Current PSYCHIATRY

When does conscientiousness become perfectionism?

Traits, self-presentation styles, and cognitions suggest a persistent psychopathology

Mr. C is a 50-year-old professional writer who recently made a serious suicide attempt. At his initial session, Mr. C was hesitant to discuss his situation and reason for attending. He did, however, bring a copy of his résumé so the therapist could "get to know him quickly."

He said he had been depressed for a long time, especially since he found an error in one of his published works. His confidence and writing abilities seemed to decline after this discovery, his career took a downturn, and ultimately he was fired from his position. He described often being at odds with his supervisors at work, whom he saw as critical and condescending. He was mortified by his job loss and did not inform his wife or friends of his firing.

Mr. C had always been a bit of a loner, and after losing his job he further distanced himself from others. He began drinking heavily to avoid the pain of "letting everyone down." His wife, family, and friends were shocked at the suicide attempt and expressed dismay that Mr. C had not confided in anyone.

Mr. C describes himself as being perfectionistic throughout his life and never being quite good enough in any of his pursuits. This leads to self-recriminations and persistent feelings of shame.

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Far from being a positive attribute, perfectionism is a neurotic personality style that can result in serious psychopathology, including relationship problems, depression, anorexia nervosa, and suicide. Determining a patient's perfectionistic traits is essential when evaluating those who seek treatment specifically for

Perfectionism

Table 1

How perfectionism differs from conscientiousness

Perfectionism	Achievement striving/conscientiousness
Receives no satisfaction from any performance	Experiences satisfaction with good performance
Experiences no rewards from any performance	Rewards self or others for good performance
Maintains expectations in the face of failure	Alters expectations in the face of failure
Is motivated by fear of failure	Is motivated by desire for success
Shows poor organization	Is organized
Focuses on flaws as indication of self-worth	Focuses less on flaws

this distressing behavior as well as patients in treatment for other issues who may have a perfectionistic personality. Accurately assessing perfectionism can help you predict and forestall noncompliance, assess suicide risk, determine appropriate treatment and identify circumstances under which a patient might be particularly vulnerable to relapse.

This article describes:

- 3 traits of perfectionism
- 3 dimensions of perfectionistic self-presentation
- perfectionistic cognitions
- useful self-report tools for clinical practice
- effective treatments.

Clinical Point

Perfectionism is a neurotic personality style involving perfectionistic traits, self-presentation styles, and cognitions

Characteristics of perfectionism

Although perfectionism initially was viewed as self-related cognitions, recent models suggest it incorporates intrapersonal and interpersonal dimensions.[1] A person with perfectionism has a marked need for absolute perfection for the self and/or others in many—if not all—pursuits that is strongly rooted in his or her intrapersonal and interpersonal worlds. Other characteristics of perfectionism include:

- equating self-worth or esteem with performance
- self-punishment in failure and a lack of satisfaction in success
- maintaining and needing to strive for unrealistic expectations
- unrealistic criteria for success and broad criteria for failure.

Some clinicians have suggested that perfectionism may be adaptive,[2] but "adaptive perfectionism" is more likely a reflection of conscientiousness or achievement striving (***Table 1***). Although perfectionism can involve rumination, it is much broader than simply having an obsessional cognitive style.

We define perfectionism as a neurotic personality style involving perfectionist traits, self-presentation styles, and cognitions that is a core vulnerability factor for a variety of psychological, physical, achievement, and relationship problems (***Table 2***).[1,3]

3 traits. Three traits of perfectionism reflect the desire for the self or others to be perfect:

- self-oriented perfectionism—a requirement for the self to be perfect
- other-oriented perfectionism—a requirement for others to be perfect
- socially prescribed perfectionism—a perception that others require perfection of oneself.

Each of these traits is associated with different Axis I and Axis II disorders, which we outline below.[4] In addition to these traits, perfectionism includes interpersonal and intrapersonal expressions.

