Perfectionism and Help-Seeking for Depression

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Declaration

I hereby declare this document as being submitted as partial requirement of the requirements for the Bachelor of Arts (Honours) degree in Psychology at Central Queensland University. I further declare that the contents are my own work, are 12,687 words in length, and have not been submitted previously for the purpose of assessment.

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Abstract

This study examined the relationship between perfectionism, the personality trait of setting excessively high standards for personal performance (Stoeber, Feast & Hayward, 2009), and help-seeking for depression. It was hypothesised that
maladaptive perfectionists may differ from other participants in their likelihood to seek help for depression, their tendency to delay help seeking and their strength of preference for non-face-to-face help for depression. Adult male (n = 35) and female (n = 55) participants (n = 91) were identified as non-perfectionist (n = 54), adaptive perfectionist (n = 12) or maladaptive perfectionist (n = 21) based upon scores on the Almost Perfect Scale-Revised (Slaney et al., 2001). Likelihood of seeking help for depression and strength of preference for professional, nonprofessional and non-face-to-face sources was measured using the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi & Rickwood 2005). Participants tendency to delay help seeking was measured using a one item self-report tool. Results indicated that (1) maladaptive perfectionists were more likely to delay seeking help than other participants and (2) differences were not found in participants likelihood to seek-help for depression or in strength of preference for non-face-to-face help based on perfectionist type. Incidentally however, it was found that strength of preference for informal help sources was lower for maladaptive perfectionists than other perfectionist types. The implications of these findings are discussed, along with directions for future research.
Chapter 1

Introduction

Often in life situations arise where an individual has a need that they are unable to adequately address alone and external help must be sought to arrive at a fitting solution. In fact, in the social climate prevalent in Australian society presently, it can be difficult to identify a domain in which individuals do not seek help. It is common to enlist help from medical practitioners when unwell, teachers to assist in educating our children, mechanics when our cars need tuning, gym instructors to achieve and maintain physical fitness, financial planners to manage our monitory assets, solicitors when negotiating legal contracts, plumbers when sewerage issues arise and rubbish collectors to take away our household refuse. Thus, the ability to locate and accesses suitable assistance is integral in effectively negotiating life in the current Australian climate. Fortunately, many organisations whose purpose it is to provide assistance to people exist. However, research indicates that often help can be under-utilised (Ryan, Shochet & Stallman, 2010, Buscemi, Murphy, Martens, McDevitt-Murphey, Dennhardt & Skidmore, 2010). Thus, connecting people with the available help is not always as trouble-free as it would seem. Logically, this would suggest that, for some individuals who would benefit from a particular form of help, functioning is negatively impacted because they do not access available help. This phenomena is worthy of investigation as increased understanding may be instrumental in establishing practices that facilitate connection of individuals with appropriate assistance (Rickwood, Deane, Wilson & Ciarrochi, 2005), thus promoting individual functioning. The aim of the
proposed study is to investigate the impact that perfectionism may have upon help-seeking behaviours.

1.1 Help-Seeking

The term help refers to external assistance provided to achieve a goal. By its very nature, help introduces an outside source into the problem solving context. A helping relationship can be initiated by either the assisting party offering help or an individual requesting help. Help-seeking is a term used to refer to this latter process (Cleavenger, Gardner & Mhatre, 2007). Help-seeking has long been recognised as a facet of human behaviour and, as such, has been the subject of much research (Kakhnovets, 2011). Early conceptualisations of help-seeking viewed it as potentially unhelpful because it was thought to promote dependance on others. From this perspective it was feared that help-seeking would hinder self-reliance and proficiency (Marchand & Skinner, 2007). However, because of its utility in addressing felt needs, current conceptualisations of help-seeking categorise it as a coping strategy (Rickwood et al, 2005). Requiring active participation on the part of the help-seeker, help-seeking is classified as an approach coping strategy (Rickwood et al.). Within this perspective help-seeking is valued as not only acceptable but an adaptive strategy to employ when one’s personal resources alone are not adequate to deal with the demands of the current situation (Jarvela, 2011).

Indeed, within today’s communities a plethora of formal help is available from a range of different sources including doctors, psychologists, teachers, financial planners, lawyers, community programs, sporting organisation and
religious groups. Furthermore, informal help may be sought from family and friends. Babitsch, Veith, Borde, Borde and David (2010) report that often informal help is sought prior to seeking formal assistance.

Clearly, help-seeking skills are necessary if one is to gain optimal benefit from opportunities available within the environment. Evident of its importance, help-seeking has been the focus of a considerable amount of research. Perhaps the most consistent finding in the help-seeking literature is that individuals vary greatly in the extent to which they engage in the help-seeking process (Ryan, Patrick, Shim, 2005). Unless an individual is willing and able to seek help available assistance will not be accessed. When needs are trivial the decision whether or not to seek help may be arbitrary. However, when important situations of need for which personal resources alone are inadequate arise, wellbeing may be dependant upon their engagement in help-seeking behaviours (Nam, Chu, Lee, Lee, Kim & Lee, 2010). Thus help-seeking is a vital coping strategy important for promoting wellbeing across a range of domains.

As a process, help-seeking requires successful progression through several steps, each offering their own unique challenges to be negotiated. Help-seeking requires acknowledgement of a problem/need, decision to seek help, selection of the source of help and communicating a request for help to the selected helper (Gulliver, Griffiths & Christensen, 2010). In view of this model help-seeking is a complex process.

Research indicates that difficulty engaging in appropriate help-seeking behaviours is a problem common in a variety of different contexts including
education (Ryan et al., 2005), physical (Boyer & Lutfey, 2010) and mental health (Gulliver, et al., 2010), addictions (Buscemi et al., 2010) and abuse (Smith, Bryant-Davis, Tillman & Marks, 2010; McCart, Smith, Sawyer, 2010).

Furthermore, particular populations that typically experience greater than average difficulty engaging in help-seeking behaviour have been identified through research. Such studies have revealed that men (Nam et al., 2010), minority groups, adolescents (Wilson, 2010), gender role conflicted persons (Tsan, Day, Schwartz & Kimbrel, 2011) and closed personality types (Liao, Rounds, Klein, 2005) tend to exhibit inhibitions in help-seeking behaviour. Identification of these groups is important as it allows intervention aimed at fostering help-seeking to be directed at these populations (Mansfield, Addis & Courtenay, 2005).

Four qualities found to decrease the likelihood of seeking help have been identified; the belief that the problem signifies a personal flaw, how unusual a problem is perceived to be, slim chances of repaying the help in the future and a greater tendency to protect or restore autonomy (Mansfield et al., 2005). Within the academic setting three factors have been found to inhibit help-seeking behaviour; the desire to act autonomously, the fear that seeking help communicates personal inadequacy and the belief that assistance will be ineffective (Ryan et al., 2005). Furthermore, in the development of their scale measuring barriers of men’s help-seeking, Mansfield et al. discovered five clear factors these were need for control and self reliance, concrete barriers and distrust of caregivers, minimising problem and resignation, desire for emotional control and privacy.
Having reviewed some of the barriers to help seeking it is possible to identify other populations who may be at risk of experiencing difficulty in seeking help. One such group are maladaptive perfectionists, the focus of the proposed research.

