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A randomised controlled trial of face to face versus pure online self-help cognitive behavioural treatment for perfectionism

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ABSTRACT

Previous research has shown cognitive-behavioural treatment (CBT) to be effective in reducing perfectionism. The present study investigated the efficacy of two formats of CBT for perfectionism (CBT-P), face-to-face and pure online self-help, in reducing perfectionism and associated psychological symptoms. Participants were randomly allocated to face-to-face CBT-P ($n = 18$), pure online self-help CBT-P ($n = 16$), or a waitlist control period ($n = 18$). There was no significant change for the waitlist group on any of the outcome measures at the end of treatment. Both the face-to-face and pure online self-help groups reported significant reductions at the end of treatment for the perfectionism variables which were maintained at the 6-month follow-up. The face-to-face group also reported significant reductions over this time in depression, anxiety, and stress, and a significant pre-post increase in self-esteem, all of which were maintained at the 6-month follow-up. In contrast, the pure online self-help group showed no significant changes on these outcomes. The face-to-face group was statistically superior to the pure online self-help group at follow-up on the perfectionism measures, concern over mistakes and personal standards. The results show promising evidence for CBT for perfectionism, especially when offered face to face, where sustained benefit across a broad range of outcomes can be expected.
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Across a number of studies perfectionism has been found to be elevated in the presence of depression, social anxiety, panic disorder, obsessive-compulsive disorder, and eating disorders. Perfectionism impedes the treatment of depression and anxiety disorders (e.g., Blatt & Zuroff, 2005; Lundh & Ost, 2001). Accordingly, perfectionism appears as a risk and maintaining factor in a number of cognitive behavioural models (e.g., Fairburn et al., 1998; Obsessive Compulsive Cognitions Working Group, 1997).

Consistent with the predictions of the models, cognitive behaviour therapy for perfectionism (CBT-P) has been found to reduce perfectionism, anxiety, depression and eating disorders in clinical samples (Egan & Hine, 2008; Glover, Brown, Fairburn, & Shafran, 2007; Riley, Lee, Cooper, Fairburn, & Shafran, 2007; Steele & Wade, 2008; Steele et al., 2013). It is effective in both individual (Egan & Hine, 2008; Glover et al., 2007) and group treatment formats (Handley, Egan, Rees, & Kane, under review; Steele et al., 2013). However, to date only four randomized controlled trials (RCTs) exist. Riley et al. (2007) conducted an RCT of a 10-session CBT-P versus a waitlist control in individuals with elevated perfectionism and comorbid depression and/or anxiety disorders. CBT-P was superior to waitlist in reducing perfectionism, and there was a 50% reduction in comorbid disorders at post-treatment and 4-month follow-up. However this study was underpowered with only 20 participants. Steele and Wade (2008) conducted an RCT with an eating disorder population, finding CBT-P to produce reductions in perfectionism and symptoms of bulimia nervosa, depression, and anxiety. CBT-P had smaller effect sizes compared to standard CBT for bulimia nervosa with respect to reducing eating disorder behaviours, however larger effect sizes for eating psychopathology and anxious and depressive symptoms were associated with CBT-P. The third RCT examined group therapy in 40 participants with mixed anxiety disorders, depression and eating disorders (Handley et al., under review). Significant

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improvements in perfectionism and psychological symptoms were maintained at 6 month follow-up compared to waitlist control.

The fourth RCT, and of most pertinence to the current investigation, involved the delivery of CBT-P in a self-help format. Pleva and Wade (2006) compared the efficacy of CBT-P based on Antony and Swinson (1998) in guided self-help (GSH) versus pure self-help (PSH). Both treatment conditions produced significant reductions in perfectionism, depressive and obsessional symptoms, although the authors did not report on diagnostic status thus the results cannot be generalised to a clinical population. The GSH condition was associated with significantly greater improvements in obsessive compulsive symptoms than the PSH group. One of the major limitations of this study was that participants were informed of their condition assignment over a baseline observation period, which was associated with a significantly greater symptom improvement over this time in the absence of treatment for the GSH group and a significantly higher drop-out rate in the PSH group.

Therefore further research is required to determine the efficacy of self-help for perfectionism, in particular the comparative efficacy of the guided versus pure forms and the impact on diagnostic status. Self-help interventions are important to investigate due to increasing accessibility, improved dissemination and reduced cost (Williams & Whitfield, 2001). Therefore the current study investigated the efficacy of face to face CBT-P and online pure self-help CBT-P with respect to perfectionism and other psychopathology utilising: (i) an updated treatment model and intervention (Shafran, Egan, & Wade, 2010), (ii) a mixed clinical population, and (iii) a sample size that was powered sufficiently to detect differences.

