**Introduction**

The researcher has been working as a Cognitive-Behavioural Psychotherapist for over 13 years. During this time she has encountered clients with a range of conditions meeting the criteria for Axis I disorders (American Psychiatric Association, 2000). In some cases working on the maintenance factors of the Axis I disorders appeared to be effective in terms of the clients meeting their treatment goals and achieving symptom reduction. However, with several clients problems occurred in that:

* Certain clients would make some improvement but then the progress would stop and they were unable to progress further by applying the techniques learnt;
* Others, although they would make progress and move into follow-up and/or discharge, would later relapse and return to active treatment.

A common theme was identified with these clients in that they all held perfectionist beliefs and were lacking in self-esteem. They would engage in self-blame and critical self-talk; they had a dichotomous thinking style; and they were lacking assertiveness. This presentation appeared to stem from fear of rejection and fear of failure. Having identified this theme, the researcher (being the therapist at the time) modified the treatment plan and focused on these elements. This then resulted in quicker and more effective progress in resolving the presenting problem.

These clinical problems have inspired this research work in the search for a way of helping clients who are perfectionists to overcome their difficulties through the systematic development of a treatment protocol that leads to a less distressing and better quality of life.

The thesis is divided into six chapters:

* Τhe first two chapters provide a detailed description and critical review of the literature related to the nature of perfectionism and the relationship with low self-esteem. They provide an understanding of the concept in terms of characteristics; developmental factors; the development and critical evaluation of relevant measures; and the research related to perfectionism (and low self-esteem) and Axis I disorders. The chapters provide an evaluation of empirical studies conducted to date and implications for practice.
* The third chapter describes the methodology, that is, the theoretical underpinnings of the research design. Different methodologies and methods will be critically evaluated in order to provide the rationale as to why the particular method was chosen. The fourth chapter describes the research design of the current research including exclusion / inclusion criteria, and the ethical considerations and how they were addressed.
* The fifth chapter presents the results of the current research, from both a quantitative and qualitative perspective.
* The final chapter discusses the findings of the current research including its strengths and limitations and areas for future research.

**Chapter 1**

**Understanding Perfectionism: A blessing leading to success or a curse leading to emotional pain?**

Over the last decade perfectionism has received considerable theoretical and clinical attention. Literature consists of multiple themes that will be reviewed critically in this chapter. These themes include early definitions of perfectionism; types of perfectionism and dichotomies of perfectionism. Furthermore, the link between perfectionism and low self-esteem will be explained. Towards the end of this chapter developmental factors of perfectionism will be outlined. However, before all of these a description of the literature search will follow.

The literature review was undertaken focusing on definitions of perfectionism; studies that focused on how perfectionism and low self-esteem are related to other disorders; and factors that affect the development of perfectionism. Cognitive-behavioural psychotherapy (CBP) treatment and perfectionism, in conjunction with low self-esteem, was of particular relevance and was also perused. As there appeared to be sparse literature in relation to perfectionism, low self-esteem, psychopathology & treatment, a wide range of sources were utilised. The internet was used to access websites, which provided numerous further links including Google Scholar. Various databases were used, for example, Medscape, PubMed Query, PsychNet, Cambridge Journals. Bibliography, such as, peer-reviewed journals and books were reviewed. In addition, several unpublished pieces of work were reviewed from databases such as Open thesis and ProQuest.

Overall 1237 journals were reviewed with keywords including clinical perfectionism, multidimensional, self-oriented; socially prescribed perfectionism; negative/positive perfectionism, adaptive/maladaptive perfectionism, developmental factors, family factors and perfectionism, perfectionism and self- esteem; domains of perfectionism. 77 articles were reviewed with keywords including treatment of perfectionism; reaction to treatment, cognitive behavioural therapy, assertiveness training and compassionate mind training. 345 Articles were reviewed including keywords related to perfectionism and Axis 1 disorders: Social phobia/anxiety-31; Depression-32; Anorexia-153; Bulimia-72; OCD-45; Chronic Fatigue-12. Other keywords were: mixed methods, multiple baseline design, single cases design, multiphase design, phenomenology, IPA, research methods. Over 250 articles were reviewed including these keywords.

**1.1 Early Definitions of Perfectionism**

One of the earliest definitions was proposed by Horney (1950) who described perfectionism as ‘*the Tyranny of the shoulds’* and ‘*the practice of demanding of one self or others, a higher quality of performance that is required by the situation’* (Hollender, 1965, p.94). Horney (1950) viewed perfectionists as ‘neurotics’ who attempt to create an impossible image of themselves resembling an ideal image that meets unrealistically high standards. Building upon Horney’s definition, Hollender (1965) underlined that perfectionists have the tendency to focus on their mistakes and whatever goes wrong as opposed to what goes well:

‘*the person is constantly on the alert for what is wrong and seldom focuses on what is right. He looks so intently for defects or flaws that he lives his life as though he were an inspector at the end of the production line’* (p.95)

The process of focusing on mistakes was also underlined by Beck (1976). He identified that the tendency to focus on ‘mistakes’ and ‘flaws’ was a characteristic of depressed clients and very much linked to low self-esteem and perfectionism. He argued that:

*‘the person who discovers a deficiency in himself tends to view this presumed deficiency in greatly exaggerated terms…he has great difficulty shifting his attention to his abilities and achievements and glosses over or discounts attributes he may have valued in the past’* (p.112-3).

The process of setting high standards in perfectionism was also identified by Hamacheck (1978) who argued that perfectionists:

‘*stew endlessly in emotional juices of their own brewing about whether they are doing the task right; the tasks are not translated into doing one’s best, but rather, doing better than ever before; their efforts never seem quite good enough, but it seems that person should do better (p.27). Therefore they set unreasonably high standards and may over- value performance and undervalue the self’* (p.29).

Hamacheck (1978) identified that a factor linked to perfectionism is the fear of failure. He stated that ‘perfectionists’ are constantly alert and defensive to avoid failure.

The process that perfectionists set high standards was also adapted by Burns (1980). He proposed that people with perfectionism set unrealistic standards; adhered to them in a very rigid manner; interpreted those in a distorted manner; and define themselves in terms of their achievements. He reported that striving for perfection includes a harsh price to pay. He specifically defined perfectionists as

‘*those whose standards are high beyond reach or reason, people who strain compulsively towards impossible goals and who measure their own worth entirely in terms of productivity, the drive to excel is self-defeating’* (p.34).

Furthermore he stated that perfectionists are driven by fear of rejection. If not perfect they feel unworthy of any praise, love and affection, consequently they engage in unhelpful behaviours marked by anger and avoidance of forming close relationships. The anger and defensive response to potential criticism often frustrates and alienates their peers and others, thus causing the very disapproval they fear: ‘*Consequently the irrational belief is reinforced that they must be perfect to be accepted’* (Burns, 1980, p.34).

In summary the earlier definitions, provide some understanding of perfectionism as a construct characterised by focused attention on mistakes; setting high standards; engaging in self-criticism and avoidance driven by the fear of rejection and failure. The early definitions viewed perfectionism mainly as a uni-dimensional concept focusing entirely on the self. Whilst some still view perfectionism as uni-dimensional, others propose that it is multidimensional, which will be covered in greater detail later on. However, prior to this, current research on perfectionism and low self-esteem will be reviewed.

**1.2 Perfectionism and Low Self-esteem**

Self-esteem can be seen as a stable and broad schema involving memories, emotions, cognitions and bodily sensations regarding oneself and the relationship with others. It is developed during childhood and is expanded throughout one’s lifetime (Fennell, 1997; Young, Klosko, & Weishaar, 2003). It has been referred to either as a global term, or as a domain specific term. For example, Rosenberg (1965) defined self-esteem as a global judgement indicating self-worth and self-acceptance; a number of researchers (Woike & Baumgardner, 1993; Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995) suggest it also refers to evaluations of aspects of the self in specific domains such as academia and appearance.

Both classifications are considered as a stable over time trait (Rosenberg et al, 1995; Fennell, 1997; Young et al, 2003) or as a state that varies according to different situations (Heatherton & Polivy, 1991; Leary & Downs, 1995; Leary & Baumeister, 2000). Crocker and Wolfe’s self-esteem model (2001) views it as both a trait and a state. Their approach viewed self-esteem as a concept that included domains in which self-worth is contingent (Crocker & Wolfe, 2001; Crocker, Luhtanen, Cooper, & Bouvrett, 2003; Crocker & Park, 2004). The domains, or contingencies, included personal competencies, inter-personal competition, approval by others, family affection, physical appearance and ‘’God’s Love’’ and virtue (Crocker & Wolfe, 2001; Crocker, Luhtanen, Cooper, & Bouvrett, 2003; Crocker & Park, 2004). It has been proposed that these contingencies can be wide and varied, as well as enhanced and endangered (Crocker, Luhtanen, Cooper, & Bouvrett, 2003). Crocker and Wolfe (2001) challenged the idea of high self-esteem as being a defensive term hindering feelings of worthlessness, thus they questioned people who scored high on self-esteem measures. They concluded that the idea of genuine self-esteem refers to people who have a sense of self-worth and self-acceptance despite their flaws and weaknesses.

With regards to the link between perfectionism and low self-esteem, early theorists proposed that perfectionists experience low self-esteem since the slightest negative feedback will be seen as evidence that the person is failing to achieve the ‘perfect’ self (Horney, 1950; Sorotzkin, 1985). Others suggested that perfectionism functions as a coping mechanism to protect fragile self-esteem (Adler, 1956). Moore and Barrow (1986) argued that the perfectionist's self-worth is dependent on performance and achievement of unattainable goals.

More recent research has shown that unhealthy perfectionism is connected with a lack of self-esteem (Cheng, Chong & Wong, 1999; Stumpf & Parker, 2000). However, it was not clarified in what way specific dimensions of perfectionism are related to self-esteem. Some studies showed that socially prescribed perfectionism was the dimension mostly linked with low self-esteem and depression (Flett, Hewitt, Blankstein & O'Brien, 1991; Bento, Pereira, Marques, Saraiva & Macedo, 2013). Other studies identified that maladaptive perfectionism, specifically concern over mistakes and doubts about actions, was related to lower levels of self-esteem (Gotwals, Dunn & Wayment, 2003).

Ashby and Rice (2002) identified that not only maladaptive, but also adaptive, perfectionism appeared to be predictors of low self-esteem. Further studies showed that conditional self-worth and acceptance (dimensions of self-esteem) appeared to be associated with both self-oriented and socially prescribed perfectionism (Flett, Russo, & Hewitt, 1994; Flett, Besser, Davis, & Hewitt, 2003; Hill, Hall, Appleton, & Kozub, 2008; Stoeber, Kempe, & Keogh, 2008; Sturman, Flett, Hewitt, & Rudolph, 2009; Hill, Hall & Appleton 2010).

The studies mentioned so far show a direct link between perfectionism and low self- esteem. However, other research has viewed low self-esteem as a mediator between perfectionism and psychological disorders. This hypothesis was originally based on results which showed that maladaptive perfectionism (socially-prescribed and self-oriented perfectionism) was related to elevated depression, when individuals experienced low self-esteem (Preusser, Rice, & Ashby, 1994; Blatt, 1995; Rice, Ashby, & Slaney, 1998).

Self-esteem has also been found to play a mediating role between perfectionism and distress (Preusser, Rice & Ashby, 1994; Rice, Ashby & Slaney, 1998). However, a more recent study did not find supporting evidence of this, that is, the results showed that self-esteem was a mediator between maladaptive coping and distress rather than a mediator between maladaptive perfectionism and distress (Park, Heppner & Lee, 2010). Further studies showed a significant mediating role between self-esteem, perfectionism, depression, and eating psychopathology (Button, Loan, Davies, & Sonuga-Barke, 1997; O'Brien & Vincent, 2003), as well as between self-esteem, perfectionism, depression, and attachment styles with eating psychopathology (Mikulincer & Shaver, 2007; Shanmugam, Jowett & Meyer, 2012).

Furthermore, a mediating role was evident between low self-esteem, worry, and perfectionism (parental criticism and concern over mistakes) with eating disorders (Sassaroli & Ruggiero, 2005). A series of studies showed a significant interaction between perfectionism, body dissatisfaction and low self-esteem, with bulimic behaviour. Women with high perfectionism who were dissatisfied with their weight, engaged in bulimic behaviours only when they experienced low self-esteem (Vohs, Bardone, Joiner, Abramson, & Heatherton, 1999; Bardone, Vohs, Abramson, Heatherton, & Joiner, 2000; Vohs, Voelz, Pettit, Bardone, Katz, Abramson, Heatherton & Joiner, 2001). Whilst these studies support the mediating role between self-esteem and perfectionism with eating disorders, a more recent study showed that the combination of high perfectionism, low self-esteem, and over concern with weight and shape, was not associated with binge-eating and purging (Watson, Steele, Bergin, Fursland, Wade, 2011).

To date the research does not clarify what the connection is between perfectionism and low self-esteem. It is not clear whether perfectionism is an antecedent, or a consequence of self-esteem. Neither is it clear whether low self-esteem is indeed different from perfectionism, or if perfectionism (especially maladaptive) is a part of low self-esteem. A further critique of the aforementioned studies is that almost all of them focus on elite athletes and/or university students, thus, the results cannot be generalised to a clinical population. Additionally, as they all used quantitative methods there is significant lack of qualitative research, which could lead to more conclusive results as per the relationship between perfectionism and low self-esteem.

Despite this, clinical models focusing on low self-esteem and/or perfectionism (Fennell, 1998; Shafran, Egan & Wade, 2010) frequently used in the field of Cognitive-Behavioural Psychotherapy, refer to the connection between the two concepts. That is, Fennell’s (1998) model of low self-esteem includes dysfunctional assumptions related to perfectionism: “Unless I am the life and soul of the party, no-one will want to know me; I must work extremely hard all the time, or I will fail” (p298); Shafran, Egan and Wade’s model (2010) of perfectionism includes the concept of self-worth, which is viewed as a dimension of self-esteem. Diagram 1 provides a representative example of a case study that shows how perfectionistic beliefs ‘feed’ low self-esteem. This diagram illustrates Fennell’s model of low self- esteem (1998).

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***Diagram 1: Case illustration of Fennell’s Model of Low Self Esteem, adapted from McManus, Waite & Shafran (2009), which shows perfectionistic beliefs being a part of low self- esteem (p.271).***

**1.3 Perfectionism as a Multidimensional Construct**

The definition of perfectionism has been subject to recent criticisms on the grounds that uni dimensional theories do not acknowledge interpersonal issues. Clinical observations indicated that perfectionism was not defined as exclusively focused on self-directed cognitions but was also viewed as having a social and interpersonal component (Frost, Marten, Lahart & Rosenblate, 1990; Hewitt & Flett, 1990, 1991). Frost et al (1990) were the first to propose perfectionism as a multidimensional concept when they developed one of the most well-known and widely used measures, that is, the Multidimensional Perfectionism Scale (MPS-F; Frost, Marten, Lahart & Rosenblade, 1990).

Frost et al (1990) identified six components of perfectionism. These were divided into two main dimensions of perfectionism: ones diverted to the self and the other placed by parents. Those directed towards self are 1) organisation; 2) high personal standards; 3) doubts about actions; and 4) concern over mistakes. The other two refer to the perceived demands upon the self, placed by parents and are 5) high parental expectations, and 6) parental criticism. In line with Frost et al’s (1990) perception of perfectionism as multidimensional, Flett and Hewitt’s (1991) definition of perfectionism is also a construct divided into three main categories. They also developed another well-used measure, which shares the same name as Frost et al’s (1990), that is, the Multidimensional Perfectionism Scale (MPS-H). They suggested that perfectionism is defined as self-oriented; other-oriented; and socially prescribed perfectionism. Earlier developmental work by them (Flett & Hewitt, 1990) included two more dimensions, that is, perfectionist motivation and world-oriented perfectionism. However, they included the former in self-oriented perfectionism and stated that the world-oriented aspect, which involved specific irrational beliefs, such as ‘*the perfect solution to broad problems*’, was ‘*a global concept’* (Flett & Hewitt, 2002, p.11). Their 1991 definition does not significantly differ from some of the other definitions described so far but appears worthy of expanding upon further.

Flett & Hewitt (1991) define self-oriented perfectionism as setting high standards; having a concern over mistakes; overemphasising flaws and mistakes; and having the tendency to doubt one’s actions. Other-oriented perfectionism is defined by expecting others to attain one’s high and unrealistic standards. The perfectionist here engages in critical behaviours towards others; often displays anger and dissatisfaction towards others; and blaming others when encountering failure. This type has been strongly associated with poor interpersonal relationships and poor family adjustment (Hewitt, Flett & Ediger, 1995). It has been argued that it appears to be the weakest of the three dimensions and has been criticised as being too vague and ambivalent (Enns & Cox, 2002).

Socially prescribed perfectionism is defined by the person’s preoccupation that others impose high and unrealistic standards on them and that if they do not meet them then they will be rejected. The fundamental difference to self-oriented perfectionism is that the standards have an external origin and the result of this is that people feel out of control resulting in greater emotional and psychological impairment. Flett and Hewitt (1995) found that both self-oriented and other-oriented perfectionism were associated with higher levels of personal control and desire for control, whereas in socially prescribed perfectionism there was a lack of control. Furthermore, Flett and Hewitt (1991) reported that perfectionists falling into this sub-category; apart from feelings of hopelessness, consider themselves worthless and engage in severe self-criticism. It is clear that there are several commonalities between this type of perfectionism and self-oriented perfectionism.

With regards to domains that are affected by perfectionism, Flett and Hewitt (2002) argued that *‘perfectionists are people who want to be perfect in all aspects of their lives*’ (p.5) and also that ‘*by definition, the study of perfectionism as a personality trait implies generalization across situations and life domains’* (Hewitt, Flett, Sherr, Habke, Parkin, Lam, 2003, p.1319). In contrast, Shafran, Cooper & Fairburn (2002) stated that perfectionists tend to demand high standards of themselves in one area only:

‘*people with perfectionism have a scheme of evaluating themselves that is dysfunctional in two ways. First, it is overly dependent on one area. Such overdependence means that self-evaluation is vulnerable and failure to meet standards results in self-criticism. Second, self-evaluation is highly dependent upon the domain perfectionism is expressed*’ (Shafran et al, 2002, p.778).

Interestingly, empirical studies did not support either Flett and Hewitt’s (2002), or Shafran et al’s (2002) findings. Several studies (Slaney & Ashby, 1996; Mitchelson & Burns, 1998; Rice, Bair, Castro, Cohen & Hood, 2003; Dunn Gotwals, Causgrove Dunn, 2005; Dalbert & Stoeber, 2006; Stoeber & Rambow, 2007; Stoeber, Kempe, & Keogh, 2008; Stoeber & Stoeber, 2009) showed that:

* Perfectionists display different levels of perfectionism in different domains suggesting that most perfectionists have certain areas, where their perfectionism is higher. That includes multiple domains such as work, sports, motherhood, relationships and others.
* The more perfectionistic the person is, the more domains that are affected, but not that perfectionists want to be perfect in all domains. However, in contrast to this statement, Stoeber & Stoeber (2009) concluded that:

*‘Some perfectionists may strive to be perfect in all domains of life, but most perfectionists have specific domains where they are perfectionistic—and other domains where they are not’ (p.14)*

Shafran and colleagues are some of the most recent researchers focusing on perfectionism in the field of Cognitive-Behavioural Psychotherapy (CBP) and developed the concept of ‘Clinical Perfectionism’. This has predominantly been the focus of the limited research into the effectiveness of CBP treatment for perfectionism (examples: Riley, Lee, Cooper, Fairburn & Shafran, 2007; Steele, Waite, Egan, Finnigan, Handley & Wade, 2013) and, therefore, will now be reviewed.

**1.4 Clinical Perfectionism**

Shafran et al (2002) proposed that perfectionism was not multidimensional based on empirical and clinical observations and proposed the concept of *‘clinical perfectionism’*. They stated that it seems only self-oriented perfectionism, marked by personal standards and concern over mistakes is more in line with perfectionism, than that of the definition of multidimensional perfectionism. In addition, it was argued that interpersonal processes, such as perceived expectations placed by others and the pressure placed by others to meet high expectations, are not related to the internal nature of perfectionism. Regarding the other reported aspects of perfectionism, Shafran et al (2002) stated that *‘they assess related constructs, but not perfectionism per se’* (p.776). They further defined perfectionism in terms of setting high standards and engaging in extreme self-criticism, not out of fear of rejection and disapproval by others, but due to not meeting personal standards, thus perceiving the self as a failure.

‘….*an important fact of clinically relevant perfectionism is that it is dysfunctional; perfectionism is expressed as a morbid fear of failure and the relentless pursuit of success*’ (Shafran et al, 2002, p.778-779).

Developing the concept of clinical perfectionism further, they proposed a cognitive-behavioural model (see diagram 2, Shafran et al, 2002); a specific measure, that is, the Clinical Perfectionism Questionnaire (CPQ; Fairburn, Cooper & Shafran, 2003); and a preliminary treatment protocol (Riley, Lee, Cooper, Fairburn & Shafran, 2007).

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***Diagram 2: The Cognitive Behavioural Model for Clinical Perfectionism as proposed by Shafran, Cooper & Fairburn (2002).***

Whilst there are some valid points and strengths to the concept and model of clinical perfectionism, such as, setting high standards and engaging in extreme self-criticism; it is proposed that it omits a number of important factors. Hewitt et al (2003) proposed that it omitted other cognitive biases, such as, rumination processes; amongst other factors. They stated:

‘*Failure to examine the interpersonal dimensions of perfectionism may result in an under-appreciation of the role of perfectionism in a variety of disorders, suicidal behaviour, and in marital and family distress’* (p.1226).

Despite the criticisms from proponents of a multidimensional approach, Shafran et al (2003) stated that:

‘*it is not necessary to have a complex dynamic model of psychology involving developmental processes, self- presentational styles, environmental variables, physiological responses, interpersonal dynamics, cognitive patterns, and personality traits….there is no empirical evidence to support such an assertion in any area of psychopathology…rather it is the focus on specific mechanisms of maintenance that has yiel advances in the psychological treatment of psychiatric disorders.’* (p.1219)

It is proposed that this response goes against validated and recognised models and theories. Erikson (1968), in his developmental theory indicated that primary school children develop a sense of industry or inferiority based on the feedback they receive. Beck’s (1976) model of emotional disorders acknowledged the weight and importance of early life experiences in the development of unhelpful beliefs and behaviours that interfere and maintain the person’s presenting difficulties. Fennell’s (1998) model of low self-esteem places great emphasis on early learning experiences as developmental factors influencing later behaviours and processes, which are central to perfectionism. Special emphasis is placed on standards not being met or partially being met and self-criticism that operate as a maintenance factor of emotional disorders.

The definitions and constructs detailed so far have mainly focused on the negative/maladaptive aspects of perfectionism. Therefore, the following sections will review the literature as to whether there are positive/adaptive/healthy aspects of the same.

**1.5.1 Dichotomies of Perfectionism**

The ‘positive’ aspects of perfectionism were mainly overlooked in the literature until the mid-90’s, however, there are early arguments that highlight these aspects. Adler (1956) argued that ‘*striving for perfection is innate in the sense that it is part of life, a striving, an urge, a something without which life would be unthinkable’* (p.104). Hamacheck (1978) proposed that normal (positive) perfectionism is characterised by a healthy striving to achieve reasonable goals that once achieved lead to a sense of satisfaction and elevation of self-esteem. Roedell (1984) supported this notion:

‘*perfectionism can provide the driving energy, which leads to great achievement. Setting high standards is not necessarily a bad thing. However, if coupled with a punishing attitude towards one’s own efforts, it can handicap performance that an individual may never fulfil the promise of early talent’* (p.127).

Silverman (1995) later on stated that ‘*the process of pursuing a goal to the best of one’s ability may be so rewarding that the attainment of the goal is of only secondary importance’* (p.3).

Throughout literature the dichotomy of perfectionism has been given different labels, that is, positive strivings and maladaptive evaluation concerns (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993), positive & negative perfectionism (Terry-Short, Owens, Slade, & Dewey, 1995), active & passive perfectionism (Adkins & Parker, 1996), adaptive and maladaptive perfectionism (Rice, Ashby, & Slaney, 1998), healthy & unhealthy perfectionism (Stumpf & Parker, 2000), personal standards and evaluative concerns perfectionism (Blankstein & Dunkley, 2002), and conscientious and self-evaluative perfectionism (Hill, Huelsman, Furr, Kibler Vincente, & Kennedy, 2004).

Some studies supported the concept of perfectionism both being ‘positive’ and ‘negative’. Frost, Heimberg, Holt, Mattia, and Neubauer (1993) found that the maladaptive factor of perfectionism (concern over mistakes, doubts about actions, socially prescribed perfectionism, parental expectations, and parental criticism) was the one associated with depression and emotional distress. Whilst positive striving (personal standards, organisation, self-oriented perfectionism, and other-oriented perfectionism) was not related to depression, it was significantly related to positive affect. Frost et al (1993) argued that ‘*the Positive striving factor forms the factor representing the positive aspects of perfectionism*’ (p.134).

