PERFECTIONISM

A Relational Approach to Conceptualization, Assessment, and Treatment

Paul L. Hewitt, Gordon L. Flett, and Samuel F. Mikail

ebook

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To my wife, Barbara Calvert, and our children,
Harris, JC, Jack, and Mac. And Henry and Barney, too.
—P. L. H.

To my wife, Kathleen; our daughters, Hayley and Alison;
and, of course, our beloved Toby.
—G. L. F.

To my mother, Samiha Sidrak, who always encouraged
us to do our best and never expected perfection.
This was the means by which she lived her own
personal, professional, and spiritual life.
—S. F. M.

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Preface

Our purpose in writing this book was not to review the extant research in the perfectionism literature, but to capture in one place our thinking, conceptual analyses, and both models and specifics of the individual and group psychotherapeutic treatment of perfectionism that we have been developing over the past 30 years. The work emphasizes several detailed models outlining our understanding of the multidimensional and multilevel nature of perfectionism; the development of perfectionism as arising from early childhood relational experiences; the mechanisms involved in perfectionism's role as a core vulnerability factor in many, many forms of dysfunction, distress, and disorders; and, finally, models explaining our individual and group psychotherapeutic treatment of perfectionism.

Although this book focuses on perfectionism, if you asked us what this book is about, we would answer quite simply, "It's about people." It is too easy to think of perfectionism as a personality construct that exists in and of itself, and to forget that perfectionism exists as a part of a complex person—usually a person in some kind of psychological pain. This volume is inspired by the countless people who have approached us as part of their ongoing search for help with their own perfectionism. Some of them have been willing to travel hundreds or thousands of miles because they are desperate for help and have not found local resources to deal with their perfectionistic behavior. These people usually tell us that their therapists or counselors did not address the specific issues and themes related to their perfectionism, or used a treatment approach that just did not seem very well suited to their daily lives and concerns.

The theme "This book is about people" is reflected in various ways. Our emphasis on a relational approach reflects our realization that for the vast majority of perfectionists, being able to help them requires

extensively considering the relationships in their lives, both past and present. This is just one of many reasons why we discuss perfectionism and especially its treatment in terms of attachment issues from a psychodynamic-relational perspective.

The importance of focusing on people is also reflected in the conceptual model of perfectionism outlined in this book. Readers may wonder, when considering perfectionism as a multidimensional entity, whether so many dimensions and factors are actually needed. The answer is "Yes!" Our emphasis on multiple trait, self-presentational, and self-relational dimensions is guided by the insights that arise when seeking to understand "what makes people tick." For instance, it became apparent early from Paul L. Hewitt's clinical work that many perfectionists' difficulties are not adequately captured by the trait dimensions we first outlined in our work in 1991. Although many perfectionists are trying to be perfect, there are many others whose perfectionism is self-presentational; that is, they are primarily invested in trying to seem perfect or appear perfect. Self-presentational perfectionists are dominated by a false sense of self and chronic concerns about acceptance and fitting in the world. Their overarching fear is that other people will discover their imperfections.

PERFECTIONISM PARADOXES

Two particularly intriguing paradoxes with perfectionism have captured our attention and have dominated our thinking over the past several years. First, why does perfectionism persist, given its costs? An individual who requires perfection for him- or herself and fails (the only possible outcome, as far as we know) experiences intense self-blame, self-criticism, and aversive emotions including shame, guilt, and depressive affect—all different ways of saying "self-punishment." In the face of such punishment and lack of reward, why would perfectionism persist and come to dominate an individual's life? This directly contravenes decades of research and thought on reinforcement, which indicate that when negative consequences occur in relation to some behavior, that behavior decreases in frequency. (In fact, the "law of effect" states that punishment reduces or extinguishes behavior.) This seems not to be the case with perfectionism, in which individuals (especially those who are seen in treatment) hold tightly to their perfectionistic behavior, even at times increasing the behavior to make up for past mistakes. All this makes perfectionism a particularly difficult clinical problem to tackle. Moreover, perfectionists also experience little if any self-reward, regardless of the quality of their performances. This made us wonder: What maintains the perfectionistic behavior in the face of lack of reward and

significant punishment? It would seem that perfectionistic behavior has a powerful purpose or role in a person's life.

The second paradox reflects the theme introduced earlier: Perfectionism, at its core, is rooted in the relational world of the individual. It also reflects that perfectionism is the result of one of the most basic motivating forces among humans: the need to attain a sense of felt security and self-regard through being accepted, respected, and cared for, and mattering to others—in essence, a sense of belonging. The paradox is illustrated in our expanded perfectionism social disconnection model (PSDM; Hewitt, Flett, Sherry, & Caelian, 2006; see Chapters 4 and 5 of this volume), wherein individuals develop and engage in perfectionistic behavior with the ultimate goal of enhancing their connectedness with others. Yet the perfectionistic behavior produces a lack of closeness, intimacy, and connection with others, and results in alienation and belief in one's defectiveness and separateness from others. This is an excellent example of the neurotic paradox, whereby the perfectionistic individual actually creates the situation he or she fears the most and has been absolutely driven to avoid.

Although there are many disagreements in the perfectionism literature—most of them reflecting definitional concerns regarding what constitutes perfectionism and how to measure it—there seems to be agreement that perfectionistic behavior arises from early relationships. These early relationships are most often with primary caregivers and involve early experiences of insecurity and unfulfilled (or, at best, tenuously fulfilled) needs to be accepted, loved, and noticed, and to avoid rejection, abandonment, and negative affective states of shame, humiliation, and despair. The emphasis of much of our thinking about perfectionism, and especially the treatment, lies in the development of perfectionistic behavior.

THEORETICAL/CONCEPTUAL ANALYSIS

In an extremely thought-provoking article published in the *American Psychologist* in 2007, Armando Machado and Francisco Silva reminded us that three elements of science are fundamental to understanding processes, be they processes in nature or processes in human behavior. These elements, as they point out, were first elucidated by Galileo Galilei and involve experimentation (i.e., testing hypotheses), mathematization (i.e., mathematical analysis of data), and theoretical/conceptual analysis (i.e., clarifying and refining the concepts used in hypotheses, models, and theories). They argued that although the field of psychology has emphasized and valued the first two elements, the field has placed

much less emphasis on conceptual analysis. This article resonated powerfully with us, and we believe that it captures the state of perfectionism research. For example, many articles in the field provide analyses and findings regarding relationships between perfectionism and outcomes, but these papers are often not really testing a particular theory of perfectionistic behavior and, because of this, may not advance our understanding of the perfectionism construct. There are numerous conceptual concerns in the literature, and one of the difficulties, we believe, is the lack of good comprehensive conceptual models of perfectionistic behavior. We have attempted to address this in the book by outlining a descriptive model, a causal model, and a model of treatment that has evolved over the years. The models' development has been guided by the clinical work of Paul L. Hewitt and Samuel F. Mikail, and by the consultation and research that all three of us have conducted. We hope that the models will provide ways to understand and treat perfectionism, act as springboards for further research on the construct and its relation to difficulties that people experience, and refine the assessment and treatment of perfectionism.

A case in point is the concept of "adaptive perfectionism," which seems to have arisen originally from a paper by Hamachek (1978), who argued that perfectionism could have adaptive outcomes. Hamachek described a kind of perfectionism known as "normal perfectionism." Although many articles use the concepts of adaptive, normal, or healthy perfectionism, there is little conceptual clarity with respect to what is adaptive about adaptive perfectionism and what the nature of perfectionism is in adaptive perfectionism. For example, researchers seem to have operationalized adaptive or healthy perfectionism in a multitude of ways, as well as to have used a multitude of terms to name this construct (see Blasberg, Hewitt, Flett, Sherry, & Chen, 2016). We have argued that what others have termed "adaptive perfectionism" is actually the need for achievement, or even excessive conscientiousness, and as such would be a potentially beneficial personality trait (also see Greenspon, 2000; Pacht, 1984). There are decades of research on the need for achievement and its predecessor, level of aspiration, and even more work on conscientiousness. Adaptive perfectionism has not been distinguished from these other notions, conceptually or empirically. Simply renaming the construct as "adaptive perfectionism" obscures it.

These issues notwithstanding, our primary reason for not embracing adaptive perfectionism comes back to the people we see for treatment. We have encountered far too many individuals who have been driven to the brink of despair by their perfectionism. Some of these individuals can be quite accomplished and successful according to objective criteria, but it often seems as if their achievements are secrets that have

been kept from them. That is, they have lived their lives and evaluated themselves by expectations, either their own or others', that are impossible to meet. As a result, they have seldom experienced a sense of satisfaction. The people who may be especially at risk are those perfectionists who have actually had some significant accomplishments. These people are in jeopardy in two key respects. First, what is next for the perfectionists who achieve an exceptional performance, feat, or accomplishment? What do they do for an encore? These people cannot take time to enjoy their accomplishments, because they are quickly preoccupied with the sense that now the expectation level is even higher and the pressure is even greater to maintain this level. A poignant illustration is one of Hewitt's patients, who received a coveted promotion at work following a period when he was producing extremely well. The patient, after receiving the promotion, was riddled with anxiety and despair over the "fact" that "now everyone will expect me always to perform at this level."

Second, perfectionistic people are at risk because they have lived much of their lives according to a central principle: "If I am perfect, then something highly valued will ensue, or some horrific occurrence will not ensue. For example, other people will give me the love, attention, respect, comfort, or acceptance I have longed for." Unfortunately, in real life the contract is often not lived up to; the pursuit of perfect performance, in and of itself, typically does not yield sustained improvements on the interpersonal front.

It is also important for clinicians to consider the reasons why someone is perfectionistic and what purpose his or her perfectionism serves. Due to the multifarious nature of perfectionistic behavior, perfectionism can be complex, and individuals with the personality style can be heterogeneous in their manifestations of the perfectionism, the developmental routes they take to perfectionism, and the kinds of difficulties arising from the perfectionism. It is important to pay attention to the complexity of perfectionism in research efforts and, perhaps more importantly, in conducting clinical work with those experiencing distress and psychological pain as a result of their perfectionistic tendencies. It is for this reason that a dynamic-relational approach is very well suited to perfectionism—both to understanding it and to treating it.

As has been indicated numerous times (Bornstein, 2005; Bornstein & Masling, 1998; Linden & Hewitt, 2012; Shedler, 2006, 2010), many students of clinical psychology have a rather misguided or misinformed understanding of psychodynamic and psychoanalytic research and treatment. In fact, many apparently hold to the erroneous beliefs that psychodynamic and psychoanalytic therapies do not have empirical validation, that there has been little or no development of psychoanalytic theory since Freud's death, and that little research has been done on psychoanalytic

concepts and theories (see Bornstein, 2005; Shedler, 2006). This could not be further from the truth (see Bornstein & Masling, 1998; Gibbons, Crits-Christoph, & Hearon, 2009; Leichsenring & Rabung, 2008; Levy & Ablon, 2009; Masling, 1986, 1990; PDM Task Force, 2006; Shedler, 2010). We hope that the description of our models in this book and the specifics of our treatments will help to inform others of this fact.

We also hope that the discussion in this book serves as a catalyst for future work that will aid in the further understanding of perfectionism and alleviation of attendant difficulties. At present, there are more questions than answers when it comes to perfectionism, but we hope that this volume helps in getting us closer to understanding perfectionistic behavior and addressing the personal, familial, and societal factors that contribute to its development.

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We are thankful for the many interested and talented researchers and clinicians who have been captured by the construct of perfectionism and who have moved the field ahead with their work. Their writings have influenced our thinking, the kinds of research questions we have posed, and the models that have arisen.

We would especially like to thank the numerous people who provided valuable feedback at various points in the completion of this work, including Simon Sherry, Chang Chen, Xiaolei Deng, Taryn Nepon, Marie Habke, Carol Flynn, Brandy McGee, Sue Song, and Joanne Zhou. We would also like to thank the many other undergraduate, graduate, and postdoctoral students who have contributed to our research, as well as the many scholars who have contributed to the burgeoning literature over the years.

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Perfectionism assessment measures discussed in the text are available at *www.guilford.com/hewitt-materials*.

CHAPTER 1

Introduction to Perfectionism

This book outlines our unique conceptualization of perfectionism, as well as assessment and treatment approaches for it. It represents the culmination of over two decades of research and clinical work on this topic. Our primary purpose for writing this book is to offer insight into the complex construct of perfectionism—not only as a personality style involving traits and relational elements, but also as a clinically relevant personality vulnerability factor that predisposes individuals to myriad problems. We also provide information on appropriate assessment and treatment of those people who are paying a significant personal price for their perfectionism.

THE COSTS OF PERFECTIONISM

We view perfectionism in terms of its costs. Although perfectionism may sometimes yield some tangible benefits (such as higher levels of accomplishment), we regard it as a core personality vulnerability factor that is likely to have significant negative consequences, especially when misfortunes, shortfalls, and other life stressors are experienced. If viewed from this perspective, perfectionism represents an approach to life that makes stressors and failures not only more aversive and distressing, but also more likely to occur (see Hewitt & Flett, 2002). That is, pursuing extreme and unrealistic requirements, or having extreme and unrealistic requirements imposed on the self, constitutes a tormenting way of going through life. When a perfectionistic person is unable to modify his or her requirement for perfection in all contexts, the intransigence ends up generating significant, unnecessary distress and potential health problems.

It will become evident throughout this book that perfectionistic people often present complex clinical pictures. It is essential to find appropriate means to work with the difficulties and psychological pain these people experience. The complexity of these clinical problems is not surprising, because, as an ingrained personality style, perfectionism is a multifarious construct that operates on many levels. Perfectionists are driven to attain the impossible, if we accept the axiom that no one is or can be perfect. Yet these individuals continue to require perfection. At some level, perfectionistic people have come to function as if perfection is attainable, and to believe that attaining perfection or getting closer to perfection will somehow enhance their lives.

The issue of whether perfectionism is adaptive has been a matter of debate in recent years. What is beyond debate is the notion that perfectionism can be highly dysfunctional and can undermine an individual's interpersonal and emotional functioning. Indeed, for some people, it seems that perfectionism can be deadly, as illustrated by its link with early mortality (Fry & Debats, 2009) and with a heightened risk of suicide (Blatt, 1995; Flett, Hewitt, & Heisel, 2014; Flett, Molnar, Sirois, & Hewitt, in press; Hewitt, Flett, Sherry, & Caelian, 2006; O'Connor, 2007). Another compelling indicator of the pernicious nature of perfectionism is the personal distress that troubles perfectionists who are successful by objective standards; they do not seem to recognize any success or find it possible to enjoy their accomplishments (see Blatt, 1995). Instead, they experience an emptiness in their attainments. Perfectionists who achieve success are often so self-denigrating that they will endorse such beliefs as "Well, I know I finally made it, but I shouldn't have had to try so hard," "Now I will be expected to perform even better next time," or "Nothing has gotten better in my life, so I obviously did not perform perfectly enough." This mentality deprives them of any sense of self-satisfaction and enjoyment and can turn even excellent performances into abject failures, at least in their own eyes (see Hewitt & Flett, 2002). Given these potential costs, a reasonable question is this: Why not strive for excellence rather than absolute perfection? Why is it that some people must be perfect, rather than simply preferring to be almost perfect or good enough? Why isn't being conscientious sufficient for some people? The all-or-none, driven approach—the belief that perfection is both possible and an absolute requirement, despite the costs—convinces us that perfectionism is maladaptive and motivated by forces both inside and outside the self.

In this introductory chapter, we overview what some seminal writers in the area have written about perfectionism as an important clinical variable, and we also highlight some key themes that recur throughout this book. Chapter 2 introduces our comprehensive model

of perfectionistic behavior (CMPB). Based on over 30 years of research and clinical work, the CMPB depicts perfectionism as a multifaceted and multilevel personality style that confers vulnerability to many forms of pathology.

Chapter 3 makes the case for the clinical relevance of perfectionism by describing research linking our conceptualization of perfectionism with a wide variety of clinical disorders. We argue that perfectionism reflects a complex personality factor that interferes with the process of seeking appropriate help, establishing and maintaining relationships with helpers, and benefiting from psychotherapeutic interventions.

The precursors, causes, and drivers of perfectionism are then detailed in three important models we present in this book. Chapters 4 and 5 present our perfectionism social disconnection model (PSDM), with Chapter 4 focusing on how perfectionism develops, and Chapter 5 focusing on the mechanisms that contribute to distress and impairment. Chapter 6 presents our theoretical model for treatment of perfectionistic behavior. This model provides a framework for understanding idiosyncratic patterns involving perfectionism, and it aids in assessment, clinical formulation, and individualization of treatment. Chapter 7 offers guidelines for psychodiagnostic assessment of perfectionism and case formulation. The perfectionism assessment measures are available online (see the box at the end of the table of contents). Chapter 8 illustrates various aspects of perfectionistic behavior and its assessment through detailed discussion of four cases, along with their assessment findings and case formulations. Chapter 9 describes our approach to individual psychotherapy of perfectionism and illustrates the use of the treatment framework outlined in Chapter 6. An extension of the individual treatment to a group psychotherapy format is presented in Chapter 10.

TREATING UNDERLYING CAUSES VERSUS SYMPTOMS

A great deal of attention has been given to evaluating the appropriateness of particular psychotherapeutic approaches since the publication of Eysenck's (1952) provocative article suggesting that psychotherapy is not effective. Even though psychotherapy approaches have been examined empirically over the decades (see Bergin & Garfield's multiple-volume works for descriptions [e.g., Lambert, 2013]), in recent years psychotherapy researchers have placed considerable emphasis on developing guidelines to establish specific criteria for determining whether psychotherapeutic treatments are empirically supported. The work appears to stem from conclusions drawn early in psychotherapy research in response to the "dodo bird verdict" (Luborsky, Singer, & Luborsky,

1975; Rosenzweig, 1936), whereby disparate treatments were found to be essentially equal in producing treatment effects. The predominant response to the dodo bird verdict was to shift research away from pitting one treatment approach against another, and toward identifying which treatment is most effective for which disorder (e.g., Beutler, 1991). This has been referred to as the "treatment × individual" interaction, and there have been important findings indicating which treatments have empirical support for particular homogeneous groups based on *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses. In these studies, the "individual" is most often defined as a diagnostic category for one and only one disorder. This approach assumes homogeneity of the diagnostic group; it does not take into account substantial and substantive individual differences and environmental contexts and influences in those individuals constituting the group. In contrast, our approach recognizes the need to tailor treatment to each individual's needs, and to acknowledge that two people can be described as perfectionists yet can vary substantially in the factors that contribute to their perfectionism and the ways it is expressed.

Many writers have raised similar issues in psychotherapy research over the years (Beutler, 1991; Cronbach, 1953; Garfield, 1994). Blatt, Auerbach, Zuroff, and Shahar (2006) described intervention research that supports the role of personality and individual differences in affecting treatment process and treatment outcome. This approach truly puts the *individual* back into the treatment × individual interaction. In essence, Blatt's work focuses on two personality styles (i.e., the self-critical style and dependent style) and associated developmental pathways that have significant influences on the nature and effectiveness of psychopathology and psychotherapy. These influences are significant, regardless of the type of psychotherapy conducted. Moreover, both of these developmental pathways have direct implications for our work on perfectionism.

We are in agreement with the idea of concentrating on personality characteristics rather than symptoms in psychotherapeutic treatment, and we have raised this issue specifically in terms of perfectionistic behavior (e.g., Hewitt, Habke, Lee-Baggley, Sherry, & Flett, 2008). Thus we would agree with many others that symptoms of DSM-based disorders or syndromes can best be seen as expressions of underlying processes that are dysfunctional. This theme is reflected in a great deal of research and theorizing from traditional and contemporary psychoanalytic and psychodynamic work on attachment styles and underlying mechanisms of dysfunction.

A basic premise guiding our work is that treatment in general, and the treatment of perfectionistic individuals in particular, needs to focus on "patient characteristics and personality vulnerabilities that

bear directly and indirectly on the psychopathology the patient exhibits rather than on the symptoms of the clinical syndrome *per se*" (Hewitt et al., 2008, p. 116). This is analogous to focusing treatment not solely on the fever and headache experienced by a physically ill person, but also on the putative cause of the fever and headache.

We briefly argue that perfectionism is an important personality variable by describing what some of the seminal writers from the past, as well as more contemporary writers, have said about the importance of perfectionistic behavior. We also discuss some relevant themes regarding the complexity of perfectionism that appear throughout the book. In order to make the discussion come more alive for readers, we provide descriptions of individual patients and the nature of their perfectionism in this chapter and throughout the rest of this book.

THE HISTORICAL IMPORTANCE OF PERFECTIONISM

We believe it is essential to acknowledge and describe the work of classic theorists who have discussed the clinical relevance of perfectionism, and who have greatly informed our theorizing, research, and clinical work. These authors continue to have an impact on the perfectionism literature, even though they have long since passed away. In particular, we express our admiration for, and acknowledge the seminal work of, Alfred Adler, Karen Horney, Hilde Bruch, and Harry Stack Sullivan. Moreover, we wish to underscore the more contemporary contributions of Asher Pacht and Sidney Blatt in helping to clarify the importance of perfectionism as a pernicious personality style. It is also important to acknowledge Leon Salzman, Thomas Greenspon, and Ben Sorotzkin; their insightful contributions to the treatment of perfectionism have provided important frameworks for therapy with individuals with perfectionistic tendencies. The clinical relevance of studying perfectionism is reflected by the fact that all of these authors have been recognized as master clinicians demonstrating their astute insights into the nature of humans suffering from problems in living. Each contributor has discussed the concept of perfectionistic behavior as an important feature and potential cause of individuals' suffering, and has described how perfectionism is an important focus in alleviating that suffering.

The importance of perfectionism, and the need to focus specifically on the underlying themes that drive perfectionism, constitute a viewpoint that was originally expressed in the seminal writings of Alfred Adler and Karen Horney. In the sections below, we provide brief overviews of their beliefs about the nature of perfectionism, as well as some of their insights about the therapeutic focus.

Alfred Adler and Perfectionism

The theorizing on perfectionism really began with Alfred Adler's work. According to Adler, feelings of inferiority represent a basic, universal element of human existence. That is, every person experiences an "inferiority complex" that can be addressed in either an adaptive or a maladaptive manner. Adler (1938/1998) emphasized the unity of psychological life; he suggested that, to some degree, everyone has a form of psychological movement that is purposeful and focused adaptively on overcoming personal difficulties in order to achieve the goal of perfection.

Adler also hypothesized the presence of a "superiority complex" that is designed to compensate for feelings of inferiority and mask the presence of the inferiority complex. For certain individuals, the superiority complex can involve a complete lack of social interest as the person "aims for the glitter of personal conquest" (1938/1998, p. 38). The superiority complex involves a conscious sense of possessing superhuman gifts and abilities, and a tendency to make extreme demands of both self and others. The superiority complex is both expressed and experienced in idiosyncratic ways; this is a source of individual differences in Adler's approach, known as "individual psychology." Some people take their superiority strivings to the extreme by striving for a godlike perfection. Adler (1938/1998) posited that these individuals are "perpetually comparing themselves with the unattainable ideal of perfection, are always possessed and spurred on by a sense of inferiority" (pp. 35–36).

Anxiety is one of the most tangible and obvious indicators of the inferiority complex, and Adler observed further that some people develop a compulsion neurosis as feelings of anxiety mount. They try to overcome this anxiety by achieving a level of perfection that highlights their superiority relative to other people. Adler illustrated compulsion neuroses in 12 case study vignettes, including one in particular that clearly reflected perfectionism. He described a man in an insane asylum who had suffered since childhood from memories of a mistake he had made as a child in kindergarten that he had kept hidden from his teacher. He could not stop thinking about this mistake for 2 years, so he eventually took his father's advice and confessed his mistake to his kindergarten teacher. Unfortunately, he had already adopted a pattern of compensating for this mistake by striving for a godlike superiority and perfection. Adler noted that later, as an adult, this man had considerable accomplishments, but tended to fall apart whenever life circumstances tested his capabilities and the neurotic compulsion came to the fore once again. His desire to be great fused with his sense of inferiority when he had a breakdown during a church service: He threw himself on the floor

in front of the congregation, proclaiming himself to be the greatest sinner on earth (Adler, cited in Ansbacher & Ansbacher, 1979).

Adler's views on treatment goals are very much in keeping with our own views, in that Adler suggested that when strivings produce dysfunction, there is little benefit in focusing therapeutic interventions solely on symptoms. Rather, he indicated that "we must look below the surface . . . for the underlying coherence, for the unity of the personality. This unity is fixed in all its expressions" (Adler, 1931/1958, p. 59). And this unity is linked inextricably with underlying neurotic tendencies, feelings of inferiority, and deficits in social interest.

Karen Horney and Perfectionism

As part of her cultural views on personality and human adjustment, Karen Horney (1950) outlined several contradictions that confront every person. One contradiction is the need to be competitive and successful versus the need for love, affiliation, and humility. This is the classic conflict inherent in focusing on our own accomplishments versus yielding to others and promoting their welfare. A related contradiction is the stimulation of our idealistic needs versus the pain and frustration associated with being unable to attain these ideals. Horney (1950) recognized that we are bombarded with cultural images and messages about what constitutes an "ideal life," but we are troubled because most people's lives fall far short of this ideal.

According to Horney (1950), neurosis is rooted in early life experiences and is a reflection of basic anxiety and basic hostility. "Basic anxiety" is a fear of helplessness and worries about possible abandonment. It occurs when important needs are not met. A child may also develop a sense of "basic hostility" as a response to parental indifference and neglect. Because the child is fearful about what will happen after expressing basic hostility, this hostility is not openly displayed. Horney posited that neurosis becomes reflected in 10 neurotic needs that reflect our conflicting desires to move simultaneously toward people, away from people, and against people. One of the 10 needs identified by Horney is the neurotic need for perfection and unassailability.

Horney (1945/1972), in her classic book *Our Inner Conflicts,* suggested that an individual has two ways of addressing neurotic conflicts. The first way is to engage in repression and banish the conflict from awareness. The second way is to create an idealized image of the perfect self that the individual views as attainable. It is in her discussion of the idealized image that we get a sense of Horney's views about the folly of striving for perfection. She characterized such striving as dooming an individual to failure and reflecting an intolerable life situation that

restricts personal development. Horney also identified the interpersonal manifestations of perfectionism in a manner that has had a profound influence on our conceptualizations of the perfectionism construct. For instance, Horney (1945/1972) suggested that addressing neurotic conflicts via perfectionism often takes the form of lording these standards over people and "swinging those standards as a whip over others" (p. 113). This was a forerunner to our concept of "other-oriented perfectionism," the requirement that others be perfect (Hewitt & Flett, 1991a; Hewitt, Mittelstaedt, & Wollert, 1989; see Chapter 2 of this book). Horney also discussed externalization and suggested that neurotic conflicts expressed as perfectionism include a hypersensitivity to any sort of demands and external pressures placed on the self. This paved the way for our concept of "socially prescribed perfectionism" (again, see Chapter 2).

Horney (1950) stated that individuals who attempt to live up to their ideal selves not only have an overdependence on others, but also fear making mistakes and have a decided hypersensitivity to criticism. The consequence of this conflict is to "ward off disconfirmation . . . by covering up personal flaws before others become aware of them" (Horney, 1950, p. 120). This influenced our concept of "perfectionistic self-presentation" (i.e., the drive to be seen by others as perfect; see Chapter 2 and Hewitt, Flett, Sherry, et al., 2003). A key point raised by Horney (1945/1972) is that perfectionism and the idealized image contribute to a range of negative emotions that goes beyond the obvious links with anxiety. In particular, Horney focused on a form of rage that is often directed not only at others, but also at the self when it becomes evident that the person is unable to live up to the idealized image of the perfect self. Indeed, we have often found in our clinical work that a profound sense of anger and hostility seems to pervade many perfectionistic individuals. This anger, although not always immediately apparent or expressed openly, is directed both at the self and at others.

We also acknowledge the seminal work conducted by Hilde Bruch on the nature and etiology of anorexia nervosa (e.g., Bruch, 1962) and her acknowledgment of how perfectionism involves self-concept issues rooted in the interpersonal context. Initially, she described how the anorexic girls she treated were driven to achieve perfect grades and how this could be traced back to the unresolved psychological needs of the girls' mothers and fathers. Her views about the role and nature of perfectionism were elaborated in several influential books that were punctuated by Bruch's remarkable clinical insights (see Bruch, 1973, 1988). This work by Bruch foreshadowed the current emphasis on socially imposed factors. She discussed the pressures to conform that face adolescent girls and the problems that ensue when it is not possible to meet demands

to be perfect. In her final book, titled *Conversations with Anorexics* (Bruch, 1988), Bruch outlined views similar to those expressed by Horney in concluding that perfectionism is largely a façade designed to cover up a highly inadequate self. For instance, she observed:

> Deep down, every anorexic [girl] is convinced that basically she is inadequate, low, mediocre, inferior, and despised by others. She lives in an imaginary world with an assumed reality where she feels that people around her—her family, her friends, and the world at large—look down on her with disapproving eyes, ready to pounce on her with criticism. The image of human behavior and interaction that an anorexic constructs in her apparently well-functioning home is one of surprising cynicism, pessimism, and bitterness. All her efforts, her striving for perfection and excessive thinness, are directed toward hiding the fatal flaw of her fundamental inadequacy. (Bruch, 1988, p. 6)

This passage reflects a central theme of this book: For many people, perfectionism involves negative views of the self and either a negative or uncertain sense of personal identity.

Finally, Horney (1950) also dispensed with the notion that perfectionism is a self-determined, positive form of striving. She emphasized that perfectionism is actually a reflection of an "inner coercion" or "inner pressure" that is often directed jointly at the self and at others. Horney (1945/1972) maintained that the pressure can progress to the point that "the personality is cramped by the authoritative control of the idealized image" (p. 123). We have come to appreciate this emphasis on an inner compulsion and have increasingly come to regard self-oriented perfectionism (the requirement of perfection for oneself) not as a form of autonomous intrinsic motivation, as we suggested originally (Hewitt & Flett, 1991a), but as an inner-directed, "introjected requirement" that aligns nicely with the distinction made by Albert Ellis (2002) between wanting to be perfect and feeling that perfection *absolutely must be obtained*. For Ellis (2002), the latter form of perfectionism attaches an irrational importance to being perfect and to making no mistakes whatsoever.

As a master clinician, what did Horney recommend for treatment? At the root of her psychoanalytic treatment were promoting an awareness of the true self and living life in accordance with the true self, rather than living according to the wishes and desires of other people or society in general (see Horney, 1999). Her observations were quite comparable to the later views of Carl Rogers and his discussion of a conditional sense of self-worth that rendered people vulnerable. According to Horney (1950), one by-product of losing touch with or suppressing the actual self is that people with this neurotic conflict are not in touch with their

true emotions. Thus, for Horney, a key element of the recovery process is learning how to experience and understand actual emotions such as the basic hostility and resentment that may have developed early in childhood. Finally, Horney was a rich source of clinical observations. Many of these observations have been summarized in a book titled *The Therapeutic Process* (Horney, 1999). This book includes the theme of replacing self-idealization with self-realization—a topic to which we return later in this chapter.

Harry Stack Sullivan and Personality

Harry Stack Sullivan did not discuss perfectionism per se, but his influence is reflected here in terms of an interpersonal approach to the conceptualization of perfectionism. Sullivan's views are summarized in his 1953 book *The Interpersonal Theory of Psychiatry*. His theory rests on the basic premise that "personality" has meaning only in how people interact with each other; he also emphasized that in the initial stages of development, parents play a crucial role. He defined personality as "the relatively enduring pattern of recurrent interpersonal situations which characterize a human life" (Sullivan, 1953, pp. 110–111). Sullivan`s theory was a broad influence on the interpersonal components of perfectionism in our model—that is, how perfectionism is expressed and experienced within the context of relationships with other people.

A key element of Sullivan`s theory has direct implications for the association between perfectionism and anxiety, which is another theme we elaborate later in this chapter. Sullivan's work focused on the precursors and the manifestations of anxiety; like Freud, he saw anxiety as playing a key motivational role. He was particularly concerned with the way in which early social relationships set the stage for anxiety. He suggested that perceived lack of love and caring from significant others results in insecurity and anxiety, because the child is totally dependent on significant others.

A third aspect of Sullivan`s theory has influenced our model of perfectionism and psychopathology, now called the PSDM (Hewitt et al., 2006). The importance of social connection is discussed in more detail later, and the model itself is outlined more fully in Chapters 4 and 5. Our basic premise is that people with excessive levels of perfectionism are at risk because they perceive themselves as, or have actually become, disconnected and alienated from other people (see Hewitt et al., 2006). Sullivan introduced similar themes partly because of his own experiences: He was an only child, led an isolated existence detached from peers, and suffered from profound loneliness. His developmental experience is particularly

interesting in light of his conclusion that an only child is almost always pampered and restrained from developing a realistic self-appraisal system. This restriction is problematic because it contributes to a lack of acceptance by the child's peers (see Perry, 1982). Sullivan suggested that these tendencies and experiences decrease the possibility of developing a complete personality. Clearly, this lack of acceptance and limited social integration can be debilitating for people with a strong need for social approval, which is a core feature of perfectionism.

CONTEMPORARY PERFECTIONISM THEORISTS AND RESEARCHERS

Asher Pacht

Asher Pacht's contributions to the perfectionism field also deserve mention. Pacht (1984) did not go on to make extensive contributions to the perfectionism literature, but in an invited address as president of the American Psychological Association, he made several observations that continue to ring true, and this timely statement paved the way for subsequent empirical developments. First, he stated that he picked perfectionism as the topic for his address because "it is such a recurrent theme among people I see in all aspects of my professional work" (p. 386). He was one of the first to allude to the pervasiveness of perfectionism and related problems.

Second, Pacht rejected the notion of "normal perfectionism" and suggested that we need to reexamine this concept from a definitional perspective. His comments still apply today. Specifically, he stated:

> Unlike Hamachek [1978], however, I prefer not to use the label "normal perfectionism." Other labels appear more appropriate, and even he suggests the similarity of normal perfectionism to "skilled artists or careful workers or masters of their craft" (p. 27). The insidious nature of perfectionism leads me to use the label only when describing a kind of psychopathology. (Pacht, 1984, p. 387)

Pacht (1984) also provided a clear account of the suffering that accompanies perfectionism, and he made particular note of the chronic dissatisfaction found among perfectionistic individuals.

Third, Pacht's (1984) sage observations culminated in a composite sketch of perfectionists as people who are striving to convince their parents that they are lovable after all. With that in mind, he offered some clear statements about what is needed in treating perfectionists:

> In almost all of these cases, there is a need to help patients achieve a separation from their parents and an individuation of self before they can modify the value system that demands that they be perfect. (p. 388)

> The prerequisites include: strong motivation; the ability to develop a close caring therapeutic relationship; agreement on the goals of therapy, including the important subgoals; reasonable ego strength, and a recognition that therapy may be painful. . . . therapy with these patients requires maximum flexibility in approach. I use any technique with which I am comfortable that will help lure individuals away from their persistent patterns of obsessive thinking and compulsive behavior over which they have little control. . . . Key goals include accepting imperfection and recognizing that the goal is some change rather than "180 degrees of change." (p. 389)

Several of these themes are addressed at length later in this book, because we have found them to be exceptionally relevant.

Sidney Blatt

Sidney Blatt`s contributions to the study and treatment of perfectionism began with his work on depression and the roles of the self-critical, introjective style and the dependent, anaclitic style (Blatt, 2004; Blatt, D`Affliti, & Quinlan, 1976). His two primary contributions to the field of perfectionism are his seminal paper on the destructiveness of perfectionism (Blatt, 1995) and his work on the role of perfectionism in treatment outcome. His article on the destructiveness of perfectionism illustrated, through case examples, that perfectionists can be objectively successful but nevertheless painfully distressed to the extent that they take their own lives. This article heightened interest in research designed to understand perfectionistic individuals. Meanwhile, at the treatment level, Blatt (1992) analyzed data from the Menninger Psychotherapy Research Project and found that patients with strong perfectionistic tendencies responded better to long-term, intensive psychoanalytically oriented treatment than to short-term (Blatt & Ford, 1994) or other forms of treatment (see Blatt & Zuroff, 2002). Blatt, Quinlan, Pilkonis, and Shea (1995) observed that therapists are seeking to change personality structure when treating problems related to perfectionism, and that this focus requires a complex treatment approach that must unfold over a longer time period. In addition, Blatt's work with David Zuroff involving the reexamination of data from the Treatment of Depression Collaborative Research Program (TDCRP; summarized in Blatt & Zuroff, 2002) provided important evidence that personality variables such as perfectionism need to be targeted in order to reduce relapse, aid in establishing

therapeutic alliance, and help patients gain benefit from treatment. This work was pivotal in guiding some of our research on the role of perfectionism in clinical contexts, including the initial clinical interview (Hewitt et al., 2008) and psychotherapy (Hewitt, Dang, et al., 2016).

Leon Salzman, Thomas Greenspon, and Ben Sorotzkin

The three other contributors acknowledged earlier, Leon Salzman, Thomas Greenspon, and Ben Sorotzkin, have all discussed the importance of focusing treatment on perfectionism. Salzman, in *Treatment of the Obsessive Personality* (Salzman, 1980), underscored the importance of dealing with perfectionism directly in the treatment of obsessive disorders. He indicated that perfectionistic behavior can lead to a variety of complications in psychotherapy, especially because of the individual's defensiveness, inability to admit deficiencies, hostile attacks on the therapist, "tendency to think and live in the extremes" (p. 205), and omnipresent conflict between needing others and needing to be seen as perfect. Moreover, he discussed the inability to form a collaborative therapeutic relationship among the difficulties encountered in treatment. The ideas expressed by Salzman underscore the importance of the therapist's awareness of a patient's perfectionism and how it can influence treatment for any disorder. Thus knowledge of the patient's personality features, regardless of the specific disorder, is pivotal to effective treatment. Salzman's ideas are a salient reminder that this kind of personality style can have a significant impact on the treatment process and outcome.

The writings of Greenspon are consistent with our views of the genesis, relevance, and treatment of perfectionistic behavior. Describing specifics of the perfectionism construct, developmental pathways, and treatment issues, he presented a cogent account of conceptual issues (Greenspon, 2000, 2014) and treatment processes (Greenspon, 2008). Similarly, Sorotzkin's descriptions of narcissistic and neurotic perfectionism (e.g., Sorotzkin, 1985) and his approach to the treatment of this population (e.g., Sorotzkin, 1998) have also informed and influenced our thinking about clinical issues regarding the treatment of perfectionism. We believe that anyone interested in providing treatment for individuals with perfectionistic tendencies would do well to read and heed these authors' works.

Cognitive Theorists

Seminal cognitive theorists are represented in our 2002 edited volume on perfectionism (see Flett & Hewitt, 2002). In addition to the chapter

by Blatt and Zuroff (2002) summarizing their work, the chapter by Brown and Beck (2002) outlines Aaron T. Beck's views on perfectionism as a type of dysfunctional attitude and discusses how perfectionism contributes to elements of the negative cognitive triad. Similarly, Albert Ellis's (2002) chapter conceptualizes perfectionism as an irrational belief. A key theme posited by Ellis (which we have alluded to earlier) is that perfectionism becomes problematic when it becomes irrationally important, such that the afflicted individual has an absolute *need* to attain perfection rather than simply wanting to be perfect or liking to be perfect. This emphasis on having to be perfect in a hypercompetitive manner makes it clear that self-oriented perfectionism, at extreme levels, is a compulsion or drive that involves intense internal pressure to be not just successful, but perfect and unassailable.

Perfectionism Researchers

Numerous contemporaries of ours have also influenced our conceptualizations of perfectionism, including Randy Frost, Robert Slaney/Kenneth Rice, and Paul Gilbert. Frost's early work coincided with our early work on perfectionism as multidimensional and as involving both self-related and social components. Unknowingly, our research groups actually titled our multidimensional measures by the same name (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991a). Although our conceptualizations differ, they dovetail in many respects, and many studies in the literature incorporate both. The work of Frost and his colleagues has always influenced our work and the field generally. We discuss some of this research and their conceptualization later in the book. Similarly, Paul Gilbert's work on status, shame, and perfectionism has influenced our understanding of many of the underlying mechanisms that we believe are involved in the development of perfectionism (e.g., Gilbert & Andrews, 1998; Wyatt & Gilbert, 1998).

Slaney, Rice, Mobley, Trippi, & Ashby (2001) developed still another conceptualization of the perfectionism construct, which has also had a broad impact on the field. These researchers focus on perfectionism from a counseling psychology perspective. One component of their model in particular, discrepancy between performance and expectation, has had an important role in work on diathesis–stress models of perfectionism.

We now turn to an overview of some core themes that are featured throughout this book. These themes are derived in part from our theoretical formulations, but they also reflect classic case illustrations of the ways that perfectionism manifests itself in clinically significant problems.

CORE THEMES

The Heterogeneity among Perfectionists

There are many comparisons in the literature of "perfectionists" versus "nonperfectionists," and it is commonly suggested that perfectionistic individuals share many features. However, just as there is great heterogeneity among individuals who share a clinical diagnosis, there is great heterogeneity among perfectionistic individuals. This key theme is discussed at length in Chapter 7, which focuses on the specific assessment of perfectionistic behavior. There is substantial variability among people both in the level of perfectionism and in the specific elements of the perfectionism construct that are involved. Understandably, perfectionists differ substantially in the specific life circumstances that likely contributed to their perfectionism.

For instance, consider the unique elements of two case studies of "perfectionists." The first illustrates that perfectionism often develops in response to troubling early life experiences. Garland and Scott (2007) documented the case of a 36-year-old married mother of two children suffering from severe depression, which was seemingly triggered by the births of her children. Ms. A (as we refer to this patient) was separated from her parents at the age of 7 and was sent to live with her aunt and uncle. There was some violence in the family of origin, but life with her other relatives was just as challenging if not more so. Ms. A was both physically abused and emotionally neglected by her uncle. She was exposed chronically to criticism from her aunt and uncle throughout her childhood and adolescence, so that she felt that she was "always in the wrong" (p. 280). This contributed to a form of perfectionism that pervaded most aspects of her life, including her maternal role. Garland and Scott's (2007) clinical case formulation emphasized several dysfunctional core themes. Ms. A believed that "If I don't do things perfectly, I will be criticized, humiliated, and rejected" (p. 280). She also endorsed the views that "If something goes wrong it is my fault," and "If I show my feelings, I will be punished." The role of interpersonal factors in Ms. A's life experiences were clearly linked with her abiding sense of shame and fear of humiliation.

This case contrasts with the description of Mr. R, a 41-year-old gay man suffering from "sexual addiction" (Shepherd, 2010). Although Mr. R had had a partner for several years, he obsessively searched the internet for sexual materials. In any given week, Mr. R engaged in casual sex with an average of seven different partners. Mr. R had been raised by strict Jewish parents who valued perfection; however, unlike Ms. A, Mr. R was told repeatedly that "he was special" and "the best

in the world" (Shepherd, 2010, p. 20). The community in which he was raised also held the view that being gay was highly inappropriate. Mr. R's sense of self was thus one of being an abject failure. The therapeutic response was to focus jointly on addressing his sexual addiction and the perfectionism that was at the root of this behavior. This case is complex, in that it uniquely involved elements of perfectionism complicated by Mr. R's experience of having been raised in a community that espoused values in direct opposition to his identity.

Although both cases reflect perfectionism, it is clear that these two individuals had different familial and cultural contexts. The test manual that accompanies our Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 2004) addresses the heterogeneity theme. It shows differences among perfectionists in their levels of trait perfectionism across various dimensions, and differences among these people in their life situations and contexts. The MPS manual contains case descriptions drawn from Paul L. Hewitt's clinical experience. In Chapter 2, we describe the various dimensions of perfectionism that make up our comprehensive model. The content and processes involved in the treatment of individuals with different constellations of perfectionism traits can vary substantially. Although some patterns of behavior are consistent across perfectionistic individuals, the differences underscore the need for an individualized person-centered approach that emphasizes the unique features of each case conceptualization. This theme is explored more extensively in Chapter 7, which focuses on the clinical assessment of perfectionism.

The Importance of Adapting Psychotherapy to the Individual

Although a focus on the individual patient has always been present in psychodynamic treatments, there is a growing emphasis in other orientations that it is important to adapt psychotherapy to the characteristics and needs of each individual, and to focus treatment on these characteristics as well as symptom relief (see Norcross & Wampold, 2011). The need to focus interventions based on case formulations has certainly been a focus of psychodynamically oriented treatments (e.g., McWilliams, 1999) and is also more recently reflected in cognitive therapies for complex cases (e.g., Persons, 2008). As we (Hewitt et al., 2008) and many others have indicated, much recent psychotherapy research has been directed toward treatment of symptoms or DSM-based disorders, and not toward the potential underlying mechanisms that produce those symptoms or disorders. Thus our clinical work is not focused on targeting symptoms. Rather, the emphasis is on the underlying mechanisms that produce the symptoms.

The approach outlined in this book reflects our conviction that perfectionists tend to be complex people. When an intervention is required, elements of the intervention must consider the specific characteristics of the individual, the unique context in which the perfectionistic person exists, underlying and unconscious processes, and the ways in which the perfectionism evolved and is currently expressed and experienced. Although this may seem like an obvious point to make, it is important to underscore this theme; it is quite common for researchers to test the effectiveness of therapeutic interventions for perfectionists without incorporating much of an explicit emphasis on the perfectionism itself. When it is found that an intervention was only partly successful (i.e., perfectionism was reduced somewhat), this often signals the need for a more explicit and extensive focus on the specific factors and processes contributing to the perfectionism. Another common occurrence is that researchers and clinicians may conclude that a treatment was successful, but the lack of an explicit focus on perfectionism still leaves the patients with elevated levels of perfectionism that represent significant risk for subsequent disorder once life stressors and setbacks begin to accumulate. In our approach, we always attempt to tailor the intervention to the needs, strengths, and challenges of each patient.

Perfectionism as a Reflection of Identity

Perfectionism is a reflection of meaningful personal issues involving an individual's sense of self and personal identity. As such, and in keeping with the work of Blatt and associates (see Blatt & Zuroff, 2002), perfectionists typically require a longer-term intervention focused on personality change rather than a brief intervention that may not address these core aspects of personal identity. This is not to suggest that a brief intervention will not provide some symptom relief, but the overarching goal should be to promote change in the self and personality, and by doing so to mitigate the effects of the personality vulnerability process.

It is our experience that perfectionistic people often suffer from the identity confusion and diffusion described so insightfully by Erik Erikson. According to the social reaction model we have proposed (see Flett, Hewitt, Oliver, & McDonald, 2002), a large number of perfectionistic individuals have developed perfectionism as a response to unfavorable and perhaps chaotic or traumatic life experiences, in keeping with Adler's notion that perfectionism is a form of overcompensating for feelings of inferiority. Indeed, Adler's description of striving for superiority emphasized compensating for a less than perfect self; he noted that when perfectionism exists, it is usually at the center of the self and forms a core aspect of the person's identity. As such, there is often a

great unwillingness to give it up, particularly among those persons who have embraced a perfectionistic orientation as a way of coping with mistreatment. Many perfectionistic patients, particularly early in treatment, may be quite unwilling or frightened to consider abandoning their quest for perfection. We suggest that it may be best not even to introduce this theme because of the reaction it can receive. Also, some individuals will not be aware that perfectionism is causing widespread difficulties in their lives. Adler (1938/1998) noted that the inferiority complex can be expressed in a variety of ways, including a tendency for some people to hide it behind a mask of arrogance and apparent superiority. He suggested that this move toward superiority is a move toward "the useless side of life" (p. 52), because acts of compensation are now directed away from the real problems that are responsible for these behaviors.

A related implication is that it is also vitally important to consider the meaning that perfectionism has in an individual's life. This consideration will provide the clinician with an understanding of the importance of perfectionism to the patient, as well as an awareness of the need to tread lightly when discussing reducing the perfectionism. What perfectionism can mean to the individual person who is struggling with it was articulated by a patient described by Karen Horney. Horney received a letter from the patient and published it anonymously in an article in the *American Journal of Psychoanalysis* (Horney, 1949), which was later reprinted in the 1999 collection of her work. The patient, a woman who had suffered from depression, stated in her letter that perfectionism served a purpose for her during turbulent times. Specifically, she noted: "This rigid and compulsive perfectionism was all that held me up; outside it and all around lay chaos" (Horney, 1999, p. 138). An elegantly written letter from a patient of one of Hewitt's supervisees illustrates this in a poignant fashion. The patient described her "perfect self" as almost a separate being, who provided an entity that could be trusted and a model. She stated that her perfect self became not only a friend, but a parent who offered the promise of peace and contentment, and the importance of this promise came to dominate the patient's life. To relinquish this entity was terrifying, but upon coming to understand that this entity was precluding the possibility of intimacy and self-love—in other words, that it was a manipulation—the patient released the relationship with this entity.

Unmet Needs: Safety, Connection, Control, Competence, and Autonomy

It is important during the assessment and development of case formulations and throughout the course of treatment to consider the unmet

psychological needs of the perfectionistic patient. In fact, as we describe later, unmet or tenuously met needs for connection and fitting in the world—the needs to feel safe and to feel that one matters—constitute some of the most crucial themes to focus on in treatment. It is this focus that helps the clinician understand the origins of perfectionistic behavior and the factors and processes that may be maintaining it. These strivings can manifest themselves as needs for recognition, admiration, love, or acceptance, and as excessive fears of abandonment, rejection, or not being accepted. Much of the behavior of perfectionistic people is fueled by the fantasy that the attainment of perfection will result in the attainment of positive interpersonal outcomes (such as recognition, respect, or acceptance) or avoidance of negative interpersonal outcomes (such as abandonment, ridicule, shame, humiliation, or being shunned). Why? As almost all perfectionism theorists have stated, perfectionists have a need for acceptance and approval that is rooted in their perceptions of unfavorable early experiences with family members and with peers. We return to this need for acceptance and caring at various points throughout this book.

Many perfectionists have an inordinate need for control. Mallinger (2009) has argued that perfectionistic individuals have a powerful need for control in their lives, in order to avoid any pitfalls, failures, near-misses, or inadvertently revealing the self. A very salient life challenge and transition for many perfectionists is the loss of a sense of control that previously existed. When taken to the extreme, the emphasis on having perfect control can contribute to overcontrol and associated forms of dysfunction. An earlier paper on perfectionism, life stress, and depression (Flett, Hewitt, Blankstein, & Mosher, 1995) outlined the premise that underlying the diathesis–stress model of perfectionism (e.g., perfectionists are vulnerable to depression following the experience of life setbacks and failures) is a perfectionist's dispositional need for control. Life stressors by definition are uncontrollable and are highly threatening to the perfectionist, who needs to retain a sense of self-control. Flett, Hewitt, Blankstein, et al. (1995) showed that trait perfectionism was associated with higher scores on a scale measuring desire for control, and that people who believed others expected them to be perfect (i.e., socially prescribed perfectionism) were prone to distress at least in part because they felt that they were being controlled by other people's demands and expectations.

The unmet psychological needs have not been studied extensively, but evidence is beginning to illustrate the role that these needs can play in contributing to behavior and levels of well-being. Sheldon, Elliot, Kim, and Kasser (2001) showed that among 10 needs being surveyed, the 3 top psychological needs of most respondents seemed to be the needs for

connection, autonomy, and competence. Recent data collected in our laboratories indicate that those perfectionists who feel external pressure to be perfect tend to have frustrated needs in all three areas. That is, they experience the imposed demands and expectations as eroding their sense of autonomy, feel incompetent when held up to impossible standards, and experience a lack of connection with others. If viewed from a needs perspective, the tenacious striving and sense of being driven can be construed as attempts to regain a sense of competence and perhaps get to a point where there is more opportunity to exercise a sense of self-determination.

Perfectionism and the Therapeutic Relationship

Another basic theme running throughout this book is that the specific needs and general tendencies of perfectionists are expressed in various contexts, and so it is expected that these needs and tendencies will be seen in the therapeutic context. This, of course, is known as "transference." We expect the therapist or therapy group to become the source of need satisfaction, and the patient to respond to the therapist or group in a similar manner as to other people (past and present) in that patient's life. Perfectionistic individuals seek and require the constant self-evaluation of their acceptance or connection. It can be particularly important to gain the approval and acceptance of the therapist or group, and to be ever-vigilant regarding the indications of the potential disappointment, disapproval, or lack of caring of the therapist/group. This vigilance can create an exquisite tension whereby the patient, in revealing him- or herself more and more, will be risking more and more the therapist's or group's evaluation and potential negative judgment. Obviously, this is a crucial process component; the therapist needs to be aware of it throughout the course of psychotherapy, and to keep the issue of the therapist's perceived or feared judgment a part of the dialogue of psychotherapy. Moreover, if someone habitually demands perfection of the self or of other people, this same expectation will, in all likelihood, be applied to the treatment process and to the psychotherapist. The therapist can become a major source of disappointment and a target of hostility or derision because he or she is less than perfect (and we all are imperfect), and often because the patient can come to see the therapist as not perfectly accepting or as a powerful source of ridicule and scorn if the therapist should actually "see" the patient for what he or she is. This suggests that early termination is always a possibility and underscores the importance of developing a strong therapeutic alliance.

Although these dynamics are shared by other patients in treatment, such as individuals with personality disorders, they seem to be prominent

for individuals who are plagued by perfectionistic tendencies. It is not at all surprising that clinicians have reported that their perfectionistic patients often try to become perfect patients (e.g., Hollender, 1965). Some have suggested that this is a good thing and should be promoted in therapy, so as to get good efforts out of such a patient (e.g., Hirsch & Hayward, 1998). However, if left unattended and not altered, such striving by the patient simply maintains the pathological process of the requirement of perfection, and thus leaves the individual vulnerable. Again, the therapist needs to be aware of this issue, so as not to engage with the psychopathology and simply repeat maladaptive relational patterns that have dominated the patient's life.

The case of Ms. A, described earlier, is a clear illustration of how perfectionism can pervade the therapeutic process. Recall that Ms. A suffered from clinical depression after experiencing a lifetime of abuse, neglect, and criticism. Garland and Scott (2007) reported that Ms. A frequently failed to complete homework assignments, because she was so certain that less than perfect performance on these assignments would result in scorn and ridicule from the therapist. The same fear led Ms. A to miss several therapy sessions at the beginning of treatment. Ms. A's case illustrates not only how perfectionism can undermine the therapeutic process, but highlights how avoidant a perfectionist can become. This account underscores the need to focus on the therapeutic process and to be sensitive to the appropriate timing of certain themes. For instance, Garland and Scott (2007) made the point that Ms. A had such an abiding sense of unworthiness that she would have no doubt rejected their attempts to help her develop self-compassion if this theme was introduced too early in treatment. This is a very insightful observation, given the paucity of self-compassion that tends to accompany perfectionism.

Later in this book, we discuss in more detail the impact that perfectionism can have on the therapy process. For now, we simply point to some parallels found elsewhere. For instance, there are now extensive discussions and related research on the destructive role of insecure attachment styles. It is generally believed and empirically supported that an insecure attachment style gets expressed in behaviors and tendencies that undermine treatment (see Diener & Monroe, 2011). In their paper on the assessment and treatment of eating disorders, Tasca, Ritchie, and Balfour (2011) made the important observation that "those with attachment-based insecurities are likely to be the least to benefit from symptom-focused therapies" (p. 249). This observation has clear implications for the assessment and treatment of perfectionism, given the acknowledged role of perfectionism as a personality vulnerability factor in many different disorders (see Bardone-Cone et al., 2007; Dunkley, Berg, & Zuroff, 2012; Hewitt et al., 2006; Schieber, Kollei, de Zwann,

Müller, & Martin, 2013). There are now several studies linking perfectionism with insecure attachment (e.g., Chen et al., 2012; Dunkley et al., 2012; Rice & Mirzadeh, 2000; Wei, Heppner, Russell, & Young, 2006), and work in our laboratories finds consistently that insecure attachment is associated with interpersonal forms of perfectionism. It follows, then, that insecurely attached perfectionistic patients will have tendencies that can greatly complicate the treatment process. Failure to address the roots of these insecure attachments can result in treatment failure.

Perfectionism, Fear of Failure, and Anxiety Sensitivity

Perfectionists (especially those who are procrastinators) are frequently described as motivated by fears of failing. Once the salience of the fear-of-failure motive is highlighted, the tenacious striving of some perfectionists seems rather desperate. Covington's self-worth model of achievement goals and school achievement is helpful in terms of characterizing the complex goals and motivations that underscore perfectionistic behaviors (see Covington, 2000; Covington & Müeller, 2001). Covington's quadripolar model is based on the assumption that approach and avoidance orientations are independent dimensions, so that it is possible for individuals to be low or high on both approach and avoidance tendencies. As such, four types of individuals emerge: (1) failure avoiders; (2) failure acceptors; (3) success-oriented students; and (4) overstrivers. Covington and Müeller (2001) describe "overstrivers" as persons who are characterized jointly by high hopes for success and an excessive fear of failure. Their behavior is driven by the desire to avoid failure by succeeding at an exceptionally high level, and they can engage in slavish overpreparation as they approach success, for highly defensive reasons (i.e., the need to avoid failure and its negative implications for the self or acceptance). As well, these individuals can arrange reasons for nonsuccess by self-handicapping, procrastination, or statements to others that they are perfectionistic individuals and should be excused.

The complex motives and goals that operate in perfectionistic overstrivers have been described eloquently by Covington and Müeller (2001). They summarize the plight of overstrivers as follows:

> According to a self-worth interpretation, the dominant survival strategy for this group is to avoid failure by succeeding. This means that overstrivers are sustained in their drive to succeed both by the temporary relief of having not failed (negative reinforcement) and by the positive sources of pride and intrinsic appreciation that accompany noteworthy achievements. Motivationally speaking, then, the relationship between these respective sources of rewards—pride and relief—is compl[e]mentary and additive,

> but in a perversely painful and conflicted way; pride at having succeeded and simultaneously having avoided failure (relief) on one occasion sets the stage for having to prove oneself at even higher levels of distinction on the next occasions. This is a never-ending treadmill. (Covington & Müeller, 2001, p. 170)

This notion that overstrivers experience an extreme approach–avoidance conflict with a strong orientation toward both the approach of success and the avoidance of failure fits well with evidence that self-oriented, workaholic perfectionists are people who are relentlessly "driven" (see Spence & Robbins, 1992) and are chronically dissatisfied and unhappy.

In an important development, research and theory have linked fear of failure with shame. McGregor and Elliot (2005) have based their analysis on earlier suggestions that the overarching fear is the anticipated shame that will accompany being exposed as a failure (see Atkinson, 1957; Birney, Burdick, & Teevan, 1969). This is a key point to emphasize for our purposes, because it highlights the concerns about self and identity that are ever-present for perfectionistic individuals. It is the case for these people that while they seem to be overstrivers driven by a fear of failure, they are actually compelled and driven by a fear of shame. The compulsive need to have everything just so and perfect as a way of restoring a sense of power and battling feelings of shame was described by Erik Erikson (1953) in his discussion of how his proposed second stage of development (i.e., autonomy vs. shame and doubt) proceeds, and how some children are treated in ways that restrict their sense of autonomy. Those children who are overcontrolled by their parents are left with a lasting sense of shame and doubt; for these children, wanting everything just so and becoming sticklers for precision and detail are parts of a compulsion neurosis that has clear negative implications for the subsequent development of personal identity. The role of shame avoidance as a motivator for perfectionistic behavior was also noted by Nathanson (1992), who viewed the tendency to strive relentlessly for perfection as an attempt to correct personal deficiencies and a general sense of being defective.

CONCLUSION

The central focus of most perfectionists is on the needs to perfect the self and to correct or hide aspects of themselves that they see as imperfect. Perfectionism is less problematic when it is focused selflessly on doing something perfectly or on creating something that is perfect, and this is done solely for the purposes of perfection for the sake of perfection; unfortunately, most attempts to be perfect are indeed designed

to overcompensate or correct for some less than perfect aspect of the self. Typically, perfectionism reflects significant ego involvement and self and identity issues that undermine the ability of the persons involved to derive actual enjoyment from their successes and accomplishments.

This chapter has included an overview of the seminal views of classic theorists, and we incorporate these contributions throughout the book. Not only are they remarkable insights, but they serve as reminders of the importance of understanding perfectionism and perfectionists, together with the general value of embracing an explanatory approach.

In the next chapter, we outline the descriptive model of perfectionism that we have developed over the past several decades. In later chapters, we present some clinical cases of individuals struggling with perfectionism and its outcomes, in order to illustrate many of these issues.

CHAPTER 2

The Comprehensive Model of Perfectionistic Behavior

This chapter details the concept of perfectionism and describes our comprehensive model of perfectionistic behavior (CMPB). In this conceptualization, the components of the perfectionistic personality are regarded as dimensional and as diathetic factors that confer significant vulnerabilities to a wide range of difficulties and dysfunctions.

We have come to understand perfectionism as a multifaceted and multilevel personality style in our theorizing, research, and clinical work over the past 30 years. Our conceptualization of perfectionism is broad. Historically, various authors have regarded perfectionism as a set of self-related and unidimensional dysfunctional attitudes, beliefs, or cognitions (e.g., Burns & Beck, 1978; Ellis, 1962, 2002), and some recent authors (e.g., Shafran, Cooper, & Fairburn, 2002) still regard perfectionism from a unidimensional perspective. For instance, in his influential work on early maladaptive schemas, Jeffrey Young captures perfectionism in the form of unrelenting standards for oneself, and assesses these standards via the unrelenting standards subscale of the Young Schema Questionnaire (see Young, Klosko, & Weishaar, 2003). This work recognizes the early developmental origins of perfectionistic tendencies; however, unrelenting standards reflect just one of many perfectionistic themes, and the focus on exacting standards is limited, as it does not capture the interpersonal expressions or elements of criticism of individual differences in perfectionism. Moreover, it is crucial to understand that high standards, difficult-to-attain standards, or even excessive standards are not the same as perfectionistic or unrealistic standards (see Blasberg et al., 2016).

Our conceptualization of perfectionism emphasizes the relational and motivational elements. Moreover, we regard perfectionism as a personality style that can operate at several behavioral levels for an individual. That is, perfectionistic behavior can function at a dispositional/trait level that energizes, directs, and focuses behavior toward the preoccupation with perfecting the self. It can also function at the other-relational level in the expression or demonstrated appearance of the purported "perfection" to others. Finally, it operates at the self-relational or intrapersonal level, as an individual expresses the requirement for perfection or the appearance of perfection to him- or herself in the form of perfectionism-themed thoughts, self-statements, and self-recriminations. The latter two levels are reflective of the Sullivanian notion of "relationship styles" that people can have with others and with themselves (see Sullivan, 1953). We have included these elements in the CMPB, which we describe in detail in this chapter. We begin, however, by briefly outlining several influences that have informed the development of the model and the operationalization of its components.

INFLUENCES IN DEVELOPING THE CMPB

Psychodynamic and Interpersonal Models of Personality

Various relational psychoanalytic and interpersonal models of personality and personality functioning have played a major role in our theorizing. Concepts and processes deriving from psychoanalytic, psychodynamic, and interpersonal theorists (e.g., Karen Horney, Alfred Adler, Lorna Benjamin, Sidney Blatt, David Malan, Heinz Kohut) have influenced our understanding of perfectionism as a complex, multifaceted, neurotic relational personality style. Moreover, theories that place importance on underlying cognitive processing structures—person schemas, both self-related and other-related—have played important roles in informing our model (e.g., Andersen, Glassman, Chen, & Cole, 1995; Baldwin, 1992; Horowitz, 1988, 1991, 1998; Markus & Wurf, 1987).

Clinical Experiences

Although extant research, case descriptions, and other writings on perfectionism have had strong influences on the development of the CMPB, this model has been influenced greatly by our clinical and consulting work with individuals who actually experience perfectionism and its negative sequelae. The nature and results of their perfectionistic behavior have been pivotal in directing our thinking. The richness of information from prolonged and in-depth psychotherapy has aided

our understanding tremendously. The development of our models of perfectionism and of its treatment and research questions, has derived largely from these kinds of interactions. Moreover, this work has been influenced by the perfectionists we have encountered in other settings, including students, colleagues, and professionals, as well as the large number of people seeking assistance who have corresponded with us over the years.

Comprehensiveness

Personality constructs that have significant clinical relevance are most often conceptualized as traits, and when such a personality construct is assessed, the focus of measurement is on the amount or level of the trait. We argue that when conceptualizing such personality constructs, it is imperative to incorporate not only trait components of the constructs, but also process components of those constructs (see Buss & Finn, 1987; Kline, 1993; Thorne, 1995; Paulhus & Martin, 1987; Wachtel, 1994). For example, several personality theorists have argued that although traits are important in understanding personality and in predicting various outcomes (e.g., Buss, 1989), a distinction is needed between levels of traits and the expressions of those traits. Buss and Finn (1987) suggested that stylistic features of traits are distinct from the content aspects of traits, and that both the levels of traits and the expressions of those traits are independent predictors of outcomes. They describe traits as the content or "what" of personality, and differentiate this from the style of personality, which reflects "how" personality is expressed or displayed. Similarly, when discussing personality and cognition, Cantor (1990) makes the important distinction between "having" and "doing." Personality traits are what someone has, but another way to consider these individual differences is in terms of the thoughts and behaviors people express.

The need to consider how perfectionism is expressed was fortuitously realized many years ago when one of us (Paul L. Hewitt), in anticipation of a visit from another of us (Gordon L. Flett), rearranged his schedule in a way that meant providing individual treatment to several patients in a row. Each of these patients had significant issues with perfectionism, but not in ways that had been described in the existing literature. Their main tendency was a need to seem outwardly perfect while attempting to hide or divert attention from their flaws and imperfections. This realization was the beginning of our work on the concept of perfectionistic self-presentation, which is described in more detail below. It is useful for readers to keep this brief anecdote in mind when considering the benefits of being both scientists and practitioners.

When researchers and clinicians are conceptualizing, measuring, assessing, and treating personality vulnerability factors, such as perfectionism, it is imperative to do so comprehensively, taking into account both trait levels and processes in order to explicate and take into account the levels and expressions of the constructs. To this end, we have conceptualized perfectionism as involving trait components, as well as process components reflecting the interpersonal expression of perfectionism (e.g., perfectionistic self-presentation styles) and the intrapersonal or self-relational expression of perfectionism (self-directed perfectionistic and evaluative thoughts, internal statements, recriminations, etc.). This emphasis on the cognitive component is important, because much of the distress experienced by perfectionists is attributable to obsessive automatic thoughts about their need to be perfect.

Psychometrics

The various components of the CMPB have been assessed with carefully designed measures developed according to a classic sequential construct validation approach (see Jackson, 1970). The three major psychometric instruments that we have developed for adults are the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991a, 2004), the Perfectionistic Self-Presentation Scale (PSPS; Hewitt, Flett, Besser, Sherry, & McGee, 2003), and the Perfectionism Cognitions Inventory (PCI; Flett, Hewitt, Blankstein, & Gray, 1998). The clinical utility and specific psychometric characteristics of these measures are described in Chapter 7. Here it is important to note that these measures were developed, refined, and validated on substantial numbers of community members; clinical, psychiatric, and rehabilitation patients; and university students, to ensure the generalizability of the effectiveness of the measures. As well, we have developed child and adolescent versions of the MPS and PSPS, known as the Child–Adolescent Perfectionism Scale (CAPS; Flett, Hewitt, Boucher, & Davidson, 1997) and the Perfectionistic Self-Presentation Scale—Junior Form (PSPS-Jr; Hewitt et al., 2011), using the same approaches and diverse community and student samples. Our intent to develop psychometrically strong measures was to aid in the clinical work of psychologists and other clinicians in terms of comprehensive assessments and formulations of perfectionistic behavior and to develop quality instruments useful to researchers.

Specificity

Finally, with the delineation of any construct, it is important to indicate what the construct does not include. In this instance, we have adopted

the stance that others have embraced (e.g., Adler, 1956; Burns, 1980; Greenspon, 2000; Hollender, 1965; Horney, 1950; Missildine, 1963; Pacht, 1984; Spence & Robbins, 1992) by envisioning perfectionism as destructive and as differing qualitatively from such concepts such as conscientiousness, striving for achievement or mastery, striving for excellence, striving for difficult-to-attain or high standards, and so forth. We conceive of perfectionism as involving the requirement for, expression of, and thoughts pertaining to *perfection*; it is not simply a striving to meet exacting or difficult to attain standards and expectations (see Greenspon, 2008, for a cogent discussion of these issues). Moreover, although others have suggested that there are concepts termed "adaptive perfectionism" or "healthy perfectionism," these concepts differ fundamentally from our conceptualization. Perfectionistic people are compulsively driven, and as noted by writers such as Horney (1950) and Ellis (2002), their perfectionism has become imbued with an irrational importance. These individuals do not simply aspire to be perfect; for them, attaining perfection has become a necessity and a way of being secure and safe in the world. Being excellent is nowhere near good enough for these people, because there are only two options—total perfection or total failure. Coming close, even very close, can be perceived by these individuals as a failure and a marker of how much better they need to do next time. Being hypercompetitive plays a role, because a perfectionist who does exceptionally well but who is outperformed by someone else tends to regard his or her own performance as unacceptable and an indicator of personal inadequacy. Also, as noted in Chapter 4, the ultimate goal of perfectionistic behavior is to perfect the self so that the individual can develop a cohesive sense of self-regard and worth, and can fit interpersonally in the world with others. This focus on an overgeneralized need for a perfected self that fits securely with others contributes to the marked shame that is ubiquitous among perfectionists in treatment. These persons should be contrasted with individuals who are not trying to perfect the self, but are trying to perfect things in their environment or tasks that must be completed. The perfecting of things may be relevant for the artisans that Pacht (1984) discussed, but the perfecting of the self represents a destructive approach to life.

Similarly, our concept of perfectionism differs from "clinical perfectionism" described by Roz Shafran and her colleagues (see Shafran et al., 2002). According to these authors, clinical perfectionism is a unidimensional cognitive-behavioral conceptualization of perfectionism: It focuses solely on self-oriented perfectionism attitudes and on the negative self-worth appraisals and negative outcomes associated with perfectionism. The essence of clinical perfectionism is the overdependence on or preoccupation with self-evaluations tied to the pursuit of

extreme standards. Although we agree in general with an emphasis on the role of the self in perfectionism, conceptualizations and research in the perfectionism literature over the past two decades have moved away from unidimensional approaches and have illustrated the usefulness of multidimensional models of perfectionism and measures reflecting these models (see Enns & Cox, 2002).

Although the initial Shafran et al. (2002) paper on the nature of "clinical perfectionism" has been followed by several articles and case series analyses that have illustrated how a focus on "clinical perfectionism" can be applied to people suffering from perfectionism (see Glover, Brown, Fairburn, & Shafran, 2007; Riley, Lee, Cooper, Fairburn, & Shafran, 2007; Riley & Shafran, 2005; Steele et al., 2013), there have been criticisms of narrowly defining a broad personality construct as a set of attitudes. Elsewhere, we (Hewitt, Flett, Besser, et al., 2003) have outlined an extensive set of objections to this conceptualization of perfectionism. For example, we have argued that rather than simply defining perfectionism as only a set of self-related attitudes, we see compelling reasons (both conceptual and empirical) to incorporate broader information-processing mechanisms, motivational factors, and intrapersonal and interpersonal behaviors into the perfectionism construct. In addition, analyses of the measure tapping clinical perfectionism have found that this supposedly unidimensional measure is actually multidimensional (see Dickie, Surgenor, Wilson, & McDowall, 2012; Stoeber & Damian, 2014), and it remains to be determined whether these findings reflect a measurement problem, a conceptualization problem, or both. More importantly, the need to consider perfectionism as multidimensional is particularly evident at the individual case level. Indeed, we have encountered many people experiencing problems with perfectionism for whom, upon further analysis, the essence of their problems is that they perceive extreme demands for perfection to have been imposed on them and they see no escape from these demands.

Although we have embraced a different conceptualization, the work of Shafran and colleagues is useful in many respects. For example, their work underscores that perfectionism is broadly associated with clinical problems, may be a crucial personality vulnerability that underlies comorbidity, and is amenable to psychotherapy.

There have been other important contributions that help us better understand those people who are seeking treatment for perfectionism. Recently, for instance, Egan, Piek, Dyck, Rees, and Hagger (2013) described evidence testing clinical perfectionism as a transdiagnostic process. They showed that the sense of self as being a failure was a salient theme among people seeking treatment and that even though these people's perfectionism caused significant distress for both themselves and

other people, for the most part they did not want to change their perfectionism. This is in keeping with our experience that for many people, perfectionism is a deeply ingrained and strongly endorsed part of their identity and self-definition; as a result, consideration needs to be given to the potential harm and psychological damage that can ensue when perfectionism is so central to these persons' sense of self. In such instances, it seems more appropriate to focus on the unmet psychological needs and the interpersonal factors implicated in the development and persistence of this perfectionism, and to promote better forms of emotional and cognitive self-regulation when these persons are confronted with the many life stressors that tend to accompany lives focused on needing to be perfect.

INTRODUCTION TO THE CMPB

We introduce the CMPB by presenting a composite sketch of an individual with attributes that reflect most elements of the model. The elements of the CMPB are listed in Table 2.1. This composite is informed by the many accounts from the business and management fields of the problems experienced by and created by perfectionists in leadership positions (for a related discussion, see Flett & Hewitt, 2008).

Brenda is a well-known 38-year old businesswoman who runs her own company. She has had numerous difficulties in her personal life because she has been described as a relentless workaholic. These tendencies were evident in high school, when she passed up numerous social opportunities because she was working to get the grades needed for entry into college. She strives relentlessly and will not accept second-best, either from herself or from other people. In terms of her leadership style, Brenda finds it difficult to retain her best employees because she is always hovering over them, micromanaging them, and delivering excessively harsh criticisms of their work. She reminds them almost daily that anything less than perfect effort with a perfect outcome is just unacceptable, because perfection is required in order to outperform the competition. This managerial behavior reflects her tendency to worry chronically about whether things are being done perfectly, as well as her need for control. This worry has resulted in many sleepless nights, but Brenda is good at hiding that she is exhausted.

While Brenda appears on the outside to be a tough, resilient individual, she is actually extremely sensitive to criticism and quite fragile. This sensitivity stems from being raised by parents who were perfectionistic themselves; they instilled in their daughter a strong work ethic and the belief that things can always be done better, no matter how well

TABLE 2.1. Elements of the Comprehensive Model of Perfectionistic Behavior (CMPB)

Trait components: Perfectionism trait dimensions

Self-oriented perfectionism
Drivenness for oneself to be perfect; excessively stringent self-evaluation; requirement for the self to be perfect
MPS item: "I demand nothing less than perfection of myself."