3 self-presentational dimensions. The interpersonal expression of perfectionism is perfectionistic self-presentation. In our model, the 3 facets of perfectionistic self-presentation are:

- perfectionistic self-promotion—overt displays and statements of one's supposed "perfection"
- nondisplay of imperfections—hiding any imperfections
- nondisclosure of imperfections—

Table 2

Psychopathologies associated with perfectionism

Perfectionism component	Description	Psychiatric outcomes
Perfectionism traits		
Self-oriented perfectionism	Requires self to be perfect	Unipolar depression, anorexia nervosa
Other-oriented perfectionism	Requires others to be perfect	Personality disorders (PDs), relationship problems
Socially prescribed perfectionism	Perceives that others require one to be perfect	Suicidal behavior, general distress
Perfectionistic self-presentational styles		
Perfectionistic self-promotion	Overtly promotes one's 'perfection'	Narcissistic PD, other dramatic cluster PDs
Nondisplay of imperfections	Avoids demonstrating one's imperfection	Poor help seeking, treatment nonadherence, anxiety in assessment and therapy
Nondisclosure of imperfections	Hides perceived imperfections from others	Poor therapy alliance, relationship problems
Perfectionistic cognitions	Inner dialogue regarding requirement to be perfect	General distress, severity of depression, anxiety

Source: References 1,3,5

avoiding disclosure or discussion of any imperfection.[3]

Perfectionistic cognitions. The intrapersonal expression of perfectionism is perfectionistic information processing and ruminative thoughts regarding the need for perfection for the self or others.[5] This state component reflects the self-related inner dialogue of the patient's requirement for perfection, recriminations, etc. Perfectionistic cognitions are associated with state levels of distress and symptom severity.

Traits tied to psychopathology

Each of the 3 traits of perfectionism in our model has been associated with psychopathology in multiple studies.

Self-oriented perfectionism is often involved in Axis I disorders, including unipolar depression. This trait is elevated among adults and children diagnosed with major depressive disorder and may be pernicious in the presence of stressors, particularly achievement-related ones.[6] In other words, self-oriented perfectionism appears to be a risk factor for unipolar depression.[7,8]

It also is elevated in women with anorexia nervosa compared with normal and psychiatric controls.[9] Individuals with anorexia nervosa appear to have the highest levels of self-oriented perfectionism among clinical groups.

Other-oriented perfectionism is associated with antisocial and narcissistic personality disorders.[10,11] It also is related to interpersonal problems and difficulties with marriage and intimate relationships.[12]

Socially prescribed perfectionism is highly elevated in patients with social phobia[13] and narcissistic[11] or borderline personality disorder.[10] It also is associated with severity of depression, anxiety, and symptoms of hostility.[7]

Perhaps most important, determining a patient's level of socially prescribed perfectionism can aid in assessing suicide risk. Socially prescribed perfectionism has been shown to be highly relevant in suicide ideation, ratings of suicide risk, and moderate- to high-intent suicide attempts in adults,[14] adolescents, and children.[15] Socially prescribed perfectionism has been found to be a unique predictor of suicide

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Individuals with anorexia nervosa appear to have the highest levels of self-oriented perfectionism

Perfectionism

Clinical Point

Perfectionistic self-presentation appears to impair patients' ability to access and benefit from treatment

Table 3

Perfectionism self-report assessment tools

Traits or trait components
Hewitt and Flett Multidimensional Perfectionism Scale (for adults)
Flett and Hewitt Child and Adolescent Perfectionism Scale
Frost Multidimensional Perfectionism Scale (for adults)
Perfectionistic self-presentation
Hewitt and Flett Perfectionistic Self Presentation Scale (for adults)
Hewitt and Flett Perfectionistic Self Presentation Scale Junior (for children and adolescents)
Perfectionistic cognitions
Flett and Hewitt Perfectionism Cognitions Inventory (for adults)
Dysfunctional Attitude Scale (one subscale measures perfectionism; for adults)

behaviors even after controlling for common predictors such as depression severity and hopelessness.

