



The structure and reliability of the Clinical Perfectionism Questionnaire

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ABSTRACT

Pathological perfectionism is of increasing interest in clinical research, although the dimensionality of this construct is actively debated. Most studies refer to two underlying dimensions associated with evaluative concerns and personal standards, and multidimensional scales are used to capture these. The more recently proposed construct of 'clinical perfectionism' (CP), is argued as unidimensional, as is the Clinical Perfectionism Questionnaire (CPQ) arising from this. This study assesses the reliability and validity of the CPQ in a sample of young adults. Utilising a survey design, participants were 491 undergraduate students aged 18–30 years who completed a battery of psychometric measures, of whom 142 were retested after 4 months. After removal of two items, exploratory factor analysis and parallel analysis revealed two distinct factors broadly consistent with existing two-factor formulations of pathological perfectionism, but with modest internal consistency and test–retest reliability. Norms need to be established in order to ascertain meaningful cut-offs and to aid understanding about significant improvement in the different dimensions if the CPQ is to be used in future research. Further research also needs to consider the relative utility of the CPQ against already existing measures of pathological perfectionism in common use.

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1. Introduction

The construct of perfectionism has long held interest as being both causal and maintaining factors of a variety of psychological conditions (see Shafran & Mansell, 2001 for a review). Arising from this, debates have arisen about the dimensionality of perfectionism particularly as these relate to certain disorders. Generally two higher order dimensions have been focused on: adaptive or 'benign' forms of perfectionism, and pathological or 'problematic' forms (Frost, Marten, Lahart, & Rosenblate, 1990). The former typically involves high self-imposed, personal standards (PS), while the latter involves self-critical evaluative concerns (EC) including excessive concern over mistakes and doubts about actions (see Dunkley, Blankstein, Masheb, & Grilo, 2006). Factor analytic studies have largely supported the importance of distinguishing between these two dimensions (e.g., Bieling, Israeli, & Antony, 2004; Dunkley, Zuroff, & Blankstein, 2003; Hill et al., 2004) and measures reflecting these are in common use. In the main, researchers have used relevant subscales from the Frost et al. (1990) Multidimensional Perfectionism Scale (FMPS) or the Hewitt, Flett, Turnbull-Donovan, and Mikail (1991) Multidimensional Perfectionism Scale (HMPS). These measures are closely related (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993).

Critical of this multidimensional approach, Shafran, Cooper, and Fairburn (2002) coined the term clinical perfectionism (CP) to de-

scribe "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" (p. 778). Unlike the broader construct of perfectionism which may have some benefits such as positive striving (Bieling et al., 2004), the self-imposed standards in CP are dysfunctional, striving for these is continuous but results in multiple psychological consequences. CP is argued as the clearest conceptualisation of pathological perfectionism (Shafran, Cooper, & Fairburn, 2003; Shafran et al., 2002) and has been applied to a range of conditions particularly eating disorders (Rieger et al., 2010; Riley, Lee, Cooper, Fairburn, & Shafran, 2007).

However the construct of CP is not without its detractors (e.g., Dunkley et al., 2006; Hewitt, Flett, Besser, Sherry, & McGee, 2003). In particular, Hewitt et al. (2003) argue that Shafran et al. (2002) overly emphasise the self-orientated aspects at the cost of wider relational and interpersonal dimensions that make up the multiple aspects which existing multidimensional measures are designed to capture. They go on to criticise CP as "a self-contained unidimensional model" (Hewitt et al., 2003, p. 1232) and if applied to treatment, risks bringing about temporary change only. Glover, Brown, Fairburn, and Shafran (2007) likewise consider CP as "largely speculative" (Glover et al., 2007, p. 86). Shafran et al. (2003) do not dispute that perfectionism (as opposed to CP) may have multiple dimensions but reemphasise that CP is a more "circumscribed clinical construct" (Shafran et al., 2003, p. 1218).

When first proposing the construct of CP, Shafran et al. (2002) considered that existing psychometric measures of perfectionism

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were too broad and therefore failed to adequately capture the elements of self-evaluation core to their theoretical model, and were problematic because of the inclusion of benign aspects of perfectionism. This prompted Fairburn and associates (see Riley et al., 2007) to propose a specific measure of CP, the 12-item Clinical Perfectionism Questionnaire (CPQ). The CPQ has since been used in a number of published studies (Shafran, Lee, & Fairburn, 2004; Steele, O'Shea, Murdock, & Wade, 2011) and larger treatment trials including those targeting CP (Glover et al., 2007; Riley et al., 2007). Preliminary psychometric properties of the CPQ have been reported against an interview-based measure, the Clinical Perfectionism Examination (CPE) (Riley et al., 2007) which is itself awaiting the fuller publication of psychometric properties. These preliminary data showed that the CPQ had adequate convergent validity ($r = .57$), and that it could distinguish between clinical and non-clinical samples, although the data relating to these samples are unpublished (see Riley et al., 2007). Steele, O'Shea, Murdock, and Wade (2011) recently reported high internal consistency ($\alpha = 0.83$) in a sample of 39 eating disordered women.

In light of the increasing use of the CPQ in clinical and non-clinical research, and the limited published psychometric qualities of this, the purpose of this study was to explore the psychometric properties of the CPQ in young adults, and to consider these findings in the context of debates about the dimensionality of CP. We hypothesised that the CPQ contains two perfectionism factors.

