

THE PROBLEM OF PERFECTIONISM

An integrative approach to ease the demands of perfectionistic thinking

It's interesting that we often hear people say "I'm such a perfectionist". We also know that perfectionism is considered a prized attribute and is common among high achievers. While this sounds good (after all who wants to be operated on by a sloppy surgeon... Or have your teeth treated by a disorganised dentist), we also know of the significant challenges associated with perfectionist thinking such as suicidal thinking, depression and anxiety.

It is recognised that the problem of perfectionism lies in the fact that rather than experiencing a sense of satisfaction, perfectionistic thinking focuses on the negative and rarely leads to a lasting feeling of personal satisfaction and fulfilment. It can contribute to a highly critical and punitive attitude towards the self, leading to feelings of worthlessness. It also has links with procrastination and an inability to make decisions. Conscientiousness, on the other hand, relates to the desire to do your duty well, knowing perfect may not be attainable or realistic.

Hamilton (2000) studied 405 university students who completed the General Health Questionnaire (GHQ-28), and the Multidimensional Perfectionism Scale. Higher scores on total perfectionism and two perfectionism dimensions, and total GHQ scores were correlated with the presence of suicide ideation. Likewise Masson et.al (2003) highlight links between perfectionism, nutritional problems, OCD and insomnia.

Perfectionism Defined

The Diagnostic and Statistical Manual of Mental Disorders 5th Ed. defines perfectionism as "the rigid insistence on everything being flawless, perfect and without errors or faults, including ones own and others' performance; sacrificing of timelines to ensure correctness in every detail, believing there is only one right way to do things; difficulty changing ideas and or viewpoint; preoccupation with details, organisation and order" (p. 768).

There are useful studies examining perfectionism more closely. Enns et.al (2001) differentiated between positive adaptive perfectionism (achievement striving) and negative perfectionism (excessive evaluative concerns) facilitating psychopathology. Hewitt et.al (1996) highlights the difference between self, social, and other oriented perfectionism. Self-oriented perfectionism, needing ones own standards and achievements be perfect, Socially-prescribed perfectionism, seeking to maintain others approval by being perfect and Other-oriented perfectionism, expecting perfection from others. His study found that Self-oriented perfectionism may be most important as a stress-vulnerability factor to depression.

Perfectionism is not commonly the initial reason for seeking treatment and exists in the context of other difficulties. Rather than managing this personality trait with an individual treatment modality, it may respond better to a flexible, integrated approach some of which are suggested below.

1. Clarify core values

Acceptance and Commitment Therapy (Harris, Russ 2009) provides a framework for exploring a persons values and convictions represented in what they are doing. Asking clients questions such as: what is more important to you (in the short and long term), what are the costs to "self" (meaning your core authentic sense of who you are) if you prioritise correctness and order. What will be gained if you allow greater self-expression versus avoiding uncomfortable emotions such as fear and anxiety? Will a focus on "getting it perfect" vs. "doing it right" prevent opportunities for growth and wisdom?

2. Learn to tolerate discomfort

Drawing on cognitive behavioural ideas along with Marsha Linehan's (1993) model of distress tolerance, clients can be encouraged to redirect attention and use self-soothing to shift thinking temporarily until anxiety is more manageable. Aim to distinguish the "actual vs. perceived" threat and identify the belief driving the worry such as "people must approve of my efforts", "I must do things perfectly all of the time or things will be a disaster", "I am a failure if I make a mistake". Challenge unrealistic thinking by asking questions such as "what is the evidence for the worry",

“what is the probability of a bad outcome”, “if the feared event occurred what resources can I call upon to help me cope.” Even if my most feared event happened, was it as bad as I thought ... and if it was then will people remember it tomorrow?”

Accept a level of discomfort and the desire to return to the familiar. Encourage a belief in the clients potential to tolerate discomfort with a reminder that the feeling is not permanent.

3. Recognise self-doubt

The fear of failure and losing status in another’s mind can be driven by the need to seek and maintain the approval of others by being perfect. Procrastinating (i.e. “I’ll only start it if I can get it perfect”) will lead to avoidance of real opportunities. Interactions may be overly agreeable, as opposed to authentic and assertive, which may lead to a loss of self-worth. Rather than shunning social events (“I’ll say something I’ll regret”) try “acting opposite”, and see what happens (use thought challenging techniques and self-soothing).

4. Identify pleasure in the present rather than chase unhelpful soothing strategies

Being grateful in current circumstances or finding pleasure in the here and now is difficult when your focus is on achieving perfection. Coping strategies such as alcohol abuse, overeating or acquiring things (the latest gadgets, cars) may bring short-term relief but can be undermining in the long term. It is known that Mindfulness Based Stress Reduction originally derived from John Kabat-Zinn (1991) and later manualised by Williams and Teasdale (2007) which encourages “paying attention, non-judgementally, in the present moment” has had had positive results with depression and anxiety.

5. Attend to relationships and encourage mentalizing.

Assist clients to develop an objective understanding of themselves and attribute mental states to oneself and others, including recognising that others have different beliefs and desires than ones own. Encouraging ideas around Theory of Mind (Perner 1991) to develop empathy and awareness. Furthermore, understanding the role of unconscious projection of ones desires onto another, especially in the area of micromanaging. It can be useful to consider the work of Jeffrey Young (1993) on Schema Therapy which highlights underlying core beliefs such as defectiveness/shame, approval seeking, unrelenting standards/hypercriticalness that drive maladaptive coping styles.

6. Acknowledge small achievements and build on existing strengths.

Taking a positive approach will build confidence while examining how people respond to when things are less than perfect. Encouraging the return to an old hobby or training for an event using graded steps, will build capacity for taking risks.

To summarise, waiting for the perfect conditions to change anything can mean the right time never comes. Using an integrated approach and encouraging small moves in the right direction, clients are more likely get to their destination sooner.

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Further Reading and References

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