Cognitive-Behavioral Treatment of Perfectionism: An Overview of the State of Research and Practical Therapeutical Procedures

Melanie Wegerer

Department of Psychology, University of Salzburg, Salzburg, Austria

Keywords
Perfectionism · Self-criticism · Self-esteem · Self-compassion

Abstract
Background: Perfectionism represents an important transdiagnostic predisposing and maintaining factor in a number of psychological disorders. Moreover, perfectionism can complicate the treatment of psychological disorders and contribute to treatment resistance. In the present article, cognitive behavioral therapy (CBT) interventions to reduce perfectionistic patterns are explained. In addition, specifics of the therapeutic relationship with perfectionists as well as the etiology and possible functionalities of perfectionistic patterns are discussed.

Summary: The effectiveness of classical CBT interventions for reducing perfectionism has been demonstrated in a number of studies. Recent research furthermore points to the (potential) benefit of interventions that fall into the third wave of CBT (such as mindfulness-based, schema therapeutic or self-compassion-based approaches) – however, there is still a lack of studies with sufficient methodological quality.

Key Messages: While a number of different CBT approaches are available for the treatment of perfectionism, future studies should increasingly examine which interventions are particularly indicated for which patient characteristics.
1 Introduction

Perfectionism is the exaggerated striving for perfection or flawlessness in one or more areas of life. While striving for high standards doesn’t need to be problematic per se, dysfunctional manifestations of perfectionism are referred to as “clinical” or also “maladaptive” perfectionism. In their cognitive-behavioral model of perfectionism, Shafran et al. [2002] define “clinical perfectionism” as an excess dependence of a person’s self-evaluation on striving for or achievement of demanding, self-defined goals. Furthermore, in clinical perfectionism this style of self-evaluation and the associated striving persist despite negative consequences. Maladaptive perfectionism is associated with consequences such as strong self-criticism, fear of negative evaluations and failure, various behavioral problems (such as excessive rechecking or procrastination), and increased stress (also in terms of increased cortisol secretion) in response to psychosocial stressors [Shafran et al., 2002; Wirtz et al., 2007; Rice et al., 2012; Spitzer, 2016].

Maladaptive perfectionism is an important transdiagnostic predisposing as well as maintaining factor in a number of mental disorders including depression, anxiety disorders, obsessive-compulsive disorder, eating disorders, insomnia, and suicidality. Moreover, correlations between perfectionistic patterns and levels of measured depressiveness and anxiety are also found in nonclinical samples [Vincent and Walker, 2000; Limburg et al., 2017]. Studies suggest that perfectionism can complicate the treatment of various mental disorders or contribute to treatment resistance. On the other hand, if perfectionism is explicitly treated, this can also have a beneficial effect on symptom reduction in various disorders [Lloyd et al., 2015; Hewitt et al., 2017]. For these reasons, attention should be paid to maladaptive perfectionism and its modification not only when patients explicitly suffer from their excessive standards, but also when perfectionistic patients seek treatment primarily for other complaints.

Perfectionistic patterns are often considered difficult to treat. However, several meta-analyses have demonstrated the efficacy of cognitive behavioral therapy (CBT) for the treatment of perfectionism. In a recent meta-analysis, Galloway et al. [2022] included 15 randomized-controlled trials that examined the effect of CBT for perfectionism in subjects with elevated perfectionism scores, self-reported problems due to perfectionism, and/or mental disorders (6 of 15 included trials reported on subjects’ diagnoses and thus can be classified as clinical trials). Similar to previous meta-analyses [Lloyd et al., 2015; Suh et al., 2019], Galloway et al. [2022] found moderate effect sizes for reductions in perfectionism scores. In addition, medium effects were also found for reductions in depression and eating disorder symptoms and small to medium effect sizes for reductions in anxiety scores, which points to the potential of CBT for perfectionism as a transdiagnostic intervention. It should be noted that the meta-analysis by Galloway et al. [2022] – similar to previous meta-analyses – to a large extent also included self-help interventions (partly Internet-based, partly based on self-help books) besides therapist-guided face-to-face interventions. However, some of the self-help-based interventions were at least partially guided by therapists (in total, interactions with therapists took place in 7 of the 15 included studies). Comparing therapist-led face-to-face interventions and self-help interventions, Galloway et al. [2022] found similar effects in terms of their effectiveness for perfectionism reduction. However, this result should be viewed with caution due to the overall small number of included studies and the high proportion of non-clinical samples included therein.

