Inadequacy, the psychopathological component of perfectionism: Validation of the Inadequacy Scale

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INADEQUACY, THE PSYCHOPATHOLOGICAL COMPONENT OF PERFECTIONISM: VALIDATION OF THE INADEQUACY SCALE

By

Brandon S. Park
Bachelor of Arts
University of Nevada, Las Vegas
2002

A thesis submitted in partial fulfillment of the requirements for the

Master of Arts Degree in Psychology
Department of Psychology
College of Liberal Arts

Graduate College
University of Nevada, Las Vegas
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ABSTRACT

Inadequacy, the Psychopathology Component of Perfectionism: Validation of the Inadequacy Scale

by

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This study tests a new measure of inadequacy and assesses its reliability and validity on a sample of 227 college students. The Inadequacy Scale (INAD) was compared to 2 measures of perfectionism: the Frost-Multidimensional Perfectionism Scale (F-MPS) and the Almost Perfect Scale-Revised (APS-R). The INAD showed equivalent or greater correlations with measures of depression, anxiety, self-esteem, and stress as compared to the full-scale measures of the F-MPS and the APS-R, as well as the subsets of their maladaptive components. The INAD was also more highly predictive of depression, anxiety, and stress (and equivalent to the F-MPS on self-esteem) than the maladaptive portions of either the F-MPS or the APS-R. Limitations of this exploratory study and plans for future research are discussed.
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CHAPTER 1

INTRODUCTION

In 'Perfectionism: Theory, Research, and Treatment' (Flett and Hewitt, 2002) the first chapter is dedicated entirely to the definition of perfectionism. The initial definition provided in this book states, "Perfectionism is the striving for flawlessness, and extreme perfectionists are people who want to be perfect in all aspects of their lives." Hewitt (1986) earlier described perfectionism in terms of rigid goals upon which self-worth was based on productivity and accomplishment, illustrating perfectionism’s connection to forms of distress. The theoretical relationship between perfectionism and psychopathology provided the basis for study and research by many of the early authors on the subject (Adler, 1935, 1956; Hollender, 1965; Hamachek, 1978; Burns, 1980; Pacht, 1984). Frost et al (1990) differentiated the previous idea by stating, “The setting of and striving for high standards is certainly not in and of itself pathological” (p.450).

The question then arises, what is the pathological aspect of perfectionism? Difficulty in defining perfectionism, and its connection to psychopathology, has been a perpetually problematic issue in this field.

It is Flett and Hewitt’s (2002) assertion that any serious investigation into perfectionism first requires an understanding of how the author conceptualizes and assesses perfectionism. In this current paper we propose that there is a healthy pursuit of goals and standards that drives a person towards excellence; alternatively there is a
maladaptive striving for goals and standards that have shown through research and experience to be connected to diverse psychopathology. This assertion has been supported by early authors, such as Don E. Hamachek (1978) who suggests that there are two kinds of perfectionists: ‘normal perfectionists’ who find pleasure in precision and who are willing to allow for mistakes. In contrast, Hamachek also alleged there are ‘neurotic perfectionists’ who are never satisfied with their own efforts. David D. Burns (1980), who developed one of the first measures of perfectionism, also differentiated those who would strive for excellence from maladaptive perfectionism. He defined the latter as, “those whose standards are high beyond reach or reason, people who strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment” (p. 34).

The hallmark distinctions contrasting healthy endeavors for excellence and maladaptive perfectionistic striving have also been substantiated through research. Over the past decade the work of three groups of researchers, Frost, Marten, Lahart, and Rosenblate (1990), Hewitt and Flett (1991), and Slaney, Rice, Mobley, Trippi, and Ashby (2001) have provided valuable evidence that perfectionism is a multidimensional subject. This multidimensional view has assisted in the operationalization of a definition for research and clinical purposes. The use of reliable and valid multidimensional perfectionism scales from the previous authors has also aided in the illumination of the distinction between maladaptive and adaptive perfectionism. Frost and colleagues developed the Multidimensional Perfectionism Scale (F-MPS; 1990) which consists of six subscales: Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC), Concern over Mistakes (CM), Doubts about Actions (DA), and
Organization (OR). Hewitt and Flett also developed a scale termed the Multidimensional Perfectionism Scale (HF-MPS; 1991) that consists of three subscales: Self-Oriented Perfectionism (SOP), Socially Prescribed Perfectionism (SSP), and Other-Oriented Perfectionism (OOP). Slaney et al. developed a scale termed the Almost Perfect Scale-Revised (APS-R; 1996, 2001), which consists of three subscales: High Standards (HS), Order (OD), and Discrepancy (DIS). The use of these psychometric instruments and factor analyses of their subscales over several subsequent studies have provided evidence that there exist two higher order factors involved in perfectionism supporting earlier theories concerning the division. In this paper the two factors shall be termed adaptive perfectionism and maladaptive perfectionism.

Many recent authors have found significant correlations between maladaptive (negative) perfectionism and diverse psychopathology (Terry-Short et al., 1995; Juster et al., 1996; Enns & Cox, 1999; Kawamura et al., 2001; & Enns, Cox, & Clara, 2002) and lowered self-esteem (Stumpf & Parker, 2000; Slaney et al. 2001). These results appear to indicate that the construct of maladaptive perfectionism may have a direct effect on psychopathology. It is important to assess how to best measure maladaptive perfectionism and its connection to psychopathology. Shafran and Mansell (2001) state that,

...we conclude that the existing measures of perfectionism are flawed. Rather than changing the construct of perfectionism so that it is in accord with the assessment measures, we propose that there is a need for new assessment scales that truly measure the concept. Further research could also explore which psychological features of perfectionism make it dysfunctional. New assessment
measures should also have clinical utility and be sensitive to clinical change (p. 901).

In accordance with Shafran and Mansell’s call for a measure of the dysfunctional aspect of perfectionism, we suggest that the maladaptive component of perfectionism is the fear of, or feeling that, one is inadequate to attain the goals and/or expectations they believe are required of them.
CHAPTER 2

LITERATURE REVIEW

While reviewing perfectionism, Enns and Cox (2002) evaluated adaptive (normal; positive) and maladaptive (neurotic; negative) perfectionism. In their review they cited many early writers who, based on theory and experience, wrote of normal and neurotic perfectionists (Adler, 1935, 1956; Hollender, 1965; Hamachek, 1978; Burns, 1980; Pacht, 1984). Normal perfectionism was supposed to be associated with a positive striving for excellence, while neurotic perfectionism was associated with a maladaptive need to be perfect. From a review of the literature by Enns and Cox, the differences between adaptive and maladaptive perfectionism is summarized in Table 1. This table illustrates a distinct conceptual difference between the two types of perfectionism. This theoretical division of adaptive and maladaptive perfectionism has been greatly aided by the development of reliable and valid multidimensional measures of perfectionism (Frost et al., 1993; Hewitt & Flett, 1991; Slaney et al., 1996, 2001).

The first major paper to demonstrate the actual division between adaptive and maladaptive perfectionism using established psychometric measures, and subsequently the correlation between maladaptive perfectionism and pathology, was by Frost et al (1993). In this study two measures of perfectionism were compared; Frost, Marten, Lahart, and Rosenblate (F-MPS; 1990) and Hewitt and Flett (HF-MPS; 1991) both measures named the Multidimensional Perfectionism Scale. The F-MPS consists of six
subscales: Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC), Concern over Mistakes (CM), Doubts about Actions (DA), and Organization (OR). The HF-MPS consists of three subscales: Self-Oriented Perfectionism (SOP), Socially Prescribed Perfectionism (SPP), and Other-Oriented Perfectionism (OOP). The Beck Depression Inventory (BDI; Beck et al. 1961, Beck & Steer, 1987), and the Positive and Negative Affect Schedule (PANAS; Watson et al. 1988), was administered in conjunction with the two aforementioned scales. Participants were 553 undergraduate students from a large Eastern University (51% female, 49% male) who completed the four measures. A factor analysis of the nine combined subscales from the two perfectionism measures provided evidence for two higher order factors, 'Positive Achievement Striving' and 'Maladaptive Evaluation of Concerns.' Positive achievement striving consisted of Parental Standards, Organization, Self Oriented Perfectionism, and Other Oriented Perfectionism and was correlated with positive affect from the PANAS scales (r=0.24, p<0.01). Positive achievement striving was not correlated with negative affect or the BDI and was therefore proposed to be the positive or healthy form of perfectionism. The scales that clustered among the maladaptive evaluation of concerns were Concern over Mistakes, Parental Criticism, Parental Expectations, Doubts about Actions, and Socially Prescribed Perfectionism. Maladaptive evaluation of concerns was correlated with negative affect from the PANAS (r=0.29, p<0.01) and with the BDI (r=0.31, p<0.01). These results suggest a connection between maladaptive perfectionism and psychopathology.