Self-presentation. Fewer studies have evaluated a potential link between perfectionistic self-presentation and psychopathology. However, levels of all 3 dimensions of this style—self-promotion of perfection, non-display of imperfection, and nondisclosure of imperfection—appear to be higher in patients with anorexia nervosa than in normal and psychiatric controls.[9]

In addition, perfectionistic self-presentation appears to impair patients' ability to access and benefit from treatment. Researchers (Hewitt PL, Lee-Baggley D, Sherry SB, et al., unpublished data, 2007) have found that the various dimensions of perfectionistic self-presentation are associated with:

- difficulty in seeking help for psychological problems
- increased distress in clinical interviews
- fears of psychotherapy and psychotherapists
- early termination of treatment.

Assessing perfectionistic behavior

A variety of brief self-report measures of perfectionism components—and at least one interview measure—can aid your assessment. These are brief instruments and take only a few minutes to complete. Each self-report measure assesses different aspects of perfectionism, such as traits, self-presentational styles, or cognitions (***Table 3***). The interview can be used as an alternative to the self-report tools.

Mr. C's scores on several of these measures appear in ***Table 4***. Interpretive information is available from the authors (see ***Related Resources, p. 60***). Empirical evidence supports the reliability and validity of these measures in clinical samples of both adults and children/adolescents.

Table 4

Interpreting scores on perfectionism self-reports

Measure	Mr. C's score	Possible outcome
MPS: Self-oriented perfectionism	2 SD above normative mean	Depression symptoms
MPS: Other-oriented perfectionism	0.5 SD above normative mean	
MPS: Socially prescribed perfectionism	1 SD above normative mean	Suicide behavior
PSPS: Perfectionist self-promotion	1.5 SD above normative mean	
PSPS: Nondisplay of imperfection	1.5 SD above normative mean	Shame, avoidance
PSPS: Nondisclosure of imperfection	2 SD above normative mean	Withdrawal from others, nondisclosure
PCI: Perfectionistic cognitions	.75 above normative mean	

MPS: Hewitt and Flett Multidimensional Perfectionism Scale; PCI: Hewitt and Flett Perfectionism Cognitions Inventory; PSPS: Hewitt and Flett Perfectionistic Self-Presentation Scale; SD: standard deviation

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highest dose of oral olanzapine (15±2.5 mg/d). In controlled clinical trials of intramuscular olanzapine for injection, there were no statistically significant differences from placebo in occurrence of any treatment-emergent extrapyramidal symptoms, assessed by either rating scales incidence or spontaneously reported adverse events.

Other Adverse Events: Dose-relatedness of adverse events was assessed using data from this same clinical trial involving 3 fixed oral dosage ranges (5±2.5, 10±2.5, or 15±2.5 mg/d) compared with placebo. The following treatment-emergent events showed a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

In an 8-week, randomized, double-blind study in patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder comparing fixed doses of 10, 20, and 40 mg/d, statistically significant differences were seen between doses for the following: baseline to endpoint weight gain, 10 vs 40 mg/d; incidence of treatment-emergent prolactin elevations >24.2 ng/mL (female) or >18.77 ng/mL (male), 10 vs 40 mg/d and 20 vs 40 mg/d; fatigue, 10 vs 40 mg/d and 20 vs 40 mg/d; and dizziness, 20 vs 40 mg/d.

Vital Sign Changes—Oral olanzapine was associated with orthostatic hypotension and tachycardia in clinical trials. Intramuscular olanzapine for injection was associated with bradycardia, hypotension, and tachycardia in clinical trials (*see* PRECAUTIONS).

Weight Gain—In placebo-controlled 6-week schizophrenia studies, weight gain was reported in 5.6% of oral olanzapine patients (average 2.8-kg gain) compared to 0.8% of placebo patients (average 0.4-kg loss); 29% of olanzapine patients gained >7% of their baseline weight, compared to 3% of placebo patients. During continuation therapy (238 median days of exposure), 56% of patients met the criterion for having gained >7% of their baseline weight. Average gain during long-term therapy was 5.4 kg.

Laboratory Changes—Olanzapine is associated with asymptomatic increases in SGPT, SGOT, and GGT and with increases in serum prolactin and CPK (*see* PRECAUTIONS). Asymptomatic elevation of eosinophils was reported in 0.3% of olanzapine patients in premarketing trials. There was no indication of a risk of clinically significant neutropenia associated with olanzapine in the premarketing database.