The CBT interventions investigated in previous studies each included a combination of elements such as psychoeducation on perfectionism, cognitive restructuring of dysfunctional beliefs or cognitive biases, behavioral experiments, as well as reduction of self-criticism and strengthening of self-esteem. The present article provides an overview of these elements of classical CBT for perfectionism (see especially chapters 6 and 7), but also of newer approaches that fall into the third wave of CBT and whose effectiveness for the treatment of perfectionism has been investigated in initial studies (chapter 8). Furthermore, the article addresses issues of the diagnostic assessment, the therapeutic relationship, and the individual etiology and functionality of perfectionistic patterns.

2 Diagnostic Assessment of Perfectionism

A number of questionnaires exist to assess perfectionistic behavior and thinking. These scales can helpfully complement exploration by providing an assessment of therapeutically important subdomains of perfectionism. The Hewitt and Flett Multidimensional Perfectionism Scale (HMPS), for example, allows differentiation into self-oriented (“I think I should be perfect”), other-oriented...
Cognitive-Behavioral Treatment of Perfectionism

3 Etiology of Perfectionism – Exploring the Underlying Conditions and Functions of Perfectionism

The individual analysis of predisposing and maintaining factors as well as possible functionalities of perfectionism represent an important basis for the subsequent therapeutic process. In general, the etiology of perfectionism is thought to be based on an interaction of biological, social (educational and environmental), and learning factors. (Twin) studies suggest a moderate heritability of perfectionism. In addition, strong correlations have been found between the extent of individual perfectionism and neuroticism [Tozzi et al., 2004; Moser et al., 2012; Burcas and Cretu, 2021]. Parental behavior (such as high parental expectations or criticism) is another factor associated with the development of perfectionism [Maloney et al., 2014]. Besides model learning, negative attachment experiences with parents or other close persons can contribute to the development of perfectionism, which is used as a kind of “safety strategy” by these persons (see below).

For the development of perfectionists’ success-dependent self-esteem, experiences of receiving recognition primarily for “being perfect” play an important role [Spitzer, 2016]. In Shafran et al.’s [2002] model of clinical perfectionism, such a dependence of self-esteem on success in a personally significant domain represents the central underlying as well as maintaining factor for perfectionistic efforts: Failure to meet personal standards leads perfectionists to self-criticism. Self-criticism, in turn, weakens self-esteem and results in the maintenance of high personal standards in order to stabilize self-esteem. However, if personal goals are achieved, perfectionists tend to consider their own standards as no longer demanding enough and subsequently increase them. In this way, as well as through a permanent monitoring of one’s own performance and a number of cognitive biases (such as dichotomous thinking) that occur during self-evaluation, perfectionistic strivings are maintained.

For the individual planning of the therapy process, it is helpful to distinguish between primary and secondary perfectionism as proposed by Spitzer [2016]. Primary perfectionism is defined as high and rigid standards that do not serve the individual as a means to something else. In a sense, perfectionism here stands for itself. Secondary perfectionism, on the other hand, can be understood as a means to a more important result, i.e., it has some kind of function for the individual. In general, perfectionism can serve the satisfaction of various basic psychological needs [Grawe, 1998]. While the model of Shafran et al. [2002] focuses mainly on securing the need for self-esteem (or the avoidance of feelings of own inferiority, shame, or guilt), perfectionism can also serve to secure attachment (or to avoid rejection and isolation), to maintain security and control (or avoid dangers or punishment), and also to gain pleasure (e.g., in the form of contentment or pride in the case of satisfying results).

Following the Perfectionism Social Disconnection Model of Hewitt et al. [2017], perfectionism develops in the context of relationships and arises as a consequence of perceived lack of social connectedness. Fittingly, Dobos et al. [2021] found an association between aversive childhood experiences or attachment traumas and perfectionism. Pointing in a similar direction, a schema therapy-oriented study found associations between perfectionism and schemas of the domain “Disconnection and Rejection” (i.e., “Abandonment,” “Emotional Deprivation,” “Mistrust/Abuse,” “Defectiveness,” and “Social Undesirability/Isolation”) according to Young [Young et al., 2003; Maloney et al., 2014]. Similarly, Boone et al. [2013] found associations between levels of perfectionism and scores in the schema domain “Disconnection and Rejection,” but also other maladaptive schemas. In summary, this indicates that parental behavior (such as neglect, shaming or punishment) influences the development of perfectionistic patterns and that this appears to be mediated by the development of early maladaptive attachment schemas. In the schema therapeutical model, perfectionistic patterns are seen as a dysfunctional coping strategy [Maloney et al., 2014]. Similarly, Compassion Focused Therapy (CFT) conceptualizes the strong self-observation and self-criticism inherent in perfectionism as a kind of safety strategy designed to avoid interpersonal threats [Gilbert, 2013]. Contrary to neglect or punishment, overprotectiveness is another factor that can contribute to the development of perfectionism – namely, when it leads to excessive worry about mistakes and their possible negative consequences which the individual is not confident of mastering [Flett et al., 2002].