Frost and colleagues have examined several aspects of anxiety involved in maladaptive perfectionism. Juster, Heimberg, Frost, and Holt (1996) found a positive
A correlation between maladaptive perfectionism and symptoms of social phobia. 61 patients with social phobia (38 males, 23 females) and 39 non-clinical community volunteers (18 males, 21 females) completed the Frost et al.'s MPS (F-MPS). The measures used to assess anxious symptoms were as follows: The Social Interaction Scale (SIAS; Mattick & Clark 1989), the Social Phobia Scale (SPS; Mattick & Clark 1989), the Social Phobia subscale of the Fear Questionnaire (FQSO; Marks & Mathews, 1979), the Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969), and the Trait form of the State-Trait Anxiety Inventory (STAI-T; Spielberg et al. 1983). Also administered were the BDI (Beck, 1987) and the Global Symptom Index (GSI) of the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1977). The volunteer group scored higher on the OR ($F=7.67$, $p<0.007$) subscale of the F-MPS, while the patients with social phobia scored significantly higher on subscales Doubts about Actions ($F=7.21$, $p<0.009$), Concern over Mistakes ($F=12.83$, $p<0.001$), and Parental Criticism ($F=4.15$, $p<0.044$) of the F-MPS. Doubts about Actions, Concern over Mistakes, and Parental Criticism are three of the four subscales from the F-MPS associated with what is considered maladaptive perfectionism, however Parental Expectations, the fourth subscale considered maladaptive, was non-significant. Concern over Mistakes and Doubts about Actions subscales were positively correlated with social phobia, trait anxiety, and general pathology was confirmed. Evidence indicates that maladaptive perfectionism is significantly associated with social anxiety and related constructs.

In a recent paper by Kawamura, Hunt, Frost, and DiBartolo (2001) the connection between depression, anxiety, and maladaptive perfectionism was assessed and reported. The participants consisted of 209 college students (56 males, 145 females, and 8
subjects who did not indicate gender) who received credit for participation in the study.
The F-MPS was used to assess general perfectionism. To assess anxiety the following scales were used: the State-Trait Anxiety Inventory, the Brief Fear of Negative Evaluation Scale (Leary, 1983), the Social Phobia and Anxiety Inventory (SPAI; Turner et al. 1989), the Penn State Worry Scale (PSWS; Meyer et al., 1990), Padua Inventory-Washington State University Revision (PI-WSUR; Burns et al. 1996), Post-Traumatic Stress Disorder Checklist-Civilian Version (PCL-C; Weathers et al. 1991), and the Anxiety Sensitivity Inventory (ASI; Reiss & McNallay, 1985). The BDI was also used in this study. To examine the relation between anxiety and perfectionism while controlling for depression, anxiety measures were grouped into three factors (Obsessive-Compulsive Disorder [OCD], social/trait/worry, & Post Traumatic Stress Disorder [PTSD]) and then tested in separate hierarchical regression analyses with depression entered in the first step. Maladaptive perfectionism was significantly associated with social/worry/trait ($\beta = 0.31$) after controlling for depression. Adaptive perfectionism was significantly associated with PTSD ($\beta = 0.13$) after controlling for depression. Neither perfectionism factor was significantly associated with OCD after controlling for depression. They next performed a similar regression analysis to examine the association between perfectionism and depression while holding constant the three anxiety factors. There was a positive relationship between maladaptive perfectionism and depression ($\beta = 0.31$), and a negative relationship between adaptive perfectionism and depression ($\beta = -0.15$).

Rice and Mirzadeh (2000) performed a two-part study and the second part compared depression rates among the types of perfectionism. The F-MPS was used to assess
perfectionism and the Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) was used for measuring depression. Participants were 218 college students (54 male, 164 female). The results showed those with elevated levels of maladaptive perfectionism scored higher on the CES-D ($M=20.54$, $SD=10.08$) than those with elevated adaptive perfectionism ($M=11.90$, $SD=8.96$) [$t=5.65$, $p<0.001$]. These results are significant in that those persons with elevated scores on maladaptive perfectionism scored well above the score of 16, indicating significant depressive symptoms for the CES-D.

Terry-Short, Owens, Slade, and Dewey (1995) created a scale, specifically related to measuring positive and negative aspects of perfectionism. A forty-item questionnaire equally measuring positive versus negative and personal versus socially prescribed perfectionism. There was 21 female patients with eating disorders, 15 female patients with depression, 20 successful female athletes, and 255 female college students, used as a control group, participated in the study. A factor analysis yielded a two-factor model of positive and negative perfectionism. Significant differences were found between the control and clinical groups ($F=25.64$, $p<0.0001$) with respect to the ratio of negative to positive perfectionism. Subjects with depression showed high negative perfectionism and low positive perfectionism. Subjects with eating disorders showed high positive and negative perfectionism, while successful athletes showed high positive and low negative perfectionism. To date, no further reliability or validity of this scale has been reported.

Antony, Purdon, Huta, and Swinson (1998a) explored the role of perfectionism across Panic Disorder, OCD, Social Phobia, and Specific Phobia. The F-MPS and the
HF-MPS were used to assess perfectionism. The BDI was also included due to the overlap between anxious symptoms and depression. There were 44 participants diagnosed with panic disorder, 45 with OCD, 70 with social phobia, and 15 with specific phobia were compared to a group of 49 non-clinical volunteers across the three measures. The authors found that those diagnosed with panic disorder, OCD, and social phobia had higher scores on the CM and DA factors when compared to the non-clinical volunteers. The only other significant difference found above the non-clinical volunteers was that diagnosed with social phobia had higher PC scores. This study appears to show the CM and DA factors as being the strongest predictors across varying anxiety disorders. While significant group findings of the BDI were found, no differences among subscales were reported.

Stumpf and Parker (2000) conducted a hierarchical structural analysis of perfectionism, during which they looked at pathology and personality characteristics. The sample consisted of two separate groups. One group was made up of 855 (62% male, 38% female; 85% Caucasian, 10% Asian, 5% Other) academically talented sixth graders from across the United States. The second group was made up of 224 college students from three different colleges within the United States. The F-MPS was used to assess perfectionism. The Adjective Check List (ACL; Gough & Heilbrun, 1983), the Myers-Briggs Type Indicator (MBTI; Meyer & McCaulley, 1985), and the NEO-FFI (Coasta & McCrae, 1992) were used to assess broad personality characteristics. The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to assess self-esteem. Finally, overall adjustment was measured using the Global Severity Index of the Brief Symptom Inventory (BSI; Derogatis, 1993). Results indicated two higher-order factors.
across both sets of participants where factor A (constituting maladaptive perfectionism) was positively associated with pathology and factor B (constituting adaptive perfectionism) was negatively associated with pathology. Among lower order factors, findings indicated that CM and DA were closely related and could be construed as one factor. PE and PC were also factor related as well and could be formed into one factor. The construction of four lower-order factors (CM-DA, PE-PC, PS, and OR) confirmed previous findings by Stober (1998). The CM-DA factor appears to have a stronger positive correlation to neuroticism (r=0.42, p<0.01) than the PE-PC factor (r=0.16, p<0.05). The General Severity Index of the BSI indicated the CM-DA factor as slightly higher (r=0.29, p<0.05) than PE-PC (r=0.20, p<0.05), though the difference here doesn’t appear to be statistically significant. Thus, there seems to be some evidence that the combined CM-DA factor of F-MPS comprises the best indicator of the concept of maladaptive perfectionism.

Enns and Cox (1999) used both the F-MPS and the HF-MPS to look at aspects of maladaptive perfectionism, depression, and personality traits. There were 145 clinically depressed outpatients (55 males, 90 females) who participated in the study. The measure used to assess personality traits was the NEO-Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992), which measures five personality factors: neuroticism, extraversion, openness-to-experience, agreeableness, and conscientiousness. To measure depressive tendencies they used the Depressive Experiences Questionnaire (DEQ; Bagby et al., 1994) that measures two distinct factors involved in depression, dependent and self-critical. This study also used the BDI (Beck, 1987). Positive correlations between the BDI and Socially Prescribed Perfectionism (r=0.45, p<0.01),
Concern over Mistakes ($r=0.51$, $p<0.01$), Doubts about Actions ($r=0.31$, $p<0.01$), PC ($r=0.21$, $p<0.05$), and Parental Expectations ($r=0.17$, $p<0.05$) were found. However, the BDI also had a positive correlation with Self Oriented Perfectionism ($r=0.19$, $p<0.05$) and Other Oriented Perfectionism ($r=0.20$, $p<0.05$). Interestingly Neuroticism showed a positive correlation with all aspects of maladaptive perfectionism except Parental Expectations. Extraversion showed a negative correlation with Concern over Mistakes – Doubts about Actions but not with Parental Criticism – Parental Expectations.