In clinical trials among olanzapine-treated patients with baseline random triglyceride levels of <150 mg/dL (N=659), 0.5% experienced triglyceride levels of ≥500 mg/dL anytime during the trials. In these same trials, olanzapine-treated patients (N=1185) had a mean triglyceride increase of 20 mg/dL from a mean baseline of 175 mg/dL. In placebo-controlled trials, olanzapine-treated patients with baseline random cholesterol levels of <200 mg/dL (N=1034) experienced cholesterol levels of ≥240 mg/dL anytime during the trials more often than placebo-treated patients (N=602; 3.6% vs 2.2% respectively). In these same trials, olanzapine-treated patients (N=2528) had a mean increase of 0.4 mg/dL in cholesterol from a mean baseline of 203 mg/dL, which was significantly different compared to placebo-treated patients (N=1415) with a mean decrease of 4.6 mg/dL from a mean baseline of 203 mg/dL.

ECG Changes—Analyses of pooled placebo-controlled trials revealed no statistically significant olanzapine/placebo differences in incidence of potentially important changes in ECG parameters, including QT, QTc, and PR intervals. Olanzapine was associated with a mean increase in heart rate of 2.4 BPM compared to no change among placebo patients.

Other Adverse Events Observed During Clinical Trials—The following treatment-emergent events were reported with oral olanzapine at multiple doses ≥1 mg/d in clinical trials (8661 patients, 4165 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. *Frequent* events occurred in ≥1/100 patients; *infrequent* events occurred in 1/100 to 1/1000 patients; *rare* events occurred in <1/1000 patients. ***Body as a Whole***—*Frequent:* dental pain, flu syndrome; *Infrequent:* abdomen enlarged, chills, face edema, intentional injury, malaise, moniliasis, neck pain, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt; *Rare:* chills and fever, hangover effect, sudden death. ***Cardiovascular***—*Frequent:* hypotension; *Infrequent:* atrial fibrillation, bradycardia, cerebrovascular accident, congestive heart failure, heart arrest, hemorrhage, migraine, pallor, palpitation, vasodilatation, ventricular extrasystoles; *Rare:* arteritis, heart failure, pulmonary embolus. ***Digestive***—*Frequent:* flatulence, increased salivation, thirst; *Infrequent:* dysphagia, esophagitis, fecal impaction, fecal incontinence, gastritis, gastroenteritis, gingivitis, hepatitis, melena, mouth ulceration, nausea and vomiting, oral moniliasis, periodontal abscess, rectal hemorrhage, stomatitis, tongue edema, tooth caries; *Rare:* aphthous stomatitis, enteritis, eructation, esophageal ulcer, glossitis, ileus, intestinal obstruction, liver fatty deposit, tongue discoloration. ***Endocrine***—*Infrequent:* diabetes mellitus; *Rare:* diabetic acidosis, goiter. ***Hemic and Lymphatic***—*Infrequent:* anemia, cyanosis, leukocytosis, leukopenia, lymphadenopathy, thrombocytopenia; *Rare:* normocytic anemia, thrombocythemia. ***Metabolic and Nutritional***—*Infrequent:* acidosis, alkaline phosphatase increased, bilirubinemia, dehydration, hypercholesteremia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, hyponatremia, lower extremity edema, upper extremity edema; *Rare:* gout, hyperkalemia, hypernatremia, hypoproteinemia, ketosis, water intoxication. ***Musculoskeletal***—*Frequent:* joint stiffness, twitching; *Infrequent:* arthritis, arthrosis, leg cramps, myasthenia; *Rare:* bone pain, bursitis, myopathy, osteoporosis, rheumatoid arthritis. ***Nervous System***—*Frequent:* abnormal dreams, amnesia, delusions, emotional lability, euphoria, manic reaction, paresthesia, schizophrenic reaction; *Infrequent:* akinesia, alcohol misuse, antisocial reaction, ataxia, CNS stimulation, cogwheel rigidity, delirium, dementia, depersonalization, dysarthria, facial paralysis, hypesthesia, hypokinesia, hypotonia, incoordination, libido decreased, libido increased, obsessive compulsive symptoms, phobias, somatization, stimulant misuse, stupor, stuttering, tardive dyskinesia, vertigo, withdrawal syndrome; *Rare:* circumoral paresthesia, coma, encephalopathy, neuralgia, neuropathy, nystagmus, paralysis, subarachnoid hemorrhage, tobacco misuse. ***Respiratory***—*Frequent:* dyspnea; *Infrequent:* apnea, asthma, epistaxis, hemoptysis, hyperventilation, hypoxia, laryngitis, voice alteration; *Rare:* atelectasis, hiccup, hypoventilation, lung edema, stridor. ***Skin and Appendages***—*Frequent:* sweating; *Infrequent:* alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, pruritus, seborrhea, skin discoloration, skin ulcer, urticaria, vesiculobullous rash; *Rare:* hirsutism, pustular rash. ***Special Senses***—*Frequent:* conjunctivitis; *Infrequent:* abnormality of accommodation, blepharitis, cataract, deafness, diplopia, dry eyes, ear pain, eye hemorrhage, eye inflammation, eye pain, ocular muscle abnormality, taste perversion, tinnitus; *Rare:* corneal lesion, glaucoma, keratoconjunctivitis, macular hypopigmentation, miosis, mydriasis, pigment deposits lens. ***Urogenital***—*Frequent:* vaginitis*; *Infrequent:* abnormal ejaculation,* amenorrhea,* breast pain, cystitis, decreased menstruation,* dysuria, female lactation,* glycosuria, gynecomastia, hematuria, impotence,* increased menstruation,* menorrhagia,* metrorrhagia,* polyuria, premenstrual syndrome,* pyuria, urinary frequency, urinary retention, urinary urgency, urination impaired, uterine fibroids enlarged,* vaginal hemorrhage*; *Rare:* albuminuria, breast enlargement, mastitis, oliguria. (*Adjusted for gender.)