Other-oriented perfectionism
Requirement for others to be perfect; stringent and critical evaluations of others
MPS item: "If I ask someone to do something, I expect it to be done flawlessly."

Socially prescribed perfectionism
Belief or perception that others require oneself to be perfect
MPS item: "People expect nothing less than perfection from me."

Interpersonal components: Perfectionistic self-presentational facets

Perfectionistic self-promotion
Actively promoting one's supposed perfection
PSPS item: "I must always appear to be perfect."

Nondisplay of imperfections
Avoiding displaying imperfections
PSPS item: "I do not want people to see me do anything unless I am perfect at it."

Nondisclosure of imperfections
Avoiding disclosures of imperfections
PSPS item: "Admitting failure to others is the worst possible thing."

Intrapersonal or self-relational components: Automatic perfectionistic cognitions

Automatic ruminative self-statements regarding the attainment of perfection
PCI item: "I should be perfect."

Note. MPS, Multidimensional Perfectionism Scale (Hewitt & Flett, 1991a, 2004); PSPS, Perfectionistic Self-Presentation Scale (Hewitt, Flett, Sherry, et al., 2003); PCI, Perfectionism Cognitions Inventory (Flett, Hewitt, Blankstein, & Gray, 1998).

they are done. Brenda's perfectionism and need to have the outward appearance of perfection have been reinforced by kudos she has received for her boardroom presentations and her meetings with business associates. Although she seems to be a "natural" in regard to her presentation skills, this belies her significant anxiety; indeed, she secretly rehearses for hours, because it is essential to her never to make a mistake in front of others.

Although she strikes most people as someone who is popular and has many friends, Brenda is actually quite lonely and feels alone in the world. Her isolation is attributable in part to her fear of looking stupid or weak, because she has never developed the ability to establish intimate

relationships by confiding personal matters and feelings to others. And she has continued to pass up social opportunities, often with the excuse that a project needs more work or that she is exhausted from her work schedule. Brenda also tends to annoy and push others away. Her interest in others seems quite superficial; it often appears to be focused more on feeling superior than on any concern or empathy for another person. She does not mind pointing out to other people the mistakes they have made, because, in her mind, she is only trying to help them improve. While she will never admit it, Brenda is quite frustrated that she has had little success in her interpersonal relationships, despite her achievements. Not surprisingly, perhaps, her accumulation of achievements, kudos, and rewards has not produced the sought-after self-acceptance and acceptance by others. Her feelings of emptiness and disconnection have come to dominate her affective states.

This depiction of Brenda illustrates that perfectionism can be expressed in various ways that can contribute to a life characterized by anhedonia, cursory involvement with other people in spite of a desire for deep involvement, a ubiquitous lack of satisfaction, and a profound sense of emptiness. As indicated above, perfectionistic behavior operates at several levels and incorporates (1) perfectionism traits, or dispositional components reflecting the need or requirement *to be perfect,* either for the self or for others; (2) perfectionistic self-presentation, or a drive *to appear to be perfect to others* by either promoting one's purported perfection or concealing any imperfections; and (3) the intrapersonal expression of perfectionism, which reflects the relationship one has with oneself regarding one's need for and lack of perfection. Figure 2.1 is a graphic representation of the CMPB, showing that the components—namely, the traits, self-presentational facets, and cognitive features—overlap with one another. We view these components of the CMPB as essential to the overall perfectionism construct. Also, each component has unique elements that contribute to the overall construct. We describe these components in detail below.

PERFECTIONISM TRAITS

Initially, we conceptualized perfectionism as involving trait or dispositional dimensions that are stable and consistent personality constructs reflecting a powerful need to be perfect (Hewitt & Flett, 1991a). Other writers have also suggested that perfectionistic behaviors have a stability and breadth that support their being described as dispositions (Adler, 1956; Hollender, 1965; Horney, 1939), and there is evidence for the traits' stability over time (Hewitt & Flett, 1991a, 2004). The trait

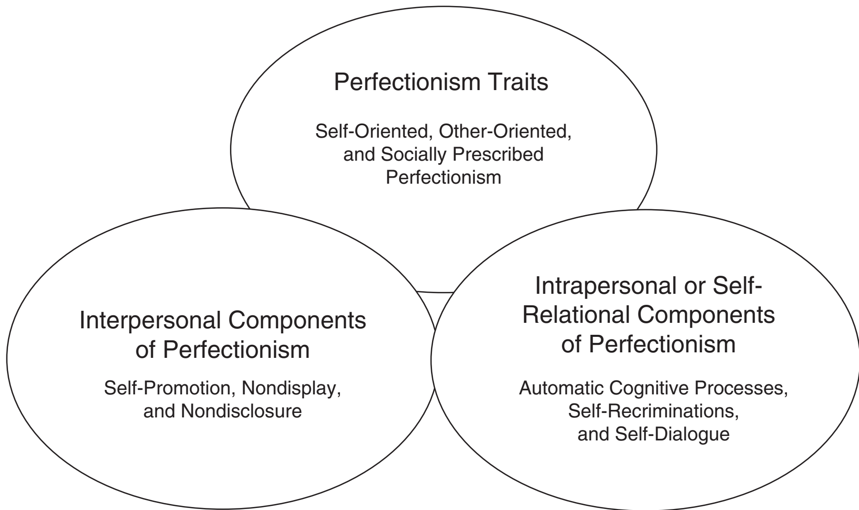

FIGURE 2.1. The comprehensive model of perfectionistic behavior (CMPB).

dimensions reflect not only the motivation for and requirement of perfection for the self, but also the motivation and requirement that other people be perfect (Hewitt et al., 1989; Hewitt & Flett, 1990). Thus, we have included the interpersonal domain in our trait conceptualization. Furthermore, extensive clinical work with perfectionistic individuals reveals that many of these individuals are driven to attain perfection not because of their own internal expectations and requirements, but because of the perceived requirements of others (see Horney, 1939). Perfectionism traits include both intrapersonal and interpersonal components, such as a requirement for the self to be perfect ("self-oriented perfectionism"), a requirement for others to be perfect ("other-oriented perfectionism"), and perceptions that others require perfection of oneself ("socially prescribed perfectionism"). A distinguishing characteristic of the traits involves the direction of characterological focus. That is, in self-oriented perfectionism, the focus for perfection is on the internal world or the self of the perfectionist, whereas in other-oriented perfectionism, the focus is external or having others be perfect. Lastly, socially prescribed perfectionism involves an internal focus (requiring the self to be perfect), but also an external focus whereby others are the source of the expectations and acceptance.

These trait components are thought to be relatively independent and are thought to be associated differentially with negative or maladaptive outcomes.[1] Although there is a good deal of evidence for the differential

relationships with outcomes (see Chapter 3), this does not mean that the traits should be considered only in isolation. There is very good evidence suggesting that interactions between two or more perfectionism traits can not only provide an important understanding of the nature of outcomes (see Gaudreau, 2012; Gaudreau & Thompson, 2010; Gaudreau & Verner-Filion, 2012; Powers, Koestner, Zuroff, Milyavskaya, & Gorin, 2011; Powers, Milyavskaya, & Koestner, 2012), but also aid in understanding individuals who exhibit complex blends.

The three trait dimensions tend to be positively intercorrelated in variable-centered research, but individuals can vary in terms of whether they are high in all or just one or two trait dimensions.

Self-Oriented Perfectionism

Self-oriented perfectionism involves the requirement of perfection for the self (see Hewitt & Flett, 1991a, 2004). It is a trait dimension whereby perfectionistic behavior that derives from the self is directed toward the self (Hewitt & Flett, 2004). Central to self-oriented perfectionism is a salient motivational component that drives the individual's concern with attaining perfection and his or her avoidance of imperfection at all costs. This motivation can take the form of a preoccupation with the necessity of attaining perfection and avoiding imperfection, rather than actually driving behavior to attain perfection. In addition to the motivational component, the perfectionistic behavior involves the expectation that perfection (in many if not all endeavors) is not only possible, but necessary or expected of oneself. Furthermore, the individual's self-worth is dependent upon and equated with the attainment of perfection.

One feature that distinguishes the self-oriented perfectionist from the person who would simply like to do as well as possible is the extreme importance of attaining perfection. It is important to perfectionists that they are perfect in everything that has any significance to them. Ellis (2002) has suggested that perfectionists have imbued being perfect with an irrational importance, so that they no longer merely wish to be perfect; they *must* be perfect. According to our conceptualization, this importance is also relevant to the other dimensions of perfectionism described below. That is, people who expect perfection from others see it as exceptionally important, while people who are trying to live up to demands to be perfect come to regard the meeting of expectations and demands as essential. And people who are invested in seeming perfect also attach irrational importance to projecting this image. We would like to underscore the "importance of importance" because we have found that reflecting on this element of the perfectionism construct has substantially clarified our thinking about what is problematic in perfectionism. Why do some

people settle for excellence, while other people are consumed with a drive to be absolutely perfect? Why is it so important to them, and what events and experiences have contributed to this importance? We have found that the great importance of being perfect is typically a reflection of an ego-involved state and a degree of self-focused awareness, in keeping with the notion that perfection is a defensive response to feelings of inferiority or feelings of not mattering to other people.

Another element of perfectionism is that it tends to generalize across life domains and various ways of evaluating oneself. Accordingly, the perfectionist not only wants perfect performance; he or she also wants perfect relationships and whatever else it takes to have the perfect life. One aspect of this orientation that has not received enough attention is the notion of emotional elements in perfectionism. This concept was introduced by David Burns (1980), who noted that perfectionists often strive for perfect emotional control and will often suppress their emotions. Many perfectionists are hypervigilant to emotional experience; in keeping with suggestions by Burns (1980), strong negative emotions can be particularly threatening, because they signal to the self and others that life failures have occurred or that the person is a failure in terms of his or her ability to control negative occurrences and generate positive outcomes and experiences. What we are essentially reiterating here is that the need to be perfect found among self-oriented perfectionists also applies to their emotional experiences. The goal with some emotional experiences will be to learn to accept them with self-compassion, in keeping with the more general goal of developing self-acceptance and self-compassion. But it is also important for a self-oriented perfectionist to explore the roots of these emotional experiences, in order to reach a point when troubling emotions are no longer experienced with such frequency and intensity. Our emphasis on shame here is not coincidental; clinical experience suggests that shame is one of the most predominant emotions, if not the most predominant, experienced by troubled perfectionists. It is common among people who go beyond self-dislike to develop a form of self-hatred.

It should be noted that this focus on unrealistic or perfectionistic expectations for the self is a feature of our conceptualization of dispositional perfectionism, but it is also an element of the conceptualization of multidimensional perfectionism advanced by Frost et al. (1990). The final version of the Frost et al. model includes high personal (but not necessarily unrealistic) standards as one of five trait dimensions. Other trait dimensions in this formulation reflect the defensive and self-questioning tendencies of anxious perfectionists (e.g., concern over mistakes and doubts about actions) and the social aspects that are involved in the development, maintenance, and expression of perfectionism (i.e.,

high parental expectations and high parental criticism). Typically, when it comes to maladaptive perfectionism, most authors focus on concern over mistakes—but we feel that doubts about action are just as important, because these doubts really reflect a profound sense of ambivalence regarding the self. We return to the role of parental expectations and parental criticism below in our discussion of the social pressures to be perfect. However, in the present context it is important to acknowledge the role of parental pressures to be perfect, because of parents' role in fostering the conditional sense of self-worth that is found so commonly among perfectionists.

While these contingent beliefs about the need to be perfect are focused on what can be gained (i.e., others' approval or respect), we have also encountered many perfectionists who are motivated defensively by the belief that they must be perfect in order to avoid negative consequences. For instance, someone prone to social anxiety may feel that he or she must be perfect in order to avoid scorn and criticism, as well as the feelings of humiliation and shame arising from these judgments.

The only way to account for this complex blend of motives is to acknowledge that perfectionists are often faced with a conflict between seemingly opposing motives. To couch this conflict in terms of the motivational orientations proposed by Higgins as aspects of his regulatory focus theory (see Higgins, 1987; Higgins, Roney, Crowe, & Hymes, 1994), perfectionists have a promotion orientation focused on success and the attainment of goals, and a prevention orientation focused on the avoidance of failures/mistakes and the punishments that follow from not measuring up. Covington and associates (see Covington & Müeller, 2001) have highlighted the complexities in the achievement context in their descriptions of perfectionistic overstrivers who strive tenaciously not only to achieve success, but also to avoid the shame and embarrassment of failure. The caveat here is that in this particular form of approach–avoidance conflict, success is defined for perfectionists in the attainment of absolute perfection; thus any falling short, while perhaps somewhat satisfying to nonperfectionistic people, can be seen as an abject failure by the perfectionists, who will only accept flawlessness.

As we have mentioned earlier, one of the chief difficulties here for perfectionists is that success and failure are often defined in relative terms that involve self-evaluations guided by social comparisons. Indeed, we have heard of situations in which highly perfectionistic people were successful according to typical criteria, but not according to their own evaluative criteria because of their abiding need to outperform other people. A perfectionist who does very well but who is outperformed by someone else is unable to enjoy his or her own successes. One compelling example occurred several decades ago. We learned from a music teacher the story

of her father, who had been an exceptionally talented but extremely perfectionistic artist. As an emerging adolescent, he entered an international competition, and his magnificent work earned one of five scholarships available to the five students who won this competition. These full scholarships could be used at universities around the world. Although this would produce joy among most young people, this young man turned down the scholarship! Why? He refused the scholarship on the grounds that he had finished second and someone else had outperformed him, so his work was not perfect. We have witnessed other situations in which a goal was achieved, but a perfectionistic person castigated him- or herself for not being able to achieve the goal in an effortless manner.

This brings us to another key observation about many self-oriented perfectionists: At the root of their difficulties are a negative view of the self and a quick, relentless readiness to be self-critical. Indeed, self-oriented perfectionists hold highly stringent and inappropriately negative appraisals of their own performance, whether the performance is in the achievement domain or in other domains. In their eyes, they are always falling short somehow. Such an evaluation results in an individual's tending to overgeneralize failure to the self, and in so doing becoming further entrenched in viewing him- or herself as an utter failure. The attendant self-recriminations, self-blame, censure, and admonishments follow. Importantly, even in situations where his or her performance may be superior, or objectively viewed as a success or even perfect, a self-oriented perfectionistic individual will maintain the stringent evaluation and, at a minimum, find fault with his or her performance or turn success into an abject failure. This behavior not only influences the distress experienced with any task the self-oriented perfectionist evaluates; it can also create significant failures where none objectively exist.

When people are asked to describe perfectionists, they usually focus on the features of self-oriented perfectionism. Many writers have described this kind of perfectionism in comparable ways (e.g., Hollender, 1965; Missildine, 1963), and some have focused on the setting of unrealistic standards. But unrealistic standard setting is not necessarily the core feature of self-oriented perfectionism. In fact, it is not clear that such individuals actually set specific standards prior to engaging in a task. It may be that they do not engage in specific standard setting because, quite simply, they always expect perfection. This, of course, makes perfection a nebulous and unarticulated goal. On the other hand, after receiving feedback following a performance in which he or she was not successful, the self-oriented perfectionist often will maintain or even increase the level of expectation, in order to compensate for negative emotions and to make up for past performances that were less than perfect (for a related discussion, see Scott & Cervone, 2002).

Some key caveats about self-oriented perfectionism are now in order. First, while the focus of self-oriented perfectionism is often an agentic emphasis on achievement, achievement striving is typically driven by interpersonal needs. The role of underlying interpersonal needs is illustrated in the not atypical case of Mr. G, a 46-year-old market analyst who was crippled by perfectionism and procrastination. Extensive assessment established that Mr. G had a harshly negative view of himself, which resulted in his sense that he had to be perfect. Further probing established his deeply held sense that he was inherently unlovable. As a result, he felt that he could never make mistakes or admit to mistakes, and he avoided any situation where his mistakes and imperfections would be revealed.

Second, while self-oriented perfectionists are sometimes portrayed as being self-assured and confident people brimming with a sense of self-efficacy, this is far from the lived reality of those who experience clinically significant problems. Concerns about the possibility of failing or being shamed in public settings often translate into an overgeneralized sense of worry. Similarly, self-conscious and self-doubting self-oriented perfectionists are strong candidates for experiencing the kind of brooding and despairing rumination described so elegantly by Nolen-Hoeksema (1991). We have recently summarized several studies indicating that self-oriented perfectionism is associated consistently with chronic forms of pathological worry and ruminative brooding, and these pervasive links with worry and rumination must be considered in efforts to determine whether self-oriented perfectionism could possibly be adaptive (see Flett, Nepon, & Hewitt, 2016). More generally, we have argued that perfectionists are prone to various forms of cognitive perseveration that can not only prolong and exacerbate psychological problems, but can also contribute to health problems, given recent evidence linking cognitive perseveration with health difficulties (Flett, Nepon, & Heiwtt, 2016). While this tendency for cognitive perseveration points, at least on the surface, to the need for cognitively based interventions, we reiterate that at the root of this cognitive style is a sense that the self is inadequate, deficient, or fundamentally flawed.

Case Examples of Self-Oriented Perfectionism

Hollender (1965) described a woman with excessive levels of self-oriented perfectionism. The patient in question was a 22-year-old mother who was hospitalized following a suicide attempt. She described herself as constantly trying to be the perfect mother that she expected herself to be. It was reported that after two occasions when she believed she fell short in her attempts to be perfect, she became desperate and made an attempt

to end her life, believing she was not good enough for her infant son. She also indicated that her perfectionism was long-standing from childhood, stating, "I can forgive other people their mistakes, but I could not allow myself to make the same mistakes. No matter what I did, I had to do it perfect the first time. . . . I was afraid to take on . . . greater responsibility for fear of failing" (quoted in Hollender, 1965, p. 101). She indicated that she exhibited the same requirement for perfection for her work, appearance, home, entertaining, and relating to others. This compelling case underscores the absence of self-compassion often found among people with extremely high levels of self-oriented perfectionism.

Another example was a patient named Brianne, a single, unattached 53-year-old adult education instructor. She presented with excessive levels (> 85th percentile) of self-oriented perfectionism, and with moderately severe levels of depressive and anxious symptomatology. In the past, Brianne had participated in individual therapy on two occasions for difficulties with depression. With respect to her excessive self-oriented perfectionism, Brianne revealed that she was burdened markedly by her own perfectionistic expectations and punitive self-evaluations. She considered herself to be ineffective and undesirable, despite successful performance reviews in her working role and several attractive suitors in her dating life.

Brianne recalled her mother as being controlling, demanding, and domineering. She reported that throughout her childhood and adult life, her mother had dictatorially restricted her freedoms and rigidly controlled her actions. Brianne recalled struggling to appease her mother and to gain her affection and approval throughout her life. Even long after her mother's death, she stated that she continued to struggle to attain unrealistic expectations and punish herself in efforts to become the person her mother would have approved of.

Other-Oriented Perfectionism

Other-oriented perfectionism involves beliefs about and expectations of others. This externally directed, interpersonal trait component of perfectionism entails behavior similar to that in self-oriented perfectionism, but in this case the perfectionistic behavior is directed outward toward others. Rather than requiring the self to be perfect, other-oriented perfectionists require others to be perfect, although self-oriented and other-oriented perfectionism (and socially prescribed perfectionism, for that matter) can coexist. Thus the other-oriented perfectionist requires others to attain perfection or to function at some perfect level, and makes use of a preponderance of other-directed "should" statements. Although these requirements and statements are often directed toward significant

others or people known to the perfectionist, the targets can also include individuals or groups who are strangers, or even people in general. The other-oriented perfectionistic individual requires perfection of others in authoritative and dominant fashion and places great importance on others' attainment of perfection, evaluating them critically and stringently. If others do not attain the imposed perfection, the other-oriented perfectionist is likely to experience anger and contempt, and the targets are evaluated, criticized, and blamed excessively harshly. If a target of an other-oriented perfectionist does attain success or even approximate perfection, little reward or praise follows, and the expectations of the other-oriented perfectionist are either maintained or raised in response to the success. Thus people targeted by such a perfectionist seldom if ever feel that they are able to please the individual.

Our depiction of other-oriented perfectionism is consistent with other writers' descriptions of forms of perfectionism. For example, Hollender (1965) indicated that "some persons, who do not demand perfection of themselves, demand it of others" (p. 100)—suggesting, as we have, that self-oriented perfectionism and other-oriented perfectionism can be independent. Horney (1950) was explicit in her description of this form of perfectionism:

> A person may primarily impose his standards upon others and make relentless demands as to *their* perfection. The more he feels himself to be the measure of all things, the more he insists—not upon general perfection but upon his particular norms being measured up to. The failure of others to do so arouses his contempt or anger. (p. 78)

Other-oriented perfectionism can take the form of requiring perfection in others in order to provide a source of esteem for the other-oriented perfectionist. For example, Missildine (1963) suggests that some individuals will require perfection of others so that they themselves will not be judged negatively by others (see also Hollender, 1965). As a part of their own narcissistic need for and appearance of perfection, these individuals require others to be perfect, as any imperfection may reflect badly on them. This suggests that other-oriented perfectionism may involve the presence of diffuse boundaries reflective of borderline pathology (Roxborough, Hewitt, Flett, & Abizadeh, 2009; Hewitt, Flett, & Turnbull, 1994; Stoeber, 2014). Another manifestation of other-oriented perfectionism involves expectations for support. We have encountered other-oriented perfectionists who demand that others always demonstrate their loyalty and support. This too is an all-or-none phenomenon; other-oriented perfectionists see people as either totally supportive or antagonistic.

An interesting feature of other-oriented perfectionists is their tendency to be hypercompetitive. How would these perfectionists respond to other persons they perceive to have exceeded them in some significant domain? Other-oriented perfectionists tend to be narcissistic and find it highly threatening when they are outperformed by others. Most embrace a "win at all costs" approach to life, and being outperformed becomes a source of narcissistic injury that can evoke rage and aggressive behavior. One motive for other-oriented perfectionism is a need for control; impossible expectations of others may be largely attempts to control other people (Mor, Day, Flett, & Hewitt, 1995). Perfectionists by nature are also self-conscious individuals, and other-oriented perfectionism can be an unconscious means of diverting attention away from the self.

Case Examples of Other-Oriented Perfectionism

There are many clinical examples of other-oriented perfectionism. Albert Ellis (2002), for example, when asked by us to consider perfectionism among couples, recounted the story of Mr. J, a 36-year-old accountant who demanded perfection of his wife, Sally, and both of his business partners. As Ellis noted, Mr. J was in line for a "double divorce," because he had worn out his welcome both with Sally and with his business partners. He demanded perfection in their work performance, appearance, dress, and even tennis ability. He could not tolerate the carelessness of his wife and his business partners. Sally also ended up receiving treatment because both Mr. J and their daughter, Electra, demanded that Sally be perfect and keep up with their relentless pursuit of perfect achievements.

Cecilia was a 45-year-old married mother of two, and a self-employed professional. She readily admitted difficulties with perfectionism. Her initial assessment showed that Cecilia scored at the 86th percentile for women on other-oriented perfectionism, whereas her scores on other components of perfectionism were generally in the average range. She also scored in the mild to moderate range on both depression and anxiety symptom severity. Other assessment results indicated elevated and variable mood difficulties, with fluctuations in positive and negative self-evaluations. Cecilia stated that she had a dominating interpersonal style and that she was described by others as irritable, impatient, and easily provoked. Overall, she was seen by others as demanding and impatient. Moreover, she required exceptional results from those she worked with; likewise, she imposed unrealistic demands on those she lived with. Accordingly, Cecilia often censured her subordinates at work and frequently rebuked her family members at home. For example, her unrealistic expectations for her daughter's behavior throughout her

life resulted in recurrent and chronic conflict. Cecilia was one of five children; she recalled her father as dominant and authoritarian, and her relationship with her mother as characterized by constant concern over obtaining and maintaining her mother's tenuous caring. She had been involved in therapy for more than 7 years prior to seeking treatment on this occasion.

We have suggested that although other-oriented perfectionism can be associated with negative outcomes for the perfectionist, it is commonly the case that the target(s) of the other-oriented perfectionist will experience distress and negative outcomes. Although there is little research on how people cope with being the targets of other-oriented perfectionism, there is some evidence indicating how challenging life can become for these people. One of our studies found that the highest levels of marital and family adjustment problems were found among those perfectionistic people who had actually lived with other-oriented perfectionists (Hewitt, Flett, & Mikail, 1995; also see Habke, Hewitt, & Flett, 1999). Moreover, the aggressive and hostile displays of individuals with excessive levels of other-oriented perfectionism can have a huge impact on other people.

Unfortunately, in some instances, extreme other-oriented perfectionism can escalate into aggression and violence. One of the most poignant illustrations of this was recounted to us by a former student who had the misfortune of being married at one point to an exceedingly narcissistic man who demanded absolute perfection. The husband's anger at her perceived imperfections escalated at one point to such an extent that he threw her through a glass door—an action that could have easily killed her. Most chilling was his continuing chiding of her; he stated regularly that he was perfect and that the only mistake he had ever really made was marrying her (see Flett & Hewitt, 2002, for a complete account).

Socially Prescribed Perfectionism

In our third trait component of trait perfectionism, the perfectionistic individual perceives or believes that others demand perfection, and this belief may or may not be veridical. The others can be family members, friends, or colleagues, or they can be strangers. Our conceptualization of socially prescribed perfectionism is broad and generalized, and can capture a general societal pressure to be perfect, such as the collective social pressures to be perfect that have been identified in descriptions of the Church of Jesus Christ of Latter-Day Saints (i.e., the Mormon faith; see Lyon, 2013; Spotted Eagle, 2015).

Similarly, socially prescribed perfectionism can reflect the pressures

in a work situation: An already perfectionistic individual may find him- or herself in a job context where perfectionistic demands are imposed on the self because mistakes are not allowed or have high costs of some sort (e.g., surgeons, architects designing public buildings, referees in professional sports).

Although socially prescribed perfectionists may behave somewhat similarly to self-oriented perfectionists in their need for perfection, the former's drive for perfection stems from overtly interpersonal sources. For example, the motivational components of the socially prescribed perfectionist are concerned with attaining perfection as a means of securing acceptance, succor, love, and a sense of belonging and fitting, or of avoiding rejection and abandonment (Flett et al., 2002; Hewitt et al., 2006). Although these interpersonal needs are relevant for all components of perfectionism, they are particularly salient for the socially prescribed perfectionist.

Although the socially prescribed perfectionist experiences an inability to perform to the expected level of perfection, he or she derives little satisfaction from situations where he or she actually attains some success. Commonly, once he or she achieves some level of accomplishment or achievement, such a perfectionist will state, "Now this level of performance or more will be expected of me all the time," which results in even more distress.

We have noted (Hewitt & Flett, 1991a) that elements of helplessness and hopelessness are inherent in socially prescribed perfectionism. People who have extremely elevated levels of socially prescribed perfectionism will endorse the view that the better they do, the better they are expected to do. Success only brings higher expectations and even more impossible demands. The tendency to feel that demands for perfectionism can never be satisfied is amplified for those who actually have people in their lives making such demands (veridical evaluations of others' expectations). Extreme despair and demoralization can result in this situation. Indeed, recent data suggest that this helplessness and hopelessness among socially prescribed perfectionists can become precursors to suicide (Flamenbaum & Holden, 2007; Shneidman, 1993). Given that inescapable exposure to imposed demands to be perfect can represent a chronic source of stress, the stage is also then set for socially prescribed perfectionists to experience health problems—particularly if they lack the psychosocial resources and coping skills needed to respond to this interpersonal stress.

Socially prescribed perfectionists are people who have incorporated imposed expectations into their broader sense of self. They come to believe that people in general, or society as a whole, has placed on them an unrelenting pressure to be perfect. These individuals should be

distinguished from those who have the sheer misfortune of encountering a particular person who is impossible to please (e.g., a boss with unrealistic other-oriented perfectionism who expects too much).

Case Examples of Socially Prescribed Perfectionism

Thase et al. (2007) outlined the case of Ms. X, a 58-year-old married woman who had a major depressive episode following an interpersonal conflict with her boss. This episode was characterized by feelings of inadequacy, helplessness, and hopelessness. Her interpersonal sensitivity probably reflected her developmental history, which was characterized by emotional abuse from her father. Socially prescribed perfectionism was indicated by her conviction that she had to be absolutely perfect in order to please her abusive father (see Thase et al., 2007). While this case illustrates socially prescribed perfectionism that was seemingly veridical because of having had a father who was a harsh, other-oriented perfectionist, this tendency to judge others according to extreme standards was also part of Ms. X herself. That is, she was chronically dissatisfied with her husband, whom she perceived as a burden because he did not meet expectations and fell short of her standards. According to Thase et al. (2007), treatment focused on Ms. X's negative automatic thoughts and perfectionistic beliefs, and on how these tendencies affected her relationships. A key stage in her improvement was reached when she came to regard stressful situations as problems to be solved, rather than as illustrations of her failings and inadequacy.

Daniel was a 33-year-old single man working as an assistant clothing designer who sought treatment for perfectionistic behavior. He scored 1.5 standard deviations above the mean (93rd percentile) on socially prescribed perfectionism, and he endorsed moderately severe depressive symptoms and mild anxiety symptoms. Other testing indicated that he experienced significant irritability and verbal aggression, identity problems, and episodes of marked suicidal ideation. Daniel reported that he frequently felt a strong desire to excel, but was hindered and sometimes paralyzed by an intense fear of facing new challenges and profound expectations for success. He described himself as an "underachiever," because he had passed up career opportunities due to a debilitating fear of failing and of not being "good enough" in the eyes of others. After any success, the satisfaction he experienced tended to be short-lived, as he quickly doubted the quality of his performance. Daniel perceived that others set unrealistically high expectations for him and had pressured him to be perfect throughout his life. He had studied music at a high level and felt that he had always been pushed by teachers and coaches for the perfect sound, the perfect pitch, the perfect emotional expression,

and the perfect rhythm. He stopped studying music due to a physical injury and had lamented this loss ever since. He found it difficult to meet others' expectations and felt that even if he did, he would be expected to do even better the next time—a never-ending requirement to be perfect. In addition, it was important for Daniel to appear to be "on top of things," as he felt that mistakes made in front of others were the worst kind. In order to maintain this image of competence or perfection in the eyes of others, Daniel actively and anxiously managed others' impressions of his abilities.

Daniel's family of origin was described as somewhat chaotic, with his father being a harsh and strict disciplinarian who was "hard, cold, and unreachable," and his mother needing to be cared for. Daniel came to play a parental role with his mother, protecting her and attempting to regulate her neediness and emotions. Thus he played a complex role of taking care of his mother's needs in order to gain her acceptance, and attempting to placate his father by excelling. Prior to treatment, Daniel felt unsure of who he was, felt lost, lacked focus in life, and was uncertain of his goals for the future. He stated that he did not know how to determine what he should be doing in the future. This profound sense of being lost in the world was markedly distressing for Daniel, as was the sense that he could not trust others to be appropriate sources of guidance.

Newer Insights on Self-Oriented, Other-Oriented, and Socially Prescribed Perfectionism

We have now been studying the three trait dimensions of perfectionism for over 30 years, and some new insights have emerged, with some of these insights qualifying how these dimensions were originally described (Hewitt & Flett, 1990, 1991a). We briefly mention some of the more salient insights.

First, self-oriented perfectionism was described originally as a dimension with a motivational component that seems to reflect autonomous self-determination. However, clinical experience and accumulated research findings suggest that extreme self-oriented perfectionism reflects a compulsion and a sense of internal pressure. Thus the person has to *be* perfect, rather than simply *wish* to be perfect. This is a key distinction, because it accounts for situations in which the person strives for perfection when it is not necessary and is counterproductive. Another key insight is an increasing appreciation of the fact that even self-oriented perfectionism is rooted in interpersonal needs for admiration, recognition, and approval. Accordingly, the self-oriented perfectionist who believes that attaining perfection will positively transform

his or her interpersonal world is someone who is likely to be bound for disappointment when the perfectionistic ideal is achieved.

Second, it is important to recognize the vulnerability in other-oriented perfectionism. There are many issues involving self and identity that seem to fuel other-oriented perfectionism. Indeed, one way of viewing other-oriented perfectionism is that it involves demanding perfection from other people because these other people and their imperfections are reflections upon the self. For example, the coach who relentlessly demands perfect performance from his or her players is making these demands with the realization that how the team performs is ultimately a reflection on the coach. The sense of personal responsibility for outcomes is quite salient for other-oriented perfectionism.

Third, it is important to consider socially prescribed perfectionism from a person-centered perspective. There are many people who feel that excessive demands have been imposed on them and that they must try daily to live up to these expectations. But this pressure has not been incorporated into a high level of self-oriented perfectionism. The person who is high in only socially prescribed perfectionism is different in many respects from the person who is high in self-oriented, other-oriented, and socially prescribed perfectionism. Another difference found among people who are high in socially prescribed perfectionism is that many but not all of them are characterized by a public need to seem perfect to others. Perfectionistic self-presentation and its various facets are now described in greater detail.

INTERPERSONAL EXPRESSION OF PERFECTIONISM: PERFECTIONISTIC SELF-PRESENTATION

As noted earlier, we view perfectionistic self-presentation as a process component of the perfectionism construct (Kline, 1993; Thorne, 1995). In other words, self-oriented, other-oriented, and socially prescribed perfectionism represent content traits and reflect what people *have* in terms of perfectionism (see Cantor, 1990), whereas perfectionistic self-presentation represents a *dynamic* interpersonal style that directly reflects the drive to display one's perfection or conceal one's imperfection. There appears to be agreement from several sources that although levels of dispositional variables are important in influencing outcomes, the expression or process features of dispositional variables are also relevant (e.g., Paulhus & Martin, 1987; Wachtel, 1994). Although there has been little work generally focusing on levels and expressions of traits, we have attempted to incorporate these findings into our conceptualization of perfectionism, as they seem to be particularly relevant.

Numerous theorists have argued that fragile or low self-esteem and a fragile sense of connectedness with others are at the root of perfectionistic behavior, and that individuals will engage in perfectionistic behavior to garner approval, acceptance, or respect, or to avoid rejection, abandonment, and aversive emotional states. As a result of garnering this approval or acceptance, the individual believes that he or she will experience an increase in self- and other-regard and in personal equilibrium.

In order to obtain these interpersonal goals, of course, there must be an interpersonal context in which one's "perfection" is made visible or promoted, or where imperfections are hidden. Some individuals have perfectionistic self-presentational styles that involve not a drive or need to *be* perfect, but a drive or need to *appear to others* as perfect (Hewitt, Flett, Sherry, et al., 2003). Consistent with Sullivan's (1938/2000) notion that personality is made manifest through interpersonal interactions, we consider perfectionistic behavior to be a highly neurotic and maladaptive form of self-presentation. This striving to create an image of flawlessness or perfection to others is distinct from other components of perfectionism, and reflects the expression of perfectionism in the interpersonal context (Hewitt, Flett, Sherry, et al., 2003).

The notion that perfectionism involves a need to seem perfect to others is a theme that has been discussed by early symbolic interactionists (e.g., Cooley, 1902; Goffman, 1959a; Mead, 1934) and classic psychoanalytic theorists. For example, Karen Horney (1939) took issue with some of Freud's notions that neurotic behavior involves an overactive superego that is driven to comply with moral strictures to achieve perfection. Horney elegantly stated: "Those who seem to be driven by a relentless need for perfection only go through the motions of exercising the virtues they pretend to have" (p. 213); she added that "the type in question [i.e., perfectionist] is driven not by a need for an 'ever-increasing perfection,' . . . but by a need to maintain the *appearance* of perfection" (p. 215). Clearly, she was arguing that the essence of neurotic behavior, from her perspective, is not so much the drive to attain perfection, but rather the attempts to portray and convince others that one is perfect. Moreover, she indicated that the appearance of perfection is directed toward the self in order to garner self-approval, and is directed toward others in order to foster others' approval and acceptance. The sense of not living up to the standard of perfection is also relevant in perfectionistic self-presentation. For instance, Hilde Bruch (1973) not only described the striving for an image of perfection as part of a strong need to gain social approval; she also observed that patients often describe the discrepancy between the image they present to others and their inner experience of themselves.

As Bruch's work progressed, she became more aware of the façade that masked the inner turmoil of young people suffering from anorexia nervosa. Here again, we see the theme that what seems to have worked at one point in life does not work at another point in life. Specifically, Bruch (1988) observed in her book *Conversations with Anorexics* (published after her death): "It seems that the façade of perfection and the praise for it is reassuring during childhood, often until adolescence. Yet this façade is not sufficient to ward off anxiety and panic when puberty and changes in social roles and relationships and expectations demand different behavior and coping mechanisms, for which these young women are completely unprepared" (p. 5).

Although these comments and observations are highly insightful in focusing solely on the efforts to appear perfect, our conceptualization of perfectionism emphasizes that this need has distinguishable forms and manifestations. That is, there is both a need to be perfect and a need to appear to be perfect, and each of these can influence behavior and is associated differently with outcomes. Thus the perfectionism traits can energize and direct perfectionistic self-presentational interpersonal behaviors; however, it is also the case that individuals may not have elevated levels of trait perfectionism (i.e., the requirement for themselves or others to be perfect), but may simply attempt to present themselves interpersonally as perfect. Furthermore, individuals can present themselves as perfect to others in several ways, which we describe below.

A person who projects an image of him- or herself as perfect is prone to many sources of distress and possible health problems. The perfectionistic self-presenter is someone leading an inauthentic existence, and our empirical work has established strong links between this self-presentational style and feeling abjectly like an imposter (see Hewitt, Flett, Sherry, et al., 2003). The person with these tendencies is going throughout life according to a false sense of self and a paucity of feelings of authenticity. At the same time, he or she is ever-vigilant and hypersensitive to any sort of cue or sign of disapproval, and this vigilance is fueled by an excess of public self-consciousness.

An extreme form of this self-presentational style is the tendency to try to seem effortlessly perfect. Some individuals wish to seem like "born experts" or "naturals," and they will go to great lengths to make it seem as if their achievements were the products of little effort. This orientation is likely to be rooted in beliefs that those who have to exert themselves will be seen by other people as not having the capacity to be perfect (see Travers, Randall, Bryant, Conley, & Bohnert, 2015).

Unfortunately for perfectionistic self-presenters, this approach to life has severe psychosocial consequences. These individuals are regarded as unreachable and annoying, and are not popular with others. People find it difficult to relate to them, and as a result, they find it difficult to

establish any sort of intimate connection. This sets the stage for a form of social disconnection that we have incorporated into a model of vulnerability to maladjustment and psychopathology, which is outlined in Chapters 4 and 5.

In addition, by presenting themselves as perfect and not being able to admit to any form of imperfection, these people cut themselves off from viable sources of social support, especially during the challenging times in their lives. This observation is supported by growing empirical evidence linking perfectionistic self-presentations with perceived deficits in social support (Sherry, Law, Hewitt, Flett, & Besser, 2008) and avoidance of seeking support from others (Crâciun & Dudâu, 2014), including professionals (Hewitt, Dang, et al., 2016).

Other difficulties associated with perfectionistic self-presentation are that it involves a heightened self-focus, and that it appears to promote a tendency to engage in ruminative brooding. In our recent work, we have been focusing on the notion that these persons seem perfect on the outside, but can experience despair and are depressed and brooding on the inside. But by putting on a mask and not seeking others out or admitting to difficulties, they make it impossible for other people to see their distress or perceive that they need help (see Flett & Hewitt, 2013).

Finally, perfectionistic self-presenters must be hypervigilant so that mistakes are minimized. They must be constantly on the defensive—and this can be a highly exhausting orientation.

Important distinctions in the self-presentation literature are made between "inclusionary" (attributive) and "exclusionary" (protective) self-presentation, and between "promotion" and "concealment." There are two general motivational components in perfectionistic self-presentation. One involves striving to present one's "perfections" by actively proclaiming them. The other involves striving to conceal any of one's "imperfections" by neither displaying nor disclosing any flaws or shortcomings (Hewitt, Flett, Sherry, et al., 2003).

Perfectionistic Self-Promotion

The first facet of perfectionistic self-presentation, perfectionistic self-promotion, involves actively proclaiming and displaying one's own "perfection" to others.[2] This dimension is an attributive self-presentational style (Leary, 1993; Wolfe, Lennox, & Cutler, 1986) that involves proclaiming a desired identity by attempting to infuse what are presumed to be positive aspects of the self into interactions with others. Individuals with excessive levels of this interpersonal style are acutely aware of others' appraisals and emotions (Hewitt, Flett, Sherry, et al., 2003), and attempt to influence these appraisals by actively portraying themselves in a perfect manner. They attempt to promote a picture of themselves as

exceptionally capable, competent, successful, and on top of things. This kind of behavior "involves attempts to look, demonstrate, or behave in a perfect manner to others . . . the individual communicates a picture of being flawlessly capable, moral, socially competent, absolutely successful" (Hewitt, Flett, Sherry, et al., 2003, p. 1305).

Individuals with this interpersonal style look for opportunities to impress others. They are likely to seek out the most powerful and influential person in a group, to attempt to gain this person's admiration and to impress him or her—thereby bolstering their own sense of importance and worth.

Case Examples of Perfectionistic Self-Promotion

Kuyken (2000) described the case of Ms. B, a 26-year-old married woman who suffered from major depression. She had been functioning well for an extensive period (or at least seemed to be), but then she started two new jobs at virtually the same time. Kuyken (1999) observed that her coping resources seemed to be overwhelmed by starting these new jobs while feeling she had to seem perfect in public.

Ms. B was raised in a home characterized by extreme marital discord. Her mother was overinvolved with Ms. B, while her father was domineering and critical of both Ms. B and her mother. An initial assessment indicated that Ms. B exhibited a sense of incompetence reflecting the theme "I can't think for myself" and a belief that "I must present a perfect public façade" (p. 51). In her life, Ms. B sought to limit opportunities for failure or being seen as a failure, as well as the possibility of experiencing negative emotions. Ms. B believed that if she could appear to be a success, then no one would "figure out her inner turmoil" (p. 51). Thus, while she seemed highly defensive, she took the approach of trying to promote herself as perfect rather than minimizing displays or admission of imperfections.

A patient undergoing individual psychotherapy also illustrates the self-promotion of perfection. Elaina, a 47-year-old single mother of one, had a highly demanding job and was consistently in the public eye. She was described by others as "overfunctioning" and as highly skilled and gifted in her profession. Although viewed positively by others for her accomplishments and her work ethic, she stated that she was driven to work to her full potential at all times; she always felt that she was never doing enough and could not relax. She tried very hard to present an image of perfection to those around her, and was concerned that others not know how hard she worked to maintain this façade. Nor did she want others to know the pain and turmoil she experienced in presenting this highly competent, highly functioning, professional image. For example,

Elaina was terrified of making mistakes, especially those that would be known to others. Elaina had tremendous respect for her colleagues, whom she described as highly professional and talented. Even though her profession was not an inherently competitive one, she found herself consistently striving to outperform her coworkers. When not at work, when she could be relaxing, she often found herself crying uncontrollably. She experienced severe migraines, high levels of tension and anxiety in her daily life, and symptoms of depression (including self-criticism, sleeping difficulties, and fatigue). Her mood was extremely labile, and she was prone to sudden, explosive fits of anger. She also used various medications to control her emotional states as well as her physical symptoms. Although she admitted that she had burned out at work a long time ago, to her, quitting would mean admitting and portraying failure.

Although perfectionistic self-promotion involves displaying one's purported perfection, the other two facets of perfectionistic self-presentation are both concealing forms of self-presentation: "nondisplay of imperfections" and "nondisclosure of imperfections." They share some features. Both facets involve vigilance of others' emotions, appraisals, and interpersonal behaviors (both verbal and nonverbal). Nondisplaying and nondisclosing perfectionistic self-presenters are acutely aware of whether others view them in a positive or negative light, and experience interpersonal encounters as risky. They experience anxiety, stemming from feeling vulnerable to harsh judgments, ridicule, and nonacceptance. Interpersonal encounters are situations in which they might be seen as imperfect; as such, these encounters are to be avoided. The strong needs to avoid public appraisal represent efforts to avoid painful reminders of personal inadequacies and failure to live up to expectations of perfection. Denial, deception, and secrecy are characteristics of individuals who exhibit such perfectionistic behavior, which clearly suggests an unwillingness or inability to admit to problems and shortcomings (e.g., Bruch, 1973; Horney, 1939). These two concealing forms of perfectionistic self-presentation are discussed separately below.

Nondisplay of Imperfection

The nondisplay of imperfection involves a passive, concealing interpersonal stance—a repudiative style of behavior entailing avoidance or concealment of any behavior that could be judged by others as imperfect or as reflective of the individual's imperfections. Rather than focusing on demonstrating perfection to others, this dimension involves avoiding being seen, behaviorally, in any less than perfect way. This avoidance includes not allowing others ever to observe any imperfect behaviors or performance (e.g., public speaking) by not participating in such activities.

Nondisplay of imperfection involves disavowing an undesired identity (i.e., being imperfect) by concealing negative or imperfect aspects of the self (Leary & Kowalski, 1990). If imperfections cannot be detected or viewed by others, the individual can protect a "perfect" image and avoid being revealed as flawed.

Individuals with excessive levels of the nondisplay of imperfection will, of course, avoid situations that involve scrutiny of or evaluation by others, as well as ones where any personal shortcomings, mistakes, or inabilities may be revealed. They engage in attempts to hide mistakes from others, including prevarication as well as outright hiding of errors. These individuals view any situation where they are required to perform in any manner as risky, and experience in such situations a profound sense of vulnerability and anticipation of humiliation and shame.

Case Example of Nondisplay of Imperfection

Gil, a 38-year-old unemployed artist and instructor, reports that his perfectionism affects all aspects of his life. He is a visual artist, but is held back creatively because he does not want to take risks and potentially experience the ridicule or humiliation of failing. Although he has excellent credentials to function in a professional capacity in a position he would love to be involved in, he does not seek such a position, because he feels he is not ready or good enough. Moreover, in all of his education and training courses, he would become overwhelmed with the need to get all A's and yet would perform very well in the end. He reports that he is concerned about not looking good in front of others, or having them see that he may have fallen short somehow. He feels incompetent most of the time. He will work hard to conceal any parts of performances or classes that he is not absolutely sure about, and expresses concern with hiding or fixing errors before anyone can become aware of them. He is concerned about pleasing others and receiving accolades, and will spend inordinate amounts of time preparing classes and presentations in an attempt not to reveal any shortcoming, error, or faltering. He has never been in a romantic relationship and experiences significant isolation and alienation. He seeks and receives some support and reassurance about his life from his family members, but he does not trust their support, believing that they say positive things only because they are family. Gil has described his childhood experiences with a supportive and nurturing mother but a cold, critical father who provided meager positive feedback or attention only when Gil excelled at some task. His need for A's in school began in high school and continued throughout his educational career. Overall, Gil experiences significant anxiety, with a marked desire to appear competent at all times and not to reveal any flaws.

A second detailed case example of someone with excessive levels of nondisplay of imperfections, Frances, is presented in Chapter 8.

Nondisclosure of Imperfection

The last dimension, nondisclosure of imperfection, also reflects a passive and concealing interpersonal style. In this case, the focus is on not disclosing or revealing verbally to anyone any shortcomings, imperfections, or any information in general that could be judged negatively by others. Thus personal verbal disclosures (such as revealing one's thoughts, emotions, or any other personal information) are avoided. Individuals with excessive levels avoid situations that involve admitting or discussing their perceived shortcomings. If compelled to be in one of these situations, they will not fully engage in self-disclosure, and thus may come across as cold, distant, and unlikable. As discussed earlier, we (Hewitt et al., 2008) showed that clinicians who conducted initial clinical interviews rated those high on perfectionistic nondisclosure as less liked, and said they would prefer not to see them for treatment. Individuals with excessive levels of this facet are likely to view any conversation or interaction in which there is an expectation to be personally revealing as anxiety-provoking and to experience a sense of vulnerability in such a situation.

Case Example of Nondisclosure of Imperfection

Justine was a 38-year-old mother of three who was a school teacher and also an accomplished actress in a local theatre group. She sought treatment for her long-standing depression and anxiety after hearing a presentation by one of us (Paul L. Hewitt). She indicated that she had significantly low self-confidence, despite her significant accomplishments. She stated that she had to be perfect in everything she did, and she believed this contributed to her depression. She scored at the 99th percentile on nondisclosure of imperfections, but scored somewhat less high on the other components of self-presentation and on the perfectionism traits. Other assessment material supported her significant depression and anxiety, social isolation and withdrawal from intimate relationships, family discord, and sense of alienation and disconnection. Her perfectionistic tendencies were evident throughout the treatment. At one point, following a time when she experienced serious physical health concerns, the depression reappeared; she indicated that she had passive thoughts about suicide, but did not admit to a plan or intention to die. Moreover, she also did not admit to any pain or hopelessness. The clinician evaluated Justine at many points throughout the therapy for suicidal intention, and although she indicated that she had some minor suicidal thoughts, it

was only after her hospitalization for a serious suicide attempt that she admitted that she did not want to reveal to anyone, including the therapist, the magnitude of her distress or her desire to end her life. She did not want to lose any respect from others, or to be viewed as flawed or in need of help in any way by anyone.

As we have discussed earlier, in addition to psychoanalytic writings that underscore the importance of needs for acceptance and approval, researchers in the self-presentation field have suggested that general self-presentation is motivated intrapersonally by a desire for self-esteem maintenance and enhancement (Schlenker & Weigold, 1992), and interpersonally by a desire to please an audience (Baumeister, 1982) or to avoid negative social outcomes (Baumeister & Tice, 1986; Leary & Kowalski, 1990; Schlenker, 1980). It seems reasonable to propose that the perfectionist's already fragile sense of self-esteem (Flett, Hewitt, Blankstein, & O'Brien, 1991) is protected to the extent that he or she is able to avoid criticism or to elicit praise (see Leary & Kowalski, 1990). The strong need for approval that drives perfectionism is also likely to promote a defensive posture that protects the self from being known by others as imperfect.

A second detailed case example of a patient with excessive levels of nondisclosure of imperfections, Charles, is provided in Chapter 8.

INTRAPERSONAL OR SELF-RELATIONAL COMPONENTS OF PERFECTIONISM

In the perfectionism literature, there is much discussion of cognitive or attitudinal elements of perfectionistic behavior (Frost et al., 1990; Shafran & Mansell, 2001). In fact, some have suggested that the perfectionism construct is entirely cognitive and can be wholly captured by the concepts of dysfunctional attitudes or beliefs (e.g., Burns & Beck, 1978; Ellis, 1962). Although we view the perfectionism construct as broader, there is little doubt that the cognitive and information-processing elements represent an important component of the perfectionism construct. The tendency to process evaluative information in a social-cognitive context and to criticize oneself harshly are key cognitive processes underlying perfectionism. Early writers have described these cognitive elements in terms of recriminations from an overly harsh superego or ego ideal (Freud, 1923), tyrannical "should" statements (Horney, 1950), irrational self-related beliefs (Ellis, 1962), or dysfunctional attitudes (Burns & Beck, 1979). We have suggested that these components arise from the "ideal self" that influences information processing, which indicates that the individual fails at perfection (Besser, Flett, Hewitt, & Guez, 2008;

Hewitt & Genest, 1990). Moreover, we would suggest that this processing of information, and the processing of information using what others have termed the “ought self” (Higgins, 1987) or “other-relational schemas” (Baldwin, 1992), result in a sense of social disapproval, judgment, or evaluation. Individuals who are perfectionistic will have “ideal-self” and “ought-self” schemas that are easily accessed and frequently used to process information.

Perfectionists often hold internalized conceptions of ideals and goals for themselves that represent the “perfected parents and fictional finalisms of culturally supported, highly desirable end states” (Ogilvie, 1987, p. 380). Rogers (1961) was one of the first to describe and develop the concept of the ideal self as what an individual feels he or she should ideally be, and representing the person’s goals, aspirations, and hopes (see also Piers & Singer, 1971). The ideals and goals are thought to derive from a variety of sources.

Similarly, the ought self represents the ideals, aspirations, and attributes that an individual perceives others believe he or she should possess. Thus, as Higgins (1987) suggests, the ought self (sometimes referred to as the “social ideal self”) is a representation of others’ beliefs about the individual’s “duty, obligations, or responsibilities” (p. 321). These “others” may be known or unknown, specific persons, or people more generally.

We suggest that the ideal self and the ought self can function as schemas (also see Wyer & Srull, 1994) in processing information, and especially in evaluating oneself and one’s performance. But there has not been a great deal of research determining whether these selves can function as schemas. One exception was a study done by Hewitt and Genest (1990), who provided evidence that the ideal self can function in processing perfectionistic information, much in the same manner that the actual self can function as a schema. Moreover, Strauman and Higgins (1988) and Strauman (1989) provided evidence that discrepancies between the actual self and ideal self, and between the actual self and ought self, are differentially associated with dejection-related and agitation-related negative affect and with pathological states (see Higgins et al., 1994).

A major aspect of the cognitive component of the CMPB is the inner expression of perfectionism: one’s internal dialogue and preoccupation with the need to be perfect, which results in automatic thoughts or ruminations, self-recriminations/self-censure, and so forth. Flett et al. (1998) have suggested that these automatic cognitions arise when a perfectionistic individual experiences a discrepancy between the actual self and the ideal self. Whereas the other components of the CMPB are stable and dispositional, the cognitive component can be seen as more state-like, comprising aspects of perfectionism that can be triggered in a variety of

contexts. However, perfectionism cognitions can be seen as more trait-like when they are chronically activated. Indeed, research suggests that scores on a measure of perfectionistic automatic cognitions are stable over time and may reflect personality processes and chronic activation of cognitive processes. The work conducted by Bargh and Chartrand (1999) highlights that cognition may be automatic and unconscious, instead of reflecting conscious, systematic processing and related decision making. Perfectionistic thinking may be so ingrained for some people that it can be activated automatically as a cognitive filter. However, there is still a role for conscious cognition, in the form of a preoccupation with shortfalls and ruminating about imperfections.

Many observations suggest that perfectionistic individuals are preoccupied with thoughts and images involving the need to be perfect (e.g., Moore & Barrow, 1986). For example, Frost and Henderson (1991) had a sample of women athletes complete measures of perfectionism and a thought-reporting measure prior to competition. They found that perfectionists, as defined by the Frost et al. (1990) measure, reported more perfectionism-themed thoughts and images and more thoughts about mistakes than others reported. Thus the perfectionism construct involves ruminative perfectionism-themed thoughts regarding the self.

Consistent with the conceptualization of individual differences in automatic thoughts about the need to be perfect, the preoccupation with perfection can be triggered by a range of failures and stressful events that invoke the internal dialogue of perfectionism-themed ruminations and self-recriminations. Failures and indications of one's lack of perfection will produce self-focused thoughts and ruminations, but they also will trigger ruminations that are interpersonally themed (such as fears of lack of belonging and lack of approval or acceptance), because the need to be perfect is often rooted in the needs to matter to others, to be accepted, to fit, and to belong, and not to be abandoned, ridiculed, or rejected. Although there has been little research done on the latter component, one study (Nepon, Flett, Hewitt, & Molnar, 2011) provided some initial evidence of this need. A sample of 155 undergraduate students completed our measures of perfectionistic traits and perfectionistic self-presentation, as well as measures of interpersonal rumination and measures of depressive symptoms and social anxiety. The results confirmed that socially prescribed perfectionism and perfectionistic self-presentation were associated significantly with negative social feedback and rumination following a distressing interpersonal event. People who frequently received negative social feedback not only were exposed to a chronic and destructive form of stress; they were essentially being told that they didn't matter or that they were not acceptable to other people, so it was not surprising that negative social feedback exposure was also

linked with depression. Additional findings showed that negative social feedback and interpersonal rumination mediated the links between components of the perfectionism construct and distress. These findings provide some initial evidence that following a distressing event, perfectionistic individuals engage in rumination on interpersonally related themes, and that this rumination plays an important role in the distress they experience.

Case Examples of Perfectionistic Automatic Thoughts

Pélissier and O'Connor (2004) utilized cognitive-behavioral therapy (CBT) to treat trichotillomania, an impulse control disorder characterized by recurrent hair pulling, in a 23-year-old woman named Ms. C. She sought treatment both for her hair pulling, which prevented her from being able to study and perform academically, and for the feelings of depression, anger, and frustration that accompanied her trichotillomania. Ms. C's distress and lack of impulse control were fueled by persistent thoughts reflecting the theme "Everything must be perfect," and associated attitudes and beliefs including "I should understand things perfectly and right away," "Things should always go as I planned them. I shouldn't be late or have to wait. If I do, it means I'm disorganized and imperfect," and "My friends (and boyfriend) should think like me or else it means that we're not on the same wavelength (it's not a perfect relationship)" (p. 65). Ms. C also had elevated scores on all trait dimensions assessed by the Frost Multidimensional Perfectionism Scale (hereafter abbreviated as the FMPS, as opposed to our own MPS). A specific goal of the treatment was to reduce Ms. C's hair-pulling behaviors by targeting the perfectionistic thoughts that were identified as preceding these behaviors. The authors noted that perfectionism complicated the treatment process, because Ms. C had difficulty envisioning alternatives to the perfectionistic thoughts she was experiencing; this is not surprising, in the sense that these thoughts are chronic and seemingly uncontrollable when experienced by someone who is cognitively preoccupied by these thoughts.

Another particularly remarkable example is the case of a female university student who suffered from comorbid posttraumatic stress disorder (PTSD), generalized anxiety disorder, and major depressive disorder (see Lobenstine & Courtney, 2013). Her PTSD stemmed from the death of her sibling when the patient was quite young, as well as a history of being emotionally abused for several years by her mother. Assessment and treatment with a form of ego state therapy identified five ego states, including one that the patient referred to as "the perfectionist." "The perfectionist" component of the ego operated according to the

belief "I must be perfect." Especially revealing findings for our purposes are that the patient based her identity on the theme "I must be perfect," and that this need to be perfect was developed to try to compensate for her sibling's physical vulnerabilities before the sibling's death. However, after her sibling's death, the need to be perfect in combination with her mother's emotional abuse led to the development of a fragility and sense of self-hatred that became magnified over time. The realization as an emerging adult that the need to be perfect actually stemmed from her positive feelings for her deceased sibling, rather than personal deficiency, was a key development in this young woman's recovery.

THE INTERPLAY OF PERFECTIONISM TRAITS, STYLES, AND COGNITIONS

Rather than thinking about the components of the CMPB as reflecting seven different kinds of perfectionism, we view the traits, self-presentational styles, and automatic cognitions as interacting with each other. They reflect various levels of behavior that must be taken into account when seeking to understand a particular person's perfectionism as part of the person's treatment. Clearly, various combinations of these components are exhibited in the particular idiosyncratic manifestations of perfectionism, and the combinations can shift and alter depending on the context of each individual. Thus, although scores on the various measures tend to be substantially intercorrelated, it is possible to identify people with distinct patterns characterized by elevations on one or two of the components.

Earlier in this chapter, we have suggested that the three components of the CMPB are overlapping but independent. There is evidence, for example, that the traits, self-presentational facets, and automatic cognitions are associated with one another, but that the components also predict unique variance in outcomes (Flett et al., 1998; Hewitt & Flett, 1991a; Hewitt, Flett, Sherry, et al., 2003). For example, many studies have shown that trait components of perfectionism are associated both with perfectionistic self-presentation facets and with perfectionistic cognitions, but that the various components account for unique variance across disorders and presenting problems (see Flett et al., 1998; Hewitt, Flett, Sherry, et al., 2003).[3]

In addition to providing a descriptive model of the perfectionism construct, we have suggested that perfectionistic behavior is associated with a variety of maladaptive outcomes in the psychological, relational, physical health, and achievement domains. The model is outlined in detail in our earlier book (Hewitt & Flett, 2002), where we have suggested that

perfectionistic behavior can powerfully influence the experience of distressing events in an individual's life. Because the perfectionistic behavior is a component of the individual's personality, the behavior can create a life full of distress, pain, and feelings of being defective.

DISTINGUISHING AMONG THE FACETS OF THE CMPB AT THE DESCRIPTIVE LEVEL

We have described evidence above that attests to the empirical distinctiveness of the various facets of the CMPB, and we have adopted a person-focused perspective to highlight the heterogeneity among people who are quite different, even though they all qualify for the generic designation of being perfectionists. In this final major section of the chapter, we illustrate the distinctions involved here by briefly examining how reactions and themes vary across the CMPB facets in two situations that are relevant to an understanding of perfectionism: (1) the anticipation period just before an important test, when tension and worry are mounting (e.g., a driving test or a final exam); and (2) the evaluation situation after the test, when negative performance feedback is received.

When a challenging test is looming, the self-oriented perfectionist taps into themes that involve concerns about failure, while studying excessively in order to achieve success and avoid failure. Other-oriented perfectionism involves managing personal feelings of tension through distracting oneself by focusing on other people's flaws and shortcomings. Someone with high levels of socially prescribed perfectionism senses a pressure to live up to unrealistically high standards imposed on the self. Whereas the self-oriented perfectionist feels that he or she must be perfect in order to attain high personal goals, the socially prescribed perfectionist feels that he or she must be perfect to meet social expectations. The individual who also feels a need to seem perfect is focused on presenting a calm demeanor in public, but is more likely to avoid social interactions that could reveal the growing sense of fear and worry, because of this person's sensitivity to displaying visible signs of anxiety (see Flett, Greene, & Hewitt, 2004). Finally, the perfectionist plagued by an excess of automatic thoughts about the need to be perfect is cognitively preoccupied with thoughts like "Why can't I be perfect?" and "I have to be the best." According to previous empirical findings (see Flett et al., 1998), such thoughts are accompanied by reports of fear-of-failure imagery and problems with wandering of the mind and lack of attentional control.

One week later, when negative performance feedback is received, both self-oriented and socially prescribed perfectionism should be linked with strong feelings of distress; however, socially prescribed

perfectionism is likely to reflect a complex blend of negative emotions that include sadness and upset, but also a sense of shame because others will know about the failure to meet expectations. Other-oriented perfectionism is likely to involve an attributional pattern of defensively blaming others (for a discussion, see Hewitt & Flett, 1991b). The person with a high score on perfectionistic automatic thoughts now experiences postevent thoughts about mistakes that were made and ruminating about falling short of the ideal standard. The greatest distinction is likely to be found for the self-presentational element of the CMPB. The perfectionistic self-promoter may act as if nothing is wrong and all has gone according to plan, thus providing a false social comparison target for other students who took the same test. The person more focused on nondisplay and nondisclosure of imperfections is likely to become even more socially isolated, avoidant, and disconnected from other people. If the failure is known to others, he or she is likely to experience a profound sense of shame and humiliation, because public mistakes and setbacks can prove overwhelming to the person.

The reactions described above are discussed as if separate people were involved. However, when the person in question has elevations across multiple perfectionism components (e.g., the person is high in trait, self-presentational, and cognitive perfectionism), then it is evident that this person could be subject to an intense and complex blend of emotions. However, because of the tendency to engage in perfectionistic self-presentation, this person may appear outwardly calm and placid in a way that does not at all reveal the rumination and distress lurking below the surface.

CONCLUSION

In this chapter, we have provided a discussion of the descriptive CMPB and have described the model's three major components: perfectionism traits, self-presentational facets, and automatic thoughts about the self. We have argued that perfectionism can function at different levels and in different ways, depending on the perfectionism components in question. It is our belief that when broad personality variables, such as perfectionism, are being considered as relevant clinical factors, these three levels of trait, interpersonal expression and intrapersonal expressions need to be considered. Lastly, we have operationalized all of the components of the CMPB for adults and children (see Chapter 7) and evaluated extensively the empirical support for components of the model (e.g., Flett et al., 1998; Hewitt & Flett, 1991b; Hewitt, Flett, Sherry, et al., 2003; Hewitt et al., 2008).

NOTES

1. Elsewhere, we have discussed a fourth perfectionism trait (Hewitt et al., 1989; Hewitt & Flett, 1990), termed "world-oriented perfectionism" (WOP; Hewitt et al., 1989). This seems consistent with Watzlawick's (1977) description of perfectionism as a concern with making society or the world perfect. He described the concept as the belief that the world is a perfectable place, and that individuals who pursue perfecting social order are fanatical and responsible for many great ills and catastrophes in history. This incorporation of perfectionism into a world view is focused at a different level from that of self or others. The focus is more broadly at the societal level and suggests that this kind of perfectionism may be one component of the personality of individuals who are fanatically oriented toward perfecting the world. Hewitt et al. (1989) suggested that the Perfectionism subscale of the Irrational Beliefs Test (IBT; Jones, 1969) roughly captured WOP as a belief that "there is invariably a right, precise, and perfect solution to human problems and that it is catastrophic if this perfect solution is not found" (Jones, 1969, p. 9). The existing research using this IBT subscale suggests that it is not related to other measures of other forms of perfectionism. For example, Jones (1969) found that it was not associated with a Perfectionism subscale of the Sixteen Personality Factor Questionnaire (16PF), and we (Hewitt & Flett, 1990) found that it was not associated with self- or other-oriented perfectionism attitudes. Whereas perfectionism that is directed toward the self is generally associated with depression in patients (Hewitt & Flett, 1991b, 1993), and other-oriented perfectionism is not associated with depression, WOP seems to be negatively associated with depression and positively associated with externalizing conditions (Cash, 1984; Hewitt & Flett, 1990; Lapointe & Crandell, 1980; Nelson, 1977). Overall, the findings of these few studies support the idea that WOP is independent of other forms of perfectionism and represents a unique form of perfectionism functioning at a different level from that of other perfectionism traits. The notion that this kind of perfectionism functions at a much broader level may account in part for some of the heinous and notorious attempts to create a perfect social order, a perfect race, or a perfect world. We are in the process of investigating this component of perfectionism and its outcomes. Certainly this is a potentially important avenue for future research.
2. The behaviors discussed are similar to some of the descriptions of "narcissistic perfectionism" that others have described. Narcissistic perfectionists have a drive to gain admiration and respect from others, and to avoid the shame and humiliation that would arise from not being perfect or not being able to appear perfect (Sorotzkin, 1985). One way this can be done is through overt demonstrations of superior characteristics and claims that perfection has been attained.
3. Using factor-analytic techniques, we examined several samples of patients (n = 541), community members (n = 475), and students (n = 741) who completed our measures of traits, self-presentational facets, and perfectionistic

cognitions. We conducted principal-components analyses, with varimax rotation on the 45 items of the MPS, the 27 items of the PSPS, and the 25 items of the PCI. A three-factor solution was specified in each analysis. It was found in all samples that Factor 1 comprised mainly PSPS items, Factor 2 comprised mainly or solely PCI items, and Factor 3 was composed mainly of MPS items. These findings suggest that the three components of our model—perfectionism traits, self-presentational styles, and cognitions—are not redundant with one another.

CHAPTER 3

Evidence for the Clinical Relevance of Perfectionism

There are numerous reasons why a focus on reducing or eliminating perfectionism should be a goal in assessment and treatment. Perfectionism can influence the difficulties endured by individuals in both direct and indirect ways by creating vulnerabilities to disorders or influencing symptom expression (Hewitt & Flett, 2002). It can also have an impact on how individuals deal with difficulties arising from their perfectionistic behavior. In this chapter, we describe research illustrating the links between perfectionism and the domains of psychopathology, relationship problems, health issues, and finally psychotherapy process and outcome.

Extensive evidence suggests that perfectionistic behavior is directly related to pathological outcomes. We have suggested that perfectionism functions as a vulnerability factor in, or a maintenance factor for, a variety of disorders, syndromes, and symptoms. The majority of research on perfectionism, defined and operationalized in various ways, has focused on the hypothesized psychopathology outcomes and the nature of the relationship between perfectionism and such negative outcomes. Most research on perfectionism in clinical dysfunction has focused either on mood and anxiety disorders or on the eating disorders. Below we summarize some of the research on multidimensional perfectionism in these disorders. Our select review focuses mainly on perfectionism research that has used multidimensional measures with demonstrated reliability and validity among clinical populations. It is not meant to be an exhaustive review.

PERFECTIONISM IN MOOD AND ANXIETY DISORDERS

Although a great deal of research has been done on nonclinical samples and depression, we (Hewitt & Flett, 1991b) illustrated the clinical relevance of perfectionism traits in groups of depressed patients, anxious patients, and matched nonclinical controls. Self-oriented perfectionism was found to be significantly higher in the group of depressed patients than in the other two groups. There were no group differences in other-oriented perfectionism. However, both clinical groups had higher mean levels of socially prescribed perfectionism, relative to the nonclinical controls.

Subsequent research has clarified the similarities and differences between self-oriented and socially prescribed perfectionism. There is some evidence that self-oriented perfectionism is a significant vulnerability factor in unipolar depression. This component, in the presence of stressful events, and perhaps especially self-related failures or stressors, appears to result in increases in unipolar depression symptoms in cross-sectional research (see Hewitt & Flett, 1991b, 1993) and in longitudinal research (Enns & Cox, 2005; Hewitt, Flett, & Ediger, 1996). Moreover, although the role of socially prescribed perfectionism appears to have less specificity, there is support both for its association with unipolar depressive symptoms and for its interactions with stressors (in some cases, only social stressors) to predict increased depression symptoms (Cox & Enns, 2003; Hewitt & Flett, 1993; Hewitt et al., 1996).

Another study of 121 patients with depressive disorders assessed whether perfectionism might be associated with chronicity or persistence in unipolar and bipolar mood disorder symptoms (Hewitt, Flett, Flynn, Norton, & Ediger, 1998). It was found that self-oriented perfectionism was uniquely predictive of chronic unipolar symptoms when considered along with other-oriented and socially prescribed perfectionism, again supporting the link between self-oriented perfectionism and unipolar depression. Socially prescribed perfectionism was uniquely predictive of state unipolar symptoms. Finally, both other-oriented and socially prescribed perfectionism were unique predictors of chronic bipolar symptoms. These findings are generally consistent with research showing that patients with bipolar disorders tend to have elevated perfectionistic dysfunctional attitudes (e.g., Scott, Stanton, Garland, & Ferrier, 2000), and with evidence suggesting that mania is linked with striving for highly ambitious goals (see Johnson, 2005).

Enns and Cox (2005) extended this research on the persistence of unipolar depression symptoms among patients and found that self-oriented perfectionism interacted with achievement life events in the prediction of symptoms at a 1-year follow-up. Evidence was found that

socially prescribed perfectionism predicted depression symptoms only as a main effect, and that it did not interact with either achievement or interpersonal stressors to predict follow-up depressions symptoms.

Although there has been no work examining our conceptualization of perfectionism and dysthymia, other work has shown that components of perfectionism as measured by the FMPS (Frost et al., 1990) are elevated among patients diagnosed with dysthymia (Huprich, Porcerelli, Keaschuk, Binienda, & Eagle, 2008) and among persons with high scores on a measure of depressive personality disorder (Huprich, 2003b). The components most relevant were elements of self-oriented perfectionism, including concern over mistakes and doubts about actions.

There appears to be good evidence of association between components of perfectionism and unipolar mood disorders. It also appears that, depending on the trait dimension, the relationships differ with unipolar and bipolar symptoms. Self-oriented perfectionism seems likely to confer a vulnerability to unipolar depression that becomes manifest in the presence of stressors, and, in some cases, achievement or self-related stressors in particular (Hewitt, Mittlestaedt, & Flett, 1990). As for socially prescribed perfectionism, existing evidence suggests that it is likely to be a concomitant of the depressive experience that may play an important role in increasing or maintaining existing symptoms of unipolar depression. More work is necessary to replicate findings that other-oriented and socially prescribed perfectionism may be associated with the chronicity of bipolar disorders.

The findings from the Hewitt and Flett (1991b) study established that socially prescribed perfectionism was associated with DSM-based anxiety disorders as well as depression. A more extensive analysis of the clinical relevance of trait perfectionism in anxiety disorders was conducted by Antony, Purdon, Huta, and Swinson (1998). They administered both multidimensional perfectionism instruments to a mixed sample of 70 patients with social phobia, 45 with obsessive–compulsive disorder (OCD), 44 with panic disorder with or without agoraphobia, and 15 with specific phobia. A comparison group of 49 nonclinical volunteers was also obtained. Significant group differences were found on socially prescribed perfectionism. Levels of socially prescribed perfectionism were elevated in the groups with social phobia and panic disorder relative to the nonclinical volunteers and the patients with specific phobia. On Frost's MPS (Frost et al., 1990), there were group differences on four of the six subscales; the subscales for high standards and organization were the only ones that did not yield significant group differences. The group with social phobia was distinguished by substantially elevated scores on concern over mistakes. They also had the highest mean score on the parental criticism factor. Both the group with social phobia

and the group with OCD had significantly higher scores on doubts about actions, relative to the mean scores for the other two groups.

A subsequent study by Wheeler, Blankstein, Antony, McCabe, and Bieling (2011) examined levels of perfectionism in a mixed sample of patients with DSM-IV disorders and a control group. Specifically, there were 68 patients with social anxiety disorder, 58 patients with panic disorder with or without agoraphobia, 26 patients with OCD, 39 patients with major depression, and 22 nonclinical volunteers. Higher levels of self-oriented perfectionism were found among those with depression, social anxiety disorder, or OCD than among the control participants or those with panic disorder. Levels of socially prescribed perfectionism were significantly higher among people with depression or social anxiety, relative to people in the other three groups. When compared with the clinical norms in the MPS test manual (see Hewitt & Flett, 2004), patients in the depression group had levels of self-oriented perfectionism that were in keeping with previously determined clinical norms. Similarly, the depressed and socially anxious participants had elevated levels of socially prescribed perfectionism that were comparable with clinical norms for these perfectionism dimensions.

Several studies have looked at perfectionism in specific anxiety disorders, such as social phobia/social anxiety disorder. Jain and Sudhir (2010; see Juster et al., 1996 and Saboonchi, Lundh, & Öst, 1999) examined the FMPS and the facets of perfectionistic self-presentation; they found that the self-oriented components of concern over mistakes and doubts about actions, as well as parental criticism were elevated among those with social phobia. Moreover, the group with social phobia also had higher levels of the nondisplay of imperfections as a facet of perfectionistic self-presentation, suggesting that both trait components and interpersonal expression components of perfectionism are important in this disorder.