1.2 Perfectionism

The trait of striving for flawlessness and setting excessively high standards for personal performance combined with the tendency to be overly critical in evaluations of one’s own behaviour is termed perfectionism (Stoeber, Feast & Hayward, 2009). As a trait, perfectionism is stable, persistent and integral part of an individual’s personality (Mallinger, 2009). Perfectionistic traits are all encompassing as they can effect behaviour across all domains of life (Stoeber & Otto, 2006). Like perspectives on help-seeking, conceptualisations of perfectionists have changed over time in response to a growing body of research. Early theories centred around the understanding that perfectionism was a unidimensional trait that was invariably adverse (Ashby, Kottman & Stoltz, 2006) describing perfectionists as susceptible to experiencing shame and guilt while being unable to experience pride (Stoeber, Harris & Moon, 2007). Indeed, within the early literature it was assumed that perfectionism was pathological (Gansky & Ashby, 2007). It is true that research has found perfectionism to be associated with a range of undesirable outcomes including distress and rumination (Randles, Flett, Nash, McGregor & Hewitt, 2010), fear of failure and procrastination (Chan, 2010) self-criticism and depression (Gilbert, Durrant & McEwan, 2006), obsessions (Mallinger, 2009), eating disorders (Shafran & Mansell, 2001) and maladjustment
and distress in children (Hewitt, Caelian, Flett, Sherry, Collins & Flynn, 2002). However, the universality of this notion was challenged, as investigations continued and reports arose demonstrating that, in some contexts, perfectionistic traits can be advantageous. Hamachek’s 1978 report, identifying two types of perfectionists which he labeled as ‘normal’ and ‘neurotic’, was the first to suggest that perfectionism was multidimensional (cited by Chan, 2010). The idea that perfectionism is multi-faceted, containing features that are adaptive as well as those that are unhelpful, fuelled a new era of research into perfectionism that focussed on identifying these dimensions (Ganske & Ashby). Within this framework several models of perfectionism have been developed. These models are not necessarily antagonistic. Rather, they focus on different ways of categorising the wide range of behaviours typically associated with perfectionism.

Following in the footsteps of Hamerchek’s two dimensional model of perfectionism, many studies have provided evidence for the existence of two distinct subtypes within the perfectionist classification (Stoeber & Otto, 2006). Researchers who have chosen to follow this stream have focussed their effort on uncovering the differences between healthy and unhealthy perfectionists and currently conceptualise that individuals can be classified as non-perfectionists, adaptive perfectionists or maladaptive perfectionists (Stoeber et al., 2007).

From this viewpoint, although both adaptive and maladaptive perfectionists strive for high standards. These groups can be most clearly distinguished from each other by their attitude towards their own limitations (Chan, 2010). It is proposed that all perfectionists are driven to strive for high standards however,
when performance fails to reach the perfectionists self-imposed goals, adaptive perfectionists are able to accept their short-falling, experiencing minimal stress (Slaney, Rice, Mobley, Trippi & Ashby, 2001). Conversely, maladaptive perfectionists experience a marked increase in stress when faced with a discrepancy between expectations and performance (Slaney et al.). Research based on this model has revealed that adaptive perfectionism is associated with higher internal locus of control (Periasamy & Ashby, 2002), heightened satisfaction and pride (Stoeber & Yang, 2010), lower susceptibility to shame (Stoeber et al., 2007) and increased self-esteem, better social integration and fewer somatic symptoms (Stoeber & Otto, 2006). A link has also been identified between maladaptive perfectionism and higher external locus of control (Periasamy & Ashby), increased need for control and tendency to outdo others (Ashby et al., 2006), poorer physical health (Ofoghi & Besharat, 2010) and self-worth dependant on external judgement (Hill, Hall & Appleton, 2011).

Another multi-dimensional model of model of perfectionism, focusing on the source of expectations, identifies three different facets of perfectionism; striving highly to meet their own self-determined goals (Self-Oriented Perfectionism, SOP), striving highly to meet standards perceived to be imposed by others and believe to be prerequisites for acceptance by others (Socially Prescribed Perfectionism, SPP) and expecting high standards from others (Other-Oriented Perfectionism, OOP) (Hewitt & Flett, 1991). Research using the source of expectations to distinguish between perfectionists reveals that the negative outcomes seem to be mainly associated with SPP rather than SOP or OOP (Hill et
al. 2011, Stoeber & Otto, 2006). These findings indicate that it is the external motivation, under girdled by fear of the judgements of others, that give rise to dysfunctional perfectionistic behaviours.

Mallinger (2009) asserts that maladaptive perfectionism is an obsession stemming from an inordinate need for control that becomes of paramount importance due to its ability to reduces anxiety associated with vulnerability. From this perspective, perfectionistic strivings are borne from the perceived necessity to insulate oneself from vulnerability arising from disapproval, incompetence, rejection or belittlement. Thus, much of the perfectionists effort is directed toward asserting and confirming the illusion of absolute competence, and thereby control, to the self and others (Mallinger). This position is supported by the findings of Ashby et al. (2006) who discovered that the maladaptive perfectionists efforts to outdo others was driven by a need for control. Understandably, for such a person, being faced with a scenario involving the possibility of a flawed response becomes highly stressful as it involves the chance of exposing the maladaptive perfectionists imperfections. To avoid this stress, it is suggested that maladaptive perfectionists either make preparations that ensure a flawless performance or find a way to avoid the threatening situation (Mallinger). Thereby, the perfectionist’s tendency develop and become highly committed to behavioural patterns that are engineered to conceal any facet of the self deemed to be flawed or needy are borne.

As previously mentioned, although each has a different focus, these contemporary strands of research can stand alongside one another, each
contributing important understandings to the overall conceptualisation of perfectionism. Combining information gained via different strands of perfectionism research, the current understanding of perfectionism pertinent to the proposed research is that perfectionistic behaviours are adopted for the purpose of enhancing feelings of control and minimising felt vulnerability (Ashby, 2006). Furthermore, maladaptive perfectionism is associated with striving for high standards that are driven by a desire to meet the expectations of others (Hill et al. 2011, Stoeber & Otto, 2006) and the perception that their short fallings are intolerable and likely to result in negative appraisal by spectators (Hewitt & Flett, 1991). Thus, behavioural patterns are designed to promote the image of total competence and avoid revealing any personal limitations (Mallinger, 2009).

1.3 Perfectionism and Help-Seeking

Surprisingly, the relationship between help-seeking and perfectionism is yet to be investigated. However if this picture of maladaptive perfectionism is considered alongside current conceptions of the help-seeking process it becomes apparent that this population is likely to experience difficulty engaging in appropriate help-seeking behaviours. Given that maladaptive perfectionists experience marked stress when faced with a discrepancy between their own high expectations and their actual performance (Slaney et al., 2001) it would follow that, motivated by a desire to minimise stress, this group would seek to avoid situations where this discrepancy is apparent such as help-seeking, requiring admission of need.
It is easy to envisage that maladaptive perfectionists may find the first task of the help-seeking process, problem acknowledgement, difficult. Maladaptive perfectionists tend to perceive any inkling of failure or need as a potential threat to being accepted and approved by others (Hewitt & Flett, 1991). Thus, it is conceivable that maladaptive perfectionists, in an effort to protect themselves from threat, may be unwilling to acknowledge presence of a problem. In the absence of such acknowledgement, the maladaptive perfectionists help-seeking would be thwarted before it even began.

If the maladaptive perfectionist was able to acknowledge a problem the decision to seek help, the next step in the process, may prove to be an obstacle. An intention to seek help requires a willingness to reveal a personal limitation to an external helper (Cleavenger, Gardner & Mhatre, 2007), the precise vulnerability that maladaptive perfectionists tend to avoid (Mallinger, 2009). Supporting this notion, Ryan and Pintrich (1997) found that students who were concerned about being judged by others were less likely to seek assistance.

Again the final stage of the help-seeking process, making a request for help, may be particularly challenging for the maladaptive perfectionist. After going through the steps of acknowledging the need for help, deciding to seek help and selecting the help source, implementing this plan could be incredibly hard as it involves enacting the planned behaviour and actually revealing to another one's limitations and inability to deal with the problem alone. Indeed, if help-seeking is defined as the process whereby an individual elicits assistance from an external source when personal resources fall short in meeting felt needs, then its counter
process would be that of concealment of personal need (Marchand & Skinner, 2007), a behaviour associated with maladaptive perfectionists (Stoeber & Otto, 2006).

