CHAPTER 1

Nature and Causes of Perfectionism

What is perfectionism? As we will discuss shortly, there is no universally agreed-upon definition of the term, and even experts define it in different ways. For the purpose of this book, we focus on *dysfunctional perfectionism*—a tendency to hold excessively high standards associated with clinically significant distress or impairment. Some examples include:

- A woman who struggles to be a perfect parent, a perfect wife, and a perfect employee, often to the detriment of her own emotional and physical health.
- A graphic artist who constantly seeks reassurance that his work is of the highest quality, and that he is well respected and well liked by others.
- A student who constantly strives to meet excessively high academic standards and who is devastated when she receives a grade that is less than perfect.
- An individual who spends hours planning every aspect of every day and who becomes very distressed when things don't go according to his plans.

This guide assumes that perfectionism is a transdiagnostic process occurring across a wide range of disorders, including anxiety and related disorders, eating disorders, and depression, to name a few (Egan, Wade, & Shafran, 2011). It is generally assumed that perfectionism is a dimensional construct that can vary in severity from low to high, and recent evidence confirms this notion (Broman-Fulks, Hill, & Green, 2008). In other words, perfectionism is not something that people either *have* or *don't have*. Rather, it is something that we all experience to varying degrees.

This book provides an evidence-based framework for the psychological treatment of clinical perfectionism. It was written with the therapist in

mind and is filled with summary tables, troubleshooting boxes, bulleted lists, forms, and various other resources that busy clinicians need to have at their fingertips. This guide takes a nonprescriptive approach, supporting the clinician's work within an individualized and collaborative case conceptualization framework.

This first chapter provides an introduction to the construct of perfectionism, including definitions, descriptive features, and etiology. The next three chapters review research concerning both the treatment of perfectionism (Chapter 2) and the relationship between perfectionism and various forms of psychopathology (Chapters 3 and 4). Next, the book discusses assessment of perfectionism (Chapter 5) and issues related to treatment planning (Chapter 6). The remainder of the book focuses on treatment, including cognitive-behavioral case formulation (Chapter 7); strategies for enhancing engagement in therapy, including the importance of developing a good therapeutic alliance (Chapter 8); self-monitoring (Chapter 9); cognitive strategies (Chapters 10 and 11); behavioral experiments (Chapter 12); tools for dealing with self-criticism (Chapter 13); strategies for dealing with procrastination and poor time management (Chapter 14); and methods for preventing relapse (Chapter 15). Chapter 16 provides a review of emerging treatments, including interventions for children and adolescents, and techniques involving imagery. The book also includes appendices containing a wide range of clinical resources and tools (e.g., self-help books, referral sources, handouts, and questionnaires).

This book is appropriate for clinicians from across disciplines and professions, and will be helpful to both students and seasoned therapists alike. We recommend that you use the book in the way that best serves your needs. Some therapists (e.g., those who are new to the treatment of perfectionism) may choose to read the entire book from cover to cover. Other therapists may find it most helpful to read particular chapters or sections, depending on what they are hoping to get out of this guide.

Definitions of Perfectionism

There are many different ideas about what perfectionism is and whether it is a good or bad thing, among our clients, the general public, and experts in the field. Oxford Dictionaries online defines perfectionism as the "refusal to accept any standard short of perfection" (Oxford Dictionaries, 2013). In an early psychological definition, English and English (1958) defined perfectionism similarly, as "the practice of demanding of oneself or others a higher quality of performance than is required by the situation" (Hollender, 1965, p. 94). Both of these are examples of *unidimensional* definitions, and a number of other unidimensional definitions have been proposed over the years.

Clinicians have tended to define perfectionism in terms of its negative impact. For example, in his classic *Psychology Today* article, "The

Perfectionist's Script for Self-Defeat," David Burns (1980) provided an early definition of pathological perfectionism, distinguishing *perfectionism* from the *healthy pursuit of excellence*. He defined perfectionists as "those whose standards are high beyond reach or reason, people whose strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment (p. 34). Similarly, the Obsessive Compulsive Cognitions Working Group (OCCWG) defined perfectionism in the context of obsessive–compulsive disorder (OCD) as "the tendency to believe there is a perfect solution to every problem, that doing everything perfectly (i.e., mistake-free) is not only possible, but also necessary, and that even minor mistakes will have serious consequences" (1997, p. 678).

