Personality and Individual Differences 54 (2013) 744–749

Contents lists available at SciVerse ScienceDirect

Personality and Individual Differences

journal homepage: www.elsevier.com/locate/paid

Predicting eating problems among Malaysian Chinese: Differential roles of positive and negative perfectionism

Ser Yin Choo, Carina K.Y. Chan *

Jeffrey Cheah School of Medicine and Health Sciences, Monash University (Sunway Campus), Malaysia

ARTICLE INFO

Article history:
Received 9 July 2012
Received in revised form 24 November 2012
Accepted 30 November 2012
Available online 20 January 2013

Keywords:
Perfectionism
Chinese
Eating disorder
Validation
Cross-cultural

ABSTRACT

Positive and negative perfectionism (measured by the Positive and Negative Perfectionism Scale; PANPS) are found to have differential roles in predicting eating problems. This study translated and back-translated the PANPS into Chinese and then examined whether its factor structure was comparable to the original PANPS. The relationships between positive and negative perfectionism (using Chinese PANPS) and eating problems were also evaluated. Malaysian Chinese (N = 205) adults completed the Chinese PANPS, Eating Disorder Inventory (EDI) and Marlowe-Crowne Social Desirability Scale. Principal Component Analysis showed the two-factor solution of the Chinese PANPS accounted for 33.42% of the total variance, which was comparable to previous studies. Hierarchical multiple regressions revealed that negative perfectionism significantly predicted all eating disorder symptoms for females, but not drive for thinness and body dissatisfaction for males. Conversely, positive perfectionism significantly predicted lower total EDI scores, lower ineffectiveness and lower interpersonal distrust, but only predicted lower body dissatisfaction among females. In conclusion, negative perfectionism was consistently associated with eating problems whereas positive perfectionism might be a potentially adaptive factor, confirming the distinctive roles each played in the development of eating problems, even in a non-Western population.

1. Introduction

Among the common bio-socio-cultural factors, perfectionism has been documented as an important "trans-diagnostic" process that contributes to the development, maintenance and recovery of eating disorders (Bardone-Cone et al., 2007; Egan, Wade, & Shafran, 2011; Fairburn, Cooper & Shafran, 2003; Pearson & Gleaves, 2006). Perfectionists often strain themselves toward unrealistically high standards and measure their self-worth in terms of their accomplishments (Burns, 1980). While evidence has shown that perfectionism is multidimensional (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991), other studies have confirmed Hamachek's (1978) suggestion of two major types –"normal" and "neurotic" – of perfectionism (see Stoeber & Otto, 2006 for a review). The former is described as more beneficial and the latter as reflecting more detrimental aspects of perfectionism.

Derived from learning theory, a dual process model – "positive perfectionism" and "negative perfectionism" – was proposed (Slade & Owens, 1998; Terry-Short, Owens, Slade, & Dewey, 1995). Positive Perfectionism is defined as perfectionistic behavior driven by the desire to achieve favorable outcomes (e.g., achieving high standard for one's pleasure), while Negative Perfectionism is perfectionistic behavior driven by the goal to prevent adverse consequences (e.g., achieving high standard to avoid disapproval from others). Consistent with this model, research has demonstrated the differential roles of positive and negative perfectionism using the Positive and Negative Perfectionism Scale (PANPS) whereby negative perfectionism is associated with more psychopathology among clinical and non-clinical groups (Haase, Prapavessis, & Owens, 1999, 2002; Terry-Short et al., 1995). This is also in line with various findings that found associations between eating pathology and the maladaptive or neurotic aspects of perfectionism (Altug, Elal, Slade, & Tekcan, 2000; Mitzman, Slade, & Dewey, 1994).

Similar studies have explored the perfectionism-eating attitudes relation among other cultural groups, e.g., Chinese (Chan & Owens, 2006) and Korean (Chan, Ku, & Owens, 2010) immigrants in New Zealand where negative perfectionism was consistently found to be related to eating disordered symptoms. This underscored the fact that negative perfectionism was a salient characteristic for those who exhibit problematic eating behaviors. In contrast, positive perfectionism was related to less eating pathology and lower levels of psychological correlates of eating disorders (Chan & Owens, 2006; Chan et al., 2010), demonstrating that positive perfectionism might be an adaptive characteristic that contributes to beneficial psychological outcomes.

* Corresponding author. Address: Jeffrey Cheah School of Medicine and Health Sciences, Monash University (Sunway Campus), Jalan Lagoon Selatan, Bandar Sunway 46150, Selangor Darul Ehsan, Malaysia. Tel.: +60 3 55144913; fax: +60 3 55146323.
E-mail address: carina.chan@monash.edu (C.K.Y. Chan).

0191-8869/$ - see front matter © 2013 Published by Elsevier Ltd.
http://dx.doi.org/10.1016/j.paid.2012.11.036

Overall, these findings have reinforced the delineation of positive and negative perfectionism, suggesting that negative perfectionism significantly contributed to severe disturbances in eating attitudes and behaviors, even in non-Western populations; whereas positive perfectionism might reduce the risk of developing eating disorders.

The reason why negative perfectionism may be particularly relevant to eating disorder symptoms is because individuals with high negative perfectionism may disallow the display of imperfections and shortcomings by focusing on readily quantifiable dimensions, such as body appearances (Bardone-Cone et al., 2007). These individuals, thus, tend to hold excessive concerns on the social evaluation of their appearances. To them, minor flaws in body image may remind them of their failure to live up to the expectations of perfection (Frost et al., 1990; Hewitt, Flett, & Ediger, 1995). This in turn brings about self-criticism and weakening of self-efficacy, thus elevating negative emotions that can lead to depression or anxiety. Positive perfectionists, however, have better adaptive coping skills and are able to self-regulate their eating habits in a healthier way (Haase et al., 2002). Even though they may fall short of their high expectations at times, the relatively higher self-esteem may prevent them from being dissatisfied with their body images (Slade & Owens, 1998; Stoeber & Otto, 2006).

