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Perfectionism

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DESCRIPTION OF PERFECTIONISM

The key defining feature of perfectionism is holding high personal expectations for performance and behavior (Stoeber & Otto, 2006). Perfectionism is generally viewed as having both an adaptive and maladaptive form (Gnilka, Ashby, & Noble, 2012; Rice & Ashby, 2007; Stoeber & Otto, 2006).

Adaptive perfectionists hold high personal expectations, but are also able to gain a sense of well-being and pleasure from their personal efforts even when their high standards are not fully met. Adaptive perfectionism has been associated with lower levels of anxiety (Gnilka et al., 2012), lower levels of perceived stress (Ashby, Noble, & Gnilka, 2012), lower levels of depression (Ashby et al., 2012; Gnilka, Ashby, & Noble, 2013; Rice & Ashby, 2007), higher levels of life satisfaction (Gnilka et al.,2013), increased positive family relationship characteristics (DiPrima, Ashby, Gnilka, & Noble, 2011), and the use of more healthy coping processes (Gnilka et al., 2012).

Conversely, maladaptive perfectionists hold similarly high personal expectations, but chronically view their attempts to meet those standards as deficient. Recent studies have associated maladaptive perfectionism with unhealthy family relationship variables (DiPrima et al., 2011), increased levels of depression (Ashby et al., 2012; Gnilka et al., 2013), lower levels of self esteem (Wang, Slaney, & Rice, 2007), lower levels of hope (Ashby, Dickinson, Gnilka, & Noble, 2011), and higher levels of anxiety (Gnilka et al., 2012).

IDENTIFICATION/ASSESMENT STRATEGIES

There are several different scales that are currently used to identify and measure perfectionism. Each of the below scales differ somewhat in their theoretical view of perfectionism and conception of the types/forms of perfectionism that may occur. A thorough assessment of perfectionism is a starting place for counselors to help determine the best treatment options.

Frost Multidimensional Perfectionism Scale (FMPS; Frost, Marten, Lahart, & Rosenblate, 1990)

The FMPS is a 35-item scale that has six subscales that measure various components of perfectionism: Concern Over Mistakes, Personal Standards, Parental Expectations, Parental Criticism, Doubts About Actions, and Organization. The psychometric properties of the FMPS are considered good (Enns & Cox, 2002).

Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991)

The MPS is a 45-item scale that measures three different forms of perfectionism: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. The MPS has good psychometric properties (Hewitt & Flett, 2004). This instrument is for sale by Multi-Health Systems Inc.

To purchase the instrument go to: http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=mps

Almost Perfect Scale – Revised (APS-R; Slaney, Mobley, Trippi, Ashby, & Johnson, 1996; Slaney, Rice, Mobley, Trippi, & Ashby, 2001)

The APS-R is a 23-item scale that includes three subscales: High Standards, Discrepancy, and Order. The High Standards subscale (7 items) measures high personal standards and achievement expectations. The Discrepancy subscale (12 items) measures an individual's perception that one fails to meet the high standards set for oneself. The Order subscale (4 items) measures the preference for organization. The psychometric properties of the APS-R

are excellent (e.g., Slaney et al., 2001). The scales are available for free along with an extensive bibliography.