Definitions of perfectionism all share the assumption that perfectionists hold elevated standards. However, definitions also differ in important ways. The definitions by Burns (1980) and the OCCWG (1997) focus on *pathological* or *problematic* forms of perfectionism, in which self-worth is contingent on meeting one's high standards, and in which perfectionism has negative consequences (e.g., functional impairment) for the individual. Implicit in these definitions is that pathologically perfectionistic standards are *rigid*, that is, individuals do not adjust their standards when they are unmet. In contrast to these clinically oriented definitions, neither the Oxford Dictionaries online definition of perfectionism nor English and English's (1958) definition assumes that perfectionism is necessarily a problem. For example, some very successful individuals (e.g., film director James Cameron, business magnate and television personality Martha Stewart) are self-described "perfectionists" (Antony & Swinson, 2009). Of course, it is likely that the clients seeking treatment for perfectionism and related problems are experiencing clinically oriented perfectionism, rather than a healthy pursuit of excellence.

In contrast to the unidimensional definitions reviewed earlier, other authors have suggested that perfectionism is a multidimensional construct, though there is wide disagreement regarding the number of dimensions and what the core dimensions are. The two most influential multidimensional models are those of Hewitt and Flett (1991b) and Frost, Marten, Lahart, and Rosenblate (1990). Each of these is described below, followed by descriptions of other multidimensional approaches. An understanding of the different definitions of perfectionism provides a framework with which to recognize the different forms that it may take, when it requires an intervention, and how it should best be assessed.

Hewitt and Flett's Multidimensional Model

Hewitt and Flett (1991b) define perfectionism along three dimensions: (1) *self-oriented perfectionism* (SOP; a tendency to set demanding standards for oneself and to stringently evaluate and criticize one's own behavior);

(2) *other-oriented perfectionism* (OOP; the tendency to set demanding standards for others and to stringently evaluate and criticize the behavior of others); and (3) *socially prescribed perfectionism* (SPP; the belief that significant others have unrealistic expectations, and that it is important to meet the high standards of others). Hewitt and Flett (1991b) published an initial validation study on their *Multidimensional Perfectionism Scale* (HMPS), which, along with subsequent studies, generally supported their tripartite model of perfectionism.

Frost et al.'s Multidimensional Model

Frost, Marten, Lahart, and Rosenblate (1990) defined perfectionism along six dimensions: (1) *concern over mistakes* (CM; excessive anxiety over making mistakes, in which any minor flaw is considered to represent failure); (2) *doubts about actions* (DA; doubts about the quality of one's work); (3) *personal standards* (PS; a tendency to have excessively high standards for one's own performance); (4) *parental expectations* (PE; the belief that one's parents set standards that one could not meet); (5) *parental criticism* (PC; the belief that one's parents were overly critical in response to unmet standards); and (6) *organization* (O; a tendency to overemphasize precision, order, and organization). On the surface, some dimensions (e.g., CM, DA, PS, O) appear to measure *aspects or features* of perfectionism, whereas others (e.g., PE, PC) appear to measure *causes or correlates* of perfectionism. In addition, whereas four of these dimensions (CM, DA, PC, PE) appear to be elevated in people with various forms of psychopathology, such as anxiety disorders and depression, the PS and O dimensions are typically not (though PS is elevated in people with eating disorders).

Frost et al. (1990) published an initial validation study on their *Multidimensional Perfectionism Scale* (FMPS), and there have been several subsequent studies evaluating the scale and the six-factor model underlying it. As reviewed in Chapter 6, findings suggest that O is distinct from the other dimensions of perfectionism (e.g., Frost et al., 1990), and that some of Frost et al.'s dimensions appear to be redundant. For example, items measuring PE and PC tend to load together in factor analytic studies, as do items measuring CM and DA (for a review, see Hawkins, Watt, & Sinclair, 2006).