In addition to the family context, other caregivers (e.g., teachers) or social environments (e.g., competitive sports, excellence-oriented educational institutions, arts or science institutions), but also the larger societal context, may exert influence [e.g., Curran and Hill, 2019]. Overall, striving for optimization experienced in different contexts can be seen as an important predisposing as well as maintaining factor for perfectionism [Spitzer, 2016].

Finally, on an individual level, a tendency towards “not just right experiences” (NJRE) may also play a role in some perfectionistic patients, similar as for patients with obsessive-compulsive disorder. NJREs describe a person’s discomfort with an action or perception that does
not yet feel “just right” to the person (e.g., the hair does not sit “just right,” a text does not feel “quite right or finished”). NJREs show correlations with maladaptive perfectionism, are also referred to as “sensation-based perfectionism,” and are putatively associated with a neurobiological basis [Coles et al., 2003; Ecker and Gönner, 2017].

4 Therapeutic Relationship with Perfectionistic Patients

Due to their high self-expectations, perfectionistic people often tend to experience shame at the beginning of therapy and to feel failed in view of the fact that they need help. In addition, there are also fears of being rejected by the therapist for weaknesses, which can be explained by the success-dependent self-esteem of perfectionists and/or aversive relationship experiences they often have [Egan et al., 2014]. To counteract shame and promote self-opening, the patient’s expert role for his/her problems can be emphasized. Furthermore, selective self-opening by the therapist can be used at appropriate points as an element to build community. Many perfectionists also focus their high standards on their own behavior in the therapy process and try to fulfill therapy tasks optimally and to be ideal patients. It is helpful here to emphasize the processual character of psychotherapy and the importance of even small changes. Moreover, perfectionistic behavioral tendencies should be addressed when they arise in the therapy process.

Case study: Patient with agoraphobia and stress-associated psychosomatic complaints overstrains herself by carrying out some of the possible exposure exercises explained by the therapist in the initial consultation on her own even before the second appointment. Example of therapeutic response: “Many people who, like you, set high goals for themselves in everyday life also put themselves under pressure in the therapy process. Is it possible that you interpreted things I mentioned as suggestions or perspective possibilities as binding tasks to be performed as quickly as possible? Does it happen more often in everyday life that you tend to interpret statements of those around you as orders to be carried out immediately? In general, how could we make sure that you take good care of yourself in the course of therapy and don’t ask too much of yourself?”

In addition to submissive behavior aimed at acceptance by the therapist, behavior that excessively controls the therapy process can also occur [Spitzer, 2015; Lee-Bagley et al., 2016] (e.g., excessive talking to avoid preoccupation with painful feelings, excessive interrupting or questioning of interventions). A possible variant to empathically confront patients with such behaviors is to mark them — in the sense of a schema therapeutic approach — as an activated mode (in this case: an overcompensatory controlling coping mode; see chapter 8.2). In addition, the biographical significance of the controlling behavior can be appreciated while at the same time emphasizing the consequences for the therapy process and the therapeutic relationship [Zens and Jacob, 2014].

Example: “Mr. X., I have the feeling that I hardly get a chance to speak in our conversation today. In this way, it is hardly possible for me to help you, which would be very important to me. In addition, we have already been able to work out that some of your problems are also related to the fact that you try to strongly control a lot of things in your life. I am sure that there are good reasons why you behave this way. Why don’t we try to get to the bottom of this?”

