The Role of Perfectionism as a Transdiagnostic Factor in the Prediction of Emotional Disorders Symptoms Severity

Reza Abdi [1*], Gholamreza Chalabianloo [1], Afsaneh Joorbonyan [1]

1. Department of Psychology, Faculty of Education and Psychology, Azarbaijan Shahid Madani University, Tabriz, Iran.

ABSTRACT

Objective: Although emotions help us respond compatibly to the problems and opportunities we encounter in life, their deviation can lay the foundation for emotional disorders. Perfectionism is a person's wish to meet ones as well as others' expectations, albeit with better quality than what the situation allows. According to research literature it seems that dimensions of perfectionism can predict the severity of emotional disorders. The purpose of this study was to examine the relationship between perfectionism and symptoms of emotional disorders.

Methods: This study was a descriptive, cross sectional, and correlation research. To achieve the research objectives, two questionnaires of inventory of depression and anxiety symptoms (IDAS), and perfectionism inventory were administered to a sample of 385 students studying at Azarbaijan Shahid Madani University.

Results: The results demonstrated that there is a strong correlation between perfectionism and severity of the emotional disorder symptoms. Furthermore, the independent variables such as the component of perfectionism can optimally predict the emotional disorders severity (sig=0.001).

Conclusion: Considering the role of perfectionism in the prediction, etiology, and treatment of emotional disorders, in order to enhance the mental health of the society, it is essential to take a practical approach towards such studies.

1. Introduction

Emotions are mental feelings, which are perceived as specific states such as anger, grief, or happiness (Power & Dalgleish, 2008). Although emotions help us respond compatibly to the problems and opportunities we encounter in life, their deviation can lay the foundation for emotional disorders. Noncompatible emotional responses have been found effective in more than half of the axis I disorders and almost all axis II personality disorders (Gross, 2008). New approaches introduce the disorders resulting from malfunction and dysregulation of emotions as emotional disorders. These disorders are common in Transdiagnostic

Factor (Harvey, Watkins, Mansell, & Shafran, 2004). Other common disorder are simultaneity, as well as impact on social, career, and educational functions (Ehring et al., 2011). Considering the result of cognitive epidemiological studies based on the growing outbreak and appearance of emotional disorders and their negative impacts on individuals and the society, identification of the factors causing this category of disorders can be instrumental in diagnosis as well as in performing preventive and treatment interventions.

Emotional disorders are a spectrum of psychiatric disorders in which emotional dysregulation and some other common transdiagnostic factors play an important role. These factors include mood disorders, stress, somatoform

* Corresponding Author:
Reza Abdi, PhD
Address: *Department of Psychology, Faculty of Education and Psychology, Azarbaijan Shahid Madani University, Tabriz, Iran.*
Tel: *+98 (914) 4007477*
E-mail: *rezaabdi55@gmail.com*

disorders, dissociative disorders, and borderline personality disorders (Payne, Ellard, Farchione, Fairholme, & Barlow, 2014). In general, most researchers believe that emotional disorders include unipolar depressive and anxiety disorders (Barlow, 2004). One solid piece of evidence to use the term 'emotional disorder' is the considerable overlap between anxiety and mood disorders (Kessler et al., 2005). Because of their effect on the personal and social functions, as well as their association with a broad range of simultaneous disorders, these disorders have attracted a lot of attention in the recent years. In addition, these disorders impose heavy material, somatic, and spiritual costs on the society. Hence, to reduce these costs and the time spent on the treatment process, and by taking account of common aspects of these disorders, the prevention, intervention, and treatment process are followed. For this purpose, researchers are trying to find the common aspects of these disorders and introduce some factors known as transdiagnostic factors as common features among these disorders. One of these transdiagnostic factors is perfectionism. Various studies have demonstrated the effect of perfectionism in the creation and prolongation of emotional disorders (Egan, Wade, & Shaffan, 2011).