Positive and Negative Perfectionism

There is a long tradition in the literature of distinguishing between positive and negative forms of perfectionism. For example, more than three decades ago, Hamacheck (1978) distinguished between *normal* and *neurotic* perfectionism, where a main difference between the two forms was the extent to which high standards are flexible (with normal perfectionists being more likely to allow for minor errors in their performance, relative to neurotic perfectionists). Early on, dysfunctional perfectionism was described as

the "tyranny of the shoulds" (Horney, 1950). A few years later, Hollender (1965) painted the following clinical picture of perfectionism:

> The perfectionist finds it difficult to sort out items in the order of their importance or to maintain a sense of proportion. A small detail that has been missed may deprive him of gratification from a job otherwise well done. He is constantly on the alert for what is wrong and seldom focuses on what is right. He looks so intently for defects or flaws that he lives his life as though he were an inspector at the end of a production line. (p. 95)

Perhaps the most succinct description is that given by Albert Ellis, which we share with our clients with whom we have a good relationship. He simply called it "musterbation" (Ellis & Harper, 1961).

More recently, researchers have attempted to verify these two forms of perfectionism empirically. In perhaps the earliest of these studies, undergraduate students completed both the FMPS (Frost et al., 1990) and the HMPS (Hewitt & Flett, 1991b) and their responses on all nine subscales from the two measures were factor analyzed (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993). Two higher-order dimensions were identified. The first of these, referred to as *Maladaptive Evaluative Concerns*, was comprised of items from Frost et al.'s CM, DA, PE, and PC subscales and Hewitt & Flett's SP subscale, whereas the second factor, referred to as *Positive Achievement Striving*, included PS and O from Frost et al.'s measure and SOP and OOP from Hewitt and Flett's measure. Whereas maladaptive evaluation concerns were found to be positively correlated with depression and negative affect (but not positive affect), positive achievement strivings were found to be related to positive affect (but not depression or negative affect) (Frost et al., 1993).

A number of subsequent studies have confirmed these findings, supporting the notion of both positive and negative forms of perfectionism, based on the FMPS and HMPS scales (e.g., Bieling, Israeli, & Antony, 2004). In addition, there have been a number of theoretical and empirical papers exploring the notion of positive (i.e., adaptive, healthy, normal) and negative (i.e., maladaptive, unhealthy, neurotic, clinical) forms of perfectionism based on other measures (e.g., Hill et al., 2004; Owens & Slade, 2008; Rice & Ashby, 2007; Terry-Short, Owens, Slade, & Dewey, 1995). For the most part, research supports the distinction between positive and negative perfectionism. For example, several studies suggest that constructs such as maladaptive evaluative concerns and dysfunctional perfectionism are more strongly related to mental health problems (e.g., obsessive–compulsive symptoms, depression, anxiety, suicidality, shame, guilt) than are constructs such as positive striving and adaptive perfectionism (e.g., Bieling et al., 2004; DiBartolo, Li, & Frost, 2008; Klibert, Langhinrichsen-Rohling, & Saito, 2005; Rhéaume et al., 2000). Of course, it is maladaptive perfectionism that is most likely to bring clients into treatment.

Dysfunctional Perfectionism

Although our clients are unlikely to want a tutorial on the various different definitions of perfectionism, it is important for the therapist to offer them a working definition of unhelpful perfectionism that will be the focus of therapy. In this book, we focus on the type of perfectionism that results in psychopathology, referred to as *dysfunctional perfectionism*.

In their paper on perfectionism, Shafran, Cooper, and Fairburn (2002) argued that it is unhelpful and confusing to use the term *perfectionism* to refer to both the healthy pursuit of excellence and the dysfunctional high standards often seen in clinical samples. They focused on one aspect of perfectionism that was often seen in the clinic. This specific form of perfectionism was termed *clinical perfectionism* and defined as "the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards in at least one highly salient domain, despite adverse consequences" (Shafran et al., 2002, p. 778). According to Shafran and colleagues, the adverse consequences of clinical perfectionism may be emotional (e.g., anxiety), social (e.g., lack of social support), physical (e.g., poor nutrition from excessive dieting), cognitive (e.g., poor concentration), or behavioral (e.g., procrastination). That is not to say that they did not recognize other forms of perfectionism to be of clinical relevance, for example, it can be highly disabling to have high expectations of others that are not met, and the belief that others have high standards will also be associated with anxiety. They argued, however, that it was important for the development of effective treatment to have a narrow focus on the sort of perfectionism that is routinely seen in the clinic.