Finally, noting that a heightened need for control has been associated with reduced help-seeking (Mansfield et al., 2005) and with maladaptive perfectionists (Ashby et al., 2006) gives a clear indication that investigating a possible link between maladaptive perfectionism and help-seeking shows great potential.

1.4 Depression, Perfectionism and Help-Seeking

Depression, characterised by symptoms such as depressed mood, absence of positive mood, agitation, tiredness, feelings of worthlessness and guilt, impaired concentration and decisiveness, changes in appetite, weight, physical activity and sleep patterns and suicidal ideation (American Psychiatric Society, 2000), is one of the more prevalent mental illnesses (Schomerus, Matschinger & Angermeyer, 2009). Highet, Luscombe, Davenport, Burns and Hickie found, in a large Australian survey, 18.7% of participants reported having personally experienced depression and a further 46.7% disclosed having encountered depression via exposure to the experience of someone close to them (2006). Furthermore, several evidence based treatments have been shown to be effective in the treatment of depression (Corrigan, 2004). Thus, research indicates that within Australia depression is a relatively prevalent mental illness tending to have a positive prognosis if intervention is sought.

Of concern is the fact, despite its prominence, depression, like other mental illnesses, is renowned as an area where sufferers are reluctant to seek help with
estimates suggesting that over fifty percent of Australians experiencing depression do not seek professional help (Barney, Griffiths, Jorm & Christensen, 2006). Stigma associated with depression has been identified as a key factor contributing to reduced help-seeking. Schomerus et al. (2009) investigated the impact of stigma of psychiatric treatment on help-seeking intentions for depression. They investigated two potential sources of stigma thought to inhibit help seeking, anticipated discrimination by others and personal discriminatory attitudes, and found evidence to suggest that it is self-stigmatizing that reduces ones propensity to seek psychiatric help for depression (Schomerus et al.).

Whilst at a mild level, due to the absence of easily observable symptoms, depression may be concealed and even denied by an individual. Furthermore, given that there is a stigma associated with all mental illnesses, including depression, it would seem plausible that those overly troubled by the discrepancy between their own flawless self-expectations and reality, maladaptive perfectionists, may experience difficulty in acknowledging their problem, seeking help and revealing their need to the appropriate professional. Thus, it is possible that maladaptive perfectionists tend to experience difficulty in engaging in help-seeking behaviour for depression.

Types of help available to those experiencing depression are many and varied (Cummings & Kropf, 2009). Help may differ in terms of its source, duration, frequency, delivery, context and underlying beliefs. Help for depression can be formal or informal, pharmaceutical or non pharmaceutical, delivered to inpatients or outpatients, provided by professionals or friends, focussed on the past
or present or any imaginable eclectic arrangement of appealing aspects from many different approaches. Also notable is the fact that sources of help for depression are ever evolving as evidenced in the growth in the past decade of websites as a source of information and treatment (Oh, Jorm & Wright, 2009).

Help for depression may be sought from professional practitioners such as doctors and psychologists, informal sources including family or friends or even sources that do not require face-to-face contact like the internet and telephone helplines. As previously posited, reluctance to disclose of personal need may inhibit engagement in the help-seeking process for maladaptive perfectionists experiencing depression. Thus, it would follow that the characteristics of the one to whom personal needs are revealed may be an important factor influencing willingness to seek help. It could be that a non face-to-face help source may be preferable for those who struggle with disclosure of personal need. Thus, consideration of willingness to use a variety of help sources including ones that do not require face to face contact is an important component of an investigation into the relationship between perfectionist type and help-seeking for depression. An increased understanding of individual differences in preferred sources of help for mental illness is vital in promoting connection between those affected and appropriate treatment (Leach, Christensen, Griffiths, Jorm & Mackinnon, 2007).

1.5 Aim and Hypothesis

The purpose of this project was to explore the relationship between perfectionism and help seeking. More specifically it seeks to uncover differences in help seeking behaviour between non-perfectionists, adaptive perfectionists and
maladaptive perfectionists. Three aspects of help-seeking were identified as potential sources of variation in help-seeking behaviour; the likelihood of engaging in help-seeking, the timing of help seeking and preferred sources of help. Thus, the investigation explored the way different perfectionist types tend to behave with regard each of the three facets of help-seeking in order to explore the relationship between help-seeking and perfectionism. Given its familiarity within the Australian population and its association with help-seeking difficulty, particularly for those with the tendency to self-stigmatise, depression was selected as the context in which the relationship between perfectionist type and help-seeking would be explored. Thus, the impact of perfectionism upon help-seeking within the arena of mental health, specifically depression, was investigated.

It was hypothesised that maladaptive perfectionists would be less likely to seek help for depression than adaptive perfectionists or non-perfectionists. Furthermore, it was posited that maladaptive perfectionists would be more likely than adaptive perfectionists or non-perfectionists to delay help-seeking. Finally, it was thought that maladaptive perfectionists would be more likely have a stronger preference for help sources for depression that do not involve face-to-face contact with the helper than adaptive perfectionists or non-perfectionists.
Chapter 2

Method

2.1 Participants

The sample comprised of 91 adults; 35 males, 55 females and 1 participant missing data for the gender item. Participants were diverse in age; 20 18-35 years old, 50 36-60 years old, 20 aged over 60, and 1 participant missing data for the age group item. Within the sample 83 reported having the ability to use the internet, 7 reported being unskilled in internet use and 1 participant did not respond to this item.

The voluntary nature of participation was emphasised throughout the recruitment process via spoken word and the written information. Completion and return of surveys was taken to indicate informed consent.

2.2 Materials

2.2.1 Demographic scales.
Demographic data collected included gender, age and internet ability (See Appendix D). Given the finding that gender influences help seeking (Nam et al., 2010) it is important to gain this information. Gender was indicated by circling either ‘male’ or ‘female’. Similarly, participants were asked to select which age bracket they belong to; 18-35, 36-60, >60. Participants circled either ‘yes’ or ‘no’ to indicate whether or not they have the ability to use the internet to conduct simple searches and locate web pages. This question was important as it allowed the researcher to distinguishing whether lack of skill or personal preference that underpinned participants willingness to seek help via an online resource.

2.2.2 Perfectionism scale.

Participants perfectionistic type was identified via completion of two sub scales (19 items) of the Almost Perfect Scale-Revised, APS-R (Slaney et al., 2001; See Appendix B). The APS-R is comprised of 23 items rated using a 7-point scale (1= strongly disagree to 7= strongly agree) and has three sub scales; high standards, discrepancy and order. The high standards scale, consisting of 7 items (Chronbach’s coefficient alpha=.85), measures tendency to strive for high standards (Slaney et al.). Twelve items combine to form the discrepancy scale (Chronbach’s coefficient alpha=.92) which evaluates stress associated with the discrepancy between actual performance and expectations (Slaney et al.). The remaining four items comprise the order scale (Chronbach’s coefficient alpha=.68) which was not presented to participants in the research as it plays no role in identifying and classifying adaptive, maladaptive and non perfectionists (Slaney et al.).
The APS-R cut-off criterion proposed by Rice & Ashby (2007) was utilised to classify participants' perfectionist type. Rice & Ashby derived these cut-offs by utilising statistical methods including cluster analysis, functional analysis and receiver operating characteristic curve for sensitivity and specificity of APS-R scores. Validity of the cut-offs was supported by evidence showing convergent and criterion related validity (Rice & Ashby).