Further empirical studies provide evidence that the element of perfectionistic striving is related to a sense of satisfaction and achievement, whilst perfectionistic concerns are related to psychological distress (Parker & Stumpf, 1995; Ashby & Kottman, 1996; Slade & Owens, 1998; Rice, Ashby, & Slaney,1998; Lynd-Stevenson & Hearne, 1999; Dunkley, Blankstein, Halsall, Williams, & Winkworth, 2000; Stumpf & Parker, 2000; Choy & McInerney, 2006; Enns, Cox, Sareen, & Freeman, 2001; Suddarth & Slaney, 2001; Cox, Enns, & Clara, 2002; Rice, Bair, Castro, Cohen & Hood, 2003; Dunkley, Zuroff, & Blankstein, 2003; Rice, Bair, Castro, Cohen & Hood, 2003; Chang, Watkins, & Banks, 2004; Rice, Lopez & Vergara, 2005; Stoeber & Otto, 2006;Verner-Filion & Gaudreau, 2010).

More studies support the notion of positive and negative perfectionism by showing that healthy perfectionists demonstrate greater levels of positive characteristics than unhealthy perfectionists and non-perfectionists (Ashby & Kottman, 1996; Rice, Ashby, & Preusser, 1996; Ablard &Parker, 1997; Ashby, Kottman, & DeGraaf, 1999; Rice & Mirzadeh, 2000; Rice & Slaney, 2002; Rice & Dellwo, 2002; Rice, Bair, Castro, Cohen, & Hood, 2003; Grzegorek, Slaney, Franze, & Rice, 2004; Ashby & Bruner, 2005; Gilman, Ashby, Sverko, Florell, & Varjas, 2005; Mobley, Slaney, & Rice, 2005).

Whilst there appears to be a wealth of evidence to support the presence of both positive and negative aspects of perfectionism, some researchers suggest that this area needs to be researched in greater depth. For example, Flett and Hewitt (2002) state that:

‘*the distinction between adaptive and maladaptive perfectionism has been accepted without criticism… . we believe that this issue is far from resolved, because a number of issues have not been evaluated’* (p.17).

Therefore, a critique of the dichotomies will now follow.

**1.5.2 Critique of the Dichotomies of Perfectionism and Current Research.**

There are several limitations with regards to the studies outlined above. Stoeber and Otto (2006) provide a sound criticism of the above studies. Firstly they argue that researchers have used different features and different combinations of these features in order to arrive at their conceptualisations of the two forms of perfectionism. Secondly, not all studies have found perfectionistic strivings and healthy perfectionists to be associated only with positive characteristic. Some studies found perfectionistic strivings and healthy perfectionists to be associated with both positive and negative characteristics, and a few studies with only negative characteristics.

It is questionable as to whether a distinction between positive and negative perfectionism actually does exist. Research to-date has shown that self-criticism, conditional acceptance, guilt and shame appeared to be negative factors influencing positive/adaptive and negative/maladaptive perfectionism (Ashby & Kottman, 1996; Lutwak & Ferrari, 1996; Slade & Owens, 1998; Rice et al, 1998; Choy & McInerney, 2006; Cox et al, 2002; Tangney, 2002; Gilbert, 2003; Stoeber & Otto, 2006; Hill et al, 2008; Stoeber et al, 2009; Verner-Filion & Gaudreau, 2010).

So, what happens when positive perfectionists are faced with the possibility of failure or even failure itself? Based on research, when ‘failure’ occurs, then the person will experience shame, guilt and engage in self- criticism. Thus, the positive aspects of perfectionism will be undermined by the processes described above. Therefore the dichotomy of perfectionism is a relative term.

Flett and Hewitt (2003) refer to conscientiousness and they questioned whether this is necessarily indicating positive/adaptive perfectionism. According to Costa and McCrae (1992) people with conscientiousness are ambitious, driven, motivated, organised and reliable. Flett and Hewitt (2003) questioned to what degree adaptive perfectionism overlaps with conscientiousness and argued that self-oriented perfectionism goes well beyond conscientiousness - it is also a form of extreme striving. Extreme striving could lead to maladaptive aspects of perfectionism.

Further critique of the above conceptualisations of perfectionism refers to the methodology and the significant lack of qualitative studies. The majority of the studies that attempted to provide an understanding of perfectionism have utilised quantitative methodologies and used non-clinical populations. This leaves several gaps with regards to the understanding of perfectionism within a clinical population and can question the dichotomies of perfectionism. Indeed, the studies provide a picture of how perfectionism can manifest in different domains and how it can be related to emotional problems or positive experiences, however, the lack of qualitative studies indicate a lack of a deeper understanding of perfectionism as it is experienced by individuals. They do not provide ‘*the essential nature of the lived experience’* (Van Manen, 1997, p.39), but provide an overview of relationships between factors, correlational and mediated relationships, thus, omitting the real essence of the experience of perfectionism.

There are very few studies to-date that have investigated perfectionism from a qualitative point of view (Slaney & Ashby, 1996; Rice, Bair, Castro, Cohen & Hood, 2003; Neumeister, 2004a-b-c; Egan, Piek & Dyck, 2013). However, these too had several limitations in terms of having a biased view of perfectionism as maladaptive/negative, which did not allow objectivity of the investigation and also viewing perfectionism as uni-dimensional (Egan, Piek & Dyck, 2013). Other limitations were related to guided questions that prevented the richness of information (Slaney & Ashby, 1996; Rice, Bair, Castro, Cohen & Hood, 2003). Furthermore, the studies did not focus on specific traits, thus not providing an open, detailed view of the experience of perfectionism (Neumeister, 2004a-b-c).

**1.5.3. The working definition of perfectionism as conclusion**

The working definition for perfectionism in the present study is that perfectionism is a multidimensional construct that can be adaptive and productive as well as maladaptive and unproductive.Perfectionism stems from a fear of rejection and fear of failure. Perfectionists are characterised by a number of interpersonal and intrapersonal traits that affect their sense of worth and well being. Perfectionism is a lifelong trait that co-exists with self- esteem and affects it accordingly.

In its maladaptive form, intrapersonally it is characterised by unrealistic high standards, doubts about actions, concern over mistakes, self – criticism, parental criticism/ expectations and inability to recognise achievements. Behaviourally is characterised by avoidance and procrastination or exhausting overworking.

On the other hand productive perfectionism is characterised by setting realistic achievable standards, positive/ non -exhausting striving, sense of achievement and satisfaction and ability to recognise achievements.

Due to its multidimensional nature, perfectionism affects several life domains such as work, sports and relationships with others and manifests as self-oriented, other –oriented and socially prescribed.

Interpersonally perfectionists lack assertiveness, they engage in people pleasing behaviours, in unfair comparisons with others and/or in controlling attitudes towards others. They also engage in behaviours that promote a ‘perfect’ self such as non- disclosure of imperfection and/ or striving to appear perfect in front of others.

**1.6 Overview of Developmental Factors to Perfectionism**

Whilst it is not within the scope of this study to fully examine such factors, it is proposed that in order to understand more extensively the construct of perfectionism it is important to identify the factors that may influence its development. However, it is important to note that, whilst there has been extensive empirical evidence with regards to cross-sectional factors influencing perfectionism, there is very little empirical evidence to date regarding developmental factors. There are a number of factors which could be seen to be influential in the development of perfectionism. Diagram 3 is a diagrammatic representation of the main ones proposed to date

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***Diagram 3: Modified Representation of Developmental Factors of Perfectionism (Flett & Hewitt, 2002)***

Parental Expectations and Parental Criticism

This theory supports that central to the development of perfectionism in children is the concept of conditional self-worth. This means that when children are not meeting the parental expectations they are prone to developing feelings of hopelessness and low self-worth (Flett & Hewitt, 2002). A number of researchers have focused on this in their work, for example:

Rice, Ashby and Preusser (1996) examined the link between the relationship of parents, children and perfectionism. It appeared that maladaptive perfectionists viewed their parents as less encouraging, harsh and demanding; whilst adaptive perfectionists viewed their parents as supportive. This research was one of the first to investigate the possibility that parental expectations and behaviours were operating as developmental factors for perfectionism. However, this study was conducted using a non-clinical population and in addition the results were based not on factual evidence, but on the individual’s perceptions of their parents’ behaviour. Therefore, this could be viewed as being biased as neither direct observation of parents’ behaviour, nor actual test of parents’ expectations were carried out.

McArdle and Duda (2007) conducted a study that linked perceived parental expectations and perceived parental criticism in relation to perfectionism. The findings revealed that individuals who perceived their parents as critical, harsh and punitive, displayed greater concern over their mistakes perceiving them as personal failure. They also expressed greater doubts over their actions and the quality of their achievement. This research provides further evidence regarding the effect of parental expectations and criticism in the development of perfectionism. However, there are criticisms such as: the findings are based on self-evaluation scores; it could be argued that based on the participants’ ages and general sense of and stability of self-worth, the interpretation of parental attitudes could be biased; the findings cannot be generalised to the rest of the population, or the clinical population, as it focused on specific groups of elite athletes.

One recent study was conducted by DiPrima, Ashby, Gnilka and Noble (2011) who investigated the effect of parental styles and different parental variables as developmental factors of adaptive and maladaptive perfectionism in adolescents. The results revealed that family environments that were perceived as positive, adaptable, flexible and cohesive indicated a strong influence to the development of adaptive perfectionism even more so than students who were classified as non-perfectionists. Overall adaptive perfectionists received more support, greater academic achievement, were able to form better relationships and display greater confidence in terms of social interactions, than maladaptive perfectionists and non-perfectionists. Maladaptive perfectionists perceived less parental nurturance and higher levels of conditional approval. This study provides useful information regarding the relationship between family environment and perfectionism, although it focuses more on a cross-sectional than a longitudinal view.

Further research (Chorpita & Barlow, 1998; Pomerantz & Eaton, 2001; Flett & Hewitt, 2002; Kawamura, Frost & Harmatz, 2002; Fei‐Yin, Kenney-Benson & Pomerantz, 2004) showed that parental control leads children to develop maladaptive perfectionism. Soenens, Vansteenkiste, Luyten, Duriez, and Goossens (2005) defined parental psychological control as guilt-inducing, as disregarding their point of view, and as being responsive only when parental standards are met. They argued that ‘*Psychological control is neither about overt conﬂict nor about manifest judgmental or neglecting parenting. Instead, it deals with covert, indirect techniques that are communicated in a subtle, implicit fashion’* (p.489).

An interesting argument made by Flett and Hewitt (2002) was that the child might develop perfectionistic high expectations in the absence of parental expectations overall. The key factor here is parental neglect:

‘*several adults in treatment have indicated that they adopted perfectionism as a way of coping with parental neglect. In this situation children set high expectations for themselves as a way of coping with the absence of clear standards and expectations and the uncertainty as to whether a certain behaviour is punishable or likely to be rewarded’* (p.91)

Interpersonal and Social Experiences

Theorists propose that when an individual is exposed to certain unhelpful environmental experiences, such as, physical abuse, harsh criticism by peers, and psychological maltreatment including neglect and exposure to shame, then they develop perfectionistic traits (Flett & Hewitt, 2002; Miller & Vaillancourt, 2007). Flett and Hewitt (2002) argued that the child becomes perfectionistic as a coping strategy to cope with aversive social circumstances. They argue that ‘*the child can become perfectionistic in an attempt to escape from or minimise further abuse or to reduce exposure to shame and humiliation*’ (p.93-94).

There are a few early studies (Schaaf & McCanne, 1994; Zlotnick., Zakriski, Shea, Costello, Begin, Pearlstein & Simpson, 1996), which showed that sexual abuse operates as a factor influencing the development of perfectionism and also as a mechanism to maintain control. Other studies, such as, Miller and Vaillancourt (2007) showed that there was a significant relationship between direct and indirect victimisation with aspects of perfectionism. More specifically, increased indirect victimisation during childhood was related to elevated levels of all aspects of perfectionism. However, decreased indirect victimisation was related to later development of other-oriented perfectionism. This study had some limitations because, apart from not focusing on a clinical population, the participants’ low mood could bias the significance of the experience of victimisation and aggression. In addition, potential victimisation experiences that could be occurring at the time of the study could bias retrospective reports of childhood victimisation.

Flett and Hewitt (2002) proposed that external social experiences affect the development of perfectionism in childhood when the child is exposed to experiences of shame, guilt and humiliation. Tangney (2002) and Gilbert (2003) identified that pride, shame and guilt are emotions that fundamentally involve an evaluation of the self. A few studies focused on how perfectionism relates to shame and guilt (Hewitt & Flett, 1991; Campbell & Paula, 2002 ; Tangney, 2002; Klibert, Langhinrichsen-Rohling & Saito, 2005) and only two on how it relates to pride (Tangney, 2002; Stoeber et al, 2007). The results showed that negative perfectionism was related to shame and guilt, whilst positive perfectionism showed a negative correlation with shame. Once again, these studies were conducted using a non-clinical population and quantitative methods.

Modelling

Flett and Hewitt (2002) refer to the role of modelling as a developmental factor of perfectionism and they refer to it as the Social Learning Model, which has its basis in the work of Bandura (1986). When the child is continuously exposed to perfectionistic attitudes it is expected that these will appear the ‘norm’, thus increasing the possibilities of adapting the same attitudes. There is a great deal of evidence to support that children take on adults’ behaviour and, also, they have the tendency to idealise their parents and not critique their behaviour (Young, 1999; Flett & Hewitt, 2002). However, there is very little empirical evidence to date to support this.

Very few studies (for example, Soenens, Vansteenkiste, Luyten, Duriez, & Goossens, 2005) investigated the link between parental perfectionism and children’s perfectionism; however the results revealed a very weak or almost non-existing link between the two. In a very recent study, Appleton, Hall and Hill (2010) investigated the relationship between parents’ and children’s perfectionism amongst a group of young athletes. The athletes’ perception of parents’ self-oriented perfectionism predicted their own perfectionism. The same accounts for other-oriented perfectionism and socially- prescribed perfectionism. What appears interesting is that the results were not replicated when the comparison was made with the parent’s scores on the MPS-H. This means that there was a strong relationship between the athlete’s perfectionism and the perception of the parents’ perfectionism, but not the actual parental perfectionism. These findings do not rule out the emergence of modelling as it appeared that the athletes were imitating what they perceived as perfectionism from their parents. As with previous studies, this one has focused on a non-clinical population and provided a cross-sectional analysis, rather than a longitudinal one, therefore the causal effects on perfectionism have not been addressed in detail. Finally, the results of this study are difficult to generalise to the rest of the population as it focused on athletes and males only.

Temperament and Personality

Hewitt and Flett (2002) reported that temperament is very important and that perfectionists are characterised by a temperament with high levels of emotionalism marked by high anxiety and high persistence. They further advocated that temperament might account for fear of failure; concern over mistakes; intolerance of criticism; tendency to thrive; and need for approval. To date there are very few studies to support this but, as previously discussed, a number of studies (Fee & Tangney, 2000; Enns & Cox, 2002; Stoeber et al, 2006; Ashby & Slaney, 2007; Dunkley & Kyparissis, 2008) have shown that, with regard to the Big Five traits, conscientiousness and neuroticism are associated with perfectionism.

A very recent study by Dunkley, Blankstein and Berg (2012) identified a strong link between personal standards and the generally adaptive nature of perfectionism to conscience. Evaluative concerns and the maladaptive nature of perfectionism were strongly linked with neuroticism. This study not only provided a clear distinction between adaptive and maladaptive perfectionism, but also showed that personality traits are related to perfectionism. Specifically, the individuals that scored high on personal standards would evaluate themselves as hard-working and focused; assertive; active; and receptive to their own inner feelings and emotions. In contrast, individuals who scored high on evaluation concerns described themselves as prone to feelings of sadness; cynical and sceptical of others; often unprepared and inept; and easily discouraged and eager to quit. They saw themselves as sensitive to ridicule and prone to feelings of inferiority and formal, reserved and distant in manner. In addition, anxiety and depression were highly linked with neuroticism and evaluation concerns. Taking the personality traits theory, if a person exhibits the above negative traits, then his/her social relationship will be poor thus leading to less support and unhelpful interpersonal relationships, which have been linked with the development of perfectionism. This study has some limitations: it focuses on a non-clinical population from Canada, which makes the generalisation of results difficult; it was based on self-reports that could bias the reality and it could be argued that the responses, once again, were biased by the person’s mood.

Neurobiological Processes

Recent studies (O’ Connor & Forgan, 2007; Harris, Pepper & Maack, 2008; Kaye, Conroy & Fifer, 2008; Randles, Flett, Nash, McGregor & Hewitt, 2010; Turner & Turner, 2011) have focused on the neurobiological aspects of perfectionism by investigating the influence of the Behavioural Approach System (BAS) and the Behavioural Inhibition System (BIS) on this construct. BAS triggers behaviours in relation to reward or non-punishment. Personality traits such as extraversion (Eysenck, 1967), impulsivity (Zinbarg & Revelle 1989), novelty seeking (Cloninger 1987), and positive affectivity (Tellegen 1985; Depue & Iacono 1989) have been associated with the BAS. In contrast, the BIS is associated with signals of punishment, non-reward, novel stimuli, and innate fear stimuli. The BIS may be considered both as a cognitive and physiological system (Fowles, 1988).

The most recent study was that of Randles, Flett, Nash and Hewitt (2010), who investigated the association between BAS/BIS, perfectionism, and rumination. The findings showed that socially prescribed perfectionism was strongly linked to BIS as expected. BIS was also linked to rumination, indicating that perfectionists who are more concerned about criticism and negative evaluation are more likely to engage in rumination. In addition, the findings indicated that self-oriented perfectionism was associated with elevated BIS and it was also related to BAS-drive. These findings indicate that self-oriented perfectionism is linked to anxiety, irrelevant of whether perfectionism is adaptive or not. One explanation could be that the central concept is the drive to achieve, but not necessarily the satisfaction after the accomplishment. The study focused on a non-clinical population and was gender biased as it only examined females. It is very difficult overall to test a hypothesis that is based on neurological functioning based on the use of self-reports, therefore, the results could be biased based on the individual’s perception. Whilst this study showed some evidence of the role of BIS to perfectionism and trait rumination, it does not clearly provide a causal link.

**Chapter 2**

**Perfectionism: Psychopathology and Treatment**

This chapter will outline the main findings with regards to the link between perfectionism (and low self-esteem) and Axis I disorders as defined by the American Psychiatric Association (2000). Relevant empirical evidence will be presented that supports the link between perfectionism and a number of Axis I disorders, including co-morbidity. Finally, current treatment will be outlined.

**2.1 Eating Disorders**

There is a large body of research that indicates a significant link between perfectionism, self- esteem and eating disorders. Specifically with anorexia (Bastiani, Rao, Weltzin, & Kaye, 1995; Hewitt, Flett, & Ediger, 1995; Davis, 1997; Fairburn, Cooper, Doll, & Welch, 1999; McLaren, Gauvin, & White, 2001; Fairburn & Harrison, 2003; Sassaroli, Gallucci, Ruggiero, 2008) and bulimia (Hewitt et al., 1995; Davis, 1997; Fairburn, Welch, Doll, Davies, & O’Connor, 1997; Joiner, Heatherton, Rudd, & Schmidt, 1997; Fairburn & Harrison, 2003). Even research focusing on non-clinical populations identified a link between perfectionism and maladaptive eating attitudes (Button, Sonuga-Barke, Davies, & Thompson, 1996; Sassaroli &Ruggiero, 2005). Some research showed that even after successful treatment of an eating disorder, perfectionistic traits remain. These traits then become risk factors for relapse and maintenance of the disorder (Bastiani, Rao, Weltzin, & Kaye, 1995; Fairburn, Cooper, Doll, & Welch, 1999; Bardone-Cone, 2007; Jacobi & Fittig, 2010).

In many studies perfectionism was viewed as a multi-dimensional construct, where parental criticism, doubts about actions, personal standards and concern over mistakes appeared to play a key role in the development of eating disorders (Bastiani et al., 1995; Davis, 1997; Fairburn et al., 1997; Hewitt et al., 1995; Joiner et al., 1997; McLaren et al., 2001; Sassaroli & Ruggiero, 2005).

Whilst, some studies showed that self-oriented and socially prescribed perfectionism are associated with eating disorders (Castro, Gila, Gual, Lahortiga, Saura and Toro, 2004; Franco-Paredes, Mancilla-Díaz, Vázquez- Arévalo, López-Aguilar, & Alvarez-Rayón, 2005), other findings question whether there is a link to socially prescribed perfectionism at all (Bardone-Cone, 2007;Lethbridge, Watson, Egan, Street, Nathan, 2011; Watson, Fursland, & Nathan, 2011; Egan, Watson, Kane, McEvoy, Fursland, Nathan, 2013).

Dichotomous thinking has been linked to eating disorders (Fairburn et al, 2003; Byrne, Cooper & Fairburn, 2004; Riley & Shafran, 2005; Burns & Fedewa, 2005; Egan, Piek, Dyck, & Rees, 2007). Fairburn et al (2003) proposed a model of maintenance of eating disorders. They argued that dichotomous thinking maintains the eating disorder cycle, as it becomes a link between dietary restraint and binge eating. When it is combined with perfectionism (high standards & self- criticism) it can reinforce extreme weight and eating goals. Fairburn et al (2003) acknowledged that low self-esteem is a vulnerability factor for the development of eating disorders, as individuals tend to evaluate their self-worth based on their body shape & weight.

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***Diagram 4: The Cognitive–Behavioural Model of Maintenance of Eating Disorders (Fairburn, Cooper & Shafran, 2003).***

Rieger, Buren, Bishop, Welch and Wilfley (2010) criticised Fairburn et al’s (2003) maintenance model due to the fact that there is a lack of acknowledgement of interpersonal factors. They stated ‘the *domain of bodily control is both public and socially valued…the potential for social rewards is part of the core perfectionism in eating disorders’* (p.406). Rieger et al (2010) proposed a model that highlights that negative social evaluation triggers negative affect and low self-esteem, which in turn triggers eating disorders symptoms as a form of coping with the fear of rejection and satisfying people’s need for approval. However, as with Shafran and Fairburn’s model (2003) theirs has not received any empirical support.

**2.2 Social Anxiety**

There has been some research that links perfectionism to social anxiety symptoms within a clinical population (Juster, Heimberg, Frost, Holt, Mattia, & Faccenda, 1996; Lundh & Ost, 1996; Saboonchi & Lundh, 1997; Bieling & Alden, 1997; Antony, Purdon, Huta, & Swinson, 1998; Saboonchi, Lundh, & Ost, 1999; Rosser, Issakidis & Peter, 2003; Jain & Sudhir, 2010; Kumari, Sudhir & Mariamma, 2012). Within a non- clinical population (Knappe, Beesdo-Baum, Fehm, Stein, Lieb, & Wittchen, 2011; Al-naggar, Bobryshev & Alabsi, 2013). Empirical findings showed that social anxiety is linked to parental criticism and critical evaluation as indicated by concern over mistakes and doubts about actions (Juster, Heimberg, Frost, Holt, Mattia, & Faccenda, 1996; Lundh & Ost, 1996; Saboonchi & Ost, 1997; Antony, Purdon, Huta, & Swinson, 1998; Saboonchi, Lundh, & Ost, 1999; Rosser, Issakidis & Peter, 2003; Kumari, Sudhir & Mariamma, 2012; Al-naggar, Bobryshev & Alabsi, 2013). In addition, non- display of imperfections appeared to be linked to social anxiety (Jain & Sudhir, 2010).

Juster et al. (1996) was the first to show that social phobics were holding unreasonably high standards for performance in social settings, interpreting any deviation from those standards as failure. This was in line with Clark and Well’s (1995) model of Social Phobia that highlighted high standards as a common feature of people with social anxiety. Some other findings, though, have been contrary to the argument that there is a link between high standards and social anxiety (Alden, Ryder, & Mellings, 2002; Shumaker & Rosenbaugh, 2009). It is interesting that these studies were focused on non-clinical populations, thus the results might be different for a clinical population.

Whilst the above studies provide significant empirical evidence regarding the relationship between perfectionism and social phobia, they do not clarify whether perfectionism is a causal factor of the disorder or vice versa. All studies were based on a cross-sectional basis rather than a longitudinal one. A further criticism is that almost all of the findings are based on self-report measures, which could be biased based on the emotional state of the participants at the time.

**2.3 Chronic Fatigue Syndrome (CFS)**

There is some empirical evidence to support the link between perfectionism and somatic disorders, in particular CFS. People with CFS have been described as hard working and holding rigid perfectionistic beliefs. They are overworking individuals who do not receive pleasure and cannot meet their high expectations (Forman, Rudi & Tosi, 1987;Puffer & McShane, 1992; Shafran & Mansell, 2001)**.**

Studies focusing on non-clinical groups identified that perfectionism was associated with exhaustion in career mothers (Mitchelson & Burns, 1998); fatigue and depression in night shift workers (Magnusson, Nias & White, 1996); and burnout in competitive tennis players and employees (Spence & Robbins, 1992; Gould, Udry, Tuffey, & Loehr, 1999; Shaufeli, Bakker, Schaap & Hoogduin, 2001). Studies in clinical populations, have found that patients with CFS exhibit higher levels of perfectionism as compared to a normal control group (White and Schweitzer, 2000; Deary and Chalder, 2010). Luysten, Cosyns, Van Den Broeck and Van Houdenhove (2006) showed that there is a clear relationship between perfectionism and fatigue both premorbid as well as post-morbid. High standards, concern over mistakes and doubts about actions were linked to fatigue. Furthermore, the participants would display excessive attention to detail and order. The results also indicated that perfectionism prior to the development of fatigue was significantly high with regards to both the adaptive, as well as its maladaptive form.

