



Psychometric properties of the Persian version of Clinical Perfectionism Questionnaire: Findings from a clinical and non-clinical sample in Iran



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ABSTRACT

Clinical perfectionism has been viewed as a transdiagnostic process for emotional disorders. The aim of the present study was to explore the structural, convergent, divergent, discriminative validity, and reliability of the Persian version of Clinical Perfectionism Questionnaire. A general population sample ($n = 384$) and patients with Major Depressive Disorder ($n = 40$), Social Anxiety Disorder ($n = 35$), Obsessive Compulsive Disorder ($n = 39$), and Eating Disorders ($n = 38$) completed Clinical Perfectionism Questionnaire, Perfectionism Inventory, and Depression, Anxiety, Stress Scale-21. Confirmatory factor analysis showed that the two-factor model provides the best fit with data. These factors showed positive significant correlation with congruent subscales of Perfectionism Inventory. The Evaluative Concern factor had significant correlation with depression, anxiety and stress, while Personal Standards factor did not associate with these symptoms. These factors successfully distinguished clinical groups from general population. Internal consistency of CPQ was acceptable in both samples. Collectively, findings provided promising evidences for the validity and reliability of the Persian version of the Clinical Perfectionism Questionnaire in both general population and clinical group.

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1. Introduction

Perfectionism is an important maintaining factor in Eating Disorders (EDs) (Fairburn, 2008), Social Anxiety Disorder (SAD) (Heimberg, Juster, Hope, & Mattia, 1995) and Obsessive-Compulsive Disorder (OCD) (OCCWG, 1997) to mention a few. An extensive body of research has introduced perfectionism as a transdiagnostic process (see Egan, Wade, & Shafran, 2011 for a review). In an attempt to explain the maintaining mechanisms of the perfectionism, Shafran, Cooper, and Fairburn (2002), and Egan, Wade, and Shafran (2011) developed a transdiagnostic model of clinical perfectionism. The model explains how clinical perfectionism evokes maladaptive behaviors such as performance checking, procrastination, and avoidance. In this model, clinical perfectionism was defined as “the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards in at least one highly salient domain, despite adverse consequences” (Shafran et al., 2002, p. 778). Some researchers have criticized the uni-dimensional nature of clinical perfectionism and pointed out that it captures only the high-standard part of perfectionism (Dunkley, Blankstein, Masheb, & Grilo, 2006; Hewitt, Flett, Besser,

Sherry, & McGee, 2003). However, Shafran et al. (2002) and Egan et al. (2011) argued that trying to be excellent is not dysfunctional per se, but over dependency of self-worth on achieving personally demanding goals results in negative psychosocial outcomes.

As the existing measures of perfectionism were too broad to capture the core concept of clinical perfectionism, Fairburn, Cooper, and Shafran (2003) developed a 12-item Clinical Perfectionism Questionnaire (CPQ). The CPQ measures cognitive, behavioral and emotional components of setting high standards, striving towards them, and its relation to individual's self-evaluation. This is a brief instrument, has a time frame of one month and therefore is sensitive to change in perfectionism over treatment. Another advantage of CPQ is that it targets the specific core components of perfectionism rather than other relevant variables such as “Parental Expectation”. Some studies provided promising evidences for reliability and validity of the scale (e.g., Chang & Sanna, 2012; Hoiles, Kane, Watson, Rees, & Egan, 2016). Also, exploratory factor analytic studies of the CPQ resulted in a two-factor solution reflecting positive striving and maladaptive evaluative concern in university student samples (Dickie, Surgenor, Wilson, & McDowall, 2012; Stoeber & Damian, 2014), as well as community and eating disorder sample (Egan et al., 2016). Moreover, Dickie et al. (2012), Egan et al. (2016), and Stoeber and Damian (2014) showed that positive striving was more strongly correlated with Personal Standards (PS), whereas maladaptive evaluative concern showed stronger relationship with

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Evaluative Concern (EC), which is the sum of Concern over Mistake and Doubt over Action subscales of Frost Multidimensional Perfectionism Scale (FMPS) (Frost, Marten, Lahart, & Rosenblate, 1990). Egan et al. (2016) found that CPQ accounted for an additional 11% of variance of negative affectivity beyond the variance accounted for by the FMPS. Finally, Chang and Sanna (2012) reported that the CPQ significantly correlated with symptoms of depression, anxiety, perceived life stress, and negative affectivity. They also indicated that CPQ accounted for 11% of additional variance in depression, 13% of additional variance in anxiety, and 18% of additional variance in perceived life stress beyond what was accounted for by Hewitt Multidimensional Perfectionism Scale (HMPS) (Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).

However, to our knowledge, no published investigation has yet tested the construct of clinical perfectionism based on CPQ via confirmatory factor analysis (CFA). Running a CFA is a logical next step as Exploratory Factor Analysis tends to produce factors that are exclusive to the sample at hand rather than theoretically based constructs (Thompson & Daniel, 1996). Thus, the present study aimed to explore factorial validity of the CPQ using CFA, as well as its discriminative validity, convergent validity, divergent validity, and its reliability in a general population and a clinical sample consisting of patients with EDs, SAD, OCD, and Major Depressive Disorder (MDD). These clinical groups were chosen as they are fairly prevalent psychopathologies in Iran, and perfectionism is suggested to be an important maintaining factor for these disorders (see Egan et al., 2011 for a review). Based on the theory of clinical perfectionism and previous studies, we expected to find a two-factor solution (Personal Standards (PS) and Evaluative Concern (EC)). In order to explore convergent and divergent validity, we predicted that PS factor would have strong positive correlation with following subscales of the Perfectionism Inventory (PI) (Hill et al., 2004): Organization (Or), Planfulness (Pl), and Striving for Excellence (SE) subscales, and weak or negative association with Concern over Mistakes (CM), Need for Approval (NA), and Rumination (Ru). However, EC factor would show positive correlation with CM, NA, and Ru subscales and weak or negative relationship with Or, Pl, and SE. Given previous researches (Chang & Sanna, 2012; Egan et al., 2016) we also predicted that EC factor would correlate with symptoms of depression, anxiety, and stress, while PS factor would show weak or negative relationship with these symptoms. Finally, discriminative validity of CPQ was tested by examining whether the factors of the scale could successfully differentiate between the clinical and non-clinical samples.