2.2.3 Help-seeking scales.

Help-seeking behaviour was measured using the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi & Rickwood 2005; See Appendix C). The GHSQ, designed to be adapted by the researcher to suit the specific needs of their investigation, is a highly versatile tool that can be used to assess help-seeking intentions in a wide range of contexts (Wilson, Deane, Marshall & Dalley, 2010). Both problem type and potential sources of help can be designated by the researcher (Wilson et al., 2005). When completing the GHSQ participants are asked to rate the likelihood that they would seek help from a specified source for a given problem. Participants were asked to use a seven point likert scale to indicate how likely it is that they would seek help from six different sources; two professional (doctor and psychologist), two informal (friend and family member) and two non-face-to-face (telephone help line and online help), if they believed they were experiencing depression that was impacting on their daily functioning. Ratings were made on a 7 point scale (1=extremely unlikely to 7=extremely likely). Wilson et al. (2010) report that the format of the GHSQ has been used in a range of research settings with acceptable reliability and validity.
Finally, the tendency of participants to delay help seeking was measured using a one item self-report item (See Item 20, Part A; Appendix B) where participants were asked to rate on a 7 point likert scale the extent to which participants endorsed the statement “I tend to avoid asking for help until problems become serious” ranging from 1 (Strongly Disagree) to 7 (Strongly Agree).

2.3 Procedure

After receiving ethical clearance, participants were recruited via convenience sampling. This method was acceptable as the research was of an exploratory nature; aiming to reveal relationships between perfectionism and help seeking behaviour for further investigation. Convenience sampling was considered advantageous as it allowed the researcher to perform inexpensive initial probing into unexplored territory. Participants were recruited by the researcher via word of mouth. Those who were interested in participating were provided with an information sheet (See Appendix A). This sheet informed participants of the nature of the research including rationale, method, risks and possible outcomes. It also clearly outlined participants’ rights and responsibilities. The information sheet explained that participation would occur on the basis of voluntary consent. It informed potential participants of their right to withdraw without reason, justification or penalty. However, since returning the completed survey according to the procedure stipulated in the information sheet rendered surveys unidentifiable, withdrawal following submission was not possible.

Those who agreed to participate were asked to complete a self-report questionnaire consisting of three parts. Part A consisted of 20 questions, the first
19 being the two relevant scales of the APS-R and question twenty measured the
tendency to delay help-seeking (See Appendix B). Part B consisted of the GHSQ
that stipulated a depressed condition and required participants to self-rate their
likelihood of seeking help from six different sources and finally asked them to rate
the likelihood that they would not seek help for the problem outlined (See
Appendix C). Finally, Part C gathered relevant demographical data (See Appendix
D).

The time to complete the forms was approximately 10-15 min. Completed
forms were returned via the mail or in person using an addressed envelope that
was provided. Participants were also given the opportunity to elect to receive
feedback on the results of the study. Those wanting to receive feedback could fill
in their contact details on a form provided and return it to the researcher in the
addressed envelope marked ‘feedback request’ provided with the surveys (See
Appendix E).

2.4 Research Design

The study sought to uncover variation in help-seeking behaviour for
depression based upon perfectionist type. Specific aspects of help-seeking that
were investigated for differences related to the timing of help seeking, the
likelihood of seeking help and the preferred source of help.

The research design involved three dependant variables and one independent
variable with three levels. Two oneway ANOVAs were used in an effort to
uncover differences between mean scores on two of the dependant variables
(tendency to delay help seeking & strength of preference for non-face-to-face help
sources) between perfectionist type groups. Perfectionist Type was the independent variable with its three levels being, non-perfectionist, adaptive perfectionist and maladaptive perfectionist. If significant differences in help-seeking scores between the perfectionist groups were revealed by oneway ANOVA planned contrasts were used to determine precisely where the difference exists. However, to explore for significant differences between perfectionist group scores on the variable of likelihood of seeking help nonparametric analysis was required followed by Mann-Whitney tests to locate the differences. Data was also screened to check for data that may uncover other unhypothesised relationships that may exist.
Chapter 3

Results

Data were analysed using the statistical software SPSS version 19. The raw output from all analyses conducted is presented in Appendix G and the SPSS data set used is located in Appendix F.

3.1 Calculation of Dependant Variables

Raw data was used to calculate scores for each of the three dependent variables.

3.1.1 Likelihood of seeking help.

In order to seek help for depression an individual only needs to engage assistance from one help source. Thus, the highest rating for likelihood of seeking help across the six different sources on the GHSQ (see Appendix C) was taken to be a measure of an individual’s likelihood of seeking help for depression. Thus, scores for likelihood of seeking help ranged from 1 (extremely unlikely) to 7 (extremely likely) with $M = 6.07$, $SD = 1.14$ and $n = 88$.

3.1.2 Tendency to delay help-seeking.

Scores for the likelihood of delaying help seeking were taken directly from responses to the single item self-report of tendency to delay help-seeking (Part A, Item 20; See Appendix B) where participants were asked to indicate on a scale of 1 (strongly disagree) to 7 (strongly agree), how much they agree with the
statement ‘I tend to avoid asking for help until problems become serious’. Scores ranged from 1 to 7 with $M = 4.59$, $SD = 1.18$ and $n = 91$.

### 3.1.3 Strength of preference for non-face-to-face help.

Relative preference for non-face-to-face help sources in seeking help for depression was measured by forming a ratio of each participant’s highest rating of non-face-to-face help to their highest rating of help across all help sources. The advantage of utilising this method for scoring relative preference of help sources is that it reveals whether a non-face-to-face help is an individual’s preferred help source as well as providing information regarding the proximity of the preference for non-face-to-face help to the overall favoured help source. Furthermore, measuring relative preference in this manner eliminates the potential for between subject variability in likelihood of help seeking to confound the analysis as the participants’ rating is calculated by comparing two of their own scores on the GHSQ. Analysis revealed that relative preference scores could be calculated for 79 participants with a mean score was 0.49 ($SD = .30$).

For exploratory purposes the same method was used to calculate participants scores for the variables relative preference for professional help sources and relative preference for informal help sources.

### 3.2 Calculation of Independent Variable: Perfectionist Type

Identification of a participant’s perfectionist type was conducted on the basis of their responses on the APS-R high standards and discrepancy scale presented in Part A, Items 1-19 (See Appendix B). Firstly, participants were categorised as
perfectionists or non-perfectionists with perfectionists scoring highly (> or equal to 42) on the high standards sub scale (items 1, 3, 5, 8, 10, 14, 18). Those who scored below 42 on the high standards sub scale, regardless of their scores on the other scale, were identified as non-perfectionists. From within the group of perfectionists, scores on the discrepancy scale (items 2, 4, 6, 7, 9, 11, 12, 13, 15, 16, 17 & 19) were used to distinguish between maladaptive and adaptive perfectionists with maladaptive perfectionists scoring highly (> or equal to 42) and adaptive perfectionists scoring below 42.

On the basis of this information a new grouping variable was formed containing 54 non-perfectionists, 12 adaptive perfectionists and 21 maladaptive perfectionists. Perfectionist type could not be ascertained for 4 of the participants as they were missing data.

3.3 Data Screening

Data collected was entered into a custom made data file for statistical analysis using SPSS v19 (See Appendix F).

Prior to analysis cases were screened for outliers and missing or ambiguous data, 15 cases were found. Of these, 13 had failed to complete one or more items on the surveys and 2 had responded in an ambiguous manner to one or more questions. Four cases, despite missing data in the APS-R, provided enough information to conclusively determine their perfectionist type, thus not preventing their inclusion in the statistical analysis. The remaining 9 cases that had unanswered items were used wherever possible and excluded when analysis was dependant upon incomplete items. The two cases involving unconventional
responses or ambiguous data were considered on a case by case basis. In one of these cases, the participant had responded to three items on the GHSQ by circling two consecutive points on the scale. In a similar vein, the second case had circled a mid point between two digits on the scale in the GHSQ and in items of the the APS-R. In the interests of not disturbing frequency distributions for these items on the GHSQ, it was decided to omit the scores rather than introducing new midpoint scores into these scales. However, where mid points were provided in participants APS-R responses, mid points were taken as the average of the two surrounding scores and these half point scores were retained as these scores were used to classify a participants perfectionist type and had no potential to disturb frequency distributions.