The logic behind the emergence of transdiagnostic approaches was to investigate the common dimensions of different disorders, observance of the parsimony principles and, as a result, simplification of the process and reduction of treatment costs (Barlow, Allen, & Choate, 2004). Despite the fact that research in this field and the clinical use of the transdiagnostic approach started a short time ago, considerable attention has been drawn to this method (Barlow, Allen, & Choate, 2004) and the effectiveness of its interventions in the emotional disorders has been demonstrated (Norton, 2012). In general, according to the research conducted to identify the common or transdiagnostic factors and processes leading to emotional disorders, these factors include repetitive negative thinking (Ehring & Watkins, 2008), insomnia (Harvey, 2008), repetitive thoughts (Watkins, 2009), emotional regulation (Aldao & Nolen-Hoeksema, 2010), mindfulness (Bernstein, Galia, & Vujanovic, 2011), rumination (McLaughlin, & Nolen-Hoeksema, 2011), intolerance of uncertainty (McEvoy & Mahoney, 2012), and perfectionism (Egan, Wade, & Shaffan, 2011).

Perfectionism is a person's wish to meet one's as well as others' expectations (Frost, Marten, Lahart, & Rosenblate, 1990), albeit with better quality than what the situation allows (Flett, Davis, & Hewitt, 2003). Hamachek (1978) divided perfectionism based on its resulting actions into the two categories of normal and neurotic perfectionism. By differentiating between normal and neurotic perfectionism, he believed that a normal perfectionists attempt to compete for supremacy and perfection and at the same time recog-

nize their personal limitations, while neurotic perfectionists are never content with themselves because of their unrealistic expectations and thinks that they can never do anything appropriately enough to enjoy it. Neurotic perfectionists are impatient and self-critical. In contrast, a normal perfectionist tries one's hand at hard activities and is motivated by success and, by emphasizing high standards of performance, can understand external realities and accept the limitations. On the other hand, a neurotic perfectionist is stimulated by failure of defeat and, consequently, is always worried about achievement of unrealistic, higher objectives (Egan, Piek, Dyck, & Rees, 2007).

By highlighting perfectionism during recent years, researchers intend to have a deeper look at it. In this regard, Hill et al. (2004) presented a detailed picture of this psychological indicator based on 8 dimensions of "concern over mistakes", "high standards for others", "need for approval", "organization", "perceived parental pressure", "planfulness", "rumination", and "striving for excellence". These dimensions separated positive and negative perfectionism. Thus, identification and understanding the role of associated and causative factors of emotional disorder formation can help researchers codify and design preventive and interference plans.

Egan, Wade, and Shaffan (2011) reviewed perfectionism as a transdiagnostic process. Their claim regarding the transdiagnostic nature of perfectionism was based on the 4 proven characteristics of this factor. The first reason was that studies have shown that perfectionism is seen in various disorders such as anxiety disorders, depression, and eating disorders more than in healthy individuals. In addition, evidence shows that high perfectionism leads to the individual's increased vulnerability to eating disorders and the prolongation of obsessive compulsive disorder, social anxiety, and depression (Shafran & Mansell, 2001; Quoted Egan, Wade, & Shaffan, 2011). Afterwards, investigations revealed that high perfectionism is largely accompanied by many psychological disorders (Harvey et al., 2004; Quoted Egan, Wade, & Shaffan, 2011). The third reason was that making cognitive-behavioral conceptualization from clinical perfectionism paves the way to understand transdiagnostic processes. Also, evidence shows that treatment of perfectionism results in decreased anxiety, depression, and eating disorders (Glover, Brown, Fairburn, & Shafran, 2007; Quoted Egan, Wade, & Shaffan, 2011). Pourshahbaz, Nonahal, Dolatshahi and Omidian (2014) Showed that there are a significantly correlation between perfectionism and Emotion Regulation. Lotfi, Bakhtiyari, Asgharnezhad Farid, Amini (2013) In the study showedTransdiagnostic treatment was confirmed in decreasing negative affects and negative cognitive emotion regulation strategies and

improving positive affect and positive cognitive emotion regulation strategies in patients with depression and anxiety disorders, and was more effective than cognitive-behavior therapy for increased positive affects.

The investigations show that more than 300 studies have been performed to investigate the dimensions and disorders associated with perfectionism (O'Connor, 2007) but not enough attention has been paid to the role of this factor in predicting and preventing the disorders. So, we decided to assess the share of this diagnostic factor in predicting a range of emotional disorders by new approaches.

