



Dimensions of perfectionism and perfectionistic self-presentation in social phobia

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ABSTRACT

In a cross sectional study we examined the dimensions of perfectionism and perfectionistic self-presentation in patients with social phobia. We also examined associations between perfectionism and self-report of anxiety and depression with fear of negative evaluation. Thirty patients with a diagnosis of social phobia and 30 community volunteers completed two measures of trait perfectionism, fear of negative evaluation and measures of anxiety and depression. The clinical sample had overall higher levels of perfectionism and had greater fear of negative evaluation, social anxiety, trait anxiety and depression than the community sample. The clinical sample had significantly higher concern over mistakes, doubts over actions, parental criticism (F-MPS, Frost et al., 1990) and scored higher for non-display of imperfection on the Perfectionistic Self Presentation Scale (PSPS; Hewitt et al., 2003). The two groups did not differ on other dimensions of perfectionism, or on both measures of perfectionism. The two measures of perfectionism were positively correlated. There was a significant correlation between trait perfectionism and Brief Fear of Negative Evaluation scale (BFNE). The paper discusses the importance of examining perfectionism in social phobia.

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1. Introduction

The hallmark of social phobia (SP) is a marked fear of social or performance situations, fear of scrutiny and negative evaluation and the avoidance of situations in which these fears are triggered (APA, 1994). It is the third most common psychiatric disorder (Kessler et al., 1994) with a poor rate of spontaneous remission (Bruce et al., 2005). The lifetime prevalence of SP ranges from 2.4% to 13%. Co-morbidity rates for SP are high and include other anxiety disorders, mood disorders, substance dependence and bulimia nervosa (Federoff and Taylor, 2001; Kessler et al., 1999). The onset of SP is typically early although people with SP seek treatment much later when they experience impairment in social and occupational roles.

Persons with SP are excessively concerned with possible errors they may make in social situations and predict rejection or loss of status as a result of their behaviours. Fear of negative evaluation (FNE) is a core feature of SP and is associated with heightened negative affect and interpersonal awareness (Beck et al., 1985; Harb et al., 2002). It reflects the tendency to focus selectively on evidence of failure and to be self-critical. In order to avoid possible failure, persons with SP set unrealistically high standards for themselves (Clark and Wells, 1995; Rapee and Heimberg, 1997). These personally demanding standards are motivated largely by a

fear of failure and need to impress, which in turn leads to avoidance and hyper vigilance (Eysenck, 1997; Hamachek, 1978). Alden et al. (1994) suggest that persons with SP may actually set lower standards than their actual potential and may continually underestimate themselves.

Clinical evidence suggests that perfectionism is relevant to SP (Heimberg, 1996; Juster et al., 1996). Perfectionism refers to the desire to achieve the highest standards of performance, in combination with unduly critical evaluations of one's performance (Frost et al., 1990). It is a multidimensional personality trait, with both adaptive and maladaptive aspects (Hewitt and Flett, 1991). The first multidimensional measure of perfectionism was developed by Frost et al. (1990) and consists of six dimensions that include concern over mistakes, doubts about actions, parental expectations, personal standards, parental criticism, and organization. Perfectionism has been identified as a vulnerability factor in the development of depression (Chang and Sanna, 2001; Hewitt and Flett, 1991; Hewitt et al., 1996), and other psychological problems such as hopelessness, suicidality, (Hewitt et al., 1998; O'Connor and O'Connor, 2003), eating disorders (Minarik and Ahrens, 1996), obsessive-compulsive disorder and other anxiety disorders (Antony et al., 1998).

Perfectionistic self-presentation (PSP) is yet another dimension of perfectionism that includes an interpersonal aspect (Hewitt et al., 2003). PSP includes an excessive need to appear perfect in the eyes of others, with distinct, stable dimensions of, perfectionistic self-promotion i.e., proactively promoting a perfect image, non-disclosure of imperfection i.e., concern over verbal disclosures of

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imperfection and non-display of imperfection i.e., concern over behavioural displays of imperfection (Hewitt et al., 2003). Although the two aspects of trait perfectionism overlap to a certain degree, they are considered to be conceptually distinct from each other and both function as vulnerabilities in the development of emotional problems (Dunkley et al., 2003).

Research suggests that perfectionism is much more likely to develop in families where parental anxiety concerning social interactions is high and need for others' approval is excessively emphasized (Bruch et al., 1989; Juster et al., 1996). Asian American samples report higher personal standards, strict parental control, lack of open communication with parents, and higher educational expectations and emotional alienation than their Caucasian peers (Kawamura et al., 2002).

Patients with SP report a higher concern over mistakes, doubts of one's action and parental criticism than community controls and patients with panic disorder (Juster et al., 1996; Saboonchi et al., 1999). However, this has been relatively less researched in comparison to other psychiatric conditions and there are no cross-cultural comparisons.

The clinical implications of perfectionism and its role in maintenance of anxiety disorders and SP in particular, have received relatively less attention. High levels of clinical perfectionism that includes personally demanding standards with self-criticality hampers the progress of therapy and maintains negative affect through excessive self-criticality (Shafran et al., 2002).

