety of populations.

Results

Perfectionism and Personality Disorders

The correlations between the MPS and MCMI personality subscales are shown in Table 4. Interestingly, self-oriented perfectionism was not correlated with any personality subscales for the total sample. Although direct tests found that there were no gender differences in the strength of the correlations, it should be noted that self-oriented perfectionism was correlated positively with paranoia, $r(37) = .40$, $p < .05$, for men, and it was correlated negatively with the schizotypal subscale, $r(36) = -.34$, $p < .05$, for women. There was also a marginally significant relation between self-oriented perfectionism and dependency, $r(37) = .27$, $p < .10$, for men.

Other-oriented perfectionism was correlated positively with the histrionic, narcissistic, and antisocial subscales and negatively with the schizotypal subscale. As for gender differences, other-oriented perfectionism was not correlated with any basic personality patterns for men, with the exception of a marginally significant correlation with paranoia, $r(37) = .27$, $p < .10$. However, for women, other-oriented perfectionism correlated positively with the histrionic, $r(36) = .36$, $p < .05$; narcissistic, $r(36) = .41$, $p < .05$; and antisocial subscales, $r(36) = .41$, $p < .01$. It was negatively correlated with the schizoid, $r(36) = -.37$, $p < .05$; avoidant, $r(36) = -.29$, $p < .10$, and schizotypal subscales, $r(36) = -.42$, $p < .001$.

The greatest number of significant correlations was obtained with the socially prescribed perfectionism dimension. Socially prescribed perfectionism correlated positively with the schizoid, avoidant, and passive aggressive patterns and correlated negatively with the compulsive pattern. Furthermore, it correlated in a positive direction with the schizotypal and the bor-

Table 4
Correlations Between MPS Subscales and MCMI Subscale Measures

MCMI subscale	Self-oriented	Other-oriented	Socially prescribed
Basic personality patterns			
1. Schizoid	−.07	−.11	.33**
2. Avoidant	.03	−.09	.38**
3. Dependent	.17	−.06	.12
4. Histrionic	.09	.26*	−.13
5. Narcissistic	.13	.31**	−.17
6. Antisocial	.08	.29**	−.08
7. Compulsive	−.11	−.10	−.27*
8. Passive Aggressive	.07	.00	.40***
Pathological personality disorders			
S. Schizotypal	−.17	−.23*	.27*
C. Borderline	.11	−.08	.49***
P. Paranoia	.19	.17	.08
Clinical symptom subscales			
A. Anxiety	.12	.01	.42***
H. Somatoform	.23*	.04	.35**
N. Hypomania	.33**	.23*	.28*
D. Dysthymia	.03	−.07	.40***
B. Alcohol Abuse	.22*	.20	.27*
T. Drug Abuse	.08	.31**	.02
SS. Psychotic Thinking	−.02	−.12	.31**
CC. Psychotic Depression	−.03	−.16	.39**
PP. Psychotic Delusions	.16	−.02	.08

Note. Correlations are based on the responses of 77 psychiatric patients. MPS = Multidimensional Perfectionism Scale. MCMI = Million Clinical Multiaxial Inventory.
* $p < .05$. ** $p < .01$. *** $p < .001$.

derline patterns. The obtained pattern of correlations was virtually identical for men and women.

Perfectionism and Clinical Symptom Syndromes

The correlations between perfectionism measures and clinical symptom syndromes are also presented in Table 4. Self-oriented perfectionism correlated significantly with somatoform symptoms, hypomania, and alcohol abuse. Men demonstrated positive correlations between self-oriented perfectionism and alcohol abuse, $r(37) = .32$, $p < .05$, and drug abuse, $r(37) = .35$, $p < .05$. As for women, greater self-oriented perfectionism was associated significantly with greater hypomanic symptoms, $r(36) = .32$, $p < .05$, and reduced symptoms of psychotic thinking, $r(36) = -.27$, $p < .10$.

With other-oriented perfectionism, there were significant correlations between other-oriented perfectionism and hypomania and drug abuse. There were no gender differences.

Finally, socially prescribed perfectionism was correlated positively with all of the clinical symptom syndromes with the exception of drug abuse and psychotic delusions. The largest correlations were obtained with anxiety, dysthymia, and psychotic depression. A noticeable gender difference was evident with respect to socially prescribed perfectionism and alcohol abuse. Whereas men showed a nonsignificant correlation, $r(37) = .08$, *ns*, women showed a significant positive correlation, $r(36) = .47$, $p < .01$.

Discussion

Study 5 examined the extent to which the three perfectionism dimensions were related to personality disorders and symptom syndromes in a clinical sample. Overall, analyses revealed that other-oriented perfectionism and socially prescribed perfectionism, in particular, were correlated with several personality disorders as assessed by the MCMI. These findings clearly demonstrate the importance of considering the interpersonal dimensions of perfectionism in severe psychopathology.