Enns, Cox, Sareen, and Freeman (2001) assessed 96 medical students with regards to personality and depression in association with maladaptive perfectionism. Both the F-MPS and the HF- MPS were used to assess perfectionism. The Neuroticism and Conscientiousness subscales of the NEO-Five Factor Inventory (Costa & McCrae, 1992) were used to assess personality. The BDI (13-item version; Beck & Beck, 1972) was used for depression along with the Beck Hopelessness Scale (BHS; Beck et al., 1974), which assesses pessimistic views of the future. Also assessing suicide was the Suicidal Ideation Questionnaire (SIQ; Reynolds, 1987) that measures the frequency of passive and active suicidal thoughts in the past month. Those scales found to assess maladaptive perfectionism (Doubts about Actions, Concern over Mistakes, Parental Criticism, & Socially Prescribed Perfectionism) correlated with the BDI ($r=0.38$, $p<0.001$), BHS ($r=0.36$, $p<0.001$), SIQ ($r=0.42$, $p<0.001$), and Neuroticism ($r=0.63$, $p<0.001$). No significant change was found when controlling for age, gender, and year in school. Through this study, maladaptive perfectionism has further shown a strong connection to forms of distress and pathology.
In another study by Enns, Cox, and Clara (2002) the developmental origins of maladaptive perfectionism were investigated with regards to depression proneness. There were 261 college students (147 males, 114 females) who participated for course credit in this study. The following measures were used to assess depression: the Profile of Mood States-Depression Scale (POMS-D; McNair, Lorr, & Droppleman, 1971) consists of 15-items using a 5 point Likert scale in which respondents indicate how much specific emotional words apply to them, the BDI, and the Depression Proneness Rating Scale (DPRS; Zemore et al. 1990), a 13-item scale assessing feelings and symptoms of depression. The F-MPS and the HF-MPS were used to measure perfectionism. The following scales were used to assess parental influences: the Critical Parenting Inventory (CPI; Randolph & Dykman, 1996) has separate versions for identifying mother and father, in which respondents report frequencies of critical and non-critical statements made by their parents; the Modified Socially Prescribed Perfectionism Scale (MSPS; Randolph & Dykman, 1998) is a modified mother and father version of Hewitt and Flett’s Socially Prescribed Perfectionism subscale from their MPS; the Parental Bonding Instrument (PBI; Parker et al., 1979) has a father and mother version assessing attitudes and behaviors of parents during first the 16 years of childhood; the Parental Personal Standards (PPS, Enns, Cox, & Clara, 2002) is a modified version of Frost et al.’s PS subscale from their MPS with separate versions for mother and father. Statistically significant correlations were found between the BDI and the subscales Doubts about Actions ($r=0.48$, $p<0.01$) and Concern over Mistakes ($r=0.42$, $p<0.01$) subscales of Frost et al.’s Multidimensional Perfectionism Scale and the HF-MPS Socially Prescribed Perfectionism subscale ($r=0.39$, $p<0.01$).
was correlated with Doubts about Actions \((r=0.34, p<0.01)\), Concern over Mistakes \((r=0.24, p<0.01)\), and Socially Prescribed Perfectionism \((r=0.17, p<0.01)\).

Slaney, Ashby, and Trippi (1995) replicated the previous study by Frost et al. (1993) using both MDP scales and also included the Almost Perfect Scale (APS, Slaney & Johnson, 2002). The original APS consists of six subscales Standards, Order, Relationships-interpersonal, Relationships-counseling, Anxiety, and Procrastination. The study used 167 undergraduate students from a Northeast University (74% female, 26% male) who received credit in their upper division classes for participation. Also used were the Burns’ Perfectionism Scale (1980) a unidimensional measure of perfectionism, the BDI, the Penn State Worry Questionnaire, and the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) a measure of social desirability. The results confirmed Frost et al.’s (1993) factor analysis of a higher order two-factor model with a negative and positive form of perfectionism. The results also found that the APS subscales of Standards and Order loaded on the positive (adaptive perfectionism) factor and the subscales of Relationship, Anxiety, and Procrastination clustered with the negative (maladaptive perfectionism) factor. The BDI correlated with the Relationship \((r=0.41, p<0.01)\) subscale, the Anxiety \((r=0.45, p<0.01)\), and Procrastination \((r=0.34, p<0.01)\) subscales. These preliminary results provide further evidence of a two-factor conceptualization of perfectionism.

Rice, Ashby, and Slaney (1998) performed a confirmatory factor analysis on the F-MPS and the APS. The participants were 464 undergraduate college students. Along with the two previously mentioned perfectionism measures participants completed the BDI and the Rosenberg Self-Esteem Inventory. Factor analysis confirmed a two-factor
division of what they termed adaptive and maladaptive perfectionism. Adaptive perfectionism showed no association with depression. However, as predicted, they found a significant interaction among maladaptive perfectionism, self-esteem, and depression ($R^2 = 0.31$, $F=101.62$, $p<0.001$) such that self-esteem appears to mediate between maladaptive perfectionism and depression.

Accordino, Accordino, and Slaney (2000) authors attempted to assess perfectionism, mental health, and self-esteem. The participants were 123 high school students (48% male, 52% female) from tenth to twelfth grade. To assess perfectionism, the authors chose the Almost Perfect Scale-Revised (APS-R; Slaney et al., 1996), a 59-item measure using a seven point Likert scale with three subscales ‘Standards,’ ‘Order,’ and ‘Discrepancy.’ Discrepancy is proposed to be a strong indicator of maladaptive perfectionism, and looks at the failure to adequately achieve one’s goals. To assess depression, the authors selected the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1986), which measures various depressive symptoms. The Rosenberg Self-Esteem Scale was chosen for a self-esteem measure. Through regression analysis, discrepancy was shown to have a significant negative correlation with self-esteem and a significant positive correlation with depression. Transversely, standards (associated with adaptive perfectionism) had significant correlations in the opposite direction with depression and self-esteem. These results appear to strongly support a two-factor model of perfectionism where maladaptive perfectionism is associated with depression and negative appraisal.

In a further revision of the APS-R, Slaney, Rice, Mobley, Trippi, and Ashby (2001) reduced the APS-R from 59 to 23-items, while still maintaining the APS-R three-factors.
Also used were the F-MPS and the HF-MPS. The BDI, the Penn State Worry Questionnaire, the Rosenberg Self-Esteem Inventory, the Marlowe-Crowne Social Desirability Scale, and GPA (as an indicator of achievement) were used to assess related factors to perfectionism. The participants were 809 college undergraduates (38% male, 62% female) from 3 different universities who completed the measures for class credit. The APS-R Discrepancy subscale was positively correlated with the BDI ($r=0.49$, $p<0.05$) and the Penn State Worry Questionnaire ($r=0.46, p<0.05$), and negatively correlated to self-esteem ($r=-0.44, p<0.05$) and GPA ($r=-0.23, p<0.05$). With regards to Hewitt and Flett’s Multidimensional Perfectionism Scale the Socially Prescribed Perfectionism subscale, positive correlations were found with the BDI ($r=0.39, p<0.05$) and PSWQ ($r=0.35, p<0.05$), and negative correlations to self-esteem ($r=-0.31, p<0.05$). Frost et al.’s Multidimensional Perfectionism Scale the Concern over Mistakes and Doubts about Actions scales had positive correlations with the BDI ($CM \ r=0.41; DA \ r=0.48$) and the Penn State Worry Questionnaire ($CM \ r=0.48, p<0.05; DA \ r=0.47, p<0.05$), and a negative correlation to self-esteem ($CM \ & \ DA \ r=-0.28, p<0.05$). GPA had a negative correlation with DA ($r=-0.17, p<0.05$). Social desirability scores were not significantly correlated with any of the perfectionism scales.

Rice and Slaney (2002) followed up these results with a similar study. The participants were 258 college undergraduates (79% female, 21% male). To assess perfectionism the 23-item APS-R (Slaney et al., 2001) was employed. The Center for Epidemiological Studies-Depression Scale (CES-D; Raloff, 1977) was utilized to assess depressive symptoms, and the STAI (Speilberg, Gorsuch, & Lushe, 1970) was used to assess anxious symptoms. The Rosenberg Self-Esteem Inventory measured self-esteem,
and GPA was used to indicate achievement. Using the APS-R participants were divided into three groups, adaptive perfectionists (Those with elevated scores on the Standards subscale), mal adaptive perfectionists (Those with high scores on the Discrepancy subscale), and non-perfectionists (Those with no elevated scores on either the Standards or Discrepancy subscales). The maladaptive group, as compared to the adaptive and non-perfectionist groups, showed a statistically significant difference with regards to lower self-esteem scores ($F=54.96, p<0.01$), higher trait anxiety ($F=40.55, p<0.01$), higher state anxiety ($F=13.01, p<0.01$), and elevated depressive symptoms ($F=11.42, p<0.01$). Differences were again confirmed between adaptive and maladaptive perfectionism, with the latter being significantly related to symptoms of pathology and low self-esteem.