The CBT-P used in this study is based on the Shafran et al. (2010) model of clinical perfectionism where self-worth is determined on the basis of striving for, and achieving, high standards. The model postulates that dichotomous thinking is an important mediator of the relationship between perfectionism and psychopathology, including depression, anxiety, disordered eating, and other indicators of such psychopathology including self-esteem and quality of life. Given that the literature suggests that self-help has generally been found to be less effective than face to face therapy (e.g., Beintner, Jacobi, & Schmidt, 2014), it was hypothesised that face to face CBT would be significantly superior to pure online self-help CBT, which would be significantly superior to waitlist control, with respect to our outcome variables of interest. These included the primary outcome, negative affect (including anxiety, stress and depression), as well as secondary outcomes of perfectionism, disordered eating, dichotomous thinking, and increases in quality of life and self-esteem. We also examined the impact of the interventions on diagnostic status of the participants over time.

Method

Participants

Recruitment was through advertisements to psychologists, GPs, mental health services, newspapers and radio stations seeking people who experienced difficulties with perfectionism. There were two inclusion criteria, including age being $\geq$18 years and having elevated perfectionism, defined as a cut–off score of $\geq$25 on the Concern over Mistakes subscale of the FMPS (Frost, Marten, Lahart, & Rosenblate, 1990). While no established criteria have been set to determine clinically significant perfectionism, a review (Egan, Wade, & Shafran, 2011) indicated this score to be the average across all clinical anxiety disorder samples. This means that the sample was likely to have been experiencing a clinically significant level of perfectionism. Exclusion criteria were serious active suicidal ideation/intent, substance abuse or dependence, psychosis, Body Mass Index of less than 16.5, and currently receiving psychological treatment. If applicable, participants were required to be on a stable dose of antidepressant medication for 1 month prior to the study, and be willing to remain on the same dose during the study.

Fig. 1 illustrates a flow chart of participants. Of the 27 participants who were ineligible, 18 (67%) did not have elevated CM scores, 6 had serious suicidality and/or substance dependence and 3 withdrew. The final sample was 52 (22%) of 241 participants who initially expressed interest. There were 58% females, age range 20–65 years ($M = 39.88$, SD = 11.88). No significant differences in gender ($F(2, 47) = 2.58$, $p = .086$) or age ($F(2, 47) = 0.698$, $p = .503$) were found between the three treatment conditions.

Measures

Self-report measures were utilised, with four different measures of perfectionism, one measure related to postulated mediating variables (dichotomous thinking), and five indicators of psychopathology.

Frost Multidimensional Perfectionism Scale (FMPS). The FMPS (Frost et al., 1990) was used to measure perfectionism. It is a reliable and valid 35-item measure consisting of Personal Standards (PS), Concern over Mistakes (CM), Doubts about Actions (DA), Parental Expectations (PE), Parental Criticism (PC), and Organisation (O). Only the CM and PS subscales of the FMPS were used as they comprise items that reflect "clinical perfectionism" (Riley et al., 2007) and main aspects of Positive Striving and Evaluative Concerns. There was good internal consistency ($\alpha = .84$ and $\alpha = .75$ respectively).

Clinical Perfectionism Questionnaire (CPQ). The CPQ (Fairburn, Cooper, & Shafran, 2003) is a 12-item questionnaire assessing levels of clinical perfectionism over the past month using a 4-point Likert scale ranging from 1 (not at all) to 4 (all of the time). It has good convergent validity (Chang & Sanna, 2012), internal consistency, and test-retest reliability (Dickie, Surgenor, Wilson, & McDowall, 2012), although current internal consistency was marginal ($\alpha = .69$).

Dysfunctional Attitude Scale (DAS) – Self Criticism (SC) subscale (Weissman & Beck, 1978). Independent factor analyses of the 40-item DAS have identified a 15 item self-criticism subscale (DAS-SC; e.g. Cane, Olinger, Gotlib, & Kuiper, 1986; Imber et al., 1990). Studies have confirmed that this construct is also indicative of the maladaptive, self-critical aspects of the evaluative concerns perfectionism construct (Dunkley, Sanislow, Grilo & McGlashan, 2004). The DAS-SC has been demonstrated to uniquely predict depressive symptoms, major depression and global psychosocial impairment over four years in a clinical sample after controlling for baseline assessments of these measures (Dunkley et al., 2004). It had good internal consistency ($\alpha = .91$) in this sample.

Dichotomous Thinking in Eating Disorders Scale (DTEDS). The DTEDS (Byrne, Cooper, & Fairburn, 2004) assesses dichotomous thinking over the past month using a 4-point Likert scale ("not at all true of me" to "very true of me"). Only the general dichotomous thinking subscale was used the eating subscale was excluded. It has good validity (Byrne, Allen, Dove, Watt, & Nathan, 2008) and acceptable internal consistency in this study ($\alpha = .79$).

Depression Anxiety and Stress Scale (DASS-21). The DASS-21 (Lovibond & Lovibond, 1995) was used to assess depression, anxiety and stress over the past week, it has good concurrent validity (Antony & Swinson, 1998) and good internal consistencies in this study: $\alpha = .87$ (Depression), .74 (Anxiety), and .84 (Stress).

Rosenberg Self–Esteem Scale (RSES). The RSES (Rosenberg, 1965) is a 10-item measure that was used to assess self-esteem

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