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Brief Clinical Reports

THE PERFECT PATIENT: COGNITIVE-BEHAVIOURAL THERAPY FOR PERFECTIONISM

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Abstract. A case is described in which the patient's perfectionistic assumptions seemed to play a major role in perpetuating his anxiety and depression. Techniques to deal with perfectionistic assumptions are discussed, and the various effects that perfectionism may have on therapy, both positive and negative, are considered.

Keywords: Perfectionism, cognitive therapy, core beliefs.

Introduction

The many conceptualizations of perfectionism have one element in common, namely excessively high standards of performance (Burns, 1980; Pacht, 1984). However, setting of high standards is not in itself pathological. Hamacheck (1978) proposes that the ability to accept a minor flaw is the critical difference between a perfectionist who is "normal" and one who is not. Hamacheck believes normal perfectionists set very high standards but they "feel free to be less precise as the situation permits" (p. 27). In contrast, individuals for whom perfectionism is a problem set high standards, which cannot be deviated from. Nothing can ever be done well enough and they make highly critical evaluations of their behaviour. In the case described here, such unhelpful perfectionism was an important focus of treatment.

Perfectionism has been associated in the literature with a variety of psychological problems, of which depression is probably the most common. Unhelpful perfectionism described above will often result in the setting of high standards, harsh self-evaluation, a focus on negative aspects of personal performance, and low levels of satisfaction. These individuals often equate perfection with self-worth, so that any deviation from perfection is interpreted as a sign that they are not good enough. Hewitt, Flett and Ediger (1996) offer evidence that self-oriented perfectionism, characterized by the setting of goals that are difficult to attain and harsh self-evaluation, is a stress-vulnerability factor for depression. In so far as it is a risk factor for depression, perfectionism can also provide a focus for cognitive therapy (Burns, 1980).

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The case

Mr R was 40 years old and lived with his partner, Mr P. For the previous seven years Mr R had been a manager in a printing company. He was referred for help with his anxiety and depression. Mr R professed to being a perfectionist and, whilst admitting during the assessment session that this sometimes caused problems for him, he reported using it as his principal coping strategy. His perfectionism has changed over the course of his life, which may be typical of many perfectionists. Mr R reported always having been a perfectionist, but in the past (e.g., five years ago) he was able to tolerate minor flaws in his performance. However, at some point in the years prior to assessment Mr R's perfectionism became much less accepting of flaws and mistakes.

Mr R presented with a relationship problem and a work problem. Mr R's partner, Mr P, had a long-term problem of alcohol abuse. Mr P had been drinking heavily for a number of months prior to Mr R's initial assessment. Mr R was worried about the possible negative effects of his partner's excessive intake of alcohol. He believed that he should be able to stop Mr P from drinking, and that if he were not able to do so, Mr P would die. Mr R had been employed as a manager of a printing company for eight years. In the preceding years there had been an expansion in the amount of work contracted to the firm, without a corresponding increase in resources available to do the work. Hence, Mr R's workload had increased. Though Mr R felt he had been able to achieve what was expected of him up until the assessment session, he feared that at some point in the future he might fail to do his job satisfactorily. He became very anxious because he believed that any failure to achieve the targets set by his manager would demonstrate that he was "not good enough" as a person.

The stressors of Mr P's excessive drinking and Mr R's increased workload, combined with the belief that he "ought" to be 100% successful in dealing with these stressors, appeared to have triggered the episode of depression and anxiety for which Mr R sought treatment. Figure 1 offers a diagrammatic conceptualization of Mr R's perfectionistic assumptions and negative thoughts and shows how Mr R's perfectionistic beliefs influenced his thoughts, feelings and behaviour.

Measures before therapy

The Dysfunctional Attitude Scale (DAS; Weissman, 1980) is a self-report scale that aims to measure beliefs that predispose to depression. It contains items that relate to perfectionism, and a perfectionism factor has been retrieved by factor analysis (Cane, Olinger, Gotlib, & Kuiper, 1986). This contains 13 items such as: "If I fail at my work then I am a failure as a person", and "People will probably think less of me if I make a mistake". Mr R scored 184/240 on the Dysfunctional Attitude Scale and 67/90 on the perfectionism sub-scale, indicating high levels of perfectionistic beliefs. He scored 29 (Severe Depression) on the Beck Depression Inventory (BDI) and 22 (Moderate to Severe Anxiety) on the Beck Anxiety Inventory (BAI). His score was 15 on the Beck Hopelessness Scale, which indicated a hopeless view of the future and placed him in the range that suggested a suicide risk.