Further findings supported that both adaptive and maladaptive perfectionism appeared to be related to CFS (Deary and Chalder, 2010; Kempke, Van Houdenhove, Luyten, Goossens, Bekaert & Van Wambeke, 2011). Other studies showed that perfectionism played a significant mediating role between depression and CFS (Houdenhove and Luyten, 2008; Van Houdenhove, Kempke & Luyten, 2010; Kempke, Goossens, Luyten, Bekaert, Van Houdenhove & Van Wambeke, 2010).

A limitation of the studies is that they do not provide a causal explanation of fatigue in relation to perfectionism as they are conducted in a cross-sectional design. Once again, the hypothesis as to whether perfectionism might be a causal factor regarding the development of disorders is lacking empirical evidence.

**2.4 Depression**

Lengthy research has supported that perfectionism, specifically self-oriented perfectionism, is strongly linked to depression and high relapse rates (Hewitt & Flett, 1991; Frost, Heimberg, Holt, Mattia, & Neubauer, 1993; Hewitt, Flett, & Ediger, 1996; Norman, Davies, Nicholson, Cortese, & Malla, 1998; Enns & Cox, 1999; Kawamura, Hunt, Frost, & DiBartolo, 2001; Sassaroli, Romero Lauro, Ruggiero, Mauri, Vinai & Frost, 2008). However, other findings showed that positive striving (linked to self- oriented perfectionism) is not associated with subsequent depressive symptoms. These findings found that concern over mistakes, doubts about actions, parental criticism and socially prescribed perfectionism appeared to be maintenance factors of depression (Antony, Purdon, Huta, & Swinson, 1998; Stober, 1998; Enns & Cox, 1999; Sherry, Hewitt, Flett, & Harvey,2003; Enns, Cox, & Clara, 2005). People who are depressed hold very low standards with regards to their performance, due to decreased evaluation and distorted evaluation of self-worth and increased levels of self-criticism.

Further findings supported that self-criticism plays a mediating role to depression (Dunkley, Sanislow, Grilo, and McGlashan, 2006; Dunkley, Sanislow, Grilo, & McGlashan, 2009). According to Dunkley, Zuroff and Blankstein, (2003) self-critical perfectionists experience high levels of distress when they are faced with achievement stressors, due to their tendency to harshly evaluate themselves as well as magnify the negative aspects of the given event/stressor.

Self-esteem (Flett, Hewitt, Blankstein, & O’Brien, 1991), maladaptive defense styles (Flett, Besser, & Hewitt, 2005) and maladaptive coping styles (Dunkley, Zuroff, & Blankstein, 2003) also play a mediating role. Furthermore, Dunkley, Sanislow, Grilo and McGlashan’s study (2006) found that negative social interactions and the negative perception of social support are also mediating factors between perfectionism and depression. It was reported that perfectionists experience high distress because they engage in defensive behaviours out of fear of rejection by others, which in turn validates their beliefs as these behaviours tend to drive people away.

There is clinical evidence to support the significant role of perfectionism, specifically socially- prescribed perfectionism, in suicidal ideation and hopelessness (Hewitt, Flett and Weber, 1994; Hewitt, Newton, Flett, & Callander, 1997; Hewitt, Norton, Flett, Callander, Cowan, 1998; Donaldson, Spirito, & Farnett, 2000; Hewitt, Flett, Sherry, & Caelian, 2006; Rasmussen, O'Connor, & Brodie, 2008) and in self- harm (O’Connor, Rasmussen, Miles, & Hawton, 2009; O'Connor, Rasmussen & Hawton, 2010). There are also findings supporting that perfectionism is a vulnerability factor for bipolar disorder (Alloy, Abramson, Walshaw, Gerstein, Keyser, Whitehouse & Harmon-Jones, 2009).

**2.5 Obsessive-Compulsive Disorder (OCD)**

Rheaume, Freeston, Dugas, Letarte and Ladouceur (1995) argued that perfectionism is ‘*necessary, but insufficient trait for the development of OCD’* (p.793). Research in clinical populations of OCD & Body Dysmorphic Disorder found that concern over mistakes and doubts about actions were significantly related to OCD symptoms. However, parental criticism was not found to be related to OCD (Frost and Steketee, 1996; Buhlmann, Etcoff & Wilhelm, 2008; Moretz & McKey, 2009; Manos, Cahill, Wetterneck, Conelea, Ross & Riemann, 2010). Furthermore, several studies focusing on non-clinical populations found a significant relationship between OCD and perfectionism (Frost & Gross, 1993; Frost, Steketee, Cohn & Greiss, 1994; Ferrari, 1995; Shafran & Tallis, 1996). Coles, Frost, Heimburg and Rheaume (2003) found that people with OCD, when asked with regards to the functionality of compulsive activity, very often state that they cannot stop until ‘it’s just right’.

Lee, Prado, Diniz, Borcato, DaSilva, Hounie, Leckman and Rosario’s research (2009) looked specifically at the notion of ‘feeling just right’ and correlated this to perfectionism. The results, once again, replicated previous findings by showing that the OCD patients scored significantly high on concern over mistakes, doubts about actions. However, contrary to previous research, parental criticism appeared significantly related to OCD. In this study personal standards did not seem to relate to OCD, once again indicating that setting high standards is not a necessary factor regarding the development and maintenance of a disorder or a central factor.

A more recent study by Wetterneck, Little, Chasson, Smith and Sanley (2011) focused on comorbid Obsessive Compulsive Personality Disorder in OCD patients and the relationship of the disorder to perfectionism. The results were similar to previous research in terms of indicating a strong correlation between doubts about actions and concern over mistakes with OCD.

**2.6 Comorbidity**

Comorbidity amongst different disorders is an extremely common phenomenon, however, there is limited evidence of any studies focusing on perfectionism and level of comorbidity. Brown, Cambell, Lehman, Grisham and Mancill’s (2001) study involved 670 outpatients and it was identified that 73% of patients with Generalised Anxiety Disorder (GAD) had an additional diagnosis including OCD and/or depression. Bieling, Summerfeldt, Israeli and Antony (2004) focused on 345 patients who were suffering from comorbid disorders with equivalent numbers of men (49%) and women (51%). With regards to comorbidity figures: 65% were diagnosed with at least two disorders; 36% with three or more; and 18% had an additional diagnosis of four or more disorders. The most frequent diagnoses were social phobia (53%); panic with/without agoraphobia (35%), OCD (33%); specific phobia (26%); major depressive disorder (20%); GAD (15%); and dysthymic disorder (13%).

In Bieling et al’s study (2004) the results showed a clear correlation between perfectionism and comorbidity. Even when severity of the disorder was controlled, perfectionistic evaluative concerns emerged as a significant predictor of comorbidity. However, the study, as most of the studies reviewed, is based on self-evaluation which could be biased by the participant’s presenting problem. In addition it was based on a cross-sectional design that indeed shows a correlation between perfectionism and comorbidity, however, it does not provide a clear picture of causal factors. Another study that looked at the relationship between perfectionism and comorbidity was carried out by Van Yperen, Verbraak and Spoor (2011). They found that socially- prescribed perfectionism was strongly associated with comorbidity of disorders including burn out, anxiety and depression in a large sample of clinical population. It was interesting that self-oriented perfectionism did not appear to relate to comorbidity in this study.

Findings to-date supported the comorbidity of OCD with eating disorders (ED) (Bogetto, Venturello, Albert, Maina, & Ravizza, 1999; Lochner et al., 2004). A very recent study showed that perfectionism mediated the relationship between ED and OCD symptoms (Bernert, Kiara,Timpano, Petersonc, Crowc, Bardone-Cone, Grangee, Kleinf, Crosbyg, Mitchell, Wonderlichg, & Joiner, 2013).

In conclusion, all of the research perused so far indicates a relationship between perfectionism and a variety of different disorders. Socially prescribed perfectionism appeared very significant in disorders such as social phobia and depression. In addition, it appears apparent that setting high standards is not always relevant to the maintenance of a disorder, specifically in cases like OCD, social phobia and depression. In light of this the treatment of perfectionism will now be discussed.

**2.7 Trans-diagnosis and Critique of Current Treatment for Perfectionism**

It is proposed that, from the research on perfectionism across different disorders, perfectionism should be viewed as a trans-diagnostic issue and a target of treatment. Bieling et al (2004) argued that ‘*perfectionism plays an important role across a variety of disorders, acting both as a predisposing variable and a potential target for intervention’* (p.199). Furthermore, Egan, Wade and Shafran (2011) argue that *‘if perfectionism is a transdiagnostic process, one would predict that high levels of perfectionism would impede treatment across different psychopathologies and that treating perfectionism should reduce a variety of psychopathologies’* (p.208).

Trans-diagnosis is still a very recent issue and a growing number of researchers are beginning to advocate a trans-diagnostic approach to the treatment of anxiety and mood disorders (Barlow, Allen, & Choate, 2004; McManus, Shafran & Cooper, 2010). Recent studies (Erickson, Janeck & Tallman, 2009; Norton & Hope, 2005; Norton, 2008; Ehrenreich, Goldstein, Wright, & Barlow, 2009) showed some promising results with regards to the efficacy of a trans-diagnostic treatment protocol for anxiety and mood disorders. However, these studies have been criticised as they consisted of small sample sizes and had no comparison with control groups. Therefore, they do not provide substantial evidence regarding the actual efficacy of the interventions over other factors in terms of improvement (McManus, Shafran & Cooper, 2010).

There are a number of studies that have investigated how perfectionism interferes with therapeutic alliance and people’s response to treatment (Blatt, Zuroff, Quinlan & Pilkonis, 1996; Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow, & Simmens, 2000).

To-date there is very limited research that focuses on the treatment of perfectionism (Ferguson & Rodway, 1994; Shafran, Lee & Fairburn, 2004; Glover, Brown, Fairburn & Shafran, 2007; Riley, Lee, Cooper, Fairburn & Shafran, 2007; Radhu, Daskalakis, Arpin-Cribbie, Irvine & Ritvo, 2012; Steele, Waite, Egan, Finnigan, Handley & Wade, 2013). This research provides a valuable contribution to the understanding of perfectionism and in addition some guidelines with regards to its treatment, trans-diagnostically.

Some of the studies carried out in this area only investigated the efficacy of specific interventions on reducing perfectionistic traits (Hirsch & Hayward, 1998; DiBartolo, Dixon, Frost & Almodovar, 2002). Others evaluated the efficacy of self-help treatment protocols, either on a one-to-one basis or on web-based Cognitive-Behavioural Psychotherapy (CBP) for individuals and groups (Steele & Wade, 2008; Pleva & Wade, 2007; Radhu, Daskalakis, Arpin-Cribbie, Irvine, & Ritvo, 2012; Steele, Waite, Egan, Finnigan, Handley & Wade, 2013). These studies have several limitations as they did not always use clinical population and/or they did not evaluate the efficacy of the treatment trans-diagnostically as they focused on specific disorders. Whilst there was a decrease in perfectionism there was little shift on emotional distress. Further, limitations are related to the methodology as little evident efficacy was shown when the treatment was delivered via the Web or in groups.

There are studies that have been based on multiple base line cases with clinical populations where a specific CBP treatment protocol was delivered focusing on clinical perfectionism on single cases (Ferguson & Rodway, 1994; Shafran, Lee & Fairburn, 2004; Glover, Brown, Fairburn & Shafran, 2007; Riley, Lee, Cooper, Fairburn & Shafran, 2007). However, the majority of these showed little change in emotional distress and limited improvement regarding the treatment of the presenting problem, even if a significant reduction in perfectionism occurred. Additionally, in several cases it could be argued that the sample was sub-clinical as pre-treatment baseline scores on anxiety and depression scales were significantly low. Finally, it is proposed that a significant limitation was that the proposed treatment protocols were based on the definition of perfectionism as a uni-dimensional construct, which did not address interpersonal factors. However, whilst the construct of clinical perfectionism has received criticism due to its uni-dimensional nature and omission of certain factors, Shafran, Egan & Wade (2010) expanded on the initial treatment protocol in their self-help book ‘Overcoming Perfectionism’ and it continues to show promise (Steele et al, 2013).

Despite how valuable the research to-date is, there is no specific research that evaluates the experience and the efficacy of a treatment protocol for perfectionism from the client’s perspective.

**Chapter 3**

**Methodology**

This chapter will describe the methodology for this research. The aims and objectives of the study will be highlighted and then the theoretical underpinnings of the research design will be explored. This will include positivism and quantitative research; social constructionism and qualitative research; mixed methodologies; and the interpretative phenomenological approach.

**3.1 Research Aims & Objectives**

**Aims:**

* Develop an understanding of the experiences of perfectionism (and low self-esteem) and the impact on different aspects of people’s lives.
* Develop a trans-diagnostic cognitive-behavioural treatment protocol for anxiety and mood disorders, which focuses on perfectionism.
* Test the effectiveness of the treatment protocol with respect to symptom reduction and improvements in quality of life.

**Objectives:**

* To gain a greater understanding of the concept of perfectionism and low self-esteem in people’s lives.
* To evaluate the client’s overall experiences of treatment on perfectionism (and low self-esteem).
* To evaluate which techniques appeared most helpful, and which less helpful.
* To evaluate how perfectionism (and low self-esteem) changed and how this affected aspects of people’s lives post-treatment.

**3.2.1 Positivism and Quantitative Research**

Positivism adapts the correspondence theory of truth by accepting that the truth is what can only be proved, measured and replicated; and anything else is subject to doubt. It is irrelevant who is observing a phenomenon, but how this phenomenon has been measured and evaluated (Gergen, 2001). Positivism gave rise to the development of statistics and positive science as the use of quantitative methods. Ponterotto (2005) argued that a positivist approach is able to produce accurate and reliable results, hence, the use of experimental methodologies are considered the most superior methods to produce valid results, especially when there is a well- developed theory that assesses measurement errors based on validity and reliability. A further advantage of quantitative methods is the fact that researchers can make comparisons of responses, variables, and stimuli, over large populations. Overall quantitative research fits well with hypothetico-deductive approaches.

**3.2.2. Critique of Quantitative Research**

Quantitative methods are predominantly applied within the field of social sciences but there are a number of criticisms to their use. Mitchell’s (1999) critique reported that researchers applying quantitative methods to measure and address psychological attributes, do not have a strong definition of measurement (Lee, Mitchell & Sablynski, 1999). Toomela (2008) reported that quantitative variables are frequently ambiguous, thus the interpretation often is not meaningful: without knowing what information is encoded in a variable it is not possible to make an interpretation that provides deep meaning. Chow, Quine and Li (2010) suggested that such methods do not investigate the phenomenon researchers are interested in, more so only look at the size of the problem. Furthermore, quantitative research can be limiting, as it rules out psychological constructs that attempt to capture important aspects of experience, such as, feelings, values, meaning, experiences, culture, etc. When quantitative research is carried out very rigidly, it can lead to major restrictions as to what can be talked about and studied (Barker, Pistrang & Elliott, 2002). In other words, quantitative research is focused on counting rates and phenomena.

Another criticism refers to the rigidity of questionnaires and measures that are applied in quantitative research. It is suggested that these can often limit the individual’s responses as they can omit important information that might not be included in the questionnaire, yet is part of the individual’s perception and understanding of phenomena (Smith & Dunworth, 2003). Often, the response could be biased by a variety of factors, such as, the person’s mood on the day, attention, tiredness, and environmental circumstances.

The majority of research carried out with regards to the investigation of perfectionism has been based on measures and questionnaires given to children, adolescents and their families. Eiser & Morse (2001) identified some issues with this process. One was that it is often difficult for individuals, based on their cognitive skills, to generate a response to a measure that they then have to translate in a way that fits the category on a specific response scale. That would mean that they have to recall accurately from memory, and accurately critically evaluate the response, in order to decide where and how much it fits in the questionnaire. This can be a biased and difficult process not only for children, but also for adults. In addition, empirical evidence suggests that people tend to provide extreme responses when given a specific scale as they are less likely to critically evaluate the particular statement on the questionnaire and the actual rating scale. Therefore, once again, the responses might be biased and inaccurate (Eiser & Morse, 2001). Another issue is that rating scales, such as, ‘often’ and ‘occasionally’, can be interpreted differently by individuals.

The application of quantitative methods alone rules out the richness of information to understand certain factors in greater detail. This prevents new theories from developing in related fields such as psychotherapy, where human nature, behaviour, thoughts, emotions and intrapersonal/interpersonal factors are the central focus. Mullen and Iverson (1986) stated that ‘*Quantitative methods have developed largely to confirm or verify theory, whereas qualitative methods were developed to discover theory’* (p. 150). In relation to evaluation studies, where the focus is to understand the mechanisms that affect the effectiveness of intervention, quantitative studies focus on the intervention outcome alone. However, this does not provide enough information as to why and how these interventions appear effective. According to Swanson & Chapman (1994):

*‘the evaluation of an intervention has involved measuring participants before they entered a ‘black box’ and then measuring them again as they emerge from the ‘black box’ what actually occurs during the intervention may largely remain a ‘black box’* (p.67).

In spite of these criticisms, quantitative methodology continues to be the main focus of research in the field of Cognitive-Behavioural Psychotherapy (CBP) and perfectionism (and low self-esteem). It is likely that focusing on this field of research from a social constructionism and qualitative research perspective may add value to these areas so the theoretical underpinnings of such will now be reviewed.

**3.2.3 Social Constructionism, Phenomenology and Qualitative Research**

Social constructionism is directly opposite to positivism in that it rejects the notion that there is one fundamental truth. In contrast, it emphasises that there is a set of different realities: a fact is the product of the thing itself and how the individual interprets it and the meaning it attaches to it, based on his/her knowing (Barker, Pistrang & Elliott, 2002). Guba & Lincoln (1994) argued that constructivism ‘*denies the existence of an objective reality asserting instead that realities are social constructions of the mind and that there exists as many such constructions as there are individuals’* (p.43). Social constructionists apply a more flexible attitude towards what is considered truth and acknowledge the role of society and interpersonal relationships when investigating what is considered truth for an individual. They do so by focusing on the meaning, the language, and the written word, not trying to identify whether what is said is true but what it means to the individual and to society on a larger scale (Barker, Pistrang & Elliott, 2002).

Phenomenology stems from the same philosophical principles as social constructionism. However, social constructionists look at language as a social product in itself questioning other concepts such as reality and the truth or even the actual person (Barker, Pistrang & Elliott, 2002). On the other hand, phenomenologists are more interested in how people interpret their reality and the meaning they attach to their experiences and language is the tool they communicate their interpretation, their thoughts and emotions. Applying phenomenology in the present research means that not will it only provide evidence of what is important to each individual’s experience, but also what are the common themes related to the experience of a group that shares similar experiences and events. Berg-Schlosser (2009) states that ‘*qualitative techniques allow researchers to share in the understandings and perceptions of others and to explore how people structure and give meaning to their daily lives’* (p.8).

It is proposed that qualitative methods are closer to the practice of CBP in that it treats the individual idiosyncratically, based on an individualised formulation and considers different factors including culture, early life experiences and environment (Beck, 1979, Greenberger & Padesky, 1995, Fennell, 1997, 1998). Furthermore, the hermeneutic nature of phenomenological approaches seems relevant when looking at perfectionism (and low self-esteem) than a purely positivist position, because it investigates the construct of perfectionism as it is experienced and understood by individuals. Additionally, it explores the process of therapy and what appeared more helpful, as opposed to just the outcome of the interventions. Interpretative Phenomenological Approach (IPA) appeared to be relevant to this study methodology and the rationale for the application of IPA will now follow.

**3.2.4a Interpretative Phenomenological Approach (IPA)**

IPA was developed by Smith (1995) and aimed to explore idiosyncratic and subjective experiences. It examines the meaning individuals attach to their experiences and how they make sense of the world (Smith & Osborn, 2003). It was designed to gain insight into individual’s experiences, how they viewed them; the meaning attached to them; and how they impact one’s life (Willing, 2001). This is in line with the overall phenomenological approach described previously.

According to IPA, people can ascribe different meanings to the same event, indicating that people develop different realities, which are equally valid through the process of interpretation (Brocki & Wearden, 2006). The meaning attached to situations derives from a generic social interaction, however, it becomes idiosyncratic to each individual and the meaning attached to situations can be responsible for the reaction to the given situation. The above is in agreement with Beck’s argument that

‘*to understand the emotional reactions to an event, it is necessary to make a distinction between the dictionary or public meaning of an occurrence and its personal or private meaning. The first is the objective view - devoid of personal significance*’ (Beck, 1976, p.48).

There is a clear similarity between the theoretical underpinnings of IPA and cognitive theory, which makes IPA appear even more appropriate as a method to use in order to explore the phenomenon of perfectionism and low self-esteem, and its treatment.

Smith & Osborn (2003) argued that ‘*IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between people’s talk and their thinking and emotional state’* (p.53).

This is also in agreement with the researcher’s clinical approach, making the decision of IPA as the chosen methodology very appropriate. In addition, Smith (2003, 2011) underlined that IPA is concerned with situations in individual’s everyday lives that affect their everyday functioning in a significant way. Once again, this is in parallel with the present study as one of the aims is to understand deeper how perfectionism and low self-esteem impacts everyday life and different life domains.

The quantitative methods are very limited in investigating the personal understanding of perfectionism and low self-esteem and how these have impacted the individual’s lives. Thus, IPA seems to be the most relevant method in terms of investigating idiosyncratically those concepts. In addition, the fact that IPA refers to social interactions and how they construct meaning is in agreement with the treatment protocol and the overall investigation that emphasises the multidimensional nature of perfectionism.

Smith (2003, 2011) stated that in IPA there is an element of identifying, emphasising and understanding what is said and actually making sense of it. The researcher’s role is not only to identify what is said, but also to interpret what the individual is trying to say. The researcher is also trying to understand the individual’s perspective using psychological interpretation to include aspects the individual is not 100% aware of. One could argue that the researcher’s perception, personal beliefs, experiences, etc., could bias the understanding of what is being said. A criticism that can emerge regarding the use of IPA is that if the researcher is lacking reflexivity, then the results will be biased (Caelli, 2001; Finlay and Gough, 2003).

On the other hand, Smith (1996, 2007, 2011) argues that the researcher’s role is not seen as a bias, but necessary in order to make sense of the person’s experience:

‘*Allowing for both aspects in the inquiry (understanding the individual’s understanding of the event) is likely to lead to a richer analysis and to do greater justice to the totality of the person*’ (Smith & Osborn, 2007, p.53).

With regards to reflexivity Fade (2005) argues ‘*Reﬂexivity is viewed as an optional tool, enabling the researcher to formally acknowledge his or her interpretative role, rather than as an essential technique for removing bias’* (p.648). Nevertheless, the dual hermeneutic process that underpins IPA simulates in a way the therapeutic alliance that is built within psychotherapy and counselling, where the therapist is trying to understand the client’s point of view and empathise, interpreting the information often filtered via the therapist’s perspective. Certainly this is in agreement with the researcher’s practice as a cognitive-behavioural therapist and it is a process that seems very familiar, thus providing another rationale for the use of IPA.

Finally, a criticism of IPA refers to the fact that it is difficult to understand the meaning of the experience in question, when the researcher has not explored the individual’s background information (Willing, 2001). This issue will be addressed as the researcher will be fully informed regarding the individuals’ backgrounds, since they would have all undergone therapy prior to the interviews.

**3.2.4b IPA Over Other Methodologies**

A widely used qualitative method is that of grounded theory. Grounded theory is very similar to IPA in terms of methodology (use of interviews, sampling), data analysis/collection and the fact that both methods are focusing on understanding an individual’s perspective of their world/events, etc. Whilst they appear very similar, it has been argued that grounded theory is more appropriate when conducting sociological research as its aim is to discover what symbolic meaning in objects and words for groups of people as they interact (Glasser & Straus, 1967; Willing, 2001). Willing (2001) underlined that the use of grounded theory is better suited for sociological research by arguing that ‘*Grounded theory’s intention is to identify and explicate contextual social processes, which account for phenomena’* (p.69). It appears that the analyses of data are not as ‘deep’ as in IPA, which is aiming a deeper psychological understanding of people’s experiences.