The highest and lowest scores in each variable were viewed in order to screen for errors in the data set and frequency distributions were created to scan for the presence of invalid scores. Questionnaires were assigned a number from 1 to 91 that was recorded as the participant number in the data file. Identification of which questionnaire was associated with each case in the data file is important as it allows accuracy of data in the file to be checked if the need arises.

Following decisions regarding missing data, the data analysis process commenced. The possibility that demographic variables of age and gender were impacting the results was statistically explored. Data was screened graphically by producing three bar graphs with error bars depicting one standard deviation either side of the mean for each dependant variable (Refer to Appendix G). The simplest graph depicted the mean scores of each perfectionist type on the given variable.
Another graph showed the mean variable score of each gender in each perfectionist type. While the final graph displayed the mean variable score of each age group in each perfectionist type. Examination of these graphs indicated that scores across gender and across age groups were similar and thus unlikely to be significantly associated with differences in the dependant variables.

3.4 Descriptive Analyses

Initial analysis involved examining examination of the mean scores of each dependant variable across the three perfectionist types. Table 1 contains the mean values, standard deviations and sample size in each perfectionist type for the three dependant variables. Also found in Table 1 are the numbers of participants that comprised each of the perfectionist types overall. Of the participants able to be classified according to perfectionist type, 62.07% were non-perfectionists, 24.14% were maladaptive perfectionists and the smallest group was the adaptive perfectionists that comprised of the remaining 13.79%.

Table 1
Means, Standard Deviations and Sample Size for Likelihood of Seeking Help, Preference for Non-Face-to-Face Help and Tendency to Delay Help-Seking for Perfectionist Types

<table>
<thead>
<tr>
<th></th>
<th>Non perfectionist</th>
<th>Adaptive perfectionist</th>
<th>Maladaptive perfectionist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>54</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td><strong>Likelihood of seeking help</strong></td>
<td>51</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>1.23</td>
<td>0.65</td>
<td>1.07</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>5.90</td>
<td>6.67</td>
<td>6.05</td>
</tr>
<tr>
<td><strong>Preference for non face to face help</strong></td>
<td>46</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>0.32</td>
<td>0.30</td>
<td>0.26</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>0.46</td>
<td>0.56</td>
<td>0.53</td>
</tr>
<tr>
<td><strong>Tendency to delay help seeking</strong></td>
<td>54</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>1.53</td>
<td>2.23</td>
<td>1.56</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>4.48</td>
<td>3.67</td>
<td>5.57</td>
</tr>
</tbody>
</table>

Table 1 shows that the mean score for likelihood of seeking help for depression was highest for the adaptive perfectionists, followed by the maladaptive perfectionists and lowest for the non-perfectionists. Similarly, mean strength of preference for non-face-to-face help was highest for the adaptive perfectionists, closely followed by the maladaptive perfectionists and least for the non-perfectionists. Finally, for tendency to delay help seeking, on average
maladaptive perfectionists scored the highest followed by non-perfectionists and then adaptive perfectionists.

3.5 Inferential Analyses

Although the mean scores outlined in Table 1 were an accurate reflection of the given data set, in order to establish whether these trends could be validly generalised to the wider population, inferential statistical methods were employed. Throughout the analysis \( p = .05 \) was taken to be the threshold at which significance was endorsed.

3.5.1 Perfectionist type and likelihood of seeking help.

The first analysis investigated the hypothesis that maladaptive perfectionists \((n = 21)\) were less likely to seek help for depression than adaptive perfectionists \((n = 12)\) or non-perfectionists \((n = 51)\). The measure used to indicate likelihood of help-seeking was the dependent variable created from responses to the GHSQ (highest help seeking) indicating a participant’s highest rating response over all of the six different help source items in the GHSQ.

First, homogeneity of variance and normality of the distribution of the highest help seeking scores in each of the perfectionist type groups was investigated. Homogeneity of variance across the three perfectionist types was established via Levene’s test \( F(2, 81) = 1.55, p > .05 \). The Shapiro-Wilk test was used to explore the distribution of highest help seeking scores for each of the three perfectionist types. Shapiro-Wilk statistics are displayed in Table 2 below.

Table 2
Shapiro-Wilk Statistics (W) for Distribution of High Help Seeking Scores of Participants for each Perfectionist Type

<table>
<thead>
<tr>
<th>Group</th>
<th>Shapiro-Wilk</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Perfectionist</td>
<td>0.80</td>
<td>51</td>
</tr>
<tr>
<td>Adaptive Perfectionist</td>
<td>0.59</td>
<td>12</td>
</tr>
<tr>
<td>Maladaptive Perfectionist</td>
<td>0.81</td>
<td>21</td>
</tr>
</tbody>
</table>

Note* p > .05

The Shapiro-Wilk statistic indicated that for all groups of perfectionist type participants highest help seeking rating distributions significantly deviated from normality at α = .05. Further analysis of normality was conducted by calculating z-scores for skewness and kurtosis for each perfectionist type. Absolute value of Z-scores for skewness ranging from 2.20 for maladaptive perfectionists to 4.65 for non perfectionists, all indicate significant skewness at α = .05 across all three perfectionist types. Furthermore, although the Z-score for Kurtosis was acceptable for the distribution of scores within the maladaptive perfectionist group (1.54) those for the non perfectionist (5.17) and the adaptive perfectionist (2.57) groups exceeded the threshold of α = .05. Thus, it was concluded that the assumption of normality could not be established and non parametric tests were utilised.

The null hypothesis tested by the Kruskal-Wallis analysis was that the three perfectionist type groups have the same scores on the variable of highest help seeking. The obtained Kruskal-Wallis statistic is interpreted as a chi-square value and is shown to be non significant, $\chi^2 (df = 2) = 5.08, p > .05$. Thus, the null hypothesis was upheld indicating that there is no difference in highest help seeking scores between the three perfectionist types.
3.5.2 Perfectionist type and tendency to delay help seeking.

In order to support the hypothesis that maladaptive perfectionists tend to delay seeking help until symptoms intensify more than adaptive perfectionists and non perfectionists participants rating on Part A Item 20 ‘I tend to avoid asking for help until problems become serious’ (Refer to Appendix B) were statistically analysed for differences based on perfectionist type. Initial investigation showed, as predicted, the mean score on tendency to delay help seeking was highest in the maladaptive perfectionist group ($M = 5.57$, $SD = 1.60$) with both non-perfectionist ($M = 4.48$, $SD = 1.53$) and adaptive perfectionist ($M = 3.67$, $SD = 2.23$) groups having a lower mean rating.

Again, data was screened to assess whether the assumptions of normal distribution and homogeneity of variance between the groups being compared were met. Shapiro-Wilk’s test for normality of distribution was employed. Results of this test can be found in Table 3 below. The Shapiro-Wilk test revealed that the adaptive perfectionist groups had data that was normally distributed but that for both of the other groups distribution deviated from normality.

Table 3

Shapiro-Wilk Statistics ($W$) for Distribution of Tendency to Delay Help-Seeking

<table>
<thead>
<tr>
<th>Group</th>
<th>Shapiro-Wilk</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Perfectionist</td>
<td>0.90*</td>
<td>50</td>
</tr>
<tr>
<td>Adaptive Perfectionist</td>
<td>0.88</td>
<td>12</td>
</tr>
<tr>
<td>Maladaptive Perfectionist</td>
<td>0.84*</td>
<td>20</td>
</tr>
</tbody>
</table>

Note* $p > .05$
Investigation of the skewness and kurtosis scores revealed that Z-scores for skewness ranging from .28 for maladaptive perfectionists to 1.86 for non perfectionists all fell below the 1.96 threshold as required to maintain $\alpha$ at .05. The Z-scores for kurtosis (non perfectionists Z-score = .56, adaptive perfectionists Z-score = .23, maladaptive perfectionist Z-score = 1.99) were generally acceptable at $\alpha = .05$. The only group whose Z-score for kurtosis exceeded the 1.96 threshold was the maladaptive perfectionist group whose deviation was very slight (.03 above the threshold of 1.96). Thus, examination of Z-scores for skew and kurtosis revealed that the distribution of scores for the item relating to tendency to delay help seeking in each of the perfectionist type groups approximated normality.