Considering the related literature, it is assumed that perfectionism is related to the severity of the symptoms of emotional disorders and hence this study investigates the question as to whether perfectionism plays a significant role in predicting the severity of emotional disorders.

2. Methods

The present study is descriptive and correlational To test the proposed hypothesis, out of 6170 students of Azarbaijan Shahid Madani University, 400 students were selected in 2015. The sampling method was single stage cluster random sampling from 7 faculties according to Morgan sampling and by predicting experimental mortality. The selected students were assured of their information privacy. Then, the questionnaires were distributed among the students with different orders and collected after being filled out. However, only 385 questionnaires were assessed after eliminating invalid questionnaires. Participants were students with the average age of 23 years from 3 levels of bachelor, master, and PhD of all fields. General criteria of entering the research included educating during academic year of 2014-15, being interested and volunteered in the research and criteria of leaving the research were having special psychological disorder and being under drug and non-drug treatment due to psychological problems.

IDAS is a factor-analytically derived, multidimensional inventory that uses a 5-point Likert-type scale (1=not at all to 5=extremely) to assess current symptoms. In the proposed study, we focus a priori on symptoms of psychopathology related to traumatic stress, including general depression, suicidality, panic, posttraumatic stress, and well-being subscales, experienced in the past 2 weeks. IDAS has demonstrated strong internal consistency, test-retest reliability, good convergent, and discriminant validity with respect to formal diagnostic and self-report symptom measures in different populations (Watson et al., 2007). Internal consistency of the IDAS subscale scores were good to excellent (Cronbach

α=0.79 to 0.93), consistent with the past work (Watson et al., 2007). The α coefficient of this scale was determined to be 0.95. It should be noted that this inventory was used for the first time in this study in Iran.

The perfectionism inventory (Hill et al., 2004) is a 59-item questionnaire to test the multidimensional aspects of perfectionism. Two types of perfectionism have 4 subscales each. Conscientious perfectionism is considered an adaptive form of perfectionism, and includes "high standards for others", "organization", "planfulness", and "striving for excellence". Self-evaluative perfectionism is considered maladaptive perfectionism, and includes "concern over mistakes", "need for approval", "perceived parental pressure", and "rumination". The scores are based on a 5-point type scale (1=strongly disagree; 5=strongly agree). Hill and colleagues have reported that the internal consistency of this inventory was high, ranging from 0.83 to 0.91 for all of the subscales. Factor analysis of the questionnaire showed 6 factors and so the number of items was reduced to 51 items (Jamshidy, Hosseinchari, Haghighat, & Razmi, 2009). The coefficient of this scale was determined to be 0.92.

After consideration of the presuppositions such as normality, multicollinearity, and independence of the errors, the obtained data were analyzed using descriptive and inferential statistics methods of the Pearson correlation and enter multiple regressions by SPSS version 20.

3. Results

In this study, to evaluate the hypothesis and research questions, descriptive and inferential statistics such as Pearson correlation and regression tests were used. The sample comprised 155 men and 230 women with a mean age of 23 years.

Results are presented in Table 1 as the central index and distribution of symptoms of emotional disorders. They demonstrate that men's mean score in the scales of anxiety and depression and, consequently, in emotional disorder symptoms are generally higher than the women's mean score in these two scales.

The Pearson correlation was used to investigate the research hypothesis regarding the existence of a correlation between the symptoms of emotional disorder and perfectionism. Results presented in Table 2 show that the symptoms of emotional disorders have a high positive, significant relationship to perfectionism. The highest amount of correlation exists between negative perfectionism and emotional disorder symptoms (r=0.45,

Table 1. The mean and standard deviation of variables.