Perfectionism and interpersonal aspects of perfectionism have been previously studied in western populations and largely in non-clinical samples and limit generalization of findings to other populations (Hewitt et al., 2003; Juster et al., 1996). In the Asian Indian setting, perfectionism has been explored in a few recent studies on university samples (Slaney et al., 2000). The cross-cultural aspects of perfectionism have been inadequately addressed in clinical samples. The need to examine cognitive features such as FNE in association with trait perfectionism has also been emphasized (Antony et al., 1998). The purpose of this study was to examine the dimensions of perfectionism patients with SP in an Asian Indian setting. We also examined associations between trait perfectionism and anxiety, depression, and FNE. Perfectionism, particularly its interpersonal aspects, is likely to be influenced by socio-cultural factors. To our knowledge there are no published studies examining trait perfectionism in a clinical sample in this cultural context. The findings of such a study would contribute to a cross-cultural understanding of perfectionism in SP.

2. Methods

2.1. Sample and design

Thirty patients with an ICD 10 (WHO, 1992) diagnosis of SP (F 40.1) and 30 community volunteers formed the sample for the study. A cross sectional, case control design was adopted. The clinical sample consisted of patients with a primary diagnosis of SP and was selected from the psychiatric outpatient services of NIMHANS, Bangalore. Patients with co-morbid anxious avoidant personality disorder (ICD 10; AAPD; F-60.0) and depressive disorders, other than severe depressive disorder, (F-32.2 and 32.3) were also included. The community sample was recruited using the snowball technique. Exclusion criteria were a diagnosis of psychosis, bipolar affective disorder, severe depressive episode with psychotic symptoms, other anxiety disorders, Axis II disorders other than anxious avoidant personality disorder, current psychoactive substance abuse, organic and neurological disorders and major physical illnesses or structured psychological intervention in the last 12 months for SP.

The MINI (the mini-international neuropsychiatric interview M.I.N.I.; Sheehan et al., 1998) was used to confirm diagnosis of SP. The community sample was screened both on the General Health Questionnaire-12 (GHQ-12; Goldberg and Williams, 1988) and the MINI. The average age of participants in the two groups was 28.90 years (SD = ±8.256), and 28.73 years (SD ± 7.334) in the clinical and community sample respectively. A majority of the participants in both groups were male (93% and 80%) and single (70% and 76.7%). Experts at the department of mental health and social psychology, NIMHANS reviewed the study for ethical considerations. A written informed consent was obtained from the participants. The order of administration was kept constant.

2.2. Measures

Frost's multidimensional perfectionism scale (F-MPS; Frost et al., 1990) is a 35 item questionnaire with six dimensions, namely concern over mistakes (CM), personal standards (PS), parental expectation (PE), parental criticism (PC), doubts about actions (DA) and organization (O). The reliability of the total perfectionism scale is 0.90. Internal consistency of the F-MPS ranges from 0.77 to 0.93.

The perfectionistic self-presentation scale (PSPS; Hewitt et al., 2003) is a 27-item measure with three subscales: perfectionistic self-promotion, non-display of Imperfection and non-disclosure of Imperfection. Higher scores indicate greater levels of need for perfection. Coefficient alpha for PSPS subscales range from .75 to .90 (Hewitt et al., 2003).

Brief fear of negative evaluation scale (BFNE; Leary, 1983) is a 12-item measure that assesses concerns over negative interpersonal evaluation, based upon the original FNE (Watson and Friend, 1969). It correlates highly ($r = .96$) with the original FNE and has demonstrated good test-retest reliability and internal consistency (Leary, 1983).

Liebowitz social anxiety scale (LSAS; Liebowitz, 1987) measures fear and avoidance of social interactions and performance situations. LSAS has adequate psychometric properties. It was used as self-report of social anxiety in this study.

State-trait anxiety inventory (STAI; Spielberger et al., 1983) is a 20 item self-report measure with two forms that assess state and trait anxiety. It is a widely used measure of anxiety with adequate psychometric properties.

Beck depression inventory II: (BDI II, Beck et al., 1996) was used to assess severity of depression.

Descriptive statistics, *t*-test, correlations and partial correlations were used to analyse the data obtained (Table 1).

3. Results

Sixty seven percent (67%) of the clinical sample had a primary diagnosis of SP, 33% had a diagnosis of SP with anxious avoidant personality disorder (AAPD). Research indicates that 60% of patients with SP also receive a diagnosis of AAPD (Heimberg, 1996). In addition, two patients had co-morbid depression that included recurrent depressive disorder and dysthymia. As expected the clinical sample scored higher than community controls (Table 2) on LSAS, (Mean = 72.53; $t = 8.31$, $p < .001$), state (Mean = 41.97; $t = 3.29$, $p < .05$) and trait anxiety (Mean = 54.60, $t = 7.40$, $p < .001$) indicating presence of significant anxiety symptoms at the time of assessment. The clinical sample had a mean BDI score of 17 (±11.20), indicating mild severity of depressive symptoms. This was significantly higher than that of the community sample ($t = 4.49$, $p < .001$).

The average duration of illness was 10.6 years (±6.62), with a range of 3–28 years indicating a chronic course.

Patients with SP had a significantly higher total score on F-MPS (Table 2; Mean = 92.4; $t = 2.78$, $p < .001$) than the community

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