Furthermore, Shafran et al. (2002) argued that several of the constructs typically considered dimensions of perfectionism (e.g., other-oriented perfectionism, socially prescribed perfectionism, concern over mistakes, doubts about actions, parental expectations, parental criticism) are actually associated features of perfectionism but are not the core construct itself, as described in their definition. The paper by Shafran et al. (2002) generated a number of responses and considerable scholarly debate (e.g., Dunkley, Blankstein, Masheb, & Grilo, 2006; Hewitt, Flett, Besser, Sherry, & McGee, 2003; Shafran, Cooper, & Fairburn, 2003). For example, Hewitt et al. (2003) disagreed with Shafran et al.'s (2002) view that perfectionism is unidimensional, and with their definition of clinical perfectionism (e.g., their failure to incorporate interpersonal aspects into their definition). The debate regarding the definition, boundaries, and dimensionality of perfectionism is far from over, and has been a source of confusion and disagreement in the literature for as long as perfectionism has been a topic of study.

Of course, this book is focused on the *treatment* of perfectionism and is therefore concerned primarily with its dysfunctional aspects. The definition and model of clinical perfectionism that forms the basis for the treatment outlined in this book, explained in more detail in Chapter 7, is supported

by the ways in which perfectionists often describe their symptoms. For example, in an effort to further understand the phenomenon of clinical perfectionism, Riley and Shafran (2005) interviewed 15 individuals who were identified as being high in clinical perfectionism and 6 individuals identified as low in clinical perfectionism. To be considered high in clinical perfectionism, participants had to endorse three core features of clinical perfectionism identified by the authors: (1) self-imposed dysfunctional standards, (2) continual striving to reach goals, and (3) significant adverse consequences resulting from continual striving for perfection. Among those who were low in clinical perfectionism, none endorsed dysfunctional standards or significant adverse consequences, though two-thirds endorsed continual striving to reach their goals. Commonly endorsed mechanisms for the maintenance of high perfectionism included self-critical reactions to failure, cognitive biases, rules and rigidity, positive emotional reactions to success, fear-driven motivation for achieving, and safety behaviors. Positive emotional reactions to success were also common among those who were deemed low in clinical perfectionism, whereas the other mechanisms were endorsed infrequently in this group. This study provides a rich description of clinical perfectionism that therapists can use when assessing and treating their clients.

There is another sense in which dysfunctional perfectionism can present in the clinic, and that is the perfectionism that is often seen in obsessive–compulsive personality disorder (OCPD). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), the critical nature of OCD involves being overly concerned with perfectionism, order, and control, which leads to the person becoming inefficient in completing tasks and having a lack of personal flexibility and openness. Here, perfectionism is not so much about having excessively *high* standards, but rather about having *arbitrary* standards (attention to rules, unimportant details, order, etc.) that are excessively rigid. Although this form of perfectionism can be clinically impairing and affect a wide range of life domains (e.g., work, relationships), it appears to be quite different from the perfectionism that is often seen in other forms of psychopathology (e.g., as reviewed earlier, elevated attention to organization is not correlated with other forms of perfectionism as measured on the FMPS; Frost et al., 1990).

Causes of Perfectionism

Little is known about the etiology and development of perfectionism. However, if we assume that perfectionism develops in the same ways as related forms of psychopathology, then it makes sense to turn to some of the same factors that are known to contribute to associated problems, such as anxiety and depression, where it is well established that both biological (e.g., genetics) and psychological (e.g., learning) factors play a role.