Variables	Boys		Girls	
	Average	Standard deviation	Average	Standard deviation
Anxiety	34.92	13.06	32.38	12.21
Depression	102.58	26.57	97.68	11.67
Emotional disorders symptoms	137.50	37.99	129.91	32.78
Negative perfectionism	85.86	19.95	86.19	18.77
Positive perfectionism	82.86	15.68	81.60	12.89
Perfectionism	168.93	28.23	167.49	26.20

PRACTICE in CLINICAL PSYCH☺LOGY

P<0.001). Between anxiety and positive perfectionism, however, no significant relationship was found. In addition, positive perfectionism has a high negative correlation with depression and emotional disorder symptoms severity, whereas negative perfectionism has a positive, significant relationship to severity of 3 variables of anxiety, depression, and emotional disorders. Considering the values obtained from the correlation analysis, the relationship between perfectionism and severity of symptoms of emotional disorders is confirmed.

To determine the prediction symptoms of emotional disorders severity, we used regression analysis. The results are shown in Table 3. As presented in Table 3, dimensions of perfectionism with a multiple correlation coefficient of 0.57 can account for 32% of the variance of the severity of emotional disorder symptoms, among which "negative self-perception" (β=0.58), "discipline and organization" (β=-0.14), and "attempting to be perfect" (β=-0.14) are significant. However, "perceived parental pressure", "high standards for others", and "planfulness" do not have meaningful contribution in this model. By account of the value of beta which is equal to

Pearson's r, it appears that the "negative self-perception" plays a positive role, while "sense of purposefulness" and "attempting to be perfect" play negative role in this prediction. On the whole, this model can be a good predictor for emotional disorder severity.

4. Discussion

Considering the importance of severity of emotional disorders for the individual and society, and the considerable influence of transdiagnostic treatments for these disorders, the present study investigated the role of perfectionism as one of the transdiagnostic elements in prediction of emotional disorders such as anxiety and depression. According to the obtained results, perfectionism as a transdiagnostic factor has a significant share in predicting the severity of emotional disorder symptoms. In line of the literature results suggesting the relationship of perfectionism with the amount of emotional disorder symptoms; perfectionism has effective and significant share in predicting emotional disorder symptoms and considerable part of variance in negative

Table 2. Correlations among perfectionism dimensions and severity of emotional disorder symptoms.

Variables	Positive perfectionism	Negative perfectionism	Perfectionism	Anxiety	Depression	Emotional disorder symptoms
Positive perfectionism	-					
Negative perfectionism	0.29***	-				
Perfectionism	0.72***	0.86***	-			
Anxiety	-0.07	0.44***	0.27***	-		
Depression	-0.17***	0.42***	0.21***	0.78***	-	
Emotional disorder symptoms	-0.14***	0.45***	0.24***	0.90***	0.97***	-

*** P<0.001, ** P<0.01.

PRACTICE in CLINICAL PSYCH☺LOGY

Table 3. Hierarchical emter multiple regression predicting emotional disorders through the dimensions of perfectionism.

Predictor variables	Changing criterion	Tolerance	VIF	Durbin Watson	R	R²	Beta	t	Sig.	f	Sig.
Negative perfectionism	Negative self-Evaluative	0.55	1.79					0.58	10.30	0.000		
	Perceived parental pressure	Emotional disorder symptoms severity	0.67	1.47	1.86	0.57	0.32	-0.02	-0.46	0.57	30.28	0.001
	High standards for others	0.67	1.47					0.03	0.03	0.52		
Positive perfectionism	Organization	0.59	1.68					-0.14	-2.70	0.00		
	Planfulness	Emotional disorder symptoms severity	0.58	1.71	1.86	0.57	0.32	-0.07	-1.31	0.19	30.28	0.001
	Attempting to be perfect	0.57	1.74					-0.14	-2.55	0.01		

PRACTICE in
CLINICAL PSYCH⊕LOGY

emotional symptoms intensity can be associated with person's perfectionism.

Investigation of within group correlation of the aspects of perfectionism indicates the presence of a significant positive relationship between positive and negative perfectionism. These findings are consistent with the findings of Jamshidy et al. (2009). Therefore, a high score in one of the positive or negative aspects of perfectionism is accompanied by a high score in the other aspect of perfectionism in the individual. This, of course, does not necessarily indicate the individuals' involvement in emotional disorders, for it is the individual's ability to control perfectionist tendencies which can predict the possibility of his or her development of such disorders. As mentioned in the regression analysis results, attributes such as discipline, organization, and attempting to be perfect which are considered as positive aspects of perfectionism can negatively predict the emotional disorder symptoms severity, i.e. increased positive perfectionism in an individual is accompanied by decreased possibility to develop emotional disorders severity. In contrast, an individual's negative self-perception with a high level of significance can positively predict perfectionism.