Treatment

Therapy for his anxiety and depression was based on standard CBT techniques, but certain specific interventions were aimed at Mr R's perfectionism. The main cognitive

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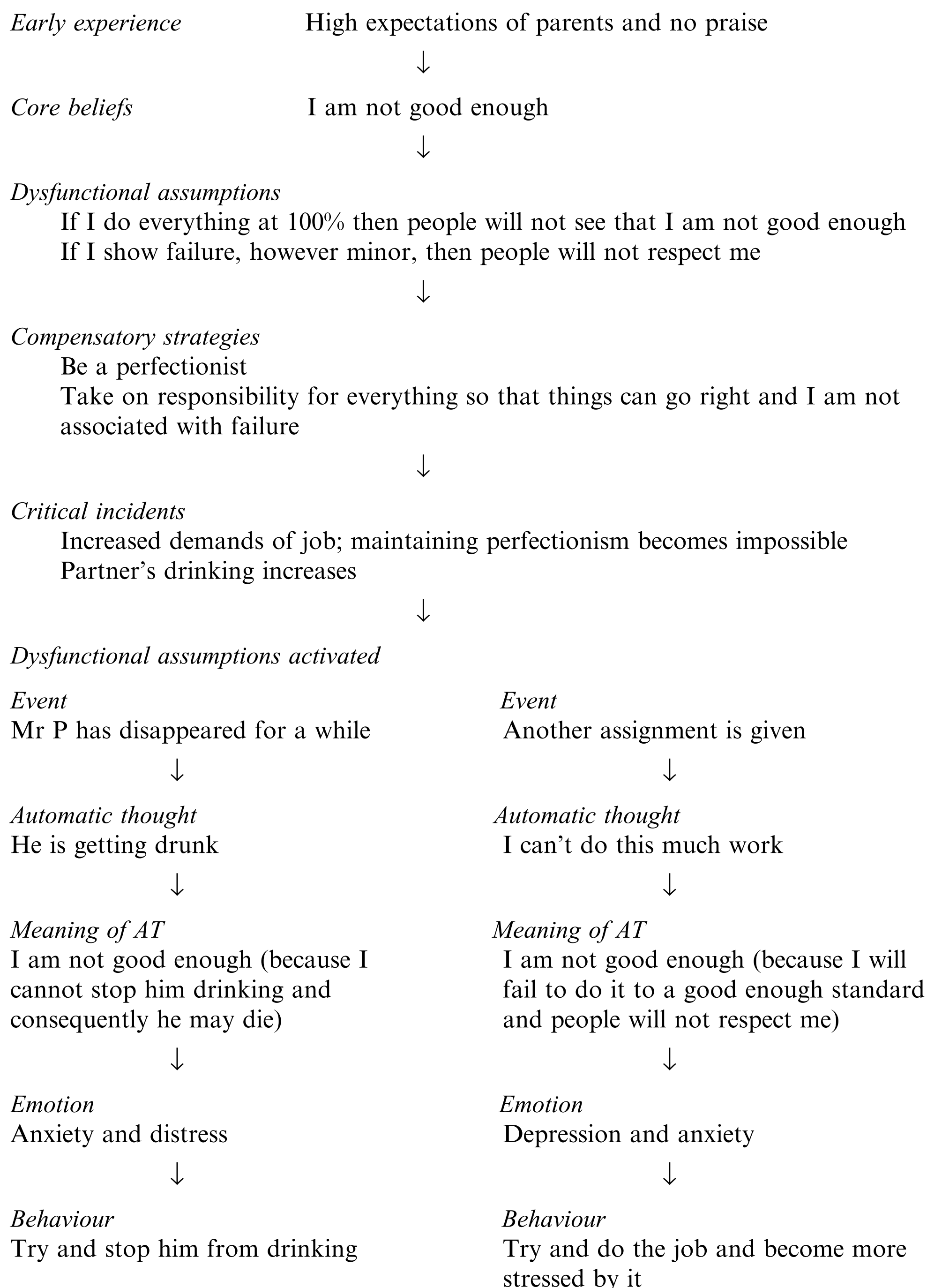

Figure 1. Mr R's perfectionistic formulation

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intervention in this area was to examine aspects of Mr R's perfectionistic beliefs ("I am not good enough", "If I do not perform at 100% the people will think I'm defective"). Mr R initially found it very hard to see any negative effects of forcing himself to achieve 100%. He felt he would lose his standards if he stopped being a perfectionist and this would be catastrophic. Later he was able to see some disadvantages in being perfectionistic, and he felt that the opportunity to think in less black and white terms would be beneficial. New assumptions and beliefs were then developed. These included "I am good at some things and bad at others and that is OK" and "I don't have to perform at 100% in order for people to think well of me". The old and new beliefs were then rated daily to enable Mr R to consider their validity and examine fluctuations in how strongly he believed them. He initially wanted to see rapid changes in his ratings of old and new beliefs. Thus he had a perfectionistic standard about reducing perfectionism. This was discussed in therapy. Over time his perfectionism diminished and he took on tasks that he was unable to do at 100% and felt OK about this. Later, he did not rate the beliefs each day and felt all right about not doing his homework. His decision to not rate the belief and thus no longer be a "perfect patient" may be interpreted as evidence that his perfectionism was beginning to decrease. Of interest is the fact that he continued to progress in therapy without the perfectionism, as indicated by changes in psychometric measures (BDI: 29 pre, 8 post; BAI: 22 pre, 8 post).