PERFECTIONISM IN EATING DISORDERS

The research focused on the role of trait dimensions of perfectionism in eating disorders has garnered considerable attention (e.g., Bastiani, Rao, Weltzin, & Kaye, 1995; Halmi et al., 2000; Hewitt, Flett, & Ediger, 1995; Minarik & Ahrens, 1996; Srinivasagam et al., 1995). This is in keeping with the general observation that some of the highest levels of perfectionism can be found among patients with eating disorders. Even a brief interaction with someone suffering from an eating disorder confirms that perfectionism is not only elevated; it is typically central to the person's self-definition and goal striving. Research with the Hewitt and

Flett (1991a) MPS has confirmed that trait self-oriented perfectionism and socially prescribed perfectionism are significantly higher in patients with eating disorders (Bastiani et al., 1995; Cockell et al., 2002; Pratt, Telch, Labouvie, Wilson, & Agras, 2001). For example, Cockell et al. (2002) used a clinical sample of women diagnosed with anorexia nervosa or bulimia nervosa. They found that these women had significantly higher self-oriented and socially prescribed perfectionism scores, compared to a control group. A noteworthy aspect of this study is that self-oriented and socially prescribed perfectionism were assessed with both the self-report MPS and an interview measure of these dimensions that is under development (see Chapter 7).

One important element of research on trait perfectionism and eating disorders is that it has confirmed that the levels of trait self-oriented and socially prescribed perfectionism in clinical samples are among the highest levels of perfectionism reported to date (see Cockell et al., 2002; Davis, Kaptein, Kaplan, Olmsted, & Woodside, 1998). Moreover, there is evidence that perfectionism confers a stable vulnerability to eating disorders. In a 16-year follow-up study of individuals with anorexia nervosa, restricting type, it was found that whereas other symptoms of anorexia nervosa decreased over the follow-up period, both self-oriented perfectionism and socially prescribed perfectionism remained elevated (Nilsson, Sundblom, & Hägglöf, 2008). It may be that when perfectionism is a specific focus of treatment (see Fairburn, 2008; Hewitt, Mikail, et al., 2015), changes in perfectionism do occur for individuals with eating disorders. This was one conclusion reached by Bardone-Cone, Sturm, Lawson, Robinson, and Smith (2010), who showed that when patients with eating disorders were defined as "fully recovered," levels of perfectionism did not differ between such patients and healthy controls. This is an important finding, because it suggests that focusing efforts on underlying vulnerability factors may be important in reducing those vulnerabilities. Importantly, Bardone-Cone et al. found that self-oriented and socially prescribed perfectionism, all perfectionistic self-presentational facets, and the automatic perfectionistic thoughts were elevated in the patients with eating disorders defined as "symptomatic" and as "partially recovered," in comparison to the healthy controls.

Perfectionistic self-presentation has also been linked to eating disorder symptoms both in samples of female college students (who are often seen as a vulnerable group) and in clinical samples. Higher scores on all three PSPS subscales were related to eating disorder symptoms and appearance concerns in female college students (Hewitt, Flett, & Ediger, 1995; Hewitt, Sherry, Flett, & Shick, 2003). That is, college students with higher levels of eating disorder symptoms showed stronger needs to present an image of perfection to others and to avoid displaying

or disclosing imperfection to others. Likewise, McGee, Hewitt, Sherry, Parkin, and Flett (2005) found that all three facets of perfectionistic self-presentation were associated with eating disorder symptoms in a sample of university women. In addition, McGee et al. (2005) found that perfectionistic self-presentation predicted eating disorder symptoms among women who were dissatisfied with their bodies, but did not predict eating disorder symptoms among women who were not dissatisfied with their bodies. Similarly, clinical samples of women with anorexia nervosa and bulimia nervosa, when compared with a nondisordered control group, had higher scores on all three PSPS dimensions (Cockell et al., 2002)—a finding replicated by Bardone-Cone et al. (2010) in their mixed sample of patients with eating disorders, although the individuals with anorexia nervosa were not analyzed separately.

Trait perfectionism and perfectionistic self-presentation also seem quite relevant in adolescents who have been diagnosed with eating disorders. Castro et al. (2004) administered measures of perfectionistic self-presentation and trait perfectionism to an adolescent sample of 71 female patients with anorexia nervosa and 113 female students from primary and secondary schools. They found that the group of patients had significantly higher levels of self-oriented perfectionism and perfectionistic self-presentation, but not higher levels of socially prescribed perfectionism. This study illustrated the potential relevance of perfectionistic self-presentation among younger people, but the relative predictive utility of trait perfectionism and perfectionistic self-presentation was not assessed in this study. The Castro et al. study was also limited because perfectionistic self-presentation was assessed overall, and the three facets identified by Hewitt, Flett, Sherry, et al. (2003) were not distinguished.

PERFECTIONISM AND PERSONALITY DISORDERS

Although there has been less research dedicated to perfectionism and other diagnostic entities, there has been some research on people suffering from personality disorders. As an extension to research linking trait perfectionism with personality disorder symptoms (e.g., Hewitt, Flett, & Turnbull, 1992), Hewitt, Flett, and Turnbull (1994) established elevated levels of socially prescribed perfectionism among a small sample of participants with borderline personality disorder in comparison to a clinical control group. These data accord with a conceptual analysis of the relevance of interpersonal perfectionism in borderline personality organization (see Roxborough et al., 2009). Ayearst, Flett, and Hewitt (2012) have summarized research in this area and made the argument in a special issue of the journal *Personality Disorders: Theory, Research,*

and Treatment that perfectionism is a core dimension in psychopathology. Ayearst et al. (2012) focused their argument on the need for existing diagnostic and classification systems to afford a greater role to perfectionism, including considering multidimensional perfectionism as an element implicated in certain people with extreme forms of personality dysfunction.

PERFECTIONISM IN OTHER FORMS OF CLINICAL DYSFUNCTION

Perfectionism has been implicated in various other forms of dysfunction that do not qualify as disorders according to DSM, but that nevertheless pose significant and painful psychological disturbances. Some examples of this kind of clinical dysfunction that have been investigated include suicidal and parasuicidal behaviors, relationship problems, achievement problems (such as burnout and job-related stress), and physical health issues. The findings from the research on these issues not only underscores the importance of perfectionism as a clinically relevant variable but also illustrates the breadth of dysfunction that is associated with perfectionistic behavior. In fact, one of the ways that perfectionistic behavior creates complexity in cases may be that it is associated with multiple problems in individuals (see Bieling, Summerfeldt, Israeli, & Antony, 2004). Indeed, many of the clinical cases described throughout this book involve people with various forms of dysfunction and impairments. Accordingly, some authors have argued for a transdiagnostic process, because perfectionism underlies a great many difficulties (Egan, Wade, & Shafran, 2011).

Our discussion of perfectionism in this chapter has linked it with various individual disorders, but there is also growing evidence for its role in comorbid disorders. For instance, in their comparison of women with eating disorders who either did not have an alcohol use disorder as well, Bulik et al. (2004) reported that overall scores on the FMPS were significantly higher among those women who had both an eating disorder and an alcohol use disorder. This group of women, relative to those who had only an eating disorder, also had significantly elevated scores on various subscales (including those for levels of concern over mistakes, doubts about action, parental criticism, and parental expectations). Another investigation involving members of this same research team showed that higher levels of perfectionism were detected among women with an eating disorder who also had a lifetime anxiety disorder diagnosis (see Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). Similarly, the Wheeler et al. (2011) study described earlier found with its clinical patients that the number of additional comorbid disorders

was correlated significantly with various trait perfectionism dimensions, including socially prescribed perfectionism, concern over mistakes, doubts about actions, and parental criticism. A measure of self-critical perfectionism developed by the authors had the strongest association with the number of additional comorbid disorders ($r = .33$).

The link between perfectionism and comorbid disorders is often reflected in clinical cases involving multiple forms of personality disorder, where maladaptive relational tendencies are clearly on display. One illustration is an intriguing case example recounted by Fiore, Dimaggio, Nicolo, Semerari, and Carcione (2008). They described Alberto, a man diagnosed with both obsessive–compulsive personality disorder and avoidant personality disorder; he also had several features of dependent personality disorder. Alberto was described as setting high, rigid, all-or-none standards for himself, and even though he was highly self-critical and ashamed of himself, he saw himself as superior to and as more conscientious than his coworkers, whom he regarded as immoral. Although these authors did not use the term "other-oriented perfectionism," it seems that Alberto had clear signs of a narcissistic, other-oriented perfectionism in the work context as part of a form of his moral perfectionism. Alberto's superior morality had various consequences, including a tendency for him to be socially isolated. The situation was further complicated by Alberto's fears of being excluded and neglected, and a tendency to intellectualize his difficulties instead of experiencing and examining his emotions (referred to by the authors as the "think rather than feel pattern"). Although Alberto was seen as emotionally cold, his emotions were actually complex blends involving feelings of shame, guilt, anxiety, dejection, and an inability to access positive emotions. Fiore et al. (2008) determined that Alberto's dysfunctional behavior and painful emotions stemmed largely from a perfectionistic self-image reflecting his fear of making mistakes and letting down other people.

PERFECTIONISM AND SUICIDAL BEHAVIOR

Some of the most important findings in the perfectionism literature have come from the work on perfectionism and suicidal behavior in both adults and children. Although the specific mechanisms that link perfectionism with suicidality are not fully understood, perfectionism has been acknowledged in typologies of suicidal individuals that include a depressed-perfectionistic type (see Orbach, 1997). Moreover, scholars such as Thomas Ellis have concluded that perfectionism "is an important cognitive aspect of suicidal ideation and behavior" (Ellis & Rutherford, 2008, p. 52). Similarly, Wenzel and Beck (2008) placed central

importance on the role of perfectionistic standards in their model of cognitive factors in suicide.

Much of the early research on perfectionism and suicidality is reviewed in Hewitt et al. (2006) and also in O'Connor (2007). The overall evidence from several research groups indicates that one perfectionism trait in particular, socially prescribed perfectionism, is associated strongly, consistently, and uniquely with suicidal behaviors (including suicidal ideation and risk) in numerous cross-sectional studies among various clinical and nonclinical adult populations (e.g., Beevers & Miller, 2004; Blankstein, Lumley, & Crawford, 2007; Chang, 1998; Dean, Range, & Goggin, 1996; Dean & Range, 1999; Hamilton & Schweitzer, 2000; Hewitt, Flett, & Turnbull-Donovan, 1992; Hewitt, Flett, & Weber, 1994; Hewitt & Flett, 1993; Roxborough et al., 2012). Furthermore, in many of these studies it was found that socially prescribed perfectionism was a unique predictor of suicidal behavior, even after the researchers controlled for such traditional powerful predictors as hopelessness and depression severity (e.g., Hewitt, Flett, & Turnbull-Donovan, 1992; Hewitt, Newton, Flett, & Callander, 1997; Hewitt, Caelian, Chen, & Flett, 2014).

Some studies have assessed perfectionism and suicide attempts, and, again, socially prescribed perfectionism is seen to play an important role. In a sample of adult individuals in a residential treatment facility for alcoholism, we assessed the role of perfectionism in a sample of patients who had made moderate- to high-intent suicide attempts, in comparison to a matched sample of patients with no history of suicide attempts (Hewitt, Norton, Flett, Callender, & Cowan, 1998). The group with attempts had higher levels of socially prescribed perfectionism, achievement, social, and general hopelessness, and depression severity than the no-attempts group. Four variables were found to provide unique predictive power: higher levels of depression, social hopelessness, and socially prescribed perfectionism, as well as lower levels of other-oriented perfectionism.

Other research has examined suicide attempts among children and adolescents. Boergers, Spirito, and Donaldson (1998) examined self-reported reasons for suicide attempts among 120 adolescents shortly after they were admitted to a hospital following a suicide attempt. Those adolescents expressing a significant wish to die had markedly elevated levels of socially prescribed perfectionism, compared with adolescents who indicated less severe wishes to die. Also, Donaldson, Spirito, and Farnett (2000) investigated the relationship among risk factors for suicide, including perfectionism, self-criticism and hopelessness, in a sample of 68 adolescents who had made a suicide attempt. It was found that socially prescribed perfectionism and self-criticism were associated

with hopelessness, and that both of these risk factors contributed unique variance to the prediction of hopelessness, even after the researchers accounted for the variance contributed by prior suicide attempts (a powerful predictor of future suicide attempts).

The relevance of socially prescribed perfectionism continues to be illustrated in a number of more recent studies. Investigators have identified several mediators and moderators of the perfectionism–suicide link (for a summary, see Flett, Hewitt, & Heisel, 2014). For instance, Blankstein et al. (2007) examined suicide ideation in 205 university students. Socially prescribed perfectionism was associated robustly with suicide ideation in both women and men, and there was a smaller but still significant link between self-oriented perfectionism and suicide ideation in women. Additional analyses found evidence for an incongruence model, in which achievement-oriented women high in self-oriented perfectionism were higher in suicide ideation if they also had elevated interpersonal stress; men with high socially prescribed perfectionism had higher suicide ideation if they had high levels of academic hassles. Social support also buffered the association between self-oriented perfectionism and suicide ideation among women, while high levels of hopelessness exacerbated the link between socially prescribed perfectionism and suicide ideation in men. Collectively, these data highlighted several mechanisms and processes implicated in perfectionism and suicidality.

Another study published simultaneously with the Blankstein et al. (2007) study tested the roles of goal reengagement and the behavioral inhibition system (BIS). O'Connor and Forgan's (2007) study of 255 undergraduate students confirmed the link between socially prescribed perfectionism and elevated suicide ideation. In addition, low goal engagement and high socially prescribed perfectionism combined interactively to predict elevated suicide ideation. It also found that socially prescribed perfectionism mediated the link between an elevated BIS and suicide ideation. Rasmussen, Elliott, and O'Connor (2012) provided additional support for this meditational model linking the BIS, perfectionism, and suicidality. Their study of individuals who had made very recent suicide attempts confirmed an association between socially prescribed perfectionism and suicidal thinking. It also yielded strong evidence for socially prescribed perfectionism as a mediator of the link between the BIS and suicide ideation.

Rasmussen, O'Connor, and Brodie (2008) had shown previously in parasuicidal patients that greater suicidality was evident among people with a high level of socially prescribed perfectionism and with poor recall of specific positive autobiographical memories. These data suggest that the suicidality of perfectionists may be rooted in the low cognitive salience of positive personal events.

Research on perfectionism and suicidal tendencies in adolescents also continues to support this interest in the role of socially prescribed perfectionism. A study conducted in Israel with 100 adolescent inpatients contrasted 45 nonsuicidal adolescents with 55 adolescents exhibiting a high level of suicidal behavior (see Freudenstein et al., 2012). The latter group included 31 adolescents who had already made either a mild or serious suicide attempt. It was found that this group had significantly higher scores on dependency and socially prescribed perfectionism, and that these factors contributed to group differences in a discriminant-function analysis.

A recent investigation comparing 17 patients who had made suicide attempts with 17 nonsuicidal patients found via interviews and a procedure known as "plan analysis" that the suicide attempters placed greater emphasis on their inability to meet socially imposed expectations of perfection, especially in the workplace (see Brudern et al., 2015). This study not only confirmed the relevance of socially prescribed perfectionism, using methods that were quite different from those used in past research; it also reinforced the idea that these pressures are experienced in an interpersonal context. Other key themes that emerged from this study included desires to avoid being criticized and rejected by other people, as well as the general need to protect self-esteem.

Another study (O'Connor, Rasmussen, & Hawton, 2010) focused on students from high schools in Ireland and Scotland. The students either had no self-harm history (n = 4,219), a history of self-harm ideation (n = 675), or a history of self-harm behavior (n = 628). These three groups of participants were compared on several variables, including an abbreviated measure of socially prescribed perfectionism derived from our CAPS (see Chapters 2 and 7). It was found that both the group with suicidal thoughts and the group with self-harm behaviors had significantly higher levels of socially prescribed perfectionism, relative to those with no self-harm history.

Roxborough et al. (2012) reported the results of a unique study of children and adolescents who were psychiatric outpatients in Canada. To our knowledge, this study is the first to examine suicidal tendencies in adolescents and both trait perfectionism and perfectionistic self-presentation. It was found that both socially prescribed perfectionism and perfectionistic self-presentation were associated with a measure of suicide potential. Evidence for the perfectionism social disconnection model (PSDM) was also obtained. This model is based on the premise that interpersonal perfectionism fosters a sense of isolation and interpersonal alienation that potentiates suicide (Hewitt et al., 2006; see Chapters 4 and 5 for a full discussion of the PSDM). Roxborough et al. (2012) reported that the association between suicide potential and the need to

avoid seeming imperfect was mediated by a history of being bullied and elevated interpersonal hopelessness. These data suggest that the traumatic experience of being bullied is felt most acutely by interpersonally sensitive perfectionists who need to maintain an image of being flawless and totally in control at all times. What remain to be established are the processes implicated in how perfectionistic youth become the targets of bullies.

In an earlier chapter, we have alluded to the Flamenbaum and Holden (2007) study of perfectionism, "psychache," and suicidal tendencies among university students. In addition to linking trait perfectionism with psychache, Flamenbaum and Holden (2007) established uniquely that both self-oriented perfectionism and socially prescribed perfectionism were associated with the planning component of suicidality and a reported history of suicide attempts. Unfortunately, a growing number of case studies of suicide deaths have consistently illustrated the degree of planning and the lengths to which certain perfectionists will go in an attempt to end their lives. The hyperconscientiousness of perfectionists is quite troubling when viewed from this perspective.

Our understanding of the nature of perfectionism in suicide has been enhanced recently by qualitative analyses examining the factors that have contributed to deaths by suicide. For example, Bell, Stanley, Mallon, and Manthorpe (2010) provided rich descriptive analyses of three university students who killed themselves: Ryan, Sam, and Dan. This article is highly recommended, because it illustrates how significant pressures can erode the sense of agency and result in a profound loss of human potential. The students' problems were cogently summarized in the following manner:

> Ryan's striving for perfection drove him to the point of agony and eventually despair. In the second [case], Sam's self-criticism and self-doubt, together with unrealistically ideal expectations and dichotomous thinking, made for a devastating combination. For Dan, who was also highly self-critical and terrified of failure, the reality of failure was finally too much to bear. (Bell et al., 2010, p. 264).

These students showed many elements of perfectionism as described by Blatt (1995) and by Pacht (1984).

Another recent series of articles, from a team of researchers in Norway, has sought to understand perfectionism and suicide by reviewing the lives of six men who committed suicide (Kiamanesh, Dieserud, Dyregrov, & Haavind, 2015; Kiamanesh, Dieserud, & Haavind, 2015). Interviews were conducted with 41 key informants, and some key conclusions emerged as a result of examining recurring themes. For instance, the

developmental analysis focused on three themes: (1) exposure to exceedingly high expectations, with little experience of parental warmth; (2) a diminished ability to cope with failures and weaknesses; and (3) an abiding fear of emotional rejection. Other key themes included a propensity to experience shame and an unfulfilled need for attachment, love, and recognition. These authors also discussed at length the tendency for these six men to conceal their distress behind a façade. These themes are in keeping with our emphasis on the interpersonal roots of perfectionism and the role of perfectionistic self-presentation in hiding signs of despair and psychological pain.

One clear realization that becomes apparent in considering the lives of perfectionistic people is that the people themselves and their lives are very complex. Below we focus on two factors that add to the complexities in providing effective treatment to people who self-identify as perfectionists.

PERFECTIONISM AND RELATIONAL PROBLEMS

One of the difficulties in treating people with extreme levels of perfectionism is that their psychological difficulties are often experienced within the context of significant relationship problems, and these relationship problems can be a cause or a consequence of dysfunction and impairment. It is important for these individuals to come to realize how perfectionism may be at the root of not only their emotional turmoil, but also their relationship conflict.

Our discussion of stress included the example of creating conflict by holding others up to impossible standards and judging them for falling short of those standards. There are several accounts of how perfectionism undermines intimate relationships in general. One such account comes from a description of the results of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) project (see Thase et al., 2007). This complex case (described briefly in Chapter 2) involved Ms. X, a 58-year-old married woman, who had been raised by an emotionally abusive father who required her to be perfect in order to please him. Ms. X incorporated the need to be perfect into her own beliefs and tendencies, and these tendencies were addressed when she sought treatment for depression as a result of a workplace problem. One of her complaints was that she had too much work to do, both at work and at home. She admitted that she was never satisfied with her husband. He had stopped trying to do things and left them to her because he could not meet her exacting standards. Once her perfectionism was addressed, the level of relationship functioning improved.

One line of research in our laboratory has consisted of attempts at empirically documenting the impact of perfectionism on relationships, and at establishing which elements of the multidimensional components of perfectionism are most problematic (as assessed by various indices of relationship functioning). One of our initial studies in this area (Hewitt, Flett, & Mikail, 1995) focused on patients with chronic pain and their partners. This research established that lower levels of dyadic adjustment and feelings of diminished support were reported by patients who actually lived with other-oriented perfectionists. However, partners with high other-oriented perfectionism did not report lower dyadic satisfaction. These data seem to indicate that some people who are struggling with chronic pain and are typically not able to work are bearing the brunt of the judgments and the disappointment being experienced by their other-oriented partners.

It is important to note from the outset that some empirical evidence indicates that perfectionism is actually reflected in behavioral interactions. A multifaceted investigation (Habke, Hewitt, Fehr, Callander, & Flett, 1997) had partners discuss a topic that had caused relationship problems, and observations were made of expressed negative and positive behaviors. In addition, reports of dyadic adjustment were obtained, along with spouse-specific versions of our MPS. Spouse-specific other-oriented perfectionism was assessed by items such as “I have high expectations for my spouse.” Spouse-specific socially prescribed perfectionism was assessed by items such as “I feel that my spouse is too demanding of me.” Reduced dyadic adjustment was associated with women who felt that their partners were expecting them to be perfect. Similarly, men who felt that they were the targets of expectations to be perfect also reported lower dyadic adjustment. As for the behavioral analyses, the perception among men that their partners expected perfection was associated with a greater proportion of negative behavior being expressed by both men and women. The other main finding that emerged was that men who expected perfection from their partners (i.e., who exhibited high other-oriented perfectionism) also expressed a greater proportion of negative behaviors. A more complete description of these findings can be found in Habke and Flynn (2002).

Perfectionism in relationships can be expressed in many ways, including in sexual intimacy problems. Habke et al. (1999) had 74 married or cohabiting couples complete measures of sexual functioning, along with a spouse-specific version of our MPS and PSPS. Habke et al. (1999) found that spouse-specific socially prescribed perfectionism was associated with reports of lower sexual satisfaction for both men and women. In addition, other-oriented perfectionism and perfectionistic self-presentation in women were associated with reduced sexual satisfaction.

Researchers have extended this work by examining domain-specific relationship perfectionism as a supplement to research on trait perfectionism. Initially, Wiebe and McCabe (2002) developed and showed the relevance of a measure that assessed "self-directed relationship perfectionism" (extreme expectations of oneself in a relationship) and "other-directed relationship perfectionism" (extreme expectations of one's intimate partner or a friend). A team of researchers from the University of Ottawa took this work one step further by adapting the Wiebe and McCabe (2002) measure so that it referred specifically to romantic relationships. The measures created by Matte and Lafontaine (2012) were then examined in terms of their psychometric properties and associated correlates. This impressive work has helped establish that demanding perfection in relationships is highly maladaptive in ways that are at variance with key psychological needs.

PERFECTIONISM AND HEALTH PROBLEMS

Our previously described study of patients with chronic pain (Hewitt, Flett, & Mikail, 1995) is relevant not only because it examined relationship adjustment problems, but because it highlighted the complexities that are involved when someone must cope with a challenging health problem. There is now a burgeoning literature on perfectionism and health problems. The most dramatic illustration of the perfectionism and health link can be found in Fry and Debats (2009), who conducted a 7-year longitudinal study of the role of perfectionism in health outcomes in a large sample of middle-aged Canadians. Participants completed a battery of measures that included several personality measures, including our MPS. This study found that self-oriented perfectionism and socially prescribed perfectionism predicted all-cause early mortality, and these findings held even after the researchers took into account other broad personality factors linked with health problems, such as neuroticism and low conscientiousness.

Our work on perfectionism in health problems is guided by two basic premises: (1) Perfectionism is implicated in the etiology of health problems among some vulnerable individuals; and (2) perfectionism complicates and undermines the recovery process.

Regarding our first premise, a prototypical study by Saboonchi and Lundh (2003) investigated the associations between perfectionism and health problems in a randomly selected sample of 186 Swedish men and women. They found small but significant positive associations between self-reported somatic complaints and both self-oriented and socially prescribed perfectionism. Because self-oriented perfectionism was also

linked with low positive affect, greater negative affect, and anger, they concluded that there was no support in their study for the notion that self-oriented perfectionism is adaptive in the health context.

Additional evidence of a link between perfectionism and health problems was provided by Archer, Adrianson, Plancak, and Karlson (2007). They administered a battery of measures to a sample of 208 professional office employees, including 73 employees in leadership positions. The age of their participants ranged from 27 to 61 years. Perfectionism was assessed with an abbreviated version of the MPS, which was then scored as a total overall perfectionism score. Archer et al. (2007) contrasted four distinguishable groups of participants: (1) self-fulfilled (i.e., high positive affect and low negative affect); (2) low affective (i.e., low on both positive and negative affect); (3) high affective (i.e., high on both types of affect); and (4) self-destructive (i.e., low on positive affect, high on negative affect). Advantages were found for the group of self-fulfilled people. Comparatively, they had significantly lower levels of perfectionism; better psychological functioning; and better health profiles in terms of self-reports of more energy, less stress, better sleep, and fewer psychophysiological symptoms (e.g., muscle tension).

Whereas most research on perfectionism and health has been largely atheoretical, Molnar, Reker, Culp, Sadava, and DeCourville (2006) posited a conceptual model involving the prediction that perfectionism would be associated with health symptoms, through the link that specific perfectionism dimensions have with low positive affect and high negative affect. Molnar et al. (2006) confirmed that a preponderance of high negative affect and low positive affect was a full mediator of the link between self-oriented perfectionism and health symptoms, and a partial mediator of the link between socially prescribed perfectionism and health symptoms.

As for the proposed role of perfectionism in poor responses to chronic health problems, the literature is replete with illustrations of the association between perfectionism and maladaptive coping (see Hewitt & Flett, 2002; Hewitt, Flett, & Endler, 1995). In the past few years, several studies have shown that perfectionism is also linked with maladaptive orientations in coping with illness. Although research on the specific self-care behaviors of perfectionists has yet to be conducted, it is likely that perfectionists engage in behaviors antithetical to their recovery efforts.

Intriguing data have emerged from research examining the association between perfectionism and recovery from cardiac illness. A longitudinal study of depression among hospitalized patients with coronary artery disease found evidence indicating that perfectionism predicted persistent and elevated depression (see Stafford, Jackson, & Berk, 2009).

This study assessed perfectionism with the perfectionism subscale included in a multidimensional measure of autonomy. This subscale was described by Stafford et al. (2009) as a brief measure of self-oriented perfectionism. Comparison of the three subscales assessing autonomy and the three subscales assessing sociotropy found that perfectionism was the best predictor of depression at Time 1 (3 months postdischarge) and at Time 2 (9 months postdischarge). Stafford et al. (2009) concluded that there is clinical benefit in early detection of cardiac patients with higher levels of autonomy and self-oriented perfectionism.

Another investigation conducted by Parker, Manicavasagar, Crawford, Tully, and Gladstone (2006) in Australia focused on 489 patients with acute coronary syndrome. Diagnostic interviews were conducted to distinguish 52 patients with current depression from 437 patients who were not depressed. Lifetime histories were also assessed to distinguish 187 patients with a lifetime history of depression from 302 patients without a history of depression. Perfectionism was assessed with a measure of self-oriented perfectionism developed by Parker and his associates. They found that the currently depressed patients were distinguished by a marginally significant elevation in levels of perfectionism, as well as by elevated self-criticism. Both perfectionism and self-criticism were significantly higher in those patients with versus without a lifetime history of depression. These data suggest that self-critical perfectionists are particularly likely to experience depression during the cardiac recovery period.

Further evidence of the risk associated with perfectionism for people with cardiac illness has been provided by research on correlates of the "Type D personality," defined as characterologically high negative affect and social inhibition. Type D personality is associated with greater mortality among cardiac patients. A comprehensive investigation by Dunkley et al. (2012) examined self-critical perfectionism versus personal standards perfectionism in a sample of 123 patients with clinically significant coronary artery disease. Personal standards perfectionism was assessed with seven items from the personal standards subscale of the FMPS. Unfortunately, the other subscales of the Frost instrument were not administered. Self-critical perfectionism was assessed with the McGill Depressive Experiences Questionnaire. This study found no association between personal standards perfectionism and Type D personality, but self-criticism was associated with both Type D facets. This study also evaluated general coping styles and found that self-criticism was associated with avoidant coping and lower problem-focused coping. Collectively, the data from this investigation continue to point to a heightened level of risk for cardiac patients who are also self-critical perfectionists.

Finally, a study conducted with 100 patients in cardiac recovery has illustrated the need to consider trait perfectionism and perfectionistic self-presentation (Shanmugasegaram et al., 2014). The perfectionistic self-presentational style is particularly problematic, in that potential support providers may never know the stress that someone is under if a perfectionist is good at presenting a mask indicating good coping when just the opposite may be true. Specifically, Shanmugasegaram et al. (2014) examined the extent to which perfectionism is associated with the Type D personality and ways of coping with illness. Results indicated that all facets of trait perfectionism and perfectionistic self-presentation were associated with the Type D facet tapping chronic negative emotionality, and with emotional preoccupation as a maladaptive coping style. In addition, socially prescribed perfectionism and perfectionistic self-presentation were linked with the Type D social inhibition component. Collectively, these data suggest a significantly elevated level of risk for perfectionists with cardiac illness, due to long-lasting emotional difficulties and possible psychosocial difficulties reflecting social avoidance and impoverished social support networks. It seems that perfectionists with cardiac illness have an orientation toward coping and recovery that is far from ideal, and this orientation is likely to be exacerbated by their all-or-none approach to succeeding or failing. Also, it is likely that the tendency for perfectionists to be dissatisfied (see Pacht, 1984) is magnified substantially among those who have an illness that prevents relentless goal pursuit.

The negative impact of perfectionistic self-presentation and trait perfectionism in chronic illness was further illustrated in a study (Flett, Baricza, Gupta, Hewitt, & Endler, 2011) examining the extent to which trait perfectionism and perfectionistic self-presentation related to coping and psychosocial adjustment in people with colitis or Crohn's disease. The focus on perfectionism in these individuals was suggested by previous work noting the prevalence of perfectionism in patients with these illnesses. For instance, psychiatric evaluations in one study found that 25 of 30 patients with ulcerative colitis had elevated perfectionism (Holub & Kazubska, 1971). The Flett et al. (2011) examination of coping styles showed once again that both trait perfectionism and perfectionistic self-presentation were associated with maladaptive emotional preoccupation as a form of coping with this chronic illness. In addition, trait perfectionism and perfectionistic self-presentation were associated robustly with higher ratings of the psychosocial impact of colitis or Crohn's disease. This finding held even after the impact of other personality factors (such as optimism and conscientiousness) was accounted for.

We have so far focused on health and interpersonal relationship issues as two factors that can complicate cases and the course of

treatment. Several other factors may also be complicating the approach that needs to be taken with people suffering from their perfectionism. Below we discuss perfectionism and the clinical process in more detail.

PERFECTIONISM AND THE CLINICAL PROCESS

Our process approach to perfectionism is based on the premise that perfectionism exerts its negative influence right from the initial stages of treatment (i.e., during the initial assessment or evaluation), and does so in ways that can undermine the clinical process and the development of a positive therapeutic alliance. We (Hewitt et al., 2008) conducted a study of 90 psychiatric patients who completed measures of perfectionism and cognitive, affective, and physiological symptom measures during an initial clinical interview. There were several key findings from this work. First, interpersonal components of perfectionism were associated with patients' increased distress both before and after the interview. Second, perfectionism was associated with patients' increased negative expectations and perceived threat of the clinician prior to the interview, and greater dissatisfaction following the interview. Third, perfectionism—in particular, one facet of perfectionistic self-presentation—was associated with greater levels of distress over the course of the interview. Overall, this study demonstrated support for the idea that perfectionistic behavior can have an impact on the process of the clinical interview and can influence the development of confidence in the clinical process. One particularly intriguing finding was that the clinicians, who were unaware of the patients' levels of perfectionism, completed ratings of the patients following the clinical interview. The ratings included ratings of how much a clinician liked a patient and how willing the clinician would be to accept the patient for psychotherapy. It was found that perfectionism (especially the self-presentation facets) was associated significantly with decreased liking and decreased willingness to accept the perfectionistic participants for psychotherapy. It was clear that the perfectionism of these patients did seem to interfere with the establishment of a good therapeutic connection, in terms of both their own transference responses and the countertransference responses of the clinicians. This is clearly consistent with Blatt and Zuroff's reexamination of the Treatment of Depression Collaborative Research Program (TDCRP) data, in which they found that attitudes reflecting perfectionism were associated with relationship difficulties and establishment of a therapeutic alliance, and also that these relationship difficulties were predictive of poorer outcome (see Zuroff et al., 2000). Our work indicates that attitudes regarding perfectionism may not be the crucial component; rather, the

interpersonal expression of perfection in interaction with others may be the important perfectionism element.

Regarding the influence of perfectionism on treatment, there are numerous studies that support the deleterious effects of perfectionistic behavior. First, there is some suggestion that perfectionism—in this case, other-oriented perfectionism—predicts early dropout from treatment (see McCown & Carlson, 2004). Second, unless perfectionism is targeted specifically, it remains elevated and, as a putative vulnerability factor, can continue to be a predisposing factor for symptom development. For example, the Bastiani et al. (1995) study reported on two groups of women with anorexia nervosa: a posttreatment weight-restored group and a pretreatment underweight group. A nondisordered control group was also included. Analyses established that the two clinical groups did not differ from one another on measures of perfectionism, and that both had higher scores than the control group. Thus, even though the one clinical group had been treated, perfectionism was still elevated overall. Given the often-described vulnerability role of perfectionism in anorexia nervosa (e.g., Bruch, 1978), it appears to us that although there may be symptom reduction as a result of treatment, it may make more sense to focus on underlying mechanisms, such as perfectionism, that have been shown to act as vulnerability factors.

Similarly, other studies have found that perfectionism traits and attitudes remain elevated and unchanged in response to psychotherapy (e.g., Blatt et al., 1995; Chik, Whittal, & O'Neill, 2008; Rosser, Issakidis, & Peters, 2003); have shown only moderate reductions in some components of perfectionism (Ashbaugh et al., 2007; Enns, Cox, & Pidlubny, 2002; Lundh & Öst, 2001); or have indicated that despite reductions in perfectionism levels, these levels remain in the clinical range (e.g., Salbach-Andrae, Bohnekamp, Pfeiffer, Lehmkuhl, & Miller, 2008). Moreover, research on the stability of perfectionism and depression over time has shown that even when interventions are successful in reducing levels of perfectionism and depression, posttest data still indicate that perfectionism predicts persistent residual symptoms (Cox & Enns, 2003).

Blatt and Zuroff's work is pivotal in underscoring the importance of perfectionism on treatment. For example, they and their colleagues (Blatt et al., 1995; Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998) found that attitudes related to perfectionistic behavior predicted poor treatment outcomes (i.e., social adjustment, depression severity, and overall clinical functioning) up to 18 months after treatment. In addition, we recently completed an evaluation of our interpersonal/psychodynamic approach for the treatment of perfectionism (Hewitt, Mikail, et al., 2015). This was a group psychotherapy treatment of 71 perfectionistic individuals who completed comprehensive assessments and

exhibited various levels and types of psychopathology and distress, as well as elevated levels of perfectionism traits, self-presentation, and/or perfectionistic automatic thoughts. A goal of the overall project was to evaluate not only outcome, but also the relationship between perfectionistic behavior and various process variables in the therapy. The outcome study is described in greater detail in Chapter 10, but for our purposes here, several findings were particularly germane. Evidence showed that trait and self-presentational components of perfectionism were linked to greater stress during therapy, and were also associated with less of a decrease in depression and other symptoms and stress reactivity following treatment. Importantly, the results further indicated that components of perfectionistic self-presentation were associated with poorer outcome, and that this relationship was mediated by anxiety and lack of self-disclosures.

Overall, there appears to be good evidence for the pernicious nature of perfectionism and its deleterious impact on people who are hoping to benefit from professional help after experiencing psychological problems. In a sense, perfectionists are faced with a situation of "double jeopardy," in that they have a personality orientation that can create lasting psychological and interpersonal problems, and also tend to have far less than an optimal response to these problems. Given the complexities involved here, and the complicating factors outlined above, it would seem to make good sense to have treatments that focus specifically on the perfectionistic behavior—both to reduce attendant psychological difficulties and to aid in the prevention of future episodes of those difficulties.

STUDIES ON THE TREATMENT OF PERFECTIONISM: CONCLUSIONS AND SUPPORT

At present, there is a growing body of research evaluating the effectiveness of perfectionism treatment. The studies can be differentiated according to several distinguishing features. Three key questions to consider when evaluating and considering previous intervention efforts are these: (1) Did the treatment include an explicit focus on perfectionism, or was it treatment focused on symptoms of a disorder? (2) Was a meaningful control group included? (3) Did the study include clinical participants, or was the focus on perfectionistic university students?

Previous treatment studies can be easily divided into whether researchers included a specific treatment focus on perfectionism or merely exposed participants to a standard form of treatment that did not specifically target levels of perfectionism. To a large extent, much of what

is known about the modifiability of perfectionism comes from broad investigations of the effectiveness of various forms of treatment without an explicit treatment focus on perfectionism. However, in these studies, perfectionism was typically assessed due to its relevance in predicting outcome measures such as depression. Readers may well be aware of the influential work of Blatt and associates as part of the TDCRP, sponsored by the U.S. National Institute of Mental Health (Blatt & Zuroff, 2002). In that program, perfectionism was assessed in terms of levels of dysfunctional attitudes. Blatt and his associates, on the basis of extensive analyses reported in a series of papers, made several noteworthy findings. First, patients with higher levels of perfectionistic attitudes had less positive treatment outcomes across all treatment modalities (see Blatt et al., 1995; Blatt & Zuroff, 2002). It was also found that perfectionists had poorer outcomes because they tended to have less positive therapeutic alliances with their therapists throughout the course of treatment (see Shahar, Blatt, Zuroff, & Pilkonis, 2003). Subsequent analyses illuminated the role of Rogerian concepts, such as empathy and perceived level of regard from the therapist, in reducing levels of perfectionistic attitudes (Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010).

Although the work of Blatt and his colleagues has clearly had the greatest influence, other investigators have examined whether perfectionism is reduced as a result of symptom-focused treatments. Some investigations have focused on reducing depression or anxiety, while others have focused mostly on reducing eating disorder symptoms. An overall evaluation of intervention studies yields a number of key conclusions that help provide a clearer picture of the dysfunctional nature of perfectionism and the possibility of reducing it. Below we present eight conclusions and refer to findings that support these conclusions.

Conclusion 1

Our first conclusion from this research is as follows: **Interventions without an explicit focus on perfectionism have minimal impact on perfectionistic behavior.**

Several studies were conducted with general interventions that did not have a specific and explicit emphasis on perfectionism. Overall, these investigations indicate that interventions usually result in some reductions in perfectionism, but the reductions that do occur are not large. That is, posttreatment levels of perfectionism tend to remain quite elevated. These studies can be further subdivided according to whether they did or not include a meaningful comparison group; for instance, Rosser et al. (2003) found that a form of group CBT for social phobia yielded a significant decrease in perfectionism (i.e., the FMPS concern

over mistakes subscale), but no comparison condition was included, and overall levels of concern over mistakes assessed at posttest were still elevated.

A study by Nobel, Manassis, and Wilansky-Traynor (2012) evaluated whether it was possible to reduce levels of perfectionism by exposing at-risk children to a CBT intervention as part of a school-based program targeting symptoms of depression and anxiety. This study found that the treatment and control groups (the control group was a structured activity group) both resulted in reductions in self-oriented perfectionism, as well as levels of anxiety and depression. Thus improvements were not specific to the treatment condition. In addition, reductions were not found in levels of socially prescribed perfectionism.

Other research continues to highlight the difficulties associated with treating perfectionism. For instance, an investigation found among patients with bulimia nervosa that exposure to CBT decreased maladaptive tendencies across several indicators, but perfectionism was one of only two variables that were not lowered as a result of treatment (Agüera et al., 2012). Similarly, a study conducted in Sweden on adolescents with anorexia nervosa found that treatment resulted in improvements across all Eating Disorder Inventory subscales except the perfectionism subscale (Nilsson et al., 2008). Other investigators have found similarly that perfectionism can remain at a high level, despite treatment gains and weight restoration, in patients with anorexia nervosa (Bastiani et al., 1995; Srinivasagam et al., 1995; Sullivan, Bulik, Fear, & Pickering, 1998). This pattern of findings suggests that these young people may remain vulnerable, to the extent that perfectionism is implicated in susceptibility to relapse.

Another recent study that added an emphasis on perfectionism to a CBT-based treatment-as-usual intervention found that there was no substantial benefit associated with this added emphasis (Goldstein, Peters, Thornton, & Touyz, 2014). This intervention incorporated the distinction between key trait dimensions of perfectionism, but the overall focus on perfectionism was limited to just 7 of the 136 overall hours of treatment, and extreme perfectionism typically requires a more extensive focus.

Early research on the treatment of social phobia found that treatment nonresponse was associated with substantially elevated levels of trait perfectionism (Lundh & Öst, 2001). Another clinical study of social anxiety disorder evaluated possible changes in levels of perfectionism as a result of a CBT intervention (see Ashbaugh et al., 2007). Perfectionism was assessed with the FMPS (Frost et al., 1990). Data analyses showed some improvement in overall perfectionism scores, but the overall effect size was characterized as "small." Overall levels of perfectionism remained elevated at the conclusion of the study.

An impressive investigation of treatment for OCD by Chik et al. (2008) examined the association between levels of perfectionism and treatment outcome in one of four conditions: group or individual cognitive therapy, exposure and response prevention (ERP), or a control condition. This study also utilized the FMPS, and it was more sophisticated than many other treatment studies in terms of data analyses (e.g., the use of residualized change scores). Chik et al. (2008) concluded overall that there was little association between treatment response and perfectionism scores; they suggested that this could have been due in part to not targeting specific perfectionism elements in treatment. Chik et al. (2008) also noted that they found some evidence indicating that the FMPS doubts about action subscale (both by itself and in combination with concern over mistakes) did seem to predict poorer treatment outcome among those who received ERP, but that the bulk of evidence suggested a diminished role for perfectionism. Most notably, levels of perfectionism did not decrease significantly as a result of any of the treatments.

The need for an explicit, targeted focus on perfectionism was illustrated in a case example described by Manassis (2009). Manassis described the course of treatment for an adolescent girl suffering from clinical anxiety. Good progress was made after 14 sessions, but there were still times when the girl felt overwhelmed and anxious. These bouts were attributed to perfectionism and rigid thinking that were aspects of "an emerging personality style" (Manassis, 2009, p. 158). These observations point to the need for a specific and comprehensive focus on perfectionism as part of interventions for youth.

Finally, a treatment study by Riley et al. (2007) focused on their concept of "clinical perfectionism." These authors found that their CBT approach to clinical perfectionism was associated with change only on their measure of the clinical perfectionism construct. Scores on both the FMPS and our MPS (Frost et al., 1990; Hewitt & Flett, 1991a) were significantly reduced at posttreatment, but the decreases could not be attributed to the treatment, as scores did not differ between the intervention and control groups. Moreover, the decreases in trait dimensions of other-oriented and socially prescribed perfectionism were not maintained at a 4-month follow-up.

Conclusion 2

Our second conclusion is this: **Perfectionism tends to be relatively stable, and people with elevated levels of perfectionism tend to maintain those elevated levels after brief interventions.**

We have described perfectionism as a relatively enduring personality style that can become part of someone's identity fairly early in life. But what evidence is there that perfectionism is enduring? Examinations

of test–retest correlations (i.e., levels of perfectionism assessed before and after treatment) indicate that those who start with high levels of perfectionism still have high levels of perfectionism at posttreatment. This was illustrated effectively by Zuroff, Blatt, Sanislow, Bondi, and Pilkonis (1999), who found that Dysfunctional Attitude Scale (DAS) scores decreased after 12 weeks of treatment, but that these scores showed moderate to high levels of stability across time, and that pretreatment levels of DAS perfectionism predicted posttreatment DAS scores.

As indicated earlier, once an intervention has been implemented, it is commonly the case that group improvements still leave some people with dangerously high levels of perfectionism. Pleva and Wade (2006) found in their intervention study that guided self-help and pure self-help CBT-based interventions were both successful in reducing levels of perfectionism as assessed by the FMPS. We reviewed the Pleva and Wade (2006) data and noted that despite the significant improvements that were reported, overall mean levels of perfectionism at posttest remained relatively high. For instance, the mean scores on the FMPS concern over mistakes subscale following the intervention still exceeded the cutoff score of 26 used by Frost et al. (1995) to define a group of people with an exceptionally high level of concern over mistakes. This cutoff point was selected by Frost et al. (1995) because it represented scoring at the 75th percentile or higher on this key perfectionism subscale. Pleva and Wade (2006) found mean scores on concern over mistakes of 26.54 for the guided self-help group and 29.91 for the pure self-help group, so levels of perfectionism were still quite high after the intervention. Clearly, there remained a need for additional intervention.

These data are not unique in one sense. A common finding from treatment studies involving perfectionism is that when reductions are evident, overall mean scores on key indicators are typically reduced to levels that approximate normative values, but the range of scores indicates that problematic levels of perfectionism still exist for many in the sample (see, e.g., Enns, Cox, & Pidlubny, 2002).

Conclusion 3

Our third conclusion is this: **Perfectionism tends to undermine treatment success and predicts posttreatment symptoms.**

Other researchers, following the lead of Blatt and his colleagues, have provided clear indications that elevated perfectionism undermines treatment success. Jacobs et al. (2009) conducted an important study, which found that elevated scores on the DAS perfectionism subscale limited the effectiveness of treatment. They conducted a randomized controlled trial with 439 clinically depressed adolescents who were enrolled

in the Treatment for Adolescents with Depression Study. Participants received either CBT, fluoxetine, a combination of CBT and fluoxetine, or a pill placebo. Those participants with elevated DAS perfectionism scores, relative to those with lower scores at baseline, continued to have elevated depression throughout treatment, regardless of treatment condition. Elevated perfectionism also limited reductions in suicidality. The investigators concluded that perfectionism was a partial mediator of the degree of treatment effectiveness.

These data accord with another finding from the Nobel et al. (2012) study described earlier. Their school-based intervention found that pretreatment levels of self-oriented perfectionism in children influenced posttreatment depression scores, suggesting that elevated perfectionism interferes with positive treatment outcomes among children. The pernicious effects of perfectionism were also detected in earlier research with adults, which found similarly that perfectionism continues to predict residual symptoms of depression in individuals who are characterized as having recovered following treatment for depression (Beevers & Miller, 2004; Cox & Enns, 2003).

A team of researchers studying the treatment of eating disorders found that greater perfectionism was associated with less treatment progress (see Sutandar-Pinnock, Woodside, Carter, Olmsted, & Kaplan, 2003). This study found that some patients with elevated perfectionism responded well to treatment, while others did not. The researchers concluded that in general, perfectionism is likely to be associated with less responsiveness to group treatment.

Conclusion 4

Our fourth conclusion is as follows: **The emphasis on multidimensional perfectionism in research has not been translated into treatment.**

While we were compiling our overview of existing research on the treatment of perfectionism, it struck us that there is an apparent disconnection between research and practice. Specifically, although an emphasis on multidimensional perfectionism now prevails in the research literature, there seems to be relatively little emphasis on targeting multidimensional components of perfectionism in treatment research. Among our purposes in writing this book are to promote more nuanced approaches that take into account the complex ways in which perfectionism can be experienced and expressed, and to emphasize the need for complex interventions that specifically address vulnerabilities and life circumstances linked with core aspects of the perfectionism construct. The benefits of a differentiated approach and of studying perfectionism from a multidimensional perspective were illustrated by Enns, Cox, and

Pidlubny (2002). They found that symptom reductions for those people undergoing group treatment for depression was associated with changes in socially prescribed perfectionism, but not in self-oriented perfectionism.

An exception to this fourth conclusion is our paper (Hewitt, Mikail, et al., 2015) that evaluated whether the treatment approach we developed (see Chapter 10) was effective in reducing perfectionistic behaviors, including traits, self-presentational facets, and automatic perfectionistic thoughts. We proposed that by using our dynamic-relational approach in treating perfectionism, we would see reductions in perfectionistic behaviors at posttreatment and continued reductions at follow-up; that the changes in specific components of perfectionism would be predictive of changes in specific symptoms; and, finally, that the treatment effects would be the results of the treatment itself. A sample of 71 community-recruited perfectionistic individuals participated in group psychotherapy. Eighteen of these participants were initially nonrandomly assigned to a wait-list control condition. All participants completed measures of perfectionism traits, perfectionistic self-presentation, and automatic perfectionistic thoughts, as well as measures of distress (including depression, anxiety, and interpersonal problems), at pretreatment, posttreatment, and a 4-month follow-up. It was found that the treatment was effective in reducing almost all perfectionistic behaviors (with moderate to large effect sizes), and that changes in specific perfection components were predictive of changes in specific symptoms. Finally, the findings provided evidence that the treatment produced changes in perfectionistic behaviors, depression, anxiety, and interpersonal problems in comparison to the wait-list control group—thereby allowing us to conclude that the observed changes were a function of the treatment, rather than of spontaneous remission in the symptoms and perfectionistic behaviors.

Conclusion 5

Our fifth conclusion is this: **The presence of comorbid conditions, including personality disorder or dysfunction, may complicate the treatment of perfectionism.**

As discussed earlier, there is growing evidence that perfectionism is associated with comorbid disorders (see also Bieling et al., 2004; Van Yperen, Verbraak, & Spoor, 2011); perhaps this association with complex clinical conditions is one reason why there are continuing indications that perfectionism is a deeply ingrained style that hinders the course of treatment (see Blatt & Zuroff, 2002; Blatt, Zuroff, Hawley, & Auerbach, 2010; Hewitt et al., 2008; Jacobs et al, 2009; Pinto, Liebowitz, Foa, & Simpson, 2011). As a result of its association with numerous

clinical states, perfectionism has been characterized as a transdiagnostic process—one that not only is linked to different forms of psychopathology, but also acts as a risk factor for the disorder or as a maintaining mechanism (Egan et al., 2011).

Perfectionism is often implicated in complex cases involving both chronic mental health and physical health conditions. Consider, for instance, the people with chronic pain who participated in the Hewitt, Flett, and Mikail (1995) study described earlier. These were individuals who had not only chronic pain, but also a sense of distress and family problems, especially if they were paired with and lived with exacting, other-oriented perfectionists. One possibility in these situations is that perfectionistic individuals are treatment-resistant when it comes to their emotional well-being, and they can become much more willing to focus on their medical problems as a way of deflecting attention away from core issues.

Conclusion 6

Our sixth conclusion is this: **Perfectionism may be associated with early treatment termination and with disruptive behaviors.**

The topic of early termination and perfectionism has not received extensive empirical investigation; however, there are some indications of a relationship. McCown and Carlson (2004) found that outpatient cocaine users who were being treated with CBT, and who were also characterized by narcissistic personality disorder, were likely to terminate treatment as a function of high levels of other-oriented perfectionism. These data suggest that people with complex clinical conditions who also have perfectionistic behaviors are likely to terminate treatment early.

Conclusion 7

Our seventh conclusion is as follows: **Treatment needs to focus on underlying mechanisms of perfectionistic behavior and to be process-oriented.**

Few studies to date have focused treatment on characterological or relational features of perfectionistic individuals. However, several writers have suggested that this kind of focus is appropriate in the treatment of perfectionism (e.g., Blatt, 1995; Greenspon, 2007; Pacht, 1984). Our research outlined above, evaluating a dynamic-relational approach to the treatment of multifaceted perfectionistic behavior, supports the idea that this kind of approach can be very effective in reducing perfectionism and the attendant symptoms (Hewitt, Mikail, et al., 2015).

As discussed briefly in Chapter 1, Blatt (1992) reanalyzed data from

the Menninger Psychotherapy Research Project and found that patients with strong perfectionistic tendencies responded better to longer-term, intensive psychoanalytically oriented treatment than to supportive–expressive psychotherapy. Moreover, the data indicated that changes in this sort of personality configuration may require longer-term and more intensive treatment, rather than shorter-term and symptom-reduction-focused treatments (see Blatt et al., 1995). Blatt and Zuroff (2002) went on to suggest that personality variables such as perfectionism need to be addressed specifically in treatments, in order to reduce relapse, aid in establishing therapeutic alliance, and enhance benefits from treatment. According to these authors, shorter-term therapies and therapies that do not focus on personality characteristics may not be as effective (Hewitt et al., 2008).

Our treatment study described earlier (Hewitt, Mikail, et al., 2015) found clinically significant decreases in trait perfectionism, perfectionistic self-presentation, and perfectionistic thoughts. Moreover, posttreatment scores on most but not all variables were significantly lower in the treatment condition than in the wait-list control condition. Although the group treatment was short-term (approximately 4 months in duration), it was a clearly intensive treatment—one that, consistent with psychodynamic principles, focused on the precursors of perfectionistic behavior, emphasized the therapeutic process within the group and between members of the group, and utilized the group therapy context as a powerful mechanism of change in the perfectionistic individuals.

As we suggested in Hewitt et al. (2008), and as the research findings (Blatt, 1992, 2004; Blatt & Zuroff, 2005; Blatt et al., 2006; Hewitt, Mikail, et al., 2015) have supported, intensive psychodynamic treatments may be highly effective interventions for the treatment of perfectionism. Thus it would seem that treatments that emphasize process, interpersonal dynamics, and transference issues, and not simply symptoms or the cognitive components of perfectionism, may be most appropriate (Greenspon, 2007; Hewitt & Flett, 2007; Sorotzkin, 1998).

Conclusion 8

Our eighth and final conclusion is this: **CBT may not be enough in the treatment of perfectionism.**

Interventions guided by a contemporary understanding of CBT emphasize symptom reduction and, at times, underlying schemas and the developmental experiences (including family experiences and other adverse childhood experiences) that have influenced these schemas. CBT, especially when provided by an experienced and effective clinician, can focus on the cause of a presenting problem. Nevertheless, in most

instances CBT is not sufficient for people who are experiencing distress and dysfunction due, in whole or in part, to perfectionism.

Persons (2008) has provided a concise and insightful overview of CBT while describing her influential case formulation approach to cognitive-behavior therapy. She states in this even-handed analysis that "Beck's cognitive model and other cognitive theories and therapies offer powerful tools for conceptualizing and treating a wide range of psychopathology. However, they are not enough. Not all patients respond to them" (p. 40). She then advocates incorporating techniques and processes stemming from various other approaches.

The conclusions reached by Persons (2008) are well supported by empirical findings and case reports. First, perfectionists are overrepresented among those people who do not respond well to CBT. Our conclusions are based, in part, on years of extensive clinical experience providing treatment to perfectionists. They are also grounded in research findings from the treatment studies described above, which illustrate the persistence of perfectionism and the difficulties associated with achieving clinically significant reductions in levels of perfectionism. As currently conceptualized, CBT may be appropriate for ameliorating psychological symptoms rather than the deeper-ingrained perfectionism traits. At times perfectionistic individuals will experience marked symptoms that can interfere with the process of psychotherapy, and focusing on the reduction of these symptoms via medications, behavioral strategies, or CBT techniques may represent a first step in the treatment of perfectionism, with a more psychodynamic approach brought on board when there is symptom relief. Indeed, in our (Paul L. Hewitt's and Samuel F. Mikail's) practices, we have at times utilized both behavioral interventions and medications to reduce symptoms so as to enhance the psychotherapeutic engagement. CBT interventions could likewise be used in this fashion. Along a similar line, because we view perfectionism on one level as a broad and encompassing defense against aversive affective and self-states (see Chapter 4), attempting to remove perfectionistic behavior without providing other resources for coping with and defending against powerfully aversive states would only exacerbate patients' symptomatology and distress. Similarly, there may be situations where a symptom-based CBT approach is appropriate, although this is an empirical question at this point. For example, this approach may be effective if an individual's perfectionism is not deeply ingrained, if the individual's perfectionistic tendencies are confined to one domain of functioning, or if only a surface level of cognitive insight is possible.

Our focus in this book is primarily (though not entirely) on those individuals whose perfectionism constitutes deeply ingrained personality pathology. As we have argued, many people with perfectionism have

a form of dysfunction that deserves more consideration and emphasis in diagnostic systems seeking reliable and valid accounts of personality disturbance (see Ayearst et al., 2012). Perfectionists in treatment are often people with complex cases involving comorbid disorders and complex life situations, and brief interventions are often insufficient for these individuals. Moreover, in these instances, core aspects of self and personal identity are implicated—often from a relational perspective that is being affected by current and past family interactions, rules, and roles.

In keeping with our conceptualization of the multidimensional nature of perfectionism, and the fundamental role of relational factors in the development and maintenance of perfectionism, we maintain that most CBT-based treatments are not complex enough and do not capture the core themes and concerns of people struggling with perfectionism. Our approach recognizes that the personality and the self of a perfectionist are often openly expressed in ways that are inauthentic. They may seem quite different from, and more positive than is really the case for, the true self. Assessment and intervention must reflect the unique and multiple ways in which perfectionism can be experienced and expressed, and it must do so in a way that respects and recognizes the role of the self in its social context. What is required in most instances is an intervention aimed at core aspects of the self; desired identities; feared possible selves; and the negative, undesirable, and weak personal identities that currently exist. In addition, this intervention must have a strong interpersonal emphasis that takes into account the self in relation to other people.

There are substantial benefits to be derived from an integrated form of psychotherapy. Perfectionism may be well suited to a blended approach that includes a strong emphasis on psychodynamic and relational elements. Indeed, this was illustrated in one of the early papers promoting psychotherapy integration. As part of their advocacy for psychotherapy integration and their assimilative, psychodynamic approach, Stricker and Gold (1996) described the case of a 37-year-old man, Mr. S, who sought treatment for severe anxiety symptoms. Symptoms arose when Mr. S, an accountant, had a close friend at work go into retirement. His friend was also his supervisor, and Mr. S now became preoccupied with his expectation of being fired by his new supervisor. There were also indications of depressive symptoms, including irritability, and Mr. S suffered from a growing sense of social disconnection and isolation. Stricker and Gold (1996) noted that Mr. S was compulsively perfectionistic and brought his perfectionistic, avoidant, and seemingly emotionless style into treatment as well. The assimilative, psychodynamic approach employed by Stricker and Gold (1996) contained several elements. They suggested that treatment should not be focused solely at

the psychodynamic level, because this would require Mr. S to go well beyond his existing adaptive capacities, but that psychodynamic work was clearly needed because otherwise the treatment would be superficial and overly simplified. This was partly due to the poor relationship Mr. S had had with his now-deceased father, who was characterized as having treated Mr. S throughout his childhood and adulthood in a cold and rejecting manner, conveying the message to Mr. S that he did not matter. The feelings Mr. S had toward his father were brought to the surface when Mr. S was asked to participate in a series of two-chair Gestalt dialogues that required him to engage in conversations with several targets (i.e., his father, his retired work supervisor, his mother, and himself as a child). These discussions brought “tremendous anger” to the surface. Overall, Stricker and Gold (1996) provided three specific examples of how they used an integrative approach to address the needs of Mr. S. The clear message emerging from their discussion of this case is that the perfectionism displayed by Mr. S was rooted deeply in his early and current relational world, and that progress would only result when true emotions came to the surface.

GENERAL CONCLUSION

We have made the argument for the importance of perfectionism in a variety of clinical dysfunctions and in the clinical process of obtaining help. Although some forms of treatment for perfectionism have been evaluated, research in this area is still in its early stages. There is a need to go beyond CBT in the treatment of individuals with perfectionism, and there appears to be some evidence that more psychodynamic and interpersonally oriented treatments focusing on the putative causal mechanisms (e.g., personality characteristics such as perfectionism) may be effective in reducing perfectionism and its attendant difficulties (see Hewitt, Mikail, et al., 2015).

CHAPTER 4

The Perfectionism Social Disconnection Model

Development of Perfectionism

The development of perfectionism plays a pivotal role in the assessment and treatment of perfectionistic behavior. In this chapter, we describe our current understanding of how perfectionism develops by focusing first on early developmental issues. These include the formation of internal working models of others and self and the evolution of one's self-concept, based on attachment to caregivers. We believe that early childhood experiences are formative in the development of perfectionistic behavior (see also Missildine, 1963; Rothstein, 1991). We also describe family environment and parenting behavior during childhood and adolescence, which influence and contribute to the expression of perfectionistic behavior.

This chapter and the next one build on and extend the analysis of the development of perfectionism we provided over a decade ago (Flett et al., 2002), as well as our original perfectionism social disconnection model (PSDM; Hewitt et al., 2006), underscoring the importance of the role of relational connectedness in perfectionism and outcomes. Figure 4.1 presents our overall and expanded PSDM, which we discuss in this chapter and Chapter 5. In this chapter on development, we focus on the left side of the diagram (see Figure 4.2).

As the previous chapters have detailed, there is substantial heterogeneity among perfectionistic individuals. Two people can have comparable patterns and levels of perfectionism, but may differ substantially in how their perfectionism evolved. This difference has important

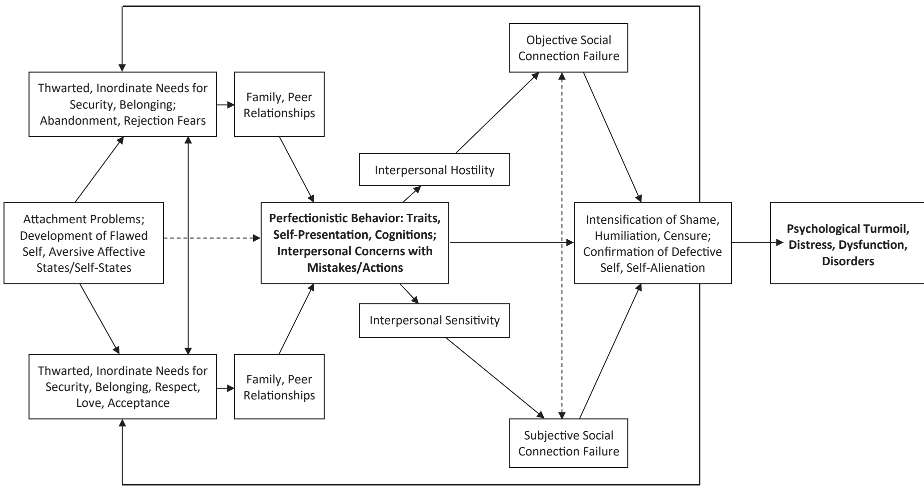

FIGURE 4.1. The overall, expanded perfectionism social disconnection model (PSDM).

implications for treatment. When a clinician and patient are embarking on the treatment process, it is crucial for the clinician to gain a clear understanding of how and why perfectionism evolved for this particular individual. It is also essential to recognize the complexities inherent in perfectionism and the multiple factors that need to be considered. These complexities were perhaps best summarized by Hollender (1965): "Discussing the psychodynamics of perfectionism is like teasing out a single thread from the intricate pattern of a fabric. A swatch must be taken to see the overall design" (p. 97). Hollender (1965) went on to state that perfectionism is learned during childhood: "The ideal subject for the development of perfectionism is a sensitive child who feels insecure. The insecurity intensifies his need for acceptance" (p. 97).

Many theorists have noted the importance of early and continuing parental and sibling relationships in the development and maintenance of perfectionism (e.g., Greenspon, 2008; Frost et al., 1990; Hamachek, 1978; Hollender, 1965; Pacht, 1984). These authors suggest that the experience of "nonattunement" to an infant's needs contributes to the development of perfectionistic behavior early and throughout the individual's life.

Perfectionism develops within the context of early interactions with caregivers or other significant figures, but we do not wish to assert that parents are to blame for a person's struggles with perfectionism or for the attendant difficulties arising from this personality structure. Nor

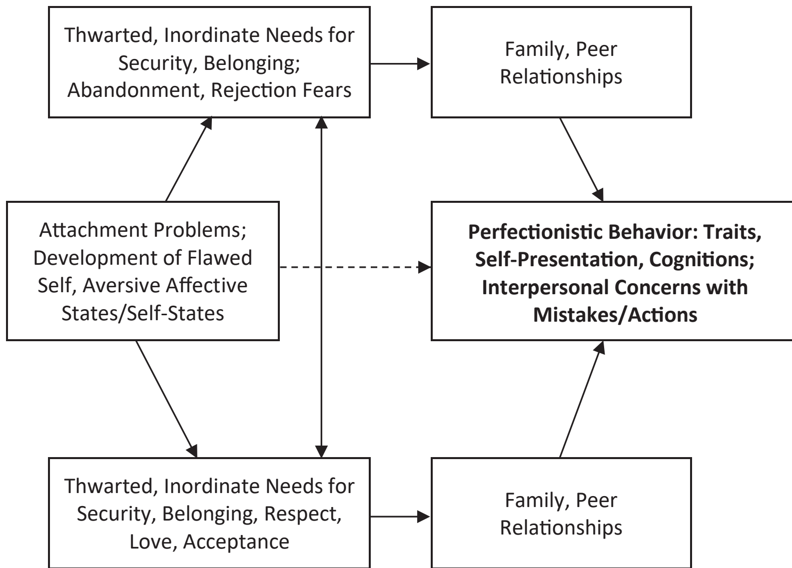

FIGURE 4.2. Development portion of the PSDM.

would we suggest that parents of perfectionists are necessarily defective in their parenting or neglectful in their interactions with their children. Rather, we adhere to views consistent with those posited by Gabbard (2004):

> Our knowledge of genetics and cognitive neuroscience suggests that the genetically based temperament of the child shapes much of the interaction with the parents. Characteristics that are inherited evoke specific parental responses. . . . The behavior of the parents, in turn, shapes the child's personality. In this regard, it is an oversimplification to blame parents for their children's problems. A complex interaction between the child's inherent traits, the parents' psychological characteristics, and the "fit" between parent and child is crucial to the developmental perspective. (p. 7)

These perceived contingencies and perceived relationships are incorporated into the individual's personality. In some instances, perceptions may be accurate, and the contingencies and inequities may be evident. In other instances, perceptions may be inaccurate, as a function of the interaction between the temperament or personality of each participant. Recent research offers evidence that children, and even infants, actively contribute to the development of perfectionistic personality features

(Macedo et al., 2011; Tong & Lam, 2011). For example, for some individuals the perfectionism can take the form of needing to care perfectly for parents or other siblings ("parentification"), or to care for the emotional state of parents. For others, the perfectionism can be seen in academic achievement, appropriate behavior, not causing problems for parents, and so forth. Our use of the term "asynchrony" is thus intentional, in order to underscore that the gap between a child's attachment needs and a parent's response does not necessarily stem from inadequate parenting. Some infants are difficult to read, and their needs may not be apparent for a myriad of reasons (deficits in emotional expression, temperament, developmental difficulties, etc.). This may be especially the case for infants with anxious temperaments, whose needs to be soothed and comforted are inordinate and demanding. Likewise, a parent with his or her own attachment anxieties or other personal struggles may not have the capacity to meet a child's needs consistently.

EARLY DEVELOPMENTAL CONSIDERATIONS

Overview of the Development of Perfectionism

As we have stressed, perfectionism is an interpersonal personality style that develops within a relational context. Attachment failures or difficulties arising from a poor fit between a child's needs (e.g., the need to be soothed, made to feel safe, validated, and stimulated) and a caregiver's responses compromise the perfectionism-prone individual's development along two independent but related pathways. The first involves the nature of the person's relational style with both others and self; the second comprises the constellation of affective states occurring within the relational context during times of heightened stress or perceived threats to the individual's sense of safety and/or self-esteem (Bowlby, 1988; Kohut, 1971; Shane, Shane, & Gales, 1997; Sullivan, 1953). Two underlying motivational forces are at play in the development of perfectionism: the need to belong and the need for self-esteem. Although the two needs are related, we believe that they contribute uniquely to the development of perfectionistic behavior and the manner in which perfectionism manifests in a given person. With respect to the need to belong, we propose that perfectionism evolves as a strategy aimed at garnering acceptance and protecting against wounding experiences of rejection. Perfectionism also serves as a means to develop self-cohesion and ego strength, which insulate the individual from the intensity of aversive affective and self-states that can arise from experiences of perceived failure and rejection. Contemporary theories of attachment (Bowlby, 1969/1970) and self psychology (Kohut, 1971; Shane et al., 1997; Stolorow, 2007) offer

frameworks for understanding the unfolding of the perfectionistic individual's personality.

In Chapter 2, we have described distinct trait components of perfectionism and their associated behavioral expressions, and have suggested that specific attachment and developmental difficulties differ for these varying forms of trait perfectionism. Although attachment theory underscores the importance of the child–caregiver bond in the development of the child's attachment style, it also recognizes the impact of other significant bonds, including sibling relationships, peer relationships, romantic relationships, and differential attachment behavior with different caregivers (Cowan & Cowan, 2007).

Asynchrony and Perfectionism

Although many deleterious effects of early attachment difficulties have been described in the literature (e.g., DeKlyen & Greenberg, 2008; Dozier & Rutter, 2008; Mills, 2005), we propose that at least three effects are of primary importance in the development of perfectionism. First, insecure attachment stemming from asynchrony between a child's needs and a caregiver's responses gives rise to attachment anxiety. This in turn contributes to negatively toned mental representations of significant others, which ultimately lead to the development of a limited and inflexible interpersonal repertoire. Significant others are perceived as indifferent, unavailable, critical, or incapable.

Second, early and persistent asynchrony erodes the possibility of forming a resilient and stable identity and self-concept, in which the self is viewed as valuable and valued by others. Instead, the individual develops a fragile and fragmented view of self that includes intense feelings of vulnerability, defectiveness, and loathsomeness. This contributes to a fragility of self-cohesion and ego strength, coupled with a pervasive tendency to judge the self harshly.

Third, these early compromised developmental experiences give rise to the internalization of relational schemas and self-schemas (i.e., "working models") characterized by affective states that include shame, anxiety, unlovableness, alienation, depression, or anger. These models are built on the anticipation or actual experiences of humiliation, rejection, and abandonment (Stolorow, Brandchaft, & Atwood, 1987). The individual's baseline affect is one of disquiet and aversive discomfort, to which the person typically responds by assuming a stance of chronic emotional numbness. However, when faced with heightened stress, particularly stress stemming from experiences or anticipation of perceived rejection and/or criticism, the individual is flooded with the intense and destabilizing emotions of shame, fear, humiliation, and anxiety.

The combination of thwarted attachment needs, compromised self-concept, and negatively toned working models contributes to the development of a distorted perceptual lens through which significant interpersonal encounters are experienced as signs of rejection, thereby perpetuating an unrelenting longing for acceptance, relational connection, and the sense that one matters (Baumeister & Leary, 1995; Kohut, 1971; Lichtenberg, 2013). The perfectionistic individual forms the belief that gratification of these desires holds the promise of eradicating the inner void and pain with which the individual lives. The perfectionist struggles with a persistent need for affirmation, belonging, and a felt sense of being loved. Although numerous defenses and coping mechanisms can emerge in response to experiences of asynchrony (see Bowlby, 1973; Kohut, 1971), we argue that a need to be and/or appear perfect is an unconsciously adopted strategy aimed at compensating for and repairing the damaged self and managing the associated interpersonal anxiety and other aversive emotions. Yet, as we illustrate throughout this book, the myriad interpersonal difficulties and subjective suffering associated with perfectionism seem to make both self- and other-acceptance elusive and unattainable.

In summary, perfectionistic behavior can be understood as a complex, characterological style aimed at repairing a defective self by gaining acceptance and achieving a sense of connection through one's presumed perfection. This view is reflected in numerous theoretical writings and cognitive or attitudinal measures of perfectionism, such as "If I am perfect, then others will care for me," "I am a second-rate person unless I am perfect," and so forth (see Brown & Beck, 2002; Ellis, 2002; Weissman & Beck, 1978). What seems to evolve is a way of being in the world characterized by both explicit and implicit beliefs that "If I am perfect, there will be nothing to criticize, to judge, or to reject—nothing to be ashamed of—and I will be accepted, I will be whole, and I will have worth." As we explain below, the specific perfectionism traits that one develops depend on the nature of asynchrony encountered during the formative years.

We now describe some of the early bonding and relational experiences involved in perfectionism and three major psychodynamic underpinnings of the development of perfectionism: (1) attachment difficulties, (2) lack of self-cohesion and view of the self as flawed, and (3) attempts to curtail rejection and aversive affective and self-states.

Child–Caregiver Relationships and Attachment

Several theoretical models of personality and psychopathology have underscored the importance of the quality and nature of the

caregiver–infant relationship in shaping a child's personality and interpersonal patterns (e.g., Ainsworth, 1969; Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988; Shane et al., 1997; Cassidy & Shaver, 2008; Zilberstein, 2011). In the early stages of development, an infant's survival is entirely dependent on receiving care and protection from a willing caregiver. The infant's capacity to thrive is determined by the extent to which the caregiver is attuned and responsive to the infant's needs for nurturance, fear reduction, and affection. Bowlby (1973, 1988) posited that infants develop a repertoire of behaviors termed "attachment behaviors," aimed at maintaining proximity to the caregiver and eliciting the needed care. As the child matures, attachment behaviors are activated when the child is stressed, faces a situation of uncertainty, or encounters a perceived threat. Bowlby suggested that at these times the parent functions as a source of reassurance and protection by responding in ways that soothe the child's distress. Bowlby referred to this as the child's "secure base." This parental function serves as the foundation for the child's emerging capacity to tolerate stress and ability to engage in adaptive self-soothing. Furthermore, Bowlby's collaborator, Mary Ainsworth, demonstrated that a child who feels secure is able and willing to explore his or her environment (see Ainsworth et al., 1978). Similarly, Zilberstein (2014) has noted that "infants and young children require closeness to caregivers and they establish various strategies for maintaining proximity and eliciting care and protection. When children feel secure in the availability of attachment figures, they feel confident to explore. In this way, the attachment system regulates both exploratory and proximity needs" (p. 93). In fact, many have underscored the centrality of attachment needs "as the primary and often unconscious movers of human thoughts, emotions, and behaviors" (Tasca, Mikail, & Hewitt, 2005, p. 161).

When primary caregivers are available and responsive to a child's needs, the child comes to view his or her relational world as safe and manageable. Consistent responding by caregivers becomes the foundation for experiencing significant others as capable ("Mom *can* take care of my needs") and available ("Mom *will be there* to take care of me"), and for viewing the self as both capable ("When I need something, *I can cry out and I will be heard and responded to*") and worthy ("My needs will be met, which means that *I matter*"). These are essential ingredients in the formation of the capacity to trust others and in the development of secure and healthy styles of relating, a cohesive and resilient self, a positive self-concept, effective coping abilities, and healthy self-esteem.

