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, nearmisses, 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.