Interpersonal Influences

Most studies examining the role of interpersonal influences on perfectionism have focused on the role of parents, though virtually all studies have been correlational, and many do not include assessments of the parents themselves, instead relying on participants' impressions of their parents' behavior. For example, Enns, Cox, and Clara (2002) found that although harsh parenting (the perceived tendency for one's parents to make critical comments about the individual) and perfectionistic parenting (the perceived tendency for one's parents to have high personal standards for themselves) were both predictive of maladaptive perfectionism, only perfectionistic parenting (and not harsh parenting) was associated with adaptive perfectionism. Another study found that perceived harsh and authoritarian parenting styles were related to maladaptive, but not adaptive, components of perfectionism, in both European American men and women and Asian American women (Kawamura, Frost, & Harmatz, 2002). Although specific findings vary across studies, there is considerable evidence that perceived parenting behaviors (e.g., parental criticism, parental perfectionism) are correlated with perfectionism (e.g., Clark & Coker, 2009; Cook & Kearney, 2009; Frost, Lahart, & Rosenblate, 1991). There is also emerging evidence that adaptive perfectionists report having more balanced, cohesive, and adaptable families with nurturing parents, relative to both maladaptive perfectionists and nonperfectionists (DiPrima, Ashby, Gnilka, & Noble, 2011). Many clients report that they have always been perfectionists, or that they were driven to achieve by demanding parents. Awareness of these research findings can help the therapist to answer questions about the associations between perfectionism in parents and their children.

A small number of studies have examined the influence on perfectionism of interpersonal factors other than those stemming from parents and families. For example, one study examined the relationship between retrospective recall of emotional abuse by peers during childhood and perfectionism in adulthood (Miller & Vaillancourt, 2007). In this study, a history of perceived *indirect* peer victimization (e.g., excluding individuals from activities, gossiping, spreading rumors) was predictive of self-oriented and socially prescribed perfectionism in adults, whereas no relationship with perfectionism was found for a history of more *direct* forms of aggression (e.g., physical aggression, verbal aggression).

Learning Factors

Slade and Owens (1998) suggest that perfectionism is shaped by social contingencies, and that these contingencies may shift over time from an initial focus on positive contingencies (e.g., rewards for meeting high standards) to a focus on more negative reinforcement (negative consequences for failing to be perfect). For example, an individual who is successful at work

may initially be motivated to achieve simply for the positive consequences (e.g., feelings of success, raises, promotions) but over time may become more concerned about letting people down if his or her performance starts to worsen. It is also possible that perfectionism is initially reinforcing, and that only later do its effects begin to turn negative, as various negative consequences (e.g., fatigue, falling behind on tasks, anxiety) start to occur (Shafran & Mansell, 2001). There is also evidence that when perfectionists do meet a particular standard, they respond by raising the standard (Kobori, Hayakawa, & Tanno, 2009).

Experimental research on the role of learning in the development of perfectionism is lacking, though learning (e.g., operant conditioning, classical conditioning, modeling) may help to explain the relationship between parenting styles and perfectionism, as reviewed earlier. In addition, there is considerable evidence that learning plays a role in the development of problems that are often associated with perfectionism (e.g., anxiety disorders; Craske, Hermans, & Vansteenwegen, 2006).

Genetic Factors

Very little is known about the relationship between biology and perfectionism, though emerging research with twins suggests that genetics may play a role. A twin study examining the heritability of perfectionism found that concordance rates were consistently higher for monozygotic twins than for dizygotic twins for three types of perfectionism measured by the FMPS: CM, DA, and PS (Tozzi et al., 2004). Furthermore, there was evidence that PS and CM (but not DA) shared some common genetic factors whereas DA and CM shared some common environmental factors (Tozzi et al., 2004). A more recent twin study found that anxiety and maladaptive perfectionism were both moderately heritable (heritability estimates ranging from .45 to .66), and that genetic factors mostly accounted for the relationship between anxiety and maladaptive perfectionism (Moser, Slane, Burt, & Klump, 2012). Although there is extensive research on the role of genetics in disorders associated with perfectionism (e.g., anxiety disorders, eating disorders, depression), more research is needed to better understand the ways in which genetics and environment interact in the development of perfectionism.