In contrast, inconsistent caregiving or asynchrony between a child's needs and the caregiver's responses evoke significant distress and establish a behavioral repertoire intended to create a state of equanimity.

Depending on the pattern of inconsistency, the availability and responsiveness of other significant figures in a child's relational world, and the child's temperament, a child will form a view of the self as flawed and unworthy (a foundation for self-oriented or socially prescribed perfectionism), a view of others as incapable and/or unavailable to respond to attachment needs (a foundation for other-oriented perfectionism), or both (a foundation for a combination of perfectionism traits and perfectionistic self-presentation styles).

An extensive body of research has demonstrated that experiences of asynchrony between infant and caregiver contribute to the formation of problematic and inflexible relational styles (Benjamin, 1996; Bowlby, 1969/1971) that remain stable over one's lifetime (Sroufe, 1996; Main & Hesse, 1992). Zilberstein (2014) notes that "through those experiences, children develop an internal representation or internal working model of the care and protection they have received, which provides a similar regulating and self-comforting role" (p. 93). Although numerous attachment styles were initially described by Ainsworth and colleagues (1978) and have been subsequently refined, expanded, and elaborated by others (e.g., Cassidy & Marvin with the MacArthur Working Group, 1992; Crittenden, 1992, 1995; Main & Hesse, 1990; Main & Solomon, 1990), all of these researchers have described a secure attachment style and several insecure attachment styles that reflect compromised, inflexible, and maladaptive styles of interaction with the self and others. We focus on two of these that are germane to perfectionism.

Insecure Attachment Styles Relevant to Perfectionism

The first insecure attachment style we describe is most relevant to the development of self-oriented and socially prescribed perfectionism. (We describe later in this chapter how self-oriented and socially prescribed perfectionism differ in their development.) It stems from experiences of early caregiving in which parental figures are intermittently responsive to the child's needs. In the face of this inconsistency, the child comes to understand over time that he or she is responsible for the lack of connection with caregivers, giving rise to a sense of defectiveness and feelings of unworthiness and shame. The child incorporates into his or her internal working model a view of others as potentially harsh, judgmental, and critical, and—importantly, especially in the case of socially prescribed perfectionism—as possessing the power to determine the child's worth and acceptance in the world. This view intensifies the child's needs and attempts to belong and matter.

In the second insecure attachment style, the early experiences of asynchrony contribute to the formation of an internal working model in

which significant others are experienced as either unavailable or available but unresponsive to one's needs. As we alluded earlier, under these conditions, the child gradually learns to blunt his or her affect when distressed while remaining physiologically aroused. This pattern of attachment has been referred to as an "anxious avoidant" or "dismissing" attachment style (Zilberstein, 2014). This relational trajectory is likely to be associated with a stance of emotional self-sufficiency built on the belief and expectation that others cannot be counted on or trusted. We consider this to be the core dynamic of the other-oriented perfectionist, who demands that others be perfect as a means of compensating for asynchrony in early parental caregiving. The same individual is often highly invested in presenting an image of being flawless and doing no wrong, and in seeking a partner and friends who are expected to admire and affirm him or her.

In both these instances, individuals develop inflexible interpersonal styles (Leary, 1957) aimed at addressing long-standing unmet needs for acceptance, love, and feelings of self-worth. Stolorow, Atwood, and Orange (2002a) and Kohut (1971) indicated that such relationships are developed as corrective attempts to fulfill the need to belong and the formation of a positive and stable sense of self. Kohut (1971) referred to these relationships as "transferences," whereby the individual uses relationships with others to correct missing components of the self and missing elements of early relationships. As Kohut put it, the individual uses other people as "selfobjects" in attempts to fulfill these needs. For example, an individual may try to bolster self-esteem by aligning him- or herself only with others who are viewed as accomplished and successful.

Thus we suggest that individuals prone to developing perfectionistic tendencies face early childhood experiences of asynchrony that create a lack of secure attachment and produce working models of others as inconsistent, unavailable, unable, or unwilling to meet the individuals' needs. They also develop stylistic interpersonal behaviors as attempts to procure acceptance or ensure nonrejection by others, and to assure themselves that they are worthy. We suggest further that the nature and quality of early child–caregiver relationships underlies all perfectionistic behaviors, including traits, self-presentational facets, and information processing, but that that family constellations, sibling relationships, and peer relationships can foster and exacerbate these behaviors.

Lack of Self-Cohesion and the Flawed Self

The quality of early relationships influences not only one's relational styles toward others, but also the way in which one views and treats the self (e.g., Bowlby, 1973; Kohut, 1971; Mikulincer, 1995; Pietromonaco

& Barrett, 2000; Sullivan, 1953). As noted above, a history of early asynchrony can contribute to the formation of a view of the self as defective, fragile, and unworthy.

Kohut (1971) suggested that the development of a healthy and cohesive self is based on early childhood interactions with the caregiver and reflects a narcissistic process that, rather than being pathological, is a normal developmental phenomenon. Based on a variety of consistent, synchronous child–caregiver interaction patterns, the self develops and incorporates others as objects that provide care, safety, security, and soothing. Furthermore, there is contiguous development of a conceptualization of the self as worthy and deserving of others' care. From this, the individual develops a cohesive self-structure that serves as a foundation for positive self-esteem, personal worth and meaning, autonomy, and a capacity for healthy reciprocal relationships.

Conversely, Kohut (1971) suggested that exposure to persistent asynchrony compromises the development of a cohesive self and thereby contributes to the formation of a disordered self (Kohut & Wolf, 1978). Banai, Mikulincer, and Shaver (2005) described individuals with the characteristics of Kohut's (1971) disordered self as "people . . . focused on their deficiencies, extremely vulnerable to criticism and failure, and overwhelmed by negative emotions, pessimistic thoughts, and feelings of alienation and loneliness" (p. 226). It is noteworthy that several theorists have ascribed all of these specific characteristics to perfectionistic individuals (e.g., Hewitt et al., 2008; Hollender, 1965; Horney, 1950).

Kohut (1971) also suggested that a disordered self can lead to a deficit in the capacity for autonomy and interdependence. In this instance, a child has difficulty differentiating him- or herself as a unique entity distinct from the caregiver. This blurring of boundaries in the disordered self continues throughout life and becomes most pronounced within the context of the person's intimate relationships. We consider this to be the dynamic at the core of socially prescribed perfectionism—a form of perfectionism characterized by a compromised and limited ability to form mutually intimate and mature relationships with others, because others are not understood or treated as separate and distinct entities from the self (see Roxborough et al., 2009). For the socially prescribed perfectionist, self-esteem and self-worth become contingent on external affirmation that is attained by perfecting the self. The socially prescribed perfectionist possesses a heightened sensitivity to the expectations of others, and feels compelled to meet or even exceed these expectations. Several studies have shown that such diffuse boundaries are characteristic of those with excessive levels of both other-oriented and socially prescribed perfectionism (e.g., Chen, Hewitt, & Flett, 2015; Hewitt & Flett, 1991b; Roxborough et al., 2009).

Perfectionistic individuals who lack a stable and cohesive self and possess low self-esteem tend to mistrust themselves in the face of major life decisions. They believe themselves to be incompetent, incapable, and lacking in adequate judgment to make wise life decisions. Furthermore, they view that which is intrinsically interesting or pleasurable to them with distrust. Their longings and desires become sources of shame that must be hidden for fear of ridicule and criticism. This dynamic has its basis in childhood experiences, which lead a child to conclude that a sense of safety and security can only be achieved by being or appearing perfect and by being judged by others as perfect. As such, the child ultimately suspends his or her intrinsic needs and desires, and invests his or her emotional resources in responding to the needs and expectations of the caregiver. Over time, the same dynamic begins to generalize to other significant relationships, with the child's inherent curiosity becoming narrowed and his or her focus directed toward perceived external expectations and demands. In our clinical experience, this process is typically accompanied by a near-constant attentiveness to evidence or markers of nonacceptance; such attentiveness firmly cements the belief that the individual is unworthy of others' regard. The outcome is a trajectory of development propelled not by an intrinsic sense of autonomy and self-regard, but by perceptions of what is needed to gain a sense of belonging. Brief periods of emotional equanimity are achieved through the individual's active efforts to avoid judgment, criticism, humiliation, or debasement, and occasionally by procuring overt demonstration of others' caring.

As a consequence, these perfectionistic individuals view themselves as imposters who must present a false, perfect external persona to the world (see Hewitt, Flett, Sherry, et al., 2003; Miller, 2001; Sorotzkin, 1985; Winnicott, 1965). Moreover, achievements and accomplishments that are attained are minimized or even dismissed (see, e.g., the case of Robert in Chapter 8), and come to be understood over time as empty and unfulfilling; thus they have little effect on enhancing self-esteem. In the course of our clinical work, we have encountered many accomplished perfectionistic individuals who in midlife experience profound identity confusion, accompanied by a feeling of being lost in the world or having lived an inauthentic life. They view their career attainments as devoid of meaning, and in turn experience a marked sense of despair and depression.

Affective and Self-States

Several writers have suggested that significant asynchrony is experienced as a form of childhood trauma (Shane et al., 1997). Stolorow

(1997) explains that the absence of adequate and appropriate parental responses to an infant's needs produce a painful emotional reaction in the infant, typically displayed in the form of crying. The infant's distress is compounded in the face of further asynchrony when the parent fails yet again to respond in a manner that offers the needed comfort and soothing. Over time, the child learns that comfort cannot be sought and obtained consistently or at all from others. States of physical and emotional discomfort become part of the infant's normative state, and in turn serve to compromise the child's development of the ability to self-soothe in the face of distress. Consider, for example, the infant of a depressed mother. The infant may be frightened and begin to cry, out of a desire to be held and comforted. The mother, thinking that the crying means the child's diaper is soiled, checks and finds the diaper to be fine. Next, she considers the possibility that the child is hungry; she warms a bottle, only to have the child reject it and continue to cry. In her negative emotional state, she approaches these tasks mechanically and laboriously. Given her own state of depression and withdrawal, thoughts of physical affection are simply not available, and thus the infant's needs for comfort and reassurance remain unsatisfied. As noted above, the infant's distress is compounded by the reality that he or she does not yet possess the capacity to self-soothe.

Sullivan, Bowlby, and Kohut all described the importance of these affective experiences in the development of one's internalized working models of self and others. For example, Sullivan (1953) viewed the regulation of anxiety in interpersonal relationships as the central motivating force in the development of an individual's personality and interpersonal style. Moreover, he argued that this core anxiety is "rooted in dreaded expectations of derogation and rejection by parents and others, and later on by oneself" (Teyber, 2006, p. 7). According to Sullivan (1953), anxiety stems from two potential sources, the first being anxiety the infant experiences in response to the mother's emotional state. Sullivan suggested that the mechanism by which this occurs is that of empathy, and noted that anxiety also stems from interactions that fail to confirm the child's ultimate expectations, particularly with respect to the "self-system" or self-concept. In order to reduce or eliminate this source of anxiety, the child develops an inflexible interpersonal repertoire that invites a restricted range of responses from others, which confirm the child's view of self. Sullivan (1953) stated that "the relaxation of the tension of anxiety, the re-equilibration of being in this specific respect, is the experience, not of satisfaction, but of interpersonal security" (p. 42). Leary (1957) refined Sullivan's formulation somewhat by postulating that personality is "the pattern of interpersonal processes employed to reduce anxiety, ward off disapproval, or maintain self-esteem" (p. 119).

To return to the example of the infant with the depressed mother, if the experience described above is repeated with some regularity, the child eventually learns that crying in order to seek physical intimacy and soothing with the mother is futile. However, crying in response to hunger or the need to have a soiled diaper changed is likely to gain the mother's attention and garner an appropriate response.

Although we agree with Sullivan's conceptualization regarding the role of anxiety management in the formation of personality, we would add that other affective states reflecting a lack of connection or lack of self-regard are pivotal in the development of perfectionism. The threat of perceived disconnection gives rise to a variety of negative affective states, ranging from a pervasive sense of disquiet to highly intense distress. For example, shame, anger, and guilt are emotions often associated with perfectionism (see Wyatt & Gilbert, 1998; Tangney, 2002), and affective states such as prolonged despair, humiliation, loneliness, or the feeling that one does not matter to others can contribute to the development of perfectionism as a perceived solution to disconnection. Each of these affective states is interpersonal in nature, having at its core an underlying sense that perfection will be met not only with affirmation, but also with acceptance—which holds the promise that one's emotional needs will be recognized and satisfied.

As previously stated, Bowlby (1988) indicated that for insecurely attached individuals, working models of others include affective memories and the expectation that others are either unwilling or incapable of providing soothing, comfort, or aid in coping with discomfort and/or distress. These children come to view their discomfort and distress as unwelcome to their caregivers, and the associated affects ultimately become sources of conflict and vulnerability (Stolorow et al., 1987). For example, Goldberg, MacKay-Soroka, and Rochester (1994) noted that specific patterns of maternal responses were associated with specific infant attachment styles. Mothers of infants classified as securely attached were responsive to their infants' expressions of positive and negative affect. In contrast, mothers of insecurely attached infants exhibited a restricted pattern of responses to their infants' affect. Specifically, mothers of infants classified as exhibiting an "avoidant" attachment style (also referred to as "dismissive") were unresponsive to the infants' expressions of negative affect. In our model, such infants are vulnerable to developing other-oriented perfectionism. Mothers of infants exhibiting a "resistant" attachment style (also referred to as "preoccupied") were more responsive to expressions of negative than of positive affect. We view such infants as vulnerable to developing self-oriented or socially prescribed perfectionism. Goldberg et al. (1994) concluded that these patterns of maternal response lead infants to learn that certain affects

are more acceptable to their mothers, and this contributes to the formation of a behavioral repertoire aimed at gaining the mothers' attention and evoking their responsiveness.

More recent empirical findings reveal that similar patterns are seen among adults. Specifically, Maxwell et al. (2012) found that adults possessing an avoidant attachment style had difficulty experiencing and expressing emotions, while those classified as preoccupied exhibited a hyperactive affect system characterized by overt expressions of negative emotionality. These findings are consistent with attachment theory, in which it is noted that over the course of development relational patterns become internalized and extend to one's significant or intimate relationships (Pietromonaco & Barrett, 2000; Bretherton, 1993).

The painful and prolonged affective reactions to thwarted needs have been described as leading to failures in the development of a cohesive self, whereby affects that are not acceptable produce self-hatred and shame (Stolorow et al., 1987). These aversive affects and states can become incorporated into the self (Linville, 1985) and become pervasive and chronic (Pietromonaco, 1985). Such an individual experiences the self as loathsome and defective, and believes that he or she is inherently bad (Sullivan, 1953). Thus intensely experienced unpleasant affects can become sources of inner conflict that compromise self-integration. Alternatively, such affective states may become split off from the self: The person may not experience the affect overtly, but may do so indirectly or unconsciously (Mills, 2005). In such instances, when the individual is asked to describe what he or she is feeling, the person struggles to go beyond noting discomfort. Affective granularity becomes elusive, as does the capacity to articulate the source of the discomfort with any precision. This phenomenon was encountered in the work with Anita (see Chapter 6). When first describing her separation from and reunion with her mother at a young age, she exhibited subtle signs of emotion that were noted by the therapist, but that Anita had little access to. However, with ongoing exploration, empathic reflection, and affective mirroring over the course of treatment, Anita's affective states became increasingly distinct and congruent, and she eventually was able to experience and lay claim to emotions that had previously been inaccessible.

Affects Relevant to Perfectionism

What sorts of affects are associated with the development of perfectionism? There are several such affects that we believe arise early in a child's development, including a sense of aloneness, shame, anxiety, depressive states, anger, and a conglomerate of these states that has been termed "psychache."

Earlier, we have described the impact of attachment anxiety within the context of perfectionism, noting that it contributes to a preoccupation with and worry about being accepted and an anticipation of being rejected. Kohut (1971) described a second form of anxiety, which he termed "disintegration anxiety"; he suggested that this is one of the most disturbing affect states one can experience. Disintegration anxiety is an "intense and pervasive anxiety that accompanies a patient's dawning awareness that his self is disintegrating and experiences of . . . severe fragmentation, serious loss of initiative, profound drop in self-esteem, sense of utter meaninglessness" (Kohut, 1971, p. 103). For the perfectionistic individual, disintegration anxiety may occur following instances of significant ego-involving failure. At these times, the perfectionist's subjective experience is one of profound vulnerability: The person feels so fragile, it is as if the self is about to crumble.

Shame

Among the affects described most consistently in the perfectionism and psychoanalytic literatures are shame and its variants (see Hamachek, 1978; Hollender, 1965; Stolorow, 2010; Tangney, 2002). Tangney (2002) has described shame as a self-conscious emotion or an emotion of evaluation specifically directed toward the self. Stolorow (2010) has enumerated several variants of shame, including self-consciousness, humiliation, and mortification, all of which have the commonality "of having exposed one's inherent 'flawedness' or 'defectiveness' (e.g., vulnerabilities and needs) to a viewing, judging other" (p. 367). Shame is seen frequently in the course of treatment of perfectionism (see Greenspon, 2008; Hamachek, 1978; Sorotzkin, 1985), and it is at the heart of the socially prescribed perfectionist's emotional world (Gilbert & Andrews, 1998; Wyatt & Gilbert, 1998; Tangney, 2002). It should be noted that for perfectionistic individuals, shame and similar emotions may be experienced at implicit levels (Tangney, 2002) and may only be accessible with continued psychotherapeutic work.

Aloneness

Another set of affects relevant for the development of perfectionism involves emotions pertaining to the belief that one is alone in the world. These emotions include not only loneliness, but also, at a deeper level, the experience of isolation, aloneness, or standing apart from others in the world. Feelings of disconnection and alienation are hallmarks of socially prescribed perfectionism as well as perfectionistic self-presentation (see Flett, Nepon, & Hewitt, 2015; Hewitt et al., 2008). In his writings,

Yalom discusses the universality of existential isolation, defining it as an acute and at times painful awareness of the "unbridgeable gulf between oneself and any other being" (1980, p. 355). Yalom goes on to state: "To the extent that one is responsible for one's life, one is alone. Responsibility implies authorship; to be aware of one's authorship means to forsake the belief that there is another who creates and guards one. Deep loneliness is inherent in the act of self-creation" (1980, p. 357).

We see this aspect of human experience depicted with poignant clarity in the film *Gravity,* at the moment when a physical separation occurs between mission specialist Dr. Ryan Stone and veteran astronaut Matt Kowalski. In that instant, Stone is faced with the terrifying awareness that she is left floating in space, separated from the whole of humanity, with a vast nothingness surrounding her. She's confronted with the reality of being entirely alone and having to assume sole authorship of how her life will take shape from there on. She experiences the anguish of that challenge repeatedly over the course of the mission, and has to decide whether to fight for life or gently embrace death. The vast majority of perfectionists with whom we have worked experience a variant of existential isolation that they find intolerable, but it is particularly accentuated among other-oriented perfectionists. Not only do they feel imprisoned and tortured by their perfectionism; they also believe it to be something that pertains only to them. This becomes a source of both pain and protection. The pain stems from an awareness of being separated and disabled by perfectionism. At the same time, there is an element of narcissistic gratification associated with a belief in one's terminal uniqueness.

The aloneness that individuals with perfectionistic behavior experience forms a pivotal component of our PSDM. We argue that experienced aloneness not only drives perfectionistic behavior, but also is actually created by the perfectionistic behavior.

Depressive States

Numerous investigations have shown perfectionism to be associated with depressive states. These are varied and can include despair, desolation, or what some have termed "depletion depression" (see Tolpin & Kohut, 1980) or "abandonment depression" (Masterson, 1988). Depletion depression involves states of felt emptiness, desolation, and helplessness that are long-standing and ubiquitous. Abandonment depression is described as a subjective state in which an individual feels as if he or she is disappearing when a valued other is perceived to have become emotionally distant. These variants of depressive experience echo Sidney Blatt's conceptualization of "introjective depression" and "anaclitic

depression." Blatt conceptualizes introjective depression as a form of depression characterized by negative self-scrutiny, low self-worth, self-blame, and guilt—all defining features of self-oriented perfectionism. In contrast, Blatt views anaclitic or dependent depression as an interpersonal phenomena characterized by fear of rejection or abandonment and by dependent neediness (Blatt & Homann, 1992)—experiences that are prototypically associated with socially prescribed perfectionism.

Anger

Another pervasive affective state exhibited by perfectionistic individuals is anger. For example, anger in other-oriented perfectionists can take several forms, including hostile reprimand when others are perceived to have failed in meeting expected standards of performance. Alternatively, other-oriented perfectionists often display a conversational tone that is more akin to interrogation than genuine curiosity, the basis of which is the implicit message that the other is being judged and has done something wrong. A common variant of this pattern is the other-oriented perfectionist's pervasive irritability, which conveys the impression that nothing is ever good enough, others are nearly always a disappointment, and that life is a state of constant drudgery.

Similarly, significant anger can be exhibited by individuals with socially prescribed perfectionism. Often this anger can cover feelings of despair and depression over the sense of inability to meet or maintain the perceived unrealistic expectations of others.

Lack of Satisfaction

In addition to the presence of negative affect, perfectionistic individuals exhibit an absence of positive affect. This is most evident in their constricted capacity to experience joy, exhilaration, or even satisfaction in the face of what others would objectively view as some significant accomplishment. This aspect of perfectionism typically has its foundation in childhood experiences in which a child and caregiver rarely shared celebrations of success or feelings of satisfaction and sustained shared pride. As such, perfectionists become visibly uncomfortable when affirmed; this discomfort can take the form of outright dismissal, emotional numbness, or simply ignoring a compliment as if the other had not even spoken. Such responses are understandable when considered psychodynamically. At a relational level, acceptance of affirmation involves choosing between one's belief regarding the caregiver's original view of oneself (and the current view of oneself), and the competing and contradictory view inherent in the affirmation. Although the established view

of self is painful, relinquishing it involves a deeper (albeit temporary) pain of deciding to stand apart from the caregiver—a choice imbued with deep grief. Moreover, believing in the veracity of the compliment would mean that the individual is entertaining the possibility of potentially being unflawed and valued by others. For a perfectionist, this is a risky and frightening prospect to entertain and believe in.

In summary, individuals exhibiting insecure attachment styles and possessing self-cohesion difficulties look to their relational worlds to overcome feelings of shame, devaluation, and unlovableness. They strive to gain a sense of belonging and acceptance as a means of warding off feelings of rejection and perceived abandonment by attempting to be or appear perfect. In our view, perfectionistic behaviors serve as defenses against the various forms of anxiety and negative affects outlined above. Kohut (1971) noted that such defenses can lead to the development of a narcissistic façade that includes grandiosity, success, and an ongoing preoccupation with fantasies of perfection and power. Many such individuals are highly invested in avoiding situations wherein their imperfections are revealed (see Horney, 1950). Moreover, Mikulincer (1995) has stated that insecurely attached individuals can become isolated because "their self-esteem is so low and fragile that they cannot tolerate discovery of the slightest flaw. . . . [This] seems to be a defense against the experience of rejection by others of the recognition of one's imperfections" (p. 1213). We would suggest that one way to accomplish this is to develop a behavioral repertoire that entails attempting to be perfect (i.e., perfectionistic traits) or attempting to appear to be perfect (i.e., perfectionistic self-presentation), to ensure acceptance and to guard against the threat of rejection, indifference, or abandonment.

LATER DEVELOPMENTAL CONSIDERATIONS

Development and Maintenance of Perfectionistic Behavior in the Family and Environment

As emphasized throughout the chapter to this point, early life and the nature and quality of caregiver–child relationships set the stage for the development of perfectionistic behavior. Our analysis is predicated on the assumption that for most perfectionistic individuals, constitutional factors (e.g., an anxious temperament) and/or early life experiences contribute to feelings of insecurity and uncertainty about the self and to negative relational expectations about others. Perfectionism develops in response to these feelings and unmet needs. Most of our discussion below is in keeping with this general theme as well. However, although early relational experiences are pivotal in the development of perfectionistic

behavior, the development of perfectionism can continue or become entrenched throughout childhood and adolescence. And although the role of early parenting continues to have an influence (Flett, Hewitt, & Singer, 1995), so too does the nature of extraparental family experiences, as well as of other relationships the individual encounters (e.g., those with friends, schoolmates, teachers, and coaches). The nature of these relationships is in turn colored by the individual's internal working models of self and of others, resulting in a reciprocal process whereby relationships shape internal working models and internal working models shape emerging and subsequent relationships. We now turn our attention to describing various pathways to the continued development of perfectionism in a child possessing the requisite dispositional vulnerability.

Pathways to Perfectionism

Harsh Parenting and Psychological Control

Numerous accounts of perfectionism emphasize the role of exposure to harsh parenting styles. For example, Frost, Lahart, and Rosenblate (1991) have noted that parents of some perfectionistic individuals have been described as excessively harsh (e.g., overly strict, guilt-inducing), and that the college-age daughters of such parents exhibit features of perfectionism characterized by overconcern with mistakes, doubts about actions, and extremely high personal standards. Moreover, Frost et al. (1991) have described two styles that appear to be evident among parents of perfectionists: namely, characterological parental criticisms and unrealistic parental expectations. The importance of parental criticism and harshness is consistent with our own work, in which we have observed that extreme parental criticism is often associated with the use of shame induction and humiliation in ways that resemble emotional abuse.

More recent work has focused on parental psychological control and its possible role in the development of perfectionism. Research with the FMPS has established a connection between parental psychological control and maladaptive perfectionism consisting of concern over mistakes and doubts about actions (Soenens, Vansteenkiste, Luyten, Duriez, & Goossens, 2005). Related research has shed additional light by showing that the degree to which the perfectionism of parents contributes to perfectionism in their daughters is due to the mediating role of parental psychological control (Soenens et al., 2005). Other research with our MPS (Hewitt & Flett, 1991b, 2004) has shown a modest link between parental psychological control and socially prescribed perfectionism in

daughters, and a recent study has indicated that increased psychological control contributes to a sense of discrepancy (Mushquash & Sherry, 2013).

Nonresponsive Parenting and Neglect

For some individuals, high levels of perfectionism reflect a lack of parental involvement and engagement—a lack that fosters a sense of self-uncertainty. From a symbolic-interactionist "looking-glass self" perspective, it stands to reason that being ignored and neglected in childhood conveys a lack of parental acceptance and interest in the child, and suggests that the child does not matter to family members. One response to such an environment is seen in the child who attempts to be the "perfect child," never causing a problem or issue for the parents in the belief that "If I am perfect or appear perfect, it will be my perfection that my parents will eventually notice and love." An illustration of this is the perfectionism exhibited by actress Ashley Judd, who has described in her autobiography the many times she was left alone for days at a time while her mother and sister pursued their music careers (see Judd with Vollers, 2011).

Nonresponsive and neglectful treatment of a child can exacerbate another critical dimension of the child's psychology: the knowledge that one matters to other people. This awareness is essential to a sense of well-being and self-worth. Rosenberg and McCullough (1981) have underscored that knowing that one matters to others is fundamental to the formation of a resilient and healthy self-concept, and ultimately shapes the sense of self-worth. Just as children who feel they don't matter are at risk, those who are secure in the knowledge that they matter to others possess a key resource that buffers them from the impact of stress and the erosion of self-esteem during periods of self-doubt. Indeed, evidence suggests that young people who exhibit high levels of socially prescribed perfectionism rate themselves relatively low on measures of mattering. Yet when a sense of mattering does exist, it can buffer the association between socially prescribed perfectionism and psychological distress (see Flett, Galfi-Pechenkov, Molnar, Hewitt, & Goldstein, 2012). Thus the powerful needs to belong, to matter, and to be accepted can be exacerbated when unmet, and a child can engage in perfectionism strategies to attempt to have these needs met.

Perfectionism arising out of such parental neglect may stem from having parents who are struggling with their own adjustment difficulties to a degree that makes them psychologically unavailable. When a parent is substantially debilitated and unable to function at an expected level, it is not uncommon for a perfectionistic child to assume a caregiving role

and develop a sense of being highly responsible for others. Perfectionism that emerges within this context is often accompanied by extensive attempts to minimize negative emotions and suppress personal needs in an attempt to gain approval, a sense of security, and attention, while also endeavoring to reduce the burden facing the afflicted parent (see Miller, 1997). This "parentification" is seen commonly in perfectionistic individuals, and these individuals continue this mode of securing interpersonal relationships into adulthood.

Traumatic and Highly Aversive Early Life Experiences

As noted previously, one important function of perfectionism is to exert control over one's environment. For some individuals, perfectionism develops in response to traumatic or aversive life circumstances that have fostered feelings of helplessness and unpredictability. The co-occurrence of perfectionism and trauma has not been studied extensively, but in our experience it is not uncommon for some individuals to develop perfectionism and become focused on trying to ensure that everything is "just so" as a means of avoiding the recurrence of traumatic stressors (especially those that involve being mistreated by others) or of avoiding a more general sense of chaos and uncontrollability. This need for control can extend to efforts to impose control over one's emotions—efforts that take the form of overvaluing emotional containment in one's interpersonal interactions. An individual possessing perfectionistic traits who experiences significant, uncontrollable trauma is likely to feel an extreme sense of vulnerability, due in large part to the perfectionist's propensity to perceive such events as due to his or her flawed self and failure to be perfect. In other words, the person's resulting vulnerability is a function of both the expected feeling of threat that most people would experience in response to a traumatic event, and the additional threat to the perfectionist's self-concept.

Perfectionism can also evolve out of prolonged and unresolved grief following the loss of someone who is highly significant in one's life (again, see the case of Anita in Chapter 6). The pain of the loss is contained by investing one's psychological resources into efforts to be perfect. Working with such an individual is often highly complex and requires a willingness to explore the individual's unconscious beliefs and expectations. In some instances, there is a longing to reunite with the person who has been lost. The self-oriented perfectionist may hold the unconscious belief that "If I am perfect, I can avoid ever feeling such pain again." The socially prescribed perfectionist may hold the unconscious belief that "If I had been better, I would not have lost the person; losing the relationship was my fault, and I must do better to please the

people in my life in order to guard against other losses." The other-oriented perfectionist may have distorted the lost relationship through idealization, and in turn may work tirelessly to recreate it by subjecting others to unrealistic expectations and standards.

Idolizing the Perfect Child and Narcissistic Grandiosity

Another pathway to perfectionism is seldom discussed: that of a parent or mentor who overidealizes a child, treating the child as if he or she is perfect. This can result from a parent's using the child as a selfobject, in the sense that a child's supposed perfection will reflect positively on the parent and give the parent a sense of esteem and value. This may be accompanied by the parent's openly and continually reminding the child that the child has special qualities and is capable of great things, regardless of the child's inherent abilities. This sets the stage for highly narcissistic forms of perfectionism and suggests that greatness and specialness are expected—placing enormous pressure on the child, who may or may not have the special talents and abilities that the parent attributes to him or her. It may be this particular family context that contributes to the development of perfectionistic self-presentational styles, especially when the child is aware that others do not share the parent's excessively glowing view of the child's abilities and potential. Such conditions can serve to foster a growing discrepancy between the manner in which the child has been defined by the parent and the external reality faced by the child in extrafamilial relationships.

Rewarded Perfectionism

Our final proposed pathway to perfectionism reflects a history of being rewarded for striving for perfectionism. The proposed developmental sequence here is based on research and theory acknowledging that there are individual differences in capabilities and that some people are able to have a history of successes (for a discussion, see Flett et al., 2002). There is a general tendency for people to increase their personal goals as they experience success, and they gain an increased sense of personal capability (see Bandura & Cervone, 1986; Locke, 1996). Moreover, Bandura (1986) has suggested that achievements providing a sense of self-efficacy can result in attempts to boost this sense of self-efficacy further by upwardly adjusting goals and standards.

Most people who continue to increase their standards will adjust them downward once they hit a point of receiving negative feedback and begin experiencing negative mood states. However, young people prone to perfectionism seem to develop a unidirectional need for improvement

and the recognition that comes from improvements and achievements, and this need may help explain a pattern of behavior that is otherwise difficult to explain. As part of his dissertation work, one of us (Paul L. Hewitt) conducted research showing that perfectionists receiving negative performance feedback, rather than lowering their goals and standards, actually raised the standards even higher—almost as if they were trying to compensate for the recent setbacks. In related work, Cervone, Kopp, Schaumann, and Scott (1994) found that the induction of negative mood states resulted in increases in levels of standards rather than decreases, but the induction of negative mood had no impact on levels of self-efficacy.

It is easy to envision a scenario in which a capable young person with elevated goals has a history of positive outcomes that result in greater and greater striving. This may especially be the case if he or she needs to make up for self-doubts or less ideal situations in life. This initially successful perfectionist can be at risk in at least two key respects. First, the lack of setbacks may prevent the person from developing resilience and learning how to deal with failures and disappointments. Second, much of the person's self-esteem is based on the sense of being able to do things at a level that is substantially better than what other people can do. Problems can ensue due to negative social comparisons when the perfectionist encounters other elite performers and realizes that his or her level of skill and performance is no longer the best. This exact scenario was described by Condoleezaa Rice, a noted perfectionist, who was striving to be a world-class pianist but gave it up as a teenager when she was confronted with the superior ability of some students at a summer music camp.

A similar sequence emerged in the life history of a male athlete named Mike who developed an eating disorder (Papathomas & Lavallee, 2006). His family of origin was described in idealistic terms. Mike's problems stemmed from continually striving for a perfect physique, which he equated with being able to perform perfectly. As he experienced constant praise and recognition for sports, he continued to strive, but this meant that he developed a narrow self-identity. Mike had always been the best, but when he joined an elite team, he was faced with the stark realization that he was not the best.

Where did Mike's need to have the perfect body come from? He had experienced a history of disparagement for his intellectual ability, including being told by teachers that he simply wasn't bright enough. But he was a superior athlete, and so he focused on his athleticism. Parenthetically, it should be noted that because it is rarer for males to develop an eating disorder, Mike kept his disorder hidden from virtually everyone, including his parents. In fact, he openly displayed a confident,

healthy side that hid his bulimia. However, his ability to fool everyone only added to his inner turmoil, according to the authors, because he realized that people were not reacting to the "real" Mike.

Transgenerational Transmission of Perfectionism

As Flett et al. (2002) have emphasized, perfectionism tends to run in families: People who are raised by perfectionistic parents tend to be at least somewhat perfectionistic themselves. This could reflect the role of imitation, or it could reflect the role of caregivers' attention in terms of encouraging perfectionism and perfect performance. Of course, another possibility, supported by limited research conducted with twins, is that there is a genetic, heritable component (e.g., Tozzi et al., 2004; Moser, Slane, Burt, & Klump, 2012).

The notion that perfectionism runs in families is supported by numerous observations and a recent unpublished dataset we have collected in collaboration with Avi Besser from Sapir Academic College (Flett, Besser, & Hewitt, 2016). This study examined the intergenerational transmission of perfectionism in 130 young women from Israel, as well as their mothers and their grandmothers. The correlations in the levels of perfectionism are shown in Table 4.1. There are significant correlations across family members in levels of all three MPS dimensions, but the conclusions must be qualified. While there was evidence that perfectionism in grandmothers was transmitted to their daughters (e.g., a correlation of .34 for self-oriented perfectionism), and the young women were more likely to be perfectionistic if their mothers were perfectionistic (e.g., a correlation of .39 for self-oriented perfectionism), the correlations between the grandmothers and granddaughters were not significant (e.g., a correlation of .13 for self-oriented perfectionism). These correlations are not large in terms of their overall magnitude, perhaps because perfectionism is influenced by multiple factors that operate inside and outside the family, but they do suggest a transgenerational transmission of perfectionistic behavior.

DEVELOPMENTAL CONSIDERATIONS IN SPECIFIC TRAITS AND PERFECTIONISTIC SELF-PRESENTATION

We have discussed, rather generally, the developmental antecedents of perfectionistic behavior. In this section, we describe some of the developmental features that may be relevant to the unfolding of specific perfectionism traits and perfectionistic self-presentation. It should be noted that we do not view the trait dimensions and self-presentational facets as

TABLE 4.1. Correlations between Generations on MPS Dimensions

MPS dimensions	Grandmothers and mothers	Mothers and daughters	Grandmothers and granddaughters
Self-oriented	.34***	.39***	.13
Other-oriented	.33***	.23**	.02
Socially prescribed	.19*	.36***	–.05

Note. Correlations for 130 three-generation triads (*n* = 390) are presented above. MPS, Multidimensional Perfectionism Scale (Hewitt & Flett, 1991a, 2004). Data from Flett, Besser, and Hewitt (2016).

*$p < .05$. **$p < .01$. ***$p < .001$.

completely independent of one another in any individual; research indicates overlap among these components. Moreover, there is broad agreement that personality is complex and is shaped by a multitude of factors, including intrapsychic, interpersonal, and environmental influences. Thus we expect that the norm for an individual troubled by perfectionism would involve development of numerous aspects of these components, rather than the development of one component solely.

Self-Oriented Perfectionism

We have suggested that early asynchronous caregiver–child relationships are characterized by inconsistent responding, and that this pattern is associated with the development of self-oriented perfectionism as well as socially prescribed perfectionism. In such a relationship, the infant's emotional displays and the associated needs are registered accurately by the parent only a portion of the time. This may be a function of limitations in the child's expressive abilities, the parent's receptive capacity, or both. Furthermore, even on occasions when the child conveys a clear signal that is recognized by the parent, the parent may fail to respond to the child's need or to respond adequately. Given that in the early years of development children's understanding of their interpersonal world is characterized by a high degree of egocentricity, the child understands instances of synchrony as "I've done something right, and so I must do more of it," while asynchrony is translated into "I've done something wrong, and I must do better next time." This becomes fertile ground for a manner of relating to others that is driven by a need to be perfect.

For self-oriented perfectionism, it would appear that demands from external sources become internalized and take the form of exacting self-expectations and personal demands for perfection. Budding self-oriented perfectionists who fail to meet their own expectations are apt to experience marked negative affect that drives them to demand more

of themselves, while also going to great lengths to conceal their distress from others due to their histories of repeated early asynchrony. Thus the self-oriented perfectionists tend to look at introjected expectations for how to be in the world and how to garner others' respect or acknowledgment. There may be several reasons for this. For example, children who repeatedly are left alone or experience emotionally traumatic separations from their parents may come to understand that others are not consistently available as sources of support, guidance, or help, but rather are there to pass judgment on their adequacy and worth. These children may learn that "If anything good is to happen to me, then I need to do it myself," and this may engender the development of a kind of autonomy. Such autonomy can take the form of being overly responsible for one's destiny, as well as a need to feel responsible for the welfare of others. We have found that women with excessive self-oriented perfectionism are certainly overly responsible (see the case of Anita in Chapter 6; see also Habke & Flynn, 2002).

Another possible trajectory in the development of self-oriented perfectionism is that of a child who develops an advanced level of competence in a domain that brings success, attention, and affirmation; in turn, this competence becomes a core component of the child's emerging identity. Thus an individual with excessive self-oriented perfectionism may focus energy on this activity or pursuit because of the attention, support, or respect (i.e., the indication that the individual matters, is cared for, or has a place in the world) garnered from others, and not from an intrinsic interest or desire in the pursuit itself. Failure to achieve and advance in that domain is experienced not only as a failure, but as an ego-involving assault on the self and on the person's sense of identity (see Hewitt & Flett, 1993; Hewitt et al., 1996). In fact, we have found that many middle-aged perfectionistic patients we have seen have hit a point in their careers when accomplishments, attainments, or success in their careers come to feel empty and meaningless, and they experience a profound sense of being lost in the world.

Several other factors may contribute to the development of self-oriented perfectionism across the childhood age span. For example, a useful clue to the development of high self-oriented perfectionism came from a qualitative study by Neumeister (2004), who found that gifted students with exceptionally high levels of self-oriented perfectionism had a history of mastering early academic challenges without exerting effort, while having had virtually no experience with academic failure. Here it is useful to underscore our finding that self-oriented perfectionists tend to be highly fearful and intolerant of failure (Flett, Hewitt, Blankstein, & Mosher, 1995). They possess a contingent sense of self-worth, consistent with the notion that striving for absolutes is a form

of overcompensation designed to ward off self-uncertainties and other negative feelings about the self.

Over the course of development, a person characterized by self-oriented perfectionism internalizes perceived external pressures that gradually become incorporated into his or her expectations of self. We have offered several examples above of how this might work, but there may be other components as well. For example, it may be important that the individual is rewarded (in the form of attention or caring), or perceives that he or she is rewarded, for striving for perfection. Slade and Owens (1998) suggested that perfectionism that is rewarded and leads to satisfaction is considered positive perfectionism rather than a self-limiting perfectionism, as we have argued. However, individuals who possess high levels of perfectionism are seldom satisfied and often exhibit other characteristics that erode the possibility of intrinsic satisfaction. One such factor is our observation that those high in self-oriented perfectionism are often hypercompetitive and acutely sensitive to social comparison outcomes. This is accentuated to an even greater degree in instances in which the social milieu of a developing child or adolescent is made up of competitive and skilled peers. Such conditions tend to promote the development of self-oriented perfectionism and the adoption of unrealistically high standards. However, as Albert Bandura noted, perfectionism fueled by social comparison concerns can come at a high cost in terms of self-evaluations and feelings of happiness. In his classic book *Social Learning Theory*, Bandura (1977) observed that children exhibiting high levels of self-oriented perfectionism had two clear vulnerabilities: (1) They possessed low levels of self-reward because, in their view, only perfect performances and perfect behaviors merited self-reward; and (2) they exhibited a highly maladaptive tendency to engage in social comparison with superior targets who set standards that were almost impossible to live up to. These factors merit further empirical investigation, because they may hold the key to helping us understand why some perfectionists can be so accomplished and yet derive little or no satisfaction from their accomplishments.

Other-Oriented Perfectionism

We have suggested that children who develop other-oriented perfectionism may experience asynchrony characterized by others' being incapable or unwilling to meet these children's needs. In the absence of adequate parental responsiveness, the emerging other-oriented perfectionists will develop a working model of others as not having the ability or desire to meet their needs; the children's experiences communicate to them that they are somewhat irrelevant, invisible, or not worth the effort. Not

surprisingly, this can serve to erode the children's self-concept. Moreover, these children can develop narcissistic tendencies by using others as selfobjects as a means of building self-esteem, albeit a rather fragile form of self-esteem. Specifically, for a temperamentally irritable child, the resulting anger and frustration emerging from unmet emotional needs become the raw material that forms a foundation for interpersonal distance, a constricted capacity for empathy, and a determination to control the child's relational world by insisting that his or her expectations are met in a highly specific manner.

To date, there has been limited analysis of how and why some people come to expect and demand perfection from others. Those with excessive levels of other-oriented perfectionism tend to exhibit high levels of authoritarianism and narcissism, a strong need for control and dominance, and a tendency to blame others (Flett, Hewitt, Blankstein, et al., 1995; Hewitt & Flett, 1991b). Yet other-oriented perfectionists are less tough-minded and resilient than they may appear. Like people with extreme narcissism, other-oriented perfectionists project an image of positive self-regard; however, this apparent self-inflation tends to be based on a shaky and uncertain sense of the self. Our observation here is in keeping with evidence demonstrating that people high in other-oriented perfectionism possess low levels of unconditional self-acceptance (Flett, Besser, Davis, & Hewitt, 2003) and harbor the same need for validation that is linked with self-oriented and socially prescribed perfectionism (Flett, Besser, & Hewitt, 2014). Indeed, we (Flett, Besser, & Hewitt, 2014) found that other-oriented perfectionism was associated jointly with validation seeking and a heightened sensitivity to rejection. This is certainly not the image portrayed by those with excessive levels of other-oriented perfectionism.

Although imitation may be operative in the development of other-oriented perfectionism as a child ages (i.e., observing parents' or the family's unrealistic expectations for others), other-oriented perfectionism is quite a distinct orientation, and other factors are likely to come into play. We maintain that other-oriented perfectionism reflects the externalization tendencies that Horney (1950) discussed in her accounts of experiencing and needing to express hostility. For many people with marked other-oriented perfectionism, this dimension of their personality develops as a defensive response that serves to deflect attention away from a flawed sense of self. In our experience, other-oriented perfectionism reflects an attempt to gain a sense of power and dominance in response to adverse life situations that contributed to feelings of powerlessness and submissiveness, which in turn fueled feelings of hostility and resentment. In some instances, other-oriented perfectionism is further accentuated by the presence of an overdeveloped sense of responsibility;

such individuals are apt to experience the mistakes and failures of others as poor reflections on themselves.

One theme seldom considered in accounts of the development of perfectionism within the family context involves the inconsistencies that often exist within the mother–father dyad. Other-oriented perfectionism can reflect a relatively chaotic and unpredictable experience of receiving mixed messages from one parent who is authoritarian and demanding, and another who is either encouraging and supportive or withdrawn and relatively unavailable. In such instances, other-oriented perfectionism represents an attempt to control and divert attention away from the self. One such example is presented in Hewitt and Flett (2004). Ms. M, who was one of nine siblings, suffered from depression and anxiety. Ms. M described her father as being highly authoritarian and domineering, while her relationship with her mother revolved around "a constant over-concern with obtaining and maintaining her mother's tenuous caring" (p. 28). Ms. M grew up to become a rather domineering individual. She demanded exceptional results from people around her, and frequently rebuked the secretaries at work as well as her children. Other-oriented perfectionism that is openly expressed and directed at others can lead to substantial interpersonal conflict, and this played a clear role in her psychological problems. In total, Ms. M had been in treatment for over 7 years. As an adult, she struggled with chronic irritability and impatience, but in keeping with Horney's account of children who suppress their basic hostility, Ms. M reported having been an extremely compliant and malleable child who went to substantial lengths to hide behaviors that her parents would not approve of. Over the course of treatment, her interpersonal patterns in adulthood betrayed the bitterness and resentment that had built up over the course of her childhood and adolescence.

Socially Prescribed Perfectionism

In our discussion above of self-oriented perfectionism, we have described the asynchrony that we believe underlies socially prescribed perfectionism. To review, we have suggested that inconsistent parental responses to a child's needs contribute to the child's developing a form of insecure attachment that can give rise to socially prescribed perfectionism. The child comes to understand that to experience safety and security in the world, he or she must look externally for "how to be" in the world and must be exquisitely aware of others' expectations, judgments, concerns, affective tones, and potential admonishments. Thus, rather than solidifying a capacity to look inward that guides actions, decisions, and relational choices (see Miller, 1997), the individual is guided by a hypersensitivity to the external interpersonal world. Individuals who

are identified as socially prescribed perfectionists have limited trust and knowledge of themselves. Thus the extent to which they experience feelings of pride, accomplishment, or self-satisfaction is largely shaped by the extent to which they are affirmed for having met others' expectations and requirements for them. The development of autonomy, independence, self-soothing, coping, and self-worth are all compromised, and the importance of others' power to accept and provide a sense of worth becomes a focus of how to be in the world.

In this way, the asynchrony between parent and child becomes a blueprint for the development of socially prescribed perfectionism. As noted earlier, in the absence of adequate parental responsiveness, an emerging socially prescribed perfectionist forms a working model of others as uninterested in or uncommitted to meeting his or her needs. This experience ultimately communicates to the child that he or she is irrelevant, invisible, or not worth the effort. The child's unconscious solution is to work hard to earn the attention and love of the caregiver. The caregiver's desires and expectations come to assume a central place in the child's emotional life and in the formation of the child's self and identity. Pleasing the caregiver becomes not only a preoccupation, but the child's very lifeline. In the most extreme instances, socially prescribed perfectionists may come to feel that their very existence hinges on attaining the approval of significant others.

In terms of later development, socially prescribed perfectionism and the associated belief that perfection is being demanded from the self may be a reflection of perceived or actual exposure to excessive parental expectations and high parental criticism. Moreover, these individuals possess a deep conviction that mattering and fitting in the world is in the control of other people, and that they are not capable on their own.

In contrast to self-oriented perfectionists, socially prescribed perfectionists' lack of autonomy and limited capacity to self-soothe compel them to turn to the external world to determine how they should be in the world, and to evaluate their worth in terms of the extent to which they meet the expectations of significant others. Although this is appropriate behavior in the early stages of development, these individuals must ultimately develop a sense of autonomy and self-efficacy that fosters individuation, rather than maintaining a self-limiting connection to and dependency upon others. It is not surprising that socially prescribed perfectionism is associated and implicated most broadly with both mild and severe pathology, and with the poorest levels of ego strength, coping, and effective defensive structures. Moreover, socially prescribed perfectionists exhibit significant psychopathology (similar to borderline psychopathology) in terms of identity diffusion and relatively diffuse boundaries.

Although parental factors play a significant role in the development of socially prescribed perfectionism, a more nuanced and complex developmental account is needed. First, we have encountered family situations in which parental pressures to be perfect were not overtly evident, suggesting that other factors may shape the development of socially prescribed perfectionism. In such instances, the children may possess a heightened level of interpersonal sensitivity that can arise from a preoccupied attachment style, and that contributes to a tendency to be highly reactive to interpersonal evaluations and apparent criticism. This link with heightened interpersonal sensitivity has been confirmed in empirical research (see Hewitt & Flett, 1991b). Second, our original developmental model pointed to the role of sociocultural pressures to be perfect. Here, however, it must be noted that such pressures are apt to affect everyone in a particular sociocultural context, but that they can have a much greater impact if a developing child or adolescent lives in a community or has a peer group that pressures him or her to live up to high expectations. We argue that personal sensitivities and attunement to these social cues must still play some role, in order to account for why certain people develop high levels of socially prescribed perfectionism.

Perfectionistic Self-Presentation

We have indicated in our CMPB (see Chapter 2) that perfectionistic self-presentation reflects the interpersonal expression of one's purported "perfection." We view this as an attempt in the interpersonal domain to procure the sense of mattering, belonging, being accepted, and being good enough that has eluded the perfectionistic individual throughout life. Thus we can understand that projecting an appearance of perfection, concealing imperfection, and creating a façade of flawlessness will potentially bring acceptance by others, reparation of the flawed self, and feelings of belonging. Consistent with our contention that perfectionistic behavior arises early and involves a sense of defective self, Hilde Bruch (1988), in her classic book *Conversations with Anorexics,* suggested that the need to seem perfect is fueled by the approval that is received for appearing perfect. Yet at the root of this behavior is a deep dissatisfaction with the self. As we have indicated, this negative orientation toward the self is rooted in early developmental experiences, but childhood is not the only key developmental period. This is clearly demonstrated by further consideration of those adolescents who go on to develop anorexia nervosa. Bruch (1988) noted that striving for perfection and the perfect body becomes quite complicated and confusing when pubertal changes occur, because these are beyond personal control, and the message is received that the current level of striving is not working. At this point, many young individuals with anorexia nervosa come to believe that the

standards they are pursuing must be made even more stringent, in order to restore a sense of control and receive the desired approval.

Perfectionistic self-presentation is rooted in either insensitive or non-responsive reactions from significant others. This is particularly the case when a child who is vulnerable and hypersensitive to others' emotions and feedback acts or performs in ways that are less than ideal. Others can react negatively to the child's misdeeds and mistakes, or instances in which the child has disappointed or fallen short of expectations, and this may be apparent to the child. Even when mistakes or shortfalls are not evident to others, the child will be vigilant for any indication of dissatisfaction on the part of others.

Perfectionistic self-presentation can also stem from a child's hypersensitivity to the moods and feelings of parents. But perhaps the most critical domain for the development of perfectionistic self-presentation involves situations in which a child openly displays distress involving complex emotional blends (i.e., anxiety, dysphoria, anger, shame, fear), and a parent is seen to react in either a dismissive or critical manner. The various ways in which this can occur are clearly illustrated by the scale content of an intriguing new measure developed by Barbot, Heinz, and Luthar (2014). These researchers developed a scale entitled the Perceived Parental Reactions to Adolescent Distress (PRAD), to assess parents who react adaptively versus maladaptively to the emotional displays of their children. The assumption underlying the development of this instrument is that insensitive parental reactions reported by adolescents reflect long-standing patterns that may go back to the adolescents' infancy. The PRAD is designed to capture different attachment styles. One PRAD subscale, comfort, taps secure attachment; scores on this subscale are linked both conceptually and empirically with a parent who provides comfort in response to an adolescent's distress—a characteristic of the synchronous responses of secure attachment. This type of response contrasts with a dismissive response, tapped by the avoidance subscale. Here the parent minimizes the adolescent's emotional response and views it as unimportant. The third subscale is the harshness subscale, which taps the tendency for the parent to respond in a critical and punitive manner that conveys disdain and shame. A fourth subscale is equally relevant, as it taps the reactions of self-centered and probably narcissistic parents. The self-focus subscale is described as assessing the reactions of self-involved parents who are focused on how their adolescents' distress has just added to their own emotional distress.

A history of negative parental reactions to emotional displays is particularly central to an understanding of the developmental origins of perfectionistic self-presentation. A hypersensitive child of parents who respond in a comforting manner is unlikely to have a need to seem perfect. In contrast, a child who perceives parental disdain learns quickly

that emotional displays will only result in more shame and humiliation, and so it is best to act not only as if everything is OK, but as if everything is absolutely perfect. The tendency to put on such a façade is also likely to be evidenced by a hypersensitive child whose attempts to discuss his or her feelings are repeatedly dismissed, minimized, or denied.

Finally, a hypersensitive child who is raised by a self-focused parent may quickly learn to suppress emotions and act as if things are perfect after having learned time after time that expressing distress compounds the parent's distress. The act of hiding emotions behind a façade functionally limits the degree to which a bad situation is made demonstrably worse. More generally, the vulnerable child who is deprived of warmth and empathy by a self-involved parent may engage in the pursuit of great accomplishments that are highly visible in order to obtain validation, praise, and positive recognition, either from the parent or from other people in the broader social network.

Another key factor in the development of perfectionistic self-presentation is being raised in a family environment that demands a public image of the family as demonstrating perfection (or an absence of imperfection). This is a theme that has emerged frequently in our clinical work among perfectionistic self-presenters. Directly or indirectly, the family makes it clear that problems and imperfections must be kept out of public view. Public displays of tension or conflict among family members are discouraged in ways that invalidate the emotional experience of family members. The stance is sustained by having pivotal family members who are psychologically invested in appearing to have the "perfect family." The position requires familial collusion. In some instances, we have witnessed the family as a whole engaged in an excessive form of overcompensation, as if the family itself is dealing with an inferiority complex. The child raised under such conditions learns that the family's public image is valued above all else, including the needs and feelings of individual members. This is often seen in families of highly public figures, or families that hold positions of significant social status, particularly in small communities where their affairs tend to be visible to everyone else.

A child with a highly emotional temperament who is easily aroused is in a particularly difficult predicament if he or she happens to be born into a family that prohibits emotional expression. The developmental framework for perfectionism outlined by Flett et al. (2002) also allows for the role of the child's temperament in the development of perfectionism, with a particular emphasis on anxious emotionality and anxiety sensitivity. Several recent studies have confirmed that perfectionists possess an overly active behavioral inhibition system as described by Gray (1982; see also Randles, Flett, Nash, McGregor, & Hewitt, 2010). Thus being discouraged to express emotionality is yet another illustration of how a developing child may experience situations that do not fit his or

her natural disposition. The child who is raised in these circumstances may develop the sense that his or her feelings do not matter. This can result in a generalized unwillingness to disclose emotions and the imperfections that gave rise to these emotions.

Linehan (1993) has described being raised in the "perfect family" as one way of accounting for the inhibition of negative emotional expression among people with borderline personality disorder. This type of family invalidates emotion because emotional displays are not permitted, especially when they come from a child. It is believed that the true roots of this phenomenon reside in the inability of one or both parents to tolerate their own emotional experiences. Furthermore, this type of "perfect family" is also mentioned frequently by theorists seeking to account for the development of eating disorders. For instance, Root, Fallon, and Friedrich (1986) differentiated various types of families, including the "overprotective family" and the "perfect family." A distinguishing feature of the perfect family was overresponsiveness to external social expectations. A similar family (the "All-American family") was described by Schwartz, Barrett, and Saba (1985), who made the point that in this type of family, the family's ideals are substantially more important than the personal needs or desires of any given member, particularly the children. As Humphrey (1992) noted, "the clinical picture of the anorexic family [is one of] trying to present a public image of perfection . . . while underneath the façade are many unacknowledged needs and problems" (p. 271). In such a family environment, women with anorexia nervosa may have learned to maintain a façade of domestic tranquility by promoting a picture of perfection and concealing any hint of imperfection. It is not uncommon to use the outward appearance of the perfect family as a way of masking severe abuse and other forms of maltreatment that are taking place behind closed doors.

We have started empirically exploring the presentation of the perfect family with a 21-item family version of the PSPS (see Chapters 2 and 7), which we have tentatively named the Perfect Family Scale. This instrument comprises subscales that parallel those found in the PSPS. Research thus far has focused on university student samples. As expected, when the PSPS and the Perfect Family Scale have been administered together, strong positive associations are found between personal perfectionistic self-presentation and family perfectionistic self-presentation. For instance, in unpublished data from 104 undergraduate women, the subscale tapping family perfectionistic self-promotion correlated .55 with the PSPS perfectionistic self-promotion subscale, .37 with the nondisplay of imperfections subscale, and .33 with the nondisclosure of imperfections subscale. Examination of correlations with the subscales of the FMPS showed that the strongest links were with parental expectations, with correlations ranging from .51 to .55. These results are not

surprising. They also have potentially grave implications when viewed within the broader context of psychological distress. A person who is high in perfectionistic self-presentation, and who has been raised in a family where perfection was a family dictate, is someone who is unlikely to seek help when it is needed. The unwillingness to seek help will be even greater if the person comes from a culture that emphasizes suppressing emotion and hiding true feelings behind a front. If these individuals actually find their way into treatment, the level of defensiveness surrounding discussions of family members and of emotional topics and themes may be difficult to penetrate.

CONCLUSION

In this chapter, we have presented a model explicating the development of perfectionistic behavior. This model involves not only the early life of a potential perfectionist, but also the kinds of continued parenting and family environments that can foster, reinforce, or exacerbate perfectionistic behavior and inclinations. Although there is some research addressing these developmental issues, further work is needed to clarify these dynamics and interactional patterns. At the same time, developmental information can be seen to be complex and idiosyncratic, and it can provide a valuable basis for the assessment and treatment of perfectionistic behavior.

Throughout the chapter, we have discussed the relational beginnings and underpinnings of perfectionism, and have underscored that the purpose of perfectionistic behavior is relational in its goals. Underscoring the importance of the relational world for perfectionistic individuals, Conroy, Kaye, and Fifer (2007) reported research showing the need to consider fear of failure and perfectionism as complex constructs. Their main finding based on research was a pervasive link between socially prescribed perfectionism and various types of interpersonal fear of failure, including fears of shame and embarrassment, fears of important others' losing interest, fear of upsetting important others, and fears of devaluing one's self-estimate. Significant links were also found between these same fears and self-oriented perfectionism. In addition, Conroy et al. (2007) reported the intriguing result that greater fear of shame and embarrassment was found among those who were characterized jointly by elevated self-oriented and other-oriented perfectionism. One implication of this pattern of results is that strong interpersonal elements underlie the fear of failure and the concern with errors and mistakes that characterize perfectionism.

CHAPTER 5

The Perfectionism Social Disconnection Model

Perfectionism and Maladjustment

Among the continuing challenges in providing treatment to perfectionists are identifying and understanding the specific factors, mechanisms, and processes that contribute to distress, diminished well-being, and life impairment. Our initial focus over two decades ago was on a diathesis–stress perspective, and the basic premise of this model was that perfectionism is a vulnerability factor that is activated by life stressors (see Hewitt & Dyck, 1986; Hewitt & Flett, 1993; Hewitt et al., 1989, 1996).

An expanded version of the diathesis–stress model was provided in a chapter of our earlier book (Hewitt & Flett, 2002). There, we outlined a model that was designed to explicate and delineate the specific stress mechanisms and processes involved in perfectionism and maladjustment. We hypothesized that perfectionism contributes to highly aversive and distressing failures, which in turn trigger the anticipation of future failure, thereby perpetuating a maladaptive cycle. We presented four pathways involving stress that link perfectionism with feelings of distress and related negative affective states, such as a sense of defeat and demoralization. Specifically, we emphasized stress enhancement, stress perpetuation, stress anticipation, and stress generation. These specific elements are described here as follows:

1. *Stress enhancement* is a path whereby perfectionistic behavior enhances or exacerbates the distress and pain being experienced. That

is, the experience of distress in response to stressful events is magnified as a function of perfectionistic behavior. Several studies have shown that perfectionism traits interact with ego-involving stressors to predict depression or suicidal behavior (e.g., Blankstein, Lumley, & Crawford, 2007; Dunkley, Zuroff, & Blankstein, 2003; Enns & Cox, 2005; Enns, Cox, & Clara, 2005; Hewitt, Caelian, Cheng, & Flett, 2014; Hewitt & Flett, 1993; Hewitt et al., 1996).

2. *Stress perpetuation* is a path whereby distress is maintained or even exacerbated through maladaptive coping and the defenses associated with perfectionism. Psychoanalytic theorists have referred to this path as the "repetition compulsion" or, in Luborsky's terminology, as the "core conflictual relationship theme" (Crits-Christoph et al., 1988). For example, various components of perfectionism are associated with a reluctance to seek support from friends, relatives, or professionals in the face of repeated difficulties in living (Hewitt, Dang, et al., 2016). Rather than show these others that they themselves are not perfect, these individuals tend to suffer their turmoil alone and without support.

3. *Stress anticipation* is a path whereby anticipation and prediction of future stressors (e.g., failures, being the target of criticism) give rise to distress. For instance, perfectionists who are highly failure-sensitive reflect on past setbacks (e.g., a history of perceived poor performance) and come to anticipate future failures; this anticipated failure contributes to ambivalence within these individuals. They want to perform perfectly, but believe they are quite likely to fail. The stress anticipation path comprises both cognitive and emotional dimensions: The cognitive dimension involves a self-schema about negative future events, whereas the emotional dimension consists of the noted ambivalence and corresponding anticipatory anxiety.

4. *Stress generation* is a path whereby perfectionistic individuals actually create failure and generate distress in response to neutral or even objectively successful situations and outcomes. This is primarily an appraisal process characterized by a propensity to distort one's experience, continually redefining it as having fallen short. For example, in Chapter 8 we describe a patient, Robert, who experienced a sense of abject failure despite having achieved a grade of A+ in a difficult course.

Much of our recent theorizing has focused on stress generation in the interpersonal context. One way of generating marked distress is to act in ways that create a distance between oneself and other people. Our initial thoughts about the role of stress generation in the perfectionism–distress link have given way to full-scale consideration of the role of social disconnection in the lives of vulnerable perfectionists. Social

disconnection is thought to be especially noxious to perfectionistic individuals, given their excessive need for approval, acceptance, and caring, and because it provides confirmation that the perfectionists are worthy only of derision from themselves and others.

The PSDM was formulated initially (Hewitt et al., 2006) in order to provide an account of how the interpersonal components of the perfectionism construct relate to suicidal behavior. In this chapter, we present a more complete and refined version of the model that incorporates developmental aspects as well as the dynamics involved in the evolution and maintenance of perfectionism, and that ultimately forms the treatment focus for individuals with perfectionism.

The extended PSDM provides a framework that helps in identifying and understanding the reasons for so many maladaptive and seriously negative outcomes attributed to and associated with perfectionism. The PSDM is important in terms of understanding not only, at a nomothetic level, how perfectionism might develop and produce pathological affective and self-states and psychopathology, but also how perfectionism functions at an idiographic level for individuals seeking treatment. That is, we use the model to explicate ways perfectionism contributes to a myriad of difficulties for people, and as a means of aiding in the assessment and conceptualization of a particular individual's perfectionism and problems when he or she is seeking treatment. Below we present an overview of the model, followed by some detailed examination of its components.

OVERVIEW OF THE EXPANDED PSDM

Initially, we (Hewitt et al., 2006) suggested that the perfectionistic individual has excessive needs for acceptance and avoidance of rejection, and that these needs reflect an underlying and inordinate need for social connection. Note that this earlier version of the model couched interpersonal perfectionism in terms of socially prescribed perfectionism, and not in terms of perfectionistic self-presentation or the relational underpinnings of self-oriented and other-oriented perfectionism. We further posited that this need for connection or belonging results in the development and intensification of perfectionistic behavior as a means to secure connection with others. But the nature of perfectionistic behavior itself results in others' viewing the perfectionist as cold, distant, or even hostile, or in the perfectionist's perceiving others as rejecting. As a consequence, the perfectionistic individual is socially rebuffed, resulting in marked distress—which can include suicidal behavior. We underscored the self-defeating nature of perfectionism: At a basic level, it develops to

facilitate interpersonal connection, but it actually creates social disconnection—which, again, can result in suicidal thoughts, risk, and behavior (the most extreme forms of disconnection). There is some support for this model with suicidal behavior and other outcomes (e.g., Chen et al., 2012; Sherry et al., 2008; Roxborough et al., 2012), but we now believe that the initial model presents only some of the theoretical picture for perfectionism.

Our expanded PSDM has been illustrated in Chapter 4 (see Figure 4.1). Figure 5.1, depicting perfectionism, social disconnection, and outcomes in adulthood, enlarges the right side of Figure 4.1. The expanded PSDM takes the original model and incorporates acquired findings from research and our clinical work, as well as theoretical work from numerous sources—including attachment theory (Bowlby, 1988), self psychology (Kohut, 1971), and interpersonal theory (Benjamin, 1996; Leary, 1957; Sullivan, 1953), as well as more contemporary developments in each of these theories (see Mikulincer & Shaver, 2016; Shane et al., 1997).

The expanded PSDM reflects our comprehensive conceptualization of perfectionism, acknowledging the substantial relevance of all the traits, perfectionistic self-presentation, and automatic perfectionistic thoughts. It also includes the developmental component discussed in Chapter 4, which sets the stage for the powerful need for belonging, connection, and correction to self–other relationships as well as self–self relationships.

Certain key elements of the PSDM were proposed in the original version of the model (see Hewitt et al., 2006). Four main associations involving objective and subjective social disconnection were postulated in the original model. Objective social disconnection (i.e., actual severed or impaired relationships) was proposed to mediate the link between socially prescribed perfectionism and suicidal behaviors. Similarly, subjective social disconnection (i.e., the phenomenological experience of aloneness) was identified as a mediator of the link between socially prescribed perfectionism and suicidal behaviors. Key roles were also identified for hostility and heightened interpersonal sensitivity. Interpersonal hostility (i.e., anger and suspiciousness directed toward others) was postulated to mediate the link between socially prescribed perfectionism and objective social disconnection. Finally, interpersonal sensitivity (i.e., evaluative fear and vigilance experienced around others) was proposed to mediate the link between socially prescribed perfectionism and subjective social disconnection. This heightened interpersonal sensitivity is likely to be a by-product of several developmental factors identified in Chapter 4 (i.e., an anxious temperament; attachment insecurity; and unmet needs for connection, safety, approval, and recognition). These various factors were implicated in the original model as contributors to

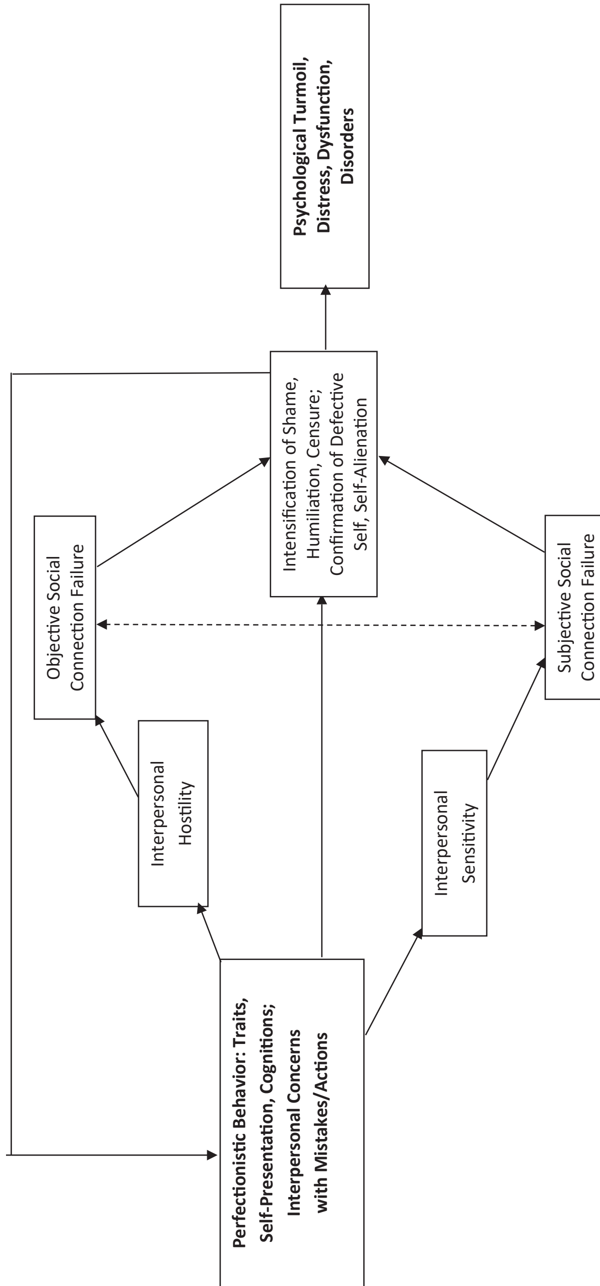

FIGURE 5.1. The portion of the PSDM showing perfectionism, social disconnection, and outcomes.

a profound sense of hopelessness about future interpersonal outcomes (i.e., social hopelessness). In summary, this model posits that people with high levels of perfectionism are at risk for serious outcomes such as depression and suicidal tendencies, because these people experience both subjective and objective social disconnection; that is, they both feel and are isolated and alienated from others, and experience profound feelings of loneliness.

As shown in Figures 4.1 and 5.1, the factors and processes included in the expanded PSDM are believed to produce a plethora of negative outcomes that go beyond suicidal tendencies. These outcomes include emotional distress, mental health symptoms that can escalate into diagnosable disorders, physical illness symptoms, and a broad category of outcomes we refer to as "psychological turmoil." Psychological turmoil that results from social disconnection can be incredibly intense; indeed, some have suggested that "experiences of social rejection, exclusion or loss are generally considered to be some of the most `painful' experiences that we endure" (Eisenberg, 2012, p. 421). The turmoil, as indicated in Figure 5.1, can involve the intensification of shame and humiliation, a sense of confirmation that the self is flawed and deplorable, self-censure, and other types of psychological pain associated with threats to self and identity (such as disintegration anxiety and self-alienation).

Some of our current work and theorizing about the results of social disconnection and psychological turmoil have been focused on the concept of "self-alienation." In essence, self-alienation is a sense of self-estrangement; the self-alienated individual feels that he or she is detached from the real self. This is similar to the disintegration anxiety we have described in Chapter 4. This form of psychological turmoil is likely for perfectionists experiencing social disconnection, as they act in accordance with other people's wishes rather than their true selves. As noted in Chapter 1, this was most insightfully described by one of Karen Horney's exceedingly perfectionistic patients, who in the 1940s sent Horney a letter that described her own discovery of the degree to which she was estranged from herself. Most interestingly, the letter was prefaced by the patient's observation that the only thing that kept her going was her perfectionism. She characterized it as "my cast-iron 'should system.' " My complete armor of 'shoulds': duty, ideals, pride, guilt. This rigid and compulsive perfectionism was all that held me up; outside it and all around lay chaos" (Horney, 1999, p. 138). This account accords with our earlier suggestion that for some, perfectionism, even though it creates powerful turmoil, is often maintained and understood as a positive thing.

The notion of self-alienation reflects our sense that certain perfectionists are disconnected not only from other people, but also from themselves. People prefer to interact intimately with others who are genuine

and sincere. The sense that someone is being false and is not attuned to his or her real self may add to objective social disconnection. The possibility that some people are also disconnected from themselves is supported by earlier research. Past work on loneliness as a form of social disconnection has shown that self-alienation is linked with loneliness. Loneliness as a multifaceted construct includes self-alienation as one of its five components (Rokeach, 1988). Our emphasis on self-alienation is in keeping with our central emphasis on the role of self and identity issues in the development and experience of problematic perfectionism. Below we describe some initial data that support the inclusion of self-alienation as a form of psychological turmoil in the PSDM.

RESEARCH FINDINGS

Roxborough et al. (2012) reported the results of a unique study testing the PSDM with children and adolescents who were psychiatric outpatients. To our knowledge, this study is the first to examine suicidal tendencies in adolescents and both trait perfectionism and perfectionistic self-presentation. It was found that both socially prescribed perfectionism and perfectionistic self-presentation were associated with a measure of suicide potential. Roxborough et al. (2012) also reported that the association between suicide potential and the need to avoid seeming imperfect was mediated by a history of being bullied (described as a marker of social disconnection) and elevated social hopelessness (hopelessness regarding future relationships). These data suggest that when being bullied has played a role in an attempted or completed suicide, the traumatic experience of being bullied is felt most acutely by interpersonally sensitive perfectionists, who need to maintain an image of being flawless and in control at all times.

Other evidence supporting elements of the PSDM was reported by Chen et al. (2012). This research explored perfectionistic self-presentation, attachment styles, and levels of connectedness to the social environment in 178 adolescents. Perfectionistic self-presentation was assessed with the PSPS-Jr inventory (Hewitt et al., 2011), while the Social Connectedness Scale—Revised (Lee, Draper, & Lee, 2001) was used to assess the degree of interpersonal connection. Results indicated small but significant negative associations between social connectedness and the three perfectionistic self-presentation facets. Moreover, nondisclosure of imperfection partially mediated the relationship between fearful attachment and social disconnection.

The initial version of the PSDM (Hewitt et al., 2006) did not go into great detail about the pervasiveness of social disconnection; however,

implicit in this model is the notion that feelings of loneliness and alienation are chronically experienced, and that for some perfectionists these feelings may seem ever-present. Some indirect evidence attesting to the frequency with which social disconnection is experienced was provided in a study (Flett, Schmidt, Besser, & Hewitt, 2009) that examined trait perfectionism, sociotropy, autonomy, daily hassles, and depression in 143 adolescents. Daily hassles were assessed with the Inventory of High School Students' Recent Life Experiences, a 41-item self-report measure (Kohn & Milrose, 1993). The measure yields three factors: loneliness and unpopularity, social alienation, and general social mistreatment (i.e., being left out of things by people). All three factors were associated significantly with socially prescribed perfectionism. Moreover, the three factors were key elements of a latent factor of interpersonal hassles, which mediated the association between socially prescribed perfectionism and depressive symptoms. These findings suggest that the social disconnection of students who feel compelled to be perfect may be a chronic source of stress that heightens their vulnerability for depression.