Disordered eating has typically been regarded as a 'Western-bound syndrome', affecting only people in developed, Western countries. Recent evidence has, however, shown growing concern in people of diverse ethnic/cultural backgrounds and socioeconomic status, including European Caucasian, African-American, Asian-American, Chinese, Indian and Arabs (Al-Subaie, 2000; Altabe, 1998; Bhugra, Bhui, & Gupta, 2000; Lee & Lee, 2000). Particularly, prevalence of eating disorder in Asian populations are increasing (Cummins, Simmons, & Zane, 2005; Lai, 2000).

Malaysia is one of the fastest-growing developing Asian countries that is exposed to modern urbanization and globalization. A predisposition towards an acceptance of the contemporary notions of slimness and 'fat phobia' beliefs has emerged (Lee & Lee, 2000; Mellor et al., 2009). Some studies have found that Malaysians were terrified at the thought of being overweight and wanted to be thinner though they were of normal weight (Edman & Yates, 2004; Mellor et al., 2009; Pon, Mirnalini, & Mohd Nasir, 2004; Swami & Tovée, 2005). Meals-skipping was the most commonly reported weight control regime (Pon et al., 2004) and this drive for thinness may eventually manifest into potentially deadly eating disorders.

Although Malaysia is ethnically heterogeneous, of particular concerns are the Chinese, due to substantial empirical evidence indicating a high rate of body dissatisfaction, disordered-eating and body change behaviors among this Asian subgroup (Lai, 2000; Lee & Lee, 2000; Xu et al., 2010). Thinness is gradually valued by Chinese culture, therefore, it was predicted that Malaysian Chinese would be prone to unhealthy eating habits in their quest for an ideal body image. Past studies have addressed the relationships between factors such as BMI, gender differences, socio-cultural influence, separation anxiety, self-satisfaction, and disordered eating attitudes of Malaysians (Edman & Yates, 2004; Gan, Mohd Nasir, Zalilah, & Hazizi, 2011). However, the role of positive and negative perfectionism in explaining eating problems among this population remains unknown.

The PANPS has been widely utilized and translated into different languages (Besharat, 2009; Seidah, Bouffard, & Vezau, 2002). However, there is no published standardized Chinese version given the large number of people coming from Chinese speaking background. Hence, developing the Chinese version of PANPS is needed.

The purpose of this study was, therefore, to: (1) translate and back-translate the PANPS into Chinese and to examine whether its factor structure was comparable to the original; and (2) evaluate the relationship between positive and negative perfectionism and eating problems among Malaysian Chinese using the Chinese PANPS. It was hypothesized that high negative perfectionism would predict higher total EDI scores as well as each EDI subscale. Conversely, high positive perfectionism would predict lower total EDI scores, ineffectiveness and interpersonal distrust.

2. Method

2.1. Participants

Two hundred and five Malaysians of Chinese ethnicity (Females = 127, Male = 78) between 18 to 46 years old (M = 22.93, SD = 3.43) were recruited. They have lived in Malaysia for between 6 and 38 years (M = 21.65, SD = 3.80). Their BMI ranged from 12.96 to 41.52 (M = 20.96, SD = 3.56), with 64.88% of them in the normal range. The inclusion criteria for participation were being a Malaysian Chinese aged above 18; and being able to read and understand both Chinese and English Languages.

2.2. Measures

2.2.1. Positive and negative perfectionism

The self-report 40-item PANPS (Terry-Short et al., 1995) was used to assess the levels of positive and negative perfectionism (20 items each). Responses were made on a 5-point scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores for both dimensions were summed separately, with higher values indicating higher levels of perfectionism. A score of 69 and above on the negative perfectionism subscale was suggested as the cut-off point for individuals at risk of eating disorders.

2.2.1.1. Translation. The PANPS was translated from English into Chinese language by a Chinese scholar and then back-translated into English by an independent translator. The back translation was compared to the original English version and modifications of the Chinese translation were made accordingly. The Chinese PANPS (α = .84 for both subscales) can be obtained from the authors.

2.2.2. Eating behavior

The 64-item self-report EDI (Garner, Olmstead, & Polivy, 1983) measures disordered eating behaviors and associated psychological characteristics on eight subscales. Three subscales assess eating disorder pathology (i.e., "drive for thinness", "bulimia", and "body dissatisfaction") and five subscales measure psychological correlates that are often associated with anorexia nervosa and bulimia nervosa (i.e., "interpersonal distrust", "perfectionism", "ineffectiveness", "interoceptive awareness", and "maturity fears"). Responses are made on a 6-point scale ranging from 1 (*never*) to 6 (*always*). EDI total and subscales scores were summed separately, with higher values indicating more symptoms related to disturbances. The perfectionism subscale was excluded from the EDI total to avoid possible inflations of interrelationships.

2.2.3. Social desirability

The self-report MCSDS (Reynolds, 1982) was used to control for the potential response bias toward socially-desirable behavior that might be associated with self-reported eating attitudes. It has 13 items and uses a dichotomous response format of 0 (*true*) and 1 (*false*). All items were summed for total score.

2.3. Procedure

Ethics approval was obtained from the university's Human Research Ethics Committee. The participants were recruited by