Although the two interpersonal perfectionism dimensions were correlated significantly with several MCMI personality disorder measures, it is especially noteworthy that the results varied substantially for other-oriented perfectionism and socially prescribed perfectionism. Other-oriented perfectionism was correlated positively with the histrionic, narcissistic, and antisocial personality patterns. The finding of a significant relation with "dramatic cluster" disorders is consistent with the findings of Study 3, which also indicated a link between narcissism and other-oriented perfectionism in college students.

Socially prescribed perfectionism, on the other hand, was correlated positively with the schizoid, avoidant, passive aggressive, schizotypal, and borderline personality patterns. The fact that the perfectionism dimensions were associated differentially with these personality patterns is perhaps best demonstrated by the *negative* correlation between other-oriented perfectionism and schizotypal tendencies versus the *positive* correlation between socially prescribed perfectionism and

schizotypal tendencies. These findings provide more evidence for the multidimensionality of the perfectionism construct, especially in relation to personality disorders.

One interesting finding was the strong, positive correlation between socially prescribed perfectionism and borderline personality. The high degree of association between these measures implies that perceiving others as unrealistic in their expectations may be at the root of the extreme anger and verbal aggressiveness characterizing these individuals (Davis & Akiskal, 1986; Gunderson, 1984). This possibility is further supported by the significant correlation in Study 3 between anger and socially prescribed perfectionism.

It was expected that there would be positive associations between the MCMI compulsive personality subscale and our perfectionism dimensions. Surprisingly, only one significant correlation was obtained, and it was negative in direction. Broday (1988) also found negative correlations using the MCMI compulsive personality subscale and two measures of self-oriented perfectionistic attitudes. These results are counterintuitive in that the *DSM-III-R* espoused perfectionism as a central feature of the obsessive–compulsive personality disorder. One explanation for these findings involves the validity of the MCMI compulsive personality subscale. Although most MCMI subscales have adequate validity, several authors have found recently that the compulsive personality subscale is not correlated significantly with concurrent measures of compulsive tendencies (e.g., McCann, 1989; Morey & Levine, 1988). This explanation is further supported by the results of a study in progress in which we administered the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1967) and the MPS to a sample of psychiatric patients. The MMPI Compulsive Disorder subscale was calculated from the MMPI raw scores (see Morey, Waugh, & Blashfield, 1985) and correlated with the MPS subscales. Although self-oriented perfectionism was not correlated significantly with the MMPI compulsive subscale ($r = .01$), both other-oriented perfectionism ($r = .25$) and socially prescribed perfectionism ($r = .33$) were correlated significantly with the compulsive subscale. Although there is need for replication, these additional data support Ingram's (1982) contention that the social aspects of perfectionism are involved in the obsessive–compulsive personality disorder.

Although there were few significant correlations involving self-oriented perfectionism and the MCMI personality disorder measures, self-oriented perfectionism was associated significantly with clinical symptom indices of hypomania and alcohol abuse. The association between self-oriented perfectionism and alcoholism is consistent with past research indicating that there is a group of alcoholics who demonstrate perfectionistic tendencies (Nerviano & Gross, 1983). Clearly, however, these findings must be interpreted within the context of apparent gender differences. Male psychiatric patients in our study demonstrated a positive association between *self-oriented perfectionism* and alcohol abuse. These data suggest that alcohol abuse in men stems from high self-standards and self-critical reactions due to a perceived failure to achieve perfection. This interpretation is consistent with self-focused attention models of alcoholism that posit that excessive drinking is an attempt to alleviate the negative affect associated with discrepancies between the actual and ideal self (Hull, 1981). In contrast, female psychiatric patients demonstrated a large positive association between *socially prescribed perfectionism* and alcohol abuse. Perhaps excessive drinking by women is in response to a perception of unrealistic social pressures being imposed by significant others and by society as a whole. To our knowledge, a similar finding has not been reported in the literature; however, a recent study of alcoholics showed that men attached greater meaning to work-related stressors and women attached greater meaning to private life events that often involved significant others (Remy, Soukup, & Tatossian, 1987). Perhaps achievement issues involving personal standards are salient for male alcoholics, whereas interpersonal issues involving social standards are salient for female alcoholics. Overall, these data suggest some potentially important insights into the nature of perfectionism and gender differences in alcoholism.

Although the findings of this study support the relevance of a multidimensional approach to assessing perfectionism and psychopathology, the data are limited in that they were gathered using a cross-sectional design on an unselected psychiatric sample. Subsequent research should directly compare groups of patients with specific clinical disorders (e.g., Hewitt & Flett, 1991) and should assess the possible role of perfectionism in vulnerability to personality disorders and other forms of psychopathology.

General Discussion

The purpose of the present research was to demonstrate that the perfectionistic personality style is multidimensional with both personal and social components and that these components are important in maladjustment. A series of studies was conducted to demonstrate that three dimensions of perfectionism—self-oriented, other-oriented, and socially prescribed perfectionism—can be assessed and identified with an adequate degree of consistency and validity and that these dimensions are related to such important phenomena as severe personality disorders and other persistent symptoms of psychopathology.