THE ROLE OF NEGATIVE INTERPERSONAL EXPECTANCIES

As part of our earlier discussion of the expanded diathesis–stress model of perfectionism and depression and the notion of stress anticipation, we (Hewitt & Flett, 2002) postulated that people with high levels of socially prescribed perfectionism have a schema about negative future events. This notion is derived from previous analyses of the cognitive aspects of attachment style differences (Bowlby, 1980) and relational schemas (Baldwin, 1992). Specifically, certain people are predisposed to anticipate negative interpersonal events involving abandonment and rejection. As we described it (Hewitt & Flett, 2002), socially prescribed perfectionism can be conceptualized as a social-cognitive variable including expectations that one will be the target of criticism and mistreatment—expectations that stem from an interpersonal history characterized by unfair expectations and inescapable social pressures to be perfect. The individual is left with one of two alternatives, both of which contribute to social disconnection and loneliness. The first, which derives from a preoccupied attachment style, involves dedicating emotional energy to meeting the perceived expectations of others to be perfect. Yet, since perfection is never achieved, the individual remains in a perpetual state of disappointment and failure that contributes to feeling on the periphery of relationships. Deriving from a fearful attachment style, this involves becoming avoidant and less engaged in social interaction, thus perpetuating and exacerbating levels of disconnection. The second alternative

involves simply reducing or eliminating social connections with others, or establishing and maintaining only superficial relations with others.

These observations were evaluated in a study (Nepon et al., 2011) with 155 student participants that included a fairly new published measure of perceived negative social feedback known as the Social Feedback Questionnaire (SFQ; Dobkin et al., 2007). The SFQ measures a social-cognitive individual-difference variable that reflects perceived inferential feedback and the heightened interpersonal sensitivity that characterizes certain people vulnerable to experiencing depression. It can be perceived as a measure of perceived exposure to lack of social acceptance. Nepon et al. (2011) confirmed that perceived negative social feedback was associated with socially prescribed perfectionism and perfectionistic self-presentation. Moreover, the association that these interpersonal perfectionism measures had with depression and social anxiety was mediated by negative social feedback. These data are in keeping with the assumptions inherent in the PSDM: The perceived exposure to negative social feedback is an indicator of perceived rejection that underscores interpersonal perfectionism's link with anxiety and depression. The proposed sequence is also supported by data indicating that students who feel insignificant to others exhibit elevated levels of socially prescribed perfectionism and perfectionistic self-presentation. Moreover, social disconnection is manifested in feeling insignificant and not mattering to others, and is another factor that mediates the link between perfectionism and psychological distress (Flett et al., 2012). It follows from the PSDM and related research that the sense of interpersonal disconnection among people with high levels of perfectionism should extend to negative appraisals of available social support, and perhaps these negative appraisals are veridical when such people experience objective social disconnection. Sherry et al. (2008) investigated the role of conflicted interpersonal relationships in influencing depressive symptoms. Their results confirmed links between perfectionism and low levels of perceived support. In addition, perceived social support acted as a mediator in the interpersonal perfectionism–depression link.

PERFECTIONISM, SOCIAL DISCONNECTION, AND PROBLEMATIC USE OF THE INTERNET

A general concern expressed about contemporary society is that social media promote social disconnection by replacing in-person social interactions. One interpretation of internet addiction and other problematic uses of the internet is that people who are highly self-conscious and defensive opt for virtual rather than face-to-face interactions; this can reflect

the social disconnection proclivities of certain perfectionists. Research led by our colleague Silvia Casale at the University of Florida, in which we are participating, is programmatically exploring the PSDM within the context of problematic internet use. Our initial research yielded a pattern of findings that is in keeping with predictions extrapolated from the PSDM (see Casale, Fioravanti, Flett, & Hewitt, 2014). A sample of 465 university students (240 women, 225 men) completed a battery of measures including the MPS, a measure of problematic use of internet communicative services, and scales tapping perceived social support and fear of negative evaluation. As expected, socially prescribed perfectionism was associated with higher levels of fear of negative evaluation and lower reported levels of social support. In both men and women, socially prescribed perfectionism was associated with problematic internet use. Separate analyses for women and men showed that among women, the association between socially prescribed perfectionism and problematic internet use was partly mediated by fear of negative evaluations. However, among men, the association between socially prescribed perfectionism and problematic internet use was fully mediated by fear of negative evaluation and the perception of low social support. These findings not only illustrate that the PSDM applies to unique forms of social disconnection; they also point to the role of fear of negative social evaluation and low social support as factors that can contribute to the social isolation of certain perfectionists.

Follow-up research is exploring the association between perfectionistic self-presentation and problematic use of internet communicative services. Another key issue to test is how interpersonal perfectionism relates to the degree of social connectedness that is established online with people. Research has established that offline social connectedness and Facebook social connectedness are distinguishable constructs (Grieve, Indian, Witteveen, Tolan, & Marrington, 2013). Critics of the PSDM and the research testing it could suggest that whereas perfectionism is associated with lower levels of offline social connectedness, perhaps the internet offers a chance for people to redeem themselves in their own eyes, and they compensate by having comparatively higher levels of Facebook social connectedness. According to this perspective, people may compensate for their low social self-confidence and fears of negative evaluation by developing strong online social networks. However, a testable hypothesis derived from the PSDM is that interpersonal perfectionism is linked jointly with lower levels of both offline social connectedness and Facebook social connectedness. This is in line with the general tendency for interpersonal perfectionism to be linked with social detachment and isolation and with reduced levels of popularity.

PERFECTIONISM AND LONELINESS

As noted earlier, a central premise of the PSDM is that perfectionism is associated with loneliness. Existing research on the association between trait perfectionism and loneliness is quite limited in scope. Before we describe the empirical research in more detail, we briefly consider past conceptualizations of this association.

David Burns was one of the first authors to point to an association between perfectionism and loneliness. According to Burns (1980), this loneliness is rooted in an anticipated fear of criticism and a tendency to react to criticism in a defensive manner, to the point at which it brings about the disapproval that the perfectionist fears. Pacht (1984) also observed that perfectionists tend to feel lonely and unlovable.

Perfectionists may be prone to loneliness because they have focused too much on achievements at the expense of developing social networks. That is, perfectionists are socially rejected by other people because they are too driven and competitive (Chang, Sanna, Chang, & Bodem, 2008).

A link between perfectionistic self-presentation and loneliness would be predicted on the basis of the PSDM, but an association can also be extrapolated from seminal theoretical observations about the nature of loneliness made by Carl Rogers. Most notably, Rogers (1961) identified the key psychological conditions that underscore a profound sense of aloneness. He posited that people become estranged from their “experiencing organism,” and that there is a potentially fatal division between actual experience and the experience that the conscious self clings to in order to gain love and acceptance from significant others. The second element in loneliness, according to Rogers (1961), is an unwillingness to communicate one’s real self to other people. Instead, the person relies on an idealized façade when interacting with others, but use of this façade only serves to add to a heightened sense of loneliness and palpable sense of estrangement from the actual self. The type of façade described by Rogers (1961) resembles perfectionistic self-presentation, so it follows that the person who is invested in seeming absolutely perfect will be plagued by a sense of self-inconsistency and a growing sense of detachment from other people and the self.

In an initial empirical study of loneliness and multidimensional trait perfectionism (Flett, Hewitt, & DeRosa, 1996), we found in a sample of university students that socially prescribed perfectionism was correlated with loneliness (r = .37) as assessed by the UCLA Loneliness Scale. As noted throughout this book, socially prescribed perfectionism is the belief or perception that others demand perfection from the self (Hewitt & Flett, 1991a). In extreme forms, socially prescribed perfectionism can reflect a sense of helplessness and hopelessness when one perceives that others

can never be satisfied, and that "The better I do, the better I am expected to do." This trait perfectionism dimension is distinguished and is distinguishable from self-oriented perfectionism and other-oriented perfectionism (Hewitt & Flett, 1991a; see Chapter 2 for a full discussion).

Subsequent research has replicated the obtained association between socially prescribed perfectionism and loneliness. In addition, this work has yielded evidence indicating that loneliness moderates the link between socially prescribed perfectionism and psychological distress with people characterized jointly by perfectionism and loneliness experiencing more severe levels of distress (see Chang, Hirsch, Sanna, Jeglic, & Fabian, 2011; Chang et al., 2008).

More recently, Sherry et al. (2012) focused on predictions derived from the PSDM and extended these predictions to the study of drinking behavior in students. A sample of 216 university students from the University of British Columbia completed a measure of perfectionism along with a measure of loneliness, a measure of depressive symptoms, and indices of alcohol consumption and level of hazardous drinking. Sherry et al. (2012) found a strong positive correlation (r = .47) between perfectionistic dysfunctional attitudes and loneliness. Although the association between perfectionism and hazardous drinking was not statistically significant, social disconnection in the form of loneliness was associated with hazardous drinking, and support was found for a mediational model in which loneliness mediated the link between perfectionism and hazardous drinking. In addition, both perfectionism and loneliness were associated with depressive symptoms, and support was also found for loneliness as a mediator of the link between perfectionistic dysfunctional attitudes and depressive symptoms.

The research conducted thus far has not examined the association between perfectionistic self-presentation and loneliness, but this void has been addressed in a recent series of studies (Molnar et al., 2013). The first study found that higher loneliness was associated with socially prescribed perfectionism and nondisclosure of imperfections. The second study found that socially prescribed perfectionism and all three facets of perfectionistic self-presentation were associated with greater loneliness. A measure of self-criticism was included for two reasons. First, there is some past work linking trait self-criticism with loneliness (e.g., Besser, Flett, & Davis, 2003; Wiseman, 1997; Wiseman, Mayseless, & Sharabany, 2006). A third study conducted by Molnar et al. (2013) extended this research beyond university student samples by studying 204 adults in the community. The participants were administered the MPS, the PSPS, and a measure of loneliness; they also completed measures of mental health and physical health. Once again, it was found that socially prescribed perfectionism and all three PSPS facets were associated significantly with loneliness. In addition, as expected, loneliness mediated

the relationship between interpersonal perfectionism and mental health symptoms. Loneliness also mediated the association between interpersonal perfectionism and physical health symptoms. Thus the PSDM can be extended to include a broader array of predicted negative outcomes reflecting health outcomes.

We briefly mention a fourth study that was also part of the Molnar et al. (2013) series of investigations. The participants in this fourth study were 294 couples. This study provided a limited test of the PSDM, in that only trait perfectionism was assessed. It was found for both men and women that socially prescribed perfectionism was associated significantly with loneliness. The impact that these variables and associated difficulties can have on people was shown by some other evidence from dyadic analyses indicating that women reported greater personal loneliness if they had partners with elevated levels of socially prescribed perfectionism. But what is perhaps most revealing is that socially prescribed perfectionism was associated with self-reported loneliness, despite the fact that the participants were in close relationships. These data suggest that even when people with high levels of interpersonal perfectionism have established connections with partners, their psychological needs for satisfying and close interpersonal connections may not be met.

PERFECTIONISM, SOCIAL DISCONNECTION, AND SELF-ALIENATION

As noted earlier, we have conducted some initial research testing the proposed tendency for socially disconnected perfectionists to experience self-alienation. This study was carried out recently with 171 university students (Flett et al., 2015). The overall results, shown in Table 5.1, confirm our past conceptualizations of social disconnection. First, we interpreted loneliness as a form of social disconnection, and a very strong association between loneliness and social disconnection was obtained ($r = .77$). Second, evidence of the link between social disconnection and self-alienation was also found. The measure of self-alienation was associated with the measures of social disconnection ($r = .43$) and loneliness ($r = .56$). We interpret the moderate correlation between social disconnection and self-alienation as a reflection of the fact that there are many pathways and routes to the experience of self-alienation beyond the role of social disconnection.

Consistent with the evidence presented earlier, perfectionism was associated with social disconnection and loneliness. The measure of social disconnection was correlated significantly with socially prescribed perfectionism and with all three PSPS facets (r's ranging from .37 to .51). Similarly, loneliness was also correlated significantly with socially

TABLE 5.1. Correlations among Measures of Perfectionism, Loneliness, Social Disconnection, and Self-Alienation

Measure	1	2	3	4	5	6	7	8	9
1. Self-oriented	—								
2. Other-oriented	.29**	—							
3. Socially prescribed	.44**	.26**	—						
4. Self-promotion	.40**	.10	.43**	—					
5. Nondisplay	.19*	.10	.45**	.66**	—				
6. Nondisclosure	.12	–.02	.42**	.64**	.59**	—			
7. Loneliness	–.04	.06	.45**	.39**	.51**	.58**	—		
8. Self-alienation	.01	.01	.45**	.35**	.42**	.41**	.56**	—	
9. Social disconnection	–.11	.07	.30**	.38**	.37**	.51**	.77**	.43**	—

Note. Correlations for university students (n = 188). Data from Flett, Nepon, and Hewitt (2015).
$^{*}p < .05$. $^{**}p < .01$.

prescribed perfectionism and all three PSPS facets (r's ranging from .39 to .58). In both instances, the strongest links were found with the PSPS facet tapping the nondisclosure of imperfections. But, most importantly, links with self-alienation were found for socially prescribed perfectionism (r = .45) and all three PSPS facets. The strongest association detected here was between self-alienation and socially prescribed perfectionism. This likely reflects the role of perceived pressure imposed on the self by others in promoting an inauthentic approach that fosters a sense of self-estrangement and detachment from the real self.

APPLYING THE PSDM TO CLINICAL CASES

The PSDM has provided us with some key insights into the psychosocial and emotional difficulties of people suffering as a result of their perfectionism. We provide below some observations stemming from the PSDM that are relevant to describing and understanding people who are struggling with their perfectionism.

First, it is important to emphasize that this tendency for perfectionism to contribute to social disconnection often generalizes across a variety of interpersonal relationships and interpersonal settings. Social disconnection can be highly salient and can have a powerful impact on both the type and the course of treatment. This possibility was suggested by one of the clinical cases described in the MPS manual (Hewitt & Flett, 2004). The first case presented was the story of Ms. S, a 55-year-old teacher who was a perfectionistic workaholic. She struggled to be a perfect mother and a perfect wife, and she felt isolated and disconnected

from those around her. She participated in a group treatment study and was characterized as having a mixed reaction to treatment. She benefited by developing a clearer awareness of the destructive impact of perfectionism, but she also "reported a feeling of isolation and disconnection from both the group members and the therapists" (Hewitt & Flett, 2004, p. 27). Thus her past history of social disconnection was evident in the psychotherapy group and became a focus.

Two other key points to emphasize are that (1) perfectionism and social disconnection reflect a sense of the self as undesirable; and (2) in many instances, both subjective and objective social disconnection play key roles. Both of these points are illustrated in the case account of Ms. P provided by Greenburg (1985). This case illustrates in general how some people require treatment over a span of several years and how self-esteem and other feelings about the self will fluctuate in response to changing life experiences. Ms. P suffered from extreme levels of perfectionism and low self-esteem in ways that are clearly relevant to various predictions from the PSDM. She had repeated bouts of depression and anxiety over an 8-year period. She explained that she sought treatment because she felt a need to get a sense of direction in her life and more self-confidence when making decisions. She was also increasingly concerned about the extent of her social withdrawal.

Ms. P's problems were eventually traced back to her mother's tendency to compare her harshly with friends and her sister in ways that stripped her of her self-esteem. She had internalized this message and developed the sense that she simply could not compete with her peers or her sister. A goal of treatment was to change her underlying belief "I am inferior" to "I have learned to think negatively about myself and can change that" (Greenburg, 1985, p. 26).

Ms. P's social disconnection took many forms. At work, she was socially isolated and interacted only with her manager. She acknowledged that she missed having close friends. While she felt close to her sister, they lived quite a distance apart. Ms. P also kept her boyfriend at a distance and was ambivalent about the relationship. She vacillated between not wanting to be with him and being concerned that he would no longer wish to be with her.

At the root of Ms. P's difficulties was her belief that mistakes would only prove to be catastrophic. Her withdrawal and social avoidance tendencies were reflections of her conviction that "If I say or do even one wrong thing, others won't like me." Further analyses established several important facts. Ms. P was both subjectively socially disconnected and objectively socially disconnected, but her former friends were quite available for her to seek out, if only she was willing to do so. Also, while Ms. P was very negative about herself and these negative self-perceptions fueled her moods and behaviors, she had many positive redeeming features,

according to Greenburg (1985). Indeed, she was described as someone who was quite likable, intelligent, and capable of having many friends.

One final point is worth noting. Ms. P's difficulties were exacerbated by her experience of psychological distress. She had developed a persistent, visible twitch that was first experienced during an attack of anxiety back in her university days. Self-consciousness about her twitch led her to avoid social encounters, including gravitating toward jobs that involved few interactions with people. This element of her personal story is in keeping with some of our past data showing that perfectionism has a strong link with anxiety sensitivity (i.e., the "fear of fear" that tends to accompany panic attacks) and that there is a clear link between interpersonal perfectionism and heightened anxiety sensitivity, due to concerns that the symptoms of anxiety (i.e., trembling, flushing, sweating) are on display and are visible to others (see Flett et al., 2004). Subsequent research has confirmed this association between perfectionism and anxiety sensitivity and has suggested that anxiety sensitivity mediates the link between perfectionism and distress (Pirbaglou et al., 2013). This pattern of findings suggests that concerns about being judged for less than perfect emotional control can exacerbate the degree of social disconnection among people who are perfectionistic and are sensitive to anxiety. At a broader level, perfectionists who are overly concerned about being stigmatized for coping in a less that optimal or ideal manner can become extremely isolated from other people.

The existing research has focused on socially prescribed perfectionism and/or the perfectionistic self-presentational facets, likely due to the fact that in our original PSDM (Hewitt et al., 2006) we focused on socially prescribed perfectionism. As we have argued in Chapter 4, we believe that all perfectionism traits act in the service of perfecting the self in order to obtain relational goals (including both connection with others and connection with the self), and to avoid the negative affective experiences of rejection, felt shame, and self-denigration. The perfectionism traits will function in different ways to attempt to accomplish these goals. In the extant research that has included measures of self-oriented or other-oriented perfectionism, the correlations between these measures and outcomes such as loneliness, social disconnection, or self-alienation have been small or nonsignificant. On the other hand, in two recent studies, we have shown that in addition to socially prescribed perfectionism and the three PSPS facets, self-oriented perfectionism, other-oriented perfectionism, and automatic perfectionistic cognitions were associated with general rejection sensitivity and appearance rejection sensitivity (van Eerden, Blasberg, Hewitt, & Flett, 2014; Kalb et al., 2014). Chen, Hewitt, and Flett (2015) found that both self-oriented and socially prescribed perfectionism were associated with higher levels

of needing to belong. These results suggest that, at times, the proposed interpersonal underpinnings of self- and other-oriented perfectionism are evident, whereas with some interpersonal variables or at other times, they are not. We suggest two possible explanations for this.

The first possibility is that, consistent with clinical experience, these interpersonal underpinnings are not immediately available to individuals with high levels of self-oriented and other-oriented perfectionism. In treatment, we have found that it takes some time and discussion of emotional experiences before this kind of content becomes available (see the case of Anita in Chapter 6). Thus the information may be available at an implicit level but not at an explicit level. Zeigler-Hill and Terry (2007) used implicit and explicit measures of self-esteem and assessed differences between adaptive and maladaptive perfectionism. The study focused on discrepant low self-esteem (i.e., low explicit and high implicit self-esteem) and not on discrepant high self-esteem or congruent self-esteem (i.e, high or average explicit and low implicit self-esteem, as we would predict for self- and other-oriented perfectionism). The methodology and paradigm of this research appear to be particularly useful for assessing the underlying interpersonal features of trait perfectionism.

A second possibility is that for both self-oriented and other-oriented perfectionism, the interpersonal underpinnings may become available to a person only in the presence of certain environmental events. We have argued that the diathesis–stress model is germane for perfectionism, and we and others have provided empirical support for this with depressive symptoms and depressed mood (e.g., Enns et al., 2005; Hewitt & Flett, 1993; Hewitt et al., 1996). Although there has not been a test of whether other emotions or interpersonal needs (e.g., shame, need to belong, or self-alienation) become evident or elevated for self-oriented or other-oriented perfectionistic individuals in the presence of ego-involving failures, this should be an important question to address in future research.

Finally, a related possibility is that trait components of perfectionism such as self-oriented perfectionism are associated with indices of social disconnection to the extent that the vulnerable individuals are aware of their imperfections, flaws, and mistakes, and that they are experiencing automatic thoughts about needing to be perfect along with the sense that the self is imperfect. Some support for this notion was obtained in a recent study that included a measure of loneliness along with the Perfectionism Cognitions Inventory and the MPS (Flett et al., 2015). Analyses found a small, significant association between self-oriented perfectionism and loneliness ($r = .18$), but a more robust association between perfectionistic automatic thoughts and loneliness ($r = .37$), and further

analyses confirmed that perfectionistic automatic thoughts mediated the link between trait perfectionism and loneliness.

Regardless of whether self-oriented perfectionism is associated with self-reported levels of social disconnection in variable-centered research, when the PDSM is viewed from an expanded perspective, it can account for behavioral patterns and life outcomes experienced by individual people who are driven, self-oriented perfectionists. Self-oriented perfectionism is often expressed in terms of compulsive, workaholic tendencies. This excessive devotion to work can foster chronic isolation from family and friends, and it may blind self-oriented perfectionists to just how isolated and detached they have become.

Furthermore, it seems possible for other-oriented perfectionism to play an influential role in social disconnection because the hostility and inability to trust other people that are often found among other-oriented perfectionists can actually create a distance by driving other people away. This is clearly evident in a case study recently detailed by Dimaggio et al. (2014): a compelling account of Mr. A, who had undergone multiple forms of abuse in infancy and childhood (including sexual abuse perpetrated by his maternal grandmother, and physical abuse and humiliation from his father). As an adult, Mr. A was deeply disturbed, with a combination of extreme narcissism, somatoform disorder, and a compulsive tendency to seek sexual relationships. Mr. A saw himself as creative, had fragile self-esteem, and embraced perfectionism to the extent that he was frequently disappointed by the limitations of other people. The details provided by Dimaggio and associates (2014) show that Mr. A had a repeated history of driving women away. A particularly compelling aspect of Mr. A's other-oriented perfectionism was his "diffident, defeatist, and critical [attitude] toward the therapist" (p. 90), which aroused anger in the therapist.

CONCLUSION

In this chapter, we have presented our revised PSDM and indicated how perfectionistic behavior, propelled by strong relational needs, actually creates social disconnection—disconnection that can result in intense and profound psychological difficulties, including suicidal behavior. In combination with the developmental model presented in Chapter 4, we have outlined how these interpersonal needs have arisen and play out in the perfectionistic individual's life and create, exacerbate, or maintain psychological turmoil.

CHAPTER 6

A Theoretical Model for Treatment of Perfectionistic Behavior

In this chapter, we provide clinicians with a framework for understanding idiosyncratic patterns involving perfectionism that can be used to tailor specific interventions for individual patients. Rather than presenting a set of techniques directed toward all perfectionistic patients, regardless of their patterns of behaviors and their life context, our approach emphasizes an understanding of the model and its theoretical underpinnings to aid in clinical formulation, assessment, and treatment.

Our treatment model extends from our understanding of the development and maintenance of perfectionism. The treatment has been refined over several decades of clinical work by Paul L. Hewitt and Samuel F. Mikail in both individual and group formats. As discussed in Chapter 4, we place primary emphasis on perfectionism's development within the context of early relationships with caregivers and on its later exacerbation and maintenance through relationships with others.

A DYNAMIC-RELATIONAL TREATMENT MODEL

The theoretical foundation of our treatment model is best characterized as an integration of psychodynamic, interpersonal, and some cognitive-behavioral principles (see Tasca, Mikail, & Hewitt, 2007). The approach emphasizes the relational basis of human behavior—particularly an individual's need for connection, felt security, and esteem—and focuses on the relational precursors of perfectionism. We assert that perfectionism develops as a means of adapting to and shaping one's primary interpersonal relationships and the relationship one has with oneself. For the

perfectionist, perfectionistic behavior becomes a vehicle that holds the promise of attaining love, acceptance, and respect from others, and eventually from the self. Failure to be perfect or to appear perfect is associated with the inevitability of abandonment, rejection, ridicule, abuse, and neglect. That is, connection, security, and worth are experienced as contingent upon perfection. It is important to note that the perfectionistic individual is likely to know he or she is perfectionistic, but may not be aware (or may be only vaguely aware) of the contingent nature of the relationship between the need for perfection and his or her security, sense of self, and relations with others. Moreover, the person is probably not aware of the purpose that the perfectionistic behavior serves, or aware of its genesis.

Within this framework, one aim of therapy is to heighten the individual's awareness of relational dynamics and the idiosyncratic interpersonal patterns giving rise to the belief that perfecting the self or others is essential. We place importance on insight and understanding, based on experiential aspects of treatment. The focus is on addressing the causes and antecedents of the person's development of perfectionism. The precursors, we believe, are relational in nature and reflect various needs (such as the need to belong; the need for acceptance by self and others; and the need not to be rejected, abandoned, criticized, or ridiculed). The specific nature and context of these causes stem from the individual's developmental history and should be explicated by and examined throughout the therapeutic experience. The ultimate therapeutic objective is to aid the individual in discovering more adaptive and flexible ways of meeting the needs for security, connection, and self-regard.

THE CLINICAL FORMULATION AND THE CYCLICAL RELATIONAL PATTERN

Two of the most important tools we use in the treatment of perfectionistic behavior are the "clinical formulation" and the accompanying "cyclical relational pattern" (CRP). In essence, the formulation is the individual's idiosyncratic story or model that helps to explain the development of perfectionistic behavior as a source of security and safety. Furthermore, the formulation clarifies the purposes that the perfectionistic behavior serves: as a means to connect and belong and to correct a flawed sense of self. It also clarifies how the perfectionistic behavior results in creating and maintaining a sense of disconnection that perpetuates a view of self as defective. The CRP spells out the overt behaviors in which the patient engages, the perceived expectations of others, and the ways in which the patient actually relates these behaviors to his

or her self-concept. With its focus on defensive interpersonal styles, the CRP provides the therapist with an important therapeutic tool, allowing him or her to respond from a complementary interpersonal position to effect change in the patient.

The formulation and CRP are made known to the patient in two ways. First, the therapist shares the initial working formulation with the patient at the beginning of treatment. In doing so, the clinician invites collaboration and ensures the accuracy of the formulation. This process is achieved through didactic means, drawing, where possible, on aspects of the therapeutic interactions that bring the formulation to life. In this way, the individual has a framework for understanding his or her own behavior. Such awareness becomes the first step in allowing the patient to move toward shifting self-limiting relational patterns and developing more adaptive ways of assuaging aversive affective and self-states. Second, over the course of treatment, the formulation gradually assumes greater emotional resonance for the individual, allowing for more penetrating insights and self-recognition. Such insights allow the perfectionist a renewed sense of choice and intentionality in his or her approach to self and others. It is important to note, however, that perfectionists will often pull for obtaining information rather than experiencing or exploring affect, and so information alone will not be sufficient. This is our reason for arguing that the use of self-help materials leads to limited change in perfectionism. Similarly, our approach to treatment extends beyond focusing specifically or overtly on perfectionistic behavior; rather, it aims to shift relational contingencies that have served as the precursors to perfectionism.

The formulation is an evolving framework that guides the clinician's understanding of the patient's behaviors and the purpose these behaviors serve in allowing the individual to maintain a coherent sense of self and the illusion of a predictable world. It is akin to a theory or model in scientific endeavor. Evidence is gathered to test hypotheses derived from the theory, and components of the theory are maintained or modified in a coherent fashion in order to accommodate emerging data. The formulation is an evolving understanding of the person's past and current behavior, dynamics, and life problems. A metaphor that we use in treatment (and share with patients) derives from the description of a painting depicting the main character's life in Robertson Davies's (1985) novel *What's Bred in the Bone*, from the Cornish Trilogies. Through history taking and the sharing of seminal experiences, the therapist and patient collaboratively attempt to create a painting that, once complete, will reflect an integrated whole—one that details and clarifies critical life experiences and the way they have contributed to, influenced, and molded the patient's personality and the associated relational patterns.

The working formulation is tantamount to the placement of small splotches of paint on disparate parts of the canvas. Initially, they appear to have minimal form and little relationship to other parts of the canvas. Yet, as treatment progresses, the small, disparate painted areas begin to coalesce into cohesive images, offering partial understanding of particular components of the individual's life. Gradually, the spaces separating these disparate sections begin to coalesce into an integrated and coherent image. The therapeutic process invites the patient to step back to take in what has been created so far. Thus the process of treatment involves the patient's attaining this insight and understanding his or her needs, dynamics, and behaviors—and, by doing so, moving toward greater intentionality in completing the canvas by engaging in behaviors and strategies that better meet these needs.

We have found several heuristics useful in guiding the development of the formulation and interventions. They include Malan's (1979) adaptation and relational matrix, elements of Strupp and Binder's (1984) cyclical psychodynamic pattern, components of Benjamin's (1974) interpersonal circumplex, and Kiesler's (1996) notion of the impact message. Some features of our model were first described in Tasca et al. (2007) as it related to the DSM-based category of binge-eating disorder, but it has been modified for the treatment of perfectionism.

THE ADAPTATION AND RELATIONAL MATRIX

The Triangles of Adaptation and Object Relations

Drawing on David Malan's (1979) concepts of the "triangle of person" and the "triangle of conflict," we have proposed a modified model comprising the "triangle of adaptation" and the "triangle of object relations" (see Tasca et al., 2005). Briefly, the triangle of adaptation describes the individual's relational or attachment needs, anxiety and other important affects, defenses (see Figure 6.1), and the interplay of these components. The triangle of object relations encompasses the individual's patterns of experiencing past relationships with significant others and self, current relationships with significant others and self, and the current therapeutic relationship with either the therapist or the group.

The triangles of adaptation and object relations are based on developments in psychoanalytic theory that are exemplified by Bowlby's (1969/1971) articulation of attachment theory, Klein's (1935) object relations theory, Sullivan's (1953) interpersonal theory of psychiatry, and Kohut's (1971) writings on self psychology. Each of these theorists viewed the need for relationship as the primary psychological element that moves individuals to act and to develop. These interpersonal models

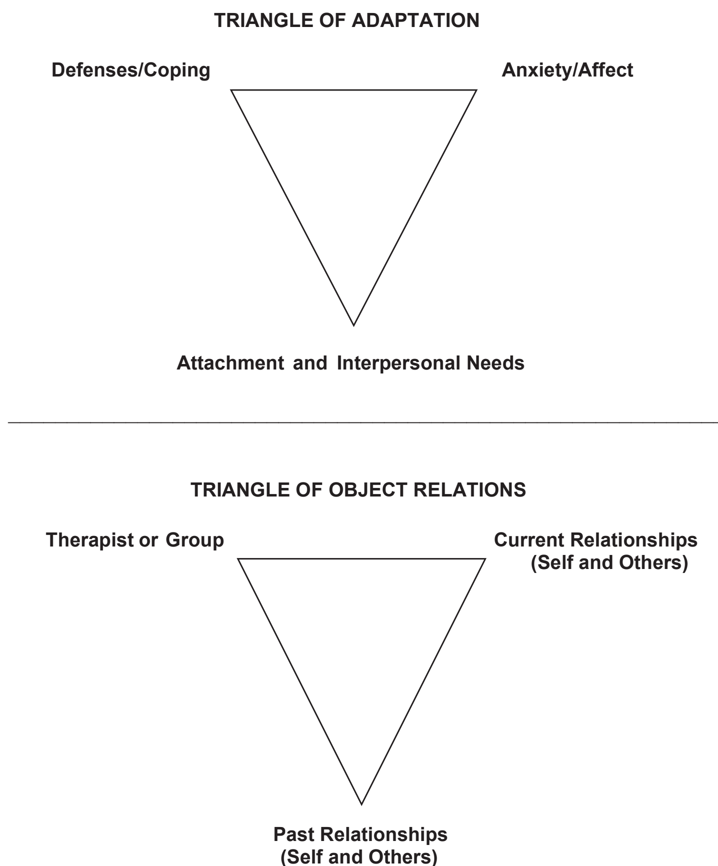

FIGURE 6.1. The triangle of adaptation and the triangle of object relations. Based on Tasca, Mikail, and Hewitt (2007).

have dominated psychoanalytic theory for the past 60 years and reflect the evolution of psychoanalytic thought.

The Triangle of Adaptation

In the triangle of adaptation, we see attachment needs as powerful and often unconscious motivators of thoughts, emotions, and behaviors. These are most often historically rooted needs that may or may not have been met adequately throughout a person's life, but most especially in the individual's early life with caregivers. They can include needs based in and specific to the person's current relationships, as well as unfulfilled

needs regarding the self in the form of internalized relationships. Anxiety and other distressing emotions (e.g., shame, humiliation, fear of rejection/abandonment, isolation) can often be the outcomes of such unmet attachment needs. The individual's unique constellation of negative emotions gives rise to the formation of defenses that serve to make the pain of unfulfilled needs more tolerable. Specifically, the resultant defensive structures serve to protect the individual's self-esteem in an effort to maintain emotional equanimity. Defenses and ways of coping are essential components of personality and can vary in their level of effectiveness. At their core, all defenses are interpersonal in nature, with their level of effectiveness defined by their appropriateness to the relational context in which they are triggered.

The Triangle of Object Relations

The triangle of object relations consists of parallel and repetitive relational themes and patterns that include relationships in the past (typically and primarily those with caregivers), relationships in the present (i.e., those with intimate and significant others and, potentially, generalized others), and the themes and patterns that become manifest in the therapeutic relationship (i.e., the relationship with the therapist and, in the case of group treatment, other group members). The triangle of object relations provides the relational context in which the emotions and defenses identified in the triangle of adaptation are triggered and understood. The task of therapy involves differentiating defenses that are adaptive and appropriate to each of these contexts and those that stem from distortions arising out of unfulfilled attachment needs or transference responses (Sullivan, 1953). The emergence of such distortions provides a powerful opportunity for the therapist or group to work in the here-and-now with the specific interpersonal style, the accompanying affect, and the individual's maladaptive defenses or coping mechanisms.

An important component of our formulation of the triangle of object relations (cf. Malan, 1979) encompasses the relationship with oneself (i.e., the introject) as well as relationships with others (Strupp & Binder, 1984; Sullivan, 1953). The notion that one engages in consistent relationship patterns with oneself that parallel the ways in which one was treated by significant figures (Benjamin, 1996; Sullivan, 1953) has gained increasing prominence in various literatures (Felson, 1989; Lemay & Clark, 2008). Moreover, there has been increasing interest in theories such as self psychology (see Baker & Baker, 1987), wherein the healthy self is defined as cohesive, vibrant, and resilient. Injuries to the self, or what have been termed "narcissistic injuries," are the results

of loss or threatened loss of important relationships that allow one to maintain a sense of self-cohesion.

The triangle of adaptation can be thought of as being embedded within each vertex of the triangle of object relations. That is, each relationship behavior is, in large part, determined by the nature of one's underlying needs, affective reactions to these needs, and associated defenses. The triangle of object relations suggests that the pattern of interpersonal responding is learned in early parental relationships (the past vertex). These patterns tend to be consistent in current relationships (the current vertex), and are likely to be repeated in therapeutic relationships (the therapist/group vertex). These consistent patterns, and the embedded triangle of adaptation within each of the vertices of the triangle of object relations, define transferences in current relationships with others (see Berk & Andersen, 2000) and self, as well as in the relationship with the therapist or group.

The Two Triangles and Perfectionism

For the perfectionist, the underlying attachment need may be one of intense craving for acceptance, caring, and love by a parent or a significant other, despite the person's incompleteness and imperfections. This need may work at both conscious and unconscious levels, especially for a self-oriented perfectionist (whose requirement for perfection has been introjected or incorporated into the self as self-expectations) or an other-oriented perfectionist (whose externalizing behavior keeps the needs from direct awareness). The affect that is generated can be complex, involving anxiety, despair, anger, and shame. The defense can be preoccupation with and a drive toward attaining perfection in various domains, but often the achievement domain can become a dominant focus. Creative and intellectually capable individuals may have discovered that this domain in particular has garnered attention and some measure of interpersonal approval or the promise of approval, and thus their need for perfection in this aspect of life has assumed greater prominence. The need for love and acceptance may be more conscious for some who have elevated levels of socially prescribed perfectionism, whereby the expectations (veridical or not) are perceived and the individuals are fully aware of them. The affect here can be anger, depression, despair, or resentment, all of which serve to perpetuate feelings of aloneness and a chronic, unfulfilled longing for connection. The defense response follows one of two possible trajectories. The first is characterized by a compulsive need to please, which ultimately contributes to an ever-growing lack of awareness of one's own needs. The second path involves a lack of authenticity and intimacy and is built upon a rigid

focus on communicating one's supposed perfection though perfectionistic self-promotion or the nondisplay or nondisclosure of imperfections.

Perfectionistic behavior can be understood within a psychodynamic interpersonal framework as a *maladaptive solution* to an experience of internal turmoil and unrequited interpersonal and self-relational needs. It serves to keep at bay disquieting emotions stemming from the belief that "I am not accepted," while perpetuating a fantasy or hope that "If I am perfect enough, or if I can appear to be perfect enough, then acceptance, love, and mattering to others will ensue." In the early stages of typical development, pleasing others and securing an illusion of acceptance evolve into pleasing the self. In this way, the perceived messages, expectations, and rules of significant others become introjected; they become the basis on which one relates to oneself (Benjamin, 1993; Strupp & Binder, 1984; Sullivan, 1953).

As our PSDM (see Chapters 4 and 5) suggests the sense of the self as unlovable, flawed, defective, or unworthy is often reinforced in perfectionists' relationships. For example, those who assume a cold and hostile interpersonal stance do so as a result of a long history of not having needs met, to which they respond by lashing out. This pattern characterizes most individuals with perfectionism, according to Hill, Zrull, and Turlington (1997). They are likely to evoke the same hostile and recoiling response in others, which reinforces their view of themselves as unlovable. Those with an overly nurturing interpersonal style typically do not get their needs met because of their exclusive focus on others. This can take the form of parentification in childhood or of being overly responsible caregivers for friends and family, coupled with hypervigilance and hypersensitivity to nonacceptance and criticism. According to Hill et al. (1997), this pattern characterizes women with self-oriented perfectionism (see also Habke & Flynn, 2002). They do not allow themselves to feel angry about unfulfilled needs for fear of losing important others, and thus they conceal their needs, personal desires, or distress. The result is a stance of altruism that masks deeply rooted feelings of alienation and worthlessness.

The Case of Anita

The case of Anita illustrates our use of the triangles. Anita was a happily married 44-year-old woman who was formerly employed as a biologist in the food industry. She had one daughter to whom she felt close and an extensive social network that seemed both warm and supportive. She was referred for treatment of severe depression and marked suicidal thoughts following a physical injury that ended her career. She had tried various treatment options to deal specifically with the depression and

marked suicidal impulses, but all were unsuccessful. She had heard an interview with one of us (Paul L. Hewitt) on the role of perfectionism in suicide and depression; she arranged an initial clinical evaluation with Hewitt in which it was determined that she was severely depressed, with a moderate to high risk of suicide. She described herself as highly perfectionistic, noting that she often spent inordinate amounts of time on attempting to be perfect.

Anita's specific assessment results appear in Table 6.1. It can be seen that Anita scored more than or equal to one standard deviation above normative means on self-oriented perfectionism and all three facets of perfectionistic self-presentation. Her scores on other-oriented perfectionism and socially prescribed perfectionism were also quite highly elevated. The findings from the Minnesota Multiphasic Personality Inventory–2 (MMPI-2) indicated the extreme level of distress that she was experiencing. Briefly, the profile was consistent with marked levels of depression, including both somatic (sleep and eating problems, decreased energy) and cognitive symptoms (rumination, brooding, concentration problems); significant anxiety, pessimism, guilt, and social isolation; and difficulties trusting others, passive dependency, and meticulousness. It was noted that few people in Anita's life knew the depth of her pain, as she kept her distress from others.

Anita came from an open and supportive family. She had enjoyed an extremely close relationship with her mother, whom she described as her absolute best friend and confidante. She stated that she had had an idyllic childhood and that she remained close to her family, including her younger sister. Anita reported always needing to do exceptionally well in school and other activities and thoroughly enjoying her work.

Over the course of psychotherapy, it became clear that Anita had a long-standing need to be perfect in all she undertook, and that this need was coupled with mistrust that others were not sufficiently capable of completing tasks. Her need for perfection extended at times to requiring her daughter's or husband's perfection. At the same time, she described herself as being extremely overresponsible, especially for others' welfare. Moreover, she took on the role of caregiver with many friends and was perceived as a kind, caring, and dedicated friend who was the "go-to person" when someone was experiencing difficulties. The loss of her job was a considerable blow to her, and the death of her mother, some 10 years prior to treatment, remained a constant source of pain and anger. Anita described her mother's death as a massive loss; she responded initially with anger and rage, followed by a sadness that never seemed to abate. Anita decided to begin swimming as a means of coping with the loss and progressed from being able to swim only a few lengths to swimming at a competitive level and for extremely long distances. She said she

TABLE 6.1. Psychometric Testing Results for Anita

MPS	
Self-oriented	67
Other-oriented	59
Socially prescribed	59
PSPS	
Self-promotion	67
Nondisplay	63
Nondisclose	60
MMPI-2	
L	52
F	58
K	43
Back F	70
TRIN	58
VRIN	50
1. Hypochondriasis	76
2. Depression	94
3. Hysteria	87
4. Psychopathic deviate	43
5. Masculinity–femininity	43
6. Paranoia	70
7. Psychasthenia	79
8. Schizophrenia	65
9. Hypomania	35
10. Social isolation	73
BDI	
Raw score	40

Note. All scores are *T* scores unless otherwise noted. MPS, Multidimensional Perfectionism Scale; Self-oriented, self-oriented perfectionism; Other-oriented, other-oriented perfectionism; Socially prescribed, socially prescribed perfectionism; PSPS, Perfectionism Self-Presentation Scale; Self-promotion, perfectionistic self-promotion; Nondisplay, nondisplay of imperfection; Nondisclose, nondisclosure of imperfection; MMPI-2, Minnesota Multiphasic Personality Inventory–2; BDI, Beck Depression Inventory.

found relief in the ability to push herself and to increase the distances she swam, adding that during her swims, especially the long-distance training swims, she experienced what she described as a "runner's high for swimmers." She would find herself fantasizing about her mother's still being alive and available to her during these states. However, she had had to give up the swimming after her injury as well as her job.

During one of her initial sessions, Anita recalled that at age 5, she and her younger sister were separated from her parents and sent to live with some relatives for a few months. Although she could not clearly recall why this occurred, it seemed that her parents were dealing with some family issue that necessitated the children's being looked after by other family members. Anita and the therapist spoke about this incident during several sessions at varying points throughout treatment, with more information surfacing each time. Anita reported that at that time, she felt upset and alone without her parents and found it difficult to be around anyone other than her sister, who was also upset at the separation. She reported feeling abandoned and unable to comprehend why she was living away from her mother and father. During one session, she reported remembering the time when her mother came to get Anita and her sister to bring them home and stated that she recalled watching the jet land and watching her mother disembark. She recalled thinking how beautiful her mother looked as she walked toward her. It was clear during her initial description of this incident that Anita was experiencing significant affect in relation to the incident, but it was unclear to her what the affect was or what specifically had evoked it.

Over the course of the sessions, it became apparent that the separation from her mother was a formative experience for Anita. In the clinical formulation, this came to be understood as a pivotal moment in establishing her extremely perfectionistic approach to dealing with the world. Anita and the therapist determined that Anita learned never to behave in any manner that might provoke another separation from her mother and in fact began to arrange her life and aspects of it to ensure proximity to her mother. For example, when her mother was still living, Anita chose to work in the same food industry field—doing the same work her mother was doing, in the same facility, and eventually even on the same ward her mother worked on. Moreover, when Anita and her husband were first married, they rented a room in Anita's parents' home, and when they bought a house it was two doors down from her parents' home.

Although the death of her mother was a profound blow to Anita, she seemed able at first to cope with the loss to some extent by perfecting and redoubling her efforts at work, focusing on raising her daughter, and swimming ever-increasing distances. As Anita and the therapist continued to speak about the loss of her mother, however, it became clear that Anita continued to have extensive grief; that she had not fully accepted that her mother was gone; and that she had been powerless to prevent the loss of her mother. In effect, Anita was faced with the ultimate separation from her mother—a separation she had worked to avoid throughout her life. Furthermore, her inability to continue swimming took away a vital

defense mechanism: Anita's ability to fantasize about her mother being alive. Anita was thus confronted with her powerlessness in the face of separation and perceived abandonment. This combination of powerlessness and abandonment had a profound effect on Anita; it was expressed through experiences of intense affect, including rage, depression, suicidal impulses, and anxiety. During this phase of treatment, as Anita and the therapist focused on the death of her mother, Anita became markedly suicidal and experienced significant depression and anger.

Anita's attachment style (see the triangle of adaptation in Figure 6.2) was characterized by a powerful need to avoid experiences of abandonment and felt rejection she encountered early in her life. As indicated above, Anita's need was manifested in several ways, including having to maintain close proximity to her mother by living and working with her mother and even assuming the same vocation. When she was unable to protect herself from subsequent losses, she responded with intense despair, hopelessness, abandonment anxiety, loneliness, and feelings of failure. Finally, her defenses could be understood as including efforts to be the perfect daughter, student, and young woman. She experienced a compulsion to be a replica of her mother by having the same passions, interests, and vocation, together with the attendant fantasy that if she perfected her athletic achievements her mother might return.

With respect to the triangle of object relations (see the lower portion of Figure 6.2), we can see an interpersonal pattern that reflected Anita's style of being close to her mother in numerous ways so as not to precipitate any distance, rejection, or abandonment. She was never demanding, and by being the perfect and compliant daughter, she tried to ensure that she did not cause problems or difficulties that would be distressing for her mother. Moreover, she would not let her own daughter or other family members or friends know that she was hurting. Even in times of extreme distress, she hid her pain. With respect to the therapeutic relationship, Anita worked hard and wanted to communicate that she valued the therapist and therapy greatly. This was reflected in worry about the therapist's dropping her as a patient, working very hard in treatment, never missing a session, never being late, and wanting to be a referral source for the therapist's practice. Moreover, she continues to communicate this even now by letting the therapist know, once a year, that she is doing well.

THE CYCLICAL RELATIONAL PATTERN

The triangles constitute a useful first step in constructing the formulation; however, the formulation and especially the triangle of adaptation can be extended by consideration of the CRP, mentioned at the start of

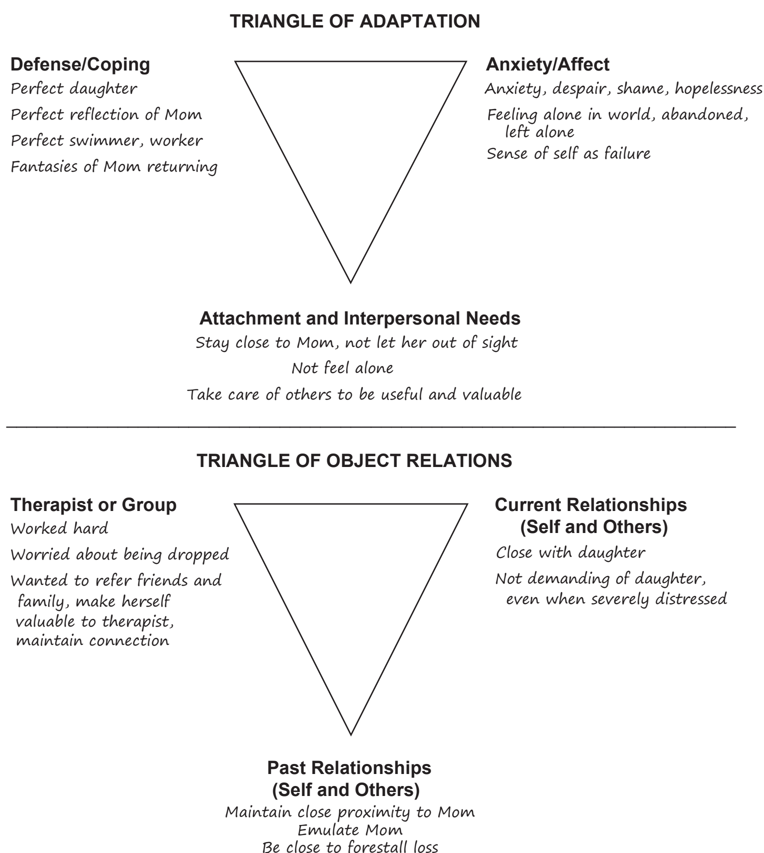

FIGURE 6.2. The triangle of adaptation and the triangle of object relations for Anita.

this chapter. We view the CRP as a heuristic that aids the therapist's understanding of the patient's specific behaviors both within and outside therapy, as well as the shaping of interventions. Some components of the CRP may be similar for certain perfectionistic individuals; however, the CRP will differ in its details, depending on each patient's environment, idiosyncratic components of the formulation (such as relational history, family constellation, and other circumstances), and current interpersonal situation and difficulties. The CRP, which becomes a component of the overall formulation, is an individual's hypothesized interpersonal pattern that emerges in response to aversive affective states arising from unmet attachment needs. The person's prototypic interpersonal pattern involves relating to others and self in a manner that is perceived

to be adaptive and offers a sense of constancy. The CRP is triggered as a means of making aversive affect more tolerable. For example, in self-oriented and socially prescribed perfectionism, the individual harbors the belief that "If I am perfect, I will be accepted, will experience a sense of belonging, and will avoid the pain of rejection." This means of coping exacts considerable emotional costs; any relief is fleeting at best. The individual is left chasing an elusive perfection, with the source of affective dysregulation remaining unresolved.

In order to articulate the CRP, we draw on the combined theoretical underpinnings of brief psychodynamic treatment as articulated by Strupp and Binder (1984) and the interpersonal circumplex as first described by Leary (1957), and later elaborated by Benjamin (1974).

Categories of Actions

Strupp and Binder (1984) described four dimensions of an individual's experience, each comprising thoughts, behaviors, and emotions that coalesce in a dynamic and interactive fashion. The four dimensions are arranged in a cyclical manner, with each being influenced by and having an influence on the others (see Figure 6.3).

Acts of Self

The acts of self include all behaviors in which the individual engages covertly and overtly. They involve affects, motives, perceptions, thoughts, overt behaviors, wishes, needs, fantasies, desires, affective states, cognitions, perceptions, and so forth. They can be both public and private behaviors (e.g., feeling sad and expressing sadness) that are more or less available to conscious awareness.

Expectations of Others

The expectations of others are the patient's expectations and beliefs regarding how others will react to him or her (i.e., what others will think, feel, perceive, etc.). They can include the imagined or anticipated reactions of others that are fully available to the patient's awareness, or expectations and perceptions that exist at a less than conscious level. When these are explored with a patient, they are often articulated in the form of "if–then" statements whereby there is an expected inner experience of another person based on the patient's acts. For example, individuals may express, in some form, the following: "If I allow my shortcomings to be exposed to another person, then this person will find me repulsive and cut off the relationship."

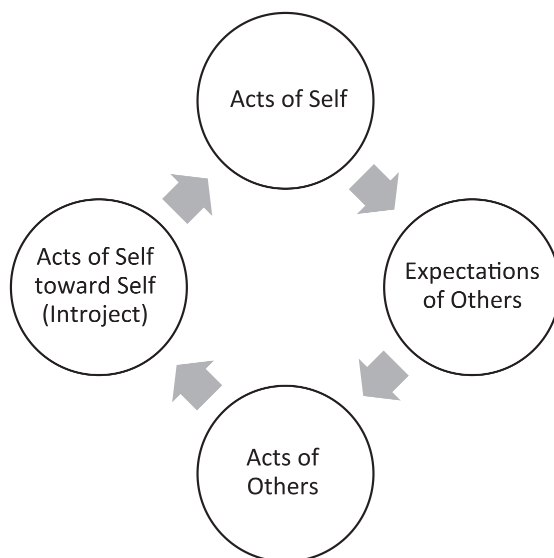

FIGURE 6.3. The cyclical relational pattern (CRP).

Acts of Others

The acts of others comprise the actual observed reactions of others, as either reported by the patient (in individual treatment) or observed by the therapist (in the course of couple or group treatment). They are observed behaviors that are assumed to occur in response to the patient's acts of self. Viewed from within the framework of interpersonal theory, the patient appears to "pull for" or "evoke" these responses from others. A patient will frequently use the observed acts of others as evidence of others' evaluation of the patient's self-worth, rather than as a response to the patient's behavior. That is, the patient typically does not recognize that others may be reacting to what has been evoked within them by the patient's behavior.

Acts of Self toward Self (Introject)

The acts of self toward self consist of how one treats oneself. Typically these are expressions of an individual's internalization of how he or she was treated by significant others over the course of development. Generally, they take the form of "When ____________ occurs, then I [am, feel, think, experience . . .] ____________." In cognitive-behavioral terms, these constitute an individual's core beliefs about the self.

Some Examples

Sue describes herself as lacking in confidence and interpersonally passive (acts of self). An exploration of her expectations of others reveals a strong conviction that others will not like her if she is assertive or appears demanding. Sue's account of several of her relationships reveals that coworkers and family members often take advantage of her (acts of others), leading her to view herself as weak, ineffective, or defective (introject). This self-view or introject becomes the source of self-derogation and passivity (acts of self toward self).

John describes himself as an introvert who tends to "blend into the woodwork" in most social situations (acts of self). John's expectation is that others are not that interested in him and will generally fail to notice him (expectations of others). Because of his reserved demeanor, others either ignore or easily overlook him (acts of others). An exploration of John's self-image suggested that John views himself as irrelevant and unimportant (introject)—a belief that has contributed to marked self-neglect and a silencing of his needs even within his closest relationships (acts of self toward self).

As these examples demonstrate, the CRP serves as a framework for understanding the process of a patient's interpersonal and intrapersonal behaviors, reactions, and symptoms. In constructing it, the clinician can begin with any one of the four components, in the knowledge that they are linked in a coherent (albeit self-limiting) pattern in which significant aspects of the patient's emotional and relational needs are not met. In fact, the hallmark of the CRP is that it is rigidly organized but allows the individual to exist and engage in an interpersonal world that is predictable and offers the illusion of manageability.

Interpersonal Models and the CRP

Although Strupp and Binder's (1984) model is interpersonally based, in constructing the CRP we find it useful to incorporate tenets of the interpersonal circumplex as articulated by theorists such as Benjamin (1974), Kiesler (1996), Leary (1957), and Luborsky (1984). This is not a particularly innovative move on our part, as these theorists have underscored the importance of interpersonal styles as a means of managing anxiety and other aversive affect states. We are simply attempting to synthesize two general approaches to psychological problem formulation and the interpersonal dynamics underlying maladjustment. To enable our readers to appreciate this synthesis, a brief description of some components of interpersonal theory is in order.

A well-adjusted individual possesses a flexible interpersonal repertoire that allows him or her to respond to sundry interpersonal situations in an adaptive manner, taking into account the demands of the situation. For example, in a job interview for a coveted position, a well-adjusted individual will modify his or her interpersonal behavior so as to assume a nonaggressive and agreeable interpersonal stance, rather than one that is controlling or adversarial. Likewise, a healthy person can express caution or apprehension in an encounter with a slick salesperson, yet exhibit trust when interacting with a colleague or intimate partner. That is, the healthy individual has the capacity to respond with flexibility, based on a reasonably accurate appraisal of the interpersonal environment. Although most of us exhibit a "preferred" interpersonal style, if we are reasonably healthy we possess the capacity to draw flexibly on a broader behavioral repertoire, with our behavior being influenced by situational demands.

In contrast, a maladjusted individual exhibits a constricted interpersonal style, characterized by a limited capacity to accommodate the varying contextual demands of interpersonal encounters (Leary, 1957). This rigidity is reflected in both the nature and intensity of the interpersonal pattern. For example, an individual who is characterologically mistrustful is uniformly suspicious, whether he or she is dealing with an intimate partner, a colleague, or someone unfamiliar.

THE INTERPERSONAL CIRCUMPLEX MODEL

Leary (1957) suggested that all interpersonal behaviors are understood by considering the extent to which they reflect two independent dimensions: a need for power or control and a desire for affiliation. Each dimension is organized along a continuum: The power dimension is anchored by the extremes of dominance and submission; the affiliation dimension is anchored by friendly and hostile behavior (see Figure 6.4). Leary (and later Kiesler, 1996) termed these two dimensions the "interpersonal circumplex" and suggested that the power and affiliation dimensions are orthogonal to one another, with power forming the vertical axis and affiliation forming the horizontal axis. As the word "circumplex" indicates, they can be depicted as two independent axes of a circle and interpersonal behavior can be located within the spaces of the orthogonal axes. Figure 6.4 depicts the quadrants of an interpersonal circle, but the circumplex can be further divided into octants (Figure 6.5), which allow for a finer distinction among behaviors (Kiesler, 1996).

In applying the principles of the circumplex, the interpersonal behavior of an individual who responds by listening actively and

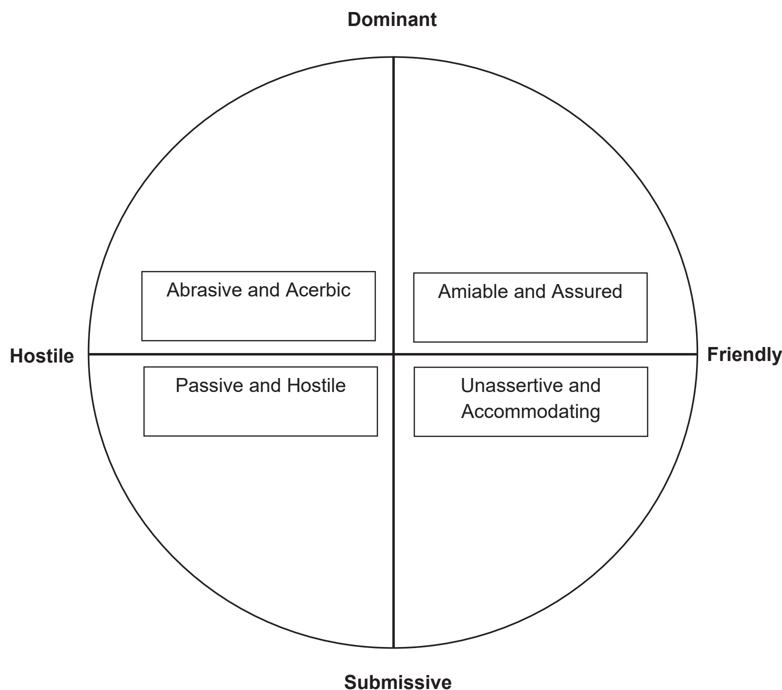

FIGURE 6.4. The interpersonal circumplex and personality styles.

empathically to another's problems in an effort to help would be classified as dominant (i.e., taking a helper role) and friendly; this behavioral style is located in the upper right-hand quadrant of the circumplex (i.e., the friendly–dominant quadrant). On the other hand, if the same individual responds by actively listening to the same problems but reacting with blame or criticism toward the other, the behavior would be classified as falling in the upper left-hand (i.e., hostile–dominant) quadrant of the circumplex.

It is assumed that these interpersonal styles exist in a fairly rigid fashion in individuals with psychological difficulties and that these styles initiate and perpetuate interactional patterns with others. The description of interactional patterns really represents the confluence of the interpersonal circumplex and the "interpersonal transaction cycle" (ITC; Wagner, Kiesler, & Schmidt, 1995), whereby two individuals reciprocally influence one another's behavior. Kiesler (1996) has described the ITC as representing the relationship between the overt interpersonal behavior of one individual (e.g., the patient) and the covert reactions of the other individual. Each person's behavior is both a cause and a result

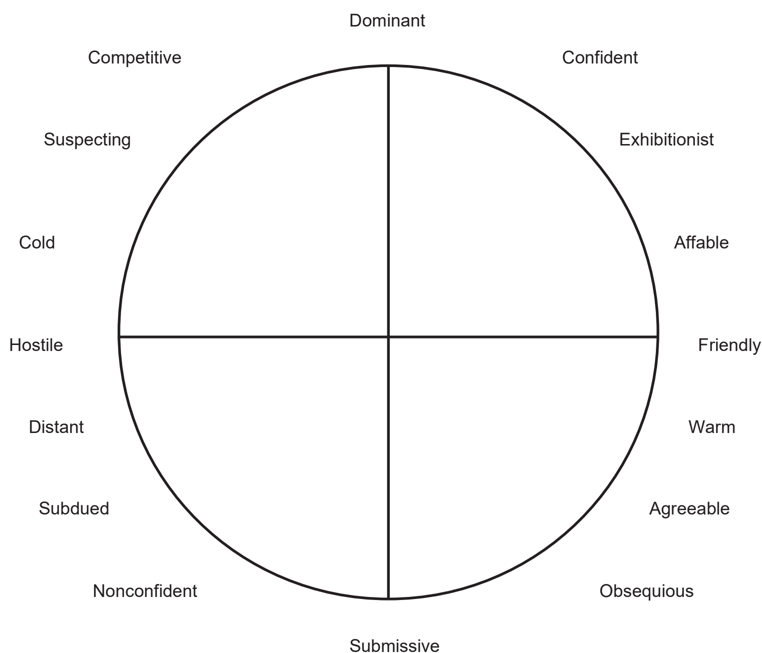

FIGURE 6.5. Octant labels for the circumplex. Dominant–submissive and hostile–friendly represent orthogonal dimensions.

of the other's behavior. Individuals with problems in living or relating tend to enact the same ITC repeatedly and thus can shape other people's responses to them. This process reinforces the perceptions, feelings, and needs that underlie the maladaptive behavior. Thus beliefs about themselves and others go unchallenged, and the ITC is sustained in a self-confirming and self-perpetuating manner.

Complementarity

A pivotal component of the interpersonal approach is the principle of "complementarity" in interactions. Complementarity suggests that an individual's interpersonal behaviors evokes or pulls for a restricted set of interpersonal responses from others. For example, an individual who is nervous about an important date and has spent several hours primping may say to a roommate, "I look awful." This statement may unconsciously pull for the roommate to reassure and comfort the nervous person by responding, "No, you look wonderful."

Carson (1969) defined complementarity as a response classified

as opposite or "reciprocal" on the power axis of the interpersonal circumplex and as the same or "corresponding" on the affiliation axis. In other words, reciprocity involves a stance of dominance in response to interpersonal behavior that is submissive. Correspondence suggests that friendly behaviors beget friendly responses and hostile behaviors beget hostile responses. If we consider behavior that falls into one of the quadrants of the circumplex, the principle of complementary would predict that hostile–dominant behaviors will evoke hostile–submissive responses (i.e., reciprocal on the power dimension and corresponding on the affiliation dimension). To take another example, friendly–submissive behavior will pull for friendly–dominant responses.

Complementary interactions tend to continue unchanged and are reinforcing to the CRPs of both participants. However, if one participant fails to assume a position complementary to the other's position, tension and anxiety ensue. The more rigidly structured the CRPs of the participants, the greater the anxiety. The resulting tension can only be dissipated in one of two ways: Either the participants disengage and leave the interpersonal field or the individual possessing a more flexible CRP assumes a position of complementarity.

Given that maladjusted individuals have a restricted and rigid interpersonal style, their interpersonal behavior tends to pull for or elicit a narrow range of complementary interpersonal responses from others. The more rigid the interpersonal style, as in someone with psychopathology, the stronger his or her ability to evoke a complementary response. The complementary responses then serve to perpetuate the person's view of others as behaving in a way consistent with the person's self-view (introject). Tasca et al. (2005) offered an example in which a woman, Jane, consistently focused on others' experiences and never self-disclosed (acts of self: walling off and avoiding), due to fears of being seen as stupid, ridiculous, unworthy, or generally imperfect (introject: neglecting self). In fact, Jane became irritated and even more guarded if someone pressed her for personal information. In her interactions with her friend Bob, Jane's relational style subtly compelled Bob to talk about himself while seldom focusing on Jane (complementary acts of others: ignoring and neglecting). Jane in turn concluded that Bob was not interested in her and considered her dull or uninteresting (expectations of others). Jane ultimately internalized this belief which in turn reified a long-established introject in which Jane held a view of herself as stupid, ridiculous, and unworthy.

Thus, important facets of the CRP are the interpersonal style and the complementary responses the individual evokes in others. Moreover, the interplay of others' complementary responses and the corresponding introject provide the therapist with an understanding of the dynamic

processes contributing to and perpetuating the individual's psychological difficulties.

Interpersonal Styles of Individuals with Perfectionism

Although relatively little research has been done on the interpersonal styles of individuals with perfectionism, some trends are emerging in the literature. For example, Hill et al. (1997) assessed the relationship between perfectionism traits and the interpersonal circumplex. They found that for men, all three trait dimensions of perfectionism fell into the hostile–dominant quadrant of the circumplex and were most closely aligned to octants of domineering and vindictiveness. Specifically, men exhibiting self-oriented, other-oriented, and socially prescribed perfectionism all fell into the hostile–dominant quadrant. When asked to identify the nature of their interpersonal problems on the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), men high in self-oriented and socially prescribed perfectionism reported a domineering and vindictive style of relating that involved controlling and manipulating others, suspiciousness, and a lack of empathy.

For women, the interpersonal picture of trait perfectionism was somewhat different, with the three trait dimensions of perfectionism falling into different octants. For example, women scoring high on self-oriented perfectionism fell into the friendly–dominant quadrant (gregarious–extraverted octant), whereas women scoring high on other-oriented and socially prescribed perfectionism fell into the hostile–dominant quadrant. These findings suggest that women may have somewhat different interpersonal styles in relation to perfectionism. With respect to the nature of self-reported interpersonal problems as measured by the IIP, women identified as having elevated levels of self-oriented perfectionism showed a slight propensity toward being overly nurturant, suggesting difficulties with trying to please others and being overly caring, trusting, and permissive in relationships. Women identified as possessing elevated levels of other-oriented perfectionism were found to be similar to their male counterparts, reporting interpersonal problems characterized by a tendency to be controlling, manipulative, and aggressive toward others. Finally, socially prescribed perfectionism in women was associated with the most interpersonal distress of any of the MPS subscales and was seemingly associated with all of the interpersonal problems in the circumplex. Similar patterns of findings were reported in work by Habke and Flynn (2002).

Collectively, these findings suggest that perfectionism trait dimensions are associated with interpersonal behaviors that are likely to have

a markedly negative impact on relationships with others. Although these interpersonal patterns differ somewhat for men and women exhibiting high levels of trait perfectionism, the findings underscore that in addition to targeting cognitive and affective dimensions of a patient's experience, treatment must also address interpersonal patterns—particularly those that are considered hostile, vindictive, and manipulative.

THERAPEUTIC CONSIDERATIONS IN REGARD TO THE FORMULATION AND CRP

We have already discussed the importance of insight and of working toward a thorough consideration of the nature of a patient's complementarity, as it will most certainly have an impact on the therapeutic encounter. There are several other important therapeutic components to consider. These include the role of attachment asynchrony and interpersonal style and the use of transference and countertransference.

The Role of Attachment Asynchrony and Interpersonal Style in Psychotherapy

The role of early attachment asynchrony is central to an understanding not only of the development of perfectionistic behavior (see Chapter 4), but of the development of particular interpersonal styles, particularly the difficulties and dysfunction reported by patients presenting for treatment. Early attachment asynchrony colors a person's experience of relationships in a manner that leads the individual to seek fulfillment of unmet attachment needs continually throughout life (Baldwin, Fehr, Keedian, Seidel, & Thompson; 1993; Hazan & Shaver, 1987, 1994). The expression of these unfulfilled attachment needs becomes manifest in the person's significant relationships, including the relation with the therapist, and is explicated by the triangle of object relations.

We view attachment style as a means of experiencing and relating to others that is designed to meet the individual's need for proximity and felt security. The perfectionistic individual continually seeks to have these needs met and, in so doing, attempts to garner a sense of acceptance, security, and worth, but to no avail. Understanding and explicating each patient's interpersonal style are important in this model of treatment for numerous reasons. First, it is assumed that the interpersonal style of the perfectionistic individual will be expressed in the therapeutic relationship, as it is in other interpersonal situations. Moreover, not only does the interpersonal style inform the therapist of the patient's expected interpersonal behavior; it also provides important information

regarding the formulation, especially as it relates to the triangle of object relations. Furthermore, it provides a marker for the therapist's choice of a behavior style. The therapist can choose to support the person's behavior with a complementary response (as is likely to be the case early in therapy) or to change the person's behavior with a noncomplementary response (a stance that tends to characterize the middle phase of treatment). For example, in the pretreatment assessment, Jane (see above) had considerable difficulty providing details of what brought her to therapy. She admitted to symptoms of disordered eating but often spoke in generalities that made it difficult for the therapist to understand the social, family, or interpersonal context of Jane's difficulties. She complained that others were uninterested in her problems and either became irritated with her or neglected her (acts of others). In fact, her relationship with her adult children had become increasingly distant. Jane also reported low self-regard, feelings of worthlessness, and self-derogation when she compared herself to others (introject). Her voice was monotone and at times whiny, having the effect of evoking feelings of boredom and disinterest in the listener. The therapist was attentive to both the content and the style of Jane's communication and manner of relating. Each dimension of Jane's means of engaging was essential to the task of constructing a sufficiently detailed and textured case formulation that could be used to elaborate the various components of her CRP and the dynamic interplay therein. A CRP not only reflects the acts of self within the interpersonal domain, but also informs the therapist's understanding of others' reactions and behaviors to the patient that ultimately perpetuate the patient's view of self (introject) and of his or her interpersonal world (expectations of others).

Transference and Countertransference as Therapeutic Guides

Exploration of the dynamics characterizing the therapeutic relationship is central to treatment. Transference and countertransference reactions serve as a means of understanding early relational patterns and the associated constellation of emotions, cognitions, behaviors, and coping mechanisms that occur in the here-and-now. Within our theoretical framework, we make the assumption that a perfectionistic patient's basic desires and longings are healthy and should be supported. As noted earlier, they include a desire for meaningful and mutually satisfying relationships, intimate attachment, felt security, and nonaversive connection with self and others. Yet we also hold the view that the patient's means of trying to fulfill these desires and longings are maladaptive because they prevent the patient from fully actualizing these fundamental interpersonal needs.

Kiesler (1996) identified seven interpersonal principles characterizing maladaptive responses: (1) They are extreme and exert an aversive effect on the recipient; (2) they are rigid, resulting in a narrow range of responses across varying interpersonal contexts; (3) they are characterized by "self–other perceptual discrepancies" (i.e., distortions in the individual's perception of his or her impact on others, or interpretation of the overt interpersonal behavior of others); (4) they constitute incongruous or duplicitous communication, which in turn evokes discrepant, mixed, or inconsistent interpersonal messages from others; (5) they reflect vicious, self-defeating cycles, which give rise to interpersonal reactions that reinforce the individual's maladaptive pattern; (6) they have tenuous stability under conditions of stress, giving rise to escalation and the formation of different self-defeating cycles; and (7) they are characterized by high levels of subjective distress. Any of these features of maladjustment can rightfully serve as the arena for therapeutic intervention, with the therapist's decision being guided by the broader context of the patient's difficulties and the therapist's conceptualization of the patient's underlying dynamics.

Interpersonal theory underscores the importance of the therapist's awareness of his or her responses to the patient's interpersonal behavior as a guide to intervention. Kiesler (1996) notes that "the therapist experiences live within the sessions a patient's distinctive interpersonal problems" (p. 230). The patient's rigid, extreme, distorted, and distressed responses have been carefully honed to generate predictable and manageable, albeit unsatisfying, reactions from others; as a result, they offer the clinician privileged access to the patient's most intimate existence. In selecting interventions, a clinician should consider whether his or her verbalizations serve to move the patient to a less extreme stance (emotionally, cognitively, or behaviorally), offer an alternative means of responding to interpersonal tension, gently challenge perceptual distortions, help the patient become more congruent in his or her communication, disrupt maladaptive cycles, build resilience, or lessen distress.

Overall, clinical work with a perfectionistic individual represents an attempt to understand and articulate the unique "story" giving rise to the need for and development of perfectionism, and to provide an understanding of the role that perfectionism currently plays in attempting to create a sense of interpersonal security and belonging in the individual's life. Implied in this approach is the assumption that the individual is not inherently flawed or responsible for the lack of felt security, for perfectionism as a means of attaining felt security is seldom consciously chosen. This detailed exploration of the individual, through psychotherapy, is guided by a spirit of "shared discovery" rather than evaluation or judgment of the patient by the clinician or, indeed, by the patient himself

or herself. In our experience, many patients struggle with this stance of collaboration and genuine curiosity, in light of a lifetime of feeling evaluated by others and of suffering from their own evaluations of the self and/or others. A central objective of treatment involves aiding the individual in trying to move toward accepting the self and establishing mutually satisfying relationships with others.

Once the formulation is understood, the therapist begins to work toward encouraging the individual to engage in behaviors that are more in line with his or her wishes and needs, despite fear and apprehension. Engaging in unfamiliar, yet more adaptive, behaviors allows for the start of a redefinition of the self in this treatment context. In psychodynamic terms, internalization of new ways of relating with others, including the therapist, allows patients to alter their core sense of self. This, in turn, affects a shift in typical or maladaptive patterns of defending and relating (i.e., perfectionism and perfectionistic self-presentation) since these are no longer required to achieve felt security and social connection.

CONCLUSION

In this chapter, we have covered a lot of theoretical ground in the formulation and treatment of perfectionistic behavior. Perfectionism is viewed as a learned response to aversive affective states arising from unfulfilled relational and attachment needs. It is important to determine the idiosyncratic dynamics of how and why the perfectionism evolved and to learn how it currently functions for a particular patient. In the next chapter, we discuss how we conduct the assessment and development of the formulation for each patient, using both psychometric testing and interviews to assess the content and process components of the individual's perfectionism and problems.