Levene’s statistic, $F (2, 79) = 3.27, p < .05$, was used to compare the variance of scores for the item concerning tendency to delay help-seeking between groups based on perfectionist type. This test revealed a significant difference in variation between the groups at $\alpha = .05$ indicating that the assumption of homogeneity of variance had been violated. This result indicated that significance group differences would be more reliably ascertained via a robust test of equality of means than an $F$ that assumes homogeneity of variance between groups. Thus, Welch’s statistic was utilised to test significance of group differences.

A oneway ANOVA was used to explore whether significant difference in group means according to perfectionist type for the self report delay in help seeking item was conducted. Welch’s static, using an adjusted error degrees of freedom, $F (2, 24.49) = 4.83, p < .05$, indicates that differences in tendency to
delay help seeking are significant between perfectionist type groups and warrant further investigation.

Planned contrasts revealed that maladaptive perfectionists were significantly more likely to report a tendency to delay help seeking than all other participants, \( t(32.44) = -3.08, p < .05 \) (1-tailed), \( r = .48 \). Furthermore, the tendency to delay help seeking was significantly stronger for maladaptive perfectionists than either non perfectionists, \( t(35.02) = -2.68, p < .05 \) (1-tailed), \( r = .41 \) or adaptive perfectionists \( t(17.58) = -2.60, p < .05 \) (1-tailed), \( r = .58 \).

### 3.5.3 Perfectionist type and strength of preference for non-face-to-face help sources.

In order to ensure that participants scores on strength of preference for non-face-to-face help sources reflected their preference for these sources rather than their inability to access them, participants who indicated that they did not have adequate internet search skills were excluded from this analysis. An exploration of mean scores of the strength of preference for non-face-to-face help revealed that maladaptive perfectionists with a mean of .53 (SD = .26) were positioned above the non perfectionist's who had a mean of .46 (SD = .32) and below the adaptive perfectionists whose mean was .56 (SD = .30). A one-way ANOVA was used to ascertain the significance of these differences.

Checking that assumptions underpinning ANOVA were met included screening for normal distribution of scores within each group and homogeneity of variance across groups was conducted. Table 4 below outlines the results of the
Shapiro-Wilk test which indicated that only one of the three groups display a normal distribution of scores namely maladaptive perfectionists.

Table 4

*Shapiro-Wilk Statistics (W) for Strength of Preference for Non-Face-to-Face Help for each Perfectionist Type*

<table>
<thead>
<tr>
<th>Group</th>
<th>Shapiro-Wilk</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Perfectionist</td>
<td>0.88</td>
<td>46</td>
</tr>
<tr>
<td>Adaptive Perfectionist</td>
<td>0.83</td>
<td>12</td>
</tr>
<tr>
<td>Maladaptive Perfectionist</td>
<td>0.93*</td>
<td>18</td>
</tr>
</tbody>
</table>

Note* p > .05

Since the Shapiro-Wilk test indicated that some groups had non-normally distributed scores a further analysis of skewness and kurtosis was conducted. Examination of Z-scores for skewness and kurtosis for the distribution of scores in each of the perfectionist types found that all values but one fell below the acceptance limit of 1.96. The sole exception exceeding the threshold was the Z-score for kurtosis of the non perfectionist distribution whose absolute value was 2.12. However, as sample sizes increase standard errors decrease resulting in Z-scores exceeding the 1.96 threshold even though they represent a distribution with only a minimal deviation from normality (Field, 2009). Justification for the conclusion that the non perfectionist distribution, along with that of other perfectionist types, approximates normality was provided by considering that the excessive z-score value indicates a quite slight (0.16) excess above the 1.96 threshold and that the non perfectionist group from which it was derived was not small, \( n = 46 \).
Levene’s statistic established at p = .05 that homogeneity of variance across non perfectionists, adaptive perfectionists and maladaptive perfectionists, $F(2, 73) = 1.57$, $p > .05$.

Having justified the use of oneway ANOVA to detect significance of group differences in strength of preference for non-face-to-face help sources this analysis was conducted. The oneway ANOVA, $F(2) = .74$, $p > .05$, revealed that the differences in the mean scores for strength of preference for non-face-to-face help seeking for depression found between the different perfectionist groups was not statistically significant at $\alpha = .05$.

### 3.6 Incidental Findings

Although not hypothesised, differences between mean scores for strength of preference for informal help between the perfectionist type groups warranted further investigation. Table 5 shows the sample size, mean scores and standard deviation of strength of preference for informal help scores for each of the perfectionist types. Maladaptive perfectionists had the lowest mean score on this variable, followed by

Table 5

| Means, Standard Deviations and Sample Size for Strength of Preference for Informal Help |
|---------------------------------|---------------------------------|---------------------------------|
| Non perfectionist               | Adaptive perfectionist          | Maladaptive perfectionist       |
| $n$                              | 51                              | 12                              | 20                              |
Preliminary data screening revealed that relative preference for informal help sources scores in each of the perfectionist type groups violate the principles of homogeneity of variance ($F(2, 80) = 5.19, p < .05$) and normality ($Z$-scores for skewness range from 0.80 to 4.77 and $Z$-scores for kurtosis range from 1.22 to 2.97). Thus, non parametric tests were used to explore the significance of these differences.

The null hypothesis tested by the Kruskal-Wallis analysis was that the three perfectionist type groups have the same scores on the variable of strength of preference for informal help. The obtained Kruskal-Wallis statistic is interpreted as a chi-square value and is shown to be significant, $\chi^2 (df = 2) = 7.88, p < .05$. Thus, the null hypothesis was rejected, indicating significant differences in strength of preference for informal help scores between the three perfectionist types.

Mann-Whitney tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a .025 level of significance. It appeared that strength of preference for informal help sources was significantly lower for maladaptive perfectionists ($U = 340.5, r = -.29$) and adaptive perfectionists ($U = 66, r = -.40$).
Chapter 4

Discussion

4.1 Discussion of Support for Hypothesis and Incidental Findings

Three hypothesis proposing differences in help-seeking behaviour between maladaptive perfectionists, adaptive perfectionists and non perfectionists were examined via statistical analysis using SPSS v19. The hypothesis that maladaptive perfectionists will be more likely to delay help seeking more than adaptive perfectionists and non perfectionists was supported. However, the data set did not support the hypothesis that maladaptive perfectionists would be less likely to seek help for depression than adaptive perfectionists and non perfectionists. Similarly, support was not found for the hypothesis that maladaptive perfectionists would have a stronger preference of non-face-to-face help sources for depression than other perfectionist types. Data analysis also disclosed an unhypothesised difference between perfectionist types. It was discovered that maladaptive
perfectionists reported a lower relative preference for informal sources of help such as family and friends than adaptive perfectionists and non perfectionists.

4.1.1 Likelihood of seeking help for depression and perfectionist type.

No significant differences concerning the likelihood of seeking help for depression were found between the perfectionist groups. The questionnaire, in presenting participants with a scenario in which they were asked to imagine that they are suffering from depression, provided the participant with a label for the condition. This type of questioning bypasses the problem recognition and acknowledgement phase of help-seeking. However, in reality, people need to recognise that the symptoms they are experiencing are abnormal and require intervention from an external helper. Ability to recognise depressive symptoms as abnormal was found to be a significant barrier to help-seeking for women with post natal depression (Bllszta, Ericksen, Bulst & Milgrom, 2010). Thus, the absence of significant differences between the perfectionist groups at this point in the help seeking process may signify that once a problem is acknowledged and named help-seeking is equally as likely for the maladaptive perfectionist as for other perfectionist types. Therefore, this finding does not necessarily mean that maladaptive perfectionists do not face unique challenges in help-seeking for depression. Rather, it suggests that if difference exist they may occur at a different point in the help-seeking process.