Especially patients with other-oriented perfectionism can also direct excessive standards towards the person of the therapist and the therapeutic methods applied. This can be manifested, for example, by a demanding, skeptical or confrontational attitude or even verbal criticism towards the therapist and can also lead to premature therapy discontinuation [Spitzer, 2015]. On the therapist’s side, perceived high expectations from patients can trigger dysfunctional cognitions (such as “If we do not achieve rapid change, the patient will reject me”), which can have unfavorable effects on therapist’s behavior (e.g., overrunning the time of sessions, too much talking by the therapist, too many interventions at too fast a pace, excessive preparation for sessions) [Egan et al., 2014]. Optimally, therapists should be a model for their perfectionistic patients for an orientation toward balanced standards, flexible approach, and acceptance of own mistakes. However, excessive standards are also a distinct pattern among many clinicians [Simpson et al., 2019]. Because of this, and also in view of the high expectations that perfectionistic patients often direct to others, it can be challenging to be such a model for them.

5 Enhancing Motivation for Change and Setting Therapeutic Goals

Trying to reduce perfectionistic patterns is typically accompanied by a high degree of ambivalence in patients [Egan et al., 2014]. Reasons for this partly lie in the functionalities of perfectionism described above, but also in the social reinforcement of flawlessness and performance. To build motivation for change, pros and cons of maintaining versus changing perfectionistic patterns can be collected (possibly supported by detailed imagination of the corresponding future perspectives). Perfectionistic behaviors and high internal standards (such as “I must strive to make no mistakes whatsoever”) can be questioned both with regard to their instrumental or life-practical value (“Does this thought help you to achieve your
important goals?" but also their hedonistic value ("How does it make you feel to have that thought?") [Spitzer, 2016].

A frequent obstacle to building up motivation for change are fears that patients have about the possible consequences of a reduction in perfectionistic efforts (e.g., that very good performance will no longer be possible, that they will then be "ordinary" or "nothing special," that they will not realize their potential, etc.). It is important to carefully examine and discuss such fears and to formulate therapy goals attractively. It can be discussed, for example, that the pursuit of high goals ("perfectionistic striving") is not problematic in itself, but that a problem arises when what is achieved is never good enough or when self-devaluation and fear of making mistakes ("perfectionistic concern") take over. Based on this, the reduction of destructive self-devaluation when goals are missed could be targeted as a therapeutic goal, for example [Egan et al., 2014].

Case study: Patient with compulsive controlling behavior at work finds it difficult to commit to the behavioral goal of reducing controls at the beginning of treatment. Example of therapeutic response: "I think it’s perfectly legitimate that you strive to do a good job and avoid mistakes. However, mistakes happen to all of us here and there, no matter how hard we try. Perhaps a good starting point would be to set as a goal that you 'flagellate' yourself a bit less for noticing that you’ve made a mistake. What do you think?"

6 Cognitive Interventions

As indicated above, cognitive interventions can pursue the goal of formulating inner standards or goals in a more moderate manner and/or avoiding self-deprecation in case of missing a goal. Cognitive therapy starts with a detailed exploration of (dysfunctional) beliefs and automatic negative thoughts related to perfectionism. Respective thoughts typically emerge in performance situations, social comparison situations, or other situations in which a discrepancy is perceived between ideals and the degree of goal attainment. With regard to high standards, it should be explored to whom they are directed (i.e., self-oriented and/or other-oriented perfectionism) and from whom they supposedly originate (i.e., self-oriented and/or socially prescribed perfectionism: "Is the goal you’re setting here something you’re striving for yourself or something you think others want you to do?") [see Spitzer, 2009].

Socratic dialogue can be used, for example, to discuss the extent to which one’s own assumptions correspond to social reality or whether one’s own standards can realistically be achieved at all. In addition, a change of perspective can be implemented, for instance, by exploring areas of life in which the patient pursues more moderate standards or by discussing whether the patient would apply similarly high standards to a loved one (such as his or her own child). A goal of cognitive therapy may also be to adapt rigid standards more flexibly to the respective context ("What is reasonable or even possible in this specific situation?") or to individual meaningfulness ("Where is a very good outcome really important to you and therefore worth the effort, and where is it justifiable for you to invest less?") [see Spitzer, 2016]. For the formulation of alternative thoughts, standards, and behaviors, orientation on helpful models can also be used ("Who in your environment reliably completes their tasks without getting too lost in details? How would this person think about the situation, how would he/she behave in it?").