**Summary**

The studies reviewed have dealt with specifically illustrating a distinction between adaptive and maladaptive perfectionism, and the connection between maladaptive perfectionism and psychopathology. This effort began with the experience and theory of early authors such as Adler (1935, 1956), Hollender (1965), Hamachek (1978), Burns (1980), and Pacht (1984). Measures of perfectionism with strong psychometric properties have been developed with the most frequently used instruments being Frost et al.'s Multidimensional Perfectionism Scale (F-MPS; 1990), Hewitt and Flett's Multidimensional Perfectionism Scale (HF-MPS; 1991), and Slaney et al.'s Almost Perfect Scale (1996, 2002). All three scales assisted in differentiating adaptive from maladaptive perfectionism, especially when scales were used in combination with each
other and factor analyses were performed. Frost et al.'s (1990) Concern over Mistakes, Doubts about Actions, and Parental Criticism subscales appear to show the best connections with the negative aspects of perfectionism. With Slaney et al.'s (1996, 2001) focus on tapping the maladaptive part of perfectionism came the development of the Discrepancy subscale of the APS-R. The Discrepancy subscale focuses on the failure to adequately achieve one's goals. Frost et al.'s Concern over Mistakes, Doubts about Actions, and Parental Criticism, and Slaney et al.'s Discrepancy, appear to show a significant correlation to the negative consequences theorized to be attributable to maladaptive perfectionism.

**Conceptualization Of Inadequacy**

The aspiration to be perfect can be motivated by many different desires, even though the presentation of perfection may be rendered behaviorally in the same way. For example, someone with the desire to achieve may fall under the definition of perfectionism, while someone who strives to perform out of a fear of appearing inferior, inadequate, or inept may also receive the same label. Frost et al.'s concept of Concern over Mistakes, Doubts about Actions, and Parental Criticism, and Slaney et al.'s concept of DIS, appear to all form around the idea of a person's negative emotional experience of *Inadequacy*. Inadequacy, as used in this paper, refers to unpleasant feelings associated with the idea of being insufficient or unable to meet an expectation. The Janis-Field Feelings of Inadequacy Scale (Hoviland & Janis, 1959) was developed to measure feelings of inadequacy. The items in this scale, however, generally measure self-esteem, and have been specifically used as such (Taylor & Reitz, 1968; Hamilton,
1971; Blascovich & Tomaka, 1991). Skolnick and Shaw (1970) found that the scale possessed low inter-item correlation. In a review of the literature, Church, Truss, & Velicer (1980) found that the Janis-Field Feelings of Inadequacy Scale is not in fact a unitary measure of self-esteem but rather is a composite of 3 distinct components of self-perception: concern about evaluation, self-regard, and interaction anxiety. Thus far the Janis-Field Feelings of Inadequacy Scale has demonstrated ambiguous performance overall and there has been little thorough psychometric research validating this instrument. Considering these findings, there appears to be a need for a more psychometrically sound measure of inadequacy.

To measure inadequacy's maladaptive effects it seems important to comprehend how it is theoretically conceived. One of the more salient points made in Alfred Adler's (1935) theory of Striving for Superiority was the idea that neuroses might be explained by a combination of feelings of inferiority and the striving for superiority. Additionally, while addressing the APA, Pacht (1984) referred to self-criticism and obsessing about one's own inability as aspects of negative perfectionism. Feeling inadequate can be conceived from these previous ideas as a negative emotional connection to the discrepancy between a person's ideal expectation and their perceived actual performance. Hamcheck (1978) stated that neurotic perfectionists are, "motivated not so much by desire for improvement as they are by the fear of failure" (p. 28). Another related concept of inadequacy appears to be the fear of failing or providing an insufficient performance. The fear of being inadequate can be considered as possessing a negative emotional connection to the fear of being unable to provide what is required or expected of oneself in any given situation. From the aforementioned concepts, it is
possible to construe that the fears or feelings of inadequacy result from a comparison to a perceived standard. Thus, the experience of being inadequate to a perceived standard can be conceptualized by the feelings of inadequacy and the fear of being inadequate.

**Hypothesis**

1. The proposed inadequacy scale will be developed and will have adequate psychometric properties. The inadequacy scale will also be significantly correlated with other measures of perfectionism.
   - The factor structure will be verified by a principal components factor analysis with varimax rotation. Reliability analysis will be performed. Items that have poor psychometric properties will be deleted from the scale. Correlations with other perfectionism scales will then be performed.

2. The proposed inadequacy scale will be a superior predictor of self-esteem, depression, and anxiety than the F-MPS or the APS-R.
   - The inadequacy scale will be more highly correlated with measures of depression, anxiety, and self-esteem than the F-MPS or the APS-R, or any of the individual subscales of these two measures. Subsequent regression analyses will then be performed to find superior predictors of depression, anxiety, and self-esteem.
CHAPTER 3

METHODS

Participants

225 undergraduate college students were recruited from the University of Nevada, Las Vegas Psychology department. Students were recruited from a psychology 101 pool of participants. Students received one hour of participation credit for participating in the study.

Measures

Development of the Inadequacy Scale (INAD): Initially, 25 items were used to assess the two factors of inadequacy; 14 items reflecting 'Feeling Inadequate' and 11 reflecting 'Fear of Being Inadequate.' Items were obtained from a theoretical analysis of the topic and by using adaptations of existing measures of perfectionism. The directions state, "Circle the number that most closely corresponds to your feelings regarding the question." The items are scored on a 5-point Likert scale from 0 "Never," to 4 "Always." The two-dimensions of inadequacy were then modified to improve psychometric properties. The time frame used for the inadequacy scale is "In the last month," although it is hypothesized that different time frames may be used depending upon the uses of the researcher or clinician, and also to improve the measures ability to be sensitive to change (see table 2).
Multidimensional Perfectionism Scale (F-MPS; Frost, Marten, Lahart, Rosenblate, 1990). This scale consists of 35 items, which provide an overall perfectionism score. It is scored on a 5-point Likert scale ranging from 1 "strongly disagree" to 5 "strongly agree." The F-MPS has six subscales with good internal consistency based on Cronbach’s alpha coefficients listed as follows: concern over mistakes (9 items; \( \alpha = .88 \)); e.g., “I hate being less than the best at things.”), personal standards (7 items; \( \alpha = .83 \)); e.g., “I have extremely high goals.”), parental expectations (5 items; \( \alpha = .84 \)); e.g., “My parents set very high standards for me.”), parental criticism (4 items; \( \alpha = .84 \)); e.g., “I never felt like I could meet my parents’ expectations.”), doubts about actions (4 items; \( \alpha = .77 \)); e.g., “I usually have doubts about the everyday things I do.”), organization (6 items; \( \alpha = .93 \)); e.g., “I try to be a neat person.”). Several confirmatory analyses of reliability & validity have been performed on this scale including comparisons to other perfectionism measures (Frost et al., 1993; Hewitt et al., 1991; Flett et al., 1995; Slaney et al., 1995, 2000). Due to the multidimensional nature of the F-MPS two different versions of the total scale will be necessary for comparison. F-MPS 1 will consist of five of the six subscales; Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC), Concern over Mistakes (CM), and Doubts about Actions (DA). Organization (OR) does not significantly correlate with several of the other subscales even though it is considered to be an aspect of perfectionism. Thus, as suggested by Frost et al. (1990), a total perfectionism should be obtained without OR. Since the measure of inadequacy is suggested in this paper to be maladaptive in nature it is necessary to compare the current measure of inadequacy to the maladaptive aspects of the F-MPS. The subscales used for the F-MPS 2 are those most highly correlated with

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maladaptive aspects of perfectionism, which are DA, CM, and PC as suggested by Enns and Cox (2002).

_Almost Perfect Scale-Revised_ (APS-R; Slaney, Rice, Mobley, Trippi, & Ashby, 2001). This scale is a revised version and is scaled down from a 59-item scale (Slaney, Mobley, Trippi, & Ashby Johnson, 1996). It is scored on a 7-point Likert scale ranging from 1 “strongly disagree” to 7 “strongly agree.” Items in the three subscales have high internal consistency with Cronbach’s alpha coefficients as follows: high standards (7 items; [α = .85]; e.g., “I expect the best from myself”), order (4 items; [α = .86]; e.g., “I am an orderly person.”), & discrepancy (12 items; [α = .92]; e.g., “I rarely live up to my high standards.”). The revision of this scale was based on Frost et al.’s (1993) comparison of two multidimensional perfectionism scales finding two overriding factors, ‘Positive Achievement Striving’ and ‘Maladaptive Evaluation of Concerns,’ and one extraneous factor ‘Organization.’ Slaney’s ‘high standards’ was meant to reflect adaptive perfectionism, whereas ‘discrepancy’ was meant to reflect maladaptive perfectionism. Similar to the F-MPS two versions of the total APS-R will be used for analysis. The APS-R 1 consists of High Standards (HS), and Discrepancy (DIS). Order (OD), however, is not significantly correlated to the other two subscales, similar to OR and the F-MPS subscales, and was thus excluded in obtaining a total perfectionism score. The DIS subscale was developed to measure maladaptive aspects associated with perfectionism and alone represents the APS-R 2.