The significant positive correlation between anxiety, depression, and perfectionism variable shows that higher perfectionist tendency in the individual leads to increased symptoms of anxiety, depression, and emotional disorders in general. The reason can be sought in inflexibilities, strictness, high expectations, and the failure of the perfectionist individual. Correlations obtained in this regard are in line with the findings of Sherry et al. (2015); Hewitt and Flett (1991); Shafran and Mansell (2001); Levinson et al. (2015); and Miloseva and Vu-

kosavljevic-Gvozden (2014). In contrast, the significant negative correlation found between the aspects of perfectionism and anxiety and depression demonstrate that increased positive perfectionism, including discipline, organization, purposefulness, and attempting to be perfect leads to decreased emotional disorders. These findings are in line with the opinions of Egan, Piek, Dyck, and Rees (2007) regarding the two-sidedness of perfectionism and the relationship between positive perfectionism and mental health as well as the relationship between negative perfectionism and psychological disorders.

It appears that purposefulness prevents depression by motivating the individual to make progress. Minamimoto et al. (2010) in their study maintained that low progress motivation was related to depression, and presumably the presence of discipline and organization in daily schedule could also result in joyfulness and decreased depression by creating purposefulness. In contrast, negative self-perception could lead to the emergence of emotional disorder symptoms severity by creating a sense of inferiority and fear of ostracism.

According to the definition offered by Hill et al. (2004), to set high standards for others means that the individual expects the others to have a perfect performance. These researchers regard this dimension of perfectionism as a positive one, whereas considering the results of this study regarding the presence of a significant positive relationship between this aspect of perfectionism and emotional disorder symptoms severity show that the assumption offered by Jamshidy (2009) regarding the effect of culture on the positive or negative assumption of this attribute may be proven.

Finally, with respect to the results regarding correlation, which are consistent with the findings of Hill et al. (2004), emotional disorders have a higher correlation with negative perfectionism than with positive perfectionism. Considering these results, data analysis revealed that there is a significant relationship between perfectionism and the severity of symptoms of emotional disorder.

The results of regression analysis demonstrate that dimensions of perfectionism can be regarded as an instrumental factor in predicting emotional disorder symptoms severity. Of course, negative self-perception as an indicator of negative perfectionism, and attempting to be perfect as well as discipline and organization as subcategories of normal perfectionism play the greatest role in this prediction. These results help achieve a more comprehensive understanding of emotional disorders in screening and preventive plans and using simultaneous multi-dimensional therapy to facilitate and speed up the treatment process. Also, there is strong evidence indicating that perfectionism as a transdiagnostic factor interrupts the treatment process and reduces the quality of this process by creating cognitive inflexibility (Ferrari & Mautz, 1997), challenging and preventing social relationships (Habke & Flynn, 2002), impeding therapeutic alliance (Blatt & Zurroff, 2005), and perfectionist's refusal to accept the disorder (Hewitt et al., 2003).

One of the limitations of this study was the use of perfectionism questionnaire of Hill et al. (2003), as this questionnaire has been normalized for the teenagers in Iran (Jamshidy, 2008). However, it appears that α coefficient obtained by this questionnaire in the present study can justify the possibility of using this questionnaire for the youth group. Moreover, the focus of this study is on nonclinical group and student population which are likely to have more perfectionism tendency due to their higher progress motivation and it may reduce the generalization of this study to other communities. Therefore, it is suggested that wider spectrum of population is assessed in future studies. Furthermore, it is recommended that the future studies investigate the intermediary role of achievement motivation and self-esteem as significant factors relating to both perfectionism and emotional disorder variables. According to the research literature of this field, these two variables are regulator and effective intermediate and interactive in psychoanalysis. Furthermore, evidence suggests that the media can affect the tendencies of perfectionism (Minoosepehr, Nikoogoftar, & Foroushani, 2014), so use of media is recommended to reduce the negative perfectionism and increase positive perfectionism. Generally, findings of this study and similar future studies can be an effective step toward designing treatment protocols and plans preventing from different emotional disorders.