With regard to the formulation of helpful alternative cognitions to rigid high standards, Spitzer [2016] summarizes that these cognitions should include the components flexible preference, motivational relevance, and acceptance: For example, instead of the internal standard "I must get an A on my dissertation," the following variant can be elaborated: "Of course, it would be my wish that my dissertation is graded with an A (flexible preference) and I will do my best to achieve this goal (motivational relevance). However, it is also a good achievement to bring a doctoral thesis to an end at all, and should it be graded lower, I will be able to accept this (acceptance)."

In the context of cognitive therapy, an important role is also played by the assessment and discussion of individual examples of cognitive errors (which occur, for example, in the course of self-evaluation). These include, for example, dichotomous thinking ("Either I do this task flawlessly or I failed"), overgeneralization ("If I get negative feedback on the job, I am worthless as a whole person"), and also selective attention to errors or negative feedback [Egan et al., 2014].

In general, addressing the issue of self-evaluation or self-worth should be a focus of cognitive therapy for perfectionism. As a starting point, patients can be encouraged to use a pie chart to reflect on the percentage of their self-evaluation that depends on success in different areas of life (e.g., 70% job performance, 20% parent role, 5% household, 5% physical appearance). Especially for patients whose self-evaluation is largely based on one or a few life domains, it is worthwhile to encourage them to include more life domains in their self-evaluation in order to develop a more differentiated self-image and make their self-worth more independent of failures in individual life domains [Egan et al., 2014; Spitzer, 2016]. Logging self-deprecatory thoughts, associated feelings, and related behavioral consequences (such as avoidance, substance abuse) can also be helpful. In addition, assumptions about the usefulness of self-deprecatory thoughts can be explored. For example, patients often hold the view that...
harder self-criticism will spur them on to greater achievements. Moreover, the idea that reducing self-criticism makes them conceited or boastful is also often persistent. In these cases, it can be discussed how realistic self-assessment – which includes highlighting one’s strengths – differs from boasting and how constructive self-criticism can be distinguished from destructive self-deprecation. In addition, patients can also think through what characteristics a coach should have to optimally motivate the patient or what type of coach a patient would choose for a loved one [Egan et al., 2014].

Overall, the reduction of self-deprecating thoughts and the development of more (unconditional) self-acceptance is a therapy goal that can usually only be achieved in a longer continuous process, which requires patience from both therapist and patient. Patients often experience that “the head already knows that the inner demands and the extent of self-criticism are excessive, but the feeling lags behind.” Emotion-activating interventions are therefore an important addition, especially when working with patients with strong self-criticism, and are described in more detail in sections 8.2 and 8.3.

7 Behavioral Interventions

Perfectionism is associated with a number of problematic behaviors that have an overall perpetuating effect on perfectionistic patterns and should therefore be reduced as part of the therapy. These include excessive preparing or rechecking, procrastination, avoidance of performance-related tasks, seeking reassurance regarding one’s own performance, and time management problems [Rice et al., 2012; Egan et al., 2014]. It is helpful to precisely operationalize the goal of behavior change – however, this can be challenging in individual cases:

Example: “What exactly would it mean for you to reduce the effort in your PhD thesis to 80%? Would it perhaps be possible for you to set a time limit for working on each chapter, and if so, what time limit? Furthermore, do you think you might be able to reduce the extent to which you reassure yourself by asking your supervisor?”

Behavioral changes can initially also be conceptualized as (behavioral) experiments and serve to check dysfunctional beliefs. For example, a task can be completed once in the usual perfectionistic manner (e.g., checking a text three times for errors before submission) and once in a new manner (e.g., checking the text only once). By experimenting with different standards of thoroughness, patients should observe the consequences of reducing perfectionistic behavior and be enabled to make an informed decision about which behavior is purposeful for them.

A common fear of perfectionistic patients is that others might react negatively to their own shortcomings. While the fear that other people might openly show negative reactions to one’s own mistakes can still be empirically verified to a certain extent, the evaluation of what other people might think is more difficult. In these cases, interviewing other people can be used as an experiment (e.g., patient asks his/her friends what they think about someone making a mistake during a presentation, on the playing field, etc.) [Egan et al., 2014].