_Beck Depression Inventory-II_ (BDI-II; Beck et al., 1996) the BDI-II is a 21-item measure that assesses symptoms of depression. Symptoms are assessed on a 4-point
rating scale ranging from 0 to 3. A score of zero is the lowest and corresponds to statements such as, “I do not feel sad.” Whereas a score of 3 corresponds to a statement typical of the following, “I am so sad or unhappy that I can’t stand it.” Total scores range from 0 to 63 with higher scores signifying more elevated depressive symptoms. The BDI-II time frame for its ratings is for the, “past two, weeks including today.” According to Beck et al. (1996), BDI-II scores ranging from 0-13 represent minimal, scores from 14-19 are mild, scores from 20-28 are moderate, and scores from 29-63 are severe. In a review by Steer & Beck (2000), the BDI-II is valid and reliable with clinical and non-clinical participants and has strong internal consistency (coefficient $\alpha > 0.90$).

**Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond, 1995).** The DASS is a 42-item measure with a 21-item short version. Respondents use a 4-point Likert scale from 0 “Did not apply to me at all” to a 3 “Applied to me very much, or most of the time.” There are three subscales composed of the following: Depression, which mainly assesses dysphoria, anhedonia, and low self-esteem; Anxiety, which mainly assesses somatic affect, fears, and worry; Stress, which mainly assesses nervous tension and irritability. The DASS has demonstrated convergent and discriminate validity when compared to other measures of depression and anxiety (Antony et al. 1998b; Brown et al. 1997). The DASS has also been reported as a reliable and valid measure of three distinct factors in both long (42-item) and short (21-item) forms (Clara, Cox, Enns, 2001).

**Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990).** The PSWQ consists of 16-items measuring various aspects of worry. Responses
are made on a 5-point Likert scale ranging from 1 “not typical of me” through 5 “very
typical of me.” Respondents to the PSWQ assess statements such as the following,
“My worries overwhelm me.” Initial coefficient alpha scores on the PSWQ were .93.
Spielberg et al. (1993) sampled 405 college students on the PSWQ and the State-Trait
Anxiety Inventory and found correlations of .64 with State anxiety and .49 with State
anxiety.

*Rosenberg Self-Esteem Inventory* (RSE; Rosenberg, 1965) The RSE consists of 10-
items measuring the self-acceptance aspect of self-esteem. It utilizes a 4-point Likert
scale ranging from 1 “strongly agree” through 4 “strongly disagree.” The RSE was
initially developed to measure the self-esteem of High School students. However, since
its creation the RSE has been used on adult populations (Stumpf & Parker, 2000; Rice,
Ashby, & Slaney, 1998). Of the 10 items half of them are in reverse order being worded
negatively. After reverse scoring negative items, an elevated cumulative score on the
RSE signifies positive self-esteem. Goldsmith (1986) reported the RSE internal
consistency ranging from .86 to .93, and further reported it to be a valid and reliable
measure as indicated by research.

**Procedures**

Participants completed the measures provided during a one-hour period of time on
the UNLV campus. The APS-R, the F-MPS, and the INAD were assembled in all
possible orders and randomly dispersed to eliminate order effects.
RESULTS

Demographics

Participants were 152 females (67%) and 74 males (32.6%), with one participant not designating. The range of participants was 18-51 years of age with a modal age of 20, a mean age of 23.14 (SD = 5.64). The ethnic background was 13.2 percent Latino/Hispanic American, 10.6 percent African American, 58.1 percent European American, 9.3 percent Asian American, and 8.8 percent were other or did not designate ethnicity. There were no significant gender differences on the variables of interest with the exception of the PSWQ in which females scored higher than males, \( F (1, 220) = 13.026, p < .001 \). There were no significant differences for ethnicity with the exception of the Parental Criticism, in which Asian Americans scored higher than all other ethnicities, \( F (3, 203) = 4.004, p < .01 \).

Factor Analyses and Internal Consistency for the Inadequacy Scale

Principal components factor analysis with Eigenvalues greater than 1 and varimax rotation revealed a four-factor solution. Factor 3 retained only two items and factor 4 retained one item so these two factors were eliminated. The two factors remaining consisted of 17-items referring to inadequacy, and 5-items referring to adequacy (reverse order questions) for the second factor. Through reliability analysis, one item from the
inadequacy subscale was deleted leaving 16-items. The 16-item inadequacy subscale (IN) accounted for 48.5 percent of the variance, and the 5-item adequacy subscale (AD) accounted for 8.7 percent of the variance. The internal consistency of the IN subscale was an alpha of .95 and the AD subscale was an alpha of .80. The combined IN and AD form the 21-item Inadequacy Scale (INAD), which obtained an alpha of .94. The IN mean score was 27.87, with a standard deviation of 12.09, and the AD mean score was 7.66, with a standard deviation of 3.1. The combined total INAD mean score was 35.6, with a standard deviation of 14.1 (see table 3). When the AD questions were reversed there was a significant correlation between the IN and AD subscales, \( r (223) = 0.57, p < 0.001 \).

Correlations with Other Perfectionism Scales

As shown in table 4, INAD was highly correlated with the total scales (F-MPS 1 & APS-R 1) and the maladaptive portions (F-MPS 2 & APS-R 2) of the other perfectionism measures. The correlations between the inadequacy and perfectionism subscales are shown in Table 5. As expected, IN showed significant positive correlations with CM, DA, and PC of the F-MPS and the DIS of the APS-R as these subscales are the most strongly associated with maladaptive perfectionism (Frost et al 1990; Slaney et al. 2001; Enns & Cox 2002). For those subscales considered adaptive, IN showed a low correlation with PS, and no correlation with HS. AD showed moderate to low correlations with CM, DA, PC, and DIS. AD also showed no correlation with PS and a small negative correlation with HS.
Relation to Measures of Distress

The correlations between the total Inadequacy scale and other measures of pathology and distress in this study (BDI-II, RSE, PSWQ, and DASS) are presented in table 6. The F-MPS (1 & 2) and the APS-R (1 & 2) are also presented in table 6 to compare correlations for significant differences to the IN AD using Dunn and Clark’s (1969) test for dependent correlations. As predicted, there was a significantly stronger relationship between INAD and the BDI-II than all other total perfectionism scales. The INAD also had a significantly stronger relationship with the depression portion of the DASS and the total DASS than all other total perfectionism scales. The INAD showed a significantly stronger relationship for the anxiety and stress subscales of the DASS than either of the APS-R scales. Lastly, the INAD demonstrated a significantly stronger relationship with the RSE than the F-MPS 1 and the APS-R 1, although the F-MPS 1 and the APS-R 1 represent a combination of adaptive and maladaptive features.

Inadequacy and perfectionism subscales were also compared to measures of distress. The IN obtained a significantly higher correlation than all other perfectionism subscales in table 7 for the BDI-II and the DASS total scale. Also, the IN showed significantly higher correlations for the D-ANX and D-STR than all other perfectionism subscales except for Frost et al.’s DA subscale. Similarly, the IN had a significantly higher correlation for the Depression subscale of the DASS than all other perfectionism subscales except for Slaney et al.’s DIS subscale. The IN obtained a significantly higher correlation than PC, PE, PS, and HS on the RSE and the PSWQ. The AD had some significantly higher correlations although far less than the IN.
Regression Analyses: Scale Totals

The maladaptive subtotals of the perfectionism scales (F-MPS 2 & APS-R 2) and the Inadequacy Scale were used as predictors in regression equations for the distress measures. The overall model INAD, F-MPS 2, and APS-R 2 did a good job predicting BDI-II scores \( F(3, 205) = 46.89, p < .001; R^2 = .41 \), PSWQ scores \( F(3, 205) = 34.25, p < .001; R^2 = .33 \), and RSE scores \( F(3, 205) = 27.30, p < .001; R^2 = .28 \); see table 8. Further, INAD was the only significant predictor in the model of the BDI-II. Both INAD and F-MPS 2 were significant predictors of the PSWQ, although INAD was the best predictor in that equation. For self-esteem both INAD and APS-R 2 predicted the RSE almost equally. The above listed model also did a good job predicting D-DEP scores \( F(3, 206) = 32.82, p < .001; R^2 = .32 \), D-ANX scores \( F(3, 206) = 27.38, p < .001; R^2 = .28 \), D-STR scores \( F(3, 206) = 27.49, p < .001; R^2 = .29 \), and the DASS total scores \( F(3, 205) = 42.57, p < .001; R^2 = .38 \). INAD was the only significant predictor in the model of D-DEP and the total DASS. Both INAD and F-MPS 2 were significant predictors of D-ANX and D-STR, although INAD was the best predictor in both equations.