Acknowledgments

References

Aldao, A., & Nolen-Hoeksema, S. (2010). Specificity of cognitive emotion regulation strategies: a transdiagnostic examination. *Behavior Research and Therapy*, *48*(10), 974-983.

Payne, L. A., Ellard, K. K., Farchione, T.J., Fairholme, C. P., & Barlow, D. H. (2014). Emotional disorders: A unified transdiagnostic protocol. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual (5th ed.).* New York, NY: The Guilford Press.

Barlow, D. H., Allen L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders**.** *Behavior Therapy. 35*(2), 205-30.

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59*(9), 869–878.

Bernstein, A., Galia, T., Vujanovic, A. (2011). Concurrent relations between mindful attention and awareness and psychopathology among traumaexpose adults: Preliminary evidence of transdiagnostic resilience. *Journal of Cognitive Psychotherapy: An International Quarterly, 25*(2), 99-113.

Blatt, S. J., & Zurroff, D. C. (2005). Empirical evaluation of the assumptions in identifying evidence based treatments in mental health. *Clinical Psychology Review, 25*(4), 459-486.

Egan, S. J., Wade, T. D., & Shaffan, R. (2011). Perfectionism as a transdiagnostic process: a clinical review. *Clinical Psychology Review*, *31*(2), 203-212.

Egan, S. S., Piek, J. P., Dyck, M. J., & Rees, C. S. (2007). The role of dichotomous thinking and rigidity in perfectionism. *Behavior Research and Therapy, 45*(8), 1813-1822.

Ehring, T., & Watkins, E. R. (2008). Repetitive negative thinking as atransdiagnostic process. *International Journal of Cognitive Therapy, 7*(3), 192-205.

Ehring, T., Zetsche, U., Weidacker, K., Wahl, K., Schnfeld, S., & Ehlers, A. (2011). The Perseverative Thinking Questionnaire (PTQ): Validation of a contentindependent measure of repetitive negative thinking. *Journal of Behavioural Therapy & Experimental Psychiatry*, *42*(2), 225–232.

Ferrari, J. R., & Mautz, W. T. (1997). Predicting perfectionism: Applying tests of rigidity. *Journal of Clinical Psychology*, *55*(1), 1-6.

Flett, G. L., Davis, R. A., & Hewitt, P. L. (2003). Dimensions of perfectionism, unconditional self-acceptance, and depression. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 21*(2), 119-138.

Frost, R. O., Marten, P. A., Lahart, C., & Rosenblate, R. (1990). The Dimension of Perfectionism. *Cognitive Therapy and Research, 14*(5), 449-478.

Gross, J. J. (2008). Emotion and Emotion Regulation: Personality Processes and Individual Differences. In O. P. John, R. W. Robins & L. A. Pervin (Eds.), *Handbook of Personality* (pp. 701-724). New York: Guilford Press.

Habke, A. M., & Flynn, C. A. (2002). Interpersonal aspects of trait perfectionism. In Flett, G. L., & Hewitt, P. L. (Eds.), *Perfectionism: Theory, Research, and Treatment*. Washington, D.C.: American Psychological Association.

Hamachek, D. E. (1978). Psychodynamics of Normal and Neurotic Perfectionism Psychology. *Journal of Human Behaviors, 15*(1), 27-33.

Harvey, A. G., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders*. Oxford: Oxford University Press.

Harvey, A. G. (2008). Insomnia, psychiatric disorders, and the transdiagnostic perspective. *Current Directions in Psychological Science, 17*(5), 299-303.

Hewitt, P. L., & Flett, G. L. (1991). Dimensions of perfectionism in unipolar depression. *Journal of Abnormal Psychology, 100*(1), 98-101.

Hewitt, P. L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., & et al. (2003). The interpersonal expression of perfectionism: Perfectionistic self-presentation and psychological distress. *Journal of Personality and Social Psychology, 84*(6), 1303-1325.