To download this free instrument go to: http://kennethwang.com/apsr/index.html

INTERVENTION STRATEGIES

Working with Adaptive Perfectionists

Not all perfectionism is unhealthy or pathological. In fact, adaptive perfectionism may actually buffer clients from psychological distress (Gnilka et al., 2012). When working with clients with adaptive perfectionism, it may be beneficial for counselors to help clients focus on maintaining effective coping styles and problem solving strategies rather than attempt to lower clients' personal high standards or expectations (Ashby et al., 2011; Gnilka et al., 2012). For example, Gnilka and colleagues (2012) noted that adaptive perfectionists use a unique set of coping processes compared to non-perfectionists and maladaptive perfectionists. In regards to healthy coping processes, adaptive perfectionists are more likely to use a coping process called self-control, which involves and increased ability to regulate emotions and behaviors. Adaptive perfectionists are also less likely than non-perfectionists and maladaptive perfectionists to use several unhealthy coping processes including: distancing, which involves persistent cognitive detachment from stressful situations; self-blame, which involves consistently blaming yourself for all problems; and, escape-avoidance, which involves wishful thinking and behavioral avoidance of stressful situations. Counselors may want to assist adaptive perfectionists in maintaining the use of these healthy coping processes while adjusting the use of these unhealthy coping processes.

Working with Maladaptive Perfectionists

Given that maladaptive perfectionism is associated with negative outcomes, most of the intervention literature has focused on this particular form of perfectionism. Clients with higher levels of maladaptive perfectionism may be hypersensitive to a counselor's interventions and feedback; therefore, counselors should use extra care and effort in making sure their clients feel safe and secure within the counseling relationship. When working with this population, treatment is typically of a longer duration with less therapeutic progress when compared to nonperfectionists and adaptive perfectionists (Gnilka et al., 2012; Hamachek, 1978).

There is a lack of quality intervention research available on changing maladaptive perfectionism. To date, only a few studies have been conducted. Preliminary research findings have tested several different intervention strategies with the majority showing promise of being effective in treating maladaptive perfectionism.

Coherence Therapy

Coherence Therapy (see Ecker & Hulley, 2000 for a review of the theory) is an emotion-focused postmodern brief therapy approach that has been shown to be beneficial in reducing self-criticalness symptoms of maladaptive perfectionism (Rice, Neimeyer, & Taylor, 2011). One of the main goals of Coherence Therapy is to validate and integrate the client's constructs and schemas of self, others, and the world. This therapy is designed to help the client become fully aware of the largely unconscious personal constructs producing the symptoms. As a client gains a deeper understanding of the constructs producing the unwanted symptoms, counselors can help clients in revising the constructs which, in turn, will lead to extinguishing negative symptoms.

For example, counselors working with maladaptive perfectionists (i.e., self-critical perfectionism) would assist clients in identifying and exploring the important roles their self-criticalness plays in their life. Next, the counselor would assist clients in exploring alternative emotions that can be connected to those roles to help them become more conscious of the limitations of having high self-criticalness. Lastly, transformation happens when clients are able to lower their self-criticalness by replacing it with other adaptive constructs. In the absence of self-critical constructs, maladaptive perfectionistic thoughts and behavior would no longer be coherent with their internal constructs and, as a result, would abate.

Cognitive Behavioral Therapy (CBT)

CBT has demonstrated effectiveness in the treatment of maladaptive perfectionism via several modalities including web-based interventions (Radhu, Daskalakis, Arpin-Cribbie, Irvine, & Ritvo, 2012), and individual counseling (Riley, Lee, Cooper, Fairburn, & Shafran, 2007). These treatments typically consist of ten to twelve sessions over eight to twelve weeks.

In one study utilizing CBT in individual counseling, Riley and colleagues (2007) used a manualized treatment strategy with outpatient clients that targeted four goals: (a) identifying perfectionism as a problem by operationally defining various characteristics (e.g., repeated performance checking, workaholism); (b) conducting behavioral experiments to increase self-awareness of their perfectionism; (c) psychoeducation and cognitive restructuring specifically around several key issues (e.g., self-criticism, selective attention to failure); and, (d) identifying and utilizing alternative self-evaluation processes that lower self-criticism. When compared to the waitlist control group, 75% of the CBT group reported clinically significant improvement at 8-week and 16-week follow-ups.

