Cognitive-Behavioural Intervention in Diminishing Perfectionistic Self-Presentation and Depression

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Abstract

Perfectionism is a multidimensional concept widely researched for the last 30 years. The empirical literature on the relationship of perfectionism and depression suggests the connection between these two. Perfectionistic self-presentation represents one of the sides of perfectionism which seems to be related with higher depressive symptoms. The purpose of the current study is to investigate the efficiency of a cognitive-behavioural intervention in reducing perfectionistic self-presentation and depressive symptoms on a sample of subjects (N=64) which take part to a group therapy programs.

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1. Introduction

Perfectionism is a treat that most of the time negatively impacts one’s life. Perfectionism is a personality disposition characterized by an individual striving for flawlessness and setting excessively high performance standards, accompanied by overly critical self-evaluations and concerns regarding others' evaluations (Flett & Hewitt, 2002). Perfectionism is best conceptualized as a multidimensional personality characteristic (Frost et al., 1990; Hewitt & Flett, 1991; Shafran, Cooper, & Fairburn, 2002).


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Numerous studies using the multidimensional perfectionism model point to a positive correlation between depressive symptoms and perfectionism (Hill et al. 1997; Lynd-Stevenson & Hearne 1999; Enns & Cox 2002). In the past years, studies recorded aspects related to investigating the clinical and nonclinical population presenting depressive states and the effect that perfectionism has in this situation (Frost, Marten, Lahart, & Rosenblate, 1990; Flett, Barnes and Hewitt, 2001).

A recent study (Stoeber, Kempe, & Keogh, 2008) provided the first evidence that, under certain conditions, people with high levels of self-oriented perfectionism striving may experience more pride than people with low levels of self-oriented perfectionistic striving. The study investigated how facets of self-oriented perfectionism (perfectionistic striving, importance of being perfect) and socially prescribed perfectionism (others' high standards, conditional acceptance) predicted emotional reactions to success and failure.

Other recent studies (Hewitt, Flett, Ediger, 1995; Hewitt et al., 2003) bring to discussion another construct related to perfectionism, called perfectionistic self-presentation. Perfectionistic self-presentation originates from the idea that part of the perfectionist people are interested in presenting to others a flawless image, as if they never made mistakes and are preoccupied with trying to present themselves as perfect or defensively minimizing the number of mistakes that are on display for others to see (Hewitt et al., 2003). The quoted author points out there are three aspects that concern perfectionistic self-presentation: perfectionistic self-promotion, no display of imperfection, and nondisclosure of imperfection.

Perfectionistic self-presentation predicts unique variance over and above the variance attributable to maladaptive trait dimensions of perfectionism, such as socially prescribed perfectionism (Hewitt et al., 2003; Sherry, Hewitt, Flett, Lee-Bagley, & Hall, 2007).

Other studies report that perfectionistic self-presentation has been empirically linked with diminished self-esteem (Flett & Hewitt, 2002). Considering that diminished self-esteem is connected to the presence of depressive symptomatology we are entitled to emit the research hypothesis that perfectionistic self-presentation can be correlated to depressive symptomatology.

Many researchers have highlighted the role of cognitions and cognitive processes in perfectionism, such as selective attention (Hollender, 1978), dichotomous thinking, overgeneralization, “should” statements (Burns, 1980), overvaluing performance and undervaluing the self (Hamachek, 1978). In these conditions, where a series of developing cognitive processes are identified and maintaining perfectionism and also perfectionistic self-presentation, we expect that cognitive-behavioural interventions will be efficient in the attempt to change this distorted tableau of the clients.

In a study conducted on a clinical population, Shafran et al. (2002), making a cognitive-behavioural analysis, suggested the existence of four objectives that should be followed when dealing with perfectionism: (1) helping the person identify that perfectionism is a problem; (2) broadening the person’s scheme for self-evaluation and reducing their reliance on perfectionism as a means of self-evaluation; (3) behavioural experiments; and (4) using cognitive behavioural methods to deal with cognitive inaccuracies.

Fewer studies were registered where the cognitive-behavioural program had an effect on perfectionist tendencies, especially those related to perfectionistic self-presentation on a non-clinical population.

The cognitive-behavioural intervention is often used in the treatment of depression and depressive symptomatology. A study to address the specific treatment of residual depressive symptoms using CBT is a controlled trial of 158 patients with residual symptoms after an episode of major depressive disorder (Paykel et al., 1999; Scott et al., 2000). The cognitive behavioural model of depression describes diathesis in terms of dysfunctional schemas that are dormant until activated by congruent life experiences. It is proposed that these schemas code aspects of the self, world, and future in broadly maladaptive ways—for example, the self as a failure, the self as unlovable, the future as hopeless, the world as malevolent, and so forth (Beck, Rush, Shaw, 1979).

Many of the psychological processes activated in response to stressors can be thought of as automatic, in that they require few mental resources and they operate largely outside the individual’s control. Most prominent
among these automatic processes are intrusive and repetitive negative thoughts reflecting the content of the underlying schemas (Segal, Williams, Teasdale, 1996).

The aim of the present study was to investigate the efficiency of a cognitive-behavioural intervention in reducing perfectionistic self-presentation and depressive symptoms on a sample of subjects which take part to a group therapy program.