With regard to the procrastination behavior that often occurs among perfectionists, it should be noted that this kind of behavior is often related to fear and can thus be conceptualized as avoidance behavior. For example, fears can relate to not being able to complete a task well enough, to experiencing great stress when trying to achieve a perfect result, or to not being able to finish in time. A starting point can be to work out such dysfunctional thoughts (e.g., “I will not succeed in preparing an excellent presentation”) as well as the corresponding behavioral consequence (preparation is postponed) and its impact on the final result as well as on one’s own self-esteem (e.g., presentation is prepared at the last minute, patient is dissatisfied with the result and devalues himself/herself). As can be worked out, self-deprecation results in the maintenance of high standards, creating a vicious circle. Perfectionistic patients rarely spend periods of time procrastinating on truly enjoyable activities or without feelings of guilt, as this would contradict the internal guideline to spend time primarily on performance-related tasks or duties [Egan et al., 2014]. Treatment of procrastination therefore requires a combination of interventions such as cognitive work on high standards, dividing challenging tasks into manageable subgoals, setting rewards for their completion, establishing anxiety management strategies, and setting sufficient breaks to be spent on pleasurable activities.

8 Perfectionism and the Third Wave of Cognitive Behavioral Therapy

In addition to the classical CBT interventions described above, in recent years initial studies have also investigated approaches from the third wave of CBT – such as mindfulness-based, schema therapeutic and self-compassion-based approaches – with regard to their effectiveness in treating perfectionism or perfectionism-associated disorders. In the following, the therapeutic procedures, underlying mechanisms of therapeutic change, and the current state of studies for each approach are presented.
8.1 Mindfulness-Based Therapeutic Approaches

Studies have demonstrated that maladaptive perfectionism is associated with lower habitual mindfulness [Flett et al., 2020]. In addition, perfectionistic patients tend to engage in dysfunctional thought processes such as rumination and worry [Xie et al., 2019] and may benefit from mindfulness-based approaches as they help for a better way of dealing with such symptoms. However, despite their potential benefits, the introduction of mindfulness exercises can cause resistance in perfectionistic patients, as the focus on “being and experiencing life in the here and now” is in clear contradiction to the focus on “doing and striving” usually anchored in perfectionists [Flett et al., 2020].

First evidence for the efficacy of mindfulness-based approaches were found by James and Rimes [2018] in a study that examined the effect of a Mindfulness-Based Cognitive Therapy (MBCT) intervention adapted to the topic of perfectionism in students with maladaptive perfectionism. The program included psychoeducation on perfectionism and mindfulness, identification of and distancing from dysfunctional perfectionistic and self-deprecating cognitions, mindfulness exercises, and a self-compassion meditation. Compared to a control group, students showed lower perfectionism scores and greater gains in mindfulness and self-compassion after MBCT. Furthermore, it could be shown that the reduction of perfectionism in the MBCT group could be explained in particular by an increase in self-compassion (see also chapter 8.3).

In another study, Acceptance and Commitment Therapy (ACT) was shown to be effective in reducing maladaptive perfectionism – more precisely, an ACT protocol adapted to perfectionism was shown to be comparably effective to a classical CBT protocol [Ong et al., 2019]. In ACT, perfectionism is understood as a form of experiential avoidance or a dysfunctional response to unpleasant internal experiences (e.g., excessive preparing as avoidance of the feeling of inadequacy). In the context of perfectionism treatment, ACT (similar to MBCT) aims to mindfully notice thoughts (such as “others might reject me if I fail”) and feelings (such as shame or fear), to create distance from these thoughts without changing their content, and to face aversive feelings with more acceptance [Spitzer, 2015; Ong et al., 2019]. Another goal of ACT interventions is to help patients to orient their behavior more toward personally meaningful goals (e.g., sufficient time with the family) and to reduce perfectionistic patterns of behavior that could stand in the way of this. In this sense, it is also considered important to make patients aware of the function that the specific perfectionistic behavior in a situation has for them: for example, time-intensive preparation for an oral exam may in one case be motivated by the desire to gather detailed knowledge in a personally meaningful subject (alignment with personally meaningful goal), but in another case serve the desire to avoid feelings of failure or shame (experiential avoidance) [Ong et al., 2019].

8.2 Schema Therapy

The use of schema therapeutic techniques may be particularly indicated in cases where patients respond poorly to classical CBT or exhibit secondary perfectionism and strong underlying maladaptive schemas (such as in the domain of “Disconnection and Rejection”) [Simpson et al., 2019]. In general, schema therapeutic interventions are highly suitable for making the biographical causes of the emergence of perfectionistic patterns perceptible for patients. Of particular importance is the therapeutic work with inner images or scenes that played a role in the genesis of hypercritical inner voices (parent modes) or dysfunctional beliefs. By means of imagery rescripting (ImRs), key scenes can first be imaginatively relived and then imaginatively rewritten in a way that means both self-empowering and -soothing and thus coping for the younger self [Arntz and Weertman, 1999; Valente, 2021]. Overall, ImRs has been shown to be able to reduce both the distress associated with mental images and the dysfunctional beliefs they contain [Lloyd and Marczak, 2022].