Regression Analyses: Subscales

Regressions were also done examining the individual maladaptive perfectionism subscales and the inadequacy subscales. The overall model IN, AD, DA, CM, PC, and DIS did a good job predicting the BDI-II \( F(6, 199) = 24.40, p < .001; R^2 = .42 \), the PSWQ \( F(3, 205) = 19.77, p < .001; R^2 = .37 \), and the RSE \( F(6, 205) = 15.27, p < .001; R^2 = .31 \). The IN and AD were the only significant predictors in the model of the
BDI-II, with IN being the best predictor. IN, DA, and CM were significant predictors of the PSWQ, with DA being the best predictor in that equation. DA was the only significant predictor for the RSE. The above listed model for the subscales also did a good job predicting D-DEP \([F (6, 203) = 16.92, p < .001; R^2 = .33]\), D-ANX \([F (6, 204) = 15.34, p < .001; R^2 = .31]\), D-STR \([F (6, 204) = 15.26, p < .001; R^2 = .31]\), and the DASS total \([F (6, 202) = 22.72, p < .001; R^2 = .40]\). For D-DEP, IN and AD were the only significant predictors in the model, with IN being the best predictor. For D-ANX, D-STR, and the total DASS, IN and DA were the only significant predictors, and IN was the best predictor in all three equations.
CHAPTER 5

DISCUSSION

The findings in this exploratory analysis provide evidence for the reliability and validity of the Inadequacy Scale (INAD). Through factor analysis, the INAD showed an unexpected two-factor solution with all the negatively oriented questions representing Inadequacy (IN: 16-items) and the positively oriented, or reverse order questions, representing Adequacy (AD: 5-items). When the scale was initially created several of the questions focused on the feelings of being inadequate while some focused on the fear of being inadequate. The fear and feelings questions were expected to factor separately. The IN subscale appears to be assessing the quintessential aspect of inadequacy that was initially envisioned and is made up of a mixture of questions related to both feelings and fears. The AD subscale on further review appears slightly different although closely related. The AD scale appears to have some relation to self-efficacy. Further research will is planned to assess this connection. Due to the exploratory nature of this project, and the unexpected factor solution, analyses of the separate IN and AD subscales and also the combined 21-item INAD were performed.

The concept of inadequacy was initially derived from the theories related to maladaptive perfectionism (Hollender, 1965; Hamacheck, 1978; Burns, 1980; Pacht, 1984; Frost et al., 1990; Slaney et al., 1992; Enns & Cox, 2002). The INAD showed high correlations with two highly researched and psychometrically sound measures of
perfectionism, the Frost-Multidimensional Perfectionism Scale (F-MPS) and the Almost
Perfect Scale-Revised (APS-R), and as expected the INAD was more highly correlated
with the maladaptive aspects of both scales. These findings support the primary
hypothesis that a measure of inadequacy would be highly related to established measures
of perfectionism, and maladaptive perfectionism in particular.

The INAD and perfectionism measures were also compared to several measures of
distress: the Beck Depression Inventory – II (BDI-II), the Rosenberg Self-Esteem
Inventory (RSE), the Penn State Worry Questionnaire (PSWQ), and the Depression
Anxiety Stress Scale (DASS). The IN and AD subscales and the total INAD
demonstrated significant correlations with all the measures of distress. The correlations
were compared for significant differences. The total Inadequacy Scale demonstrated
statistically equivalent or greater correlations with all measures of distress used in this
study when compared to the F-MPS and the APS-R in either full versions or the
maladaptive portions of the scales.

The results from the multiple regression analyses showed the INAD to be significant
for all measures of distress. For depression, measured by the BDI-II and the
Depression subscale of the DASS, the INAD was the only significant predictor. This
was also true of the total DASS scale. Further, the results showed that the INAD scale
accounted for the largest amount of variance of all measures of distress as
compared to the F-MPS and the APS-R, with the exception of self-esteem where the
INAD and the F-MPS were equal. These findings support the hypothesis that
inadequacy is a stronger predictor of distress than either of the maladaptive portions of

the F-MPS or the APS-R. The inadequacy subscales (IN & AD) also demonstrated strong predictive ability with regards to distress.

The total INAD scale appeared to represent the best predictor of distress across all measures in this study. Further, as a total scale it showed significant correlations with all the measures of distress that were equal to or greater than either the IN or AD subscales. Due to the strong correlation between the IN and AD subscales, the general similarities in the two subscales' correlations across measures, and the high combined alpha it is recommended that the INAD be used as a single combined scale rather than using the IN and AD subscales.

While these results are preliminary they do support the hypothesis that inadequacy appears to be the essential component of maladaptive perfectionism. Thus far the INAD has shown a strong significant connection to depression, anxiety, self-esteem, and stress. The negative consequences related to feeling or fearing inept, inadequate, or inferior to what a person believes he or she is expected to do is highly associated to diverse problems. This is supported by the research performed by Maltby, Macaskill and Day (2001), where they found that the inability to forgive ones self for failures was connected to psychopathology. While further research is clearly required, the results would give credence to the concept that inadequacy appears to be a significant psychological feature of perfectionism that makes it dysfunctional.

Given the strong correlation between the INAD and measures of depression in this study future research could utilize the INAD to gain further understanding of depression. One avenue of research would be to explore the connection with self-critical depression (Blatt, 1976, 1995). Self-critical depression is considered to be the most highly
associated with greater negative outcomes both therapeutically and in a general sense. It is proposed that the negative experience of inadequacy may have a strong connection to self-critical depression. This would be consistent with the findings of Frost et al. (1990) where those subscales found to be most associated to maladaptive perfectionism were the most strongly associated with self-critical depression as measured by the Depressive Experience Questionnaire (DEQ; Blatt et al., 1976). Future research regarding the INAD and the DEQ is planned by the current authors to substantiate the self-critical hypothesis.

Another area for future research would be to examine the INAD as a risk factor for psychopathology, especially depression. While this is study is correlation in basis, we hypothesize that inadequacy may be a significant part of a causal process leading towards psychopathology. In understanding the harmful characteristics of perfectionism, the setting of excessive standards may be an inus condition in a causal chain. While, the feelings and fears connected to failure or poor performance may be of a more involved connection to significant distress regardless of the excessiveness or rigidness of ones own standards.

With the exception of measuring excessive rigid standards, the Inadequacy Scale seeks to better measure the negative concept of perfectionism as theorized by past authors (Adler, 1935, 1956; Hollender, 1965; Hamachek, 1978; Burns, 1980; Pacht, 1984). Also in support of the recommendations of Shafran and Mansell (2001), we have attempted to assess the aspect of perfectionism that is most associated with psychological dysfunction. Additionally, we hypothesize that the Inadequacy Scale will
have clinical utility and be sensitive to clinical change, although substantial clinical research will be necessary to support this hypothesis.

This paper has several limitations. First, the findings were obtained from a non-clinical population. Further research with clinical populations may present significant differences in correlations for the inadequacy and perfectionism scales than found in the present sample. The study consisted of a college student sample from the same general region, which may result in unpredicted differences. Additionally, the inference that inadequacy is connected to anxiety should be viewed cautiously due to the use of only one very brief measure of anxiety from the DASS. In connection to anxiety, significant results were also found between the INAD and the PSWQ. However the PSWQ is a measure of worry, which is only one aspect of anxiety. Future research using additional established measures of anxiety would assist in supporting the INAD’s connection to anxiety.