Grounded theory is collecting in depth evidence to establish, or in other words, ground an existing or a new theory. The aim of the present research is not to ground an existing theory, but to gain a deeper understanding of people’s experience of perfectionism and low self-esteem, as well as their experience of a treatment protocol and to replicate the results of existing theories of perfectionism and low self-esteem. If the aim was to establish a theory, then there should be a large sample of participants and the relatively small sample in the present study appears to agree with IPA, rather than with grounded theory. Grounded theory has been criticised as been restrictive, on the basis that the analysis of data are such to gain enough categories to ground a theory. On the other hand, hermeneutic approaches such as IPA allow for greater flexibility as they are more idiographic and the emphasis is greater on the understanding of an individual’s understanding of events, rather than establishing a theory by collecting more generic themes of what has been said/presented by the individuals (Charmaz, 1991). In addition to this Snaw (2001) indicates that IPA is a data-driven and not a theory-driven method. If new data emerge they can be added to an existing theory, but the open-ended nature of IPA allows the individuals to tell their own story, without the researcher being biased by the research itself (Snaw, 2001; Smith, 2011).

IPA has been criticised for a significant lack of attention to language and how it is used in order for someone to get a point across (Edwards & Potter, 1992), thus another method could have been applied, that of Discourse Analysis (DA). However, the theoretical underpinnings of DA are based on social construction, which has been previously evaluated as not being as analytical as phenomenology in relation to the aims of the present research, due to its focus on mainly language. In addition, DA is focusing on the way the individuals are using language to get a point across, however, it does not pay significant attention to factors that contributed to the establishment of a behaviour, such as motivation, cognitions and early life experiences. DA appears to be sceptical with regards to how accessible cognitive processes are, thus the emphasis is on language. On the other hand IPA emphasises that cognitive processes can be accessible if one focuses on the analysis of what is said and interprets the meaning attached to it (not necessarily the words that are used) (Smith, Flowers & Osborn, 1997; Smith, 2004, 2011). Since perfectionism and low self-esteem have a developmental element stemming from early experiences, and the aim of this research is to understand the experience of these concepts as well as the effect of the therapeutic protocol, IPA seemed more appropriate method to use than DA.

**3.2.5 Critique of Qualitative Research Overall**

Despite the possible advantages of qualitative research it is not without its criticisms (Creswell & Plano Clark, 2007; Guba, 1990; Johnson & Onwuegbuzie, 2004). One criticism refers to the lack of objectivity (Gelo, Braakmann, & Benetka, 2008). Simply accepting the reality as the individual experiences it holds the risk of losing the focus and objectivity of research. Furthermore, it is possible that the researcher will address the data that ‘fit’ their needs and not provide an objective, numerical overview of the research. There is a strong need to have a stance of a relative sense of reality, in order to assess more objectively the individual’s experiences as helpful/unhelpful, realistic or not. A further criticism is the lack of generalisability (Gelo, Braakmann, & Benetka, 2008), for example, the sample size is often small, therefore, results cannot be generalised to the rest of the population as quantitative studies do. Researchers believe the lack of generalisability is a weakness of qualitative research and often causes researchers to even question the usefulness of qualitative research (Willing, 2001).

If positivism is a philosophy that undermines the identity aspect of being human, by treating individuals as numbers, likewise social constructivism, by applying a non- realistic stance, can turn any type of research into a chaotic Babylon Tower (Barker, Pistrang & Elliott, 2002). Willing (2001) suggests that the best way to conduct research is not to view it from a black and white perspective but to view it within a continuum that ranges from a realist to a relativist stance. Gelo, Braakmann, & Benetka (2008) claim the solution to critiques of qualitative research is the integration of quantitative and qualitative approaches, commonly referred to as mixed methods research, which will now be described.

**3.2.6 Mixed Methodologies and Their Purpose**

The use of mixed methods has been evident since the 40’s but it was not until recently that it has been viewed as a new paradigm (Descombe, 2008). Denzin (1978) was one of the first who advocated the use of triangulation, proposing that different perspectives could be generated in order to give a fuller and informative picture of what was occurring and was more valid than a single method alone. It is now known as the ‘third methodological movement’ (Tashakkori & Teddlie, 2003) and/or ‘the third research paradigm (Johnson & Onwuegbuzie, 2004). One of the most comprehensive definitions of mixed methods research is the following:

‘…*mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies’*. (Creswell & Clark, 2007, p5).

Even with the recent acknowledgement of mixed methodologies, Leech and Onwuegbuzie (2011), in their review of journals between 2003 and 2010, found that only a small 2% sample applied mixed methods. Smith (2011) suggests that the reason for the lack of research using mixed methods consists of a misunderstanding of the paradigm, often co-existing with resistance to embrace an unfamiliar paradigm.

**3.2.7 Critique of Mixed Methods Research**

There is on-going debate with regards to the combination of quantitative and qualitative research methodologies in a single study, as the approaches represent completely different ontologies. The purists believe that each methodology is related to different exclusive epistemological positions (the positivist and social constructionism) and, therefore, do not mix. For example, Leininger (1994) stated that in order to conduct sound research, methodologies should not be mixed across the two paradigms: ‘*such practices violate the integrity, purposes and epistemic roots of each paradigm and lead to a misuse of methods; this misuse leads to inaccurate, questionable and meaningless research findings ’* (p.101- 102). On the other hand, it has been argued that the notion of methodological pluralism can actually lead to more accurate and rich results and creates a more thorough type of research. Creswell and Clark (2007) argue that ‘*Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone*.’ (p.5).

Creswell and Clark (2007) identified certain factors that support the use of mixed methodologies in certain studies, that is, the need to:

* Include more than one data source otherwise the research can appear insufficient;
* Explain the initial results;
* Generalise exploratory findings;
* Enhance a study with a second method;
* Understand a research objective through multiple research phases.

As all research methods have significant limitations, one way of reducing subjectivity is to apply a combination of both methods (Patton, 2005). For example, in psychotherapy, in order to assess whether an intervention has appeared useful it is important to obtain the quantitative data, via the use of measures, that can support therapeutic change, but also to provide data that assess change from the perspective of the client and the therapist. Thus, a qualitative study would complement the quantitative data (McLeod, 2001; Creswell & Clark, 2007).

As stated previously, the majority of research and literature to date related to perfectionism applies a positivist approach. Furthermore, most studies have only utilised quantitative methods. The research has provided sound evidence regarding the nature of perfectionism; its relation to different difficulties; validated measures; and the relationship between perfectionism and different variables; etc. However; there is very little evidence with regard to how perfectionism operates; its causal effect; how perfectionism is experienced by individuals; how they manage perfectionism. It is proposed that the use of mixed methodology research, with a strong qualitative component would go some way to answering these questions within the present research.

**3.2.8 Mixing the Mixed Methodologies**

Andrew and Halcomb (2009) identified and themed some purposes of conducting mixed methodology research, which are in agreement with the purpose of the present study. The first one is ‘confirmation’, where the purpose is to confirm and validate the results from previous studies and also confirm and validate the results between the two different methodologies. The quantitative element of the present study will provide data to support and replicate the results from previous studies regarding perfectionism and its nature. It will also provide evidence of client’s progress and therapeutic outcome regarding the treatment of perfectionism and low self- esteem, thus complementing and adding extra validity to the data obtained from the qualitative analysis.

The second purpose is ‘expansion’ (Andrew & Halcomb, 2009). The quantitative data will be enriched and expanded by the information collected qualitatively, thus broadening the scope of the study. The qualitative element of the methodology will provide a significant account of the experiences of perfectionism and low self-esteem from the individual’s perception. It will also confirm the findings collected from the quantitative research, again expanding on the findings by giving more information. More information will be gained related to the experience and impact of perfectionism and low self-esteem in different domains of human life, that up until now very little research has investigated using qualitative methods. Expansion is relevant to the effectiveness of the therapeutic protocol on perfectionism and low self-esteem. Whilst the quantitative data will provide the statistical results supporting the effectiveness and achievement of the treatment goals, the qualitative data will expand on how the treatment has helped the individual in different life domains in terms of perfectionism and low self-esteem as well as decreasing the presenting problem. Additionally, it will address the client’s experience of treatment and which techniques have appeared more useful and why, in order to manage issues related to perfectionism.

The third purpose is known as ‘complementarity’, which enhances and clarifies the findings of the statistical method (Morgan, 1998) For example, the quantitative research conducted so far provides some evidence as per the nature of perfectionism, however, little is known with regards to this in greater detail - the qualitative findings of this study will provide further evidence in this area. Additionally, the quantitative findings will show that the protocol appeared effective, however, the qualitative findings will show which techniques, and for what reason, appeared useful and which did not.

Another purpose of mixed methodologies is called ‘initiation’ and refers to the identification of contradicting results to what is expected, or a new perspective in an area that is little investigated (Andrew & Halcomb, 2009). The treatment protocols designed to date focused on perfectionism as a uni-dimensional construct. This study will provide a new perspective as it will be focused on the treatment of perfectionism as a multidimensional construct where the interpersonal, as well as the intrapersonal, nature of perfectionism and its treatment are involved.

**Chapter 4**

**Method**

Now that the approach to the research, that is, mixed methodologies and the use of an interpretative phenomenological approach (IPA) has been established, in this chapter the method of the research will be described. This includes the design; the sample; data collection and analysis; and finally ethical considerations and how these were addressed.

**4.1 Research Design**

Creswell and Plano Clark (2003, 2007) presented six advanced mixed methods designs and they argued that a single paradigm does not apply to all the designs. This research applies a multiphase design. Multiphase designs occur when an individual researcher examines a topic through a repetition of connected quantitative and qualitative studies that are sequentially aligned, with each new approach building on what was learned previously to address a central objective. The mix between quantitative and qualitative data occur across three phases.

**Phase 1:**

The first phase included 13 participants and provided the basis for the sequence of the study. The 13 participants were all suffering from a range of Axis I disorders (in line with the Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2000). During this initial phase the researcher identified that perfectionistic traits were affecting the treatment outcome of the participants’ presenting problem(s). This was evident following the collection and analysis of measurements that showed little improvement when using traditional Cognitive-Behavioural Psychotherapy (CBP) on the presenting problem. Therefore, the researcher identified and applied a number of interventions that focused on perfectionism and low self-esteem specifically, thus treating each participant trans-diagnostically. This shift to the treatment plan appeared more effective as this was evident from the analysis of measurements collected later on. Thus, phase 1 used an A-B-A-C design where A=baseline measures, B= CBP for Axis 1 disorders, C= CBP for perfectionism (and low self-esteem). The design of this phase is explained in greater detail later on (refer to single case multiple baseline experimental design).

The measures during the C phase showed a significant decrease of the measure scores (refer to the results section). Since there was a positive outcome following the shift to the treatment plan, the researcher created a protocol specifically designed for the treatment of multi-dimensional perfectionism and low self- esteem. In addition the development of aims and objectives of this research was established. This led to the 2nd phase of the research study.

**Phase 2:**

The 2nd phase of the research had 8 participants, who were all experiencing an Axis I disorder (s). Having 8 participants was sufficient as Giorgi (2008) recommends recruiting at least three participants. He argued that the differences between them can lead to a greater understanding of the phenomenon making it more general: ‘*at least three participants are included because a sufficient number of variations are needed in order to come up with a typical essence’* (p.37). These 8 clients were exclusively treated using a protocol (see appendix 1) that specifically targeted perfectionism and low self-esteem, irrespective of the presenting Axis 1 disorder. Phase 2 used an ABA direct replication design involving baseline (A) and treatment (B) with follow up (A). This phase included the collection and analysis of the quantitative measures and the formation of semi-structured questionnaires. This process led to the 3rd phase of the research.

**Phase 3:**

The 3rd phase included the collection and analysis of the qualitative data. All 8 participants treated in the 2nd stage participated in semi-structured interviews that took place after the therapy had been concluded. These interviews aimed to understand the participant’s experiences of perfectionism and the therapy process and to further examine the effectiveness of the protocol. The use of IPA was applied in order to analyse the qualitative data. The 3rd phase was utilised in order to collect more information and explain in depth the results of the quantitative phase (Creswell & Plano Clark, 2007). Furthermore, because there is significantly little qualitative research to-date on the field of perfectionism and it’s treatment, the emphasis is mainly placed on the qualitative results.

The following diagram summarises the three phases of the present research.

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***Diagram 5: The Multiphase Design that Shows the Three Phases of the Present Study as Adapted from Creswell & Clark (2003, 2012).***

This design provides an overarching methodological framework to a multiyear project that calls for multiple phases to develop an overall program of research, or evaluation (Creswell, 2012) *For example, in the context of program evaluation, these multiple phases may be tied to phases for needs assessment, program development, and program evaluation testing* (p.100). According to Creswell and Plano Clark (2003, 2012) one of the strengths of the multiple phase design is that it provides the flexibility needed to utilise the mixed methods design that is essential in order to address a set of interrelated research questions. Another strength, is that it fits best with the typical program development (in this case treatment protocol) and evaluation of it. Finally, this design can be used to provide an overall framework for conducting multiple iterative studies over multiple years. However, there are challenges regarding this design. Creswell (2012) argues that the person conducting the research needs sufficient resources, time, and effort to successfully implement several phases over multiple years. This is relevant to the present study, where the research process took 6 years to complete.

Mixed methods approaches are very challenging to carry out and complete successfully. This is because all elements of the research have to fully comply with research quality standards. So, for example, the quantitative element of a study should have adequate sample sizes and the qualitative elements need to address credibility and trustworthiness criteria. Mixed methods research also poses the further challenge of how to interpret the findings of each individual element and between the elements and phases of the study (Creswell & Plano Clark, 2003, 2007, 2012)

**4.2.1 Single Case Multiple Baseline Experimental Design**

Single case research designs have a long history within the field of psychological research. According to Rizvi and Nock (2008), single case research designs are the most appropriate method to evaluate the success and effectiveness of an intervention or treatment using a relatively small sample size. Multiple baseline designs are those in which treatment is applied in sequence across different individuals. They can include different design methods such as ABAB / ABA / AB / ABAC designs.

Following the brief description in the previous section (refer to multiphase design) what will now follow is a more detailed explanation of the research designs utilised in this study. The present research utilised an ABAC design during the 1st phase. In an ABAC design there are four measurement periods. A indicates the baseline period before the intervention is introduced, B indicates the introduction of CBP for the presented problem and C indicates the change to the targeted condition with CBP techniques targeting perfectionism, following another baseline period (A). The rationale for this type of multiple baseline design was that measurements during period B showed little improvement, thus highlighting the necessity to shift the treatment plan towards a different condition that of perfectionism (period C). The baseline measurements following C (A) showed a significant decrease of the scores. These findings indicated the significant effectiveness of the treatment protocol for perfectionism in reducing the presenting problem. This design appeared the most appropriate to indicate individual change following each intervention period. It was also helpful in order to highlight that the change occurred because of the intervention and no other factors (Kazdin & Nock, 2003).

The 2nd phase utilised an ABA design. In an ABA design, there are three measurement periods: baseline (A), during intervention (B), and follow up, where treatment stops but the measurement of the condition continues for a period of time (A). The rationale for the use of an ABA design was to replicate the results of the previous study and strengthen the validity of the effectiveness of the treatment protocol. This was established by the results during the B period that showed a reduction in the client’s condition, which reduced further as per the final baseline measurements in period A.

In order to demonstrate the external validity of any single case experimental design, direct replication is needed. Direct replication refers to repeating the same procedures, in the same situation, with different clients who have similar characteristics (Barlow & Hersen,1984). The 2nd phase of this research aimed to do exactly that, thus enhancing the validity of the results and the efficacy of the treatment protocol. The power of these designs comes from the demonstration of the change that occurred when the intervention targeted the condition across different individuals (Rizvi & Nock, 2008).

**4.2.2 Critique of Single Case Multiple - Baseline Experimental Design (SCMED)**

SCMED have several advantages, especially over group-based studies. To begin with, one major difference between single case designs and large sample designs is the scope of investigation. In a single case design, the question is: Does an intervention work for an individual? In contrast, the question in a group design is: Does the group average change? (Johnston, Sherer & Whyte, 2006).

One advantage of the SCMED refers to the fact that they do not require control conditions or comparison groups and can be incorporated into clinical work without disrupting the natural pace of treatment (Nock, Holmberg, Photos & Michel, 2007). This is certainly relevant to the present study, where the research occurred over the course of real life treatment in the researcher’s clinical environment and not within a controlled condition. They also provide a well-organized and flexible tool in the assessment and treatment development and evaluation process. They can be effectively used to modify multiple repetitions of a specific treatment and to collect efficacy data for such a treatment. Group designs, on the other hand, do not allow the tailoring of the intervention to the individual (Moras, Telfer, & Barlow, 1993). *The opportunity to modify interventions as needed provides greater research and clinical options and can lead to more innovative treatment development* (Nock, Michel & Photos, 2007, p.348).

Large sample studies are significantly costly and time consuming and require a large amount of resources and effort, whilst single case research designs do not (Nock, Michel & Photos, 2007). Because of the small participant size, clear causal relations between intervention and behavioural change can be demonstrated more efficiently than in large sample designs (Kazdin & Nock, 2003). The evaluation of individual change patterns in the data is far more clear and measurable in the SCMED, rather than in large group studies. Large group studies design usually utilise pre and posttreatment measures, thus, preventing evaluations of how and why individuals change over the course of treatment (Kazdin & Nock, 2003). Whilst, in SCMED there is a continuous use of measurements, within multiple experimental phases that allow detailed examinations of patterns of change. Once again the above strengthens the notion that the intervention causes the change and no other factors (Rizvi & Nock, 2008). *The more data points that are collected, the less vulnerable one is to random occurrences that may affect scores. Furthermore, one can consider the stability of change by looking at the observations over time and can dispel that the findings were a fluke.* (Rizvi & Nock, 2008, p.506).

Furthermore, the fact that in SCMED multiple and various participants ake part and that the causality of treatment effects can be replicated across different phases and participants can be implemented to demonstrate generality (Nock, Michel & Photos, 2007; Rizvi & Nock, 2008). The above can counterbalance a common criticism regarding the use of single case experimental designs, which is a lack of generality of obtained effects. Especially in comparison to large sample studies, one could argue that the single- cases are more valid as they do not use a homogenous sample, which is often the case with large- sample designs.

**4.3.1 Sampling**

Smith et al (1999) argue that the basic method used in IPA is the ideographic case-study approach. This method is best suited for relatively small samples of up to ten respondents and enables the researcher to write up a single case, or an exploration of themes shared between cases. The aim of IPA is not to make generalised results for larger populations, but to arrive at more general claims cautiously, and only after the thorough analysis of individual cases (Smith & Osborn, 2003; Smith et al. 2009).

The current study uses nonprobability sampling, more commonly referred to as purposive (Ritchie, Lewis, & Elam, 2003). It does not involve random selection, and as is usual in IPA studies, it is a small sample size. In purposive sampling there is one specific group of individuals sought. This type of sampling is favoured so that participants form a homogenous group with reference to the research question (Smith & Osborn, 2003). Smith (2007) stated that:

‘*IPA researchers usually try to find a fairly homogeneous sample. The basic logic is that if one is interviewing, for example, six participants, it is not very helpful to think in terms of random or representative sampling. IPA therefore goes in the opposite direction and, through purposive sampling, finds a more closely defined group for whom the research question will be significant’* (p.56).

The requirement for IPA is that the data participants provide are rich enough to allow the researcher to explore in detail the phenomenon under investigation. Thus whilst IPA does not indicate what is a correct sample size, as it is idiographic in its nature, a small size is appropriate (Smith & Osborn, 2003). It has been argued that large sample sizes include the risk of potentially losing important reflections of meaning - a smaller size allows the researcher to see themes emerging across the cases and in addition to see the complexities of individual cases. The data can then be discussed in the light of existing theories (Smith, 1996; 2003). One criticism, and a point where caution should be kept in mind, is the fact that the data and results cannot be generalised to the population. On the other hand, they do provide great insight of the phenomenon in question. Allport (1962), criticising the nomothetic nature of psychological research, states that: ‘*instead of growing impatient with the single case and the hastening on to generalization, why should we not grow inpatient with our generalizations and hasten to the internal pattern?*’ (p.407). Smith et al (2009) suggests that four to ten participants would usually be appropriate for a professional Doctorate.

It has been argued that whilst a small sample is appropriate for such a study the sample in qualitative research should be as diverse as possible (Ritchie, Lewis, & Elam, 2003), as long as it falls within the defined inclusion criteria. The diversity facilitates the identification of many different aspects of the phenomenon (Ritchie, Lewis, & Elam, 2003). In order to ensure diversity in the sample of the present study the individuals were suffering from different types of Axis I disorders; there was a diverse range regarding their age and occupation, and it included males (30%) and females (70%). Participant information will now be described in the next section.

**4.3.2 Participants**

In Phase 1 of the study the cases analysed prior to the development of the research questions were gathered based on random selection. The participants’ ages ranged from 20 to 57 years (median age: 34). The total number of sessions they had overall ranged from 15 to 43 (median number: 30). Figure 1.1 provides details of the 13 participants with regard to such factors as gender, presenting problems, plus details related to the treatment programme, for example, number of sessions. Inclusion criteria were as follows: a) Clients whose Axis 1 disorder measurements scores would not reduce and their therapy targets were not achieved up until the shift to the treatment plan that targeted perfectionism; b) Clients who relapsed and returned to therapy, where the protocol for perfectionism was utilised and appeared more effective.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| PARTICIPANT | SEX | AGE | OCCUPATION | PRESENTING PROBLEM | NUMBER OF SESSIONS | COMMENTS |
| 1 | F | 36 | PERSONAL TRAINER | IBS / PANIC / BODY ISSUES | 31 | Treatment shifted on the 11th session due to lack of compliance with exposure. |
| 2 | F | 42 | BANK EMPLOYEE | BIPOLAR DISORDER | 30 | Treatment shifted on the 10th session due to excessive self-criticism & self-blame |
| 3 | F | 46 | SOCIAL WORKER | OCD / DEPRESSION | 35 | Treatment shifted on the 27th session, due to slow progress and no change to scores, despite exposure |
| 4 | F | 22 | NURSERY NURSE | VOMIT PHOBIA / PANIC | 39 | Treatment shifted on 22nd session due to small progress & identification of symptoms as result of lack of assertiveness |
| 5 | F | 34 | HOUSEWIFE / MOTHER | OCD / BIPOLAR DISORDER | 40 | Treatment shifted on 17th session due to little shift on scores and targets |
| 6 | F | 23 | STUDENT | BODY DYSMORPHIC DISORDER | 43 | Treatment shifted on 20th session due to lack of compliance with exposure & no shift in measures |
| 7 | F | 22 | STUDENT | OCD | 25 | There were two phases of treatment. The first lasted 13 sessions, the client relapsed and returned for treatment for 12 sessions on perfectionism & self-esteem. |
| 8 | F | 40 | SOLICITOR | POST NATAL DEPRESSION | 29 | Treatment shifted on 15th session due to no change in scores |
| 9 | F | 57 | TEACHER | FYBROMYALGIA / DEPRESSION | 29 | Treatment shifted on 13th session due to no change in scores |
| 10 | F | 30 | ESTATE AGENT | HEALTH ANXIETY (HISTORY OF SEXUAL ABUSE) | 30 | Treatment shifted on 10th session due to lack of compliance with homework |
| 11 | M | 40 | MANAGER | SOCIAL ANXIETY / GAD | 15 | Treatment shifted on 9th session due to no shift on scores and lack of compliance with exposure |
| 12 | M | 42 | NURSE | SOCIAL ANXIETY | 16 | Treatment shifted on 9th session due to lack of compliance |
| 13 | F | 20 | STUDENT | DEPRESSION / RELATIONSHIP ISSUES | 17 | Treatment shifted on 12th session due to little shift on scores |

***Figure 1.1 Phase 1 of the study that utilised an A-B-A-C design - Details of the 13 cases involved***

In Phase 2 of this study, the participants self-referred for private psychotherapy with problems in relation to Axis I disorders. Of the 8 cases, 6 were females and 2 males. The participants’ ages ranged from 26 to 53 years (median age: 34; mean age: 41.6). The total number of sessions they had ranged from 10 to 21 sessions (median number: 11; mean: 13.5). Figure 1.2 details factors, such as, demographic details and presenting problem(s).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PARTICIPANT** | **SEX** | **AGE** | **OCCUPATION** | **PRESENTING PROBLEM** | **NUMBER OF SESSIONS** |
| 1 | F | 53 | BANK MANAGER | PTSD / DEPRESSION | 10 |
| 2 | F | 26 | MARKETING ANALYST | PTSD/ DEPRESSION / OCD | 10 |
| 3 | F | 25 | ENGLISH/ FRENCH TEACHER | OCD/ DEPRESSION | 21 |
| 4 | F | 43 | SOCIAL WORKER | GAD | 12 |
| 5 | F | 27 | NURSE | DEPRESSION | 15 |
| 6 | M | 52 | ACCOUNTANCY DIRECTOR | SOCIAL ANXIETY / PANIC / GAD | 20 |
| 7 | M | 46 | MARKETING DIRECTOR | SOCIAL ANXIETY / DEPRESSION | 10 |
| 8 | F | 24 | IT/ WEB DEVELOPING SPECIALIST | DEPRESSION | 21 |

***Figure 1.2 Phase 2 that utilised an A-C design - Details of the 8 Cases involved***

The sample was selected based on the verbal information gathered during the assessment phase that indicated perfectionism and low self-esteem, as well as on the individual’s baseline measurements. The latter involved minus scores on the DAS; low scores on the Rosenberg Self-esteem scale (Rosenberg, 1986); and high scores on the Multidimensional Perfectionism scale (Frost, Marten, Lahart & Rosenblate, 1990). With regards to the MPS-F, there is no cut off point, the indication for perfectionism relates to the higher scores= higher perfectionism. Exclusion criteria applied in Phase 2 and included:

* Clients where the treatment plan needed to focus entirely on trauma & Post-traumatic Stress Disorder (PTSD) alone.
* Participants where there was no need to focus on perfectionism and low self-esteem, due to low scores in the relevant measures.
* Clients who ‘dropped out of’ therapy on the basis of feeling better, when the treatment protocol was applied.
* Clients whose Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) and Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988) pre-treatment scores were significantly low indicating a mild problem with depression and anxiety respectively.