Modern schema therapy distinguishes a variety of child, parent, and dysfunctional coping modes that can be significant in the context of perfectionism treatment. On the side of parent modes, Edwards [2022] describes demanding and punishing, but also shaming, guilt- or anxiety-inducing, overprotective or strongly controlling parent modes. Perfectionistic thinking and behavior can be classified primarily under the following specific Overcompensation Coping Modes: The Perfectionistic Overcontroller strives for perfect completion of tasks and life issues in the sense of ensuring control, security, or protection from criticism. An Anorexic or Eating Disordered Overcontroller is dedicated to monitoring one’s weight and striving for perfect body measurements. The Obsessive-Compulsive Overcontroller avoids unpleasant feelings through repetitive ritualized behaviors (e.g., repetitive compulsive cleaning). In the Invincible Overcontroller mode, people feel or behave as if they were almost omnipotent and could achieve anything by sheer will or effort [Edwards, 2022]. Of course, other Overcompensation Coping Modes can also play a role in perfectionistic patients, as can Surrender Coping Modes (e.g., submitting to the demands of others) and Detached/Avoidant Coping Modes (e.g., excessive work to distract from unpleasant feelings, procrastination, substance use, actions to neutralize obsessive thoughts). Modern schema therapy also describes a number of coping modes that are summarized under Repetitive Unproductive Thought Processes and
which can be relevant in perfectionism [Stavropoulos et al., 2020; Edwards, 2022]. These include rumination (e.g., about one’s own inadequacy or behavior in past social interactions), worrying or catastrophizing, but also excessive mental comparison with others (e.g., with regard to appearance, successes, competencies) or overanalyzing of various life issues. A common feature of all of these coping modes is that they “block” access to the underlying emotions. When working with these modes, for example, chair work can be used to first identify perfectionistic behaviors and characterize them as a coping mode (e.g., Perfectionistic Overcontroller). Patients can be asked to sit at the chair of the coping mode and be questioned there [Valente, 2021].

Example: “What is your role in Robert’s life? What are you about and how do you do it exactly? Since when are you in his life?”

In the further course, work can be done on other chairs with the dysfunctional parent and vulnerable child modes behind the coping mode. The patient switches between the chairs of the (demanding, critical, …) Parent Mode, the Vulnerable Child, and the Healthy Adult. In the chair of the Healthy Adult, the patient limits or disempowers the Parent Mode with therapeutic support. The confrontation with demanding or critical inner voices thus takes place in a rather processual way: Critical messages are not so much corrected in content or empirically questioned, but rather externalized as a separate part first, and then restricted and subsequently no longer taken seriously [Valente, 2021]. To further support this work, the parent or critic mode can also be imagined or given an appropriate name (e.g., as an evil commander, strict governess, etc.). In addition to strengthening the Healthy Adult Mode, strengthening the Happy Child Mode, i.e., engaging in play and fun and experiencing spontaneity and joy, is particularly important for perfectionists.

Although schema therapy interventions may improve therapeutic response in treatment of perfectionism, this has been little studied. Initial studies suggest a benefit of schema therapy in the treatment of perfectionism-associated disorders such as eating and obsessive-compulsive disorders [Thiel et al., 2016; Joshua et al., 2023]. However, the available evidence is limited by the small number of studies conducted, their variable methodological quality, and the lack of studies that include measurement of perfectionism as an outcome variable.

8.3 Self-Compassion-Based Approaches

Self-compassion-based approaches are particularly suited to build up unconditional self-acceptance in perfectionistic individuals [Ferrari et al., 2019]. Respective interventions focus on strengthening a person’s ability to turn toward themselves in a helpful and caring way in moments of inner distress or failure. Neff [2023] summarizes that self-compassionate people do strive for personal growth and improvement. However, they focus more on their own intrinsic interest for development instead of expectations from the outside. Furthermore, they are less afraid of failure and are more accepting their own limitations. Self-compassion-based interventions include formal meditations, letter writing or formulating helpful thoughts from the position of an ideal compassionate friend or imagining a compassionate self, amongst others [Gilbert, 2013; Egan et al., 2014].