4.1.2 Preference for non-face-to-face help for depression and perfectionist type.
Analysis of participants scores failed to reveal significant differences in strength of preference for non-face-to-face help-seeking. This was surprising as maladaptive perfectionists are discriminated from adaptive perfectionists on the basis of the difficulty they experience when confronted with self-perceived shortfalls (Slaney et al., 2001). Thus, it would seem logical to conclude that they would prefer non-face-to-face help sources as they do not require disclosure of need to occur in the physical presence of the helper. Several reasons may contribute to the lack of significant differences regarding preference for non-face-to-face help sources.

Considering that the present investigation confirmed the hypothesis that maladaptive perfectionists tend to delay help-seeking, it may be that, by the time they enact help-seeking behaviour for depression, maladaptive perfectionists symptoms are quite severe prompting the help-seeker to go straight to the help source they believe will be most effective in providing rapid relief from symptoms. In this scenario, judgements regarding efficacy of treatment override personal preference in determining the source from which help is sought. Thompson, Hunt and Issakidis (2004) in a sample of Australians who had delayed help seeking for depression identified severity of symptoms to be the most frequently quoted reason prompting help-seeking from health professionals.

4.1.3 Preference for informal help for depression and perfectionist type.

It was discovered that maladaptive perfectionists reported a lower relative preference for informal sources of help such as family and friends than adaptive perfectionists and non perfectionists, suggesting that revelation of neediness to
family and friends may present particular difficulties for the maladaptive perfectionist.

A reduced willingness to enlist the help of informal help source such as family and friends for depression is likely to hold implications for the experience of depression for the maladaptive perfectionist. Obviously, in the absence of disclosure to friends and family those close to the maladaptive perfectionist will be stilted in their ability to provide understanding, encouragement and support during depressive episodes. This is important as support of family and friends has been credited with aiding recovery from depression (Nasser & Overholser, 2005). While a lack of support from family and friends has been associated with increased depressive symptoms and greater susceptibility to chronic depression (Nasser & Overholser). In the light of these findings, the maladaptive perfectionists reduced willingness to enlist the help of family and friends appears to be a self-handicapping feature in the management of their depression.

### 4.1.4 Delay in help-seeking and perfectionist type.

It was found that maladaptive perfectionists were more likely to delay help-seeking than either adaptive perfectionists or non-perfectionists. Thus, the hypothesis that maladaptive perfectionists are more likely than adaptive perfectionists and non-perfectionists to delay help-seeking was supported by the research.

Timing is an important facet of help-seeking behaviour. Timing of intervention can impact upon severity of symptoms experienced, responsiveness to treatment, financial cost and prognosis (Thompson, Issakidis & Hunt, 2008). In the
absence of help-seeking it is likely that problems persist. Thus, help-seeking, ideally leading to problem resolution or management, plays an important role in promoting well-being. In this light, delayed help seeking is detrimental to well-being (Cornally & McCarthy, 2011).

Having identified maladaptive perfectionists tendency to delay help-seeking, and in light of the knowledge that delayed help seeking is associated with a range of negative outcomes, it is important to consider what can be done to assist this population in connecting with assistance in a timely manner. However, before this problem can be tackled, more must be known about its nature. Possible features that may underpin the maladaptive perfectionists tendency to delay help-seeking are many and varied including problem denial, inability to recognise a condition based on symptoms (Thompson et al., 2004), fear of revealing personal need to a helper, fear of stigma based rejection (Wrigley, Jackson, Judd & Komiti, 2005), belief that problems are best dealt with autonomously (Gulliver et al., 2010) endorsing stoic ideals of persistence in the face of adversity. Each of these possible barriers would give rise to different intervention strategies. Thus, action plans aimed at hastening the connection of maladaptive perfectionists with help must be formed on the basis of a thorough understanding of the underlying barriers to ensure it is appropriately targeted and to maximise effectiveness.

It might be that maladaptive perfectionists tendency to delay help seeking stems from an inability or use of more stringent criteria to recognise or acknowledge a problem. Gulliver et al. (2010) found that an inability to recognise depression from its symptoms was a major barrier to help-seeking for depression.
Thus, if this barrier were in operation, it would not be until symptoms were blatantly obvious and intrusive that recognition of need, an essential precursor to help-seeking, occurs. Thus, poor problem recognition may result in delayed help-seeking for depression. Cronally and McCarthy (2011) outline the role of a problems existence, significance, repercussions, intensity and duration in promoting problem recognition and acknowledgement.

Another possible explanation for the finding that maladaptive perfectionists tend to delay help seeking behaviour may be gleaned from other findings revealed by the current data. Current literature reports that most people who seek help for mental health issues initially confide in a friend or family member who then encourages and assists the individual in need to seek professional help (Coe, 2009). However, as discussed previously the study found that maladaptive perfectionists have a reduced preference for turning to informal help sources such as family and friends for depression. Taken together, it is possible that the maladaptive perfectionists tendency to delay help seeking might be be accounted for by their decreased preference to utilise informal help sources who, if involved, would play a vital role in promoting, and thereby expediating, the process of enlisting assistance from formal sources.

4.2 Implications and Applications of Findings

Having found that maladaptive perfectionists tend to delay help seeking and avoid turning to friends and family in the face of depression it is important to consider what can be done to alleviate their difficulties, expedite their connection
with appropriate help-sources and to facilitate their development of a support network.

If delayed help seeking arises as a result of prolonged problem recognition strategies to promote awareness of the symptoms of depression need to be explored. These strategies can include campaigns to raise community understanding of the etiology, signs and symptoms of depression so that individuals are better equipped to recognise the early signs of a depressive episode in themselves, their family and social networks. The need for mental health education within the community to promote recognition of mental illness was raised by Dennis and Chung-Lee (2006) after a qualitative review revealed the widespread difficulty reported in problem recognition of postpartum depression. Enhancing the communities understanding of the etiology of depression may enable individuals to make special efforts to protect their mental health and allow family and friends to be especially alert for signs indicative of depression at times of increased vulnerability.

Furthermore, when those who have been reluctant to seek help for depression finally do reach out for assistance, it is important to ensure that this experience is positive and worthwhile. Thus, health professionals need to be sensitive to the fact that people who arrive seeking help for depression may be feeling quite reluctant yet their symptoms have reached a level that leaves them feeling desperate for relief. To promote the clients comfort it is vital that professionals adopt a non judgmental, respectful, empathetic, professional and hopeful approach. The importance of a positive therapeutic relationship is
evidenced in the face that almost all theoretical perspectives of psychotherapy recognise the development of a positive therapeutic relationship as vital component of effective practice (Sommers-Flanagan & Sommers-Flanagan, 2009). Professionals need to be aware that self-disclosure may be very difficult for the maladaptive perfectionist and that it may take time before these clients are willing to share the full extent of their difficulties with them. Trust must be built and the maladaptive perfectionists steps toward disclosure must be supported and encouraged.

It is important for health professionals to be aware that maladaptive perfectionists are less inclined to seek help for depression from friends and family. Equipped with this knowledge, they can be alert to the fact that even if members of this population report having adequate social networks it can not be assumed that these networks are functioning as a support for depression as the maladaptive perfectionist may not have disclosed their difficulties to them. Given the fact that research has revealed the prominent role played by supportive social networks in aiding recovery from depression (Skarsater, Langius, Agren, Haggstrom & Dencker, 2005), it is vital that practitioners are aware of the difficulties that may be encountered by maladaptive perfectionists, hyper vigilant in assessing whether clients are experiencing these difficulties and armed with strategies to assist this population to form and utilise informal support networks in the face of depressive episodes.
4.3 Limitations

As is always the case when presenting participants with a scenario and asking them to indicate how they would act, there may be a discrepancy between how they indicate they would behave and how, in reality, they actually would respond. Thus, the ability of this investigation to reveal differences in help-seeking behaviour is dependant upon the participants competence in accurately predicting personal behaviour.