2. Method

2.1. Participants

The present study was part of a larger project investigating the etiological and maintaining mechanisms of perfectionism. The participants were recruited from the general population and clinics. The general population sample included 403 participants (204 women) in Tehran, Iran. They were selected via proportional quota sampling (Morrow et al., 2007) based on the last census data of Statistical Center of Iran (2011). Inclusion criteria were being between 18- and 50-years old, having completed high school, and living in Tehran for at least 6 years. The mean age of the men was 33.23 ($SD = 9.18$) and women 32.71 ($SD = 9.78$). Nineteen participants had skipped >10% of the items. Therefore, the data of 384 subjects were analyzed.

The clinical sample consisted of patients who met the DSM-IV-TR criteria for MDD ($n = 40$, women = 26), OCD ($n = 39$, women = 24), SAD ($n = 35$, women = 26), or EDs ($n = 38$ women, bulimia nervosa = 31, anorexia nervosa = 7). Based on the transdiagnostic theory of EDs (Fairburn, 2008) patients with EDs were recruited regardless of their type of diagnosis. The mean age of the four clinical groups were as follow: MDD = 29.87 ($SD = 5.94$); OCD = 31.25 ($SD = 5.52$); SAD = 28.37 ($SD = 6.37$); and EDs = 30.38 ($SD = 5.55$). Further

demographic characteristics of general population and clinical sample are illustrated in Table 1.

2.2. Material and procedure

The research procedure was approved by Ethical Review Board of University of Social Welfare and Rehabilitation Sciences. All participants provided written consent. After obtaining permission from the developer of the CPQ, the scale was translated into Persian and back translated into English. Professor Shafran then determined that the Persian version matched with the original version of the CPQ.

In order to gather data from general population sample, five social workers selected participants according to quota sampling matrix from visitors in health centers, parks, and/or cultural houses of Tehran. Participants were asked to complete a battery of questionnaires.

For the clinical sample, psychiatrists or clinical psychologists referred the patients to the first author (R.M.) for an evaluation using the Structured Clinical Interview for DSM-IV (SCID). Those who met the inclusion criteria and agreed to participate in the study, were instructed about the questionnaires and requested to complete them in one week.

2.2.1. Clinical Perfectionism Questionnaire

Clinical Perfectionism Questionnaire (Fairburn et al., 2003) assesses core components of clinical perfectionism over the past month on a four-point Likert scale (“not at all” to “all of the time”). The example of the items is as follow: “Have you been told that your standards are too high?” (PS factor); “Have you been afraid that you might not reach your standards?” (EC factor).

2.2.2. Perfectionism Inventory

Hill et al. (2004) developed a 59-item Perfectionism Inventory in order to combine and capture the core structures of FMPS and HMPS. A new subscale to measure rumination about failures has also been added to it. Subjects are asked to respond on a 5-point scale from strongly disagree to strongly agree. The exploratory factor analysis revealed 8 factors: CM (e.g., “To me, a mistake equals failure”), NA (e.g., “I am over-sensitive to the comments of others”), Ru (e.g., “If I make a mistake, my whole day is ruined”), High Standards for Others (HSO) (e.g., “I’m often critical of others”), Perceived Parental Pressure (PPP) (e.g., “My parents are difficult to please”), Or (e.g., “I like to always be organized and disciplined”), Pl (e.g., “I find myself planning many of my decisions”), and SE (e.g., “I have to be the best in every assignment I do”). A higher order exploratory factor analysis resulted in a two-factor solution called “Conscientious Perfectionism” (based on OR, SE, PL, and HSO) and “Evaluative Perfectionism” (based on CM, RU, NA, and PPC). Jamshidy, Hosseinchari, Haghghat, and Razmi (2009) demonstrated satisfactory structural validity, convergent validity, and internal consistency of the Persian version of PI. Among general population, internal consistency of PI and its subscales were as follow: PI total = 0.93; CM = 0.84; NA = 0.83; Ru = 0.82; HSO = 0.72; PPP = 0.85; Or = 0.88; Pl = 0.83; SE = 0.77. In clinical sample, internal consistency was as follow: PI total = 0.94; CM = 0.88; NA = 0.86; Ru = 0.86; HSO = 0.81; PPP = 0.90; Or = 0.90; Pl = 0.86; SE = 0.75.

2.2.3. Depression Anxiety Stress Scales-21 (DASS-21)

The DASS-21 is a self-report instrument consisted of three subscales that measure symptoms of depression (e.g., “I felt down-hearted and blue”), anxiety (e.g., “I felt I was close to panic”), and stress (e.g., “I found myself getting agitated”) over the past week. Participants were asked to answer the items using a 0 (did not apply to me at all) to 3 (apply to me very much) scale (Lovibond & Lovibond, 1995). The Persian version of the DASS-21 has acceptable construct and convergent validity as well as internal consistency (Asghari, Saed, & Dibajnia, 2008). Internal consistency of DASS-21 and in its subscales in general population were as follow: DASS-21 total = 0.92; Depression = 0.85;

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