Hill, R. W., Huelsman, T. J., Furr, R. M., Kibler, J., Vicente, B. B., Kennedy, C. A. (2004). New measure of perfectionism: The Perfectionism Inventory. *Journal of Personal Assessments, 82*(1), 80-91.

Jamshidy, B., Razmi, M. R., Haghighat, Sh., & Samani, S. (2008). The relationship between family cohesion and flexibility with dimensions of perfectionism. *Iranian Journal of Psychiatry and Clinical Psychology, 14*(2), 199-205.

Jamshidy, B., Hosseinchari, M., Haghighat, Sh., & Razmi, M. R. (2009). Validation of new measure of perfectionism. *Journal of Behavioral Sciences, 3*(1), 35-43.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

Levinson, C. A., Rodebaugh, T. L., Shumaker, E. A., Menatti, A. R., Weeks, J. W., White, E. K., & et al. (2015). Perception matters for clinical perfectionism and social anxiety, *Journal of Anxiety Disorders, 29*, 61-71.

Lotfi, M., Bakhtiyari, M., Asgharnezhad Farid, A., & Amini, M. (2013). The Effectiveness of Transdiagnostic Therapy on Emotion Regulation Strategies of Patients with Emotional Disorders: A Randomized Clinical Trial. *Practice in clinical psychology, 1*(4):26-30.

McEvoy, P., & Mahoney, A., (2012). To Be Sure, To Be Sure: Intolerance of Uncertainty Mediates Symptoms of Various Anxiety Disorders and Depression. *Behavior Therapy, 43*(3), 533-545.

McLaughlin, K. A., & Nolen-Hoeksema, S. (2011). Rumination as a transdiagnostic factor in depression and anxiety. *Behavior Research and Therapy, 49*(3), 186-193.

Miloseva, L., & Vukosavljevic-Gvozden, T. (2014). Perfectionism Dimensions in Children: Association with Anxiety and Depression. *Procedia-Social and Behavioral Sciences, 159*(23), 78-81.

Minamimoto, T., Minamimoto, A., Hori, Y., Yuji, N., & Suhara, T. (200). Behavioral characteristics of low-motivation and its relation to serotonin in a primate model of depression. *Neuroscience Research, 68*, e233- e334.

Minoosepehr, S., Nikoogoftar, M., & Foroushani, G. S. (2014). Predictors of Tendency Toward Cosmetic Surgery: Media Influences, Appearance Perfectionism and Investment. *Iranian Journal of Clinical Psychology, 2*(4), 285-292.

Norton, P. J. (2012). A randomized clinical trial of transdiagnostic cognitive-behavioral treatments for anxiety disorder by comparison to relaxation training. *Behavior and Therapy, 43*(3), 506-17.

O'Connor, R. C. (2007). The relations between perfectionism and suicidality: A systematic review. *Suicide and Life-Threatening Behavior, 37*(6), 698-714.

Pourshahbaz, A., Nonahal, S., Dolatshahi, B., & Omidian, M. (2014). The Role of the Media, Perfectionism, and Difficulties in Emotion Regulation in Prediction of Muscle Dysmorphia Symptoms. *Practice in Clinical Psychology, 2*(2), 161-165.

Power, M., & Dalgleish, T. (2008). *Cognition and Emotion*. New York: Psychology Press.

Shafran, R., & Mansell, W. (2001). Perfectionism and psychopathology: A review of research and treatment. *Clinical Psychology Review, 21*(6), 879−906.

Sherry, D. L., Sherry, S. B., Hewitt, P. L., Mushquash, A., & Flett, G. L. (2015). The existential model of perfectionism and depressive symptoms: Tests of incremental validity, gender differences, and moderated mediation. *Personality and Individual Different, 76*, 104-110.

Watkins, E. R. (2009). Depressive rumination and comorbidity: evidence for brooding as a Transdiagnostic process. *Journal of Rational-Emotional Cognitive-Behavior Therapy, 27*(3), 160-175.

Watson, D., O'Hara, M. W., Simms, L. J., Kotov, R., Chmielewski, M., & et al. (2007). Development and validation of the Inventory of Depression and Anxiety Symptoms (IDAS). *Psychological Assessment, 19*(3), 253–68.