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Clinical Perfectionism: A Preliminary Qualitative Analysis

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Abstract. A cognitive-behavioural analysis of clinical perfectionism has recently been proposed. The aim of this study was to explore the phenomenology of clinical perfectionism and its putative maintaining mechanisms. Of the 21 participants, 15 were judged to have the core psychopathology of clinical perfectionism. The data obtained were largely consistent with the model. In particular, self-imposed dysfunctional standards, continual striving and adverse consequences appeared to be highly salient features of those people who had the core psychopathology of clinical perfectionism but not of those without. A number of other possible maintaining factors not originally described in the model were also identified.

Keywords: Clinical perfectionism, phenomenology, psychopathology.

Introduction

Studies have demonstrated that levels of perfectionism are elevated in a number of disorders including obsessive-compulsive disorder (e.g. Frost and Steketee, 1997) and chronic fatigue syndrome (e.g. White and Schweitzer, 2000), that perfectionism is a risk factor for the development of eating disorders (e.g. Fairburn, Cooper, Doll and Welch, 1999), and that, in the case of depression, it is associated with poorer outcome following intervention, regardless of treatment modality (e.g. Blatt, Quinlan, Pilkonis and Shea, 1995).

However, the nature of this perfectionism has been the subject of some controversy. Originally described as a single construct (e.g. Hamachek, 1978), in the 1990s the conceptual basis of perfectionism was broadened to become multidimensional (e.g. Frost, Marten, Lahart and Rosenblate, 1990; Hewitt and Flett, 1991). Recently, these multidimensional views have been criticized for failing to distinguish between perfectionism itself and its associated features. Shafran, Cooper and Fairburn (2002) argue that such failure has resulted in few advances in the theoretical understanding or treatment of perfectionism. As a result, the cognitive-behavioural construct of "clinical perfectionism" was proposed. Shafran et al. (2002) suggest that the core psychopathology of clinical perfectionism is the overdependence of self-evaluation on the determined pursuit and achievement of personally demanding standards, in at least one domain that is of importance to the individual. It is suggested that this core psychopathology is accompanied by three features: (1) self-imposed dysfunctional standards; (2) continual striving; (3) significant adverse consequences as a result of such striving. Shafran et al. (2002) hypothesize that such clinical perfectionism is maintained by at least six mechanisms:

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(1) failure will be reacted to with self-criticism; (2) there will be an absence of a positive emotional reaction to success; (3) cognitive biases; (4) the setting of strict rules and adhering to them stringently; (5) avoiding challenging tasks for fear of failure; (6) escape from situations where failure may be imminent.

The aims of this study were: (a) to determine whether the proposed phenomenology of clinical perfectionism exists; (b) to examine whether the putative maintaining mechanisms were present; (c) to investigate whether other maintaining mechanisms might operate that were not originally described in the model.

In order to achieve these aims, a qualitative method was used, namely grounded theory. This qualitative analysis technique, developed by Glaser and Strauss (1967), has several core principles that render it suitable for a research study of this nature. It is inductive, thus the theory emerges from the data; it employs theoretical sampling to ensure detailed examination of key issues; and the analysis uses a constant comparison method, in which existing data are reanalysed as new theories emerge. Coding of the data follows some key procedures. Categories describing the content (themes) are applied to the text, and these themes guide the theoretical sampling process. The themes are then rated independently by several researchers to ensure that the analysis is unbiased.

Method

Twenty-one people participated in this study. Fourteen nonclinical participants were recruited with the use of advertisements and seven clinical participants with the help of the local community mental health team. Thus this was a mixed sample. Their mean scores on measures of psychopathology are shown in Table 1. In line with grounded theory, enough participants were recruited until "saturation of themes" was reached, i.e. no new information about clinical perfectionism was emerging. This decision was made by the primary researcher analysing the data as the study progressed, and finding that there were no new themes in the text. In addition, tape recordings of the interviews were listened to independently by the second author who agreed that no new themes were emerging.