2. Method

2.1. Design and participants

The research was completed as part of a wider range of studies investigating perfectionism and eating problems. Along with a second measure of perfectionism (see below), the CPQ was administered online at two time points 4 months apart using Survey Monkey (www.surveymonkey.com). Approval for this study was granted by the Victoria University Ethics Committee. All participants gave informed consent and anonymity was preserved. Testing at Time 1 took place in March 2009, with testing at Time 2 4 months later. Participation was extended to students in two consecutive undergraduate courses, with approximately 50% of those students surveyed at Time 1 progressing to the second course and thus available to participate at Time 2.

Participants were undergraduate students at Victoria University of Wellington. At Time 1 initially 662 participants were recruited. After eliminating cases with missing data at either Time 1 ($n = 84$) or Time 2 ($n = 7$), 175 participants had a complete matching data set for both time periods. Because few (13.8%) participants were recruited outside the age range 18–30 years, all subsequent analyses were conducted with participants within this age range. The final baseline participants included a large sample ($n = 491$) of young adults of whom 142 completed surveys at Time 1 and Time 2. Demographic features of the participants are presented in the results.

2.2. Measures

The Clinical Perfectionism Questionnaire (CPQ) is a self-report questionnaire derived from the cognitive-behavioural model proposed by Shafran et al. (2002). The 12 items (single scale) assess the core phenomenological components of CP (Riley et al., 2007). The CPQ uses a four-point Likert scale from 1 (“not at all”) to 4 (“all of the time”), with items 2 and 8 reverse scored. Participants are asked to respond as to how they have behaved or felt “over the past month”. Examples of the CPQ items are described in Table 2.

The Frost Multidimensional Perfectionism Scale (FMPS, Frost et al., 1990) is more global in its approach compared to the CPQ in that it makes absolute statements rather than focusing on recent instances. For example, “The fewer mistakes I make, the more people will like me”; “Other people seem to accept lower standards from themselves than I do”. The 35-item measure uses a five-point Likert scale from 1 (“strongly disagree”) to 5 (“strongly agree”). The FMPS has six possible subscales (Concern over Mistakes, Personal Standards, Parental Expectations, Parental Criticisms, Doubts about Actions, and Organisation), but only those directly relevant to the CP dimensionality debate, and as used in other research, were used to assess concurrent validity: the 4-item Personal Standards (PS) and 13-item Evaluative Concerns (EC) (sum of Concern over Mistakes and Doubts over Actions). Internal reliability of these scales in the sample studied was very high (PS $\alpha = .82$, EC $\alpha = .90$) and with moderate stability at 4 months (PS $r = .74$, EC $r = .80$).

2.3. Statistical analysis

All statistical analyses were completed using SPSS-19. Characteristics of the sample were examined using descriptive statistics, and univariate tests (independent sample *t*-tests and Pearson's correlation) assessed the relationship between CPQ scores and demographic characteristics (age, gender, and ethnicity). Reliability was assessed by means of internal consistency coefficient (Cronbach's alpha) and the test-retest correlation. Construct validity of the CPQ was examined by an exploratory factor analysis (principal components) with varimax rotation checked with an oblique rotation (direct oblimin). Items with a loading of greater than 0.4 were assigned to a specific factor, and the number of factors retained was based on considering initially the Scree test along with eigenvalues greater than one (EVG1 rule). As the EVG1 rule can lead to factor over-retention (Patil, McPherson, & Friesner, 2010), this was then checked with a parallel analysis (PA) with α set to .01 to determine eigenvalue significance. Concurrent validity was assessed by correlation with FMPS EC and PS scales.

3. Results

3.1. Descriptives

First, descriptive statistics were calculated for all demographic and psychometric variables for the final sample ($n = 491$). Participants at Time 1 were aged between 18 and 30 years ($M = 19.1$, $SD = 1.8$), with significantly more women (66.2%) than men. In keeping with the ethnic makeup of the wider population in this setting, the majority (78%) of the sample identified as New Zealand European, with Maori being the next largest ethnicity (4.3%). Of these, $n = 142$ also participated at Time 2, and this group was not significantly different on demographic characteristics being again mainly female (76.1%), young ($M = 18.9$, $SD = 1.6$ years), and of New Zealand European ethnicity (82.4%).

As gender, age, and ethnicity were not associated with CPQ scores, all subsequent analyses were conducted with the entire final sample. Time 1 and Time 2 CPQ total scores were $M = 25.10$ ($SD = 4.94$) and $M = 25.67$ ($SD = 5.18$) respectively. No clinically significant cut-off scores have been established in the literature although it is noted that previously recruited samples deemed to have clinical perfectionism have reported a pre-treatment CPQ mean score of 35.53 ($SD = 5.6$) (Riley et al., 2007). In the current study, such scores were in the 95th percentile rank (50th percentile rank CPQ Score = 25). PS and EC scores at Time 1 and 2 were as follows: Time 1 PS $M = 21.7$ ($SD = 5.2$) and EC $M = 31.7$ ($SD = 9.6$); Time 2 PS $M = 21.6$ ($SD = 5.1$), EC $M = 32.8$ ($SD = 10.2$).

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