Mr R's ratings of beliefs prior to each session showed a decrease in conviction for rigidly held beliefs and an increase in ratings for more flexible beliefs. Mr R recorded incidents that occurred that were in keeping with his new beliefs; the continuum technique was also introduced, to help Mr R think in terms of degrees of perfectionism, rather than viewing it as an absolute. Later in therapy Mr R was asked to look for evidence over his life for the validity of his old and new core beliefs and this evidence was evaluated objectively. Summaries of each stage of his life in relation to the beliefs were made and conclusions drawn, with the major focus of inquiry being whether or not Mr R could have been said to have performed "well enough" in the various circumstances considered. These repeated ratings may have helped Mr R to realise how arbitrary evaluations of performance can be, thus helping him to question the validity of the quest for "perfection".

Behavioural experiments were performed to test out the beliefs. For example, Mr R told his manager that he was unable to take on the extra work asked of him. His manager respected his opinion. Mr R also let his colleagues see some mistakes he had made and as a result he realised that they did not think badly of him for having made these mistakes. These behavioural experiments enabled him to see that the feared consequences of no longer being a perfectionist were not realised. Figure 2 presents a model of the role of Mr R's new assumptions in helping him to continue modifying his automatic thoughts.

Perfectionism's influence on therapy

Mr R always attended punctually and carried out homework meticulously. Perfectionism also affected progress in other ways. If all agenda items were not fully addressed, rather than seeing that some areas benefited from more in-depth discussion, Mr R was disappointed in not having achieved his targets. On one occasion when he did not do

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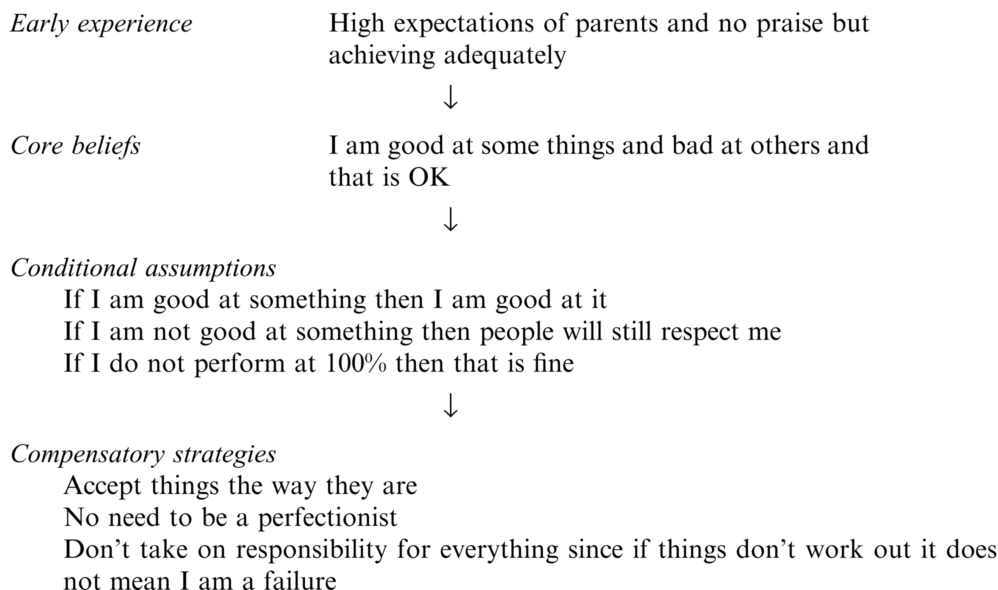

Figure 2. Mr R's new formulation

his homework he felt he had failed. Mr R admitted to being fearful of testing out some hypotheses behaviourally, because this might entail people seeing he was "not good enough". However, the fact that the therapist was able to go on working with him despite these "failures" may have modelled a more adaptive attitude towards failure for Mr R. Setbacks were exacerbated because of a perfectionistic belief that anything but rapid progress was a failure. Mr R's first setback occurred when he began to feel anxious and depressed about Mr P's drinking again after a period of less distress. He reacted to this by thinking he was back to square one and feeling like a failure at therapy. Through guided discovery he was able to see that he was utilizing his new skills to help him through the setback and that he had only lapsed.

Discussion

The reasons that Mr R changed from accepting minor flaws a few years ago to no longer accepting them might be associated with both his latent negative beliefs and his emotional state. Given a certain set of circumstances (stress of work and his partner's alcoholism) Mr R's latent belief ("I am not good enough") was triggered. Activation of rigid dysfunctional assumption about accepting minor flaws then helped to maintain his depression. Through therapy this cycle was altered. Mr R overcame his perfectionism by using cognitive techniques but additionally by utilizing his perfectionist characteristics (e.g., doing regular homework). As a result he was prepared to take on new challenges at which he would not be very successful (e.g., learning to ski, which would involve being not very good at first). For things he was very good at, he could still aim or expect to achieve very well, striving for a 100% performance but tolerating

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occasional failures. Once his perfectionism decreased he also made progress in reducing depression and anxiety. Hence, his perfectionism contributed to his difficulties in the first place but may in turn have contributed to his recovery and his present position of being less of a perfectionist.

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