Participants were divided into two groups according to whether they displayed the core psychopathology of clinical perfectionism. To avoid circularity, the presence/absence of the core psychopathology of clinical perfectionism was judged independently of the other features of clinical perfectionism separately by both authors. Fifteen participants showed the core psychopathology of clinical perfectionism and six participants did not.

A semi-structured interview schedule was designed to explore the phenomenology of clinical perfectionism and its maintaining mechanisms. The interview schedule was originally piloted on five participants who were not included in the final sample. The piloting ensured that the questions were clear to the participants, that the interview included enough items to gain a clear understanding of the nature of each individual's perfectionism, and that it could be carried out in a suitable time-frame (Table 1). Interviews were transcribed verbatim and each transcript was analysed following the principles of grounded theory.

Results and discussion

Table 2 shows the numbers and percentages for participants endorsing the various themes that emerged during the analysis.

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Table 1. Alterations made to the interview schedule as a result of piloting

Before piloting	After piloting
No questions about demographic information.	Questions asking about demographic information added.
The definition of terms, such as "striving", was not explained.	Terms were explained and the researcher used this to "signpost" what the section was going to be about, for example: "I'm going to ask some questions about striving now – that's the process of actually working towards the goal, rather than achieving the goal itself."
When asked how they reacted to meeting their goals, some participants replied that they never *did* feel that they reached their goals.	The question "Do you ever feel that you've reached your standards?" was added.
There was no item specifically asking about the individual's sense of self-worth and how this related to striving for and achieving goals.	The following item was added: "If you imagine all the things that influence how you feel (judge, think, evaluate) yourself – such as your performance at work, being a parent, your marriage, how you get on with other people – and put these things in order of importance, where does . . . (refer to domains) . . . fit in?"
Items did not always elicit a full response immediately and additional questioning was often required.	Probe items were added.
Participants did not get a chance to comment on the interview or add any additional information at the end.	The final item signalled the end of the interview and asked participants for any other information that they wanted to mention.

Phenomenology

The phenomenology of clinical perfectionism as described by Shafran et al. (2002) may be subdivided into three areas: (1) self-imposed dysfunctional standards; (2) continual striving; (3) striving in spite of adverse consequences. All participants with the core psychopathology of clinical perfectionism reported these features, thus supporting Shafran et al.'s model.

Putative maintaining mechanisms

There were six maintaining mechanisms identified in the interviews that were consistent with Shafran et al.'s model: (1) self-critical reaction to failure; (2) positive emotional reaction to success; (3) cognitive biases; (4) rules and rigidity; (5) avoidance; (6) escape.

The majority (80%) of those with the core psychopathology of clinical perfectionism displayed self-critical reactions to failure, compared to just one of those without clinical perfectionism (16.7%). One such description of this reaction is as follows: "I think if I haven't got something right, then I'm a bit of a worthless person. Or that I'm not good enough, sort of thing."

Positive emotional reaction to success was roughly equal in both groups, which was unexpected. However, it was often more fleeting in people with the core psychopathology

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Table 2. Proportion of participants endorsing each theme that emerged in the qualitative analysis of clinical perfectionism

	Number (and percentage) of participants endorsing theme	
	Core psychopathology of clinical perfectionism ($n = 15$)	No core psychopathology of clinical perfectionism ($n = 6$)
Core features		
1. Self-imposed dysfunctional standards	15 (100%)	0 (0%)
2. Continual striving	15 (100%)	4 (66.7%)
3. Significant adverse consequences	15 (100%)	0 (0%)
Putative maintaining mechanisms		
1. Self-critical reaction to failure	12 (80%)	1 (16.7%)
2. Positive emotional reaction to success	14 (93.3%)	6 (100%)
3. Biases	15 (100%)	2 (33.3%)
4. Rules and rigidity	14 (93.3%)	1 (16.7%)
5. Avoidance	9 (60%)	0 (0%)
6. Escape	4 (26.7%)	3 (50%)
Other maintaining mechanisms		
1. Safety behaviour	12 (80%)	1 (16.7%)
2. Procrastination	7 (46.7%)	0 (0%)
3. Fear driven	14 (93.3%)	1 (16.7%)
4. Value driven	4 (26.7%)	0 (0%)

of clinical perfectionism: "... within a couple of days, and often even shorter, because you've achieved it you think well, it's not that brilliant anyway."