A further limitation of this investigation was its failure to consider participants previous experiences. Given the prevalence of depression within the Australian society, it is likely that many of the participants have had previous personal experience of seeking help for depression. As is well known, our previous experiences are a context for learning and our subsequent dealing with familiar challenges will be shaped by our earlier encounters. Therefore, those who have experienced a similar scenario to that presented in the survey may be more likely to engage in negotiate the help-seeking process because they have learnt which avenues to pursue, they are not required to fearfully step into a totally unknown situation and they may have tasted the benefits that appropriate help can precipitate. Conversely, if their experience was negative, it would be plausible if they were reluctant to re-engage in the help-seeking process. Supporting this notion, Gulliver et al. (2010) found that positive help-seeking for depression in the past contributed to willingness to seek help in the future. As no data was collected relating to previous experiences with help-seeking for depression, within the bounds of this project it was not possible to take this issue into consideration when
analysing the data. Future help-seeking research could consider incorporating tools that reveal previous relevant experiences or could stipulate clearly in the scenario that it involves a first encounter with depression.

4.4 Summary and Future Directions

In conclusion, the project confirmed maladaptive perfectionists as a population who tend to experience difficulty in seeking help for depression. Aspects of help-seeking identified as particularly problematic for maladaptive perfectionists include timely initiation of help-seeking behaviour and enlisting the help of family and friends. Although the study identified delay in help-seeking and a relatively lower preference for informal help sources in comparison to other perfectionist types as characteristic of the maladaptive perfectionists response to depression, it did not provide information about the mechanisms that underlie these trends. More research is needed to extend upon the current findings and develop an understanding of processes at work in the maladaptive perfectionist that contribute to delayed help-seeking and reluctance to draw on the help of friends and family. Armed with this knowledge, intervention can be effectively targeted at reducing the difficulty experienced by maladaptive perfectionists in their help-seeking for depression.

References


Appendix A
Information Sheet
Information Sheet

The researcher is completing this project as a required component of the B. Arts (Hon) Psych program via Central Queensland University. The purpose of the research is to investigate whether people's perception of themselves and their performance is related to the ways they seek help. This information is useful in enabling helping services to increase accessibility for those who may benefit.

Participation Procedure

Participation in this project is completely voluntary and would involve completing a short questionnaire and returning them to the researcher in the envelope provided. It is estimated that it would take 15-20 minutes to complete the survey. The questionnaires concern perceptions of self and own performance, likely help seeking activities in a variety of scenarios and some basic demographic data.

Benefits and Risks

The benefit of this project to the community is that it takes another step towards ensuring that people are able to benefit from available services. Participants will know that they have played a vital and necessary part in contributing to this project. The researcher does not envisage any potential risks for participants. However, if participation was to cause distress in any way 24 hour assistance may be sought from Lifeline, a 24-hour free telephone support line. Ph: 13 11 14 or the Beyond Blue Information Line 1300 22 4636 providing information and referrals to services for depression and anxiety.

Confidentiality / Anonymity

Confidentiality and anonymity will be maintained by ensuring that names are not written on data sheets. Identity of participants will not be discernible in the final report. During the project forms will be securely stored within a locked file. Following submission of the report data will be securely stored for at least five (5) years in accordance with the CQU policy.

Outcome / Publication of Results

Results of the project will be presented in a thesis report and as a brief summary provided to interested participants. It is possible that the findings of this project may be shared via dissemination of the research at conferences or in journal publications.
Consent
Having been provided with information concerning the project participants will be recruited via voluntary, informed consent. Consent will be indicated by returning the completed questionnaire.

Right to Withdraw
Participants have the right to withdraw at any time without penalty, there is no obligation to complete and return the forms. However, once the researcher is in possession of the completed forms it will not be possible to identify an individual participants data. In this case the data would have to stay in the project.

Feedback
Participants who would like to be informed of the projects results are asked to fill out the Feedback Request form and return it in the envelope supplied.

Questions/ Further Information
e-mail: naomiburke@cqumail.com  phone: 0449 256 642

Concerns / Complaints
Please contact Central Queensland University's Office of Research (Tel: 07 4923 2607; E-mail: research-enquiries@cqu.edu.au; Mailing address: Building 32, Central Queensland University, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

Take Note: The information sheet was printed on the university letterhead

Appendix B

Questionnaire- Part A
The following items are designed to measure attitudes people have toward themselves, their performance, and toward others. There are no right or wrong answers. Please respond to all of the items. Use your first impression and do not spend too much time on individual items in responding. Respond to each of the items using the scale below to describe your degree of agreement with each item. Circle the appropriate number.

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
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1. I have high standards for my performance at work or at school.

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1. I often feel frustrated because I can’t meet my goals.

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3. If you don’t expect much out of yourself, you will never succeed.

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<th>Strongly Disagree</th>
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4. My best just never seems to be good enough for me.

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<th>Strongly Disagree</th>
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5. I have high expectations for myself.

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6. I rarely live up to my high standards.

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<th>Strongly Disagree</th>
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7. Doing my best never seems to be enough.

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<th>Strongly Disagree</th>
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8. I set very high standards for myself.

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<th>Strongly Disagree</th>
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9. I am never satisfied with my accomplishments.

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<th>Strongly Disagree</th>
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10. I expect the best from myself.

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<th>Strongly Disagree</th>
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11. I often worry about not measuring up to my own expectations.

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<th>Strongly Disagree</th>
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12. My performance rarely measures up to my standards.

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13. I am not satisfied even when I know I have done my best.

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<th>Strongly Disagree</th>
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15. I am seldom able to meet my own high standards of performance.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |


| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

17. I hardly ever feel that what I’ve done is good enough.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

18. I have a strong need to strive for excellence.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Strongly Disagree  Disagree  Slightly Disagree  Neutral  Slightly Agree  Agree  Strongly Agree

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

19. I often feel disappointment after completing a task because I know I could have done better.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

20. I tend to avoid asking for help until problems become serious.
Appendix C
Questionnaire- Part B
Questionnaire- Part B

If you believed that you were experiencing **depression** that was having a **impact on your daily functioning** please use the scale provided to rate **how likely it is** that you would seek help from each of the places listed below.

<table>
<thead>
<tr>
<th>Extremely Unlikely</th>
<th>Neutral</th>
<th>Extremely Likely</th>
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**Doctor**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Psychologist/Counselor**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
Using the same scale, please rate how likely it is that you would not seek help for the situation described.

Appendix D

Part C

For the following questions please indicate the response that best applies to you by circling the correct answer.

1. What is your gender?
   1. Male              2. Female

2. Which age group do you belong to?
3. Do you have the skill to complete a basic search on the internet and look up web addresses?

   1. Yes                       2. No

Thank you for taking the time to complete this questionnaire.

Completed questionnaire can be returned in the envelope marked “Help-Seeking Project”

If you have experienced any discomfort as a result of participating in this project please remember that the Lifeline Support Service is available 24 hours a day. Lifeline can be contacted on Ph: 13 11 14

Appendix E

Feedback Request Form

If you would like a summary of the finding of this project please fill on this form and return it in the envelope marked ‘feedback request’.

I wish to have a Plain English statement of results posted to me at the address I provide below.
Postal Address: ______________________________________________________

E-mail Address: _____________________________________________________

Appendix F

Raw Data
Appendix G

Raw Statistical Output Data