2. Method, participants and procedure

A sample of 64 individuals was selected by random sampling, including men and women aged between 23 and 60 years old, the mean age being 37.8 (SD= 11.01).

The participants whether formed cognitive-behavioural groups, or groups destined to treat social abilities, or support groups and were selected based on their informed approval.

Other sample characteristics were: Marital status: 27% married, 12.8% divorced, 25% cohabitation and 35.2% never married. Employment status: state-owned companies or private sector employees (44.7%), college and master-level students (55.3%).

The participants were informed about the purpose on which the research was based. The participants completed questionnaires in three different moments, at the beginning of the cognitive-behavioural group intervention, at its ending and a follow-up on a period of 6 months after the cognitive-behavioral program.

2.1. Measures

The following instruments have been used: Beck Depression Inventory (BDI, Beck, 1970) and Perfectionistic Self-Presentation Scale (PSPS; Hewitt et al., 2003). Also, the participants were asked to complete a series of questions requesting demographic information, such as their age, marital and employment status.

The Beck Depression Inventory (BDI, Beck, 1970, 1976) is a 21-question self-report inventory, one of the most widely used instruments for measuring the severity of depression. BDI contains 21 questions each answer being scored on a scale value of 0 to 3. The used cutoffs differ from the original: 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Higher total scores indicate more severe depressive symptoms.

Perfectionistic Self-Presentation Scale (PSPS; Hewitt et al., 2003). The PSPS is a 27-item multidimensional scale that assesses an individual’s need to appear perfect to others (Hewitt et al., 2003). The PSPS has three subscales that assess perfectionistic self-promotion, no display of imperfection and nondisclosure of imperfection. Extensive research has attested to the reliability and validity of the PSPS (Hewitt et al., 2003).

Research has indicated that the three PSPS factors have adequate levels of internal consistency and are significantly correlated with the MPS factors, but the PSPS factors account for a significant degree of unique variance in measures of self-esteem (Hewitt et al., 1995). The authors also reported that the three PSPS factors had high levels of test–retest reliability over a 2-month period, with test-retest correlations ranging from .74 to .84.

2.2. Intervention

The cognitive behavioral group therapy program was formulated based on therapeutic program proposed by Beck (2010) and Holdevici (2009) during 24 therapeutic sessions.

The main objectives settled by the members of the group in an individual meeting with the moderating therapist, previous to effectively participating to the group, sighted diminishing the depressive symptomatology and changing the dysfunctional schemas related to perfectionistic self-presentation.
During the group therapy activities, a general work agenda was built, having a clear structure which included the following steps: reviewing the main complaints; explaining to the subjects the cognitive model of depression and perfectionism; evaluating medication (where applied); periodical summary; evaluating the clients’ disposition; using feedback.

There were identified several techniques of automatic thinking, techniques of modifying the type of telegraphic thoughts, techniques of identifying emotions, techniques of using alternative questions about perfectionistic self-presentation, the disfunctional thoughts related to depression identification form, techniques of identification and modifying intermediary beliefs, modifying beliefs and using Socratic-type questions. According to the evolution of the participants, the initially settled work agenda was periodically checked and problem solving strategies were used, along with relaxation techniques and guided imagery exercises, behavioural experiments and ego strengthening techniques.

At the end, applying behavioural plan after the cognitive-behavioural intervention and the issue of relapse were discussed.

3. Results

The participants (N = 64) to this study have been investigated in three different moments, respectively before the cognitive-behavioural intervention, after its ending and a follow-up on a period of 6 months after the cognitive-behavioral program.

The statistic procedure used was the analysis of variance with repeated measures ANOVA. The results have shown that the cognitive-behavioural intervention, evaluated in the three phases of the study has a significant effect on the perfectionistic self-presentation (Pillai’s Trace = 0.502, F(2, 60) = 37.342, p = 0.000, \( \eta^2 \) partial = 0.502, observed power = 1).

Also, the results have shown that the cognitive-behavioural intervention evaluated in the three phases of the study has a significant effect on the depression level (Pillai’s Trace = 0.489, F(2, 60) = 35.375, p = 0.000, \( \eta^2 \) partial = 0.489, observed power = 1).

4. Discussion and conclusion

As indicated by our analyses the high level of depression decreases significantly after cognitive-behavioural intervention. This finding is consistent with those of prior studies (Butler, et al., 2006; Dimidjian et al., 2006; Fujisawa et al., 2010). Also, our results indicated that a part of the distorted beliefs specific to perfectionistic tendencies could be changed. These findings can be explained by the fact that the negative thoughts and negative beliefs can be replaced with positive, rational beliefs. These rational beliefs have an effect on behaviour changes, as they become adaptive. These results conform with those reported in a previous study showing that cognitive interventions can reduce perfectionistic concerns about mistakes and doubting actions (Ashbaugh et al., 2007).

Overall, these findings demonstrate the necessity of investigating the efficiency of cognitive-behavioural interventions in diminishing perfectionism and depressive symptoms. Further investigations using more data from larger number of subjects are required to better understand the mechanisms with which cognitive-behavioural methods lower this kind of problems.

References