**4.4 Data Collection and Procedure**

The quantitative part included the collection of a variety of standardised measures used in a pre-mid-post treatment basis (phase 1) and pre-post treatment & 1 month follow-up basis (phase 2). The measures used for Phase 1 were:

Beck Anxiety Inventory (BAI)

This is a 21-question multiple-choice [self-report inventory](http://en.wikipedia.org/wiki/Self-report_inventory) that is used for measuring the severity of anxiety. The items are rated on a scale ranging from not at all to severely. It has good concurrent validity, test-retest reliability and high internal consistency (α = .94; Fydrich, Dowdall, & Chambless, 1992).

Beck Depression Inventory (BDI)

This is a 21-question [multiple-choice](http://en.wikipedia.org/wiki/Multiple_choice) [self-report inventory](http://en.wikipedia.org/wiki/Self-report_inventory), for measuring the severity of [depression](http://en.wikipedia.org/wiki/Depression_(mood)). This has well-known validity and reliability (α = .89, Beck, Steer, Ball, & Ranieri, 1996) and validity (Beck, Steer, & Garbin, 1988).

Dysfunctional Attitudes Scale (DAS)

This is a validated measurement tool, which investigates cognitive distortions and factors that contribute to distress, that is, autonomy, omnipotence, perfectionism, approval, love and achievement. It consists of 35 items rated on a 5 point-Likert scale, ranging from totally agree to totally disagree. This version is a shortened version of the original Dysfunctional Attitudes Scale (Weissman & Beck, 1978). The measure has good internal consistency (α = .70, Hewitt & Dyck, 1986).

In addition to the above measures, the following were also utilised in Phase 2: Rosenberg Self-esteem Inventory

This is a validated measure that consists of 10 items rated on a 4 point-Likert scale. It measures global self-esteem and sense of self-worth. Literature supports this tool’s validity and reliability (α = .85, Blascovich, & Tomaka, 1991).

Multidimensional Perfectionism Scale

This is a validated tool that consists of 35 items used to measure perfectionism in six subscales: concern over mistakes; personal standards; parental expectations; parental criticism; doubts about actions; organisation. The items are rated on a 5 point-Likert scale. Internal consistency ranges from .73 to .93, overall α=90 for the subscales and it has good concurrent validity (Frost et al, 1990).

Perfectionistic Self-presentation Scale (Hewitt et al, 2003).

This is a 27 item questionnaire rated on a 7 point-Likert scale. It has 3 sub-scales: perfectionistic self-promotion; non-display of imperfection; and non-disclosure of imperfection. Internal consistency ranges from .45 for healthy perfectionistic traits and .66 for unhealthy ones and it has good concurrent validity (Hawkins, Watt & Sinclair, 2006).

See appendix 2 for copies of self-esteem and perfectionism measures.

The qualitative data in Phase 3 were collected from semi-structured interviews. Such interviews appeared the most relevant method of collecting data as it is appropriate when using IPA in terms of gaining in-depth understanding of people’s experiences. Smith (2007) argued that

‘*This form of interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of the participants’ responses and the investigator is able to probe interesting and important areas which arise’* (p.57).

Whilst structured interviews are faster, provide greater control, and have been classified as more valid and reliable; they follow a limited procedure, similar to quantitative methods. They appear more relevant to a study that is following an experiment and not necessarily investigating people’s experiences. Smith (2007) argued that structured interviews limit the responses of the interviewee, thus putting at risk the fruitfulness of the information gathered.

‘*The interview may well miss out on a novel aspect of the subject, an area considered important by the respondent but not predicted by the investigator. And the topics which are included are approached in a way which makes it unlikely that it will allow the unravelling of complexity or ambiguity in the respondent’s position’ (*p.58).

The semi-structured interviews lasted approximately 45 minutes. The questions asked were relevant to the research questions and the aims of the present study and they were designed to be as open as possible in order to fully explore the participants experiences.. Please refer to appendix 3 for a sample of the interview questions. The questions were asked in a different sequence when appropriate and additional questions were asked during each interview relating to the information provided by each participant. Occasionally, when appropriate, some closed questions were asked in order to obtain clarification. The interviews were recorded using IPhone technology and then were transferred to the researcher’s computer. The interviews were transcribed verbatim by a professional transcription agency, which ensured deletion of the data once the transcripts were sent in line with the Data Protection Act (1998).

In order to ensure validity of the interviews, the researcher carried out a pilot study, by interviewing two of the clients that participated in Phase 1 and had been discharged 2 years ago. Lancaster, Dodd and Williamson (2004) argue that piloting a study is essential in order to test how long it takes to complete; check that all questions and instructions are clear; and try to expose any items that will not generate usable data. In addition piloting an interview will provide the researcher with more confidence in carrying out the actual interviews.

Apart from one interview, the interviews were carried out in the environment where therapy took place. The other interview was conducted over Skype, as they were unable to travel to the venue. The participants were clear on the procedure and aim and content of the interview. They were provided with documents including the study information leaflet (Appendix 4), the consent form (Appendix 5), etc., a month prior to the interview. On the day of the interview quantitative measures were completed. The whole process lasted approximately 1 hour.

**4.5 Data Analysis**

**4.5.1 Quantitative Data Analysis**

To date there are many different types of statistical methods to analyse data. However, in the case of single case research designs there are two main methods. One is the visual analysis or visual inspection and the other is inferential statistical analysis. The present study could have utilised statistical analysis such as randomisation tests; time-series analysis; analysis of covariance (ANCOVA). In this case visual inspection of the outcome data was chosen as all of the statistical methods were unsuitable given the design of the study. So, for example, t tests could appear useful as they determine whether a specific condition, that is, interventions for perfectionism actually showed significant change for any given dependent measure i.e. Axis 1 disorder. However, there is a great possibility that they capitalize on chance, thus resulting in a Type I error (Nock, Michel & Photos, 2007).

Another method would be the randomisation tests that once they are distributed they can minimise the effect of the serial dependency (Nock, Michel & Photos, 2007). However, randomisation tests where not appropriate in this study as the sample selection was not randomly selected and the treatment conditions were specific (treatment protocol for perfectionism) and not randomly distributed (it was distributed to all participants). In addition, as Onghena (1992) argues ‘*Because of the non-independence of the measurements, parametric statistical tests based on random sampling are inappropriate for single-subject designs in general’ (p154).*

In addition, randomisation could appear more relevant if there were two subject groups, a control and an experimental one, which is not the case in this particular study. Furthermore, randomisation can be considered unethical as in principle the clients are given a treatment that is not their choice (Brewin & Bradley, 1989). Finally, if randomisation tests were utilised that would mean that following each intervention there would be a series of tests to check out the efficacy of the intervention. That could appear too time consuming and it is not the scope to identify which intervention specifically appeared the most effective based on quantitative results, but how effective the overall protocol was. For this particular reason time-series analysis was not utilised either. Analysis of covariance was not relevant to this study as this statistical method is best suited if there is no difference in pre-therapy scores and variables (Nock, Michel & Photos, 2007). Obviously this is not the case with the participants in this research who all had different conditions and scores prior to treatment.

Many researchers argue that the statistical analyses appear to hinder the data valuation process in single case experimental designs. For example Nock, Michel & Photos (2007) argue that

‘*In single-case designs, the data are from a single case (or small group of cases), and there are multiple observations per individual per condition, so the commonly used group design methods are not appropriate’* (p.346)

Furthermore it has been argued that in research, where the psychotherapy outcome is investigated, the statistical change does not necessarily mean clinical significance and does not emphasise the practical importance of the intervention (Jacobson, Follette, & Revenstorf, 1984). Statistical analyses tend to de-emphasise the variability amongst clients. It is not clear who benefitted, who did not, how much benefit was obtained with regards to the treatment etc. (Jacobson, Follette, & Revenstorf, 1984).

For the above reasons the visual inspection or analysis approach appeared to be most relevant for the analysis of the numerical data in this study. Kazdin (1986) argues that visual analysis of data is the process of judging how reliable and effective an intervention/ treatment is by visually examining graphed data. It is classified as an informal process to guide inferences (Wampold & Furlong, 1981). Researchers have advocated that visual analysis should be the main method for single-case design data, because it will highlight intervention effects that are important to clinicians (Parsonson & Baer, 1986). Furthermore it has been argued that visual analysis produces low error rates (Parker & Brossart, 2003). On the other hand though, visual analysis does not come without disadvantages. Several studies showed that the reliability of visual analysis is highly questionable, because they found low to moderate inter-rater reliabilities (DeProspero & Cohen, 1979; Harbst, Ottenbacher, & Harris, 1991).

In order to compensate with regards to the above criticism the calculation of the effect size is important. Mitchell and Hartmann (1981) argue that effect sizes show the strength of association between intervention and outcome. Whilst effect sizes tend to compliment inferential statistics, it appears that if combined with the visual inspection in this research, this would increase the validity of the quantitative data. However, several arguments state that if the sample size is small, anything less than 30 then this will affect negatively the effect size (Hattie & Gan, 2011), additionally it can produce inconclusive results (Cohen, 1965). The present study included less than 30 participants. However an effect size calculation would be relevant if measures were obtained far more frequently, for example on a weekly basis. Then the effect size could probably appear a sound tool to calculate the difference when comparing each week’s results. This relates to a hypothetical aim. For example if the study aimed to investigate which technique appeared more usefull, an effect size calculation would be necessary, following the utilisation of each technique (on a weekly basis maybe). However the aim of this study is to evaluate the effectiveness of a protocol as a whole and not of techniques individually, nor compares two different groups of participants. if there were two different groups to compare, an effect size would appear more relevant since according to Coe (2002) *‘’Effect size quantifies the size of the difference between two groups’’.*

The above reasons justify the use of visual inspection alone.

**4.5.2 Qualitative Data Analysis**

The qualitative data were in the form of verbatim transcripts derived from the original recordings of participants’ experiences of perfectionism, low self-esteem, and the treatment they received. The transcripts were analysed and interview themes were identified. IPA analysis included the close reading and re-reading of the text (Smith et al., 1999). The researcher made notes of any observations and reflections that occurred while reading the transcript. Those observations were recorded in one margin of the transcript. Later on the researcher re-read the text and identified themes (sub-themes) that included the essential qualities of the transcript; these were recorded in another margin of the transcript. The researcher also looked for possible connections between themes.

The next stage involved the clustering or grouping of the identified themes. The aim, at this stage was to arrive at a group of themes and to create master-theme categories. The whole process was repeated afresh with the remaining transcripts. A list of themes was identified for each one. These themes were then drawn together into a combined list. New themes were tested against earlier data and when necessary the original sub-themes, themes and master-themes were modified and grouped accordingly. During this stage certain themes were excluded and only the significant ones that formed master themes were selected. The final stage was to develop a 'master' table of those clustered themes, which was followed by a detailed analysis of each theme combined with representative quotations from the interviews.

Figure 1.3 demonstrates the stages of IPA with regard to identifying themes and clustering them together:

|  |  |
| --- | --- |
| Stage 1 - Descriptive codes | The 1st transcript was read repeatedly and then notes were made in the right-hand margin regarding any initial thoughts that emerged. |
| Stage 2 - Interpretative coding | The 1st transcript was analysed in greater detail, recording more interpretative themes (sub-themes) in the left-hand margin. |
| Stage 3 – Clustering | The sub- themes were grouped together into themes that reflected the connections between them. |
| Stage 4 - Repeating stages | Stages 2-3 were repeated for each transcript until theme clusters for each participant had been generated. |
| Stage 5 - Generating accounts / quotations | All theme clusters were grouped together to identify broad, general and major themes across them.  Looking at one category at a time, the researcher returned to the transcripts to ensure that all examples of the theme had been found and “a ‘complete’ corpus of data” was formed (Smith et al., 1999). |
| Stage 6 - Detailed analysis | The quotes were analysed in more detail and examined to identify if any of these more detailed themes could be grouped together. |
| Stage 7 - Choice of codes and themes | The final stage was to identify which of the themes and sub-themes would be excluded or included in the research on the basis of making a significant contribution to existing literature. |

***Figure 1.3: Summary of the Process of Conducting IPA with Qualitative Data***

**4.6 Ethical Considerations**

To ensure ethical practice throughout, the researcher conducted this research following the Code of Ethics and Conduct (British Psychological Society, 2006) and the Ethical Guidelines (Social Research Association; SRA; 2003).

a. Consent

*‘Inquiries involving human subjects should be based as far as practicable on the freely given informed consent of subjects.’* (4.2 SRA, 2003)

An informed consent form (see appendices 4 and 5) was provided that demonstrated the agreement of participation to the study, which the participants signed. The researcher also signed the consent in order to demonstrate agreement to the terms of the study. The signature is required following the principle that *‘In order to protect the researcher from accusations of failing to ensure informed consent a practice has grown of having subjects to sign the consent’* (SRA, 2003, 4.2).

Participants were fully informed with regards to the nature of the research prior to starting the interview process. The content of the consent included detailed aims of the study and the rationale for it based on the principle that

*‘the subjects should understand what is done to them, the limits to their participation and awareness of any potential risk; the amount of information needed to ensure that a subject is adequately informed about the purpose and nature of the study’* (SRA, 2003, 4.2).

In more detail it included:

• Description of the project/aims/rationale;

• Description of benefits in conducting the research (self/others);

• Description of the anonymity/confidentiality of records;

• Explanation of intervention in case of risk;

• Contact information of the therapist/researcher;

• Permission for the interview to be recorded/audiotaped;

An additional statement explained that participation was voluntary and that refusal to participate would result in no penalty, or loss of benefits to which the subject was entitled, and that participation can be discontinued at any point.

It is important to underline that the participants were asked to participate to the study after they completed therapy and not whilst they were still ongoing therapy. This approach was taken in order to avoid the client thinking that the therapist was biased towards achieving her own goals (that of research). Asking the client, before ending therapy, to consent could put the therapeutic relationship at risk as well as the therapeutic outcome. For example the client could think that if she/ he did not consent, they would not receive the best available treatment; or that he/she is not treated idiosyncratically, but following a specific protocol irrespectively of the client’s problem (s).

b. Deception

*‘To withhold material information from subjects, involves a deceit, whether by omission or commission, temporarily or permanently’* (SRA, 2003, 4.3.d).

The study does not involve any kind of deception and/or hidden agendas. The participants had a clear understanding of the research aims and the procedure involved and in case of any changes made the subject was informed. Following the interview the subject was offered the option to keep a record of the interview transcript. In addition, the subject was presented with the material that will be used in the content of the case study and again was offered the option to agree or disagree as to whether the material could be used.

c. Debriefing

It was proposed that the participants would not need debriefing as this was an interview following a course of treatment. The interview focus was such that it was highly unlikely to create distress. However, in the unlikely event of distress being caused, ‘booster’ sessions with the therapist would be offered free of charge.

d. Withdrawal from the investigation

As stated within the consent form it was clear that a participant could withdraw at any time from the research with no penalty. In addition, in case the participant wanted to stop the process of interviewing, they were informed that they do not have to answer all of the questions. Furthermore, if any distress was experienced during the interview then the process would be stopped and the recorder turned off. Finally, the participants would be presented with the case study that relates to them before submission, in case the subject had disagreements with regards to the content.

e. Confidentiality

*‘Data that do not enable identification should not be passed on without consent and should be stored safely with restricted access’* (SRA, 2003, 4.6)

All the interviews were anonymised and names are not included in the transcript - instead a number was assigned. All names and identification data were excluded from the case studies. The client files are kept in a locked cabinet at the researcher’s home and the researcher is the only person who has access to it. The files, as well as the transcripts, were destroyed after the completion of the thesis. The transcription company used for some trancripts ensured that it is binded by the Data Protection Act (1998). Within the consent it was highlighted that the researcher guarantees that all reasonable steps had been taken to prevent disclosure of identities. Furthermore, the interview numbers do not reflect the participant numbers as described in figure 1.2 in the method section (for example participant 1 is not linked to the first interview, but to a different one) in order to further protect the participants identity.

f. Protection of participants

*‘Harm to subjects may arise from undue stress through participation, loss of self-esteem, psychological injury or other side effects….the interest of the subjects may also be harmed by virtue of their membership of a group or section of society’* (SRA, 2003, 4.4).

As stated previously, it is argued that the interview content was unlikely to create harm and distress to the subject. The risk of harm is no greater than that encountered in everyday life, in terms of probability and magnitude. However, in order to minimise the possibility of distress, participants were informed that they did not have to answer all of the questions. Furthermore, they were aware that if any distress was experienced during the interview then the process could be stopped at any time. In addition the participants were told that if any feelings of distress occurred, they would be taken into consideration and a debriefing/ booster session would be arranged.

In addition, in order to minimise risk, the researcher took into consideration the following:

• The competence and capacity of the subject to communicate

• To understand relevant information

• To appreciate the situation and consequences

• To manipulate information rationally as suggested by Applebaum (1997).

As it could be viewed that there may be a conflict of interest when the clinician assumes both the role of clinician and researcher, it had been proposed that another clinician would undertake the interviews. Unfortunately, despite the attempts of the researcher, this was not possible. Therefore, it was made clear that the research was not being carried out for therapeutic purposes (at the stage of the interview), but in order to generalise knowledge. The consent form acknowledged this, thus the participants were fully informed.

**Chapter 5**

**Results**

This chapter details the results of Phase 1, Phase 2 and Phase 3 of this study. The first section displays the quantitative results obtained from the measures used in the first and the second phases. The second section includes the qualitative analysis of the interviews using the Interpretative Phenomenological Approach (IPA) method. The implications of these results will be discussed in detail in Chapter 6.

**5.1.1 Phase 1: Quantitative Data**

Figures 2.1 -2.13 show individually, the scores obtained from the Beck Anxiety (BAI), Beck Depression Inventory (BDI) and the Dysfunctional Attitudes Scale measures scored by the 13 cases in phase 1. Figure 3.1 shows the mean scores and standard deviations of the BAI and BDI scores. As can be seen there is a significant difference in both the BAI and BDI scores of all participants between Mid 2 point (the baseline prior to implementation of the interventions focusing on perfectionism and low self-esteem) and post-treatment.

**Figure 2.1**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 1, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.2**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 2, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.3**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 3, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.4**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 4, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.5**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 5, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.6**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 6, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.7**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 7, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*.

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.8**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 8, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.9**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 9, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.10**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 10, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.11**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 11, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.12**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 12, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 2.13**

***Beck Anxiety Inventory / Beck Depression Inventory/ Dysfunctional Attitudes Scale Scores – Phase 1***

*Note:**This figure demonstrates the results of the Beck Anxiety Inventory / Beck Depression Inventory & Dysfunctional Attitudes Scale for participant 12, who participated in Phase 1 of this research, which followed an ABAC design.*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline Scores Before the Shift of Treatment Towards Perfectionism*

*The Dysfunctional Attitudes Scale scores indicate:*

–*10= strong emotional vulnerability. + 10 = strong psychological strength.*

**Figure 3.1**

***Mean Scores & Standard Deviation for Both Anxiety & Depression Scores- Phase 1***

*Note: This figure shows the Mean Scores & Standard Deviation for both the BDI- Depression & BAI- Anxiety Scores as obtained from the 13 participants during Phase 1.*

The following figure shows the mean scores obtained from the Dysfunctional Attitude Scale (DAS). Whilst there was already improvement in these scores prior to the implementation of the treatment protocol focusing on perfectionism (and low self-esteem), further improvement occurred post treatment.

**Figure 3.2**

***Mean Scores for the Dysfunctional Attitude Scale- Phase 1***

*Note: This figure demonstrates the Mean Scores for the Dysfunctional Attitudes Scale as obtained from the 13 participants during Phase 1.*

*-10 = strong emotional vulnerability (maladaptive)*

*+ 10 = strong psychological strength (adaptive)*

*Pre = Baseline Before Treatment;*

*Mid 2 = Baseline scores Before the Shift of Treatment Towards Perfectionism*

**5.1.2 Quantitative Data – Phase 2**

This section presents the quantitative data obtained from the 8 participants of Phase 2 of the study. This phase adapted an ABA design, where the designed treatment protocol focused on perfectionism and low-self-esteem throughout. As is shown at the post-treatment stage there was a significant improvement in all areas for the majority of the clients.

**PARTICIPANT 1**

**Figure 4.1 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores - Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 1 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem.*

**Figure 4.2 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 1 during Phase 2.*

**Figure 4.3 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 1 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.4 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 1 during Phase 2.*

**PARTICIPANT 2**

**Figure 4.5 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores – Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 2 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem.*

**Figure 4.6 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 2 during Phase 2.*

**Figure 4.7 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 2 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.8 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 2 during Phase 2.*

**PARTICIPANT 3**

**Figure 4.9 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores – Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 3 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem*

**Figure 4.10 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 3 during Phase 2.*

**Figure 4.11 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 3 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.12 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 3 during Phase 2.*

**PARTICIPANT 4**

**Figure 4.13 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 4 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem*

**Figure 4.14 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 4 during Phase 2.*

**Figure 4.15 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 4 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.16 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 4 during Phase 2.*

**PARTICIPANT 5**

**Figure 4.17 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 5 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem*

**Figure 4.18 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 5 during Phase 2.*

**Figure 4.19 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 5 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.20 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 5 during Phase 2.*

**PARTICIPANT 6**

**Figure 4.21 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores - Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 6 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem*

**Figure 4.22 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 6 during Phase 2.*

**Figure 4.23 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 6 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.24 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 6 during Phase 2.*

**PARTICIPANT 7**

**Figure 4.25 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores – Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 7 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem*

**Figure 4.26 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 7 during Phase 2.*

**Figure 4.27 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 7 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.28 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 7 during Phase 2.*

**PARTICIPANT 8**

**Figure 4.29 *Analytical Scores for Depression, Anxiety & Self- Esteem Scores - Phase 2***

*Note:**This figure demonstrates the results of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from participant 8 during Phase 2 of this research, which followed an ABA design. Scores between 15- 25 = within normal range; scores below 15 = low self-esteem.*

**Figure 4.30 *Perfectionistic Self Presentation Scores for Phase 2***

*Note: This figure demonstrates the analytical scores of the Perfectionistic Self Presentation Scale as obtained from participant 8 during Phase 2.*

**Figure 4.31 *Multidimensional Perfectionism Scale (MPS-F) Scores- Phase 2***

*Note: This figure demonstrates the analytical scores of the Multidimensional Perfectionism Scale as obtained from participant 8 during Phase 2.*

*PRE = pre-treatment POST = post-treatment FOLLOW UP = I month follow-up*

**Figure 4.32 *The Dysfunctional Attitudes Scale (DAS) Scores: Phase 2***

*Note: This figure demonstrates the analytical scores of the Dysfunctional Attitudes Scale as obtained from participant 8 during Phase 2.*

**Mean Scores & Standard Deviation for All Participant Scores**

**Figure 4.33 *Mean Scores & Standard Deviation for Depression, Anxiety & Self- Esteem - Phase2***

*Note:**This figure demonstrates the Mean & Standard Deviation of the BAI, BDI & Rosenberg Self Esteem Scores as obtained from the 8 participants during Phase 2 of this research*

*.***Figure 4.34**

***Mean Scores & Standard Deviation for Perfectionistic Self Presentation Scale - Phase 2***

*Note: This figure shows diagrammatically the mean scores & standard deviation of the Perfectionistic Self Presentation Scale as obtained from the 8 participants during phase 2.*

**Figure 4.35**

***MPS-F Mean Scores & Standard Deviation: Phase 2***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| MEASURES | PRE | | POST | | FOLLOW UP | |
| MEAN | SD | MEAN | SD | MEAN | SD |
| PERSONAL STANDARDS | 35.6 | 3.8 | 23.2 | 3.9 | 21 | 3.5 |
| CONCERN OVER MISTAKES | 37.5 | 8.3 | 16.8 | 8.4 | 13.7 | 4.4 |
| ORDER | 24.3 | 5.2 | 20.1 | 2.3 | 18.7 | 2.7 |
| DOUBTS OVER ACTIONS | 17 | 4.8 | 10.2 | 3.7 | 9 | 2.8 |
| PARENTAL EXPECTATIONS | 15 | 8.3 | 14.6 | 8.6 | 14.6 | 8.6 |
| PARENTAL CRITICISM | 12.1 | 8.1 | 9.7 | 6 | 9.6 | 6.1 |

*Note: This figure demonstrates both as a table as well as a diagrammatic representation, the Mean scores & Standard Deviation of the Multidimensional Perfectionism Scale as obtained from the 8 participants during Phase 2.*

**Figure 4.36 *Mean Scores for the Dysfunctional Attitudes Scale : Phase 2***

|  |  |  |  |
| --- | --- | --- | --- |
| DAS SCORES | PRE | POST | FOLLOW UP |
| APPROVAL | -5 | 2 | 4.2 |
| LOVE | -4.2 | 4 | 4.1 |
| ACHIEVEMENT | -3.2 | 4.2 | 5.5 |
| PERFECTIONISM | -4.7 | 2.7 | 2.7 |
| ENTITLEMENT | 2.1 | 3.1 | 2.6 |
| OMNIPOTENCE | -2.1 | 2.8 | 4 |
| AUTONOMY | 1.8 | 2 | 2.7 |

*Note: This figure demonstrates both as a table as well as a diagrammatic representation, the Mean scores of the Dysfunctional Attitudes Scale as obtained from the 8 participants during Phase 2.*

**5.2.1 Phase 3: Qualitative Data – Overview of Master-themes, Themes and Sub-themes**

The IPA analysis of the 8 interviews identified 4 Master-themes, 20 Themes and 59 Sub-themes. The first Master-theme relates to the experiences of perfectionism and low self-esteem prior to treatment. It identifies how perfectionism and low self-esteem has affected each person’s interpersonal as well as intrapersonal relationships. This is in terms of how they view themselves; how they relate to others; and how they behave in different aspects of their lives such as domestic, family, work, social and personal life. Figure 5.1.1 summarises the findings within this Master-theme.