CHAPTER 7

Psychodiagnostic Assessment of Perfectionism

In the treatment of perfectionism, the psychodiagnostic assessment consists of the initial clinical interview and psychometric assessment. Completing these serves two general purposes. First, both provide important information regarding the level, breadth, and particular manifestations of an individual's perfectionistic behavior, including clinical dysfunction, symptoms, vulnerabilities, and other relevant personality and interpersonal characteristics. Second, the interview includes emphases on process, the history of past relationships, responses to trial interpretations, and the nature of current relationships. Overall, we are interested in determining the antecedents, consequences, and role of perfectionism in the patient's life by developing a picture of the nature of the person's current perfectionism, clinical profile, personality structure and function, and past and current relational worlds. This will allow us to establish the beginnings of the clinical formulation and CRP (see Chapter 6), which help in understanding the way perfectionism is used in interpersonal contexts to meet relational goals. To this end, we use this information in the context of the triangles of adaptation and object relations, as well as the categories of actions or the psychodynamic patterns as espoused by Strupp and Binder (1984; again, see Chapter 6). In the sections that follow, we discuss several process considerations relevant to the assessment of perfectionistic individuals, followed by discussions of the clinical interview and psychometric assessment.

CONSIDERATIONS IN THE ASSESSMENT OF PERFECTIONISTIC INDIVIDUALS

Perfectionistic individuals are apt to seek consultation from a mental health professional for several reasons. They may seek the services of a therapist in response to marked subjective distress brought on by a significant crisis or perceived failure. For example, for self-oriented and socially prescribed perfectionists, the stressful occurrence often involves expected or experienced rejection, failure to perform or accomplish something, or an expectation that a new role or circumstance is too overwhelming. Other-oriented perfectionists are likely to seek consultation because of mounting frustration and anger in response to intolerable failures by others. Still other perfectionistic individuals will seek help because they are compelled by family or concerned others, or because other treatments have not been successful. In many cases, the failure and distress that the perfectionists experience is compounded by the reality of having to acknowledge the need for assistance from a mental health professional.

An important determination in the assessment process is the extent to which a person has volitionally sought treatment and is motivated to do the work needed in order to improve. A related issue is whether the person is truly motivated to address the perfectionism and the underlying reasons that have led to mounting distress and the need for treatment. The desire to feel better is not always accompanied by a commitment to acknowledge and address the core issues that are driving the individual's difficulties. Indeed, many perfectionists are driven by their fears. One of the most common fears, especially among self-oriented perfectionists, is that their situation will deteriorate if they are required to relinquish their perfectionism. Others fear that looking too deeply into their histories and relational patterns will bring disaster. Moreover, significant concerns regarding general fears of psychotherapy and psychotherapists can compel an individual to terminate early (Hewitt, Dang, et al., 2016).

Although seeking assistance from a mental health professional can evoke feelings of shame, embarrassment, or personal failure for many people, such responses tend to be accentuated for individuals possessing excessive levels of perfectionism. These feelings can forestall attempts to seek the needed help. Furthermore, the awareness of the need for mental health treatment often further erodes a perfectionist's self-esteem (Ashby & Rice, 2002; Koivula, Hassmén, & Fallby, 2002; Hewitt, Dang, et al., 2016). Not surprisingly, this can contribute to ambivalence toward the clinician and toward the very idea of seeking consultation (Hewitt et al., 2008). On the one hand, the individual attends the assessment with a desire for relief. On the other hand, anger toward the self in response

to perceived failure may be projected onto the clinician and all that the clinician is believed to be (i.e., more capable, successful, and in control). Anyone who has ever stubbed a toe recognizes that pain often triggers anger, and that such anger is often paired with blame, directed either externally or toward the self. Such is the plight of the perfectionist suffering emotional pain, particularly at the point when he or she has elected to seek assistance from a mental health professional.

The trepidation and anxiety that the perfectionistic individual experiences can be exacerbated in particular clinical situations, particularly during the initial encounter with the clinician and office staff. It has been our experience that perfectionistic people are acutely uncomfortable in clinicians' waiting rooms. Such individuals' subjective experience is that they are announcing to everyone there that they are having personal difficulties. Therefore, perfectionists often prefer not to be seen in or associated with a clinical office in any way.

As stated above, a decision ultimately to seek consultation or assistance does not preclude ambivalence. A perfectionist may equate a request for assistance with perceived failure, whether the failure is self-defined or stems from criticism by others. The associated distress is resolved most efficiently, albeit temporarily, if the person can conclude that the clinician is ill equipped to help. In fact, as described in our explication of the PSDM in Chapters 4 and 5, compromised attachment experiences predispose perfectionistic individuals to expect that needed help and support will not be forthcoming. For self-oriented and socially prescribed perfectionists, this expectation is based on the belief that one is not worthy of care, whereas other-oriented perfectionists hold the view that others are inadequate and thus incapable of providing needed support. Thus, many perfectionistic individuals enter the assessment process with a stance of cynicism and the expectation that nothing will be of benefit. To elaborate further, we have noted in previous research that socially prescribed perfectionism and (to a lesser extent) self-oriented perfectionism are associated with a heightened level of interpersonal sensitivity (see Hewitt & Flett, 1991b). Additional elements for people high in socially prescribed perfectionism may include a stance of pessimism, and cynical, negative expectations about the future, particularly within an interpersonal or relational context. Drawing on Bowlby's attachment theory (Bowlby, 1969/1971, 1973, 1980) and Baldwin's writings on relational schemas (e.g., Baldwin, 1992), we (Hewitt & Flett, 2002) have suggested that socially prescribed perfectionists have developed a self-schema about negative future events. This schema involves expectations about becoming the target of criticism, mistreatment, and unfair experiences. In both the assessment and treatment contexts, these individuals tend to be hypersensitive to evaluative

cues and react strongly to any signs that are in keeping with their cynical expectations. Thus, care must be taken with such patients throughout, particularly in providing comprehensive assessment feedback to them. It is important to use language that is neutral and makes it clear that the formulation is based on a patient's description of self. This is essential, regardless of the specific nature of the individual's perfectionism or perfectionistic self-presentation.

FACTORS RELEVANT TO THE CLINICAL FORMULATION

Our approach to assessment includes several components that are essential to constructing a working case formulation that can ultimately guide treatment. These components involve gathering not only information specific to the two triangles, but other relevant clinical material. First, we need to determine the nature of the individual's current functioning, including symptom presentation, level of adjustment, degree/nature of distress, available supports (and the individual's willingness to access them), and general life satisfaction. We then need to identify the patient's stressors or crises, coupled with an exploration of his or her temperament. We next focus more specifically on understanding the nature of the individual's perfectionism, its consequences, and its developmental antecedents, including early and current relationships. The final component of assessment involves presenting the findings, clinical formulation, and CRP to the patient, and working collaboratively to define and agree upon treatment goals.

We begin hypothesizing about components of the clinical formulation and CRP in the initial phase of the clinical experience and then continue to refine the formulation throughout the assessment and treatment phases. For example, we pay attention to the nature of initial telephone conversations; brief interactions in waiting rooms; conversations prior to and following sessions; the initial interview; the patient's approach to completion of psychometric measures; as well as his or her response to feedback sessions about the results of testing; and, of course, the initiation of psychotherapy and the course of subsequent sessions. A clinician must always have his or her "clinical hat" on, and all information should be considered potentially relevant. The goals of the initial phase include reaching a preliminary understanding of the person's perfectionism and difficulties, providing an initial working formulation, and beginning to work collaboratively to fill out the picture of the perfectionistic individual's story.

An essential aspect of developing the initial formulation involves placing the individual's perfectionistic behavior within a broader

interpersonal context. This is best accomplished not only by focusing upon process issues within patient–clinician interactions but also by drawing information directly from partners, family members, or other sources if possible. When such data cannot be accessed directly, the clinician can make use of interpersonally based measures that possess sound psychometric properties. For instance, the information obtained from significant others must be weighed in terms of the broader family context. Patients with socially prescribed perfectionism who emphasize that they must deal with unfair demands to be perfect may or may not have significant others who actively demand perfection from them. That is, at least to some extent, their socially prescribed perfectionism may be veridical. These people need to be distinguished from those people with more generalized forms of socially prescribed perfectionism, who are experiencing broader pressures and life role demands that are not attributable to a particular person or set of people.

THE INITIAL INTERVIEW

Establishing a Working Alliance and Therapist Stance

The clinical interview is not a simple process of gathering demographic information, assessing symptom characteristics, and determining a diagnosis. The clinical interview also involves assessing process and interpersonal style variables; evaluating verbal, nonverbal, and paralinguistic behaviors; and, perhaps most importantly, establishing a safe and nonjudgmental therapeutic environment. Hilsenroth and Cromer (2007) underscore the importance of affective attunement, empathy, and the use of interventions aimed at clarifying sources of distress as essential vehicles for establishing and solidifying the working alliance. One means of achieving this at the outset of the assessment is by inviting the patient to "tell your story" with minimal intrusion by the clinician. Although diagnostic interviews are an efficient and reliable means of establishing a diagnosis, their structure is not conducive to forging collaboration and building a relationship, nor is it at all conducive to gathering other relevant clinical data. Diagnostic interviews are most consistent with the medical model, in which an expert clinician identifies and works to resolve a patient's presenting complaints. In relational terms, this approach can be understood as subject acting on object. In contrast, a dynamic-relational approach to assessment is built on an effort to understand the patient's subjective experience (Reik, 1948). In describing the therapeutic encounter, Reik (1948) emphasized that the clinician "has to learn how one mind speaks to another beyond words and in silence. He must learn to listen 'with the third ear.'[1] It is not true that you have

to shout to make yourself understood. When you wish to be heard, you whisper" (p. 144).

Reik was one of the first to emphasize the intersubjective nature of the therapeutic encounter, in which a clinician becomes immersed in a patient's inner experience, and uses his or her unconscious mind to uncover and understand the patient's unconscious wishes, fantasies, and conflicts. This form of "depth listening" goes a long way in creating a climate of respect, trust, and safety—ingredients essential to doing the invariably distressing and risky work of self-exploration. A patient's willingness to enter such shadow-filled and unpredictable terrain is made tolerable if he or she is accompanied not merely by a skilled diagnostician, but by a caring and attentive guide. Reik (1948) suggested, "When you want to rescue a person from drowning, you have to jump into the water, into *his* water. The first approach to the conjecture of the concealed meaning should be from the emotional side" (p. 310).

Inviting and deepening the patient's affective experience constitute an essential means of expanding the clinician's understanding of the individual, the patient's understanding of self, and the development of a working alliance. The psychodynamically oriented clinician not only invites the expression of affect, but welcomes and encourages the expression of emotions that may have been seen as unacceptable or undesirable, or otherwise viewed in negative terms. In their review of the literature, Hilsenroth and Cromer (2007) identify several evidence-based interventions and therapist attitudes that have been found to have a positive influence on the therapeutic alliance during assessment and initial interview. The authors classify these into three broad categories. The first is the "frame" established by the clinician. Within this category, Hilsenroth and Cromer include the clinician's ability to conduct longer, more involved, depth-oriented interviews; to adopt a collaborative stance toward the patient; to use a balanced combination of emotional and cognitive content in speaking; and to use clear, concrete, experience-near language that serves to capture the patient's subjective state. The second set of interventions is labeled "focus." Here Hilsenroth and Cromer (2007) include the following interventions: allowing the patient to initiate discussion of salient issues; thoroughly exploring these issues; identifying and clarifying sources of distress; identifying CRPs that serve to perpetuate the patient's difficulties; facilitating the expression of affect and the exploration of uncomfortable feelings; attending to in-session dynamics that play out between patient and therapist; and maintaining an active focus on these issues. Finally, they include "feedback" as an intervention whereby the patient and clinician review and explore the information gleaned from the assessment, in an effort to understand the meaning of the assessment findings and to set goals for treatment.

Perfectionists may also experience a complex blend of emotions arising from a conviction that their impossibly high expectations are bound to result in significant benefit. Numerous case illustrations describe perfectionists who are driven by the firm belief that their accomplishments and the associated recognition of their achievements will be assured by striving for perfection. At the same time, they harbor the fear that unless they constantly strive for perfection, they will become (or expose) the undesirable persons that they work so hard to conceal. Indeed, a recent study revealed that despite recognizing that they need clinical assistance, the majority of perfectionists in treatment did not want to change their standards or their general approach to life, for fear of the consequences that would follow from relinquishing their perfectionism (see Egan et al., 2013). The letter from Karen Horney's patient, excerpted in the "Core Themes" section of Chapter 1, illustrates this fear. In light of such intense fear, it may be some time before perfectionistic individuals become open to shifting their requirement for perfection; treatment is thus likely to be protracted.

Attunement to these affective states serves as an essential building block in the clinician's effort to establish an effective working alliance. Safran and Muran (2000) point out that, regardless of a clinician's theoretical orientation, a plethora of evidence has shown the quality of the therapeutic alliance to be the most robust predictor of treatment outcome. Hilsenroth and Cromer (2007) emphasize that this finding is as relevant to the assessment consultation and initial interview as it is to ongoing psychotherapy. A substantial body of work has demonstrated that failure to establish a positive working alliance in the early stages of assessment and treatment is associated with premature termination or poor outcome (Henry, Schacht, & Strupp, 1986, 1990; Binder & Strupp, 1997).

A significant barrier to a clinician's efforts to establish a state of affective attunement can be a patient's need to appear perfect. We (Hewitt, Flett, Sherry, et al., 2003) have suggested that individuals committed to appearing perfect, either through perfectionistic self-promotion or through concealing imperfection, can effectively evoke interpersonal distance in relational encounters, including encounters with clinicians. In the case of perfectionistic self-promotion, distance may be created when the clinician experiences the individual as self-centered or narcissistic—an interpersonal stance that can easily undermine the therapist's capacity to express empathy. An individual invested in concealing signs of imperfection may be experienced as intimidating and may evoke feelings of insecurity and doubt in others, including the therapist. The therapist may feel that he or she is not up to the task of helping the patient, either because the patient's difficulties seem insurmountable or because

of the therapist's diminished confidence in his or her own ability. As for a person who is reluctant to disclose imperfection, a therapist may be left feeling puzzled as to the person's reasons for seeking consultation. The interpersonal exchange may feel shallow and lacking in substance, and the clinician may feel unneeded in the person's life.

A socially prescribed perfectionist who has engaged in perfectionistic self-presentation and has tried to project an image of flawlessness will very closely resemble the patients described so eloquently by Carl Rogers in his 1961 book *On Becoming a Person*. Rogers provided an extensive description of individuals who grapple with feelings of inauthenticity, having lived their lives according to "false selves" that are focused on meeting the expectations of other. These people have spent most of their lives hiding their true selves and desires behind masks that cover their flaws and inadequacies. Of course, Rogers emphasized the importance of establishing a therapeutic setting characterized by unconditional acceptance, so that such a patient would feel free to reveal and explore the true self. These themes resonate with clinicians when they encounter perfectionists who are hiding behind fronts.

Developmental Issues

Temperament

McWilliams (1999) suggests that a comprehensive dynamic formulation incorporates an understanding of the individual's temperament and other fixed attributes, current stressors, and the nature of relevant developmental issues activated by the current stressors. Kagan (1994) defines temperament as "a changing but coherent profile of behavior, affect, and physiology, under some genetic control, that emerges in early childhood" (p. 49). Assessment of temperament begins with a consideration of the individual's predominant affective disposition. This extends beyond identifying the person's pervasive mood at the time of the assessment. Rather, the clinician aims to determine whether the individual exhibits a dispositional tendency to be fearful, dysphoric, alexithymic, hostile, contemptuous, guilt-ridden, shame-filled, or embarrassed. With the exception of alexithymia (see Taylor, 2000), these affective states constitute a subset of Ekman's (1999) basic emotions relevant to the assessment process. Kagan (1994) asserts that temperament is also expressed in the degree to which one is predominantly inhibited or uninhibited, or what others have termed "introversion verses extraversion" (e.g., Eysenck, 1971). Other dimensions of temperament include the ability to modulate arousal, or what is otherwise termed "affect regulation" (Bradley, 2003). Bradley notes that affect regulation is governed by the individual's

cognitive schemas, attributions, and available coping responses, all of which interact with the person's self-evaluation and degree of insight. Singly and collectively, these dimensions of temperament serve to shape the individual's experience of and response to interpersonal interactions.

Attachment Style

Another crucial aim of the interview is to develop a preliminary understanding of the individual's attachment style and attachment behaviors, including the unique ways in which these variables manifest themselves in the interpersonal field. This is accomplished by reviewing the patient's early attachment history and by identifying idiosyncratic features of the patient's attachment needs, unique sources of anxiety, and predominant affective and motivational dimensions of the need to belong. Although the clinician will develop an increasingly complex and refined understanding of these dimensions over the course of treatment, success is built upon the capacity to develop a preliminary case formulation that provides a plausible and coherent understanding of how and why the patient's perfectionism developed, ways in which it interferes with the attainment of connectedness and worth, and the manner in which it maintains distress and maladjustment.

Other role-related aspects of an individual's developmental experience need to be unearthed and examined. These shape the person's response to current events and stressors, relationship with self and others, and ultimately the nature of his or her perfectionism. For example, a person who assumes a pseudoparental role during childhood, particularly at a point in development when children are naturally inclined to be egocentric, is apt to develop an exaggerated sense of responsibility. This may include feeling responsible for ensuring that younger siblings are well behaved and cared for, the home is orderly and neat, the parents are shielded from daily stresses, and so on. Such a family history serves as a foundation for socially prescribed perfectionism, and for self-oriented perfectionism in some women (see Habke & Flynn, 2002). Self-oriented perfectionism is often associated with a family or social history in which the individual has been subjected to unrealistic expectations from parental figures or other significant adults, such as teachers, coaches, or religious leaders. An other-oriented perfectionist may have had a family environment characterized by high levels of parental conflict and emotional tension. Parents may have been overtly critical of each other or of their in-laws. Alternatively, one parent may have been highly vocal, dominant and outwardly hostile, while the seemingly submissive parent may have been more silent, passive–aggressive, and self-blaming.

Affect, Emotion, and Related Constructs

In the initial stages of assessment, the predominant affective state of most perfectionistic persons is a mix of shame, anxiety, anger, and dysphoria. For self-oriented perfectionists, shame and sadness are most prominent, although anger toward the self often lurks below the surface. In contrast, other-oriented perfectionists are generally most connected to feelings of anger driven by the perceived failures of others. Although shame and sadness may be part of their experience, these emotions are less accessible; indeed, they are often out of conscious awareness. Shame, demoralization, and marked self-blame are the hallmarks of socially prescribed perfectionists. Here, the failure is perceived as one of the self, and this perception may be manifested as “I am bad” or “I am wrong.” To the clinician, this can be easily misunderstood as “I have made a mistake.” For individuals struggling with high levels of socially prescribed perfectionism, the subjective experience is more akin to “I am a mistake, everything about me is a mistake, and everything I do is a mistake.”

One source of major distress is the fear of rejection, ridicule, or some other form of punishment. This fear can be traced back to the negative interpersonal expectancies that so often accompany perfectionism. Perfectionism can be viewed as a means of guarding against anticipated rejection in one of two ways. In the first scenario, the individual believes this: “If I don’t do things perfectly (or appear to do things perfectly), I will fail and be punished and rejected for my failure; therefore, I must keep at a thing until I get it perfect.” The associated affect is fear or anxiety. Alternatively, in some cases, perfectionism may serve as a means of guarding against success or unacceptable strivings. In this scenario, there is a desire to ensure that one does not exceed the accomplishments of an intimate other (such as a parent, spouse/partner, colleague, or close friend), as this can precipitate a negative evaluation by the other. The operative dynamic in these instances is that perfectionism ensures that a task or goal will always fall short of expectations and fail to come to fruition because one’s own efforts are never good enough. In this way, the intimate other remains the more accomplished. For the perfectionist, the unspoken belief may be, for example, “If I surpass my father, he will feel diminished by me and will then discard me.” The nagging yet unacknowledged implication stemming from this conclusion is that the perfectionist had an inadequate father, a father who did not measure up; this awareness can evoke a negative self-attribution by association (i.e., “If my father was an inadequate parent, what does that say about me?”).

For most perfectionists, the process of assessment itself is highly stressful and is apt to evoke strong emotional responses (see Hewitt et al., 2008). Keeping the triangle of adaptation (see Chapter 6) in mind

helps the clinician to stay attuned to the perfectionist's predominant affective state. Two levels of emotional experience are often in play. The first involves the patient's description of what he or she has been or is feeling. Most often, this is an overrehearsed narrative built upon self-observation, the individual's internal dialogue, and perhaps feedback derived from the reactions or observations of significant others. The second involves a deeper layer of emotional experience that often is not evident immediately and may operate outside the patient's conscious awareness. For example, anger may often be the first layer of emotion that a perfectionistic individual experiences, but after a clinician probes for emotional content beneath the anger, other emotions (such as shame, despair, aloneness, or fear) emerge. Accessing this layer of affect is accomplished by attending to the remaining vertices of the triangle of adaptation. Specifically, the clinician is tasked with determining the unique aspects of the patient's predominant defenses and attachment needs and with extrapolating from these dimensions of the patient's experience in order to uncover hidden layers of unclaimed and unexpressed affect.

Individuals with perfectionism generally do not experience satisfaction even when they are very accomplished. This lack of satisfaction is an important point to underscore and maintain as a clinical focus throughout the process of treatment. There is a natural tendency to focus primarily on the negative emotions that perfectionists experience (although do not always express), but they have also have a paucity of positive emotional experiences—a lack that can represent significant clinical levels of anhedonia. Research has not fully addressed the reasons for this paucity of positive emotions, but it is likely to be a reflection of the plight that faces perfectionists if their lives are viewed as a process. That is, even when they do have a significant accomplishment, perfectionists now have added pressure to prove themselves again. Other perfectionists have lived their lives according to an "if–then" contingency (e.g., "If I am perfect, others will accept me"), but they soon discover that when "perfection" is attained, acceptance does not necessarily follow. What does often follow is a sense of not being perfect enough.

Other Important Considerations

Early significant experiences or traumas within the family are important elements in a thorough developmental history. Questions can focus on early illness; prolonged separation from attachment figures; the experience of entering school and the associated parental responses; significant stressors in the family during the patient's childhood; and the patient's first experience of the death of a significant figure. These questions allow

the clinician to construct a coherent narrative of the patient's unfulfilled attachment and interpersonal needs, as well as strengths that can be drawn upon as treatment progresses. Another key consideration is whether the individual has experienced or is currently experiencing emotional, physical, or sexual maltreatment or profound neglect. Actuarially based measures of personality functioning complement this line of inquiry and provide an efficient means of identifying core defenses, predominant coping strategies, and interpersonal patterns (see the next section of this chapter).

It is essential that assessment be undertaken with a full appreciation of these contextual variables. If not, the clinician can easily become drawn into and react to the patient's maladaptive interpersonal patterns. Recall that according to interpersonal theory, behavior on the affiliation axis of the circumplex evokes symmetrical responses. Thus, hostility "pulls for" hostility, and friendliness "pulls for" friendliness. Failure to be fully cognizant of the interpersonal context and the associated intrapersonal experiences leading to the perfectionist's decision to seek mental health services can derail efforts to establish a healthy therapeutic alliance at the outset of the assessment. Henry and Strupp (1994) provided empirical evidence demonstrating that therapeutic relationships characterized by conflict or the use of pejorative language by the therapist, particularly in the first three sessions, were associated with negative outcomes. These investigators further observed that clinicians had a great deal of difficulty shifting these negatively valenced interactions into collaborative working relationships (Binder & Strupp, 1997; Henry & Strupp, 1994). These findings underscore that the assessment process involves more than compiling demographic, psychometric, formulaic, and diagnostic data. It is imperative that the clinician be continually attentive to the emotional tone of the early encounter(s). This requires vigilance in monitoring the patient's reaction to the clinician, along with the patient's subjective response to the experience of undergoing an assessment.

An understanding of the patient's available supports and relationships proceeds either through direct inquiry or through constructing a genogram that typically includes at least three generations, starting with grandparents, parents, and the patient and siblings (including partners and offspring). It is often illuminating to ask the patient whether any of these individuals exhibited any perfectionistic behavior. In addition to identifying the central players in the patient's life, it is useful to inquire about the strength of the emotional bonds connecting them and to represent these bonds schematically on the genogram. A separate but similar schematic representation can be used to identify the patient's closest friends and colleagues. In our experience, it is necessary to ask explicitly

about the patient's experience in seeking the support of family members and friends. We have found that although patients easily identify people who are available and willing to offer support, they may not necessarily be open to accessing such support. Finally, we explore the patient's overall life satisfaction, including satisfaction with intimate relationships, work, play, and self.

ASSESSING LEVELS AND MANIFESTATIONS OF PERFECTIONISM

An important element of the assessment process is determining the magnitude and degree of perfectionistic behavior, along with the specific and unique ways in which the individual patient's perfectionism is expressed and manifested. For instance, we need to address questions such as these: What kinds of perfectionistic traits or expressions of perfection does this person have? What are the particular configurations of the kinds of perfectionism the person exhibits? How extreme is the level of perfectionism? What purpose does the perfectionistic behavior serve?

The careful and comprehensive assessment of perfectionism can provide clues and hypotheses to key themes, components of the formulation, issues to be addressed as part of the treatment process, and potential breaches in the therapy alliance. Moreover, there is good evidence suggesting that individuals with elevations on many of these components represent patients who prove to be challenging in treatment, such that all traits and self-presentational styles are associated with hostile–dominant interpersonal behavior (Habke & Flynn, 2002; Hill et al., 1997), experience increased evaluative concerns, negative judgments of therapists, and anxiety in clinical settings (Hewitt et al., 2008).

It is also important to determine the individual's particular constellation of perfectionism components. For example, although a person may have one specific trait or self-presentational facet that is elevated more commonly, the person will have elevations in several perfectionism components. As each component has been shown empirically to be differentially associated with behaviors and outcomes, it suggests that any one individual can exhibit a variety of associated difficulties arising from the various aspects of perfectionistic behavior. We (Hewitt & Flett, 2004) have outlined the issues that can arise when, upon assessment, individuals have high levels of more than one trait dimension of perfectionism. We have argued that the various combinations can produce differences in how the perfectionistic behavior produces difficulties for the individual and how perfectionism is manifested in the person's life. For example, we have suggested that individuals with excessive levels of self-oriented and socially prescribed perfectionism can be particularly

prone to severe psychological difficulties, including unipolar depression, anorexia nervosa, and a sense of alienation and disconnection that can lead to suicidal behavior. Failures are understood as not only letting the self down but also letting everyone else down. Similarly, those with elevated levels on other-oriented and socially prescribed perfectionism may vacillate between desperately needing others and simultaneously pushing others away. Both of these dimensions have been associated with either borderline or narcissistic personality pathology (see Chen, Hewitt, & Flett, 2015; Hewitt, Flett, & Turnbull-Donovan, 1992), and individuals with excessive levels of both may experience identity disturbance, relationship problems, and suicidal tendencies.

Based on the CMPB, we have developed the following measures of the components of perfectionistic behavior for adults and for children and adolescents:

1. The Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991a, 2004)
2. The Child–Adolescent Perfectionism Scale (CAPS; Flett et al., 1997)
3. The Perfectionistic Self-Presentation Scale (PSPS; Hewitt, Flett, Besser, et al., 2003)
4. The Perfectionistic Self-Presentation Scale, Junior Form (PSPS-Jr; Hewitt et al., 2011)
5. The Perfectionism Cognitions Inventory (PCI; Flett et al., 1998)
6. The Perfectionism Rating Scales (Clinician/Significant Other Form; Hewitt & Flett, 2003)
7. The Interview for Perfectionistic Behavior (IPB; Hewitt, Flett, Flynn, & Nielsen, 1995)
8. The Perfectionism Sentence Completion Form (Hewitt, Mikail, & Flett, 2016)
9. Informant Ratings of Perfectionistic Behavior (Hewitt & Flett, 1991a)

We do not go into detail here about the development and validation of all these instruments or other measures of perfectionism that we use (e.g., the FMPS; Frost et al., 1990, 1991), as the measures have been discussed extensively in other works (e.g., Enns & Cox, 2002; Flett & Hewitt, 2015; Flett et al., 1998; Hewitt & Flett, 1991a, 2004; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991; Hewitt, Flett, Sherry, et al., 2003). Because the interview measure is new and unpublished, we discuss it a bit more than the others. We emphasize here, however, that we paid particular attention in creating the measures to using state-of-the-art scale development techniques and that we designed all of the measures

for use in clinical settings as well as other settings. When psychometric instruments are used in clinical work, those instruments have to have acceptable levels of reliability and validity of interpretation, and we have conducted considerable research addressing and supporting these issues with our measures (see Flett et al., 1998; Hewitt & Flett, 1991a, 2004; Hewitt et al., 1991; Hewitt, Flett, Besser, et al., 2003; Hewitt et al., 2008). We have focused our measures on the assessment of components as continuous, dimensional aspects of perfectionism, in keeping with the results of empirical tests of perfectionism as a dimensional construct versus an all-or-none personality type (see Broman-Fulks, Hill, & Green, 2008). These measures are intended to be used not only for pretreatment assessment but also throughout the course of treatment in order to provide ongoing monitoring of progress consistent with evidence-based practice (e.g., Hunsley, 2007).

Due to the complexity of the perfectionism construct, it is important to take account of not only perfectionistic traits, but also the behavioral, stylistic relational expressions of perfectionism and the internal manifestations of perfectionism (i.e., their expressions in the patient's inner dialogue). Finally, multiple methods of assessment are also frequently employed in the form of informant ratings, interviews, or projective methods.

We now briefly describe our measures and provide references that support the utility of the instruments. These measures, with scoring instructions and norms, are available online (see the box at the end of the table of contents).

Assessing Perfectionism Traits

As outlined in Chapter 2, the CMPB indicates that a major component of perfectionism involves dispositional components that demonstrate temporal and cross-situational consistency. These trait components of perfectionism energize and drive the preoccupation with and requirement for perfection and can be identified in children, adolescents, and adults (see Flett et al., 1997; Hewitt & Flett, 2004). There is a great deal of research using these traits, and this research illustrates their clinical relevance as concomitants and vulnerability factors in psychopathology and other forms of maladjustment (see Bastiani et al., 1995; Cockell et al., 2002; Flett & Hewitt, 2002; Flett, Hewitt, & Heisel, 2014; Hewitt & Flett, 1991b, 1993; Hewitt et al., 1996; O'Connor, 2007; Shafran & Mansell, 2001; see Chapter 3) and focuses for treatment (e.g., Ashbaugh et al., 2007; Enns, Cox, & Pidlubny, 2002; Hewitt, Mikail, et al., 2015). We have provided various descriptions of individuals with excessive levels of these dimensions throughout this book; however, case descriptions

with elevated traits and combinations of traits are available in Hewitt and Flett (2004).

Hewitt and Flett Multidimensional Perfectionism Scale

The Hewitt and Flett MPS (Hewitt & Flett, 1991a, 2004; Hewitt et al., 1991), with 45 items, assesses the three trait dimensions of perfectionism described in our model.[2] Each trait is thought to reflect a drive to perfect the self through different means. The self-oriented perfectionism subscale measures dimensional levels of the self-imposed requirement of perfection, whereas the other-oriented perfectionism subscale assesses the dimensional levels of requiring others' perfection. Finally, the socially prescribed perfectionism subscale measures the dimensional levels of others' perceived requirement of perfection for the self. For clinical use, the MPS and technical manual (Hewitt & Flett, 2004) are available from Multi-Health Systems, Inc. (Toronto, Ontario, Canada, and North Tonawanda, New York, United States).

Specific components of traits not directly assessed in our MPS are contained in the Frost et al. (1990, 1991) FMPS. For example, components of self-oriented perfectionism in the FMPS include measures of concern over mistakes and doubts about actions. Specific components of socially prescribed perfectionism, parental expectations, and parental criticism are also included in the FMPS, and we often use these components in our assessments. This measure has been shown to have reliability and validity of interpretations in clinical samples (Cox & Enns, 2002; Flett & Hewitt, 2015). The items for this measure are available in Frost et al. (1991).

Child–Adolescent Perfectionism Scale

The CAPS (Flett et al., 1997) assesses two trait dimensions in children between the ages of 7 and 18. As we have suggested in our model, and as others have suggested many times in the literature, perfectionism can develop early in childhood; research using the CAPS supports this notion and demonstrates that the traits are associated with negative outcomes (Boergers et al., 1998; Donaldson et al., 2000; Hewitt et al., 1997, 2002; O'Connor, Rasmussen, Miles, & Hawton, 2009). Two subscales are included in the CAPS: the self-oriented perfectionism and socially prescribed perfectionism subscales. Several studies have attested to the reliability and validity of score interpretations (e.g., Flett et al., 1997; O'Connor et al., 2009). Although other-oriented perfectionism was not included in the original CAPS, we are in the process of establishing statistically appropriate items reflecting other-oriented perfectionism for this measure.

Assessing Perfectionistic Self-Presentation

In Chapter 2, we have stated that perfectionists differ among themselves not only in their levels of trait perfectionism on such dimensions as self-oriented, other-oriented, and socially prescribed perfectionism (Hewitt & Flett, 1991a), but also in the strength of their needs to appear perfect to other people and not to display or disclose imperfections to others. Indeed, these needs to appear perfect or not to appear imperfect may be the most salient concerns of certain perfectionists. These people are focused primarily on a form of impression management that involves self-presentational attempts to create an image of flawlessness in public situations. This is in keeping with evidence suggesting that perfectionism and the ideal self are closely linked (Hewitt & Genest, 1990) and that certain individuals have developed an ideal self that keeps the public constantly in mind (see Nasby, 1997).

We have indicated that the facets of perfectionistic self-presentation may affect psychopathology indirectly (see Hewitt, Flett, Sherry, et al., 2003; Hewitt et al., 2008). As such, the assessment of perfectionistic self-presentational styles may be extremely important because these components can interfere with treatment process and outcome. We have argued previously that these facets can affect how people cope with perfectionism and attendant problems and whether they can seek and benefit from treatment (Hewitt, Dang, et al., 2016). We (Hewitt et al., 2008) showed in a large sample of psychiatric patients that individuals with excessive levels of perfectionistic self-presentation were more anxious and distressed during an initial clinical interview, felt more threatened by clinicians, and had more difficulty establishing a therapeutic alliance than those low on perfectionistic self-presentation. Moreover, we have also shown that these perfectionistic self-presentational styles are associated with increased fears of psychotherapy and with dysfunctional and negative attitudes toward seeking professional help (see Hewitt, Dang, et al., 2016). Thus we believe it is crucial for clinicians to assess levels of perfectionistic self-presentation in order to predict potential therapeutic alliance disruptions or difficulties; to determine the potential for early termination or dropout; and to aid the patient and therapist in developing an appropriate relationship that will ultimately be of therapeutic benefit to the patient.

Perfectionistic Self-Presentation Scale

The PSPS (Hewitt, Flett, Sherry, et al., 2003) is a 27-item measure of the three facets of perfectionistic self-presentation. The subscales for these facets are perfectionistic self-promotion, which assesses overt attempts to reveal one's purported "perfection"; nondisplay of imperfection, which

taps the concealment of overt demonstrations of any imperfect behaviors; and nondisclosure of imperfection, which assesses the concealment of verbal disclosures of any imperfections. The facets thus represent both promotional and concealing components of perfectionistic self-presentation. The interpersonal expression of perfectionism seems particularly germane to the entire clinical process of seeking help, accessing help, compliance, and staying the course in treatment (see Hewitt, Dang, et al., 2016). Obtaining specific information regarding these styles of interpersonal behavior can become the focus of process comments and therapeutic work that can help to forestall early termination or noncompliance.

Perfectionistic Self-Presentation Scale, Junior Form

The PSPS-Jr (Hewitt et al., 2011) is based on the same conceptualization as the adult version, with the same three subscales for facets. Developed for children between the ages of 8 and 17, this is an 18-item measure. The development of the scale, and the establishment of reliability and validity of score interpretations, are described in Hewitt et al. (2011).

Perfectionism Cognitions Inventory

The CMPB (see Chapter 2) indicates that another key element in the assessment of perfectionism involves the assessment of individual differences in automatic perfectionistic thoughts. The PCI (Flett et al., 1998) was developed for this purpose. Cognitive rumination over mistakes and imperfections has been noted often in the perfectionism literature (e.g., Frost & Henderson, 1991; Frost, Trepanier, Brown, & Heimberg, 1997; Guidano & Liotti, 1983); this research has been based on the premise that perfectionists who sense a discrepancy between the actual self and the ideal self, or their actual level of goal attainment and their high ideals, will tend to experience automatic thoughts that reflect perfectionistic themes (see Flett et al., 1998).

The PCI has a range of item content that reflects direct thoughts about the need to be perfect, as well as thoughts reflecting an individual's cognitive awareness of his or her imperfections. Several thoughts on the PCI, such as "I should be perfect," "I should never make the same mistake twice," and "I must be efficient at all times," are in keeping with general observations by Ellis (2002) about perfectionism and irrational thinking.

The Perfectionism Rating Scales (Clinician/Significant Other Form)

This measure provides narrative descriptions and examples of the various perfectionism traits and perfectionistic self-presentational facets and

asks the respondent (i.e., clinician, teacher, or significant other) to rate the target person on the various descriptions.

Interview for Perfectionistic Behavior

The IPB (Hewitt, Flett, Flynn, & Nielsen, 1995) is a brief semistructured interview that assesses the perfectionism traits, perfectionistic self-presentational styles, and perfectionistic cognitions, as well as yielding interviewer ratings of perfectionistic behavior. The IPB allows the clinician to use probes and follow-up questions to elicit more complete information regarding the various perfectionistic behaviors in order to aid in the idiographic assessment and formulation of the individual's difficulties. Specific examples of perfectionistic behavior can be elicited and explored. Because the IPB has not yet been published, we describe its development here and give some initial indications of the validity of score interpretations.

As we have done with our other instruments, we have used the construct validation approach (Jackson, 1970) in designing the IPB. It is a semistructured interview measure based on our CMPB and incorporating elements from the Frost et al. (1990) model. In its current form, the IPB yields seven subscales and ratings of a clinician's impressions on each of the seven subscales, including the three trait dimensions, the three self-presentation style facets, and automatic cognitions of perfectionism. In addition, there are clinician ratings of the perfectionism traits, self-presentational styles, and cognitions, as well as the degree to which perfectionism is problematic for the individual. Finally, there is an allowance for other relevant clinical observations germane to the assessment of perfectionism and its potential impact on the clinical process. The IPB takes approximately 20 minutes to complete.

From an original pool of items that included items assessing level and consistency of perfectionistic behaviors, we obtained correlations between each item and the MPS traits and PSPS facets. The items that were most highly correlated with given trait dimensions or self-presentation facets were selected for the IPB, provided that the item correlation with other dimensions of perfectionism did not exceed .50. This resulted in a total of 45 items: 12 items for self-oriented perfectionism, 9 items for other-oriented perfectionism, 9 items for, socially prescribed perfectionism, 4 items for perfectionistic self-promotion, 4 items for nondisplay of imperfections, 4 items for nondisclosure of imperfections, and 3 items for automatic perfectionism cognitions, plus 7 items for the interviewer's clinical impression ratings

The interviewer queries the patient and records the patient's ratings. A 4-point rating scale is used for each item, ranging from 0 (the item is not at all characteristic of or consistent for the interviewee) to 3

(the item is extremely characteristic of or consistent for the interviewee, or always applies to the person). In six of the items, the interviewee is asked whether each dimension of perfectionism "does not apply to you," "characterizes you but is not relevant or central to how you see yourself," or "characterizes you and is relevant or central to how you see yourself." The summation of items reflects the score on the subscale. The 45 patient-rated items are followed by 7 interviewer ratings on a 5-point scale regarding the degree to which each of the seven perfectionistic dimensions are present in the interviewee, ranging from none (0) to extreme (4). This rating is based on the interaction between the clinician and the interviewee. These final 7 ratings represent the overall clinical impressions. Finally, the interviewer is asked to rate how problematic perfectionism is for the interviewee on the 5-point scale and to provide a narrative description.

Initial research on a sample of 143 university students established that the IPB is reliable as a measure of the components of perfectionism and yields valid score interpretations. For example, high internal consistency and adequate item–subscale total correlations provided preliminary evidence of the IPB's reliability. Coefficients (alphas) ranged between .83 and .86 for the sample.

Evidence for the validity of score interpretations was provided by illustrating the relationships between the IPB subscales and subscales from our self-report measures of perfectionism, depression measures, and measures of intelligence. Concurrent validity was provided by the IPB's relationship with existing measures of trait perfectionism and perfectionistic self-presentation: The subscales of the interview correlated most strongly with the expected dimensions and facets of the MPS and PSPS (see Table 7.1), with the exception of the IPB automatic cognitions scale. Furthermore, for other-oriented perfectionism, socially prescribed perfectionism, and nondisclosure of imperfections, IPB subscales were significantly predicted uniquely only by the corresponding MPS or PSPS dimension. In the case of self-oriented perfectionism, perfectionistic self-promotion, and nondisplay of imperfections, more than one dimension of the MPS or PSPS uniquely predicted these subscales, suggesting that these may not indicate the given dimensions of perfectionism as clearly as the other IPB subscales do. Nevertheless, each subscale was most strongly correlated with the expected dimension of the MPS or PSPS, which supports the concurrent validity of the IPB subscales. The correlations of the IPB subscales with the paper-and-pencil self-report measures of perfectionism are provided in Table 7.1.

In this initial study, we also calculated the correlations between the IPB subscales and the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979); an interview measure of depression, the Hamilton Rating Scale for Depression (Williams, 1988); and the Shipley Institute of

TABLE 7.1. Correlations of IPB Subscales with MPS and PSPS Subscales and the PCI

	MPS				PSPS		
IPB subscales	Self	Other	Social	Promote	Nondisplay	Nondisclose	PCI
IPB Self	.69**	.33**	.38**	.45**	.47**	.44**	.73***
IPB Other	.33**	.47**	.23*	.22*	.16	.16**	.46***
IPB Social	.42**	.27**	.69**	.40**	.42**	.46**	.57***
IPB Promote	.42**	.10	.29**	.62**	.59**	.41**	.51***
IPB Nondisplay	.46**	.11	.37**	.56**	.70**	.56**	.50***
IPB Nondisclose	.27**	.09	.37**	.44**	.51**	.60**	.44***
IPB Cognitions	.53***	.17**	.40***	.43***	.30***	.32***	.51***

Note. Underscores indicate correlations between corresponding dimensions/facets of different scales.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

Living Scale (Shipley, 1940), which we used as a measure of intelligence for discriminant validity purposes. These results are presented in Table 7.2. The findings indicated that the perfectionism measures were associated with depression measures, but not with the measure of intelligence. The cognitions measure was negatively associated with Shipley B.

Components of the interview were used in a study examining perfectionism in patients with eating disorders (see Cockell et al., 2002). Only the IPB subscales for self-oriented perfectionism and socially prescribed perfectionism were administered, due to time constraints in the study. Robust positive correlations were found between the IPB self-oriented and MPS self-oriented subscales ($r = .76$), as well as between the IPB socially prescribed and MPS socially prescribed subscales ($r = .86$). Not surprisingly, both IPB measures were correlated strongly with all three

TABLE 7.2. Correlations of IPB Subscales with Depression Measures and Intelligence Measures

	Depression		Intelligence	
IPB subscales	HRSD	BDI	Shipley A	Shipley B
IPB Self	.28***	.30***	–.09	.13
IPB Other	.21**	.21**	–.02	.16
IPB Social	.42***	.48***	.01	–.09
IPB Promote	.29***	.20*	.00	–.13
IPB Nondisplay	.22**	.26**	–.09	–.14
IPB Nondisclose	.22**	.25**	–.08	–.10

Note. HRSD, Hamilton Rating Scale for Depression; BDI, Beck Depression Inventory; Shipley, Shipley Institute of Living Scale.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

PSPS subscales, in keeping with the emphasis in the IPB on the stylistic aspects of perfectionism. Group comparisons conducted by Cockell et al. (2002) found that the 21 women in the study with anorexia nervosa had substantially higher IPB self-oriented and socially prescribed perfectionism scores than the psychiatric control group had; in turn, the psychiatric control group had higher scores on these measures than the participants in the nondisordered control group had. Additional correlational analyses conducted for the sample as a whole showed strong correlations between the IPB subscales and both self-report and clinician-rated measures of depression. Robust links were also found between these IPB measures and Global Assessment Scale ratings of overall functioning, with extreme perfectionists deemed to have much lower levels of functioning.

Perfectionism Sentence Completion Form

A newly developed projective measure is in the early stages of development in our laboratories. This sentence completion measure is based on the design of other sentence completion measures: Each item provides a sentence stem for the patient to complete. The measure attempts not to assess levels or kinds of perfectionistic behavior, but rather to assess some of the underlying motives or precursors of the perfectionistic behavior. The measure is intended to provide information that can aid in the formulation of an individual's development and manifestation of perfectionism.

Informant Ratings of Perfectionistic Behavior

It is important to assess levels of perfectionism with multiple measures from a perspective of methodological pluralism. Accordingly, ideal assessments will include clinical ratings as well as informant ratings. We have developed measures in which informants complete perfectionism trait and perfectionistic self-presentation measures from the target person's perspective. We have used these ratings to provide multimethod approaches to the assessment of perfectionism. The inclusion of other people's ratings of the patient can be a valuable source of validity in the assessment process, and can also help to open a discussion with close others regarding the difficulties the patient is experiencing.

In addition, we rely on other psychometrically based instruments to ensure a comprehensive assessment of symptoms and an indication of overall distress relative to population norms. Typical measures in our armamentarium include common symptom measures (e.g., the Symptom Checklist 90—Revised [SCL-90-R]; Derogatis, 1994) and interpersonal

measures (e.g., the Inventory of Interpersonal Problems [IIP]; Horowitz et al., 1988) to provide levels and types of distress. Moreover, we include omnibus measures such as the Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), the Millon Clinical Multiaxial Inventory–III (MCMI-III; see Choca & VanDenburg, 1997), or the Personality Assessment Inventory (PAI; Morey, 1996) as needed, in order to fill out the symptom picture, clinically relevant personality characteristics, vulnerabilities, strengths, and diagnostic considerations. A full discussion of these measures is beyond the scope of this book, and the instruments are commonly used in psychodiagnostic assessments.

DATA SYNTHESIS

Once all data are gathered, the vertices of the triangle of adaptation and the triangle of object relations can be articulated with greater precision. Responses to the various perfectionism measures (MPS, PSPS, and PCI), as well as clinic interview observations of the patient's temperament, personality, and interpersonal behaviors, help the clinician to gain a more refined understanding of the patient's unique defensive structure and coping mechanisms. Recall that perfectionism and its various components (interpersonal, cognitive, and behavioral) are understood to constitute a solution to a perceived problem; in other words, they serve as a defense guarding against a perceived threat to the self. The psychometric and interview data provide a detailed means of articulating the various elements that make up the anxiety/affect vertex. An understanding of the patient's attachment style and interpersonal needs can be derived from a combination of IIP results, the genogram, and the developmental history. The latter two sources also help us to gain an understanding of the patient's past relationships, which in turn serves as a means of generating hypotheses about the types of interactions that can be expected to unfold between patient and clinician.

ASSESSMENT FEEDBACK

The final stage of the assessment process involves summarizing the results of testing and interviewing. This should naturally lead to a description of the patient's cyclical relational pattern and the ways in which it is sustained. In our experience, patients are seldom surprised, shocked, or upset by the initial formulation and relational patterns. Asking a patient for clarifications or qualifications of the data underscores

the collaborative nature of the therapeutic relationship. If anything, the feedback tends to bring the patient a sense of relief, to provide a model of the nature of his or her difficulties, and (ideally) to introduce an element of hope. Moreover, the feedback can help the patient understand that rather than being defects, the defenses have served a purpose that may have been adaptive at one point in time, but is now no longer adaptive. Assessment feedback includes reviewing and explaining the meaning of assessment results, offering the patient a new understanding of his or her difficulties, educating the patient about symptoms and the treatment process, and working collaboratively to define individual treatment goals and tasks.

CASE ILLUSTRATIONS

A Case of Self-Oriented Perfectionism

Mr. T was a middle school teacher assigned to a class of gifted students. He sought treatment after two sets of parents complained that their children were losing interest in school, after having done exceptionally well the previous year under the tutelage of a young, vibrant female teacher. In the initial interview, Mr. T said that he had been spending more than 5 hours most evenings preparing lesson plans in order to ensure that his students were challenged and engaged. But the complaints from these parents had convinced him that he was failing as a teacher. On numerous occasions, Mr. T felt compelled to abandon the established lesson plans in his teaching manuals and increase his efforts in preparing lessons. At these times he would retreat to his home office immediately after dinner, where he would remain working continuously but inefficiently until 1:00 or 2:00 a.m. His wife repeatedly complained about his lack of availability and constant irritability, leading Mr. T to conclude that he was failing not only as a teacher, but as a husband and father.

In applying McWilliams's (1999) template for a dynamic formulation, the clinician determined that Mr. T's temperament was characterized by emotional intensity, hypersensitivity to perceived criticism, and a propensity toward pessimism. Mr. T placed considerable value on being an exceptional teacher, husband, and father. Failure in any of these domains evoked marked self-criticism, compelling him to redouble his efforts at work and at home. These eventually led to a crisis of lost confidence and depression. Mr. T's irritability reflected a latent hostility that surfaced in the face of mounting stress and negative self-appraisal. His readiness to abandon methodically formulated lesson plans in response to two parental complaints revealed his emotional vulnerability and high achievement orientation. Mr. T's senses of his duties as husband, parent,

and professional collided when his wife voiced her grievance in response to his growing unavailability. Mr. T might not have sought consultation from a mental health professional had he experienced an emerging sense of inadequacy in only one of these spheres of his life. The crisis was precipitated by an amalgam of perceived failures—a combination that was given meaning within the context of Mr. T's unique developmental and interpersonal history.

An essential objective of any assessment is to uncover and explicate relevant formative experiences. Mr. T was the eldest of five siblings. His parents were accomplished professionals. His father was a theoretical physicist and his mother was a professor of nuclear engineering; both taught at a leading academic institution. As the first-born, Mr. T was expected to set an example for his siblings. Beginning in late childhood and extending throughout adolescence, Mr. T assumed considerable supervisory responsibilities for his younger siblings, in light of his parents' emotional unavailability and career demands. Mr. T felt considerable pressure to ensure that his siblings behaved well, completed their homework, and did not get into trouble outside the home. He noted that a transgression in any of these areas by one of his siblings would lead to the father's censuring Mr. T rather than the offending sibling. Mr. T commented, "I grew up in an atmosphere that demanded that I walk a straight line. I couldn't falter even slightly, nor could I allow one of my brothers or sister to stray."

Mr. T was academically successful and gained admission to the university where both his parents taught. He completed an undergraduate degree with distinction, and his parents pressured him to apply to medical school or pursue a graduate degree in biology. His decision to become an educator led to countless arguments and was met with disapproval and disappointment. Yet it was a choice that made sense in light of Mr. T's role in the family. Mr. T was determined to become the best teacher ever. His resolve was deepened early in his career when all but one of his younger siblings made career choices that followed his parents' prescribed path.

Not surprisingly, Mr. T obtained elevated scores on all three subscales of the MPS. Elevations on the self-oriented perfectionism subscale were expected in light of Mr. T's exacting standards for himself as teacher, husband, and father. His developmental history offered a context that helped explain the elevations on the socially prescribed perfectionism subscale of the MPS. Some research on exposure to parental psychological control seems particularly relevant here. Soenens and colleagues have shown that parental psychological control is elevated among perfectionistic parents and tends to contribute to dysfunctional perfectionism in their children. Perceptions of psychological control are tapped in

Soenens et al.'s research by such items as "My mother/father will avoid looking at me when I have disappointed her/him." Parental psychological control, as reported by the child as well as by parents themselves, has been implicated clearly in the transmission and the development of perfectionism as well as associated forms of distress (see Soenens, Elliot, et al., 2005; Soenens et al., 2008; Soenens, Vansteenkiste, et al., 2005).

In Mr. T's case, not only did he grow up in an environment in which his parents placed considerable demands and expectations on him, but his siblings' career choices and achievements also contributed to his sense that the world expected more from him than he had achieved. Mr. T gravitated toward teaching gifted students: Their intellectual abilities and academic achievements placed him in an emotional and intellectual environment isomorphic to that of his family, particularly the role he had assumed with his siblings. Although this context offered Mr. T a sense of familiarity, it also served as an unconscious source of tension and anxiety. Mr. T expected a great deal of his students. If any of them failed to meet expected standards, Mr. T's anxiety and depression intensified, accounting for the elevations on both MPS other-oriented perfectionism and self-oriented perfectionism.

A Case of Other-Oriented Perfectionism

Mr. D decided to consult a psychologist after months of battling the service clerks at his local department store. Mr. D had purchased a washing machine 2 years ago from the department store and was convinced that the tub of the machine was flawed. He complained on numerous occasions that the collars on his shirts were becoming pilled. He said that he had never had this problem with his previous machine; he had concluded that it could only be the result of a manufacturing defect. Several service technicians visited his home to inspect the machine and found nothing wrong with it. Mr. D was convinced that the technicians were being protective of the store and the manufacturer; he felt that they had been dismissive of his concerns. Mr. D complained to the Better Business Bureau and told his wife that he was going to initiate legal action. He had become so preoccupied with the situation and his "ruined" shirts that his sleep and concentration became increasingly disturbed.

In reviewing the findings of Hill et al. (1997), Habke and Flynn (2002) noted that other-oriented perfectionists exhibit high achievement striving and interpersonal hostility. Mr. D said that he finally decided to seek mental health consultation in response to mounting tension with his wife. He described arguments between them that would quickly escalate when he made any mention of his mounting frustration with the washing machine. On several occasions, his wife's anger flared; she accused

him of "losing his grip" and called him "paranoid." Although Mr. D's presentation was reminiscent of a focal delusion, there was no history or other evidence of a psychotic process. His description of his dealings with the department store and the service personnel were indicative of a deep mistrust but not paranoia.

Mr. D's work history revealed a pattern of strained relationships, primarily due to his dissatisfaction with the performance of his coworkers. When he joined a large accounting firm, he was viewed as a "bright light" with a promising future. But his limited capacity to work collaboratively brought his hopes of advancement to a halt. His manager elected to retain him, due to Mr. D's remarkable attentiveness to detail and superior knowledge of business taxation, and assigned him to accounts that required minimal interaction with others; he worked dutifully on these accounts for long hours. Apart from his marriage, Mr. D had no intimate friendships and only a few acquaintances, most of whom he had met through his wife. Coincidentally (or not), Mr. D's concern with the performance of the washing machine began a few weeks after the death of his dog.

In the course of the first consultation session, it was evident that Mr. D had low frustration tolerance. Attempts by the clinician to seek clarification by asking questions or offering reflections were experienced by Mr. D as interruptions and evoked irritability and impatience. Mr. D responded to the clinician's inquiries in a tone that conveyed a mix of disapproval and dissatisfaction, as if to say, "Do I have to explain everything? How can you be so daft?" In an early effort to be empathic after hearing about Mr. D's conflict with his wife and the recent death of his dog, the clinician commented, "It sounds like it's been a very difficult time for you." Mr. D responded with disdain: "That's so banal. I didn't come here to be told the obvious." Mr. D was easily provoked and appeared to have a limited capacity to modulate his affect or soothe himself in the face of stress.

Obtaining a developmental history proved difficult, as Mr. D made it clear that he felt the past had little relevance to his current circumstances. However, armed with patience and a remarkably thick skin, the clinician eventually pieced together important details of Mr. D's childhood. Mr. D's mother was a homemaker and his father was a civil engineer who struggled with chronic alcoholism. Mr. D described his mother as a woman who always seemed to be overwhelmed by life. He recalled the way in which she vacillated between submissive, solicitous attempts to appease her husband so that he would not drink and invisibility in order to avoid her husband's ire when he was intoxicated. Mr. D experienced his father as an emotionally distant man. Throughout Mr. D's childhood and adolescence, his father spent most evenings

in the basement rec room, reviewing and organizing his prized stamp collection while drinking Scotch. On occasion, however, his temper would erupt in response to some seemingly insignificant trigger. Typically either something would be out of place or he would accuse Mr. D or Mr. D's mother of having disrupted his stamp collection. Although Mr. D could only recall one instance in which his father was physically violent, the tone and volume of his father's voice as he hurled insults evoked intense fear in Mr. D, and he always felt that violence was never far off. Mr. D developed a deep disdain for both parents. He resented his mother for her seeming dependence and lack of assertiveness. In his view, she failed to protect him and was too weak to leave the marriage. His father was pathetic and powerful all at once, and the cause of everyone's misery.

Not surprisingly, Mr. D internalized aspects of both his parents. He responded to stress and to any perceived threat by trying to keep things orderly, much as his mother had often done in an effort to prevent her husband's drinking. Relationships were less valued than things that functioned efficiently and effectively. As much as possible, emotions were avoided—yet out of nowhere, they would surface and erupt without warning. Although Mr. D was never as explosive as his father, his expectations and demands of others could be equally cutting. Any source of unhappiness or dissatisfaction was attributed to the failure of someone else, thus accounting for Mr. D's markedly elevated scores on other-oriented perfectionism.

Our experience is that when perfectionistic demands are made of both oneself and other people, a perfectionist has a strong desire for control (see Flett, Hewitt, Blankstein, et al., 1995). An other-oriented perfectionist with a strong need to control other people is bound to be frustrated and disappointed. A key realization will be getting the patient to accept the fact that other people cannot be controlled and that it is important to be more accepting of other people as well as the self.

A Case of Socially Prescribed Perfectionism

In her first appointment, Ms. S said that she feared her husband would soon leave her. She was convinced that she had failed to satisfy him emotionally, sexually, and intellectually. Furthermore, she was sure that since abandoning her career in order to care for their home and children, she had become increasingly dull and could never hope to be her husband's intellectual equal. Ms. S was convinced that her husband found his female colleagues more attractive and much more interesting than she was. Ms. S compensated by keeping an immaculate home. She spent hours preparing gourmet meals, decorating, and ensuring that her

children were impeccably dressed and engaged in numerous social and sports activities.

Ms. S's expressed concerns are consistent with our findings that socially prescribed perfectionism and other-oriented perfectionism are associated with poor dyadic adjustment (Hewitt, Flett, & Mikail, 1995). Habke et al. (1997) found that women who felt their partners had unrealistic expectations of them reported lower levels of marital/couple adjustment as measured by the Dyadic Adjustment Scale (Spanier, 1976). In Ms. S's case, it wasn't clear whether her husband's expectations were unrealistic, but Ms. S was certainly convinced that she was an inadequate wife.

Ms. S exhibited a relatively even temperament. She was a pleasant, attractive woman in her early 40s. In sitting with her, one sensed that she was probably an anxious person (an intuition that was later supported by psychometric testing). Yet Ms. S was generally effective in concealing her anxiety from others, particularly in social situations. In fact, her manner of speaking, sitting, and dressing were all geared toward putting the listener at ease—a stance reflective of the tendency for perfectionists to possess a heightened level of anxiety sensitivity that is often focused on trying to control visible signs of anxiety (see Flett, Greene, & Hewitt, 2004). One only glimpsed Ms. S's discomfort by attending carefully to her eyes and her breathing. Ms. S would invariably break eye contact and gaze down at the floor whenever the therapist underscored some positive aspect of her character. At these times, Ms. S appeared to hold her breath; it seemed that she was unable to take in not only the affirmation, but the very air that carried it.

Ms. S grew up in a small rural community. Her father was a prominent businessman in town who was quite active socially and politically. For two decades he held the position of deputy mayor. Her mother was a very capable woman, having completed an honors degree in history, followed by a master's degree in library science. She oversaw the local library, chaired the women's charitable works committee at church, and ran the family household. Ms. S's childhood was free of any form of abuse or significant trauma. There was no history of parental psychopathology. She was the oldest of five children, with a brother 1 year her junior, followed by a 7-year age gap between him and the next sibling. In light of her parents' demanding careers, Ms. S assumed the role of caregiver to the younger siblings. She said that she grew up sensing tension in both of her parents' lives and in their relationship, despite the gregarious and happy front both presented to the outside world. It was evident that this had been an ongoing concern for Ms. S until she left home to attend a university. She worked hard at her studies and even harder to ensure that neither she nor her siblings were a burden to her

parents. Ms. S also felt the pressure of being a member of a family that was constantly in public view. The family reputation was of paramount importance to both parents. Her father made it quite evident that given his and his wife's public roles, the family was constantly under the scrutiny of the community. The children were frequently reminded of this reality: They were expected to be model students and model citizens. Every few years when her father campaigned for public office, Ms. S and her siblings would be "put on display," dressed impeccably (as she now dressed her children). Public opinion and external expectation defined her every move.

Ms. S lived to please others, particularly her parents and her husband. Her request for treatment came 3 months after she had been turned down for a volunteer position on the board of directors of a local children's treatment center. She was "short-listed" and felt that she had interviewed well but ultimately she was not offered the position.

Ms. S's life history is illustrative of the socially prescribed pressures that are amplified for perfectionists who often find themselves in the public spotlight. In essence, Ms. S and her siblings were required to display perfection publicly because of situational demands. We underscore this point because perfectionists often find themselves in a context that requires them to strive to be perfect (or at least seem perfect), even though they have reached the point when they would like to disavow any demands or requirements to be perfect. Perfectionists in treatment may have life circumstances that can be punishing if they make mistakes or are generally seen as imperfect and flawed. This can add to a palpable sense of ambivalence. These individuals need a strengthened and more positive sense of self and identity in order to withstand these pressures and minimize the personal importance they attach to being perfect.

Treatment of the Three Cases

Treatment was of at least moderate duration in each of these cases. Mr. D's treatment was the longest, lasting for 18 months with some success. The focus revolved around the impact of his perfectionism on the marital relationship. Mr. D never relinquished his "conspiracy theories" about the department store and its service personnel, but he recognized that his fixation with the issue was eroding his only positive relationship—that with his wife. Attempts to address Mr. D's grief in response to his dog's death were not fruitful.

Mr. T's treatment extended for 20 sessions. It began with helping Mr. T establish reasonable parameters and limits for his class preparation time. Mr. T was encouraged to use the teaching manuals the school provided in order to adhere to these limits. The hours that were freed

up were spent with his wife and children. A considerable proportion of treatment focused on linking significant aspects of Mr. T's developmental history with his current pattern of relating to self and others. The CRPs, which included a highly negative introject, were at the core of the therapy.

Ms. S was treated in group therapy that followed the model described in Chapter 10. Her marked preoccupation with external appearance and others' judgments of her made her an ideal candidate for this modality. The essential focus of treatment revolved around helping Ms. S define and claim a sense of identity that stood separate from her husband and children. Understandably, this was quite a painful and anxiety-provoking process for Ms. S—but, to her credit, she persisted with it.

CONCLUSION

We have outlined in this chapter how the assessment and case formulation process is structured and modified for perfectionists seeking treatment. Our discussion has included descriptions of three perfectionists who were all dealing with pressures to be perfect, but who each had unique needs, situations, and distinct levels and patterns of perfectionism.

As is true of nearly any complete psychodiagnostic assessment, an evaluation of a patient for perfectionism must include attempts to get beyond the patient's self-reports. Vigilance for and awareness of in-session and out-of-session behaviors, process issues, and nonverbal and paralinguistic behaviors are paramount. Relational issues, interpersonal symptoms and distress, and interpersonal styles will be manifested within the assessment interactions. The clinician needs to incorporate this information into the clinical formulation and CRP.

The various perfectionism measures and other measures of psychopathology and psychological adjustment can and should be readministered throughout the therapy to track the degree of progress. When the patient has demonstrated a tendency to experience automatic thoughts involving the need to be perfect, the PCI can be particularly useful in evaluating the degree of change; this measure is typically used to assess the frequency of thoughts over the past week, but the time frame for assessment can be modified to suit the purposes of the assessor and the person being assessed.

The entire process of assessment becomes much more complicated for perfectionists who are brought to treatment by others, since these patients are not likely to be fully "on board" for therapy. Of course,

this is a problem when anyone is brought to treatment who is not fully in favor of it, but it is especially problematic for certain perfectionists. Earlier, we have mentioned situations in which the self-presentational needs of perfectionists can result in assessments that seem to indicate no problems or not very serious problems. Unfortunately, we have seen cases in which perfectionistic individuals (adolescents in particular) have been brought to hospitals for assessment and intervention by concerned family members; however, because they are so good at hiding behind a mask of invulnerability, they are released without extensive follow-up. It is important to remain alert to the possibility that the need to avoid seeming imperfect has resulted in convincing false presentations and self-representations that can lead to the wrong decisions. We have focused on the impact perfectionistic self-presentation can have on initial assessments, but there is a need to remain cognizant of the subsequent role of such self-presentation. That is, perfectionists undergoing treatment may return to old established patterns and may begin to seem as if they have improved, but this is not actually the case. We mention this possibility as one further illustration of the intriguing complexities and nuances involved in the clinical assessment and treatment of perfectionists.

NOTES

1. "This phrase is borrowed from Nietzche, *Beyond Good and Evil,* Part VIII, p. 246" (Reik, 1948, p. 144, n. 1).
2. It should be noted that several short forms of our MPS have been reported in the literature. As these short forms do not have clinical or other normative information available, we advise that the entire 45-item version of the scale be used.

CHAPTER 8

Clinical Cases and Common Themes

In this chapter, we introduce some key clinical issues by describing several individuals who sought treatment, mostly from Paul L. Hewitt. The patients were chosen to illustrate various aspects of perfectionistic behavior, as well as to provide information germane to assessment, case formulation, and aspects of the treatment process. Psychometric testing was completed by these individuals, and test results are also presented for each person. Although we do not go into detail on all of the psychometric interpretations, certain information is presented for illustrative purposes. Of course, identifying information and descriptions have been altered to ensure privacy and confidentiality.

Collectively, the clinical cases below underscore several points. First, although a number of common themes emerge in the assessment and treatment of perfectionism, considerable heterogeneity exists among patients, as the four cases described here illustrate. A clinician must be attentive to the many factors involved in the idiosyncratic manifestation of perfectionistic behavior in a given patient in order to develop a sound formulation that provides the framework for individualized treatment. Some common themes are discussed following the case descriptions.

Previously, we illustrated the heterogeneity among perfectionists seeking treatment in the case accounts included in the published manual that accompanies our MPS (see Hewitt & Flett, 2004). Ten case studies were used to illustrate the fact that while trait self-oriented, other-oriented, and socially prescribed perfectionism tend to be at least moderately intercorrelated in most samples, it is possible to find all possible combinations among perfectionistic individuals; that is, some people have elevated scores on all trait dimensions, while others have elevations on only one or two of the subscales. These cases provide useful

supplementary information for readers interested in further information about the differences among perfectionists.

Second, it becomes increasingly apparent from these case accounts that perfectionism is often experienced and expressed clinically as one element of a complex clinical presentation (Bieling et al., 2004; Egan et al., 2011). A key consideration is whether the perfectionism has been involved in the development of clinical dysfunction. Even if this is not the case, perfectionism often substantially complicates the expression and course of symptoms, the treatment process, and the outcome. Although our focus is on perfectionism in individuals seeking treatment, some consideration must also be given to whether these people are experiencing environments (including family environments) where pressures to be perfect abound. Moreover, given that perfectionism is believed to generalize across situational contexts, it is not altogether surprising to find that the requirement of perfection linked with clinical dysfunction also extends into the therapy context, as we have already discussed.

Finally, in all of these cases, the treatment was focused on the underlying factors producing the perfectionistic behavior and was psychodynamic and interpersonal in nature. The treatment usually extended over a time period ranging from many months to several years, in keeping with Blatt's (1992) recommendations; Blatt discussed at length the importance of intensive and long-term treatment for individuals with perfectionistic behavior (see also Greenspon, 2008). We have recently provided evidence for the efficacy of an intensive dynamic-relational form of psychotherapy in treating perfectionistic behavior (Hewitt, Mikail, et al., 2015; see Chapter 10).

We now turn to our description of four individuals who received assessment and treatment for their perfectionism and associated difficulties. These cases are presented in relative depth to illustrate some of the processes involved in perfectionism, as well as its assessment and treatment. Another such case, Anita, has already been presented in Chapter 6.

CLINICAL CASES OF PERFECTIONISM

Charles

Charles was a married 50-year-old professional writer, who, 2 years previously, had made a serious suicide attempt and was probably alive only because his gun had misfired. In the initial session, accompanied by his wife, Charles appeared very well attired; he spoke with grammatical precision and diction, and came across as a friendly, polished,

and sophisticated individual. Charles was quite hesitant to discuss his current situation and his reason for seeking help. He did, however, bring a copy of his curriculum vitae and an example of a current project, so that the therapist (Paul L. Hewitt) could "get to know him." Moreover, he had read a newspaper article about Hewitt and believed that he might be someone who could be of help to him. He had carried the newspaper article folded in his wallet for over 6 months before he finally sought treatment.

Charles, with the prompting and clarifications of his wife, indicated that he had been significantly depressed for a long period of time, and his wife indicated that his use of alcohol to cope was becoming uncontrollable. Charles responded that he did not have a problem with alcohol; rather, he had a problem with life. The wife added that he had made a second suicide attempt several days previously. Charles denied that this was an attempt to die, stating that it was an error in taking too much medication. He described himself as highly perfectionistic and feeling constantly that he had never been good enough. He described his perfectionism as a positive yet tormenting factor in his life, in that he would never have accomplished as much professionally had he not driven himself so ceaselessly. He did come to understand the incredible cost he was paying for his behavior.

The testing results for Charles are presented in Table 8.1, where it can be seen that his highest perfectionism scores were on self-oriented perfectionism and the nondisclosure of imperfection. However, all components were elevated, with the exception of other-oriented perfectionism and automatic perfectionistic cognitions. Moreover, the results of the MMPI-2 were indicative of serious psychopathology; although there was no evidence of any psychotic process, the profile was consistent with long-standing distress characterized by significant depression, obsessive rumination, hostility, and anger, as well as marked needs for attention and support. The profile also suggested social isolation and passive–aggressive behavior with significant concentration and attentional difficulties.

Charles described his family of origin as not at all supportive of or interested in him. He had grown up in a rather poor household with an indifferent mother and a verbally and physically abusive father. (This theme of "not mattering" is often found in perfectionists.) Specifically, Charles indicated that his father seemed not to care for him and would criticize and ridicule him, often venting his substantial anger toward Charles. Charles remembered always being perfectionistic, and his need to achieve was predominant as an attempt to placate and mollify his father. As well, he indicated that he remembered always experiencing excessive self-recriminations and feelings of shame, which had persisted throughout his life.

TABLE 8.1. Psychometric Testing Results for Charles

MPS	
Self-oriented	70
Other-oriented	56
Socially prescribed	61
PSPS	
Self-promotion	59
Nondisplay	63
Nondisclose	70
PCI	36
MMPI-2	
L	56
F	98
K	29
Back F	67
TRIN	65
VRIN	76
1. Hypochondriasis	51
2. Depression	68
3. Hysteria	50
4. Psychopathic deviate	59
5. Masculinity/femininity	40
6. Paranoia	72
7. Psychasthenia	70
8. Schizophrenia	81
9. Hypomania	59
10. Social isolation	61
BDI	
Raw score	12

Note. All scores are *T* scores unless otherwise noted. MPS, Multidimensional Perfectionism Scale; Self-oriented, self-oriented perfectionism; Other-oriented, other-oriented perfectionism; Socially prescribed, socially prescribed perfectionism; PSPS, Perfectionism Self-Presentation Scale; Self-promotion, Perfectionistic self-promotion; Nondisplay, nondisplay of imperfection; Nondisclose, nondisclosure of imperfection; PCI, Perfectionism Cognitions Inventory; MMPI-2, Minnesota Multiphasic Personality Inventory–2; BDI, Beck Depression Inventory.

Charles became more forthcoming over the course of psychotherapy in discussing his personal issues, and it became clear that the most recent recrudescence of depression became particularly pronounced after he mispronounced a word during a televised reading of one of his works. Reportedly, from an objective perspective, the error was insignificant, as suggested by the fact that the sound editor made no changes to the recording.

However, for Charles, the perceived error eventually took on gargantuan proportions, leading him to ruminate and castigate himself ceaselessly. To him, the error was evidence of his incompetence, and he was convinced that he was now seen publicly as a bumbling fool, incapable of performing even simple tasks. People would now know him for what he was: an imposter and a charlatan. His confidence and ability to write declined after this incident, and his anger toward himself and others increased. His career took a downturn, with Charles ultimately being released from his position. He stated that he had frequently been at odds with his superiors at work, whom he saw as critical, arrogant, condescending, and not themselves capable or gifted in any way. He described feeling mortified and ashamed at his job loss and concealed the news from his family and friends, pretending to go to the office each work day and returning home in the evenings. Although he had always been somewhat of a loner, he distanced himself even further from others. He began to drink heavily to "avoid the pain of letting everyone down." His spouse, family members, and friends were shocked at the first suicide attempt and expressed dismay that Charles had not confided in anyone. His shame and sadness would turn to anger frequently, and he had few close relationships.

Treatment focused on the genesis of Charles's perfectionistic tendencies and his early relationships with his abusive father and uninterested family. The therapy progressed to a point where Charles had an understanding that his attempts to be perfect arose as ways to ward off the experienced abuse and as efforts to garner approval and a sense of being cared for and belonging. In essence, his perfectionistic approach to life reflected his profound need for validation. He attempted to succeed in order to prove his father wrong and soothe his own feelings of inadequacy. His own behavior, excelling in his chosen fields of work and interest, seemed to indicate that he was an excellent scholar—but no matter how well he did or what he accomplished, it was never enough to soothe the pain he experienced or to make him feel worthy of being in the world. Although gains were made in treatment, significant progress was not made until Charles began to comprehend clearly that he was neither responsible for nor the cause of his father's abusive and nonaccepting behavior, even though he was the target of it. Charles moved toward understanding that his father's behavior had more to do with the father's own issues of inadequacy and unhappiness. When his father died, several years after treatment was finished, Charles was able to further relinquish some of the perfectionism that had so plagued him for so many years.

Robert

Robert was a single 28-year-old university student who had been referred for psychotherapeutic treatment of perfectionism, depression,

and suicidal tendencies. He had a long-standing history of depression and suicide ideation, for which he had been hospitalized on three occasions. He had recently been discharged from an inpatient psychiatric unit following a serious suicide attempt and had been prescribed an antidepressant medication.

In the initial session, Robert presented as significantly younger-looking than his 28 years, and both of his parents joined him for that session. Over the course of the interview, he implicated his parents in, or blamed them for, many of his difficulties. In this session, Robert's parents expressed concern and worry for him but appeared to be supportive and caring. He had recently moved in with his girlfriend of several months, and he described this relationship as "pretty good." He indicated, however, that he seldom interacted with friends and that he had sabotaged many relationships in his past.