In summary, the negative self-perception a person may have of being inadequate, or the fear of becoming such, has initially shown evidence of being connected to significant types of distress and potentially psychopathology. While further research will be required to validate these initial findings, the concept of inadequacy is predicted to have relevance within clinical, educational, and occupational settings. With the concept of inadequacy however, we desire to probe the experience of feeling inadequate beyond the perfectionism literature and implications. The experience of being inadequate to expectations may be seen in connection to a wide variety of experienced distress and even psychopathology. It is believed that the perception of oneself as being inadequate extends to profuse regions of human suffering. Research involving the Inadequacy
Scale with clinical samples of diverse nature may demonstrate a broad connection to psychopathology.
APPENDIX I

Tables and Figures

TABLE 1. Differences between Adaptive and Maladaptive Perfectionists

<table>
<thead>
<tr>
<th>Maladaptive perfectionism</th>
<th>Adaptive Perfectionism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to experience pleasure from labors</td>
<td>Able to experience satisfaction or pleasure</td>
</tr>
<tr>
<td>Inflexibly high standards</td>
<td>Standards Modified in accordance with the situation</td>
</tr>
<tr>
<td>Unrealistic or unreasonable high standards</td>
<td>Achievable standards</td>
</tr>
<tr>
<td>Overly generalized high standards</td>
<td>Standard’s are matched to the person’s limitations and strengths</td>
</tr>
<tr>
<td>Fear of failure</td>
<td>Striving for success</td>
</tr>
<tr>
<td>Focus on avoiding error</td>
<td>Focus on doing things right</td>
</tr>
<tr>
<td>Tense anxious attitudes towards tasks</td>
<td>Relaxed but careful attitude</td>
</tr>
<tr>
<td>Large gap between performance and success</td>
<td>Reasonable match between attainable performance and standards</td>
</tr>
<tr>
<td>Sense of self-worth dependent on performance</td>
<td>Sense of self independent of performance</td>
</tr>
<tr>
<td>Associated with procrastination</td>
<td>Timely completion of tasks</td>
</tr>
<tr>
<td>Motivation to avoid negative consequences</td>
<td>Motivation to achieve positive feedback</td>
</tr>
<tr>
<td>Goals attained for self-enhancement</td>
<td>Goals attainable for enhancement of society</td>
</tr>
<tr>
<td>Failure associated with harsh self-criticism</td>
<td>Failure associated with disappointment and renewed efforts</td>
</tr>
<tr>
<td>Black and white thinking:</td>
<td>Balanced thinking / Desire to excel</td>
</tr>
<tr>
<td>Perfection versus failure</td>
<td>Reasonable certainty about actions</td>
</tr>
<tr>
<td>Belief that one should excel</td>
<td></td>
</tr>
<tr>
<td>“Compulsive” tendencies and doubting</td>
<td></td>
</tr>
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</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>TABLE II. Inadequacy Scale (INAD: (\alpha = .94))</strong></td>
<td></td>
</tr>
<tr>
<td>b 1. In the last month, how often were you disappointed with yourself for not meeting expectations?</td>
<td></td>
</tr>
<tr>
<td>b 2. In the last month, how often were you afraid of feeling inferior?</td>
<td></td>
</tr>
<tr>
<td>a 3. In the last month, how often did you become frustrated by your flaws?</td>
<td></td>
</tr>
<tr>
<td>b 4. In the last month, how often did you feel like you had succeeded in meeting your goals?</td>
<td></td>
</tr>
<tr>
<td>a 5. In the last month, how often were you worried about measuring up to what is expected of you?</td>
<td></td>
</tr>
<tr>
<td>b 6. In the last month, how often did you feel like you were doing all the things you needed to do?</td>
<td></td>
</tr>
<tr>
<td>a 7. In the last month, how often were you afraid of being inadequate at performing your duties or obligations?</td>
<td></td>
</tr>
<tr>
<td>a 8. In the last month, how often were you disappointed with yourself for not being what you thought you should be?</td>
<td></td>
</tr>
<tr>
<td>b 9. In the last month, how often did you feel confident in you ability to do things correctly?</td>
<td></td>
</tr>
<tr>
<td>a 10. In the last month, how often did you feel like you did not meet your standards?</td>
<td></td>
</tr>
<tr>
<td>a 11. In the last month, how often have you been disappointed in yourself?</td>
<td></td>
</tr>
<tr>
<td>b 12. In the last month, how often did you feel happy with the things you were doing?</td>
<td></td>
</tr>
<tr>
<td>a 13. In the last month, how often were you worried about failing to do something you were supposed to do?</td>
<td></td>
</tr>
<tr>
<td>a 14. In the last month, how often were you unhappy with yourself because you weren’t doing all the things you should be doing?</td>
<td></td>
</tr>
<tr>
<td>a 15. In the last month, how often were you afraid of being inadequate?</td>
<td></td>
</tr>
<tr>
<td>a 16. In the last month, how often did you feel that no matter how hard you tried you just weren’t doing things well enough?</td>
<td></td>
</tr>
<tr>
<td>a 17. In the last month, how often did you feel frustrated for not meeting your expectations?</td>
<td></td>
</tr>
<tr>
<td>a 18. In the last month, how often did you become worried and stressed about doing things right?</td>
<td></td>
</tr>
<tr>
<td>b 19. In the last month, how often did you feel happy about your accomplishments?</td>
<td></td>
</tr>
<tr>
<td>a 20. In the last month, how often did you spend time covering your flaws and mistakes so others wouldn’t see them?</td>
<td></td>
</tr>
<tr>
<td>a 21. In the last month, how often were you unhappy with how you acted in certain situations?</td>
<td></td>
</tr>
</tbody>
</table>

\(a \) Inadequacy 16-items (IN); \(\alpha = .95\)
\(b\) Adequacy 5-items (AD: Reverse order questions); \(\alpha = .80\)

* Differing time references may be implemented and still maintain integrity of the scale: In general, In the last year, In the past few weeks, In the last week, Today.
### TABLE III. Scale and Subscale Means and SD (N = 227)

<table>
<thead>
<tr>
<th>Measures</th>
<th>M</th>
<th>SD</th>
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<tbody>
<tr>
<td>IN</td>
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<td>12.09</td>
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<tr>
<td>AD</td>
<td>7.66</td>
<td>3.1</td>
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<tr>
<td>INAD</td>
<td>35.6</td>
<td>14.1</td>
</tr>
<tr>
<td>HS</td>
<td>40.5</td>
<td>5.7</td>
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<tr>
<td>DIS</td>
<td>41.19</td>
<td>15.29</td>
</tr>
<tr>
<td>APS-R 1</td>
<td>81.5</td>
<td>17.19</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>41.19</td>
<td>15.29</td>
</tr>
<tr>
<td>DA</td>
<td>10.31</td>
<td>3.36</td>
</tr>
<tr>
<td>CM</td>
<td>22.01</td>
<td>6.64</td>
</tr>
<tr>
<td>PC</td>
<td>9.08</td>
<td>3.7</td>
</tr>
<tr>
<td>PE</td>
<td>15.22</td>
<td>4.35</td>
</tr>
<tr>
<td>PS</td>
<td>25.35</td>
<td>4.47</td>
</tr>
<tr>
<td>F-MPS 1</td>
<td>82.18</td>
<td>16.82</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>41.41</td>
<td>11.69</td>
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<tr>
<td>BDI</td>
<td>9.97</td>
<td>8.02</td>
</tr>
<tr>
<td>PSWQ</td>
<td>51.59</td>
<td>15.33</td>
</tr>
<tr>
<td>RSE</td>
<td>31.6</td>
<td>5.51</td>
</tr>
<tr>
<td>D-DEP</td>
<td>3.45</td>
<td>3.74</td>
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<tr>
<td>D-ANX</td>
<td>3.59</td>
<td>3.23</td>
</tr>
<tr>
<td>D-STR</td>
<td>6.95</td>
<td>4.96</td>
</tr>
<tr>
<td>DASS</td>
<td>14.06</td>
<td>10.52</td>
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</tbody>
</table>
TABLE IV. Comparison of Total Inadequacy Scale to Total Perfectionism Scales

<table>
<thead>
<tr>
<th>Total Scale</th>
<th>F-MPS 1</th>
<th>F-MPS 2</th>
<th>APS-R 1</th>
<th>APS-R 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>INAD</td>
<td>0.615</td>
<td>0.686</td>
<td>0.661</td>
<td>0.731</td>
</tr>
</tbody>
</table>

F-MPS 1 = CM, DA, PS, PC, & PE; F-MPS 2 = CM, DA, & PC; APS-R 1 = DIS & HS; APS-R 2 = DIS.
TABLE V. Intercorrelations Among the Inadequacy and Perfectionism Subscales

<table>
<thead>
<tr>
<th></th>
<th>IN</th>
<th>AD</th>
<th>F-DA</th>
<th>F-CM</th>
<th>F-PC</th>
<th>F-PE</th>
<th>F-PS</th>
<th>A-DIS</th>
<th>A-HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>0.573&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-DA</td>
<td>0.596&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.467&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-CM</td>
<td>0.627&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.367&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.604&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-PC</td>
<td>0.518&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.286&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.492&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.580&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F-PE</td>
<td>0.334&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.110&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.300&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.383&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.582&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-PS</td>
<td>0.230&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.075&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.202&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.436&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.302&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.385&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A-DIS</td>
<td>0.711&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.565&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.658&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.625&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.530&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.308&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.265&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A-HS</td>
<td>0.134&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.209&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.022&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.225&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.148&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.276&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.651&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.158&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