Compassion Focused Therapy (CFT) according to Gilbert is a multimodal CBT approach that combines (self-)compassion-based interventions with a corresponding therapeutic relationship design and is particularly suitable for emotional disorders with strong feelings of shame and guilt. Gilbert [2013] emphasizes that attempting to merely cognitively restructure self-criticism rarely works for highly self-critical and ashamed patients. Becoming accessible to other people’s kindness (including that of the therapist) or also self-compassion is a lengthy process for these individuals, requiring desensitization to positive or affiliative emotions (similar as it is sometimes necessary for threat-based emotions). Similar to schema therapy, CFT also works with a patient’s inner critical voices or modes. However, with the exception of highly destructive perpetrator modes, these tend to be less categorically disempowered, but to an even greater extent sought to be understood against the background of their emergence, appreciated in their function for the younger self and finally countered with a compassionate voice [Gilbert, 2013].

Several studies have demonstrated that self-compassion has a protective or buffering effect against the pathogenic effects of perfectionism: Self-compassion mediates (at least in part) the association between perfectionism and clinical syndromes such as depressiveness [Ferrari et al., 2018], anxiety [Fletcher et al., 2019], burnout [Pereira et al., 2022], and body-related dissatisfaction [Barnett and Sharp, 2016]. Thus, even when high standards are maintained, enhancing self-compassion may have a protective effect on the mental health of perfectionistic patients. Moreover, initial studies also show a reduction in perfectionism as a result of self-compassion-based interventions. For example, a study by Wakelin et al. [2022] investigated the effects of an Internet-based self-compassion intervention (based to a large extent on imagination exercises) and found a reduction not only in self-criticism and work-related rumination, but also in perfectionism scores. Similar results were obtained in a single-case study with a depressed patient, who experienced reductions in depressiveness, shame, and self-criticism, but also in perfectionism or orientation to high standards as a result of a CFT treatment [Matos and Steindl, 2020].
9 Conclusion and Further Directions for Research

As has been shown, modern CBT offers a variety of evidence-based approaches for the treatment of perfectionism. However, there is a lack of studies with good methodological quality – especially for third-wave CBT approaches. Even research on classic CBT interventions, however, has a number of limitations: While several meta-analyses [Lloyd et al., 2015; Suh et al., 2019; Galloway et al., 2022] repeatedly found statistically significant reductions in perfectionism scores, this does not necessarily mean that individuals experience a clinically meaningful change. Thus, it remains to be explored what proportion of treated individuals also achieve meaningful improvements in their quality of life as a result of the reported interventions. Furthermore, a substantial proportion of studies to date have examined the effectiveness of interventions in non-clinical samples. Thus, many questions remain open, especially with regard to the effectiveness in patients with more severe psychological conditions. In a meta-analysis including face-to-face and online interventions, Suh et al. [2019] found no statistically significant differences between the effect sizes of perfectionism interventions in clinical versus non-clinical samples. However, this result should be considered very preliminary due to the small number of included studies. Overall, there are hardly any results on possible predictors or moderator variables for therapeutic (non-)response to CBT for perfectionism so far. Furthermore, there is a lack of studies comparing different CBT interventions with regard to their effectiveness (e.g., classical CBT vs. “third-wave” methods).

Based on the research to date, it is therefore hardly possible to say which interventions – in the sense of a patient-tailored therapy – are most promising for which patients. Relevant patient characteristics could be, for example, diagnosable psychological disorders or the distinction between primary and secondary perfectionism. For primary perfectionism, a smaller number of therapy sessions with predominantly classical CBT interventions might be sufficient, whereas for secondary perfectionism a combination with emotion-activating interventions (such as chair work or imagery rescripting) and a longer treatment duration might be necessary. However, the individual etiology and functionality of perfectionistic patterns were largely not assessed in previous intervention studies. A lack of consideration of all these factors in the treatment of perfectionistic patients can potentially be a reason for poor therapeutic response, which is why these questions should be given more space in future studies.

Conflict of Interest Statement

The author declares that there is no conflict of interest that could have influenced the content presented here.

Funding Sources

The writing of the manuscript and all related work was done without funding.

Author Contributions

M. Wegerer has carried out the writing of the manuscript and all related research.

References