Robert's symptoms were reported as severe and included marked depression, anxiety, and persistent suicidal ideation (see Table 8.2). He indicated that perfectionistic behavior had been a constant companion throughout his life, and he recalled that this behavior had blocked his ability to experience any sense of positive self-regard throughout grade and high school, despite having attained excellent grades. He was reportedly fearful of trying anything new: "If I can't excel at it, I won't even try it."

Robert also experienced a great deal of anger toward his parents. Moreover, he exhibited marked hopelessness that was often manifested in his ubiquitous lack of self-confidence. He came across as a very dependent man who needed others to care for him and whose anger and despair were palpable in sessions.

Robert had attended a university but dropped out on two occasions, due largely to his anxiety over needing to excel. He had recently returned to the university and once again his perfectionism was having a marked effect on his academic functioning, especially with respect to completing papers. He expressed concern over his schoolwork and excessive performance expectations, as well as significant anxiety over his uncertainty about his future career. Moreover, he exhibited numerous instances of self-limiting behavior such as procrastination, and he seemed to need reasons not to have reached his expected level of achievement.

Robert came from a high-achieving family. He stated that he had always been perfectionistic and felt "different and alienated from others," but had never misbehaved. He reported that his father wanted him to have excellent grades and papers but that his mother had not pressured him in that way. He stated that he came at an early age to the realization that it was important to make his parents proud of his endeavors and that his mother's happiness and attentiveness to him depended on his behavior and performance. At times, he would feign and express

TABLE 8.2. Psychometric Testing Results for Robert

MPS	
Self-oriented	60
Other oriented	41
Socially prescribed	58
PSPS	
Self-promotion	53
Nondisplay	66
Nondisclose	58
MMPI-2	
L	52
F	67
K	43
Back F	79
TRIN	64
VRIN	73
1. Hypochondriasis	59
2. Depression	89
3. Hysteria	69
4. Psychopathic deviate	64
5. Masculinity/femininity	58
6. Paranoia	75
7. Psychasthenia	85
8. Schizophrenia	84
9. Hypomania	56
10. Social isolation	65
BDI	
Raw score	30
BAI	
Raw score	19

Note. All scores are *T* scores unless otherwise noted. MPS, Multidimensional Perfectionism Scale; Self-oriented, self-oriented perfectionism; Other-oriented, other-oriented perfectionism; Socially prescribed, socially prescribed perfectionism; PSPS, Perfectionism Self-Presentation Scale; Self-promotion, perfectionistic self-promotion; Nondisplay, nondisplay of imperfection; Nondisclose, nondisclosure of imperfection; MMPI-2, Minnesota Multiphasic Personality Inventory–2; BDI, Beck Depression Inventory; BAI, Beck Anxiety Inventory.

exaggerated distress to try to deflect this expectation to be responsible for her happiness.

Robert's testing data in Table 8.2 indicate that he obtained the highest perfectionism scores on nondisplay of imperfections and self-oriented perfectionism. His MMPI-2 results were indicative of his level of distress

and emotional turmoil, which included depression, anxiety, and marked social disconnection. He endorsed concentration and memory problems, as well as feelings of being overwhelmed, inferior, and inadequate. He also had a rather passive–aggressive personality style and endorsed difficulties in relationships.

It became apparent over the course of psychotherapy that Robert was struggling with both dependency and autonomy issues. He experienced much anger toward his parents, especially in terms of needing to be perfect in order to take away his mother's sadness and pain. At the same time, he lamented the loss of his childhood, when the pressures seemed to be somewhat less important and he could be cared for by his family, particularly by his mother. He stated that he needed to excel in his university studies, but his efforts were fraught with exaggerated expectations and challenges to his own sense of autonomy.

A series of sessions was particularly illuminating regarding Robert's perfectionistic behavior. Robert was adamant in his desire to obtain an A+ in one of his courses; this course was considered the most challenging one in his program. Although he expressed this desire numerous times, he indicated that he was taking an intense, anxiety-laden approach to preparing for the final exam. Shortly after completing this exam, Robert arrived at a session appearing even more downcast and depressed than usual. When asked how he was doing, he indicated that he had attained the coveted A+ in the course—but he went on to explain that he was feeling horribly depressed and suicidal once again. As this was explored, Robert said that although he had received the A+, the effort required to achieve the desired grade served to confirm that he was not very bright, nor was he truly a capable student. Robert stated that if he was indeed a smart student, he would have been able to attain the A+ without having to study so hard. He thus turned an objective success into an experience and demonstration of abject failure.

Treatment continued for several months, and Robert began to understand the role that perfectionism was playing in his life. He ended treatment early, due to taking a summer job in another community, and he never returned for further treatment.

Frances

Frances was a 31-year-old married woman who was employed as a financial analyst and was also attending graduate school part-time. She sought treatment for her perfectionistic tendencies and the difficulties she had been experiencing with depression and anxiety, as well as an inability to work effectively. She described herself as needing to be perfect in all tasks and in the majority of her interactions; she added that a

great many of her perfectionistic tendencies involved not letting others see her imperfections. She described herself as living an "inauthentic life" by creating a façade centered on the person she believed she should be. Frances further described an almost constant disquiet and sense of being an imposter. She felt that at any time, if people saw what she was truly like, this would result in her being rejected, derided, and ridiculed for thinking she could actually be a professional.

Frances grew up in a family that was reasonably supportive of her. However, she noted that her family members never celebrated any of her significant accomplishments; rather, they attributed her success to luck, and often commented that she should be thankful for this luck. This lack of experienced satisfaction predominated in her life, especially with respect to her work and scholastic life, despite her doing well by objective standards. As a child, she was quite driven, studying music and dance and excelling at both. She also indicated that social anxiety was a major part of her life as a child and adolescent, and that this anxiety was a reason she threw herself into studying at school and especially into music lessons. She worked for a time as a professional accompanist, but eventually took a job in a financial institution and also decided to return to school to pursue a master's degree in business.

In her initial evaluation (see Table 8.3), Frances endorsed a high level of the nondisplay of imperfection (98th percentile). She also endorsed discomforting levels of anxiety and tensions, as well as significant cognitive inefficiency characterized by attention problems. The findings were consistent with long-standing and persistent mild to moderate depressive symptoms. Moreover, she indicated that although she had warm, close feelings of intimacy toward others, she seldom expressed them.

Initially, treatment focused on ameliorating the distress Frances was experiencing and on helping her understand the nature and purpose of her perfectionistic tendencies. It was clear that in order to feel a sense of being worthy of existing in the world, she felt a need to perform perfectly, which involved driving and castigating herself mercilessly. Frances also felt compelled to protect her sense of a "flawed real self" from being revealed to others. This need to hide her perceived deficiencies became overwhelming, particularly when she began to have more responsibility in her work and was required to make educational presentations as a component of her job. At these times, she was expected to offer opinions on a particular topic—an experience that gave rise to marked tension, as she felt that her opinions would reveal something of her true self. Frances was convinced that her true self was deserving of criticism, punishment, and ridicule.

TABLE 8.3. Psychometric Testing Results for Frances

MPS	
Self-oriented	63
Other-oriented	53
Socially prescribed	53
PSPS	
Self-promotion	60
Nondisplay	71
Nondisclose	63
IIP	
Domineering/controlling	49
Vindictive/self-centered	59
Cold/distant	69
Socially inhibited	77
Nonassertive	73
Overly accommodating	64
PAI	
Inconsistency	52
Infrequency	59
Negative impression	44
Positive impression	25
Somatic complaints	40
Anxiety	82
Anxiety disorder	50
Depression	63
Mania	51
Paranoia	41
Schizophrenia	58
Borderline	61
Antisocial	50
Alcohol problems	57
Drug problems	46
Aggression	47
Suicide Ideation	51
Stress	57
Nonsupport	45
Treatment rejection	25
Dominance	47
Warmth	31
BDI	
Raw score	15
BAI	
Raw score	15

Note. All scores are *T* scores unless otherwise noted. MPS, Multidimensional Perfectionism Scale; Self-oriented, self-oriented perfectionism; Other-oriented, other-oriented perfectionism; Socially prescribed, socially prescribed perfectionism; PSPS, Perfectionism Self-Presentation Scale; Self-promotion, perfectionistic self-promotion; Nondisplay, nondisplay of imperfection; Nondisclose, nondisclosure of imperfection; IIP = Inventory of Interpersonal Problems; PAI, Personality Assessment Inventory; BDI, Beck Depression Inventory; BAI, Beck Anxiety Inventory.

Although Frances was reasonably forthcoming and worked diligently in treatment, her fears of being judged and ridiculed did not become palpable in the therapeutic alliance until she began to discuss some needs and desires that contrasted sharply with her desired image of a career-focused, striving achiever who embraced the moniker of "feminist." With shame and trepidation, she discussed some of these desires; this development was thought to be pivotal. Frances and her therapist began to focus on her disclosures as an opportunity to begin "getting to know yourself with an air of discovery and not derision or evaluation." This is a stance often taken in the treatment of perfectionism, allowing the patient to approach his or her own idiosyncratic self with a sense of attempting to understand "Who am I?" rather than simply criticising and deriding this self. As treatment progressed, Frances became freer to express her intrinsic interests and to present parts of herself that contrasted with the supposed image of what a professional woman should be. She experienced this shift as extremely liberating.

As one example, Frances described her interest in participating in the arrangements for her niece's traditional debutante ball, which conflicted with her belief that this type of activity would be scorned as conformist and traditional by her colleagues and friends. This was the façade that Frances had created. In fact, her sister, who believed that Frances would react with disdain if asked to participate, did not invite her to take part. Frances was deeply upset by this. She recognized that she had created a façade that precluded her from participating in a deeply meaningful activity; that she was missing out on important emotional connections with close others; and, most significantly, that the persona she had created was having the opposite effect from the one she intended. Rather than being accepted, respected, and cared for as a result of her façade, she felt distant and alienated from those she truly cared about.

An important strength that became evident early in the first few sessions was Frances's ability to suspend the façade with her boyfriend, who had had to jump through numerous hoops to gain her trust, and also was not "the kind of person that the stereotyped female professional would have" for a boyfriend. This was taken as a powerful indication that Frances had the capacity to form a positive close relationship, and that she could come to trust that she could reveal parts of herself and not be abandoned.

Eunice

Eunice was a 29-year-old computer technician who had been married for 4 years when she sought treatment. She is presented as an example of a person whose perfectionism interfered with her benefiting from

treatment. Upon initial evaluation, she reported critically and harshly evaluating the performance of others, especially her husband and parents, and having excessive expectations and standards regarding their behaviors. Feelings of hostility and harboring unrealistic expectations of significant others were said to be consistent themes throughout her life, but especially toward people with whom she worked closely. She indicated that former friends and associates had informed her that she was very harsh. She saw her husband, an academic, as a disappointment due to his lack of prominent success; she also voiced disapproval that her younger sisters were not focusing on careers of stature. She added that her husband was aware of her demands and admonishments, and she feared that if she could not change this behavior, he would leave her. She reported feeling both embarrassed and frustrated if people close to her exhibited any imperfection.

In her preliminary assessment, Eunice scored more than two standard deviations above the mean on the other-oriented perfectionism subscale of the MPS (see Table 8.4). Her self-oriented and socially prescribed perfectionism scores were within the average range. Moreover, she endorsed few symptoms of depression and anxiety. The results of other testing indicated that although there were no clinical elevations, she experienced significantly reactive and labile self-esteem, self-doubt, and misgivings about her own adequacy. In addition, the results were consistent with those of individuals who are distant in the few relationships they have and who are not concerned with the opinions of others.

Eunice grew up in a supportive family, although she indicated that her father had a quick and intense temper, which was most often directed at her. She felt that her siblings were lazy and that her parents did not push the siblings hard enough, teach them to value future success, or provide them with the necessary requisites for success. She did not recall a warm home atmosphere while she was growing up; she also recalled having few, if any, friendships earlier in life. Then, as now, she found it difficult to establish and maintain friendships and often would not initiate any contact with others. She stated that she would wait for people to contact her, as she did not want to come across as needy: “If they want a relationship with me, they need to contact me.” She endorsed feeling socially isolated/detached and having few social supports, but she did not indicate any depression. Although Eunice recognized that she was demanding and critical of others, in general she demonstrated limited insight into the negative impact her perfectionism had on her relationships. Nonetheless, she expressed determination to moderate her criticalness and need for others’ perfection, especially with her husband (who was increasingly sensitive to her unceasing criticism) and with her coworkers (who, she feared, would try to have her fired). In stating goals for her treatment,

TABLE 8.4. Psychometric Testing Results for Eunice

MPS	
Self-oriented	53
Other-oriented	73
Socially prescribed	47
PSPS	
Self-promotion	54
Nondisplay	54
Nondisclose	45
PCI	39
PAI	
Inconsistency	55
Infrequency	59
Negative impression	51
Positive impression	50
Somatic complaints	44
Anxiety	43
Anxiety disorder	50
Depression	36
Mania	53
Paranoia	51
Schizophrenia	55
Borderline	49
Antisocial	42
Alcohol problems	49
Drug problems	46
Aggression	41
Suicide ideation	45
Stress	39
Nonsupport	64
Treatment rejection	57
Dominance	49
Warmth	38
BDI	
Raw score	2
BAI	
Raw score	6

Note. MPS, Multidimensional Perfectionism Scale; Self-oriented, self-oriented perfectionism; Other-oriented, other-oriented perfectionism; Socially prescribed, socially prescribed perfectionism; PSPS, Perfectionism Self-Presentation Scale; Self-promotion, perfectionistic self-promotion; Nondisplay, nondisplay of imperfection; Nondisclose, nondisclosure of imperfection; PCI, Perfectionism Cognitions Inventory; PAI, Personality Assessment Inventory; BDI, Beck Depression Inventory; BAI, Beck Anxiety Inventory.

she indicated numerous times that she would like to know whether her expectations for her husband and coworkers were reasonable and how she could ensure that her husband would not leave her.

At the conclusion of the group treatment, Eunice provided unrequested feedback to the therapists and staff, indicating that she did not benefit at all from the treatment and felt that the therapists were ineffective. She gave several suggestions as to how the therapists could improve their treatment, such as having the therapists disclosing their own personal information, giving more specific direction to group members, and providing readings so that participants would not have to depend on others for help in making changes. She believed that she was alienated from the group and from the cotherapists because she had only minor problems with her perfectionism. She also expressed the belief that focusing on emotions and relationships among the group members was not helpful; she felt that providing information so she could make the changes on her own would have been better. (Extremely other-oriented perfectionists like Eunice often use unrealistic expectations pervasively to judge the people they encounter, especially if these people might challenge them; treatment providers are no exception.) At follow-up 6 months later, she indicated that she and her husband had broken up and that he had relocated to another country with no chance of reconciliation.

COMMON THEMES

This section focuses on some themes that are common to most if not all of the patients described above. They were accomplished people in their own right. Frances was a successful businesswoman, and Charles, despite his ultimate job loss, had established himself internationally in his field. Robert did very well in school by objective standards but without any sense of accomplishment on his part. Each of them brings to mind the highly successful perfectionists that Blatt (1995) described in his seminal paper "The Destructiveness of Perfectionism." Perfectionism seems exceptionally paradoxical when it is expressed and experienced by people with such objectively established successes. Of course, not all perfectionists are successful, and it is important to note that empirical research with large samples has yet to find clear and consistent evidence linking perfectionism with performance success. In fact, Sherry, Hewitt, Sherry, Flett, and Graham (2010) found that among a sample of university psychology professors, self-oriented perfectionism was associated with less productivity and with lower levels of work quality (as indicated by the number, impact factors, and citation counts of their research publications). Furthermore, research has found that there is no strong

association between perfectionism and achievement test scores in school children (Stornelli, Flett, & Hewitt, 2009).

What has been established is a sense of unhappiness and dissatisfaction among perfectionists, who rarely seem to enjoy their accomplishments. For instance, in the research conducted with school children, perfectionism was linked with anxiety, sadness, and a lack of happiness (Stornelli et al., 2009). An earlier study with acclaimed professional performers (i.e., musicians and dancers) found that perfectionism was associated with performance anxiety, goal dissatisfaction, and less happiness while performing (see Mor et al., 1995). Satisfaction was particularly low among the perfectionistic performers who felt a sense of diminished personal control. This sense of low personal control was probably another factor contributing to the distress of the perfectionists described above. Indeed, Eunice seemed frustrated by her inability to dictate the nature and course of treatment. Other common attributes are described below.

Perfection as a Solution to a Problem

For each of the cases presented, as well as for the case of Anita in Chapter 6, it can be seen that perfectionism played an important if not crucial role in each person's life. The seeking of perfection or appearance of perfection seemed to be a means to attain self-acceptance and acceptance of others; these patients appeared to believe that if they achieved perfection, either something good would happen or something bad would be avoided. For Anita, being the perfect daughter would keep her mother in close proximity, and for Charles, being perfect would prove his father wrong that Charles was unlovable and not capable. For Frances, revealing or presenting a perfect image would allow her to avoid the scorn and ridicule of others; for Eunice, the perfection of her husband would establish her own sense of adequacy, because she would be seen as the kind of woman who had a winner for a husband.

The Need for the Self to Be Perfect

While the majority of the patients clearly had elevations in multiple aspects of perfectionism, it is evident that all but one had elevated levels of self-oriented perfectionism. These data are in keeping with our belief that the self is the ultimate focus of the need to be perfect in order to gain acceptance or caring. It is often stated that perfectionistic individuals have low self-regard. This term almost trivializes the magnitude of the sense of a flawed self that many of the individuals described above experienced. It was remarkable how concerned each individual was about

being absolutely perfect or to have others be perfect. This overcommitment and preoccupation were particularly evident in the case of Robert, who described how driven he was in terms of excessive and obsessive studying. Similarly, Frances acknowledged being driven and throwing herself into music and academic studies while growing up; Charles likewise reported that he drove himself ceaselessly, with the added touch of using self-punishment as a form of motivation. It is also clear that achievement seemed to be an area that these individuals focused upon to attain perfection. This is consistent with our contention that perfectionism is all about perfecting the self, not about perfecting things or tasks. Thus all components and dimensions of perfectionism ultimately involve attempts to perfect an imperfect self.

Self-Criticism

Although there were apparent individual differences in degree, several of the patients showed high levels of self-criticism and thus displayed the attributes of self-critical perfectionism as described by Blatt (1995). Charles acknowledged that he ceaselessly castigated himself, and Frances also acknowledged that she mercilessly derided herself. Robert took things a step further and demonstrated a phenomenon that we have often encountered. That is, once a self-critical perfectionist finally achieves a long-desired goal (the coveted A+, in the case of Robert), the person can turn the success into an abject failure and engage in self-recrimination based on how he or she went about attaining the success. Perfectionists who are self-critical focus on how much effort they had to expend to attain the goal; it is almost as if the only acceptable option is to be effortlessly perfect. All seem to have learned that whatever the performance may be, it is never good enough.

There is a tendency in the research literature to focus on the link between socially prescribed perfectionism and self-criticism, but there is also often an equally strong or more salient association between elevated self-oriented perfectionism and dispositional self-criticism. The 10 case excerpts provided in the MPS test manual contain descriptions of three highly self-critical people who were undergoing treatment and who were high in self-oriented perfectionism, but did not have elevated levels of other-oriented or socially prescribed perfectionism. The first one was a 55-year-old teacher who was a workaholic, despite the fact that she felt her work was never good enough. She had stringent self-evaluations and low self-regard (see Hewitt & Flett, 2004). The second one was a 53-year-old college instructor with debilitating anxiety and depression, who "revealed that she had been burdened by her own perfectionistic standards and punitive self-evaluations all of her life" (Hewitt & Flett,

2004, p. 27). The third one was a 50-year-old lawyer who had experienced emotional and physical abuse from her family of origin. Further assessment indicated that her self-criticism was mixed with high levels of anxiety, sleeping problems, labile mood, anger, and fatigue.

It is important to note that the original conceptualizations of multidimensional perfectionism acknowledged the role of self-criticism. Perfectionism was defined by Frost and associates (1990) as "high standards of performance which are accompanied by tendencies for overly critical evaluations of one's behavior" (p. 450), including overconcern with mistakes to the extent that performance is either "perfect" or "worthless" and that minor flaws represent failure. Similarly, we (Hewitt & Flett, 1991a) characterized self-oriented and socially prescribed perfectionism as not only having exacting expectations, but also "stringently evaluating and censuring one's own behavior" (p. 457). We noted the tendency for perfectionists to be self-critical, and we also linked perfectionism with this tendency to engage in overgeneralization as described originally by Beck (1967). The association between perfectionism and overgeneralization has been documented in a series of studies (see Hewitt & Flett, 1991a; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991). This is an important point to underscore because the self-critical nature of perfectionists is often seen as reflecting the unworthiness of the entire self in a manner that can progress and become a form of self-hatred, as illustrated by the case of the famous author Sylvia Plath, who ultimately took her own life. Thus a failure in one particular area becomes a deficiency in the entire self, in a way that is bound to heighten self-focused attention and the intensity of emotional reactions.

Signs of the Early Development of Perfectionism

Another common feature of the cases described above, and of Anita's case in Chapter 6, is that each person's perfectionistic behavior was evident relatively early in life. For example, Charles reportedly became perfectionistic as an early response to the treatment he received from his abusive father. Robert reported that perfectionism persisted throughout his childhood; Frances recounted that she was a driven child, and that when she reached high school, her perfectionism included hiding behind a façade so that her true self would not be revealed. The focus on the early development of perfectionism in childhood is a pivotal component of the treatment we discuss later in this book. Finally, one of the best examples of this is Anita in Chapter 6.

This tendency for perfectionism to be present from an early age is in keeping with the general notion of personality traits as being detectable early in life and persisting across time and situations. There is now

an extensive and growing literature on perfectionism in children and adolescents, and our own work with the CAPS is based on the premise that perfectionism can be assessed meaningfully and reliably in children as young as 7 years old.

Problems in Functioning

Although we have described three of the four perfectionists presented in this chapter as successful people, they all nevertheless experienced significant problems in achievement and relational functioning, as would be generally expected among people who seek psychological treatment. The differences among them lay in the ways in which the problems in functioning were expressed. Robert's perfectionism interfered with his school functioning and his development of self-regard. The difficulties that Charles experienced, including his inability to stop ruminating about a minor mistake, contributed to his job loss and the times he was at odds with supervisors when he did work. Finally, Frances was unable to work in an efficient manner and had difficulties establishing open relations. Overall, however, these people still were able to demonstrate a reasonable level of functioning, despite these significant problems.

Persistent Distress

One of our previously described studies highlighted the role of various trait dimensions of perfectionism in chronic depression (see Hewitt, Flett, Ediger, Norton, & Flynn, 1998; Huprich, 2003a). Clearly, the potential role of perfectionism in the chronicity of depression has not received sufficient empirical attention, but the association of perfectionism with persistent distress is clearly evident among individual perfectionists, including the four described in this chapter. Robert had repeated bouts with depression, including being hospitalized in the past. Charles admitted that he had been significantly depressed for a long period of time, while Frances had reportedly experienced social anxiety since her childhood. For these individuals, the chronic distress represented an ever-present reminder that they were not perfect and their lives were not perfect.

Suicidality

One of our chief concerns about perfectionism is that this personality orientation is often linked with suicidal tendencies, and we are disquieted by the alarming number of perfectionistic people who have taken their own lives. Readers interested in considering this topic in more detail are directed to three reviews (Hewitt et al., 2006; O'Connor,

2007; Flett, Hewitt, & Heisel, 2014). In the cases described above, two of the perfectionists acknowledged serious suicide attempts; in fact, Charles survived only because his gun misfired. It has been our experience that some suicidal patients, at the conclusion of treatment, indicate that they were not entirely forthcoming with the therapist about the degree of their suicidal behavior when they were asked about this at earlier points in treatment. For example, one patient stated that when she was quite suicidal, she did not tell the therapist that she would often drive her car to the edge of a cliff overlooking the ocean and debate with herself about driving over.

There are several reasons to be highly concerned for the well-being of suicidal perfectionists. Indeed, when assessment opportunities arise, it is always recommended that extensive evaluations should be undertaken to establish the level of suicide risk. Perfectionists are at risk because not only do they seem to have a confluence of co-occurring risk factors (i.e., depression, hopelessness, psychological pain, stress); they also tend to be highly conscientious, planful people who tend to take an all-or-none approach to life. The extent and seriousness of a suicide plan are acknowledged risk factors for completed suicide (Coryell & Young, 2005; Kessler, Borges, & Walter, 1999; Nakagawa et al., 2009). Perfectionists with suicidal tendencies often engage in extensive information searches in order to identify highly lethal means. Finally, another important factor in suicide involves the feelings of being alienated, disconnected, and alone in the world—and, as we have discussed in Chapters 4 and 5, perfectionistic behavior is driven by and exacerbates social disconnection. Unfortunately, these perfectionists may construe an unsuccessful suicide attempt as the ultimate failure, and the sense of shame that accrues from knowing that others know about the failed attempt can escalate the desire to escape by taking their own lives.

Hidden Despair and Pain

There were also signs with these perfectionists that much of their despair was kept hidden and other people were not aware of it. Although there was no mention of this theme in the description of Robert, Frances based her life on keeping her true self from others, and this extended to falsely portraying her level of functioning. The clearest illustration of this was provided by Charles, who effectively hid his depression, job loss, and suicidality—indeed, so effectively that other people were shocked when he attempted to take his own life. Moreover, his hesitancy to reveal to the therapist what he believed to be shameful parts of his life (e.g., his poor upbringing, his suicide attempts, and the depth of his despair) underscored the marked shame he experienced.

Undermining or Complicating Treatment

The cases illustrate various ways in which perfectionism can undermine or complicate the treatment process. We introduce some of these issues now, and we revisit several of these themes in Chapters 9 and 10.

Perfectionists often defend against both experiencing and revealing affective experience by focusing their attention on seeking out new information or using intellectualizing defenses. Frances and Charles both had difficulty demonstrating or discussing the depth of pain they experienced, as well as information about themselves that they viewed as particularly negative. The case description of Robert is dominated by the role of extreme imperatives and demonstrates how perfectionists feel these must be addressed. Recall that in this instance, Robert was preoccupied with getting an A+ in an extremely challenging course, but he felt he had to attain this grade without exerting substantial effort; otherwise he would be a failure. The case of Charles illustrates one of the most important issues: He viewed his perfectionism as a positive factor, and this was probably a view that went back to his initial development of perfectionism. One of the most important initial goals in assessment, therefore, is to determine the extent to which perfectionists are ready to give up their perfectionism. Many people are simply not ready, willing, or able to confront their perfectionism, and in some instances they find it too threatening to their core sense of self to relinquish this part of their identity.

Frances had a high level of a form of perfectionistic self-presentation that we discussed in Chapter 2: the nondisplay of imperfections. This is a highly defensive orientation that can result in core issues' not being acknowledged and disclosed. We have noted that Frances's self-presentation style revealed her marked anxiety over being judged—a fear that clearly had an initial impact on the therapeutic alliance. Some perfectionists need to experience an atmosphere of empathy and nonjudgmental concern as part of the process of developing a stronger sense of self-acceptance.

Finally, Eunice made her dissatisfaction well known to others. Her other-oriented perfectionism had the potential to arouse highly negative feelings in her therapists, in ways that probably mirrored her relationships in general. This other-oriented approach may be the most extreme form of defensiveness associated with perfectionism, because at root, it seems to be a need to keep attention off the self and oriented toward other people's flaws. One of the most distinguishing features (considering that Eunice had voluntarily sought treatment) was that she seemed very dissatisfied but continued to attend therapy sessions—and ultimately ensured that the therapists and research staff knew of her disappointment and negative evaluation.

Other Important Themes

Perceptions of Parents

The role of parents in the development of perfectionism has been discussed at length by many theorists (see Chapter 4), and the relevance of parents is reflected in the perfectionism construct, according to work conducted by Frost and associates on parental expectations and parental criticism (see Frost et al., 1990). Although the parents of perfectionists are often described in negative terms, some patients describe their parents or parent figures in terms that reflect their overidealization of these figures (see the case of Anita in Chapter 6).

Clearly, less favorable views of parents were found among the perfectionists described in this chapter. Robert openly blamed his parents for his difficulties, and Charles was scarred by having a father who did not seem to care about him and left him feeling inadequate. Frances had a supportive family but grew up in an atmosphere where her accomplishments were rarely recognized; when they were recognized, they were attributed externally to lucky circumstances instead of to her personal attributes or effort.

Anger

The emotion of anger is commonly experienced by people who feel that others have mistreated them in some way. Given the already acknowledged tendency for perfectionists to perceive parental mistreatment, it is not surprising that some of our perfectionists had an abiding sense of anger and resentment. Perfectionists, particularly those who are dealing with interpersonal pressures, are prime candidates for the types of hostile depressions that reflect an abiding sense of resentment. Among the people described here, however, it is apparent that the reasons for their anger varied substantially. Robert's anger was fueled by a persistent history of blaming his parents for his troubles. Although there was no explicit mention of anger in Frances's case, Charles often had his sadness turn into profound feelings of anger, which is a natural occurrence among people who have been emotionally abused early in life by a parent or other family member.

One way to characterize the affective experience of perfectionists is that in keeping with classic psychoanalytic conceptualizations, the anger felt toward others is often turned inward (i.e., "anger-in"), taking the form of self-blame and self-criticism. Even when other people are seen as being to blame, there is a sense among perfectionists that they still should have been able to do better. Perhaps this reflects the sense of excessive responsibility that perfectionists so often have (see Hill et al., 1987).

Shame and Social Disconnection

Shame is an emotion that is often found among perfectionists undergoing psychological treatment, and this theme is emphasized throughout this book. Typically, shame is experienced when a person makes negative judgments of seemingly permanent characteristics of the self, and also becomes convinced that other people are aware of these negative attributes (see Tangney, 2002). Charles expressed profound shame as a result of his job loss, while Frances was ashamed of her true self to the point that she spent much of her life trying to cover it up. We can also infer that Robert felt a sense of shame due to his self-perceived lack of intelligence and perceived inadequacy. An important therapeutic goal with most, if not all, perfectionists undergoing treatment is to move from a sense of shame toward self-acceptance accompanied by a capacity for self-compassion.

Much of the shame experienced by perfectionists is anticipatory, and much of their perfectionistic behavior is aimed at shame avoidance. Thus we see that both Charles and Frances had an expectation that criticism and negative evaluations were inevitable. For Frances, this created a readiness to respond with distress if she perceived herself to be "rejected, derided, and ridiculed" in her professional role.

It is natural for people who feel an abiding sense of shame to be socially avoidant to the point of isolation. We have discussed this in our description of the PSDM in Chapters 4 and 5. It suffices for now to note that both Charles and Frances had distanced themselves from other people in a way that cut them off from available sources of social support. With Frances, this was often experienced as a sense of missing out on emotional connections with other people. Certainly the test results in these cases were consistent with those for individuals experiencing social isolation and alienation. For example, patients had scores on the MMPI-2 or PAI above threshold for either social isolation or nonsupport.

The Sense of Being an Imposter

A distinguishing feature for two of our perfectionists was their sense of being an imposter or concern about being perceived an imposter by other people. Imposterism is an empirically demonstrated correlate of the perfectionism construct, as shown by work with people who need to present themselves as perfect to others in order to conceal their inadequacies and deficiencies (Hewitt, Flett, Sherry, et al., 2003). Frances had dedicated herself from early adolescence onward to hiding her shortcomings from others. She became increasingly paralyzed by her inauthenticity. Charles

was troubled that his true defective self would be revealed and would result in people's seeing him as an imposter. These concerns contributed to his inability to reveal his distress and job losses to others.

CONCLUSION

The cases discussed in this chapter involved people who were in treatment due to marked perfectionism. Most of these individuals experienced significant problems with anxiety, depression, and suicidal tendencies, and all experienced significant interpersonal problems. The cases have been presented in order to illustrate the manifestation of perfectionistic and associated behaviors among these individuals, the differing developmental patterns and pathways that may have contributed to their perfectionism, and some of the issues germane to treatment. Although perfectionism is associated with a variety of pernicious and distressing outcomes, it also clearly complicates treatment and can mitigate against successful treatment outcomes. In the chapters to follow, we describe in greater detail our approach to individual and group treatment of perfectionism, and we draw on additional case material to illustrate various aspects of the therapeutic techniques described.

CHAPTER 9

Individual Psychotherapy of Perfectionism

In this chapter, we describe our dynamic-relational approach to individual psychotherapy with perfectionistic individuals. We also show how the treatment model described in Chapter 6 is used in practice. We begin with several preliminary considerations that are relevant to all psychotherapeutic interventions but that are particularly germane to the treatment of perfectionism. An extended case example follows, together with a few excerpts from another case.

PRELIMINARY CONSIDERATIONS

Despite a growing acceptance of psychotherapy in Western society, many people continue to experience feelings of shame and to harbor fears of negative judgment if others discover that they are consulting a psychotherapist. This is particularly so for perfectionists, who tend to view personal limitations as fundamental flaws that must be hidden at all costs. The creation of a therapeutic alliance depends crucially on a clinician's awareness of and sensitivity to the marked anxiety, trepidation, and shame a perfectionistic individual feels about coming for treatment. We often begin our work by acknowledging how difficult it is to come through the office door (particularly the first time), and how much courage it takes to keep coming back to face one's pain head on (see Hewitt et al., 2008; Hewitt, Dang, et al., 2016). Moreover, the clinician needs to be aware throughout the treatment of the patient's propensity for experiencing shame, even while simply sitting in the therapist's waiting room.

The majority of perfectionists seeking treatment are often ambivalent about their perfectionism. On the one hand, they recognize that perfectionism has been a source of suffering and has contributed to lost opportunities, damaged relationships, and/or erosion of self-esteem. Yet they simultaneously hold on to a belief that many of their accomplishments have been the results of their perfectionism. It has been our experience that in the early phases of treatment, it is essential to honor a patient's reluctance to relinquish perfectionism. Benjamin (1993) made a similar point in her discussion of the nature of psychopathology in a paper entitled "Every Psychopathology Is a Gift of Love." Her thesis is that although maladaptive behaviors are self-limiting, they have emerged from a need to adapt to a maladaptive situation. Thus, in the early phase of our work with any perfectionistic individual, our efforts focus on exploring the nature and genesis of perfectionism, in order to understand the ways in which the individual has relied on perfectionism as a self-protective mechanism.

In Chapter 7, we have noted that at the end of the assessment process we take time to share with each patient our working formulation and, in particular, a preliminary description of the CRP. Since the assessment material stems from what the patient has described in conversation and through completion of self-report measures, this summary feedback is seldom surprising to him or her. However, the ways in which the various components of the CRP relate to each other and shape the person's experience often operate outside conscious awareness; the patient typically does not recognize the interconnections among these components of his or her psychology. In cases when we have a high degree of confidence in the initial formulation and CRP, we offer a few examples of ways in which the CRP is likely to be expressed in the therapeutic relationship or other intimate relationships. The CRP is more likely to be understood if a clinician is able to draw on specific interactions and reactions a patient has already provided, including those identified on various measures in the assessment.

Although the clinician can offer detailed explanations of the interpersonal and intrapersonal workings of the perfectionist's dynamics, therapeutic movement can only come about through the patient's own experiential understanding and encounters with unfamiliar ways of relating—both of which occur through the process of psychotherapy. We have found among perfectionists that there is a strong relationship between their need for information and their anxiety level. As core dynamics become increasingly exposed and the pressure to shift relational patterns mounts, perfectionists may express feeling confused and seek further explanations, clarifications, and even readings from their clinicians. This development is consistent with an intellectualizing

defensive position intended to ward off painful affect from immediate awareness. Given that intellectualization is a mature defense employed by many clinicians themselves, particularly in their achievement domains, therapists must always be attentive to this shift in the treatment process. Providing information about perfectionism, or even the idiosyncratic formulation of how it functions and developed, is not enough. An emotion-laden experiential process is necessary. As when learning to ride a bicycle, information on how to engage in this process will not suffice; one must mount a bicycle despite the fear of falling, and physically experience how to balance on it, before one can experience the joy of riding.

Therapists and patients can have very different markers of therapeutic movement and change. From a therapist's vantage point, a patient's ability to express deeper layers of affect and expose shame-filled examples of early relationships reflects growth and a movement toward greater acceptance of self. Yet many patients, and especially those struggling with perfectionism, may view these same experiences as confirmations that the self is flawed and treatment is stalled. In light of this reality, individual work with a patient endeavors to create an environment whereby the workings diagrammed on the two triangles described in Chapter 6 become apparent to both therapist and patient in the here-and-now. This emerging material is explored with the patient in interactions that occur in the moment at increasing depth. This exploration is aided by metacommunicating about the elements of the triangle of adaptation and the triangle of object relations, as well as the CRP as it unfolds in the therapeutic relationship. The therapist's interpersonal stance with the patient aims to invite novel responses from the patient that can, in turn, facilitate corrective emotional experiences. This combination of emotional experience and insight contribute to the patient's discovery that his or her underlying fears are not necessarily accurate and that intimacy needs can be met.

A perfectionistic individual often harbors fantasies from childhood that contribute to the onset or maintenance of perfectionism and its associated distress. These can include memories of early experiences that the patient continues to access repeatedly. The patient's repetition of this material is indicative of its importance. For example, in the treatment of an immigrant woman, the patient recalled that her first memory of her mother involved the mother in a volatile argument with the patient's father. Shortly after this event, the father was arrested and sent to a government reeducation camp. For the patient, the two events became fused, and her recollection was further complicated by the belief that she was the cause of the argument. She saw herself as having done something terribly wrong that had led to the verbal altercation between her parents. Her solution, one that she was convinced would bring her father back,

was to ensure that she would never do anything wrong again. Other patients have shared vivid memories of a parent's wrath in response to an innocent comment by a child, of being told of the death of a parent, or of a parent's despondency that a patient could never fully alleviate. All these are examples of childhood images that were formative in establishing patterns of perfectionistic behavior in patients. In recalling these images, patients can experience the same affect they experienced at the time of the events—the expression of which offers a vehicle for deeper exploration, understanding, and eventual healing.

Finally, because perfectionism, especially socially prescribed perfectionism, has strong links with suicidal behavior (see Chapter 3), it is imperative to be aware of this and to evaluate suicide potential regularly. Perfectionistic individuals will not necessarily be forthcoming about suicidal impulses, or even admit to them (see the case of Anita in Chapter 6). This should be an ongoing concern for therapists at every stage of the assessment and treatment process, and it needs to be addressed in a forthright manner.

THE CASE OF AMADA (AND EXCERPTS FROM THE CASE OF STEWART)

Clinical Assessment Findings

Below we describe our approach to individual treatment and use our work with Amada to illustrate aspects of the treatment process. (We also use a few excerpts from another case, that of Stewart.) Amada was a 64-year-old nun. She completed a psychodiagnostic assessment from which we formulated details of her intrapsychic and interpersonal dynamics, using the triangle of adaptation and the triangle of object relations (see Figure 9.1). The reader is encouraged to refer to Figure 9.1 as we progress through the discussion of Amada's treatment.

Amada was referred for assessment due to interpersonal difficulties. Specifically, her housemates had expressed concern about Amada's angry outbursts, irritability, and verbal aggression. Amada acknowledged that she felt agitated and overwhelmed much of the time. She was aware that her behavior had pushed others away, and she herself felt unsettled by her "explosions." Her responses to the MMPI-2 and MCMI-III revealed clinically significant symptoms of anxiety and depression. She reported fitful and disturbed sleep that was seldom restorative and felt a near-constant inner tension. Amada described herself as being "out of sorts" with herself. She discussed feeling useless and worthless, particularly following an outburst of anger. Amada added that in the past few years, she had become more easily overwhelmed by her emotions and the emotions of

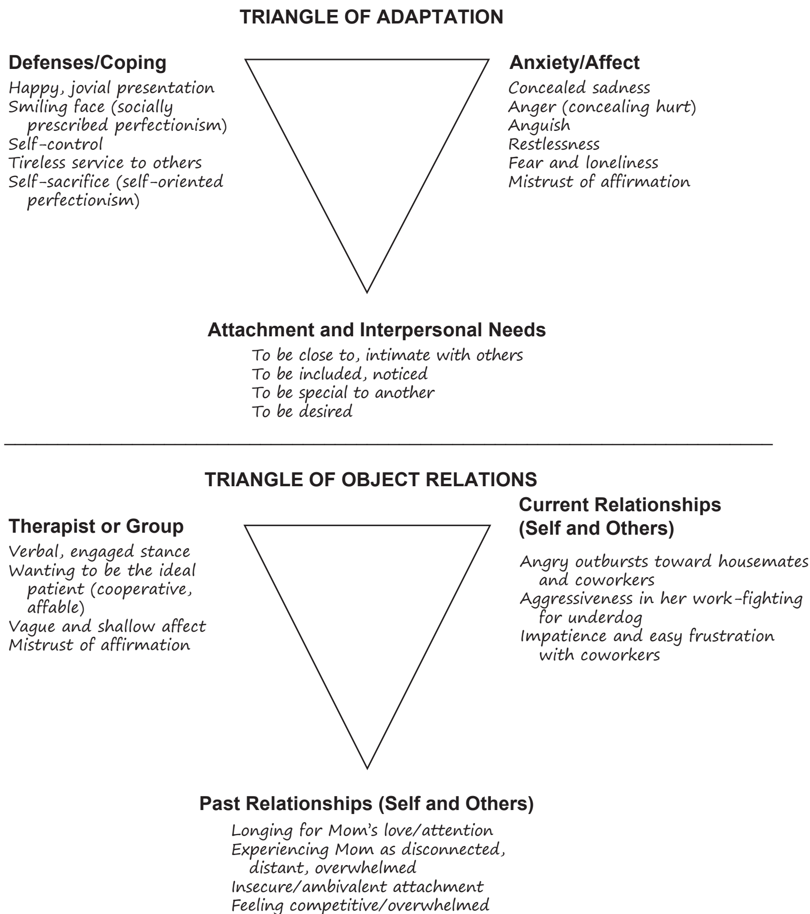

FIGURE 9.1. The triangle of adaptation and the triangle of object relations for Amada.

others. Her primary means of coping included a reliance on avoidance, intellectualization, and rationalization, all of which were intended to neutralize affect.

Amada's responses to the IIP yielded a complex interpersonal profile, which revealed a pattern of relating characterized by a tendency to be overly accommodating, nonassertive, and cold/distant. With respect to perfectionism, she exhibited a mix of self-oriented and other-oriented perfectionism; she subjected herself to highly exacting expectations that could seldom be met, while harboring similarly unrealistic expectations of those around her. Her own perceived failures and the failures

of others to meet her expectations were the foundation of her anger and hostile attacks. At the end of the assessment, Amada was given this feedback and a general description of her dynamics as we understood them to be. She also received a copy of the assessment report completed by the psychologist evaluator to whom she had been assigned.

Early Treatment Phase

Each patient has a unique starting point at the beginning of treatment. Some patients need to express anguish; others may offer detailed lists of symptoms; and still others may lament the cold and distant stance of their partners or other intimates. No matter the starting point, our work in the early phase of treatment centers on the triangle of adaptation. This doesn't mean that we ignore or move away from any patient's disclosures regarding current or past relationships. Clearly, when an interpersonal frame is used to guide therapeutic work, these revelations are core to the work. And so we take note of them and offer empathic reflections of how we imagine each patient felt in the various encounters. If we assume that "every psychopathology is a gift of love," then exploring and uncovering the patient's means of adapting to maladaptive circumstances are critical. In the early phase of treatment, we primarily focus on linking the first layers of affect with unnamed underlying needs and the associated defenses.

As part of the early phase of treatment, Amada was asked to write a letter to her deceased mother. The first part of Amada's letter to her mother spoke from the vantage point of her child-self. She described the distance between mother and child: "But I do not remember having any special closeness, trust, emotional security with you." She wondered what could have given rise to this distance. She hinted at possible jealousy: "Did you feel overwhelmed by the love that other people gave me? Did you feel displaced, as if I did not need you because I had enough people who applauded me?" She also wondered whether she was born too soon after her brother and whether her very existence was a burden to her mother. She asked whether her mother felt inadequate in her maternal role; "Were you insecure in being able to take care of me yourself? I remember better my time with the nannies than my time with you." Amada's comments conveyed a negative and distorted perception of her impact on her mother and her mother's response to her. Her words provide as clear a description as any of the connection between one's introject and the past relationship with a significant other; the parallel is striking. Amada described both her mother and herself as insecure, inadequate, and anguished. She lamented her mother's emotional distance and lack of love, and so she feared and even rejected herself.

Superimposing the triangle of adaptation onto Amada's early relationship with her mother reveals Amada's basic need to be loved and accepted (see Figure 9.1). Her letter was replete with affect, including feelings of shame, anguish, and anxiety. Amada's solution, the emergent defense, was to bury her pain for over 60 long years by presenting a public face of cheerfulness, laughter, and a driven productivity. Yet her pain occasionally would erupt in unintended ways that included outbursts of anger and despair, as well as a euphoric, adolescent-like infatuation with a man that threatened her vocation as a nun. Amada's own words illustrate with clarity the precursors and essence of her perfectionism. As noted earlier, her interpersonal style revealed a perfectionism best characterized by elements of both self-oriented and other-oriented perfectionism: She subjected herself to exacting standards of moral conduct and felt compelled to behave in accordance with what she believed others expected of her (particularly her religious superiors), but she lashed out with vitriolic anger when her housemates failed to meet her expectations. With respect to perfectionistic self-presentation, Amada's behavior was illustrative of the nondisplay of imperfection, whereas the letter to her mother suggested a lessening of the nondisclosure of imperfections.

Amada spoke of having created a public face of joy and carefree fun, intended to conceal her inner anguish and all that she felt must have contributed to her mother's indifference. She acknowledged that her solution brought only partial relief, as she was unable to trust herself or the genuine love of others. She spoke of doubting, rejecting, and being afraid of herself because she could not feel her mother's love. Her next level of defense took the form of exerting immense control over herself: She sought out selfless mission work and felt compelled to "be good" in all things. Perfectionism—in Amada's case, a combination of self-oriented and other-oriented perfectionism, along with her need to present herself as perfect—became her primary means of relating and trying to establish a feeling of security.

The Three Vertices of the Triangle of Adaptation

During the initial phase of treatment, we focus on identifying the patient's affective experience. This can be challenging, as most individuals presenting with perfectionism tend to use highly intellectualized language. Their natural propensity is to focus on what they think or what they believe others think of them. Their initial discourse often revolves around criticism and judgment of self by self, of self by others, or of others by self, and on ways in which either the patients themselves or others have failed to meet their expectations. What are often not expressed

overtly are feelings of anger, fear, sadness, or even disgust. The objective during this phase of treatment is to introduce a vocabulary of emotion. To the extent that a clinician is able to access a patient's affect and convey both understanding and permissiveness in response to the patient's experience, a bond can begin to form that serves as the foundation of an effective working alliance. It is useful to keep in mind that regardless of the form of patients' perfectionism, they are, on the surface, primarily focused on performance, accomplishment, and task completion. Their developmental histories are typically devoid of experiences in which their emotions were of consequence to significant figures in their lives. We have found repeatedly that when asked what they are feeling, patients will typically *describe* rather than *express* their emotions.

In the work with Amada, this process began with her *description* of her anger. And so, in order to meet Amada where she was and to avoid interventions that might be experienced as unsettling or overly threatening, her therapist asked, "So how does your anger show? For instance, if you were to be angry with me, what would I see?" This question generated a fuller description, and thus laid the foundation for working directly with the here-and-now of the therapeutic relationship. The therapist followed this by asking, "Can you tell me about the last time you were really angry?" It was at this juncture that affect could emerge. Amada was then aided in connecting more fully with affect in a more immediate manner through questions asking her to describe the sensory dimensions of her experience: "What did you notice in your body when he spoke to you in that manner and then ignored you?"

With patients like Amada, we make the assumption that there are deeper and more intense emotions beneath what is first expressed. Generally, we suspend an exploration of these deeper emotions until the middle phase of treatment, when we are more certain that a solid therapeutic alliance has taken hold. As we continue to explore the most accessible layers of affect, we begin to link them to the patient's underlying unmet needs. For Amada, anger often concealed feelings of shame and fear of abandonment. Although at times such emotions can be expressed spontaneously, they are more apt to emerge as we identify the underlying unmet needs that triggered the patient's initial emotional reaction. As Amada began to describe the last time she was really angry, this exchange took place:

AMADA: It made me so angry that he was so dismissive and then just ignored me.

THERAPIST: It hurt you so much that he didn't take you seriously and wasn't more attentive.

AMADA: Yes, and I felt so ashamed of myself for lashing out. It just gave him more reason to think that I'm just a petulant child. It just confirms in his mind that I shouldn't be taken seriously. I'm such an idiot sometimes.

At this juncture, the therapist began to link Amada's unmet need for closeness with the various ways in which she tried to protect herself; in other words, the therapist began an exploration of the patient's defenses. Amada revealed that she protected herself by "making nice," quickly shifting from anger to a smiling, happy demeanor, as if nothing had happened, nothing was wrong, no hurt had been felt. For Amada, these were the ways in which she tried to avoid the possibility of rejection and ultimate abandonment.

In summary, in the early phase of treatment, the therapeutic process is best served by focusing on the first layer of affect. Being attentive and fully present to the patient's affective experience contributes to the patient's feeling heard, understood, and accepted. It is essential for both the therapist's words and manner to allow the patient to own his or her emotions. In other words, the therapist should aim to offer reflections and observations rather than interpretive statements. At this juncture in the therapeutic process, the therapist neither conveys approval or disapproval of the affect, but rather focuses on allowing emotions to surface, and on facilitating their full expression as necessary. In naming the patient's affect, it is critical to avoid language that communicates blame of either the patient or the circumstances that gave rise to the emotion.

Middle Treatment Phase: The Interpersonal Circumplex and Clinical Intervention

The middle phase of treatment involves interventions that integrate components of both the triangle of adaptation and the triangle of object relations. Defenses are challenged in an effort to foster more adaptive ways of relating. Underlying needs that have remained unacknowledged, dormant, or too threatening to voice are brought into full view. Within our model, the clinician's therapeutic stance and clinical interventions are guided by the principles of interpersonal theory as articulated by theorists such as Harry Stack Sullivan, Timothy Leary, Donald Kiesler, and Lorna Benjamin. The principles on which we focus are explained below.

Contemporary interpersonal theorists (see, e.g., Kiesler, 1996) suggest that interpersonal interactions will be sustained if participants are able to assume a position of complementarity—that is, if both participants are able to comfortably enact their preferred ways of relating and

give expression to their characteristic dispositions. Each participant in an interpersonal exchange "pulls for" behaviors from the other that support each participant's view of self and expectations of others. Kiesler (1983) states that "our interpersonal actions are designed to invite, pull, elicit, draw, entice, or evoke `restricted classes' of reactions from persons with whom we interact, especially from significant others" (p. 198). The more rigidly organized and narrowly defined a participant's self-system is, the stronger and more persistent the "pull." In the absence of complementarity, one of two outcomes ensues. Typically, the more flexible or healthy individual will yield to the pull of the other. Alternatively, if both participants have rigid self-systems, each will experience mounting anxiety, and one or both will leave the interpersonal field when the level of anxiety is no longer tolerable. An example of this can be seen in an exchange between two highly dominant individuals. Each vies for power and attempts to exert control over the other. What follows is a subjective experience of mounting anxiety and tension that can only be relieved if one participant yields to the dominance of the other or if the exchange is terminated. Typically, the latter outcome takes the form of criticizing, dismissing, or attempts to diminish each other.

The stability experienced in an interpersonal interaction is dependent on the extent to which the exchange between participants adheres to the principles of complementarity. For example, if two individuals insist on assuming positions of dominance in the relationship as noted above, tension ensues, as these are considered noncomplementary positions. This can be seen in couple therapy when a couple complains of sexual incompatibility: One member of the couple insists on sexual intimacy, while the other wants no part of it. The resulting anger and tension are palpable, and if prolonged, they begin to extend to other dimensions of the relationship. Typically, when one member of the couple concedes and capitulates to the other in an effort to diffuse tension, the capitulating member often experiences the decision as a defeat and is left with anger and resentment. The silent, and perhaps unconscious, expectation is one of feeling "owed" the next time around. It is important to note that complementarity only ensures stability and not happiness or satisfaction. In the example outlined, it is clear that both participants are likely to be unhappy in the relationship; if the tension becomes chronic, the relationship is likely to deteriorate to the point of dissolution. A state of dissatisfaction is also possible in instances where complementarity exists. For example, in a scenario similar to the one described above, if one partner is dominant and the other is submissive, there may still be a lack of sexual compatibility—but, due to the complementarity on the power dimension, the partners are less likely to experience conflict as they negotiate their sexual relationship. There is likely to be greater

stability in the relationship, but not necessarily satisfaction, at least not with respect to the couple's sexual experience.

The Triangle of Object Relations: Selecting Clinical Interventions

Within an interpersonal theoretical framework, the selection of interventions is guided by the principle of antithesis and the "Shaurette principle," both of which involve strategic interpersonal behaviors exhibited by the therapist at different points in treatment (Benjamin, 1996). The clinician begins by locating the patient's problematic interpersonal stance on the circumplex. For example, other-oriented perfectionists tend to be highly critical of others. When exploring the components of the triangle of object relations, we are likely to find that the interpersonal stance best characterizing their responses in current relationships is one of blame (hostile–submissive). Similarly, parental and other significant figures in their past were likely to have been blaming, with a resulting introject of self-blame. This stance was depicted with poignant clarity in Amada's letter. On the one hand, she blamed her mother: "Did you feel overwhelmed by the love that other people gave me? . . . Did you feel overburdened by the early news of my conception, and would you have preferred to have more time between Miguel and myself to be able to reaffirm your motherhood?" On the other hand, she blamed herself for the distance in the relationship: "I felt that there must be something wrong within me, because I could not feel your closeness!!! But I couldn't know what it was, and I began to doubt, reject, and be afraid of myself. It is why I began to try to 'control myself' so that this 'horrible something' would not be seen, and I would not be left terribly alone."

In broad terms, the therapeutic objective is to shift the patient's interpersonal position in the direction of friendly acceptance. The principle of antithesis suggests that in order to shift the patient's behavior, the clinician's interpersonal stance needs to reflect the complement of the desired interpersonal position. In this case, the complement of friendly acceptance would be warm welcoming and inviting. The Shaurette principle functions in a similar manner, but is employed in instances where the patient's interpersonal stance is more rigidly organized and the level of maladjustment is more extreme. Recall that the more rigid an individual's interpersonal style is, the greater the pull on others to assume a complementary position. In such cases, assuming a stance that is complementary to the opposite of the patient's interpersonal style is likely to evoke an unmanageable level of tension and anxiety for both patient and therapist. To avoid this while still working toward the desired outcome, the Shaurette principle requires that the therapist initially match the patient's behavior in the same interpersonal space, and then gradually

assume an interpersonal stance that shifts in a stepwise manner toward the desired goal. In the case of an other-oriented perfectionist, hostile attack reflects hostility that can be expressed from either a dominant or submissive stance. Matching the patient's hostility would be countertherapeutic and damaging to the alliance. Instead, the clinician can begin by assuming an interpersonal position that falls within the same surface of the power axis of the circumplex.

We illustrate this with a brief example from another case. Stewart, a patient who had elevated scores on other-oriented perfectionism, was expressing anger and resentment toward his wife, who had failed yet again to handle their children's misbehavior in a manner consistent with his expectations:

> "It's so frustrating. I just can't seem to get through to her, no matter how many times I explain. She's always giving in to them, and I see them getting spoiled right in front of my eyes. They are going to have no discipline, and already I can see that they have no respect for me. I'm just the ogre, the bad guy who ruins everyone's fun. Well, life isn't all just fun and games. She needs to know that, and they have to learn that now; otherwise they're going to fall flat on their faces when they get out in the world, and by then it will be too late. Then what? She'll just go on rescuing them like she always does . . . telling them, `Everything will be all right; you just have to be positive.' Be positive, my ass! The world is a cold, hard place, and no one else is going to take care of you if you don't learn to take care of yourself. You've got to be disciplined in this world if you're going to get anywhere. You've got to be self-sufficient. Look at me: I didn't get where I am by having Mommy and Daddy look after me or hold my hand. I figured that out at 11 when I got my own paper route. I wasn't waiting around for some handout, like all the other kids with their allowances. If I needed something, I worked for it on my own and got it. Now she's buying them cell phone plans and video games and whatever they ask for. And what do they do in return? Nothing. They're constantly wired in, their rooms are a mess—the house is a mess. It's pathetic. I'm disgusted by the bunch of them—the kids and her."

As noted at the start of this section, in the middle phase of treatment we employ interventions that integrate components of both the triangle of adaptation and the triangle of object relations. In the service of solidifying the alliance with Stewart, the therapist began by offering an empathic reflection that named the three components of the triangle of adaptation pertaining to Stewart's relationship with his wife. Stewart

expressed a need for connection (not wanting to be "the ogre"), the frustration of which evoked intense anger and the associated defenses of attack and blame. The therapist reflected on this need as follows; our commentary is in [brackets].

> "You really want her to be on the same page as you when it comes to dealing with the kids, and when she's not, you experience her and the kids as being together and far away from you [need for affiliation/connection]. That really stirs a lot of anger in you [affect], and before long, the two of you are in the throes of another fight that eventually has you retreating to your own corner again [defense], alone and cut off. As angry as you are with her, I also sense that feeling so alone [allusion to the need] for so long has been very painful for you [direct reference to the underlying experience of the associated baseline interpersonal position]."

The therapist thus conceptualized Stewart's other-oriented perfectionism as a maladaptive means of "joining" or trying to be closer to his wife and children. He longed for a relationship in which he and his wife functioned as a team and his children valued and respected him. In both a dynamic-relational and a strategic family systems framework, rigid psychological defenses or maladaptive solutions to relational difficulties are often viewed as bringing about the very outcome the individual is trying to avoid. A clinician using a strategic family systems approach might have employed a paradoxical intervention that would have Stewart joining in his wife's indulgence of the kids. Working from a cognitive-behavioral framework, a clinician might have elected to explore Stewart's underlying assumptions and core beliefs regarding the impact of his wife's indulgence of the kids. Stewart might have been asked to engage in a behavioral experiment in which he would assume a self-observing stance the next time his wife indulged the kids. In this scenario, Stewart would describe the situation, his behavioral response to it, the associated cognitions or catastrophic thoughts (particularly those reflecting perfectionistic content), the emerging affect, and his ultimate response. Treatment would then focus on conducting additional behavioral experiments that challenge some of Stewart's distorted cognitions and core beliefs.

In the example above, the therapist's decision to omit naming Stewart's blaming and attack of his wife was intentional, as doing so posed the risk of matching Stewart's position of blame with blame (e.g., the response "That really stirs a lot of anger in you, and you end up lashing out at her" might have been perceived by Stewart as blaming him). Such a statement is illustrative of the principle of complementarity and the ease with which hostility evokes hostility. Instead, the therapist

endeavored to match Stewart's interpersonal stance on the power axis of the circumplex. The therapist's intervention targeted the submissive dimension of Stewart's stance, to ensure that the level of interpersonal tension in the exchange would be tolerable for Stewart. At the same time, the chosen intervention would be coded as friendly on the affiliation axis—a position that was antithetical to Stewart's hostility. This was achieved by drawing attention to Stewart's attempt to protect and his longing for trust (a friendly–submissive interpersonal stance—Stewart's desired outcome).

Kiesler (1996) outlines a multistep process to treatment planning that employs the circumplex to define the following: (1) behaviors the patient needs to decrease (maladaptive patterns), (2) behaviors the patient needs to increase (therapeutic goal), (3) responses the therapist needs to do less of (countertransference or the "hooked" position), and (4) responses the therapist needs to exhibit (the "disengaged" position). It is this final step that is guided by the principle of antithesis or the Shaurette principle.

The Use of Affect in the Middle Phase

Although interventions can target any component of the triangle of adaptation, being attentive to the timing of specific interventions is critical to preserving an effective working alliance. The interchange between Stewart and his therapist above occurred in the middle phase of treatment, at a point when the therapist felt confident that a strong therapeutic alliance had been established. In the early phase of treatment, interventions are less penetrating and focused on underscoring the most apparent patient affect, as in the earlier vignette between Amada and her therapist. Typically, identifying the patient's affect requires the least extrapolation, as affect is accessed either through direct inquiry or by naming what is being expressed nonverbally. Deepening affective expression allows the individual to move toward a position of congruence and authenticity, and in the process to encounter unnamed or unacknowledged needs, wishes, and assumptions about self and significant others. These become fertile ground for subsequent interventions.

However, when a clinician is inviting the expression of affect, it is not unusual to encounter well-established defenses intended to guard against deeper emotions that are viewed as either unacceptable or threatening to self and others. The person's fear of these deeper emotions and awareness of his or her lack of connectedness contribute to the emergence of perfectionistic patterns as a defense. For example, individuals exhibiting high levels of other-oriented perfectionism may rely on overt expression of anger toward others as a veil that conceals a deeper sadness from

feelings of exclusion or existential loneliness. Individuals exhibiting high levels of socially prescribed perfectionism may feel sadness as a means of guarding against anger that might emerge in a destructive rage, which could lead to rejection and abandonment. The self-oriented perfectionist can appear devoid of emotion or immersed in obsessive worry—a stance that conceals feelings of grief related to a loss of parts of the self.

The frustration of Stewart's unmet needs to connect and protect gave rise to anger, which Stewart defended against by focusing on his wife's failure to parent effectively and the belief that his children were doomed to fail in life. The therapist sensed that underneath Stewart's anger was sadness stemming from his view of himself as standing alone in the family, separate and distant from his wife and children.

As treatment progresses through the middle phase and a strong therapeutic alliance has been established, the clinician invites the expression of ever-deeper layers of affect. This is achieved in several ways. The patient can be asked to focus on nonverbal expressions or behaviors that appear to be out of conscious awareness—for example, a leg that is constantly shaking, hands that are wringing, or a fist that seems to be clenched tightly. As in the early phase, the patient can also be encouraged to attend to physical experiences that may offer clues to emotions stirring within. The therapist can facilitate this process by sharing observations of the patient's nonverbal behaviors and, where possible, linking them to specific content:

"I noticed that you held your breath right after you said that. I wonder what else you might have been holding back at that moment."

"You know, each time you tell me how you failed to meet your father's expectations, you look down at the ground or stare far off in the distance. I sense that you're feeling all sorts of emotions at those moments. I wonder what is stirring in you just now."

"Your tears seem to be very close to the surface. Can you put words to them?"

"Wow, your fists are clenched really tight. What might you be holding onto?"

The clinician can also take greater risks by conveying that the first layer of affect—the emotion that is being expressed and more accessible to conscious awareness—may be overshadowing deeper emotions. Once again, it is important to do this in a manner that does not convey judgment or blame in either content or tone. This can be accomplished by expressing curiosity and a desire to join with the patient in a process of mutual exploration:

"If you were able to get through voicing all of your frustration and anger toward her, I wonder what you would be feeling underneath that?"

"I suspect that your endless worry and all the effort you put into getting things just right might be keeping some strong emotions at bay."

"My sense is that there may be a whole lot of anger underneath the sadness and anxiety you're so in touch with each time you feel you've disappointed him."

Amada's letter to her mother provided a clear example of these various layers of affect. In this letter, she voiced for the first time in her life the various types and levels of emotion that had marked her experience of her mother. In session, Amada read the following portion of her letter with tears in her eyes, occasionally held breath, and a voice that cracked:

> "As I was growing, a sadness grew within me, hidden among so much laughter and many smiles in my funny and bright face. It was `something' inside that did not match the outside. Everybody saw me from outside, and they loved me. But I felt different inside, and I did not like it. I never was able to identify that unsettledness, that discomfort, that horrible sensation of not being truthful, that lack of honesty, that having two faces: one that I did not know and I was afraid of, the other my public face that was applauded by others."

Perfectionism as a Defense

For everyone, the sense of well-being and equanimity depends on the use of certain defenses. Defenses serve either to reduce fear and anxiety or to enhance one's efforts toward wish fulfillment (Benjamin, 1993). Typically, a defense is activated in response to an awareness of a need that one feels may not be fulfilled or of some other perceived threat. In either case, such awareness is accompanied by internal tension, anxiety, or fear, which the defense is intended to diminish or eliminate. Within the dynamic-relational framework, defenses are understood to serve an adaptive function; however, they become maladaptive when they are applied rigidly in response to experiences and situations for which they were not initially intended, or when the defenses and ways of coping rigidly dominate the individual's behavior.

Within the context of psychotherapy, the treatment process is ill served by efforts to erode or challenge a patient's defense before achieving clarity as to its purpose. The ability to facilitate a patient's movement toward greater interpersonal flexibility is advanced by identifying and

validating the unfulfilled need or perceived threat. In our model of treatment, perfectionistic behaviors are viewed as complex defenses, as can be seen in Figure 9.1.

In the middle phase of treatment, the clinician can broach this idea by pursuing one of two lines of inquiry. In the first, the patient is invited to explore the function perfectionism has served in his or her life. This will often involve identifying the genesis of the patient's perfectionism and the relational dynamics that have served to solidify and perpetuate it. Such inquiry will often bring to the surface themes of self-definition, unmet needs, perceived failure, the loss of self or parts of the self, or the perceived loss of significant attachments. Again, Amada's letter to her mother provided clear evidence of this (the italics for emphasis are ours):

> "This anguish, I am telling you, Mamá, has always been with me and has robbed me of deep joy, of trust in myself, and in the genuine love of the people who have loved me. I was unable to believe it. The question of why people outside loved me and you didn't followed me. *I felt there must be something wrong with me because I could not feel your closeness!!!* But I could not know what it was, and I began to doubt, reject, and be afraid of myself. *It is why I began to try to 'control myself' so that this 'horrible something' would not be seen . . .* "

Amada had lived her whole life acutely aware of a longing for her mother's love. The firm belief that her love for her mother was not reciprocated eroded Amada's ability to embrace and find security in others' love for her. She concluded that there must be something wrong with her self—a belief that perpetuated fear and profound self-doubt. Amada's internalization of the absence of her mother's love served as the foundation for an introject characterized by self-rejection. Her solution was to be perfect, while holding the simultaneous belief that others expected her to be perfect. Amada was convinced that perfection of self (either real or projected) would gain her the approval and love of others, particularly her mother. Hers was an activity-based perfectionism: Amada's fragile self-worth revolved around the myriad ways in which she could be of service to others, regardless of the risk to self that was often part and parcel of her ministry to refugees and illegal aliens. Expressions of gratitude, appreciation, or even love brought only temporary assurance of her goodness, but always seemed to fall short of fully dissipating her self-doubt and insecurity. That is, she was not perfect enough to fix herself. Affirmation was typically met with dismissal and embarrassment, and it was her embarrassment that served as an invaluable therapeutic portal into her inner anguish. The clinician noted Amada's constant

recoil in response to even the most minor of affirmations. At these times her face became slightly flushed, and her gaze shifted away from the therapist and toward the ground. Her expression conveyed shame and sadness.

THERAPIST: You look embarrassed and a bit sad.

AMADA: I am.

THERAPIST: Can you tell me about that?

AMADA: I don't know. I don't like it when you do that—give me a compliment or say something positive about me. It's like I can't hear it without feeling like it's an expectation.

THERAPIST: I'm not sure I fully understand. Can you help me? [The therapist uses language familiar to Amada and appeals to her prototypic manner of relating to others by being a helper.]

AMADA: Well, it just puts pressure on me to be something I'm not—this good girl that everyone believes me to be, including you. I'm not really, you know. I'm not at all what you think I am.

THERAPIST: It seems that I've become another person in a long line of people who you feel you have to please by pretending and that the person you've revealed to me isn't the real you.

AMADA: That's not what I mean. I don't hide anything in here. I've let you see me as I am, warts and all. It's just that compliments have never been comfortable for me. They make me feel like a fraud. I want to be the person people see. That's the pressure I feel. But somehow I always fall far short of that mark. I can never live up to that image.

THERAPIST: I wonder if you can describe to me the person your mother saw when she looked at you. Can you see yourself through her eyes?

AMADA: (*With tears in her eyes and a melancholy smile*) My mother was a wonderful woman, kind and welcoming to everyone, so kind to the maids and nannies.

This was a critical juncture in Amada's therapy, with the therapist's last intervention signaling an effort to move beyond Amada's long-held negative introject. Amada responded by idealizing her mother, while ignoring the invitation the therapist had extended.

Amada's personality contained elements of histrionic and narcissistic character structures. Benjamin describes the baseline interpersonal position associated with narcissism as one of "extreme vulnerability to criticism or being ignored, together with a strong wish for love, support

and admiring deference from others" (1996, p. 147). Amada's expression of narcissism was complex, in that she simultaneously longed for and needed affirmation, and yet was burdened and made anxious by the anticipated cost. Benjamin notes that the interpersonal position of the histrionic personality reflects a "strong fear of being ignored, together with a wish to be loved and taken care of by someone powerful, who nonetheless can be controlled through use of charm and entertainment skills" (1996, p. 173). Both personality organizations share a common defense that involves the formation of a public self, aimed at securing the approval and support of others while concealing what the individual believes to be the true self that could never be accepted or embraced if exposed. In the early stages of development, the child works to gain a parent's affirmation and attention by being pleasing. In the case of the narcissistic person, this striving is often realized through achievements, many of which reflect that parent's own unfulfilled hopes and longings. Individuals with emerging histrionic personalities may have perceived their humor, capacity to amuse, or beauty as a source of public pride for their parents, and therefore as an essential vehicle through which love could be secured (albeit precariously).

Amada's response to the therapist's question recapitulated the internalized dynamic—ignoring the self as she perceived herself to have been ignored, and in a sense ignoring the therapist, the latter dynamic being expressed in a response whereby Amada treated the therapist in a manner that mirrored her description of her mother's stance toward her. There was likely to be considerable internal "dis-ease" in the face of this intervention, making it essential that the therapist persist and remain vigilant to the many subtle ways in which Amada was apt to move away from this focus. Not only was it difficult for this narcissistic and histrionic patient to see the world through the eyes of another, but the therapist's request also called Amada to look inward at a part of herself she believed to be tainted. Several sessions were needed to explore this question fully, with change emerging slowly through Amada's recognition of her own and her mother's humanness with all of the inherent limitations. To the extent that she was able to come to terms with and embrace this reality, she could begin to relinquish self-oriented perfectionism as an essential defense.

THERAPIST: I noticed you moved away from my invitation to see yourself through your mother's eyes. I'd like to bring you back to that. What do you suppose this "wonderful woman" saw when she looked at you, her first-born daughter?

AMADA: I don't know. I suppose she was both pleased and terrified

> at first. I suspect she was glad to have a girl that she could share things with—things that only women can share and understand. But I think she might have felt that I came along too soon.

Amada's response served as an entry point to a line of interventions that allowed the therapist to address her self-oriented perfectionism. The first part of her response suggested that Amada possessed at least a partial foundation for a positive sense of self. She recognized that as the first-born daughter, she held a special place in her mother's inner world, having the potential to be the girl with whom her mother could share all that was feminine. This was a brief, albeit important, juncture in which her mother's hopes and dreams served as a mirror reflecting back an image that had been all too elusive for Amada. A critical component of the therapeutic work involved building on this statement and related experiences as a means of aiding Amada in her efforts to realign aspects of her self-concept.

The second part of Amada's response was equally important. She believed that she had arrived too soon after her brother's birth, and that her entry into the family had been too much for her mother. The therapist made note of this and eventually made a link between this long-held belief and Amada's overreliance on helping others as a means of affirming her importance to others and her self-worth. By assuming a stance of curiosity coupled with empathic reflection, the therapist helped Amada recognize that from a relatively early age, she had been determined that she would not be a burden to her mother. Given the presence of numerous servants and extended family members, Amada first accomplished this by gravitating toward nannies, aunts, and uncles who became both playmates and an affirming audience. As she got older, she discovered that putting herself at the service of others brought expressions of gratitude, while ensuring that no one was inconvenienced or burdened by her needs.

A second related line of inquiry involves identifying the cost of perfectionism. Most if not all patients who seek treatment for perfectionism are aware that perfectionism has exacted a high cost in their lives, and it is seen as a pervasive and ubiquitous burden that does not abate. Some patients will have faced repeated complaints or teasing from friends and coworkers in response to inappropriate standards and expectations. Others may have received mediocre performance appraisals or missed out on promotions because of work that shows great potential due to its exacting precision and quality, but is seldom completed on time for the very same reasons. Still others recognize that they have pushed people away and lost relationships, because others were left feeling that the perfectionists either expected too much or viewed them in a manner

suggesting that they could never be good enough. Amada's recognition of this reality was captured in her description of her experience at boarding school:

> "When I was upset, my reaction could be brutal. . . . Absolute silence, ignoring the person whom I had problems with. All the muscles of my face were tense. Impossible to smile. . . . One of those nights when Therasia told me to go to bed because I was tired, I knew it was a way to tell me I was incorrigible."

In the course of therapy, Amada recognized and grew increasingly uncomfortable with the discrepancy between her public persona and her hidden self. For years she had projected an image of a woman who appeared joyful, caring, and playful, even while working in difficult and at times oppressive circumstances. Amada's awareness of the incongruence between her cheery public face and the self-doubts would crystallize when she faced perceived failure. Her perfectionistic cognitions stemmed from a belief system in which perceived failure was equated with disapproval, overt criticism, and the threat of abandonment. When faced with an experience of perceived failure, Amada would either lash out at someone else or respond to those around her with emotional dismissal and silence. It was this very dynamic that had brought Amada into treatment. Those who lived and worked with her were often confused and disturbed by her unpredictable moods. Understandably, they responded to her anger outbursts with anger of their own, followed by disengagement. Amada's silence and dismissal evoked feelings of hurt and rejection in others—the very experiences that she herself feared. In the aftermath of such encounters, Amada felt regret and a sense of emptiness; these responses were made all the more acute in the face of the relational ruptures that had occurred. She often wondered how or why anyone could love her, and this doubt extended to her experience of God as well. When others retreated from her because of her anger or "silent treatment." she felt she had sinned; in Amada's world view, that meant being separated from God.

Amada focused a great deal of her emotional energy on containing her affect and retreating from any person with whom she was upset in order to avoid this pattern. Although this was her defense against the threat of rejection and disapproval, it served to reify her belief that her real self was unacceptable, flawed, and intolerable to both her and others. Amada interpreted her fear of these troubling emotions as a sign of dishonesty; this would be a painful and difficult belief for anyone, and it was particularly painful for a woman who had elected to dedicate her life to God and the service of others.