The second Master-theme relates to the participants’ experience of treatment, in terms of ‘intervention & progress’ (Theme 1) as well as ‘non-technical factors and progress’ (Theme 2). This Master-theme emphasises, which techniques appeared helpful or unhelpful and in what way, as well as, how non-technical factors affected progress. Non-technical factors refer to process issues that emerged with regards to the application of certain interventions, that is, the nature of cognitive-behavioural psychotherapy (CBP), the therapeutic alliance, and finally the pace of progress. See Figure 5.1.2.

The third Master-theme refers to participants’ experiences of change post-treatment in terms of how perfectionism and self-esteem shifted and how this affected areas of their lives. See Figure 5.1.3.

**Figure 5.1.1**

***Master-theme 1: The Effect of Perfectionism & Low Self-esteem Prior to Treatment***

|  |  |  |
| --- | --- | --- |
| MASTER-THEME 1 | THEMES | SUB-THEMES |
| The Effect of Perfectionism & Low Self-esteem  (Pre-treatment) | **Strive for perfection** | * unrealistic personal standards * meeting other's standards * unrealistic standards for others |
| **Promoting a perfect self** | * appearing as perfect * non- display of imperfection * non-disclosure of imperfection |
| **Doubting self** | * self-criticism * self-blame * concern over mistakes * doubts over action |
| **Doubting self in relation to others** | * unfair comparisons |
| **Parental influences** | * parental control * parental criticism * parental expectations |
| **Predicting rejection** | * self- fulfilling prophecy |
| **Lack of autonomy / dependency** | * lack of assertiveness * pleasing others * need for approval |
| **Dysfunctional relationships** | * wrong choice of people * conflicts with others * inability to leave relationship |
| **Coping strategies** | * avoidance * procrastination * overcompensation |

**Figure 5.1.2**

***Master-theme 2: The Experiences of the Treatment Protocol for Perfectionism & Low Self-esteem***

|  |  |  |
| --- | --- | --- |
| MASTER THEME 2 | THEMES | SUB-THEMES |
| Experiences of Treatment  Technical Factors | **Gaining insight & understanding** | * formulation |
| **Cognitive techniques** | * thought challenging * continuum * cost / benefit analysis * positive data log * compassionate mind training |
| **Behavioural techniques** | * exposure * behavioural experiments * assertiveness training |
| Experiences of Treatment  Non-Technical Factors | **Organised / educational nature of CBP** | * agenda setting * writing |
| **Therapeutic alliance** | * collaboration * trust & warmth |
| **Pace of progress** | * sudden change * gradual change |
| **Process issues** | * the perfectionist client * process with formulation * process with positive data logging * process with compassionate mind training * process with assertiveness training * therapy challenging control issues |

**Figure 5.1.3**

***Master-theme 3: The Shift of Perfectionism & Low Self-esteem Post Treatment***

|  |  |  |
| --- | --- | --- |
| **MASTER THEME 3** | **THEMES** | **SUB-THEMES** |
| **The Shift of Perfectionism and Low Self-esteem**  **(Post Treatment)** | **Managing perfectionism** | * balanced standards * decreased doubting actions * managing overcompensation |
| **Self-compassion & acceptance** | * not criticising self * not blaming self * disclosure of imperfections * recognising achievement * accepting perfectionistic traits |
| **Increased self-worth in relation to others** | * not seeking approval * not pleasing others * increased assertiveness * increased autonomy / relying on self |
| **Better quality in relationships** | * protecting self from unfulfilling relationships * establishing fulfilling relationships |

In the following sections the results related to each Master-theme, Themes and Sub-themes will be reported in greater detail. As it is not possible to include a wide range of participants’ responses a small sample will be included. Additional supporting responses can be found in appendix 6 and the full interview transcripts in appendix 7.

**5.2.2 Master-theme 1: The Experiences of Perfectionism and Low Self-esteem**

**5.2.2a Theme – Strive for perfection**

Sub-theme: Unrealistic personal standards

All participants were preoccupied with achieving perfection and they were motivated to achieve excellence, by attaining unrealistic goals and expectations that were imposed by themselves. Seven out of eight participants disclosed that they were setting unrealistic standards for themselves. These standards strongly influenced the participants’ lives, by driving them to become the best of the best in different areas and roles in their lives.

Seven out of eight participants appeared to hold unrealistic personal standards. For most of these participants, one area where personal unrealistic standards appeared to have a significant impact was within interpersonal relationships. They strived to be ‘perfect’ in relationships within the family, social, professional and romantic arenas:

P1: *I think I definitely strive to be like the perfect daughter (L214)…I guess I was kind of always looking for the perfect friendship* (L134)

P3*: I was stuck in this I’ve got to be perfect …*(L481)

P4*: I was so concerned with being a perfect friend or… connecting with people perfectly, whatever that means.* (L213)

P7*: In terms of the relationship with my family, my children and my wife... I used to be very....I tried to be, you know, the perfect dad* (L137)

P8*: I would always try and be the best daughter in a sense, and took on a lot of responsibilities at a very early age. That would cause me a lot of stress and anxiety, and trying to do everything without supervision. Trying to do everything very quickly, trying to grow up, and when I couldn’t I just felt like a complete failure towards my family and relatives and my parents* (L118).

Sub-theme: Unrealistic standards for others

Three participants held high expectations of others. These would lead them to reject people and/or appear judgemental towards them, thus experiencing loneliness and rejection themselves (P 3 & 4). Or in the case of participant 8, this tendency would lead to overcompensation.

P3*: I would also put people in categories so if someone, if someone was an alcoholic then I would almost demean them... because my head would say “well just stop” so for me that would stop me drinking at all. If someone told a lie then I would feel the same* *because to me it is not ok to tell lies so I would get myself in trouble for telling the truth* (L100)

P8: …*when other people would slip up or not do something to my standards, again I would feel disappointed in them, or disappointed in me for not having explained. Or not having done it myself* (L94).

Sub-theme: Meeting other’s expectations/standards

For most participants another motivator in striving for perfection was to meet other people’s expectations. An interesting finding was that, in most cases, the participants would assume that other people held high expectations of them, which was not necessarily true (P 4 & 6):

P4*: I am quite feminist and, you know, in principle I feel it is important to be your own person but I think sometimes I ended up doing what I think men wanted me to do and dressing how they wanted me to dress because....you know....I felt I needed.......you know...I lost a lot of weight because I felt I needed to follow this perfect model* (L232).

For participants 1, 2 and 7 others did appear to have high expectations of them, often deriving from the parental influence and the standards they held for the participants as children, or from the marital environment as in the case of participant 7. For participants 1 and 2, the parental/family influence appeared to be crucial for the development of unrealistic personal standards; the need to meet parental expectations in order to maintain acceptance and approval.

P1: *before I was always, yeah thinking, you know, I’ve got to do better for my parents really.... and they also, they kind of made me feel like that really* (L213)

P2: *I think probably a lot of it was caused by my family life anyway ....so I felt I needed to be perfect to meet certain members of my family’s expectations......but then obviously the more you do that seems perfect, the more you feel like you have got to do so you’re just never reaching the goal of being what you deem to be perfect and then I think it just kind of overwhelms you because you feel like nothing is ever good enough and you can’t ever get to that perfectionism*(L125).

Participants 3, 4 and 6 provide a different picture by taking full responsibility regarding the development of perfectionism in terms of holding high personal standards. One could argue that the reason behind this responsibility is that the participants could feel guilty to argue that their parents were responsible for the pressure they experienced in their lives due to perfectionistic standards. Another reason could be lack of awareness and insight and another could be other societal factors that were not identified in the interviews:

P3*: yet there was no pressure from them (parents), they have accepted every one of us for who we are. So it was me not them and it was me who that was kind of saying I have to do this I have to be this person I have to let everyone like me I have to do everything like me... I just had to be this perfect person* (L484).

P6: *I went back and looked at a drawing I did of a HST, a high speed train, and it is absolutely immaculate and I did it when I was about 13 but that self-pressure I would say that has really come from myself wanting to achieve things, wanting to be seen as a success. I don’t believe it has been.... instilled in me by necessarily any one person or parents or family* (L36)

Participant 8’s comments provided another perspective, that is, the absence of role models and guidance resulted in her feeling ‘neglected’ and reinforced the development of high personal standards as a way of not disappointing herself.

P8: *I think a lot ties from my family background, my parents were the exact opposite. That led me to over compensate by trying to be a perfectionist, trying to achieve everything that they couldn’t. Trying to get out of a small town with a lot of problems, and no role models, as in career wise, the more you can achieve the better* (L240)

**5.2.2b Theme – Promoting the perfect self**

Sub-theme: Appearing as perfect

Aside from the unrealistic perfectionistic standards that need to be attained, some participants were also preoccupied with appearing as ‘perfect’ towards others. This process is far more interpersonal than meeting personal or other’s expectations/standards, as it involves a direct relation with other individuals and the need to promote an ideal image specifically in social situations. The main drive behind the process of appearing perfect appeared to be the fear of judgement and rejection by others. According to the participants this ideal/perfect self could be achieved, either by trying hard to ‘appear perfect’ (sub-theme 1); or by non-disclosing (sub-theme 2) and non-display of imperfections (sub-theme 3). Regarding the need to appear perfect, participants 3 and 4 stated that it was a big part of their social life, either by appearing as a person in control with no weaknesses (P3) or as the most sociable friend (P4).

Sub-theme: Non-disclosure of imperfection

Only participant 3 stated that in order to maintain a ‘perfect self’ she was avoiding disclosing any information that could potentially show her as a person who was weak, not in control, and to her own understanding, a person who is not perfect. Control issues were not only apparent with this particular participant, but with others also. Often the concept of ‘being in control’ appeared relevant to ‘being perfect’. Once again, the motivator of not disclosing imperfections was not to be negatively evaluated:

P3: *I would not tell people things, particularly if it would make me seem like........so for instance no-one knew how I was feeling when my dad died, no-one knew that I was scared to drive around the island where I had the crash because I thought if I told them then they would think I was weak (* L137).

Sub-theme: Non-display of imperfection

For four participants another strategy of appearing perfect and convincing others that they are ‘good enough’ was not to show ‘weakness’ and ‘imperfection’. Often non-display of imperfection was accompanied by avoidance - all participants would avoid social contact, and in one case (P2) learning skills, when they thought that they would not be able to portray the ideal image they had in their mind. One participant used alcohol as a coping strategy to cover ‘weaknesses’ (P6):

P2: *not wanting to look stupid doing something that I knew I couldn’t do for example, I suppose playing some kind of sport, I would never have dreamed of doing because I am not that good at that kind of thing* (L86)

P3*: I would avoid, again I wouldn’t be seen with no makeup, I wouldn’t be seen anywhere in my house where it wasn’t, where everything was perfect, I would never say bad things in front of them. I would never ever ever swear in front of them, oh dear now I do,..... I just had to be this perfect person* (L81)

P6*: I couldn’t hold the glass, and I had to make an excuse to go out and I had two pints of cider in the pub next door to calm my nerves and came back* ( L77)

**5.2.2c Theme – Doubting self**

All of the individuals had the tendency to underestimate their abilities, be extremely critical of themselves, and doubt their performance. It was apparent that all participants would engage in maladaptive thought processes by doubting themselves. This resulted in further maladaptive behaviours, such as overcompensation and avoidance. In addition they would experience unhelpful emotions such as worry, guilt and disappointment. This theme includes three sub- themes: ‘concern over mistakes’; ‘doubts over actions’ & ‘self-criticism’. Often the sub-themes overlap with others that are included in the theme ‘coping strategies’.

Sub-theme: Concern over mistakes

All participants appeared to be concerned over making a mistake. They would catastrophize with regards to the consequences of making a mistake and predicted that it would be perceived as a sign of failure, leading to criticism and rejection by others. It is apparent that often the mistake was not a factual one, but what the individual perceived as a mistake, based on high expectations and standards. For participant 1, the concern over mistakes was translated as a sign of inadequacy visible to others and a way of undermining performance, even if it was 100% adequate:

P1*: if I harp on about the things I haven’t done right then obviously it undermines what people are thinking of my work* (L126).

P7*: I was so wrapped up with work and worries about work, worries about making mistakes.....that when I got home I had still got all these thoughts in my head* (L7)

Worry appeared to be the predominant experience linked with concern for mistakes. In addition, worrying over making a mistake was often linked to interpersonal relationships. The participants worried that their ‘perceived’ mistake could cause offence, harm and disappointment to others. This was particularly the case for participants 2, 5 and 8.

P5*: Everything domestically would make me stop and think, everything from the smallest task to the biggest task. I would have to very carefully think what I was doing...* (L96) *...because I feared if I did something wrong then it would cause harm* (L101)

P4*: if ever something I said came out ....not quite the way I intended it I would just obsessively worry about it and worry that it had hurt someone’s feelings, that I had sounded awkward and....you know....yeah...every conversation I had was just....it never lived up to my feeling of what it should be ..* (L200)

P8*: If I couldn’t be there for my friends and family and everything, I would feel disappointed in myself that I hadn’t done the best I could* (L90).

In addition to interpersonal relationships, worrying over a mistake was often linked to performance, specifically not maintaining an ‘adequate’ performance:

P7*: what I used to do if I felt something had gone wrong or I was overly worrying about something I would completely go into a blind panic ok, and I would think of loads of.....like I said earlier....loads of other things....I would then start thinking about other clients and have I got that wrong on other clients and so on and then really start to beat myself up about the whole thing* (L351).

Only one participant appeared not to be concerned over mistakes the way others were. Participant 6 provided a different approach to concern over mistakes, by stating that he would admit them openly. It can be argued that this was a strategy to lighten up the ‘significance’ of making a mistake, as this is an individual who would often use sarcasm as a way of coping with ‘heavy’ situations and the possibility of being judged by others:

P6: *about admitting mistakes, I have always actually quite happily admitted mistakes because I like to make people feel comfy and that is a human side of things, but ultimately I glamorise them and make them.....if you like...how would you say....make them an excuse.* (L107).

Sub-theme: Doubts over actions (linked to overcompensation)

Five participants disclosed that when they were presented with a task they would be excessively concerned with doing it just right and not making a mistake. This sub- theme differs from ‘concerns over mistakes’ as this thought process would occur in order not to make a mistake in the first place. It is noted that there is an overlap between the sub-themes ‘doubts over actions’ and ‘overcompensation’ as these participants would engage in overcompensation. The latter involved repeating tasks, reviewing them repeatedly, and generally overworking, which refers back to ‘striving for perfection’. The difference here is that participants were not motivated by the need to achieve, but by the fear of failing. The main area of concern was that of work/education:

P3*: I would repeat tasks, I would knit something and then undo it all and repeat it and everything just had to be ...and my house has to be perfect* (L116)

P4: *I would read obsessively for an essay until the very last minute because I would be so scared of actually doing the work and I would always then, you know, be sort of racing against time and feeling that no matter how much I worked I never seemed to get anywhere* (L74)

P5*: …confidence that what I was doing on simple day to day tasks was right, that I was doing tasks correctly …I wasn’t confident that what I was doing was right either so if I had felt more confidence as a person I presume I wouldn’t have needed to have had this behaviour and repeat things and keep checking myself all the time because I would have just believed myself and understood myself and not had this behaviour* (L35).

Overcompensation had one main function, that is, to provide the participants with the reassurance that they had achieved the best they could; that they avoided potential mistakes; and avoided as much as possible the occurrence of a possible failure. However, the down side of overcompensation was detrimental to these people’s lifestyle and also well-being. Almost all participants recognised that they fell into the trap of living an exhausting and limited life like participants 3 and 4 by sacrificing pleasure over work:

P3: *I would miss out on things because I would think I can’t go there because I have got to do this( L131)… I suppose I realise that my life was just work and getting everything perfect (L206)…. I wouldn’t allow myself time to sit and watch TV or listen to the radio or put a film on, I always had to be doing something to make sure everything was perfect. …spending more time sorting my life out to be perfect than actually living my life* (L280)

P4*: it was just this obsessive working that somehow felt like it was never achieving its goal...you know....I just.....you know...I just felt I had really no....not very much mental energy for my family you know....you know...I would avoid visiting them really....you know I would always be busy....you know...I would sort of miss parties or gatherings when they were all meeting up* (L241).

When she said *‘felt like it was never achieving its goal’*, she implied that despite overworking it felt that still all this work was not good enough, in addition it often reinforced beliefs that she was a failure. This is a paradox and in a way a ‘self-fulfilling prophecy’, since overcompensation, instead of decreasing self-doubt beliefs actually reinforced them. One of the main contributors to failure was tiredness and this was the case with other participants too:

P6: *it made me overwork, I did far too many hours….driving 70,000 miles a year, working 90 plus hours a week, not sleeping, doing 72 hours without sleep just to keep a job going, things like that ….. also must have affected me mentally because ultimately it’s, you know....you are just putting yourself under more and more stress, pressuring yourself to achieve more and more and ultimately I’ve paid a big price* (L19)

P8*: I didn’t sleep much, and I just constantly kept working and working, and my mind was always on work and achieving things …I just constantly found I didn’t have enough time to do things, and it just made me very tired… Sometimes that caused me to fail instead of succeed* (L70).

When participant 6 mentioned ‘*ultimately I’ve paid a big price’*, he refers to the fact that due to overcompensating, he exhausted himself to the point where he actually resigned from his job and fell into depression. Similarly participant 2 experienced depression due to stress resulting from overcompensation, which ultimately affected her job too. Once again, the paradox of overcompensating in order to avoid failure, would lead to potential failure:

P2: *I did sort of probably have a tendency to take more time off sick than I do now partly for the low self-esteem, partly probably because I was quite depressed* (L26).

Sub-theme: Self-criticism/blame (linked to avoidance & procrastination)

All of the participants engaged in critical self-talk. Often their perfectionism was fed by self-criticism: they would undermine their achievements and focus on their perceived ‘flaws’; had a distorted view of themselves, and judged themselves in a harsh manner:

P1*: I really am quite critical of myself, even if I do a good job I always just focus on the things that I haven’t done or that I could do better* (L121) *I can remember at college I got 100% once in an exam and even then it was like “oh but I didn’t do something else well” or “I didn’t do this well”* (L372)

P4: *I had a lot of very negative self-talk, I very firmly believed that I was very boring, unlovable, that I was incapable of sustaining conversation with other people and I sort of had this, you know, conception from a very young age that I was very different and that no-one could understand me and that I would never ever make friends and this really impacted on my life as I started to grow up* (L29)

What participant 4 meant by saying ‘*this really impacted on my life as I started to grow up’* is that when individuals engage in such harsh internal conversations, this affects their motivation to try new tasks and challenge themselves, which further undermines their self-esteem.

The results of critical self-talk were avoidance, or procrastination, out of fear of failing and/or not meeting their standards of achievement. This again fitted with a self-fulfilling prophecy, where the participants would fail, thus reinforcing their self-perception as ‘worthless’ or ‘failures’:

P2*: just avoiding things, like I wanted to do my degree and I think I avoided it....for various reasons....but perhaps that was one of them, wondering if I would be able to do it to the standard that I wanted to* (L104)

P6: *it, played a very negative part in terms of I have always got 98% of the way there and then the fear of failure or the perfectionism has probably prevented me from just taking it that step to completion really* (L13)

Here participant 6 suggested that when complete avoidance was not a strategy to cope with fear of failure, procrastination would take over. People would put off, or even give up, the completion of a task thus reinforcing self-doubts beliefs. Participant 7 provided a clearer account of this:

P7: *procrastinating is one, which used to cause me an awful lot of problems was putting things off, ok, things that I was worried …I was just worried about doing it, about what they might come up with and so on and so forth and that would then play on my mind because everything else I was doing I was still thinking about that phone call and it could have been several phone calls and I would put them off and put them off and it would all build into this confusion in my head* (L520).

Self-criticism appeared to have affected the majority of the participants’ interpersonal relationships, as they avoided socialising out of fear of negative evaluation and/or rejection. The result was to experience isolation both in a social, as well as a personal, level:

P2: *just avoiding situations with other people really, avoiding going out and being around too many other people* (L66)

P4*: I just became ...sort of really scared of physical intimacy..... I had too much sort of anxiety about it and just felt like I would be scrutinized and that I would, you know.....somehow not.....not be kind of....I don’t know....not be able to do things or just not know.....yeah or just somehow be disappointing, yeah I was convinced that I would be disappointing and so I just completely, I avoided for about 3 years maybe, any kind of contact with men* (L103)

P5: *Because I was berating myself all of the time, I was in a bad mood all the time and I was, you know, that obviously impacts on how I interact with people if I am in a bad mood* (L554)…. *very limited social life...very limited. I didn’t go out ...as much as I should have done and when I did go out I was so frightened that I didn’t particularly enjoy it and things like that so....yeah limited social life* (L45)

In the case of participant 7 this resulted in conflict and friction within existing relationships

P7: *well that led to a lot of friction because ...my wife who is at home most of the time wanted to talk more in the evenings and go places at the weekends ...... and I didn’t want to because I was becoming withdrawn....over a long period of time, not just a few months, it was years.....and so yeah it had a very negative affect on our relationship* (L61).

Limited data were identified that could provide evidence with regards to the origins of self-criticism apart from the comments made by participant 1:

P1: *like with my parents and how like from a child basically, how the way they talked to me and how they treated me… my parents were critical of me kind of, when I did do things wrong. Highly critical really and people have commented on that before ….and although they had the best intentions some of it was like a blame thing, they used to like blame me and it helped me kind of create this critical self-talk really* (L255).

This participant provides a very clear account as to how early life experiences and critical parenting can affect the way people view themselves in later adult life. It is interesting that when the participant says ‘*and although they had the best intentions’* it seems that she feels guilty for admitting something that does not favour her parents. This can be the sign of a person that learned to blame and be judgemental towards herself and feels guilty if she blames somebody else, even if this is a matter of simply stating a fact.

For some other participants, self-blame was another process they would follow to undermine themselves, because it would fit with their belief systems of not being good enough, thus it could not be anybody elses fault, but theirs:

P2: *I used to blame myself a lot for the relationships and the way that they were and the fact that they weren’t good ... and feel that it was down to me and that I was doing something wrong* (L278)

P4: *I would have a tendency to see everything completely as my own fault, you know, any situation, even situations out of my control* (L573).

**5.2.2d Theme – Doubting self in relation to others**

Many of the themes and sub-themes identified so far show what a strong significance interpersonal factors play for perfectionistic individuals and how their perfectionistic traits and low self-esteem interfere with their relationships with others. What was noted though is that the relationship with others interferes with perfectionism and low self-esteem too. It was apparent that self-doubt beliefs were reinforced and strengthened by individuals engaging in unfair comparisons with others (sub-theme), which most of the participants did. Their perception was such that they would put others on a ‘pedestal’ and see themselves as being in a ‘lower position’. They focused on the perceived strength/successes of others and compared them to their ‘perceived’ weaknesses. It appeared that the participants’ perception was biased and selective. Their attention was focused on their negatives (or perceived negatives), because they fitted with their belief systems about not being good enough. Once again, this process of unfair comparisons would reinforce self-doubt beliefs and respectively perfectionism and low self-esteem. This was certainly the case with participants 1 & 2:

P1: *the fact that I was looking for a certain type of friend and this person would be completely different to me really and I seemed to think that that was a great thing, that I want to be this perfect person like them and really it’s like me focusing on my negative parts ...and then going and, you know going and finding friendships with people that have like the strength in the areas that I have weaknesses in, almost in seeing them as the perfect person* (L140)

For some participants, the assumptions made following the comparisons, would operate as evidence that people would reject/judge them because they were not good enough. For example:

P1*: I was putting myself I guess on a lower level than them and then also that affects how they think of me because if I start thinking that I am like down there then other people judge you by that and they also think that, you know, that you’re not important really or I can kind of, I don’t know, treat you how I want to treat you* (L151)

P2:*I think comparing yourself to other people all the time, not thinking you are as good as other people, not believing that people really like you or love you, expecting them kind of go off and betray you or leave you and that’s it really I think* (L42)

The above participants and participant 4 eventually engaged in avoidance behaviour. Sometimes, they would overcompensate because of the antagonism they would experience following the process of unfair comparisons and the need to ‘prove’ that they were good enough.