Feedback on Perfectionism Assessment Results

Research has demonstrated that providing brief feedback on assessment results can be an effective intervention (Claiborn, Goodyear, & Horner, 2001; Neighbors, Larimer, & Lewis, 2004). Aldea, Rice, Gormley, and Rojas (2010) conducted a randomized, controlled trial to determine if maladaptive perfectionists who received feedback on the results of perfectionism assessment results (in this case the APS-R) would experience a reduction in symptoms associated with maladaptive perfectionism. The researchers also asked about the client's various strengths and talents (e.g., "What would you consider to be some strengths or talents you have?"). Overall, results of the study demonstrated that providing feedback on assessment results reduced emotional reactivity and global symptomatic distress (e.g., depression, low self-esteem).

Play Therapy

A number of authors (e.g., Kottman & Ashby, 2000) have highlighted the importance of treating maladaptive perfectionism in children. Ashby and Noble (2011) discussed how to integrate Cognitive Behavior Therapy (CBT) and Adlerian techniques via Play Therapy when working with young children. Overall, Play Therapy emphasizes a strong therapeutic relationship with clients, allow counselors to be active and engaged with clients, and helps counselors focus on clients' thought processes and beliefs about themselves and others. The typical phases of Play Therapy include: (a) Establishing a therapeutic relationship; (b) Exploring a child's lifestyle and cognitive self-beliefs; and, (c) assisting the child in exploring/reorienting their lifestyle and active cognitive interventions (e.g., shaping, modeling, cognitive disputation).

Guided and Pure Self-Help

Self-help has been shown to be efficacious in the treatment of multiple issues (e.g., Carter & Fairburn, 1998; Landreville & Bissonnette, 1997). Pleva and Wade (2007) conducted a randomized controlled trial to determine if guided or pure self-help strategies designed by Antony and Swinson (1998) were effective in reducing obsessive-compulsive and depressive symptoms in maladaptive perfectionists. The strategies were based on Cognitive Behavioral Therapy over an 8-week period. The guided self-help group reported a greater reduction in obsessive-compulsive symptoms compared to the pure self-help group; however, approximately 20% of the pure self-help group reported clinically significant increases in depression compared to zero percent of the guided self-help group. The findings of this study suggested that while both pure and guided self-help are effective, guided self-help may be a more appropriate intervention for clients suffering from maladaptive perfectionism.

Resources:

Antony, M. M., & Swinson, R. P. (1998). *When perfect isn't good enough: Strategies for coping with perfectionism.* Oakland, CA: New Harbinger.

REFERENCES

Aldea, M., Rice, K., Gormley, B., & Rojas, A. (2010). Telling perfectionists about their perfectionism: Effects of providing feedback on emotional reactivity and psychological symptoms. *Behavior Research & Therapy, 48*, 1194-1203. doi: 10.1016/j.brat.2010.09.003

Antony, M. M., & Swinson, R. P. (1998). *When perfect isn't good enough: Strategies for coping with perfectionism.* Oakland, CA: New Harbinger.

Ashby, J., Dickinson, W., Gnilka, P., & Noble, C. (2011). Hope as a mediator and moderator of multidimensional perfectionism and depression in middle school students. *Journal of Counseling & Development, 89,* 131–139.

Ashby, J., & Noble, C. (2011). Integrating cognitive-behavioral play therapy and Adlerian play therapy into the

treatment of perfectionism. In A. A. Drewes, S. C. Bratton, & C. E. Schaefer (Eds.), *Integrative play therapy* (pp. 225-239). Hoboken, NJ: John Wiley & Sons.

Ashby, J., Noble, C., & Gnilka, P. (2012). Multidimensional perfectionism, depression, and satisfaction with life: Differences among perfectionists and tests of a stress-mediation model. *Journal of College Counseling, 15,* 130–143.

Carter, J. C., & Fairburn, C. G. (1998). Cognitive-behavioural self-help for binge eating disorder: A controlled effectiveness study. *Journal of Consulting & Clinical Psychology, 66*, 616–623.

Claiborn, C. D., Goodyear, R. K., & Horner, P. A. (2001). Feedback. *Psychotherapy, 38,* 401-405.