The work with Amada illustrates that the treatment of perfectionism is by necessity multifaceted. The relational dimension of treatment centered on helping Amada respond to interpersonal conflict from a position of authenticity and congruence, while relinquishing her tendency to lash out either directly or through passive–aggressive silence. Her fear of criticism, rejection, and abandonment had to be addressed in order to achieve this, requiring the therapist to be attuned to the affect that Amada had found most troubling and then to invite its full expression. At times this process was challenging, resulting in several false starts and retreats by both Amada and the clinician. This dimension of the work began to take shape once a foundation of mutual trust and respect had been firmly established; the clinician's early responses to Amada were essential to building this foundation. As the clinician reflected back Amada's gnawing discomfort with the discrepancy between her public and private selves, she reacted with anger and irritation. She experienced the clinician's comments as criticisms and was convinced that they would be followed by rejection and abandonment. Yet the clinician responded with attentive neutrality.

Kiesler (1996) has described this work as a process of disengagement "through which the therapist prevents the relationship from ending in alienation" (p. 247). Kiesler goes on to state that "the therapist can produce cognitive ambiguity and uncertainty for the patient, as the first step toward disrupting the patient's maladaptive style, by shifting from complementary responses to therapeutic *asocial* (Beier, 1966) responses" (p. 247). The therapist's ability to withhold the expected response thus functions as a catalyst for change. Crucial to such an intervention are the existence of an effective therapeutic alliance and a norm of metacommunication whereby interactions, emotions, and perceptions can be discussed openly and nonjudgmentally. Affectively, the patient may respond with surprise or confusion when the expected retaliation does not materialize. This may actually result in an escalation in the patient's behavior (anger, brooding, dismissal), making it essential for the therapist to hold firmly to his or her stance. What follows is a shift in behavior that may take the form of metacommunication by the patient: "You don't seem to be angry with me like everyone else is when I get angry at them." This is typically accompanied by a deescalation of affect that matches the therapist's neutrality and calm, as well as a gradual shift in cognition reflected in the awareness that the patient's anger has not resulted in abandonment, criticism, or attack. Of course, these changes do not occur simultaneously, and certainly not immediately. As in all psychotherapeutic work, change is invariably characterized by movement forward, followed by a retreat to a stance that is more familiar and overlearned.

Late Treatment Phase

The themes that best capture the nature of the therapeutic focus during the late phase of treatment are accommodation and consolidation. By this point in treatment, the patient's most significant unfulfilled needs have been identified. If treatment has progressed well, the self-limiting nature of the patient's defenses has been explored and challenged. The patient's presentation is appreciably different, with the nature and quality of emotional expression appearing less conflicted and less complex. For example, sadness is expressed in an unadulterated manner, rather than the more complex mix of sadness and resentment that may have been evident earlier in treatment. The patient's communication is more congruent, as evidenced by a greater alignment between verbal and nonverbal expressions of emotion. The therapeutic focus is almost exclusively centered on the vertices of the triangle of object relations. Anger that once was felt toward demanding or neglectful parental figures shifts to growing recognition, and perhaps even acceptance, of these figures' emotional limitations. Blame and resentment are slowly replaced by grief for what was never realized and likely will never be, since as treatment begins to wind down, parental figures are recognized as having harbored their own unique psychological wounds. A parallel process unfolds with respect to current relationships, whether these are with a partner, a boss, colleagues, and/or offspring. The therapist invites an exchange that brings into full awareness the humanness, and therefore the incompleteness, of all those whom the patient has encountered, including the patient him- or herself.

Many patients who present with perfectionism tend to view their therapists in idealized terms during this phase of treatment. In a sense, this is a form of regression, and one that must be noted and addressed in any successful treatment. Patients are encouraged to express their disappointments, for invariably there will have been junctures during which their therapists failed to understand some aspects of their experiences. A great deal of growth can be realized when moments are recalled and acknowledged as having been difficult and perhaps even painful for both a patient and therapist, and yet the relationship continued and repair was possible despite the therapist's limitations.

Transference and Countertransference Considerations

In our 2004 manual for the MPS (Hewitt & Flett, 2004), we have described process-related issues that involve transference and countertransference reactions as well as other considerations. These are important issues to deal with, of course, and can affect treatment in different ways, depending

on which perfectionism trait is predominant. We have suggested that self-oriented perfectionism can create a particular challenge, because the patient's unrealistic and perfectionistic expectations can be directed toward the therapy itself. The patient may attempt to be a perfect patient in order to maximize benefit. Such a patient will want the therapist to respect his or her work, work ethic, and skills, and will require both exceptional and quick outcomes. Moreover, individuals with excessive levels of self-oriented perfectionism can become discouraged and dysphoric about their progress, viewing it as not quick enough. They may be prone to drop out or become emotionally detached. Their own appraisals are likely to focus on flaws and areas that have yet to change, rather than on satisfaction with accomplishments in treatment. This may be especially the case when a therapist and patient use different markers of progress.

Patients with other-oriented perfectionism can affect the treatment process by being demanding, critical, and provoking. This can erode the self-confidence of therapists, especially inexperienced therapists or ones whose self-esteem may be somewhat reactive. Furthermore, an individual with excessive other-oriented perfectionism may require a therapist to be perfect and may thus become judgmental, expressing hostility, aggressiveness, passive–aggressiveness, and a lack of trust in the therapist's ability (see the case of Eunice in Chapter 8). These characteristics have the potential to interfere dramatically with the psychotherapy, and the therapist must deal with these issues appropriately by using them as therapeutic opportunities.

Socially prescribed perfectionism can also have a decided impact on the therapeutic process and therapeutic alliance. These individuals have powerful needs to please others and to gain others' approval. Not surprisingly, these needs will be manifested in the therapeutic relationship: Such an individual may attempt to be the perfect patient and appear to be making strides in treatment, whereas in reality the person's behavior is driven by a longing to secure the therapist's approval. The patient remains vigilant for any sign of rejection, abandonment, or judgment, and may forgo disclosing information that he or she believes the therapist might not want to hear. The therapist, in this sort of transference, can come to be seen as all-powerful and as a potentially threatening individual who will ultimately reject the patient.

The treatment of perfectionism also requires awareness and management of countertransference reactions. It is important for clinicians to remind themselves that countertransference reactions reflect the patients' problems. A perfectionistic individual creates social disconnection, and a therapist needs to understand the nature of the experienced pulls from such a patient.

Although each specific countertransference reaction is shaped by

the intersection of each therapist's and patient's unique dynamics, we have noted certain recurrent patterns over the course of our work. In the early phase of treatment, patients are often distressed and frustrated by having been trapped in a web of standards and expectations that can never be met. The longing for relief is practically palpable, and it can pressure therapists to offer relief. In the first few sessions of treatment, therapists may also find themselves facing a barrage of questions about perfectionism, with a strong pull to provide answers. The performance and task orientations that are so often hallmarks of perfectionism manifest themselves in persistent information seeking. Self-oriented and socially prescribed perfectionists hold the belief that "If I know what I'm supposed to do and how to do it, I will get on with it, and things will be better." For other-oriented perfectionists, the expectation is that others (in this case, their therapists) should know what to do and should do it expediently. Both positions are located on the hostile–dominant quadrant of the interpersonal circumplex. The recommended therapeutic stance would be to assume a position of neutrality on the power axis and of friendliness on the affiliation axis. This can be achieved by offering an empathic reflection that acknowledges a patient's anguish and helplessness. Here are examples of reflections that can be offered to each type of perfectionist:

- *To the self-oriented perfectionist:* "Wow, it's clear how hard you've wanted to succeed, but it seems no matter what you accomplish and how impressed others are, you're left feeling that it just wasn't enough. I can see how exhausting that's been for you. And now you sense that if I just give you the right road map, you'll finally get there. That's a lot of pressure for both of us."
- *To the other-oriented perfectionist:* "It seems you've felt repeatedly disappointed by the most important people in your life. That must really hurt, and I suppose it's made you hesitant to trust. Now you're taking a leap of faith by asking me to give you some answers. I wonder if a way of taking care of yourself right now would be to approach our relationship one step at a time, so that we can begin to build a mutual trust gradually."
- *To the socially prescribed perfectionist:* "It's apparent that you've been battling this for a long time, and it's really wearing you down. I can see that you've been trying so hard to please everyone around you. That must be a terrible burden to bear."

Countertransference reactions in the middle phase are likely to take the form of impatience in response to self-oriented and socially prescribed perfectionists. This impatience can take the form of giving

advice, offering instruction, or engaging in excessive confrontation. Other-oriented perfectionists may evoke a number of reactions in therapists, including a stance of emotional disconnection, condescension, or cool indifference. Being aware of these internal responses and countering them are essential to preserving the therapeutic alliance. It is at these junctures that metacommunication and process commentary can be extremely helpful. The treatment of perfectionism is fraught with countless land mines for both patient and therapist, making therapeutic vigilance critical to effective treatment.

CONCLUSION

We have provided a description of our dynamic-relational approach to individual psychotherapy with perfectionistic individuals. One of the challenges, but also one of the joys, of individual psychotherapy is that every person is complex and unique, and comes with an idiosyncratic story, history, and manifestation of the perfectionistic behavior. Helping each perfectionistic individual is thus a unique challenge, but we believe that perfectionism can be eliminated through paying careful attention to the process and content of the therapy, and through providing as safe and secure an environment as is possible.

CHAPTER 10

Group Psychotherapy of Perfectionistic Behavior

WHY GROUP TREATMENT?

Group psychotherapy can be particularly potent in treating perfectionism, although it entails a number of significant challenges for both patients and therapists. All forms of psychotherapy require a willingness to reveal one's vulnerability—a formidable task for any individual struggling with perfectionism, particularly when self-disclosure is expected in a context that feels very public. We have shown (Hewitt et al., 2008) that perfectionistic individuals experience marked anxiety when discussing personal shortcomings, and it is reasonable to assume that this anxiety would be intensified in a group context. Moreover, Dies (1993) identified several characteristics that make group psychotherapy challenging for participants in general, and Flynn (2001) has described these as particularly relevant for persons with perfectionism. Dies (1993) indicated that group participants need to have reasonable goals and expectations, to be motivated, to be cooperative with others, and to be capable of forming an alliance. All these requirements would be challenging for perfectionistic individuals in any situation (Hewitt et al., 2008; Hill et al., 1997; Zuroff et al., 1999). Furthermore, research suggests that perfectionistic individuals tend to be hostile and domineering, making it difficult for them to form cooperative, cohesive, and constructive relationships with fellow group members and the group leaders. As Flynn (2001) has noted, "the combination of anxiety about disclosure to the group, frustration over elevated expectations for the self and others in the group, and difficulties in creating cohesive relationships with a number of different people could combine to make group psychotherapy extremely challenging for perfectionists" (p. 34).

Many of these hurdles can be addressed by knowledgeable therapists employing appropriate interventions; other challenges provide excellent opportunities for therapeutic benefit (Toseland & Siporin, 1986). Furthermore, appropriate pregroup preparation and training sessions may be used to facilitate participation and mitigate some of the possible threats (see Dies, 1993; Hewitt, Mikail, et al., 2015; MacKenzie, 1990; Piper, 1991).

General evidence suggests that perfectionists may actually prefer to avoid emotional experiences altogether. One investigation testing the relevance of variables included in acceptance and commitment therapies found that aspects of trait perfectionism, as assessed with the FMPS, were associated with experiential avoidance. In particular, perfectionists with high levels of concern over mistakes and doubts about actions agreed with such statements as “I try to suppress thoughts and feelings that I just don’t like by just not thinking about them” (see Santanello & Gardner, 2007).

These tendencies are sometimes exacerbated among group members who come from cultural or familial backgrounds where emotional display rules are focused on being inexpressive; often these individuals hide behind a mask or façade that prevents others from knowing what they are feeling. This unwillingness to share emotions can contribute to premature termination from treatment. For those who remain in treatment, the reluctance to reveal emotions can be extreme; it can make these individuals appear cold, distant, aloof, and emotionless, and can affect both treatment process and outcome. Group therapy offers such patients an opportunity to encounter feedback in a context that is made safe by the presence of an empathic and accepting group leader, and by peers who are all too familiar with the frustration and pain of walking the same path. Socially anxious people who are perfectionistic and fearful of making mistakes, particularly in public, often lack spontaneity and appear disengaged because they are highly focused on controlling visible signs of anxiety. Collectively, these problems in emotional awareness and expressivity suggest that certain perfectionists may benefit from group treatment—particularly an approach that is informed by psychodynamic principles, in which emphasis is placed on accessing affect and challenging the avoidance of anxiety and self-limiting defenses.

A DYNAMIC-RELATIONAL APPROACH TO GROUP TREATMENT

Our dynamic-relational approach to the treatment of perfectionism is particularly well suited to a group psychotherapy format. The University of British Columbia (UBC) Perfectionism Treatment Study (described

in detail later in this chapter) found that this approach was effective in reducing both perfectionistic behaviors and symptoms of dysfunction at the conclusion of treatment and at a 4-month follow-up (see Hewitt, Mikail, et al., 2015).

Our treatment model employs relatively homogeneous, time-limited groups, with treatment extending for a total of sixteen 90-minute group sessions. In this context, "homogeneity" means that all group members have elevated scores on at least one dimension of the MPS or PSPS. Typically, each of our groups comprises a cohort of 8–10 participants with two group leaders. Given the time-limited format, groups are closed-ended, so that a given cohort begins and ends treatment together. Each participant undergoes two individual pregroup sessions prior to entry. The first session focuses on assessment, while the second focuses on pregroup preparation. As part of an overall psychodiagnostic assessment, prospective group members complete the perfectionism measures described in Chapter 7. This constellation of measures provides a comprehensive understanding of each individual's perfectionism and other clinical issues. The clinician also gathers a psychosocial history and constructs a case conceptualization, using the principles of psychodynamic and interpersonal theory outlined in Chapter 6. We draw on the triangle of adaptation and the triangle of object relations as a means of understanding the individual's relational patterns, prototypic defenses, problematic affects, and attachment style.

The second pregroup session involves sharing the case formulation individually with the patient, with an emphasis on describing ways in which the patient's dynamics are likely to manifest themselves in group interactions. Where possible, we offer predictions of potential areas of tension and difficulty that may surface for the individual, given his or her interpersonal dynamics. These predictions serve to underscore and normalize the reality that each person's dynamics will eventually play out in interactions with other members of the group; that is, the group will become a microcosm of the person's interpersonal world. In this way, each individual's struggles and strengths become directly observable and available to all who are present.

The patient's goals and hopes for treatment are also reviewed and operationalized in behavioral terms. Once the individual's dynamics and goals have been covered satisfactorily, the clinician reviews group rules and expectations for participation. This begins the process of establishing adaptive group norms. We have found it helpful to provide participants with a written description of these expectations (see Appendix 10.1). Individuals who have not had prior exposure to psychotherapy may require additional pregroup preparation sessions to familiarize them with the nature of self-examination and inner work. Our experience

suggests that these individuals are often more anxious about embarking on a course of psychotherapy and may anticipate treatment akin to the traditional medical model, in which a patient is a more passive recipient of an expert clinician's direction. This additional orientation may be particularly important in work with individuals of lower socioeconomic status (SES) or those from cultures that have socialized them to assume a passive role in health care. Strupp and Bloxom (1973) found that exposing patients of low SES to a role induction procedure before their participation in group therapy led to more favorable outcomes. In addition, Rutan and Stone (1993) have found that individuals with no prior psychotherapy experience are at greater risk for premature termination. This risk is heightened when group psychotherapy is recommended, as the thought of sharing one's difficulties with eight or nine strangers can be unsettling, particularly for those people who are highly invested in concealing personal imperfections.

In instances when it is necessary to extend the length of pregroup preparation, there is a risk of a patient's becoming increasingly comfortable in the didactic (i.e., more educational) environment with an empathic clinician, and more anxious about entering a group where discussions of personal vulnerability, distress, and personal issues are expected. The clinician can reduce the likelihood that this will occur by maintaining a psychoeducational focus and repeatedly linking discussion of the patient's dynamics to the group therapy experience. We see this skillfully illustrated in an exchange between the therapist and Gus, a patient who was about to enter group treatment:

THERAPIST: It seems that for much of your life, you've taken on the role of servant and helper. There's a good chance that you could easily fall into that same role in group. You might even find yourself slipping into the role of therapist to the other members.

GUS: I suppose you're right. I've always felt it as my duty to respond to whatever was needed. If a job had to be done, I did it. If someone was hurting, I took care of them.

THERAPIST: So, in light of the deep hurt you felt when you were not elected to a position of leadership by members of your [religious] community, I wonder how you will react if in group I point out that you're taking on the role of helper, or if the other group members make it clear that they don't want you to assume the role of cotherapist.

GUS: I think I would find that embarrassing, maybe even humiliating if it came from you. Based on past experience, I would likely retreat in silence and lick my wounds, maybe even harbor

resentment toward whoever called me on that. But I see your point; that kind of feedback is probably what I need, but I doubt that I will like it.

THERAPIST: Keep in mind what we spoke about earlier—group therapy requires a willingness to offer as well as receive honest feedback. But feedback is not the same thing as giving another person advice or telling them what they need to do in order to improve their life. It means being willing to honestly share your reaction and experience of them. So it will be important to voice your hurt rather than retreating in silence.

Gus's overarching goal was to be authentic and relinquish the false "perfect" self he had hidden behind most of his life. This exchange between Gus and the therapist reflects a balance between identifying and explaining Gus's dynamics, and providing Gus with information directly linked to his upcoming involvement in group therapy.

THE FOUR PHASES OF GROUP PSYCHOTHERAPY

As noted above, our model of group treatment lasts for 16 sessions; these sessions can be roughly divided into four phases, with each phase having a predominant focus and objective. We have labeled the phases "engagement and pseudoattachment" (Phase 1), "pattern interruption" (Phase 2), "self-redefinition/painful authenticity" (Phase 3), and "termination" (Phase 4). We employ the concept of "phases" rather than "stages" to underscore the somewhat fluid yet predictable nature of group development. Specifically, our experience suggests that although the formation of group identity occurs in a coherent and progressive manner, movement through the four phases is seldom unidirectional.

Although each phase label reflects the central task in which the group is engaged during that particular phase, the parameters guiding a therapist's interventions are not rigidly defined or organized. This is reflected in the dialogue with Gus presented above, in which we see the therapist drawing on elements of pattern interruption in a pregroup preparation session. While summarizing the results of his assessment and case conceptualization, the therapist pointed out that assuming the role of helper or servant had been a core element of Gus's identity and self-worth. He cautioned that Gus could easily find himself recapitulating this manner of relating with group members. The therapist told Gus that an essential part of treatment would involve interrupting this relational pattern. The therapist, along with group members, was likely to

offer this same feedback in various forms—particularly during Phase 2, where it was apt to be even more concentrated and challenging.

Phase 1: Engagement and Pseudoattachment

The first session begins with having group members introduce themselves and summarize the reasons that led them to enter group therapy. For many, the latter task serves as an immediate source of inner tension between their need to be perfect (or appear perfect) and the willingness to reveal their vulnerability in the hope of achieving a sense of normality. In many respects, the task is to do the thing that a perfectionistic individual fears the most: reveal one's imperfect self. This early phase of treatment is characterized by a high degree of collective anxiety, made manifest in nervous laughter and self-derogatory jokes about perfectionism; these jokes are often veiled expressions of patients' anger toward themselves or toward significant figures who have been the sources of unrealistic expectations (e.g., parental figures, spouses/partners, employers, colleagues). A therapist is faced with the task of keeping anxiety at a manageable level. In order to do so effectively and therapeutically, it is necessary to differentiate between at least two distinct forms of anxiety. Anxiety deriving from real or perceived attacks on the self is apt to trigger defensiveness that stifles self-discovery and growth. In contrast, anxiety that is typically the aftershock of one's movement toward transparency can foster group cohesion and personal transformation. The group therapist is faced with the near-constant challenge of extinguishing the former and supporting the latter.

Although this challenge is not unique to the treatment of perfectionism, the quest for perfection renders criticism the "life blood" of this population. In this initial phase of the group's life, members' criticism is mostly directed toward themselves (in the case of self-oriented and socially prescribed perfectionists) or significant others (in the case of other-oriented perfectionists). However, less subtle and indirect forms of criticism are often evident, such as when members ignore or dismiss certain comments (particularly affirmations) made by other group members, while giving credence only to input from the expert, supposedly "perfect" group leader. The therapist needs to ensure that an individual is not shamed or left feeling reprimanded when such indirect criticism is revealed. The therapist can achieve this by empathically naming the mixture of longing and revulsion or disbelief evoked in response to affirmation. If the group leader judges such a statement to be too threatening or premature, the same end can be achieved by employing a less emotional statement that makes reference to feelings of discomfort or likens affirmation to an ill-fitting garment.

The therapist can also look for opportunities to underscore the

commonality of experiences shared by various group members. Descriptions of shared experiences can combat the sense of isolation felt by distressed individuals and contribute to building group cohesion. A recent meta-analysis performed on data from 40 studies (Burlingame, McClendon, & Alonso, 2011) confirmed a modest positive association between group cohesion and treatment outcome. Five moderators of this relationship were identified, including treatment length, group size, and the intentional use of interventions to foster an element of group cohesion (see Burlingame et al., 2011). Other recent data indicate that group cohesiveness is differentially beneficial as a function of personality differences; specifically, participants who reported being interpersonally distant from others in their daily lives were likely to show the greatest improvements in response to increases in cohesion (Dinger & Schauenberg, 2010). Given that perfectionism fosters social disconnection and feelings of isolation, it stands to reason that perfectionistic participants can benefit substantially from being in groups with members who are struggling to become increasingly cohesive and supportive. This observation is in keeping with Greene's (2012) recent suggestion that Blatt's distinction between the introjective and anaclitic personality styles represents a key distinction that may be reflected in sophisticated models of psychodynamic group therapy. To the extent possible, in the early stages of group formation, the therapist should use interventions that reference the group-as-a-whole as opposed to those aimed at specific individuals. Group-as-a-whole statements have greater potency fostering increased group engagement by and among group members. They also highlight shared experiences and so foster greater cohesion (Piper, Ogrodniczuk, Joyce, & Weideman, 2011). This emphasis on commonalities can set the stage for substantial progress. A theme that tends to resonate with members from the outset is being the target of unfair treatment and negative evaluations. In inviting such disclosures, it is important to establish a warm and empathic environment for the shared benefit of all group members.

Another theme that resonates strongly with group members is feeling that their experiences are entirely unique and unlike those of others. The first few sessions provide opportunities to underscore that the pressures of perfectionism are shared by many of the people in the room. The emphasis on shared experiences begins to counter the tendency for perfectionists to feel that whatever has happened in their lives—be it good or bad—is largely something that is their personal, unique responsibility.

Examples of therapist statements that can serve to foster greater cohesion and a sense of universality include the following:

> "A number of you seem to readily express your understanding of others in the room, but I've noticed that you really struggle with

receiving the compassion that others in the group have extended to you."

"Many of you have spoken about growing up surrounded by harsh, critical comments and impossible expectations. My sense is that you've internalized those voices. You might have even brought some of those critics with you today, and they seem to be standing in judgment over you, particularly when others affirm you."

This first phase of group therapy is relatively free of conflict and overt expressions of pathology. Group members generally talk about their relational difficulties to a much greater extent than *enacting* their problematic relational patterns. For the most part, group members are on their best behavior (although, of course, there are always exceptions). It is for this reason that we have referred to this phase of group development as a period of "pseudoattachment."

Phase 2: Pattern Interruption

By the third to fifth sessions, the therapist begins to employ increasingly challenging interventions aimed at inviting group members to move toward greater authenticity. One means of accomplishing this is to help group members deepen their experience and expression of affect. Although emotions such as anger and resentment may be accessed relatively easily by individuals exhibiting perfectionistic behavior, affect reflecting vulnerability is subjectively experienced as an indication of imperfection and therefore is more highly guarded and defended against.

Deepening Affective Experience

McCullough et al. (2003) have proposed a number of interventions that can serve to deepen a patient's affective experience. These include staying relentlessly focused on the patient's affect; employing empathic statements; reflecting back the patient's words; focusing on details associated with an affect-laden experience; exploring internal physical cues that may be indicative of deep emotion; serving as the patient's inner voice by suggesting what might have been felt in a given encounter or experience; and sharing one's own feelings in response to what the patient has described. When faced with the all-too-common situation in which a group member simply is unable to access emotions, despite having shared a highly painful memory, a group therapist can ask other group members what they might have felt if they had been in that person's place. If timed appropriately, this intervention often has a cascading effect akin to skipping a stone across the surface of water: It touches down at multiple points, creating independent ripples that intersect or

merge with each other. The words of one group member often touch off memories and emotions in other group members, inviting similar yet distinct contributions. All the while, the words echo within the person who first spoke, as well as in the group-as-a-whole.

The deepening of affect affords group members temporary relief from long-held pain, while also contributing to a mounting tension within the group. In revealing their vulnerability, group members encounter unwanted parts of themselves that have remained hidden from others, and perhaps even from conscious awareness. Such awareness occurs when a group member is faced with the reactions of fellow group members or interpretations made by the group leader. Kiesler (1996) has noted that interpersonal feedback within the context of group therapy has been found to be positively related "(a) [to] behavior change within the group itself, including greater in-group sensitivity and increased group cohesion, (b) to change in actions and emotional expression outside the group as rated by self and others, and (c) to improved self insights" (p. 304).

Discovering unknown parts of the self, or having that which one has hidden exposed, is uncomfortable at best and often highly disconcerting. The result is an unbalancing of one's equanimity. Understandably, the reflexive response is one of defensive denial, reactive attack, silent withdrawal, or simple dismissal. At these times, it is essential for the therapist to remember that "defenses" are just what their name suggests: responses triggered by the need to "defend" oneself in the face of perceived threat. For some group members, the threat is nothing less than a fear of complete and utter exposure. They may feel overwhelming shame and anxiety, having concluded that their "worst self" has been exposed. Often there is an accompanying fear of rejection stemming from a more primal threat of abandonment. For other group members, being challenged to relinquish aspects of their perfectionism feels like self-annihilation; this challenge is acutely unsettling, particularly when it is posed or appears to be posed by the group therapist. Such a patient's subjective experience may be a feeling of having been involuntarily pulled into an arena of competing loyalties. On the one hand, perfectionism has been the umbilical cord that has nourished the promise of parental acceptance and love. On the other hand, the patient is aware that trusting the therapist holds the potential of breaking free of a painful and oppressive existence. This latter option demands trusting a relatively unknown other.

Inevitability of Resistance and Countertransference

Resistance is at its highest level during this second phase of treatment. Self-oriented perfectionists tend to express resistance through mounting frustration at the slow pace of change, or through expressions of hopelessness that things will never change. Other-oriented perfectionists

may become overly critical of others, especially the group leader. They may question the leader's competence; express doubts about the effectiveness of group therapy; or insist that they are nothing like the other group members, who are clearly ineffectual, hapless individuals. Socially prescribed perfectionists will express their resistance through persistent (and at times desperate) pleas for direction, wanting to be told what they should do in order to make things better.

Each form of resistance has an accompanying countertransference response that serves as an invaluable portal into the patient's vulnerability. Kiesler (1983, 1996) has termed this countertransference response the "impact message." According to Kiesler (1996), interpersonal actions serve to "invite, pull, elicit, draw, entice, or evoke 'restricted classes' of reactions from persons with whom we interact, especially from significant others" (p. 83). Kiesler (1996) emphasizes the importance of therapists' attending to the emotional reactions, cognitions, and fantasy engagements triggered within them by group members. Of particular importance are any novel or unfamiliar reactions a therapist feels; these tend to reflect important aspects of a group member's core relational patterns in dealing with significant others, rather than some aspect of the therapist's own interpersonal dynamics. The primary objective of pattern interruption is to intervene in a manner that does not gratify the interpersonal pull of such a patient's communication.

Interpersonal theory suggests that in a given moment patients are bound to be more "skilled" at enacting their maladaptive patterns than therapists will be at recognizing and shifting them. Strupp and Binder (1984) have noted that clinicians will inevitably be drawn into patients' maladaptive interpersonal dynamics. Chevetz and Bromberg (2012) go a step further, suggesting that such engagement is essential to effective treatment—a position captured with great clarity in their assertion that "To be unaffected by our patients is not to have met them" (p. 173). The task is not for therapists to avoid this eventuality at all costs, but rather to make their way out of it without retaliation. It is in punishing or humiliating patients through diminishment, the use of pejorative language, or objectification of their struggles that traumas become reenacted and maladaptive patterns reified.

The Use of Group-as-a-Whole Interventions

One option available to a group therapist is to name and normalize the rising tension in the group. This is most effectively done by using group-as-a-whole interpretations, coupled with attentiveness to the individual fears of group members. Group-as-a-whole interpretations highlight the

interpersonal process by naming how group members are relating either to each other or to the therapists. The collective focus of these interpretations can serve to build cohesion, but it also has the potential to increase tension within the room. During the fourth session in one of the groups that formed part of the UBC Perfectionism Treatment Study, members exhibited mounting frustration toward the therapists in response to the absence of a clear road map instructing them on how to overcome their perfectionism. Group members became increasingly hostile, asserting that the therapists were unhelpful and ill equipped to lead the group. A group-as-a-whole intervention in this situation was to state: "There is a lot of anxiety in the room. For some of you it seems to reflect impatience with yourself, while for others there seems to be a real impatience with us. The group is uneasy with the uncertainty of where all this is going."

In this instance, these intense and protracted attacks by group members were understood as expressions of their intolerance of their own humanness, projected onto the therapists. The members' criticisms and attacks echoed the voices of internalized critical parents who were seldom satisfied with their efforts and had little tolerance for clumsiness or less than perfect efforts. Although such interpretations could have been made, doing so before empathically naming the anxiety that pervaded the room would have run the risk of leaving the group members feeling shamed or attacked. Penetrating interpretations of core dynamics require delicate timing and are more likely to be tolerated if preceded by displays of empathic attunement, captured by the saying "packing a punch with a velvet glove."

If a therapist is able to manage the group's resistance successfully, the level of emotional intensity within the group will begin to recede to a more tolerable level. The therapist's ability to protect group members from one another's attacks and to absorb the group's hostility without retaliation creates the secure base needed for self-examination, which ultimately paves the way for inner change. In the course of pregroup preparation, we tell potential candidates that an essential aspect of a therapist's work in a group is to create a safe environment in which group members can do dangerous work.

Effective Change through the Emotional Leader

Attending to the fears of group members is made more manageable by focusing on the group's "emotional leader" (Beck, Dugo, Eng, & Lewis, 1986). Beck et al. (1986) assert that the emotional leader is the group member exhibiting the greatest emotional availability, who appears poised to undertake the difficult work of change. Emotional leaders are often highly expressive, engaged group members. The quality of their

affect is characterized by authenticity and congruence, in contrast to the dramatic, undifferentiated emotional displays of hysteric or hostile individuals.

Tasca et al. (2007) note that during this phase of the group, the emotional leader "becomes increasingly self-observing and more receptive to the therapist's efforts to block maladaptive interpersonal patterns" (p. 16). The emotional leader's openness to the therapist's interventions becomes a potent source of modeling for other group members. The therapist can invite the emotional leader to examine aspects of his or her intrapsychic dynamics or interpersonal patterns through empathic reflection of unnamed affect in the here-and-now. When named, the affect can expose self-limiting aspects of the individual's self-concept or relationship with self. Another intervention is to subject an exchange between the emotional leader and another group member to microanalysis. The emotional leader might be asked what he or she was feeling at a given moment when speaking to another group member and how the leader had hoped the other would respond. The recipient is then asked what he or she felt in response to the emotional leader's comment. The intervention aims to expand the emotional leader's awareness of his or her interpersonal impact on others. Although this type of intervention appears to focus narrowly on the interaction of one or two group members, aspects of it typically resonate with others in the group.

Identifying and Disarming Hidden Shame

One of the core emotions prevalent in this phase of treatment is shame. The experience of shame reflects a fundamental paradox of group therapy: The public exposure inherent in group treatment can arouse intense feelings of shame, while offering the potential for its resolution (Alonso & Rutan, 1988). Inherent in perfectionism, particularly self-oriented and socially prescribed perfectionism, is a state of heightened self-consciousness. Individuals possessing all forms of perfectionism engage in constant self-evaluation and social comparison. Their interactional style betrays the belief that they are constantly being judged. As group treatment unfolds, and hitherto hidden parts of the self become exposed, most perfectionists experience shame—a shame that surfaces independently of reactions from fellow group members or the therapist. It is at these junctures that projections are temporarily withdrawn, and hostility that had been directed toward the therapists or other group members becomes directed toward the self. Attacks on the self are at least as damaging to the therapeutic process as attacks directed toward others.

The therapist must be constantly attentive to signs of shame and inwardly directed hostility in all group psychotherapy, but especially in

group treatment of perfectionism. Shame is problematic to the group process, as it can contribute to members' recoiling or withdrawing from group interactions. Shame is often expressed in the form of silence, a downward gaze, and an inability to sustain eye contact. A shame-filled individual is acutely aware of what he or she believes to be the critical gaze of others. For most perfectionists, a core belief is "If you really knew me, you would discard me." This stance is fortified by the conviction that true acceptance is elusive, and that if it ever comes, it is sure to be both conditional and precarious. And yet these same beliefs serve as catalysts for change in group therapy. Once voiced by a single member, these near-universal beliefs tend to resonate and, in turn, to provide the therapist with entry points into their exploration and associated developmental roots. As Shapiro and Powers (2011, p. 117) note, "precisely because the other group members are less likely to embody the altruism found in the group leader, the group's acceptance of a member's imperfect self can have more believability and staying power than the therapist's acceptance of a member's imperfect self." It is for this very reason that group therapists should strive to make member-to-member interactions a group norm.

Phase 3: Self-Redefinition/Painful Authenticity

By about Sessions 8–10, the group enters Phase 3 and the second half of treatment. Members will often experience a growing urgency prompted by the time-limited nature of treatment. Early questions such as "Will I be accepted?" or "Do I want to belong to this group?" begin to fade. Shapiro and Powers (2011) characterize this as the mature phase in a group's evolution. Having experienced acceptance and become aware that others share similar struggles, members increasingly focus on finding new ways of relating to others and themselves. These efforts can be advanced by therapist use of interventions targeting dynamics on the vertex of current relationships in the triangle of object relations. These dynamics especially include here-and-now interactions with other group members, as well as with the introject (i.e., a patient's prevailing view of self and self-expectations). The latter focus was particularly critical in the group work with Gus. Gus's introject was characterized as a harsh taskmaster. He firmly believed that the only means to establish and maintain relationships was through uncompromising self-sacrifice and a readiness to serve others, no matter the cost to self. Gus believed that if he failed to respond to these expectations, others would abandon him; he would be isolated and lonely. Gus demanded a great deal of himself. He felt that responding to the expectations of others was not enough; it was essential to do so with all-encompassing perfection. Gus's identity

and self-worth hinged on this stance. Any perceived failure in this regard was followed by episodes of deep depression and a self-imposed banishment from others, which invariably gave rise to the feeling of abandonment that Gus feared and anticipated.

Gus's dynamics were ideally addressed through group treatment. As had been predicted during the pregroup preparation sessions, Gus easily fell into the role of helper. Eventually group members pointed out and challenged his tendency to assume the role of cotherapist. Although they valued his many insights and keen observations, they felt frustrated by his propensity to stand apart from others, assuming the role of helper. This perpetuated the sense of isolation he lamented. Several members confronted Gus on his tendency to assume a position of superiority, which implied that he was different from, or better than, other members of the group. Gus responded to these comments with defensiveness that took the form of initial disbelief, followed by dismissal, denial, and deflection. The group leader responded by noting how painful it was for Gus to hear what others were saying, and observing that as their comments fully penetrated his awareness, they evoked intense feelings of shame and failure. The therapist went on to emphasize that Gus's pain was made particularly intense because his deepest desire was to be caring and more connected to members of the group. This desire illustrates the parentification that is often seen among perfectionists; although it may be most easily identified in group psychotherapy formats, it also arises in other therapy modalities.

As noted earlier, this third phase of group work tends to evoke feelings of intense shame. The predominant affect then shifts to anxiety, as members are challenged to examine and negotiate their interactional patterns and their views of themselves. Member-to-member interactions and peer feedback are more prominent. Even though the therapist becomes less active, his or her interventions remain vitally important. As noted earlier, a group leader should not ignore criticism voiced by a member, be it criticism of others or of the self. In our experience, several types of interventions form the basis of most of the therapist's activity during this phase of treatment, and all of these involve metacommunication. These can include efforts to translate one member's comment to another by emphasizing the relational intention:

> "Although there was a harshness in your voice as you spoke to Sue, I sense that you're really worried about her. Perhaps you see something of your own struggle reflected in what she's been saying."

The group leader can also employ group-as-a-whole interventions that identity the interpersonal dynamic being enacted by the group:

"My sense is that the group would like to get closer to Gus, and even though he's made several attempts to oblige by trying to be helpful, people seem to want something other than his advice. I suspect that you are trying to invite Gus to share his vulnerability."

In addition, the group leader can invite a group member to examine the meaning of a particular comment or action with respect to his or her identity and self-concept, as the following dialogue illustrates:

THERAPIST: Gus, I noticed that when you were offering Sue several suggestions about how to deal with her husband, your comments were met with silence from both Sue and the group. How did you understand that, and what did the silence mean to you about you?

GUS: It's what always happens. I try to be helpful, and in the end I end up being alone. Whatever I do, people either want more, or give me the message that what I've done isn't appreciated or even noticed. (*His eyes redden.*)

THERAPIST: Your tears are very close to the surface. I sense that you've been carrying that sadness for a long time. (*Gus's head drops in a posture of shame.*)

SUE: I feel much closer to you when I hear that. It's what I've felt most of my life. (*Gus begins to cry silently.*)

These interventions are intended to assist group members to identify and confront unwanted parts of the self. During this phase of treatment, recurrent self-limiting patterns of relating and coping that once served a protective function are vigorously challenged. Understandably, this can be a time of marked ambivalence for some members. Letting go of familiar ways of being and coping is deeply threatening; it often gives rise to a great deal of emotional upheaval and a transient wish to "put the genie back into the bottle." Ideally, work during earlier phases of treatment has reassured group members that emotions are not to be feared. Not only do emotions offer important information about self and interpersonal encounters, but they also become vehicles for deeper and more authentic connection with others. The primary therapeutic focus at this juncture is on reparation of participants' distorted introjects and expectations of others. One means of advancing this objective is for the group leader to underscore subtle changes that are occurring in members' interactional patterns:

"Gus, your openness about your fear of failure and never feeling that you were good enough in your father's eyes is a leap of faith.

It speaks to your trust that people here are willing to accept you as you are and don't expect you to be perfect."

Elsewhere, we have referred to this as a process of "rescripting" (Tasca et al., 2007).

Therapeutic Effect of the Therapist Error

Another potent form of intervention comes in the form of modeling. In the course of any psychotherapeutic treatment, therapists are bound to make mistakes. These may include empathic failures; interpretations that fail to resonate with the group-as-a-whole or with an individual group member; errors in recalling a group member's previous disclosures or history; expressions of negative countertransference; or administrative errors regarding scheduling, billing, or other matters. Such occurrences reveal a therapist's humanness and offer an opportunity to model a healthy expression of authority. This can be accomplished by assuming a stance of humility, in which the therapist takes ownership of his or her mistakes and offers an unconditional apology. The greatest impact is likely to be on members high in self-oriented and socially prescribed perfectionism. For those high in other-oriented perfectionism, such an event may simply represent yet another instance of people's failing to meet their expectations. The therapeutic process is advanced by exploring the emotional impact on respective group members and the ways in which they can begin to tolerate either their own or others' imperfections.

The group leader also models an attitude of genuine and gentle curiosity, which becomes a powerful substitute for the internalized critical tone of significant others. The developmental histories of perfectionistic individuals are replete with encounters that were perceived as interrogative in tone. Questions and requests made by others were experienced as weighty demands that imposed unreachable expectations while underscoring the individuals' shortcomings. The group leader's interest in the thoughts and feelings of group members creates a climate in which questions and directions can gradually be met without the need to defend the self.

Phase 4: Termination

In short-term, time-limited group treatment, preparation for termination begins during the pregroup preparation sessions and becomes increasingly salient with each passing week. MacKenzie (1990) has

identified three essential tasks that are part of the termination process: "The group must be incorporated as a positive and constructive experience. Each member must address issues raised by the theme of loss. Finally, material learned in the group must be applied to outside personal circumstances" (p. 185). MacKenzie suggests that the first task can be advanced by taking time in the final few sessions to systematically review critical incidents in the life of the group and the meanings these incidents have acquired for members. This can function as a form of rehearsal that helps members internalize the most noteworthy experiences and discoveries. This process can also evoke feelings of regret in some members, such as regret for missing opportunities to seek or give feedback, for failing to express a desire for greater closeness, or for holding on to resentments. As the group nears its end, some members voice appreciation and gratitude toward fellow group members and the group leader. The leader must be attentive to the potential for group members to idealize the experience as a means of defending against the pain of separation, and should gently emphasize the reality that some degree of regret or disappointment is inherent in most interpersonal relationships.

As termination approaches, members may also find themselves aware of emotions that appear unrelated to any specific occurrence in the group. In most instances, such emotions are likely to be associated with past endings and losses. It is helpful to normalize such reactions, as they are quite common and reflect the significance of the relationships that have been lost.

Finally, many individuals who have struggled with perfectionism find it helpful to spend some time in group therapy focusing on ways to apply what they have learned in the group to their other relationships. This task is not limited to the termination phase, but may take on greater urgency as the group nears its end. Benjamin (2003) suggests that it is helpful to identify a list of "code words" that can serve as a reminder of the connection between certain problematic patterns of behavior or thinking and the "countermoves that have been developed as antidotes" (p. 322).

Stanton and Reed (2003) provide a list of questions that can be posed to group members as a means of advancing the work of termination:

"Is there anything that feels unfinished between you and another group member?"

"What are your favorite memories or meaningful exchanges from the past weeks?"

"What are the feelings you have regarding the impending end of the group?"
"Are you aware of ways that your participation in the group has helped other people in your life?"
"What are the issues that are likely to continue being a challenge for you after group has ended?"
"What are the strategies that you have come to draw on to help you resolve some of the struggles that first brought you into treatment?"
"In what ways did the group experience not meet your expectations?"
"In what ways did the group experience surprise you or surpass your expectations?"
"What will help you to bring this experience to an end?"

At the start of the final month of treatment, these questions can be handed out in written form to group members for reflection. The group leader can then look for opportunities to explore these themes during the final four sessions.

The following letter was an assigned exercise written by Gus and presented to the group. It provides insight not only into Gus himself, his manifestation of perfectionism, and the dynamics underlying it, but into the changes he made in the group.

> Dear False Self:
>
> I am happy to be asked to write a letter to you because you served me for more than 25 years. You were a good servant. You helped me build a career and build an ego. You did indeed achieve many things. You were like a skilled mechanic, organized, dependable; good at fixing things, at putting things together, at providing an efficient performance. You were an agent of change, always seeking to make things better, to improve buildings, environments, lifestyles. When a particular job needed to be done, when there was a crisis, when a community or a ministry needed an injection of ideas or energy, you were available and willing to respond and were usually chosen.
>
> You were the school chaplain, the magazine editor, the vocations director, the bursar, the administrator. You were the head teacher of a secondary school, the one who organized and supervised the school's closure and who took responsibility for the sale of the property. You were the director of two

retreat centers, one of which you opened, the other of which you closed and sold. You were the formator who drafted a new formation policy for your Province. You were the project manager who supervised the design and building of two new retreat houses. You were the loyal servant and counselor to two Provincials, one of whom made you his Delegate abroad, while the other made you his Vicar.

Yes, you gave everything to your religious community. You worked for your religious order with single-minded dedication. Yet the people whom you faithfully served made it clear to you that they did not want you to be their leader. You were disappointed, angry, hurt. You felt lost. In response you withdrew, you disconnected from the business of your Province, you lost interest.

As time went by, with the help of counseling, journaling, and prayer, you began to see things more objectively. You came to accept that you had been driven by a need to be productive and to be perfect. You realized that all along you had been finding your value in what you did and in what other people, especially your brothers in the order, thought of you. You became clearly and painfully aware that you had been defining yourself by your work and by your need to be esteemed. Because of this I am now happy to let you go, to say goodbye to you—for it is only by letting you go that I can allow another part of myself, my true self, to emerge. It is only through your death that the self which has been buried beneath you all these years can rise up and begin to live. Thank you for serving me and for serving others in the way you did.

Goodbye, my old friend, goodbye . . . Gus

CAVEATS RELATED TO PROCESSES IN GROUP PSYCHOTHERAPY

Although many perfectionists stand to gain from group psychotherapy in cohesive groups, the effectiveness of group psychotherapy and overall levels of group cohesiveness can be undermined by certain characteristics commonly found among perfectionists. Most notably, participants who are high in other-oriented perfectionism have a host of interpersonal qualities that can be quite challenging, including traits of interpersonal dominance, hostility, and narcissism. This can result in direct challenges to therapists, who may be evaluated according to extreme standards. When undertaking group psychotherapy, group leaders are strongly

encouraged to be cognizant of which group members are presenting with elevated levels of other-oriented perfectionism. These individuals have a strong proclivity to be highly evaluative and to express their perfectionism in the form of cynical hostility and skepticism or in veiled humorous comments. As noted earlier, participants tend to be on their best behavior at the outset of group psychotherapy, so it may take some time before such destructive tendencies become evident. Another possible concern is the tendency for extremely other-oriented perfectionists to have strong needs to be in control. Indeed, other-oriented perfectionists' attempts to control sessions had negative effects at several key points on a few of the groups included in the UBC Perfectionism Treatment Study.

Other-oriented perfectionists can also target other group members, who may be perceived as less threatening targets than the group leader. More narcissistic other-oriented perfectionists can have a proclivity to be hypercompetitive, and may thus be openly antagonistic, critical, and derisive of others. It is not uncommon for this hypercompetitiveness to engender defensiveness. Work we are conducting at present indicates that perfectionists in general have a strong social comparison orientation and tend to be distressed when they feel outperformed by others. It is important to manage group interactions carefully and to minimize negative social exchanges that arise as a result of the competitive nature of perfectionists. Of course, this is always an important consideration, but it can be especially critical in dealing with a group of people who possess a high degree of interpersonal sensitivity to criticism.

Given these tendencies associated with perfectionism, it is essential from the outset to establish a group environment that emphasizes being accepting and supportive and keeping negative evaluations of others to a minimum. A leader may find it necessary to remind group members of group rules and to note that the rules are most effectively followed and the members are best served by offering feedback rather than being critical. Other-oriented perfectionists may have difficulty distinguishing between being critical and offering feedback. Effective interpersonal feedback takes the form of revealing one's experience (thoughts, emotions, or both) in response to an interpersonal event; criticism involves judging the behavior or intentions of another.

We have now described our group psychotherapy treatment approach to perfectionism and have illustrated how our overall treatment model can be adapted to a group format. Although there has been research addressing the effectiveness of some treatments for perfectionism (see Chapter 3), we have recently completed an evaluation of the effectiveness of this group approach to the treatment of perfectionism (Hewitt, Mikail, et al., 2015). In the next section, we provide a description of this project.

THE UNIVERSITY OF BRITISH COLUMBIA PERFECTIONISM TREATMENT STUDY

We completed a comprehensive study of group psychotherapy of perfectionism (the UBC Perfectionism Treatment Study; Hewitt, Mikail, et al., 2015) that had, as one focus, assessing the effectiveness of our perfectionism treatment approach. The main purpose of this part of the study was to assess whether our dynamic-relational approach for the treatment of perfectionism was effective in reducing perfectionistic behavior and associated measures of depression, general and social anxiety, and interpersonal problems at the conclusion of the psychotherapy and at a 4-month follow-up. We also assessed whether changes in specific components of perfectionism were associated with changes in specific forms of distress.

A sample of 60 community-recruited perfectionistic individuals completed treatment. All participants completed our measures of perfectionism traits, perfectionistic self-presentation, and automatic perfectionistic thoughts (i.e., the MPS, PSPS, and PCI), as well as measures of depression, anxiety, and interpersonal problems, at pretreatment, posttreatment, and a 4-month follow-up. The treatment followed the group treatment format we have described above, except that fewer than 16 treatment sessions were provided. The participants completed 2 pregroup sessions, to enhance the benefit that the participants would derive from the treatment (MacKenzie, 1990), as well as to receive information about the development of problems resulting from perfectionism. There were 10 group psychotherapy sessions proper. The groups ran for 12 consecutive weeks; each group included 7–10 members, and each was assigned a male and a female senior-level clinical psychology graduate student as cotherapists.

The findings indicated that the group psychotherapy treatment was effective in reducing perfectionistic behaviors, including traits, self-presentational facets, and perfectionistic cognitions, both at the conclusion of treatment and at the 4-month follow-up. The means and standard deviations of the results for the perfectionism and distress measures are presented in Table 10.1. Using multilevel modeling to assess change, we found that all variables showed a significant change from pretreatment to posttreatment to follow-up: “a precipitous reduction in scores from pre- to post-treatment, and . . . a continued reduction but at a less accelerated rate from post-treatment to four months post-treatment” (Hewitt, Mikail, et al., 2015, p. 210). We also assessed whether changes in perfectionism and distress could be attributed to the treatment by comparing the treatment groups with a wait-list control. Table 10.2 presents these data; it can be seen that significant decreases

TABLE 10.1. Means and Standard Deviations for Results of the Pretreatment, Posttreatment, and Follow-Up Perfectionism and Distress Measures

	Pretreatment (n = 71)		Posttreatment (n = 60)		Follow-up (n = 44)	
Variable	M	SD	M	SD	M	SD
Perfectionism traits						
Self-oriented	87.99	9.15	71.24	17.69	62.45	10.94
Other-oriented	72.50	13.92	63.26	17.60	60.02	4.92
Socially prescribed	69.03	16.38	56.44	17.79	62.27	10.20
Perfectionistic self-presentation						
Self-promotion	52.49	9.50	44.36	11.98	42.64	12.50
Nondisplay	55.37	9.32	46.45	11.94	46.68	11.76
Nondisclosure	30.31	8.95	24.67	9.56	24.04	8.35
Perfectionistic cognitions	51.48	18.25	37.15	19.37	37.41	23.80
Beck Depression Inventory	17.39	8.50	10.83	8.22	9.98	8.50
Beck Anxiety Inventory	15.26	10.25	10.28	7.40	9.00	7.87
Interpersonal anxiety	47.75	12.07	43.52	12.09	41.36	11.57
Interpersonal problems	1.71	0.69	1.38	0.63	1.48	0.98

Note. The perfectionism measures used were the MPS (traits), the PSPS (self-presentation), and the PCI (cognitions). The interpersonal measures used were Interactional Anxiety Scale (anxiety) and the IIP (problems). Data from Hewitt, Mikail, et al. (2015).

were found in all perfectionism components (with the exception of the nondisplay of imperfections), and in posttreatment scores on depression and interpersonal problems, in the treatment condition versus the wait-list control condition. The findings suggest that the dynamic-relational group treatment was effective in treating most perfectionistic behaviors, and that focusing on the underlying mechanisms of perfectionism also led to reductions in various symptoms measures.

We also found that the changes in the distress measures were uniquely associated with changes in specific components of perfectionism. For example, reductions in depression were uniquely associated with reductions in self-oriented perfectionism and the nondisplay of imperfections; reductions in general anxiety were linked with reductions in perfectionistic cognitions and perfectionistic self-promotion; reductions in social anxiety were linked with reductions in nondisplay of imperfection; and, finally, reductions in interpersonal problems were uniquely associated with reductions in socially prescribed perfectionism, nondisplay of imperfections, and perfectionistic cognitions. These findings suggest that reductions of particular components of perfectionism are associated with reductions in particular symptom patterns.

This study provided evidence that our dynamic-relational group

TABLE 10.2. Means, Standard Deviations, *F* Tests, and Treatment Effects for Results of the Perfectionism and Distress Measures for Treatment versus Control Groups

	Pretreatment		Posttreatment		Group differences		
Variable	Treatment	Control	Treatment	Control	Eta^2	F (1, 58)	β*>
Self-oriented	87.07 (9.25)	88.00 (10.17)	70.68 (17.06)	85.33 (11.36)	.19	13.73***	13.98***
Other-oriented	71.99 (14.30)	75.50 (11.09)	61.73 (17.40)	70.75 (14.01)	.05	2.99	5.95
Socially prescribed	65.05 (17.36)	75.17 (14.70)	52.75 (14.78)	71.75 (15.02)	.20	14.64***	14.83***
Self-promotion	51.20 (10.05)	55.50 (9.92)	43.13 (12.21)	55.00 (8.77)	.16	11.08**	9.65***
Nondisplay	53.53 (10.55)	58.94 (6.08)	44.79 (12.63)	54.58 (7.79)	.08	4.79	5.63*
Nondisclosure	29.00 (9.39)	31.83 (8.93)	21.67 (7.73)	31.39 (10.20)	.24	18.11***	8.17***
Perfectionistic cognitions	50.07 (16.40)	50.00 (22.70)	36.88 (17.56)	51.97 (20.93)	.18	12.38***	15.78***
Beck Depression Inventory	18.00 (8.47)	15.28 (8.80)	9.23 (5.66)	13.94 (9.42)	.14	9.44***	5.16**
Beck Anxiety Inventory	15.44 (11.01)	16.81 (9.83)	8.81 (6.01)	10.17 (6.07)	.01	0.49	.72
Interpersonal anxiety	45.81 (11.54)	49.44 (11.37)	41.28 (11.13)	47.53 (12.96)	.05	3.03	2.55
Interpersonal problems	1.64 (0.63)	1.65 (0.52)	1.30 (0.63)	1.66 (0.62)	.13	8.68***	.35**

Note. Alpha corrected to $p < .005$ for F test, and uncorrected for hierarchical linear modeling. Treatment group, $n = 43$; control group, $n = 18$. Group differences in changes on perfectionism and distress measures were tested via multilevel modeling and analysis of covariance, with statistical controls for pretreatment scores. According to Cohen (1988), partial eta^2 values greater than .14 reflect a large effect size, and those between .06 and .13 reflect a medium effect size. Data from Hewitt, Mikail, et al. (2015).

*$p < .05$. **$p < .01$. ***$p < .001$.

treatment had a significant effect on reducing perfectionistic behavior, as well as the distress associated with perfectionism. Moreover, as we have argued (Hewitt, Mikail, et al., 2015), the findings also suggested that treatments directed specifically at reducing perfectionistic behavior by addressing the psychodynamic and relational underpinnings of perfectionism may produce changes in perfectionism, and that these changes in turn may result in changes in depression and interpersonal problems. Furthermore, the findings from the follow-up data indicate that changes in perfectionism and distress continued to occur after the completion of the treatment, which would be expected of treatments utilizing a psychodynamic approach. For example, according to Blatt and colleagues (2010), sustained therapeutic changes should be evident when personality vulnerabilities are treated, as opposed to focusing on symptoms. Hawley, Ho, Zuroff, and Blatt (2006) assessed perfectionism changes and attendant changes in depression, and found that continued changes in depression could be predicted with changes in perfectionism. Finally, more generally, Shedler (2010) reviewed psychoanalytic treatment studies and also proposed that psychodynamic treatments can continue to have effects beyond the treatment period. Indeed, our results indicate that the effects of the treatment continued to reduce perfectionism levels several months after the treatment terminated.

CONCLUSION

In this chapter, we have outlined how our treatment model can be used in group treatment format for the treatment of perfectionism. The effectiveness study from the UBC Perfectionism Treatment Study (Hewitt, Mikail, et al., 2015) provides the first support for this dynamic-relational approach in reducing perfectionism traits, self-presentational facets, and perfectionism cognitions. We are encouraged by these findings; however, we look forward to other tests of our model and the effectiveness of the treatment we have proposed.

APPENDIX 10.1

An Introduction to Group Therapy

We hope that this brief description will assist you in understanding how group therapy works. Our approach to group psychotherapy uses the "interpersonal model." This model assumes that each person develops his or her own personality through interacting with others. In group therapy, you learn through interacting with other group members, receiving feedback from them, and examining the impact you have on others and on the group as a whole.

We draw upon interpersonal and psychodynamic theory to understand personality development. That is, we help group members identify the roles and patterns they first learned in their families of origin and in early peer groups. These are later replayed in adult life more or less unconsciously. These roles naturally recur in the group. You will have an opportunity in the group to learn more about them and to experiment with new roles.

The group's purpose is to help you and other group members know yourselves better. Each group member commits to offering honest, responsible feedback and to using others' feedback to uncover old, ineffective patterns and learn more effective ways of relating. This process is also a way to learn to appreciate your strengths and resilience. The group will assist you in learning more about your patterns of relating to others, how you get close to others, how you push others away, what triggers your feelings, and how you get stuck.

We wish to acknowledge Steven Caldwell, PhD, CGP, who developed a brochure entitled "An Introduction to Psychodynamic Psychotherapy." His work is the basis for this appendix.

CONFIDENTIALITY

Each member agrees to keep material that is shared in the group confidential. That is, what happens in the group stays in the group. This will make the group a safe place to share personal information and vulnerable feelings, and it protects the privacy of the members. Of course, you may disclose personal information about yourself to anyone, but you may never disclose personal information about another group member (other than to a member of your treatment team).

BOUNDARIES

Group members talk about feelings. Sometimes you may feel very close to a group member, or angry or frightened or sad. It is important that you express your feelings verbally, not behaviorally. Touching and hugging are examples of behaviors expressing feelings that should be articulated rather than acted upon. This is important so that the group becomes a "safe container" for all the feelings of the members. By respecting these boundaries, you have an opportunity to explore topics such as sex, anger, shame, and guilt, without becoming concerned that anyone will begin acting out feelings and impulses.

Time is another boundary. The group begins and ends on time, and members do not leave the room until the session is over. If you are late or miss a session, the tardiness or absenteeism will be explored by the group to ascertain the underlying meaning of such behavior. It is expected that the group processing of material will cease when the session ends.

HOW THE GROUP WORKS

You will discover many ways that group therapy can be helpful to you. You can receive support from other members and offer support to them. You can practice direct communication; recognize the universality of your experiences, move beyond isolation, and deepen your capacity to trust. These are powerful healing dimensions of the group process.

We, your therapists, will use interventions to heighten our therapeutic work together. These interventions include using group relationships in the "here-and-now," engaging in reactive and reflective communication, confronting broken agreements, assessing safety, making connections to childhood experiences, and exploring the whole group's development. We explain a little further about the "here-and-now" and communication below.

USING GROUP RELATIONSHIPS IN THE "HERE-AND-NOW"

Group members decide for themselves if they need time to speak in a session. Although there are no rigid rules about what is appropriate to share, the most change-enhancing work often comes out of your ability to stay in the present with your feelings about what's happening inside the group. The group's focus includes relationships, intimacy, sexuality, self-image, shame, grief, loss, aspirations, and victories. All these topics have meaning within the relationships in the group in the "here-and-now." Equally important to you may be discussing a recent experience, a problem at work, or a question that has been on your mind from a previous group session. Feel free to bring up that material. As your group therapists, we will bridge these experiences back to what is happening within the room. Examining dynamics right in front of us increases your awareness and adds meaning to your life outside the group. We can then explore how your dynamics originated in your earliest relationships in your family.

COMMUNICATION

Like all relationships, those within the group are a balance of spontaneous reaction and more thoughtful reflection. In the group sessions, you can practice both reaction and reflection and can work toward finding a healthy balance in your relationships. For example, you can practice spontaneity and honesty (a reactive mode). You can go with your gut feeling, owning your own reaction as valid and worth expressing and understanding. You can also practice reflecting on your feelings and impulses: "What feelings are being triggered in me? What am I repeating in this? Why now? Is it me, or is it him or her? Is it the group?" You may not feel ready to share each feeling, but you will gain more by taking risks, being responsible and honest, and expressing your own experience. Expressing your feeling is different from acting on your feeling.

THERAPISTS' ROLE

We, your therapists, will act to ensure safety in the group. We will interpret behaviors that could cause members to feel frightened. We will enlist the group to help understand what is happening in the group. Safety does not mean a guarantee of pain-free experience. Rather, the safety of the group is based in trust that your feelings will be respected. If you do feel dismissed or injured, you have a right to be heard, and we will work to understand the source of your injury. In this way, despite the pain and injury, you will have

a corrective experience. Rather than retreat to protected isolation, members can find deeper connection and interdependence. The whole group deepens and grows through this process.

We all have different ways of understanding what happens in our interactions. As your therapists, we will offer our own perspectives as a way to make unconscious patterns of thinking and acting more conscious. With awareness comes freedom to change rigid patterns. We will listen. We will pursue how members' words and actions are suggestive of dynamics in the whole group's development. For example, the group may be coalescing and becoming more intimate—or it may be fracturing and resisting, out of fear or anxiety or competition. We will not be the only ones with useful perspectives and insights. Each member's perspective is valid and adds to our enriched understanding of relationships.

Welcome to the Group!

EPILOGUE

Overview and Future Considerations

OVERVIEW: OUR AIMS IN THIS BOOK

The preparation of this volume has been guided by one overarching goal: to underscore the need to focus more on the conceptualization and scientific understanding of psychological constructs, as recommended by Machado and Silva (2007). This orientation has guided our work on perfectionism from its beginnings many years ago. The MPS was developed according to the construct validation approach described by Jackson (1970), and we have been guided by Jackson's emphasis on developing a theoretical understanding of the construct being measured in terms of what is part of the construct and what is not. We have also been influenced by arguments about the importance of theory and conceptualization, advanced by exceptional scholars such as Jerry Wiggins (see, e.g., Wiggins, 1973).

We have tried to highlight the importance of conceptualization in numerous ways. These ways include describing the relevance and importance of the perfectionism construct by illustrating some of its history in clinical and personality writing, as well as demonstrating its breadth by showing how many pernicious outcomes have been shown to be associated with it in the burgeoning empirical literature. This book as a whole reflects our deeply held conviction that perfectionism is a fundamental personality construct that functions as a complex and multifarious defensive personality style. At the same time, it operates as a core vulnerability factor in the genesis and maintenance of psychological, physical, relational, and achievement challenges and difficulties. A key element of our approach is the belief that perfectionism is not redundant with the

broad personality trait dimensions that constitute the seemingly ubiquitous five-factor personality model. Enough findings in the published research literature now show that perfectionism is a personality style; it cannot be minimized by suggesting naively that it is nothing more than neurotic conscientiousness.

In this book, we have also sought to present our ideas about perfectionism by describing actual people who were our patients and the difficulties they experienced. This approach too is consistent with the views espoused by Machado and Silva (2007), who have discussed the need to examine conceptual views within the context of individual cases. Our discussions of particular individuals illustrate the heterogeneity of perfectionistic behavior and its profound impact on those individuals and their loved ones. It is often too easy to develop, discuss, and conduct research at the level of constructs (e.g., perfectionism is associated with suicide), and to forget that we are talking about actual people whose perfectionism is associated with actual destructive impulses and tendencies. This point was poignantly brought home by Blatt's (1995) paper on well-known perfectionistic individuals who attained extremely high levels of success but decided to end their own lives. People who are not well known also suffer as a result of their perfectionism. A poignant example of this is the death by suicide in the United Kingdom of Alina Templeton-Perks in 2008. According to the subsequent public inquest, Ms. Templeton-Perks took her own life after being tortured by self-doubt and a secret eating disorder. She believed that she was fat, despite wearing a U.K. size 8. She ended her own life by taking a massive overdose of prescription and over-the-counter drugs. Deputy Berkshire coroner Pearl Willis analyzed the evidence and listed the cause of death as "perfectionism disorder." No such disorder exists in extant diagnostic frameworks, but this conclusion was reached nonetheless because of the central and obvious role that perfectionism played in this person's death. Ultimately, what we are attempting to do is understand and help a potentially large group of individuals who are often in a great of deal pain and turmoil as a result of this particular personality style.

After almost 30 years of thinking about, discussing, treating, and researching perfectionism, we have thus presented in this book our views on the construct of perfectionism, as well as our understanding of the workings of perfectionistic behaviors as specific traits and factors within individuals' relational and psychodynamic worlds. We have also described how and why perfectionistic behaviors may create a vulnerability to many types of disorders, dysfunction, and maladjustment. This model has been influenced by research from numerous groups of

investigators, and by the clinical work of many clinicians who have written about the treatment of perfectionism, including two of us (Paul L. Hewitt and Samuel F. Mikail). Our conceptual and treatment models are rooted in and informed by psychodynamic and interpersonal perspectives, in an effort to achieve a broad understanding of perfectionism's relational underpinnings and intrapsychic mechanisms. A model based on such principles is well suited to dealing with deeply ingrained personality variables. Using the developmental and descriptive models described herein, we have illustrated how we go about assessing and treating perfectionism as an ingrained personality pattern that functions at many levels and in many domains. We are hopeful that the models will generate hypotheses and spur researchers to test these hypotheses; to refute, support, or refine the models; and to advance our understanding and treatment of individuals with perfectionism.

The clinical approach in which we (Hewitt and Mikail) were trained, and which we continue to practice, is reflected in this work. We focus our treatment and treatment research on the underlying putative causal mechanisms of dysfunction, and not simply the symptoms of a disorder. That is, our aim in our clinical work is not simply to reduce or eliminate the symptoms in any individual, but to reduce or eliminate the purported causal mechanisms of those symptoms and the syndromes and disorders they define. As discussed in this book, the work of Sidney Blatt and colleagues (see, e.g., Blatt et al., 2006) has renewed interest in research addressing psychotherapy for personality vulnerability factors (e.g., Maxwell, Tasca, Ritchie, Balfour, & Bissada, 2014; Overholser & Fine, 1994). Our conceptualization of perfectionism reflects these same themes and represents an important personality construct to focus upon in treatment. As we have demonstrated (Hewitt, Mikail, et al., 2015), focusing on underlying putative causal factors of symptoms and distress can have an impact on those symptoms and on the vulnerability itself (see also Maxwell et al., 2014). This initial study has supported our contention that a dynamic-relational approach may be the most appropriate treatment for perfectionistic behavior.

Other pernicious personality and relational variables could be addressed in a similar fashion. In conceptualizing, measuring, and treating these variables, there is a need to go beyond simply assessing the level of a personality trait or the rated frequency of thoughts or agreement with attitudes. As Buss and Finn (1987), Cantor (1990), Paulhus and Martin (1987), and we (Hewitt, Flett, Sherry, et al., 2003) have all suggested, there is utility in considering other crucial elements of personality traits, such as the interpersonal and intrapersonal expressions of those traits.

FUTURE CONSIDERATIONS

As mentioned at the beginning of this book, there is extant perfectionism research that does not appear to be testing any specific hypotheses derived from articulated models. We hope that in our presentation of several models—including our CMPB (see Chapter 2), a model of how we believe perfectionism is associated with many deleterious outcomes (our PSDM; see Chapters 4 and 5), and a model of dynamic-relational treatment of perfectionism (see Chapter 6)—we have provided useful contexts for research and for further model development. A good many research directions can be pursued with these models as guides, and even though there have been many studies focusing on perfectionism traits and similar aspects of perfectionism in the literature, there is less information on the interpersonal and intrapersonal elements. Moreover, although we and others have developed measures of perfectionism for children and adolescents (e.g., Flett et al., 1997; Hewitt et al., 2011; Rice & Preusser, 2002), the research to date on perfectionism in children is scanty. As well, we have begun testing components of the PSDM (e.g., Chen et al., 2012; Roxborough et al., 2012; Sherry et al., 2008) with encouraging results, and we look forward to other tests of these models. Finally, we are excited about the possibility of having developed a treatment approach that appears to have some effectiveness. Further research is needed to address the efficacy of the approach and to determine whether components of the approach might be refined to enhance treatment outcomes further.

We wish to be explicit about some particular areas in the perfectionism literature that we feel are especially important to address. First, we have just mentioned the need for more work with children (and their families) to examine the early development, manifestations, and outcomes of perfectionism. Not only is such work important for understanding the nature of perfectionism in youth, but it may provide important avenues for preventive work. One of us (Gordon L. Flett) is currently involved in such efforts in consultation and research with various school boards and organizations. Given that most if not all writers in the perfectionism field believe in perfectionism's potential to cause catastrophic outcomes, implementing programs for early identification of children who might develop such tendencies is an important task. In a recent article, we have outlined our case for why perfectionism needs to be prevented, and have provided suggestions to assist school professionals who are interested in doing this (Flett & Hewitt, 2014). We are encouraged that some school boards are beginning to focus extensively on the potential destructiveness of perfectionism. Indeed, the promotion of self-compassion as a substitute for perfectionism was part of

a remarkable program implemented in June 2014 at the Oxford High School for girls in Oxford, England. The overall campaign, called "Saying Goodbye to Little Miss Perfect," was implemented proactively to address the pressures inherent in striving to be perfect (see *http://oxfordhigh.gdst.net/saying-goodbye-to-little-miss-perfect*). Prevention efforts such as these seem particularly important, in light of the growing need for the identification and assessment of perfectionistic self-presentation among suicidal youth (see Flett & Hewitt, 2013). Research is now beginning to emerge on the prevention of perfectionism in adolescents, and there is evidence from prevention efforts that reductions are attainable, along with reductions in self-criticism and negative affect. However, this research also shows that levels of perfectionism following the prevention program are still higher than they should ideally be (Nehmy & Wade, 2015).

Recent developments on university and college campuses point to the need for prevention aimed at emerging adults as well. The highly publicized death by suicide of track athlete Madison Holleran at Pennsylvania State University has focused attention on the pressures to be perfect that university students face, especially on certain campuses where socially prescribed pressures seem incredibly high. Students at Penn State have coined the term "Penn Face" (see Scelfo, 2015) to refer to the tendency for students to hide behind a front. These students are actively struggling with prescribed pressures to be perfect, but they do not want to be discovered, so they tend to project an image of flawlessness, poise, and capability. A similar phenomenon is widely recognized on the campus of Stanford University; the term "Stanford Duck Syndrome" describes those students who are faced with enormous pressures but present an image of being in control and calmly going about their business, like ducks in the water (see *www.mercurynews.com/education/ci_14832257*). As with the ducks, however, the serene image on the surface does not match the furious paddling going on underneath. We suspect that this phenomenon is occurring on campuses around the world. Potentially deadly consequences too often follow from hiding the stress and distress of trying to be perfect. We feel it is incumbent on colleges and universities to take whatever steps are necessary to heighten awareness of perfectionism's possible dangers and find ways to reduce this pressure.

It is also essential to consider patients' cultural contexts when assessing them for problems related to perfectionism. That is, to what extent is there veridical pressure on an individual to be flawless? Similarly, from a research perspective, it is important that we begin to incorporate a situational perspective and find out more about chronic exposure to such environments or roles.

The need to consider the impact of sociocultural pressures on particular individuals or families is illustrated poignantly in an important book published in 2015 by Douglas Spotted Eagle. His book, *Better Off Dead,* is an account of the suicide of his son Joshua and the pressures inherent in the Mormon faith (the Church of Jesus Christ of Latter-Day Saints) that Spotted Eagle feels were largely responsible for his perfectionistic son's death. He argues that it is no coincidence that higher rates of suicide are found in places where there are higher concentrations of Mormonism, and that the pressures to be perfect among the Latter-Day Saints have played a key role in these elevated rates (Spotted Eagle, 2015).

One of the most alarming findings involving perfectionism in young people comes from person-centered research that uses cluster analyses and more sophisticated statistical techniques to identity various groups of perfectionists and nonperfectionists. We (Flett & Hewitt, 2014) have summarized this research and concluded that perhaps as many as 3 in 10 young people have the characteristics of perfectionism. This conclusion was supported in a recent study of over 900 adolescents from Australia who completed three measures, including our CAPS for children and adolescents. Sironic and Reeve (2015) used latent class analysis to identify six subgroups, and they too were able to discern that 3 in 10 adolescent high school students had some form of perfectionism, with many of these young people feeling socially prescribed pressures to be perfect. The prevalence of perfectionism in young people points to the urgent need for programmatic research on family constellations, peer and sibling relationships, intimate relations, and any other factors that may be contributing to these high levels of maladaptive perfectionism. We are pleased that research on attachment and perfectionism is increasingly well represented in the field (Chen et al., 2012; Rice & Lopez, 2004; Rice & Mirzadeh, 2000; Ulu & Tezer, 2010; Wei, Mallinckrodt, Russell, & Abraham, 2004), but even here we believe that more work needs to be done, especially from a developmental perspective that examines attachment styles in very young children.

Finally, we have indicated at several points in this book the importance of unconscious processes and mechanisms that influence the development, maintenance, and outcomes of perfectionism. However, the extant research has utilized self-report measures of perfectionism and outcomes. Self-report measures, of course, assess only attributes and characteristics that a person is consciously aware of; they cannot tap processes and influences that the individual is not aware of. There is some intriguing research addressing implicit self-esteem and perfectionistic behavior (e.g., Zeigler-Hill & Terry, 2007), but this seems like a largely untapped area of inquiry. On a related theme, numerous writers

have described the relationship that one has with oneself (Sullivan, 1953; Benjamin, 1996), but there seems to be little work addressing this issue as it pertains to perfectionism. We have drawn attention to it in this volume, and we hope others will assess whether this idea has merit with respect to perfectionism. There is research on perfectionism and self-esteem as well, but we would encourage work on other aspects of the self and elements of self-esteem beyond simply levels of self-esteem.

CONCLUSION

One of the joys of collaborating with others is throwing ideas “out there” and seeing how intelligent and creative individuals respond. Ideally, such individuals will use empirical methods to attempt to determine whether the ideas are supported. We view it as an honor for researchers and clinicians to consider our work, whether or not they agree with it. We hope they are moved to try some new clinical approaches, to think of perfectionistic people as complex individuals with complex problems, and to conduct solid research to refute or support some of our claims.

Perhaps our most important message as we conclude this book is that there is reason for optimism in treating people who present with severe distress and dysfunction related to perfectionism. We and others believe that perfectionistic behavior is too complex and difficult to treat effectively with symptom-focused approaches. Blatt’s influential chapter written over a decade ago with David Zuroff (Blatt & Zuroff, 2002) reminds us that perfectionists typically do quite well in more intensive psychoanalytically oriented treatment (Hewitt, Mikail, et al., 2015). It is important to keep this in mind and actively communicate this to people seeking treatment. Regrettably, many of these individuals have tried alternative forms of treatment and become quite pessimistic, or even hopeless, about the possibility of recovery. The first step on the road to improvement is to help foster self-acceptance in these persons and to aid them in accepting that they do not have to be perfect to have safe and fulfilling lives.

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