There is only one account that provides some evidence with regards to possible origins of unfair comparisons with others. Participant 4 identified that having high achieving role models in their family influenced the development of perfectionism:

P4: : *my family is very high achieving ...you know....my brother is very musical and my sister is now a high flying doctor and you know is very intelligent and I think a constant comparison with my brother and sister made me very.....feel very negative(L120)…. I never really felt like I had fully formulated myself as a person, I always felt like a shadow of my mum or my sister, you know, an inferior shadow and so I never really felt like I could go and make friends on my own accord* (L83)

**5.2.2e Lack of autonomy/dependency**

So far it has been apparent that perfectionism and low self-esteem are not concepts that are based on one dimension, that is, the relationship to oneself. Interpersonal relationships often reinforced and maintained perfectionistic traits and the sense of low self-worth. The analysis of the interviews revealed that perfectionism and low self-esteem were often identified by the participants need to ‘please others’ and ‘seek reassurance & approval’. The associated behaviours were identified as ‘lacking assertiveness’ and a tendency to behave in a ‘needy’ manner by relying on others. These findings could lead to the conclusion that the need for approval and belonging can be a major motivator of perfectionism and low self-esteem traits, as well as maintenance factors.

Sub-theme: Pleasing others

Almost all participants wanted to please others. This need often derived from their fear of being rejected and ending up alone. It was frequently identified that pleasing others was linked to overcompensating in order to meet other people’s needs and putting themselves in an inferior position. Low self-esteem reinforced this kind of behaviour. Most participants, because they thought they were not worthy of other people’s attention, held the belief that they should ‘buy’ their friendship and love by pleasing them. Certainly that was the case for participants 4 and 8:

P8: *Sometimes I overpowered friendships to compensate for the low self-esteem, and other times I would just be more dormant and always be there for my friends. So they wouldn’t run away (L25) I would try and do everything for them, and always be there, and always think I could find the solutions. So it was another way of letting them attach themselves to me* (L28)

Participant 3 provides some evidence of this behaviour being learnt from her early childhood because she had tried to please her parents - behaviour that as identified previously was generalised to other people:

P3*: I have been like that since a child and I always did that to please my mum and dad and yet there was no pressure from them, they have accepted every one of us for who we are*. (L483)

Sub-theme: Need for Approval

Two processes appeared to occur that reinforced participants need to please others: one is the fear of ending up alone because they felt unworthy; and the other, a need to seek reassurance that they were not unworthy:

P4*: I had just become very negative about myself all of the time and you know, not particularly good company for my family, just very needy and they would have to reassure me all the time that I wasn’t, you know, an awful person and that I wasn’t a failure* (L333)

Participants would often engage in seeking reassurance, because of an excessive need for approval and eventually ended up pleasing others and living a life for others, often with the cost of appearing too ‘needy’:

P1: *my behaviour was affected by me becoming quite needy, quite reliant on their approval, ...reliant on what they wanted to do really rather than what I wanted to do myself...gosh the list could be quite endless here!! But ...basically it made me kind of live my life almost for them rather than myself or rather than for us together* (L65)

In contrast, participant 2 stated that need for approval did not contribute to her need to please others:

P2*: I don’t think I ever really needed their approval, I just had this need to please them and do the right thing by everybody else but then I wasn’t doing it for myself* (L175)

From different accounts it was obvious that this participant was concerned with appearing perfect, thus she did not engage in overt reassurance seeking as this undermined her ego and showed to others that she did not believe in herself.

Sub-theme: Lack of assertiveness

Lacking assertiveness was a characteristic of most participants. They did not feel entitled to express opinions; say no; set boundaries due to their self-doubt beliefs and sense of unworthiness. Lacking assertiveness was apparent in many different areas of their lives, which was linked with overcompensation due to participants’ inability to say no, but also due to their need to appear ‘good enough’ and fulfil their perfectionistic standards. For example:

P3*: I would take on extra jobs which meant I worked late which meant I didn’t have time for a social life and then I would get put upon because I don’t say no* (L168)

P8: *Lacking assertiveness, yes I would always say yes, and always try to find all the solutions for everyone (L98) Instead of delegating or saying no, I would just take everything as my responsibility and try and get it done as quickly as possible, and as well as possible (L81) …Therefore I took on more responsibilities, instead of handing them over to the appropriate people* (L20)

P6*: in many ways I made a rod for my own back because I worked so hard and so intently that ultimately I became the channel for any crap that went on was given to me to deal with and, you know, it was a big price to pay* (L140*) I put it down to loyalty because I did have a very good relationship with my boss but he was the one that was piling all the crap on me and so....I don’t blame him in any way because I wouldn’t....I just used to say yes and so he’d go “right, well xxx will deal with that, xxx will deal with that” but ultimately I didn’t take the right steps to stop that from happening or to move myself on professionally* (L149)

Furthermore, lacking assertiveness was driven by the fear of creating conflict and the participant’s lack of confidence to stand up for themselves. Feeling ‘not good enough’ would make people behave in a passive way, often accepting behaviours that would undermine their self-esteem. Once again people would find themselves trapped in a vicious circle where, because they did not want to appear not good enough, they would tolerate behaviours that made them feel not good enough, which strongly relates to the Theme of dysfunctional relationships:

P1: *… I did lack assertiveness but that was......intensified really by the fact that they didn’t want somebody who was assertive and I ended up having to give in to them to keep them happy all the time and I think that in the end you can’t reason with somebody like that* (L192)

P7: .. *in the past I have always felt like I have been doing everything not to upset everybody else, everything I have done has been to not be a failure, to not cause people problems…and to be something I am not..*.(L435)

The above process had a major effect on certain participants as it made them stay in unfulfilling relationships that did not serve any good to their low self-esteem:

P6: *I also ended up in a relationship with a lady who I should have finished....I should have been assertive and finished the relationship a long time before I did. I did get the courage to do it but it was ultimately....you know, it caused a lot of damage to her and me I believe because the relationship wasn’t going anywhere and it wasn’t fulfilling either of us and ultimately, we are still friends now, but you know, it wasn’t where either of us should be and I think I knew that and I should have been far more assertive about it so in my personal relationships, that’s really* (L47)

**5.2.2f Dysfunctional relationships**

Closely related to the Theme of lack of autonomy/dependency, etc., it appeared that participants were falling into a vicious circle, where by seeking reassurance and approval, this reinforced their negative beliefs about themselves. The reason behind this was that they could be seeking it from the wrong people, such as, participants 1 and 2:

P1*: I kind of looked to these people that you know I thought was confident and strong people and I kind of looked to them for approval a lot and often that really wasn’t the case… They were often kind of the wrong people really that I chose to be friends with*… (L22)

P2*: I used to seek approval of my grandma in particular, all of the time and think nothing that I, personally, ever did was ever going to be good enough for her* (L383)

Or, because this ‘needy’ behaviour would provoke conflict as people would feel ‘fed up’ with having to reassure others like with the case of participant 4:

P4: *I remember one phone call with my sister where she you know, I was just having a crisis, another crisis and needed to phone her and she just said, you know it can’t always be one-sided, I can’t always be just.....you can’t ...always....I can’t remember what she said but you can’t always rely on me like this all the time, for all of your crises, you know, it’s too much pressure* (L441)

Participants would choose the ‘wrong type’ of people, because this would fit with their belief systems. They would choose people that often would reinforce their negative beliefs about themselves exactly because they felt they were not good enough, thus they would allow people to treat them as if they were not good enough further falling into the vicious circle:

P8*: I would always be with the inappropriate people.* (L34) *People who also had either low self-esteem or a complex of being negative instead of positive towards their life..(*L36)

Participant 1 explains further that choosing people who would reinforce self-doubt beliefs was a familiar process that, despite how painful it was, the partner choice fitted with their belief system: they would find their relationship exciting and even passionate. On the other hand, a relationship with someone who would treat them with respect could appear boring possibly because they would not trigger the fear of rejection and disapproval:

P1*: I would say at one point that sort of person (someone who would treat her with respect) I wouldn’t have gone out with and I probably you know, I just wouldn’t have been interested because he didn’t challenge me and because he didn’t tap in, and I did learn about this in therapy, he didn’t tap into like my core beliefs and things like that ...so yeah I wouldn’t have found him exciting or anything and I probably, you know, I probably wouldn’t have wanted to go out with him because if he liked me too much or whatever else. It’s made me realise that I wouldn’t, you know, I probably wouldn’t have been attracted to him* (L334)

**5.2.3 Master-theme 2**: **Experiences of Treatment**

This section will cover the Themes and Sub-themes identified both in relation to technical and non-technical factors (see Figure 8.1.2, p…). In response to the questions related to which techniques were useful and which ones not so useful, almost all participants responded that nothing appeared unhelpful. This is a very promising introduction as it appears that the proposed treatment protocol can be helpful for people suffering from perfectionism and low self-esteem. Examples of some of the comments are as follows:

*P 3: I didn’t find anything not useful, but there was always the ones that were better than others but there was nothing that was un-useful because they all kind of followed a logical sequence so you know starting off with things and moving on to them so nothing was not useful at all (L570)*

*P 8: I found working with exercises was very efficient; it helped me push things more faster. Knowing how things - where things derive from, and finding coping mechanisms for my traits like how to actually make perfectionism a positive thing instead of a negative thing. Basically everything (L253)*

**5.2.3a Gaining insight and understanding**

Sub-theme: Formulation

All participants stated they had benefited from the psycho-educational phase of the treatment protocol. Most of the participants were aware of the nature of their presenting problem(s) but did not understand the driving force, that is, perfectionism and low self-esteem. Gaining greater understanding of these concepts through the longitudinal, idiosyncratic formulation normalised the participants’ difficulties and provided them with a sense of control as they began to understand what was going wrong and, which factors were maintaining their problems, thus they could work towards a more positive shift:

P1: *that did help me because it was like your thoughts and tapping into the core beliefs and the model did help me realise in my mind you know, what is happening and as to how I am thinking and why I am feeling like a certain way...* (L644)

The majority of participants found the understanding of schemas very intriguing and helpful. Because of the unconscious nature of schemas people used to find it difficult to understand how core beliefs and schemas could be triggered in the present, despite being established in early childhood:

P6: *once I understood what was actually happening because for me, the whole thing was just a completely new experience...it was like “whoa what the hell is going on here” because I just didn’t understand…once I understood it enabled me to actually start to habituate, to socialise again, to start doing things that I had withdrawn from probably, not completely necessarily but you know* (L304)

P7: *I mean the basic stuff about the core beliefs, that was useful to understand where it came from and I can understand that (L586) so you know, why did I feel a failure, why did I have low self-esteem, where did that come from was a starting thing* (L476)

The formulation appeared to be helpful in terms of normalising people’s behaviours and challenging self-blaming attitudes as per participant 5 comments:

P5: *You made me realise that people do things because of, you know, what they have experienced in the past but probably more importantly you made me realise that experiences, you don’t have to blame anybody for them and they just happen and some people react to them in ways....and you don’t have to, you know......(L179)*

Additionally the formulation appeared helpful in terms of understanding other people’s behaviours too. This appeared crucial when cognitive techniques were later on introduced as it helped participants to experience ‘distancing’ when working on personalisation errors:

P1: *I guess it’s good knowing that when you are in like a real life situation because you think back to why, you can understand why you behave in a certain way and also maybe why other people are behaving in a certain way as well* (L449)

**5.2.3b Cognitive techniques**

Sub-theme: Thought challenging

A major part of the therapeutic plan was to apply cognitive techniques in order to challenge core beliefs in relation to perfectionism and low self-esteem. The use of thought records was applied in order to challenge ‘I am’ statements in relation to a present situation. For example ‘I am rejectable because my friend refused to see me today’. Some representative examples from the participant’s indicated that the thought challenging promoted positive thinking. Participant 5 mentions the possibility of a relapse to old ways of thinking, however, this appears to be a balanced way of thinking as opposed to negative:

P5*: I think the cognitive stuff, the switching from the negative thought about what I am doing to looking at the positive thought of what I am doing was.....I know that I am just in remission, if you like, and I know that I am susceptible to relapses but as near to that as possible, that has cured me* (L267)

P7: *that was the core message to understand but it was the breaking it down was the....it was challenging is the word, it was challenging all those beliefs and all those thoughts that I had built up in my head (L588) I thought this was a useful exercise, to look at individual cases and again where I thought I had done really badly on something...again, to challenge that thought “have I really done badly?”* (L610)

Additionally it appeared that it helped the participants to distance themselves and balance the powerful effect of emotional thinking driven by schemas to a more realistic way of thinking:

P8: *They were very useful, very enlightening again because thinking of something or writing something down logically, it helps me distance myself and think things far more rationally. Instead of letting just the emotion overpower me and not thinking about things orderly* (L277)

Whilst thought challenging appeared very useful for the majority of the participants, for participant 4 and 5, the process of keeping a diary (thought records) did not appear helpful as it drew their attention to their problem(s) further. Both participants acknowledged how helpful thought challenging was, although in-session with the therapist’s assistance. Once they were required to do it on their own, it appeared a challenging process that would trigger their difficulties.

P4: *I mean sometimes that could encourage my obsessive tendencies and I kept on trying to get it right all the time. We did do some work on that...which did help but yeah it sometimes did exacerbate my more anxious tendencies* (L648)

P5: *I found it made me feel quite low really because there was several times in the day doing ordinary simple things that clearly distressed me and because I was recording the distresses of the day, I was recording and reminding myself of how uncomfortable these things had been so you were kind of keeping an unpleasant diary as a constant reminder of what you were not enjoying yeah* (L468)

Possibly, for the perfectionistic client, filling in records colludes with their perfectionistic tendencies:

Sub-theme: Continuum

Several participants found continuum work a helpful technique for challenging core beliefs. This technique took at least 4 sessions to be completed. The participants commented that this technique helped them gain greater self-acceptance and recognise that the standards they set in order to measure their self-worth were unrealistic:

P2: *Again when I did that it was kind of like an obvious thing, it was obvious that it wasn’t good to be....to be perfect and to think so black and white, that...it isn’t....that’s not how the world works but I think it helped me find what I deemed to be acceptable, not what I thought everyone else deemed to be acceptable* (L397)

P4*: …..as I mentioned before, the continuum really helped me examine.... my extreme thinking ...my kind of all or nothing thinking.. and it made me look at myself in far more realistic terms, you know, as someone who, you know, is shy but is perfectly capable of, you know, maintaining conversation, who is interested.* .(L482)

Additionally, the continuum appeared helpful in terms of recognising that achieving 100% was not only unrealistic, but also was equally negative and held as many costs as being in the opposed extreme of 0%. The participants reported that it helped them put things in perspective and challenge their tendency to strive for perfection and engage in unfair comparisons. This was highlighted by identifying all the costs of being in the 100% spectrum:

P2: *Yeah and both sides of what you thought how you should be, perfectionism and then what was bad.....again that was really helpful* (L306)

P7*: I think the most valuable thing was when we did the exercise to see if I was a perfectionist compared to what not being a perfectionist was and all the different things, you know, the fear about making mistakes as against making mistakes and actually finding out that the end result of a lot of these things were the same* (L478)

Only one participant mentioned that the continuum was not helpful. There could have been a number of reasons for this, for example, the timing of the technique, which usually comes after the utilisation of other more empirical techniques, that is, behavioural work: by this stage she did not identify with the concept of being a failure anymore. Her explanation was that she felt she had more important issues to deal with. Another explanation could be that she did not want to challenge her dichotomous thinking because she saw it as a powerful motivating factor to continue succeeding. Another reason could be that she was in denial, not thinking that she was a perfectionist to begin with:

P1*: Yeah the continuum and even though it looked like a good diagram I was like “I don’t feel that’s right for me at that moment”, I was like I feel like I have looked at you know, perfectionism yeah ok it does affect me but that problem isn’t that acute compared to other issues that I have got really ... so for me I was just like I don’t really need that diagram, it’s not relevant* (L507).

Sub-theme: Cost/benefit analysis

This technique was utilised in terms of challenging assumptions, such as, ‘must/should’ statements and core beliefs. It appeared to highlight to the participants that they were risking failure by trying to achieve and, that often they experienced a self-fulfilling prophecy. Participants stated that it helped them recognise this process:

P4: *then we did kind of...usefulness kind of ...assessments when we would actually look at the advantages and disadvantages of a particular thought and it just helped me realise that actually, you know, that a lot of negative self-talk was not bringing anything to my life, it was only hindering so you know, you kind of think, well....what’s the point of buying into them* (L550)

One participant reported that all cognitive techniques appeared helpful, however, he highlighted this technique as another tool that helped him gain greater insight and self-awareness:

P6: *like the cost and benefit, the reason why I’m probably sort of not picking up on all the individual ones is that to me they have all formulated into the positive process because ultimately it wasn’t something that I didn’t know, so it was like I said, the main thing was actually understanding what the problem is, or was, and then understanding the process of how to address the positive thinking and the cost and benefits, you know* (L469).

Sub-theme: Positive logging

Positive logging appeared one of the most helpful techniques in drawing the majority of people’s attention to the positives and challenging the process of underestimating positives by focusing on the negatives. Two participants identified how surprised they were to see the amount of positives they could log on a daily basis:

P3*: even starting off with my little notebook that is my good things because you don’t realise how many good things there are if you don’t store them somewhere so I really found that was good and I’m keeping that up and I’ve got lots of things in there* (L361)

P4: *I was just surprised in the positive book, sometimes overwhelmed by how much positive things I had in it, you know, (L591)*

Being surprised and overwhelmed was understandable, since their low self-esteem would draw their attention to factors that would validate their negative belief systems, because it is a familiar process. Likewise they would find it difficult to recognise positives firstly because this was not a familiar process like with participants 3 and 8:

P3*: I think let’s start with the positive logging, so I think if you look at the beginning of my book it’s got positive and negative in it so it’s like no you are focusing on the positive but I was almost writing everything down* (L576)

P8: *I didn’t have many difficulties about a week later; the first week was a bit difficult because I was more prone to think of the negative aspects in my daily routine* (L268)

Another reason that made positive logging a difficult process was that focusing on the positives would be perceived as being ‘big-headed’ or ‘full of themselves’:

P2: *obviously you could take it to the extreme and get a bit big-headed and think everyone is saying all these lovely things and I am wonderful ….* (L428)

Self- criticism can be activated when reading the positive log because this fits with participants’ negative belief systems and familiarity. One way of addressing this process was to ensure that the statements were ‘balanced’, that is not totally positive, as the latter may appear too ‘fake’ and ‘false’. Participant 4 explains how the process of positive logging could be more acceptable and helped them manage self-criticism:

P4*: because obviously it can become a little bit naff and a little bit like American positive thinking, you know, but rather than saying, you know, “I am a wonderful person” or “I looked gorgeous today”, you know, you would encourage me to write quite precise things down and sort of say what this means about me or what this means about someone else or you know....”I had an interesting conversation today, this shows that I have good intellectual ideas and friends that I can talk to with about them”, you know, that kind of thing* (L597).

On the other hand, once these processes were addressed and overcome, it seems that positive logging challenged self-criticism and increased a compassionate attitude towards themselves:

P3*: I found that it made me realise that there is a lot of good in me whereas I was focusing on that 20% that was not perfect now I focus on what I am good at and I suppose writing it down as well made me remember what people had said to me so if I am in that same situation and if I start to doubt myself I just look at it and think “no no you are good at that” and people think this of you, people have said this to you, people have sent you flowers and said thank you thank you thank you …so you don’t forget those things* (L528)

P8: *I can’t say that it’s been that critical lately, because of the positive logging. And the more positive things I think of every day the less I am critical of myself. It has helped me a lot to live on a daily basis and I’m feeling good with myself instead of feeling incompetent. I’ve tried to replace or balance the critical side on some occasions with the compassionate side of, okay, so be it* (L297)

P2:*it just made me be less critical and think that people were being less critical, so instead of picking out one thing that someone said that was bad in a week, there were probably ten others that people said that were nice but I would always focus on that one thing like someone could have told me a year ago that I was fat and I would still be going on about it now like “they said I was fat so I must be fat” instead of the amount of people that said “oh you look nice today” but you just fob it off and say “oh no, no I don’t” and you know, realising that people don’t just say things for the sake of it (L417)*

P5:*did the just log everything you were proud of that you had done and that was really helpful.. (L322) at the same time was make me look at ...the good points and that kind of switched from me thinking what I was doing was wrong and bad and stupid to what I was doing was like, most people’s something and it was understandable and there were things that I was doing that were good and those good things were the ones to look at and they gave me the ability somehow to stop the behaviour (L186)*

There was one participant who did not find the process of positive logging helpful. In his case he found mentally logging positives more helpful than writing them down. A possible reason could be the fact that because he had already done a lot of behavioural work, the cognitive shift towards positives had been achieved by that point:

P6: *I found it was actually a negative thing to be doing because I was almost like trying to think of positive things and I thought hang on a minute I’m doing loads of positive things and I don’t have to write that....you know....I...painted the wall or I....... you know...because I’m doing all the positive things and I’m just getting on with doing them instead of writing about them* (L423).

Sub-theme: Compassionate mind training

It is proposed that this was an important intervention, as it addressed the common and powerful trait in perfectionism and low self-esteem, that is, self-criticism. A few participants commented on how valuable this technique was especially when used via imagination:

P6: *And when you did the two chairs and the bully and the compassionate me, like you pointed out I started off and the bully was winning ferociously but then the compassionate me stood up for myself and it was very, very eye opening and that definitely helped me start to think more compassionately about....you know...instead of beating myself up about having this condition, this illness, whatever everybody wants to call it, you know, start working at it compassionately and just let your, you know....you don’t need to read every book about it, you don’t need to dissect every little bit of it, you don’t need to run an Excel spread-sheet with all the notes about exactly what you have done when, just let it go* (L452).

It was apparent that becoming more compassionate provided the participants with a sense of calmness, which appeared to have a positive effect both in relation to the self and with others. This was the case for participants 5 and 8.

P5*: it was quite nice really! It is quite nice sort of being compassionate about yourself and yeah, yeah..... it is quite nice for somebody to be able to switch your thinking is obviously a brilliant thing yeah (L538)*

P8: *The more I became or tried to be compassionate with myself, the more I was able to relax and feel a comfort. And the more I relaxed the more I was able to think of things clearly and be rational* (L304).

Similar to positive logging, compassionate training appeared to have the effect of triggering self-criticism.

P4:*one discussion about negative self-talk ...when…you know....you encouraged me to look...you know...to kind of imagine myself as a child and then …you know...imagine saying those things that I said to myself to a small child and of course I was horrified and it really made me realise, you know, the effects....it was a very simple way of helping me realise the effects of this very bullying talk really in my own mind, you know, and it made me just realise that actually there’s no use to them, they are just negative and ...you know....and not even really in line with my own values .. (L541)*

It is understandable because it is very difficult and is an unfamiliar territory to be compassionate towards one self when being self-critical is the strategy that one is used to do. Participant 5 highlights the self- criticism process which she experienced when compassionate mind training was first introduced:

P5: *I suppose initially you think, well I am stupid, how can I accept that I’m not stupid when it is quite clear that I am really stupid and so you kind of think well is this going to work because I am obviously stupid so I can’t you know be nice to myself about it because its really stupid, how can you be nice to yourself when you’re like that but...you kind of switch that thinking to say well you know you have done this, and you were able to do this and these things have happened so therefore it is understandable...this is probably really over-simplifying it* (L563).

Participant 8 highlighted how strong the critical voice can be.

P8*: A very big change and it was very difficult. I constantly found myself allowing the critical self to control me and manage me* (L303).

**5.2.3c Behavioural techniques**

Sub-themes: Exposure and behavioural experiments

These appeared very helpful as the empirical work appeared to be effective in challenging cognitions that were related to core beliefs and schemas. Participants stated that the techniques helped them view themselves from a different perspective. It was obvious that their catastrophic beliefs and predictions were not coming true, therefore, the experiments, etc., helped to challenge issues in relation to mind reading and predicting:

P6: *but the encouragement to go out and keep facing it and despite, you know, like you said, you know, if you feel that badly about things go and make a fool of yourself in public, I didn’t need to go to those extremes but the whole process of understanding that, you know* (L488)

P7*: the reality was when I eventually get around to making that phone call or doing that job I was putting off, like with a lot of people you know, it went perfectly well, the phone call went well, I ended up ....and probably even getting praise for something for saying thank you for ringing me up, you know and sorting that out and I felt a damn sight better after doing it* (L527).