The following treatment-emergent events were reported with intramuscular olanzapine for injection at one or more doses ≥2.5 mg/injection in clinical trials (722 patients). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. ***Body as a Whole***—*Frequent:* injection site pain; *Infrequent:* abdominal pain, fever. ***Cardiovascular***—*Infrequent:* AV block, heart block, syncope. ***Digestive***—*Infrequent:* diarrhea, nausea. ***Hemic and Lymphatic***—*Infrequent:* anemia. ***Metabolic and Nutritional***—*Infrequent:* creatine phosphokinase increased, dehydration, hyperkalemia. ***Musculoskeletal***—*Infrequent:* twitching. ***Nervous System***—*Infrequent:* abnormal gait, akathisia, articulation impairment, confusion, emotional lability. ***Skin and Appendages***—*Infrequent:* sweating.

Postintroduction Reports—Reported since market introduction and temporally (not necessarily causally) related to olanzapine therapy: allergic reaction (eg, anaphylactoid reaction, angioedema, pruritus or urticaria), diabetic coma, jaundice, neutropenia, pancreatitis, priapism, rhabdomyolysis, and venous thromboembolic events (including pulmonary embolism and deep venous thrombosis). Random cholesterol levels of ≥240 mg/dL and random triglyceride levels of ≥1000 mg/dL have been reported.

DRUG ABUSE AND DEPENDENCE: Olanzapine is not a controlled substance.

Literature revised November 30, 2006

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Limited data on treatments

Few treatments for perfectionistic behavior have been systematically evaluated. Numerous studies have attempted to assess changes in perfectionism as the result of treatment for a specific Axis I disorder, but few have addressed treatment for perfectionism as a clinical entity.

Overall, it seems reasonable to expect that because perfectionism is a personality style, improvement would require fairly intensive, long-term treatment that explicitly emphasizes reducing dimensions of perfectionism.

Psychodynamic treatments focus on perfectionism's underlying mechanisms and attempt to alter the patient's personality structure. Studies suggest that intensive psychotherapy is most appropriate.