DiPrima, A., Ashby, J., Gnilka, P., & Noble, C. (2011). Family relationships and perfectionism in middle-school students. *Psychology in the Schools, 48,* 815–827. doi: 10.1002/pits.20594

Ecker, B., & Hulley, L. (2000). Depth-oriented brief therapy: Accelerated accessing of the coherent unconscious. In J. Carlson & L. Sperry (Eds.), *Brief therapy with individuals & couples* (pp.161–190). Phoenix, AZ: Zeig, Tucker, & Theisen.

Enns, M., & Cox, B. (2002). The nature and assessment of perfectionism: A critical analysis. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 33–62). Washington, DC: American Psychological Association.

Frost, R., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy & Research*, *14*, 449-468.

Gnilka, P., Ashby, J., & Noble, C. (2012). Multidimensional perfectionism and anxiety: Differences among perfectionists and tests of a coping-mediation model. *Journal of Counseling & Development, 90*, 427-436

Gnilka, P., Ashby, J., & Noble, C. (2013). Adult attachment style differences among adaptive, maladaptive, and non-perfectionists. *Journal of Counseling & Development, 91*, 78-86.

Hamachek, D. E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology, 15*, 27-33.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60*, 456–470.

Hewitt, P., & Flett, G. (2004). *The Multidimensional Perfectionism Scale: Technical manual.* Toronto, Canada: Multi-Health Systems Inc.

Kottman, T., & Ashby, J. S. (2000). Perfectionistic children and adolescents: Implications for school counselors. *Professional School Counseling, 3*, 182-18

Landreville, P., & Bissonnette, L. (1997). Effects of cognitive bibliotherapy for depressed older adults with a disability. *Clinical Gerontologist, 17*, 35–55.

Neighbors, C., Larimer, M. E., & Lewis, M. A. (2004). Targeting misperceptions of descriptive drinking norms: efficacy of a computer-delivered personalized normative feedback intervention. *Journal of Consulting and Clinical Psychology,72*, 434-447.

Pleva, J., & Wade, T. (2007). Guided self-help versus pure self-help for perfectionism: A randomized controlled trial. *Behavior Research & Therapy, 45*, 849-861. doi: 10.1016/j.brat.2006.08.009

Radhu, N., Daskalakis, Z., Arpin-Cribbie, C., Irvine, J., & Ritvo, P. (2012). Evaluating a web-based cognitive-behavioral therapy for maladaptive perfectionism in university students. *Journal of American College Health, 60,* 357-366. doi: 10.1080/07448481.2011.630703

Rice, K. G., Neimeyer, G. J., & Taylor, J. M. (2011). Efficacy of coherence therapy in the treatment of procrastination and perfectionism. *Counseling Outcome Research & Evaluation, 2,* 126-136.

Riley, C, Lee, M., Cooper, Z., Fairburn, C., & Shafran, R. (2007). A randomized controlled trial of cognitive-behaviour therapy for clinical perfectionism: A preliminary study. *Behaviour Research & Therapy, 45*, 2221-2231.

Slaney, R. B., Mobley, M., Trippi, J., Ashby, J. S., & Johnson, D. G. (1996). The Almost Perfect Scale–Revised. Unpublished manuscript. The Pennsylvania State University, University Park.

Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The Revised Almost Perfect Scale. *Measurement & Evaluation in Counseling and Development, 34*, 130–145.

Stoeber, J., & Otto, K. (2006). Positive conceptions of perfectionism: Approaches, evidence, challenges. *Personality & Social Psychology Review, 10*, 295–319. doi: 10.1207/ s15327957pspr1004_2

Wang, K. T., Slaney, R. B., & Rice, K. G. (2007). Perfectionism in Chinese university students from Taiwan: A study of psychological well-being and achievement motivation. *Personality & Individual Differences, 42*, 1279-1290.