* Correlation correction using Modified Rank Order Method

<sup>a</sup> p < .01

<sup>b</sup> p < .05
<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>PSWQ</th>
<th>RSE</th>
<th>D-DEP</th>
<th>D-ANX</th>
<th>D-STR</th>
<th>DASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>INAD</td>
<td>0.656</td>
<td>0.559</td>
<td>-0.517</td>
<td>0.582</td>
<td>0.537</td>
<td>0.547</td>
<td>0.631</td>
</tr>
<tr>
<td>F-MPS 1</td>
<td>0.451*</td>
<td>0.507</td>
<td>-0.418*</td>
<td>0.376*</td>
<td>0.477</td>
<td>0.482</td>
<td>0.509*</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>0.491*</td>
<td>0.530</td>
<td>-0.511</td>
<td>0.432*</td>
<td>0.497</td>
<td>0.483</td>
<td>0.534*</td>
</tr>
<tr>
<td>APS-R 1</td>
<td>0.478*</td>
<td>0.484</td>
<td>-0.421*</td>
<td>0.432*</td>
<td>0.405*</td>
<td>0.432*</td>
<td>0.486*</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.536*</td>
<td>0.494</td>
<td>-0.492</td>
<td>0.491*</td>
<td>0.444*</td>
<td>0.433*</td>
<td>0.520*</td>
</tr>
</tbody>
</table>

* Indicating a significantly lower correlation than INAD with the column measure; \( p \leq 0.05 \)

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<table>
<thead>
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<th>BDI</th>
<th>PSWQ</th>
<th>RSE</th>
<th>D-DEP</th>
<th>D-ANX</th>
<th>D-STR</th>
<th>DASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td>0.632</td>
<td>0.549</td>
<td>-0.496</td>
<td>0.555</td>
<td>0.548</td>
<td>0.559</td>
<td>0.630</td>
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<tr>
<td>AD</td>
<td>0.523</td>
<td>0.408</td>
<td>-0.431</td>
<td>0.445</td>
<td>0.287</td>
<td>0.318</td>
<td>0.396</td>
</tr>
<tr>
<td>F-DA</td>
<td>0.491</td>
<td>0.534</td>
<td>-0.493</td>
<td>0.433</td>
<td>0.476</td>
<td>0.470</td>
<td>0.523</td>
</tr>
<tr>
<td>F-CM</td>
<td>0.424</td>
<td>0.494</td>
<td>-0.471</td>
<td>0.389</td>
<td>0.423</td>
<td>0.434</td>
<td>0.473</td>
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<tr>
<td>F-PC</td>
<td>0.348</td>
<td>0.303</td>
<td>-0.322</td>
<td>0.274</td>
<td>0.378</td>
<td>0.319</td>
<td>0.362</td>
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<tr>
<td>F-PE</td>
<td>0.270</td>
<td>0.238</td>
<td>-0.123</td>
<td>0.169</td>
<td>0.270</td>
<td>0.275</td>
<td>0.277</td>
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<tr>
<td>F-PS</td>
<td>0.158</td>
<td>0.280</td>
<td>-0.066</td>
<td>0.131</td>
<td>0.233</td>
<td>0.298</td>
<td>0.256</td>
</tr>
<tr>
<td>A-DIS</td>
<td>0.536</td>
<td>0.494</td>
<td>-0.492</td>
<td>0.491</td>
<td>0.444</td>
<td>0.433</td>
<td>0.520</td>
</tr>
<tr>
<td>A-HS</td>
<td>0.030</td>
<td>0.164</td>
<td>0.028</td>
<td>-0.010</td>
<td>0.057</td>
<td>0.155</td>
<td>0.086</td>
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* indicating a significantly lower correlation than IN with the column measure; \( p < .05 \)

\[ y \] indicating a significantly lower correlation than AD with the column measure; \( p < .05 \)
<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression (BDI-II)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INAD</td>
<td>0.31</td>
<td>0.05</td>
<td>0.53</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>-0.02</td>
<td>0.06</td>
<td>-0.02</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.08</td>
<td>0.05</td>
<td>0.16</td>
</tr>
<tr>
<td><strong>Worry (PSWQ)</strong></td>
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<td></td>
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<tr>
<td>INAD</td>
<td>0.35</td>
<td>0.10</td>
<td>0.32</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>0.32</td>
<td>0.11</td>
<td>0.23</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.09</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Self-Esteem (RSE)</strong></td>
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<td></td>
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<tr>
<td>INAD</td>
<td>-0.08</td>
<td>0.04</td>
<td>-0.21</td>
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<tr>
<td>F-MPS 2</td>
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<td>-0.17</td>
</tr>
<tr>
<td>APS-R 2</td>
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<td>0.03</td>
<td>-0.21</td>
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<tr>
<td><strong>Depression (D-DEP)</strong></td>
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<tr>
<td>INAD</td>
<td>0.12</td>
<td>0.02</td>
<td>0.43</td>
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<tr>
<td>F-MPS 2</td>
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<td>0.03</td>
<td>-0.01</td>
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<td>APS-R 2</td>
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<td>0.02</td>
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<tr>
<td><strong>Anxiety (D-ANX)</strong></td>
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<tr>
<td>INAD</td>
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<td>0.02</td>
<td>0.33</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>0.05</td>
<td>0.02</td>
<td>0.18</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.01</td>
<td>0.02</td>
<td>0.07</td>
</tr>
<tr>
<td><strong>Stress (D-STR)</strong></td>
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</tr>
<tr>
<td>INAD</td>
<td>0.14</td>
<td>0.03</td>
<td>0.40</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>0.07</td>
<td>0.04</td>
<td>0.16</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.01</td>
<td>0.03</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Distress (DASS Total)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>INAD</td>
<td>0.33</td>
<td>0.06</td>
<td>0.45</td>
</tr>
<tr>
<td>F-MPS 2</td>
<td>0.12</td>
<td>0.07</td>
<td>0.13</td>
</tr>
<tr>
<td>APS-R 2</td>
<td>0.06</td>
<td>0.06</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Note: $R^2 = .40$ for BDI-II. $R^2 = .33$ for PSWQ. $R^2 = .28$ for RSE. $R^2 = .32$ for D-DEP. $R^2 = .28$ for D-ANX. $R^2 = .29$ for D-STR. $R^2 = .38$ for DASS. 

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APPENDIX II

Subject Pool Research Description

Name: Brandon Park
Faculty Advisor: Mark R. Floyd, Ph.D.
Department: Psychology
Title of Study: Inadequacy and Perfectionism

This is a study that examines attitudes towards standards, self-esteem, and emotion. You will be asked to fill out a series of questionnaires that should take no longer than one hour. You will receive 1-hour research credit for completing the task and the study may only be performed once.
APPENDIX III

Informed Consent Form
Psychology Department
University of Nevada, Las Vegas

In this study, Brandon Park and Dr. Mark Floyd of the Psychology Department are examining attitudes about accomplishments, failures, and psychological well-being. You will be asked to complete various questionnaires. The questionnaires will take approximately one hour to complete. We ask that you answer each question carefully and honestly.

The risks associated with participating in this project are minimal; you may experience some mild, temporary discomfort when completing the questions. The questionnaires are completely confidential and anonymous. Your name will not be written on the questionnaire or on any other record in this study. Results will be compiled in a statistical report format that will not refer to any individual's response. The questionnaires will be stored in a locked file at UNLV for no more than three years, after which they will be destroyed.

By participating, you will be adding to the general body of knowledge on this subject. You will receive one research credit for your participation. If you decide to withdraw from participation at any time, you will still receive one research credit.

If you have any questions regarding this research, please contact Brandon Park at 895-3305 or Dr. Mark Floyd at the UNLV Psychology Department, 895-0109, CBC-
B524. For questions involving the rights of research participants, please contact the UNLV Office for the Protection of Research Subjects at 895-2794 in FDH 332.

Your participation is strictly voluntary and you may withdraw from participation at any time.

By completing the attached questionnaire, you are acknowledging your understanding of this study and are agreeing to participate in the research.

Thank you very much for your participation.
APPENDIX IV

Debriefing Form

TITLE: Perfectionism & Inadequacy

Researcher: Mark Floyd PhD, Assistant Professor & Brandon Park Doctoral Candidate
University of Nevada, Las Vegas
895-0109

The forms you have filled out today indicate your self-perception of perfectionistic standards, anxious symptoms, depressive symptoms, and self-esteem. These forms have been used in both clinical and research settings to better assess constructs.

The purpose of this research is to try to understand specific emotions, standards, and cognitions that occur in people with perfectionistic behaviors. To do this, a large group of individuals is needed to assess differences in perfectionistic standards. Scores will then be compared and assessed to create a broad understanding of associated feelings and cognitions with varying degrees of perfectionistic standards.

Talking with Someone:

For some people, this study may have raised questions regarding one's current emotional state. If you want to talk to someone about these issues, you may contact the UNLV Student Health Center at 895-3370 or UNLV Student Counseling & Psychological Services at 895-3627.
REFERENCES


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Degrees:
Bachelor of Arts, Psychology, 2002
University of Nevada, Las Vegas

Thesis Title: Inadequacy, The Psychopathological Component Of Perfectionism:
Validation Of The Inadequacy Scale

Thesis Examination Committee:
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