Third, cognitive biases were present in all participants with the core psychopathology of clinical perfectionism, and included all-or-nothing thinking, catastrophizing, disqualifying the positive, focusing on the negative, and double standards (Beck, 1995), for example: "... I set [my students] realistic, sensible standards, but *myself*, oh boy! My standards for me are completely different ..."

Participants with the core psychopathology of clinical perfectionism (93.3%) frequently reported setting dichotomous rules and rigidly adhering to them. This often resulted in inflexibility and stubbornness, for example: "I have rules in what I eat, like I don't eat after seven o'clock ... [I don't break them] unless I absolutely have to."

Avoidance of difficult tasks and abandoning tasks partway through because of their difficulty (escape) were suggested by Shafran et al. (2002) to occur as a result of fear of failure. Sixty percent of participants with the core psychopathology of clinical perfectionism reported avoiding tasks compared to none of those without.

Escape was more common in those without the core psychopathology of clinical perfectionism (50% compared to 26.7%). This was unexpected given Shafran et al.'s (2002) original hypothesis that escape would be common in individuals with clinical perfectionism, but perhaps the relatively low levels indicate that escape from difficult tasks goes against the relentless striving typical of clinical perfectionism. Those without the core psychopathology of

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clinical perfectionism reported a willingness to give up difficult tasks with far more frequency than those with the core psychopathology of clinical perfectionism, who steadfastly pursued their goals time and time again.

Other maintaining mechanisms

There were four maintaining mechanisms identified in the transcripts that were not described by Shafran et al. (2002): (1) safety behaviour; (2) procrastination; (3) fear driven motivation for achieving; (4) value driven motivation for achieving.

"Safety behaviour", i.e. behaving in a way that is designed to avert a feared outcome, for example failing, was underemphasized in Shafran et al.'s (2002) original model. In this sample, examples of safety behaviour included making lists and checking task performance (both overtly and covertly). Eighty percent of those with the core psychopathology of clinical perfectionism reported safety behaviour compared with only 16.7% of the group without the core psychopathology of clinical perfectionism.

Procrastination was reported by 46.7% of the participants with the core psychopathology of clinical perfectionism but by none of those without. Although in Shafran et al.'s (2002) model, procrastination appeared to serve a more complex function than simply delaying tasks out of a fear of failure. Although this was often the case, other reasons for procrastination included fear of the adverse consequences that striving will cause, for example: "I was frightened to death of putting pen to paper . . . writing every word of my thesis was awful. I had put it off for 2 years, and I just couldn't start because I wanted it to be perfect." Procrastination also served to protect individual's self-evaluation, buffering the fragile self-worth by acting as a "scapegoat" for failure ("it was only because I had to do it at the last minute").

Motivation for perfectionism was not explored in the original model. The primary motivation for striving to achieve appeared to be fear of failure and the implications of such failure on self-evaluation. For example: "It would just be a total loss of security if I fell from this standard . . . I suppose it is a fear of . . . knowing that I would feel insecure inside myself." This was present in 93.3% of the sample with the core psychopathology of clinical perfectionism but only 16.7% of those without. A minority of those with the core psychopathology of clinical perfectionism (26.7%) also described striving because it was consistent with their value system, i.e. being perfect is the "right" way to be.

Limitations of this study include the fact that the data were gathered using self-report measures and interviews, which are subject to self-report biases, and the relatively small sample size that prohibited the use of statistical analyses of the differences in the proportions of themes endorsed by each group. Nevertheless, the data obtained provided empirical support for Shafran et al.'s (2002) model and also highlighted additional maintaining mechanisms. This preliminary research allowed a novel empirical investigation of clinical perfectionism, and allows for the development of a more quantitative measure, as well as exploration of the role of clinical perfectionism in Axis I disorders.

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