One of the first treatment evaluations from a reanalysis of Menninger Clinic data found the greatest improvements in patients receiving intensive psychoanalytically oriented treatment, compared with short-term psychotherapy or other treatments.[16] More recent evaluations suggest that highly perfectionistic individuals can be treated effectively only with intensive, long-term psychodynamically oriented treatment[17] and short-term interpersonal, cognitive, and medication therapies do little to alter perfectionistic behavior.

In our experience [PLH] perfectionistic individuals can improve significantly with long-term intensive treatment. On the other hand, we recently completed a study of the efficacy of a short-term, intensive psychodynamic/interpersonal group approach for treating perfectionism and its sequelae.

In this study,[18] we focused on treating the interpersonal precursors or causes of perfectionism, such as attachment styles; interpersonal needs for respect, caring, acceptance, and belonging; and need to avoid rejection, abandonment, and humiliation. In 70 patients with high levels of perfectionism, this treatment significantly decreased perfectionism, symptoms of depression and anxiety, and interpersonal problems. These symptoms continued to be reduced from baseline 6 months later.

Cognitive-behavioral approaches. Several researchers' findings suggest that cognitive restructuring, bibliotherapy, role-playing, coping strategies, homework assignments, and relaxation may help reduce the cognitive component of perfectionism.[19,20] Other work indicates that cognitive interventions can reduce perfectionism.

One study linked reductions in socially prescribed perfectionism to concomitant reductions in depression.[21]

Yet other data show that patients with perfectionism traits experience residual depression even when treatment reduces perfectionism.[22] This is consistent with findings that patients with social phobia who did not respond to treatment had slightly diminished but still relatively high perfectionism levels.[23]

Cognitive interventions can reduce perfectionistic concerns about mistakes and doubting actions, but other aspects of perfectionism—such as perceived parental unrealistic standards and criticisms—remain elevated and appear more treatment-resistant.[24]

Collectively, these data suggest that some treated patients may be at risk for relapse because persistent perfectionism contributes to a vulnerability to distress.

Medication. No studies have specifically assessed whether medications might reduce perfectionism. Imipramine did not have a significant effect on perfectionistic attitudes when used in the medication protocol of the National Institute of Mental Health Collaborative Study on Depression.[17] Amitriptyline has alleviated some dysfunctional attitudes in depressed patients but not perfectionism.[25]

Research is needed to evaluate the efficacy of various treatments. At this early stage, it appears that:

- short-term gains might be achieved by reducing symptoms
- long-term, intensive psychodynamic treatment may be required to change the perfectionistic personality and its vulnerability effects.

Changing a patient's characterologic aspects tends to be difficult, however, and perfectionistic individuals often seem intransigent (***Table 5***).

Table 5

Treating perfectionism: Common patient challenges

- Transference characterized by extreme hostility, need to be a perfect patient, or extreme supplication, depending on the kind of perfectionism
- Countertransference characterized by intimidation, anger, deflation, pressure to perform
- Suicide risk
- Patient attributes accomplishments to perfectionistic behavior and does not want to relinquish perfectionism
- Perfectionistic appraisals of treatment efficacy and pressure to see quick changes
- Early termination, noncompliance, missed sessions
- Demands for therapist to be perfect, difficult therapeutic alliance
- Nondisclosure, prevarication, extreme anxiety in session

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continued

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Some treated patients may be at risk for relapse because persistent perfectionism contributes to a vulnerability to distress

Perfectionism

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Related Resources

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- Greenspon T. *Freeing our families from perfectionism*. Minneapolis: Free Spirit Publishing; 2002.
- For more information on interpreting self-report measures of perfectionism, contact Dr. Paul Hewitt, phewitt@psych.ubc.ca; 604-822-5827.

Drug Brand Names

Amitriptyline • Elavil, Endep
Imipramine • Tofranil

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Clinical Point

Long-term, intensive psychodynamic treatment may be required to change the perfectionistic personality and its vulnerability effects

Bottom Line

Perfectionism is a neurotic personality style that is associated with numerous Axis I and Axis II disorders and other psychopathologies. Facets of perfectionism can have an impact on therapeutic alliance, compliance, and other relevant features that influence treatment outcome. Research suggests that although treatment may be challenging, some approaches, especially psychodynamically oriented therapy, can reduce perfectionistic behavior and symptoms.