The importance of a multidimensional approach was demonstrated by the fact that the findings varied as a function of the perfectionism dimension in question. This suggests that the various perfectionism dimensions may play important roles in the development or maintenance of different kinds of psychopathology (see Hollender, 1965; Missildine, 1963; Pacht, 1984). The measure developed in this research will enable the assessment of self- and social perfectionistic behavior and their role, either alone or in interaction with other variables or events, in producing the many achievement, physical, psychological, or relationship difficulties that have been linked theoretically to perfectionistic behavior (see Burns, 1983; Hamachek, 1978; Hollender, 1965; Pacht, 1984; Smith & Brehm, 1981).

Although the current research represents a significant advance in the conceptualization of the perfectionism construct, several important questions remain to be addressed. One important focus for subsequent research is an examination of factors that contribute to the differences among the three perfectionism dimensions. One fundamental difference pertains to

the level and type of *motivation* associated with the various forms of perfectionism. As noted above, we believe that self-oriented perfectionism is not simply the tendency to have high standards for oneself; it also includes the intrinsic need to be perfect and compulsive striving for perfection and self-improvement. This is consistent with the views of Ellis (1962), who discussed the level of desire for certain individuals to be perfect.

In contrast, other-oriented perfectionism should not be related to indices of motivation for the self. Other-oriented perfectionism may have a motivational component, but it is interpersonal rather than intrapersonal in nature. Finally, both theory and research on socially prescribed perfectionism suggest an association with a *decreased* level of intrinsic motivation (Flett, Hewitt, & McGregor-Temple, 1990). Presumably, these deficits in motivation stem, in part, from a great desire to please others and avoid punishments. These factors tend to promote increased levels of extrinsic motivation but decreased levels of intrinsic motivation (Deci & Ryan, 1985).

Another important factor that distinguishes the perfectionism dimensions involves perceptions of *controllability.* Both self-oriented perfectionism and other-oriented perfectionism are under an individual's control and involve standards that may be changed in a proactive manner. In contrast, socially prescribed perfectionism is derived from the perception of other people's imposed expectations. As such, socially prescribed perfectionism is associated with an external locus of control, as shown in Study 3, and is reactive rather than proactive. Excessive levels of socially prescribed perfectionism may result in a sense of learned helplessness due to a perceived incontingency between one's own behavior and the unrealistic standards prescribed by others. The presence of this phenomenon would account for the numerous associations between socially prescribed perfectionism and measures of negative affect and psychopathology in the present research. Finally, if taken to the extreme, it is possible that socially prescribed perfectionism combines with such factors as hopelessness and maladaptive coping to create suicidal tendencies (see Baumeister, 1990).

The observations outlined above represent some interesting directions for future research. Another important issue for future research involves the *development* of individual differences in perfectionism. A central assumption guiding this research is that differences in perfectionism are consistent over time. Indeed, the test–retest data reported in Study 3 provided some indication that the perfectionism dimensions represent traits that are stable. Thus, it should be possible to conduct studies that focus on the development of perfectionism in children. Preliminary work indicates that these differences between children do indeed exist (Flett, Hewitt, & Davidson, 1990). The next important step in this research is to examine the relation between perfectionism and personal adjustment in children and their families.

Finally, it will be important in future work to demonstrate empirically the incremental validity of the MPS. That is, it needs to be shown that the perfectionism dimensions are able to predict clinical disorders or other personality variables beyond the prediction achieved with other measures and constructs. In a recent study (Hewitt & Flett, 1990b), we have shown that one dimension of perfectionism, socially prescribed perfectionism, accounts for unique variance in the prediction of depression symptoms in psychiatric patients over and above other personality variables such as sociotropy and autonomy (Beck, Epstein, Harrison, & Emery, 1983). This provides important initial evidence that the MPS subscales demonstrate incremental validity, but additional research is required.

In summary, the purpose of the present article was to discuss the personal and social dimensions of perfectionism, provide evidence that these dimensions can be assessed in a reliable and valid manner, and demonstrate that these dimensions are associated differentially with such important phenomena as severe clinical disorders. We believe that this work represents an important advance in the study of perfectionism and should provide an impetus for future work assessing the self and social aspects of perfectionistic behavior.

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Appendix

Sample Items From the Self-Oriented, Other-Oriented, and Socially Prescribed Perfectionism Subscales of the Multidimensional Perfectionism Scale

Self-Oriented Perfectionism

It makes me uneasy to see an error in my work.
One of my goals is to be perfect in everything I do.
I never aim for perfection in my work. (reverse-keyed)
I must work to my full potential at all times.
I must always be successful at school or work.

Other-Oriented Perfectionism

I have high expectations for the people who are important to me.
I do not have very high standards for those around me. (reverse-keyed)
If I ask someone to do something, I expect it to be done flawlessly.
I can't be bothered with people who won't strive to better themselves.
The people who matter to me should never let me down.

Socially Prescribed Perfectionism

The better I do, the better I am expected to do.
My family expects me to be perfect.
Those around me readily accept that I can make mistakes too. (reverse-keyed)
The people around me expect me to succeed at everything I do.
Anything that I do that is less than excellent will be seen as poor work by those around me.

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