Despite how useful the behavioural work was, it is important to keep in mind how difficult it is for the person to step outside their comfort zone and confront their fears. Participant 4, who found these experiments very useful and effective, also highlighted how difficult they were. Additionally, his comments suggest an element of disbelief regarding the therapist’s ability to recognise the level of difficulty when setting behavioural experiments:

P4*: I mean I did find it very, very hard to do things like that because I had very, very strong beliefs and I almost felt at the time...oh you know, you know...because my therapist is very, you know... eloquent and very sociable, maybe she just doesn’t, you know, doesn’t see how hopeless I am* (L531).

Sub-theme: Assertiveness training

It appears that assertiveness training was a crucial part of the treatment protocol, because the majority of the participants were lacking assertiveness due to the fear of rejection and negative evaluation. Lacking assertiveness had a major impact on their low self-esteem, thus becoming more assertive helped the participants to gain confidence in saying no, and standing their ground. Participant 1 places emphasis on the role of diaries as means of gaining greater understanding of the consequences of being passive on her thoughts, emotions and overall her self-esteem:

P1: *my assertiveness training when I like logged basically what had happened and I was logging things and I was thinking yeah I could have been more assertive here and then I went on to, you know, put examples of when I have been assertive and that really helped* (L463) *....that really helped because I was realising that the less that I did, the less action I took and the more passive I was, the worse I felt* (L568).

Participant 2 found it helpful in terms of learning that being more assertive would challenge her issues of rejection and negative evaluation. When used as a behavioural experiment it appeared effective in terms of challenging negative predictions regarding rejection, that eventually lead to feeling calmer:

P2: *A lot of the assertiveness stuff was helpful, just learning how to deal with....how to be assertive really because I think, like I say, I think I am a bit passive-aggressive and it is hard to know how to deal with a situation and keep calm without feeling almost criticised and feeling you have got to get annoyed, so I found that helpful* (L289).

Additionally, participant 2 provides a more practical account, which highlights that assertiveness helped her overall interaction with others, in terms of reaching a point of constructive communication even when both parties disagreed. This process underlined the ability to distance oneself and being able not to personalise it when others disagree and view it as a personal rejection:.

P2:*I think it was just knowing what to say and how to deal with things and what to do when you get somebody who is quite a strong character who is telling you that they are right but you perhaps disagree and being able to make them see without getting either stroppy or just thinking oh I’ll just completely leave it which is what I tended to do, it was either just I can’t be bothered to fight the battle in the first place or get really annoyed and stomp off or something* (L342).

Participant 8 mentioned that it helped her find a new job. Through assertiveness training she learned how to set boundaries with regards to overworking and completing others’ work: learnt to say no. This process highlighted that she was often taken for granted, thus she decided to resign from her job and find one where she felt she was more respected without the need to please others. The same accounts for participant 1, who did not resign, but learnt to set boundaries in her role:

P8: *I have found myself far more assertive with certain people who I had difficulty with in the past. It helped me a lot in finding my new job* (L281).

Participant 1 indicates one of the common process issues that can occur when a person is changing from being passive to becoming assertive. When people get used to someone being passive and pleasing them, it is understandable to react negatively when the person stops pleasing them:

P1: *it has helped me be more assertive at work, I am definitely more assertive than I used to be ...obviously like I am a supervisor at work so it has helped me deal with other people a lot more. I am a lot more assertive with them and also I don’t kind of let them, like, upset me whereas before I maybe would have and now I don’t and people didn’t really like it at first ..but that’s how things are really now* (L242).

In other cases, people’s reactions were not as negative:

P3: …*and people buy into that as well, so people like that, “thanks for being honest with me that you can’t do all this”* (L304).

For the majority of participants becoming assertive was one of the most challenging components of treatment. It challenged the most fundamental fear - the fear of rejection, that is, it involved shifting behaviours towards others, thus risking being rejected:

P1*: it was hard for me to be more assertive and it scared me, it made me feel quite anxious, it made me feel almost quite.... since I was quite, ill.... sick with worry about it really on certain situations but then after I had been assertive I felt so much better and it was a continual thing* (L570)

P8: *It’s still difficult at times, I am still getting used to it….And it’s still difficult when something catches me off guard. I think I have the technique and it’s very, very useful. I think it’s the most difficult bit* (L281*)…First of all it’s very difficult to react automatically to something that’s happening. And thinking - reacting automatically without having to think of the process and how to say something in an assertive way, or you know how you want to win the situation but it’s not very easy to think of what’s a win/win situation* (L286).

**5.2.3d Organised/educational nature of cognitive-behavioural psychotherapy (CBP)**

Sub-theme: Agenda setting

For a few clients, what appeared to be beneficial was the fact that CBP is organised by nature. This made sense because an organised type of treatment would fit with a perfectionist’s belief system(s) and style of operating:

P1: *you kind of mapped it out to me as I was always like “what am I going to be doing next, what am I going to be doing next” and you did let me know like this is the bit where...... I can’t remember what it is now but you know I’m talking about things that have happened and stuff and then there was like where I share the information and then action what are we going to do about it and to me that was like a plan and it was more of a plan in my mind as to what was happening. That, I found really useful ……* (L664).

Sub-theme: Writing

Aside from specific techniques, several participants commented on the overall style of how CBP was delivered. It was apparent that the educational nature had an appeal to participants and it makes sense in the way that, due to their perfectionistic traits, the participants would like the concept of learning:

P1*: it’s almost like a studying, kind of like an academic way of looking at it but that, I found that that helped me and that is maybe how I process information anyway, like through studying, I tend to like writing things down and then having a think about it so yeah that really helped* (L466)

P5: *maybe because that’s the type of person I am, that, you know, learning is a positive thing and understanding is a positive and its sort of that “wow” moment and “oh right I get it now” and things like that. I found it useful to be explained in a classroom sort of experience with a blackboard and pen* (L393).

As participant 1 mentioned, the educational nature of CBP was highlighted by the fact that writing was a common procedure during therapy. It appears that it helped participants refresh their memory, for example, participant 1 argues that despite the fact that she would not refer to the records very often, simply the fact that they were written would be enough to refresh her memory:

P1: *it helped me writing things down, again it goes back to like, it seems to be like an academic thing where I want to write things down and writing things down about, even though I didn’t really refer to them that often, once I had written them down I kind of remembered them more so...the things that I am saying to myself you know, you’re no good, you know kind of nobody likes you or whatever and we would go through, I can remember this technique of going through like what I am thinking and my emotions* ...(L525).

Participant 3 adds to the memory enhancement that having writing things down reinforces reflection:

P3*: I think the first time that I drove here I got home and I wrote it down and then when I reread it it means more to you because you start thinking about what it means to you rather than just being a bit of a scribble* (L519).

For participant 4, writing things down helped the process of shifting emotional reasoning to intellectual reasoning:

P4: *and there is something about writing it down as well when you are someone who kind of has a brain that can shape reality and mould it and change it and make it extreme, it is just very comforting somehow to have something written down firmly like that, it seems to......again, it seems to shift something in your brain* (L593).

Participant 8 made things more exclusive by saying that writing helped her challenge emotions and calm them down, by increasing intellectual reasoning processes:

P8: *They were very useful, very enlightening again because thinking of something or writing something down logically, it helps me distance myself and think things far more rationally. Instead of letting just the emotion overpower me and not thinking about things orderly* (L277).

Participant 7 added that it helped put things in perspective and organise confusing thoughts driven by emotional reasoning:

P7: *I think it made me realise that we could actually work it out and being somebody that can work things out because that’s what I do in my job, actually in a way that appealed to me and it did seem easier because we could actually write it down and say, you know like we did...I mean I am being a perfectionist at doing that but it was, you know, analytical, it was being analytical rather than being just completely confused in my head* (L594).

**5.2.3e Therapeutic Alliance**

The therapeutic alliance appeared to be the most important factor affecting the therapeutic outcome and almost all participants (5 out of 8) commented on the importance of establishing a positive relationship based on trust, warmth and collaboration.

Sub-theme: Collaboration

In particular, one participant commented on how important it was for her to feel that she held an active role in therapy and that it was a two-way process. This makes sense as people with low self-esteem often feel guilty to receive help as they feel they are not worthy of it; despite being able to be empathic towards others, they often fail to be empathic towards themselves. However, the collaborative nature of CBP helped her to challenge issues of guilt and feel that she is contributing to the learning process as well as receiving the benefits of treatment: .

P5*: I quite liked it because it was a learning......I wasn’t doing it on my own, it was a learning process that we were kind of doing together because you were sort of using what you were learning off me as much as I was using what I was learning off you and that made it feel all the more positive experience. It wasn’t one-sided in the fact that I was taking from you which I feel, again, a bit guilty about, sometimes you must be so exhausted having to do this for hours ...so to be able to do this process again, today for example, it feels a more positive experience if I feel I am giving (L407).*

Sub-theme: Trust and warmth

The second Sub-theme which emerged is that of the importance of establishing trust and warmth within the therapeutic relationship. It appeared that thinking about the potential success of the treatment was closely related to the level of trust established with the therapist. Certainly that was the case with participants 1 and 3:

*P3: I suppose that one of the things as well is that I warmed to you straight away and I think that is important because if you don’t warm to the person that is giving you treatment and if you’re not open and honest, because I know we were honest from the very beginning with me saying that I don’t want to be here, I don’t believe that it would work because you have to put your trust in that person. (L412) …after a couple of weeks, once you start to trust the person you know that everything is going to be beneficial so I have a difficulty but it is like yeah but this is going to work so lets just…(L587).*

Additionally, participant 4 highlighted another issue, that is, self-disclosure and the ability to maintain a balance between the professional and the humanistic side of the therapist. It appeared that being completely detached and ‘too clinical’ had the opposite effect on the participants’ involvement in the therapeutic process. The importance of being human aside from professional is highlighted in the following:

P4: *I really liked the role that you adopted as a therapist in that you know I very much felt that there was a personal kind of connection it was very important for my self-esteem actually and, you know, a personal kind of appreciation of each other’s personality and, you know...so I felt that you were ready to listen to my issues and my problems but also you were quite firm, you didn’t indulge it and that was very important for me because part of the problem was that rumination in my mind, you know, you didn’t let me ruminate really ..and...you know...I liked the way you sort of......it was a very good mix of sort of professional firmness and detachment and you know, a kind of support and emotional support for me and, you know, I remember you telling me, you know....talking about wearing clothes with brighter colours and things and, you know, and sometimes talking about your own experiences.....actually that really helped me ....but that’s a personal note really (L721).*

Participant 6 highlighted the fear of being judged as a factor that could interfere with the therapeutic process and highlighted the importance of having a therapist who is non-judgemental:

P6: *The fact that we have had a very regular process, just talking, opening up and trying to be honest about things, you know, not feeling that I am being....I come here and I know that I’m not going to be judged and if I have had....I’ve come in here when I’ve been shaking and sweating but ultimately I’ve never been judged and I can go away from that and I am lifted by it, it’s helped me immensely (L339).*

**5.2.3f Pace of progress**

50 % of the participants argued that the change they experienced was quite sudden. Apparently their accounts provide some evidence with regards to the effectiveness of the treatment protocol, that is, the change can occur at a fairly quick pace:

P2: *there was like some eureka moment where it all seemed to fall into place, it just did and I just feel happier (L154)*

P4: *You know, I would say my work is still a bit of an ongoing challenge but socially... very big seismic shifts happened quite soon after therapy (L315)*

P5*: it’s sort of that “wow” moment and “oh right I get it now” (L394)*

P6*: I have surprised myself at how quickly I have come around (L484).*

The remaining participants reported that progress occurred at a more gradual pace:

P1*: I would say also throughout the treatment I got progressively better really with it…it was kind of a progressive thing, it wasn’t suddenly like I just woke up and it was like “wow I have much better self-esteem”, it was a progressive thing (L228).*

**5.2.3g Process issues**

Many of the process issues identified have already been addressed previously, therefore, the main one left to be highlighted is that of ‘the perfectionist client’. The Sub-theme of control is referred to during this.

Sub-theme: The perfectionist client

One of the process issues that became apparent was that often the organised nature of CBP colluded with participants’ perfectionism, or simply, perfectionist tendencies would generate in treatment as well as in real life. Perfectionistic traits were used positively in order to achieve the treatment goals in an effective way. 3 participants’ responses provided evidence of perfectionistic traits being generated in treatment. For example, participant 3 identifies that in order for treatment to work, one needs to provide 100%, which is a trait that relates to striving for perfection and setting unrealistic standards. Additionally, participant 4 stated that compliance with homework provided her with a sense of achievement, which reinforced further compliance leading to eventual progress. Compliance with treatment boosted her self-esteem, because it fed positively her beliefs of being good enough:

P4*: I think just by being quite firm and having very, very practical exercises just like phoning people or having a spontaneous conversation and recording it, you know...that really.....those actions really, really helped me and they really helped me feel like I was achieving something (L534).*

Participant 6 identified his tendency to overcompensate in order to achieve the maximum result. However, he was able to recognise that overcompensation fitted with perfectionistic beliefs, for example, learning all there is to learn about his condition in two days. However, this was not the case for participant 1 who did not seem to have recognised that unrealistic standards were generating in treatment. Her statement suggested a sense of impatience:

*P1:“right this is a problem that I've got”, like my lack of self-esteem and things like that and its affecting my relationships big time...and I want to change it really as quickly as I can (L486)...so there were times during my therapy where I was like “right I think I've moved on here” and ...you know I wasn’t afraid to say “you know look I don’t think we need to do this and I think we can go onto this”(L489)*

Quite often participant 1 gave a different account with regards to her experience of treatment, for example, feeling that the continuum was not for her, or she would feel that the formulation was too simplistic:

P1*: I don’t know what some people would think but for me I just thought, at first I was like well why, why are you showing me this, because I thought it’s not really that like useful even though, I guess, you know, its just showing you an overview of the ideas behind it, I can remember at first thinking like for a first session or whatever thinking... that this isn’t really that helpful and I actually thought this is a bit too simplistic really for me...(L613)*

The above was the only case where the participant’s perfectionism interfered negatively in treatment leading them not to give a technique a chance. It appeared that she was in denial of being a perfectionist and not accepting the concept. It is interesting when she denied that she was a perfectionist, however, she frequently used the words ‘perfect’ ‘failure’ etc:

P1: *I am in some areas of my life (perfectionist) yeah and I think therapy did help me to realise that whereas before I just thought you know, “no I'm not a perfectionist at all’’ (L112) I think even though I don’t think I’m a perfectionist, and I still don’t, in some ways...I possibly am and therapy did help me to recognise that* (L107).

It is interesting that later on in the interview, she provided a clear account of still being a perfectionist, although her traits were not interfering as much with her confidence and she seemed able to cope better and tolerate emotions. This could be because through the course of the interview she could reflect back on the concept of whether she is a perfectionist or not:

P1: *there are certain things I still do, I still like double-check things through quite a bit on certain tasks, I don’t think that’s that bad really. I still strive, I guess, for like the next stage up and I don’t think that’s too bad. I do become a bit critical - I want to do better but I guess the only thing is that I recognise it now whereas before I don’t think I was at all and it has made me think you know, I guess to accept that I've done well in certain things and be happy with that whereas before I didn’t accept that I did well in anything (L363)*

Perfectionism became apparent during therapy in terms of challenging control issues. Participants 3, 6 and 8 provided their view of treatment being a very challenging process in terms of letting go of issues of control. Their statements indicated another concept of perfectionism - that of having difficulties addressing vulnerability:

P3*: I would probably start from the beginning because, I’m not sure if I told you that I was definitely definitely not having the treatment so if have the treatment that is weak and it doesn’t work anyway and you know why do I need to see a counsellor and blah bah blah and I’m not going to talk about it. The first time thought about not turning up and got someone to bring me. I went away the first time probably feeling worse than when I got here because some of the things we talked about I thought I don’t want to talk about that so previously I would cope by working harder, thinking about other things more and not dealing with what was happening so it was like put this to one side work a bit harder think about something else harder (L350)*

P6*: I wouldn’t wish it on anybody because the first probably 6 weeks from diagnosis to really getting into the nitty gritty of it and opening your mind up and ripping down the wall, and it is ripping down the wall because all of a sudden you are exposed to everything that you really don’t want to be exposed to (L485).*

**5.2.4 Master-theme 3**: **The Shift of Perfectionism and Low Self-esteem (post-treatment)**

The third Master-theme shows the effect the treatment protocol had in shifting perfectionism and low self-esteem in relation to different aspects of participants’ life. As demonstrated in Figure 8.13 there were 4 themes and 14 sub-themes identified.

**5.2.4a Managing perfectionism**

Sub-theme: Balanced standards

Seven participants disclosed that their standards had become more realistic and balanced. They accepted that they could not be perfect, which resulted in feeling more relaxed with themselves, leading to self-acceptance:

P6*: it’s a question of being realistic of what can be achieved and interestingly enough some of the stuff we talked about through the sessions, I can see now (L224)*

P7*: You know, so I have tried to be more human yeah, so more chatty, more less obsessed with going through every single point and really just letting the meetings take their course and not being as, you know, just an impossible robot if you like (L325).*

For participant 3, not worrying about meeting unrealistically high standards appeared to be a major turning point in terms of reaching fulfilment in her life:

P3*: So yes, so I am and I allow myself to have what I would have called failings they are not failings, but yes so now I look after myself, I do things for me I have me time as long as I am not hurting anybody I am almost living my life as I have wanted to live my life but not seeing it as the way you should. And I can remember saying to, as I said about a lot of youngsters working here, and they all say “oh wouldn’t you like to be young again” and I say no, actually if I’m honest I am at a time in my life where I am loving my life more than I have ever loved it (L549).*

Similarly, for participant 5 lowering her standards helped her to feel more at ease with her environment, relax and not engage in overcompensation:

P5: … *and I feel comfortable that I am at the level of effort that is required in the house that is comfortable for me, I am not doing more than I want to or less than I want to, I am doing what’s comfortable (L229).*

Two participants (4 and 6) were able to recognise that other people were not perfect by lowering their standards. It appeared that they recognised that comparing themselves to an unrealistic perfectionistic model was not constructive:

P4*: suddenly made me look at the speech of others as well and realise well ok that’s not perfect, that’s not the most interesting thing to say but they are a nice person, they are interested and you know, it doesn’t have to be solving the world’s problems or you know, performing like a great Hollywood actress to be good company and I think that was quite a very strong revelation for me (L310).*

Participants 4 and 8 identified that there was nothing wrong with setting goals and having high standards, as long as they did not interfere with their wellbeing and as long as they were realistic. This meant that they could utilise perfectionism in a positive way, where standards gave them the motivation to be productive:

P4*: I think it also helped me to view my work in perspective to see it as just one task of many tasks in life and that, you know, it’s not necessarily, you know, a complete tragedy if it doesn’t go perfectly (L278) P4: There’s a lot more preference there and a lot.......yeah...and a recognition that even though sometimes it’s good to have high standards you don’t necessarily have to have the highest standards all the time, you can sometimes just accept things, you know. (L506).*

Sub-theme: Decreased doubting actions (and concern over mistakes)

Six participants reported that they had stopped doubting themselves in terms of thinking and re-evaluating their performance and/or being concerned with catastrophic thoughts in relation to making a mistake, or the possibility of not doing things right. The more confident they became the less concerned they were with self-doubt beliefs.

With regard to Participant 1, who appeared to still occasionally hold strong traits of perfectionism, whilst she claimed that she no longer doubted her performance, she pointed out an interesting fact. That is, other people still held high expectations of her:

P1*: I would just do a piece of work and I won’t try and say “oh but I could have done this” and “I could have done that” and that’s what I always used to do because people start thinking “oh yeah you know well this isn’t quite as good” (L358).*

However, this seemed to be her perception of what people may think - an assumption that is based on her experiences and a generalisation error. As stated previously, this participant often provides contradicting statements.

For participants 3, 6 and 7 it was apparent that no longer doubting actions had affected them positively in terms of increasing their confidence and not overcompensating, which was especially evident in the workplace environment:

P3*: It’s changed my work dramatically, I’ve just taken another step up to cover my manager and that means managing in his absence people that have been doing the job longer than me and who I thought were more capable than me... but because I am now confident, I have got the best performing team, so I know I can do anything that is put in front of me (L297)*

P7*: in a way because I can analyse the whole thing about, you know, over-preparing and hang on did you really make a mistake, like break it down, you really did do a lot of work on that …the thing was hang on a minute, you have really tried here and if you do end up getting something wrong......you know, the point was you actually tried so.....therefore you haven’t failed because you really tried (L640).*

Participant 5 made it explicit that it helped her to stop obsessive-compulsive behaviours, thus indicating that increasing confidence decreases compulsive behaviour:

P5*: the positive processes that you do...that switching from negative to positive, would stop me needing to repeat things and would make me more confident about the behaviour anyway so I wasn’t too worried about not doing the behaviour because I knew the cognitive stuff would produce this inner ability to not do the behaviour anyway(L498).*

Participant 4 provided a different account by reporting that it affected positively her personal relationships, whereby feeling more confident she would not doubt how she behaved, talked and appeared to others:

P4*:I think with personal relationships it was similar, you know, because I wasn’t constantly monitoring myself I could just be a lot more relaxed...(L366).*

Sub-theme: Managing overcompensation

Six participants indicated that one significant difference in their lives was that they were spending more quality time enjoying themselves, instead of using their time striving for perfection. Participants 2 and 8 talked about the importance of prioritising and the positive impact on their lives:

P2*: I do leave things a lot more, I go home on time, leave things for another day, work out my priorities a lot better which I always tried to do but I think sometimes I used to kind of try and do everything whereas now I think well I can’t do that, I can’t do everything so these are the important parts of what I need to do and I will get those done and everything else will have to wait (L265).*

Prioritising and not overcompensating helped participant 6 to be more effective and productive in his life: before overcompensation had prevented him from doing them due to procrastination. In addition it helped him to allow other people to do things on his behalf, which showed that he was not driven by the need to prove that he was good enough:

P6*: I am coming around to the “no” and I have for example, last week I spoke to a gardener who’s going to come round and look at the garden because I know it’s too big a job for me to tackle on my own and it needs doing professionally because if I do it then I will sit there looking at it frustrated every (laughs).........so it is making me change my perspective on going forwards, you know....making changes in the house, making decisions without procrastinating about them, you know, furniture decisions, being able to go out and shop without having to do a complete research, you know, a complete theory document before I go out and buy something (L228).*

Participants 7 and 8 both underlined how much calmer and relaxed they felt in their workplace, which for both of them used to be an area that would trigger their perfectionism. Both participants had experienced ‘burn-out’ in the past, due to overcompensation:

P8*: I find myself able to work with others far more properly and in a timely fashion without causing myself anxiety and over working, or over powering others at the same time (L144)*

*I take care of things but I am far more relaxed on a daily basis. If something isn’t done, so be it, it will happen the next day, or another day. (L181).*

Finally participants 3, 4 and 8, argued that they were now able to enjoy themselves more, thus leading to more relaxed and pleasurable times: This indicates an increase in their self-esteem as it appears that they have managed to prioritise their personal needs and deal with possible guilt:

*P3: I wouldn’t allow myself time to sit and watch TV or listen to the radio or put a film on, I always had to be doing something to make sure everything was perfect. So now I have “me time” (L280)*

*P8: I am now finding more time for myself to things I want to do and feel good about instead of always trying to be there for everybody else (L153)*

**5.2.4b Self-compassion and acceptance**

Sub-theme: Not criticising self

From the analysis of previous themes it was clear that critical self-talk was familiar to almost all participants and was a strong influence in reinforcing perfectionism, decreasing self-esteem, and increasing unhelpful emotions. Almost all participants (n: 7) identified that accepting themselves, normalising imperfections and talking to themselves in a calming and reassuring way made them feel calmer, decreased worrying feelings and feelings in relation to guilt and shame. Participants 1, 2 and 5 gave emphasis to the emotional shift they experienced:

P1*: I guess before I wasn’t compassionate to myself at all, like I really wasn’t whereas now I am more accepting, I am just like you know this is me and there is nothing to be ashamed about or anything, everybody you know has.... it’s just a part of being like human, you’re not going to be like perfect whereas before I really like, you know, wouldn’t be compassionate to myself at all (L553)*

P2*: just leaving things to be done at a later time, not being as critical because they weren’t getting done because I think before they weren’t probably getting done but I was criticising myself for not doing it whereas now it is kind of like oh yeah I know it needs doing and I kind of want to do it but I am also wanting to go out so I’ll go out. yeah just not feeling as guilty about leaving things for another day or another week (L234).*

In addition, participants 3 and 5 highlighted that by being more compassionate they had fewer chances of relapsing in their areas of concern. This shows that by being more compassionate this increases their ability to cope with potential difficulties and a possible relapse:

P5: *I think just accepting the bad bits and understanding as well that now and again I am probably going to slip a bit but that’s perfectly normal and I feel a bit more confident this last time but if I do slip a bit for a week or two when I’m on holiday or whatever that I will actually be alright when I come back, I will be able to bounce back when I come back so I think that’s sort of the long term fear of relapse and things like that. I feel a bit better this time that if I relapse a bit ...I will still be strong enough to ...know that it will just be for a bit and for a specific reason (L352).*

For participants 6, 7 and 8 there was greater emphasis on the fact that being compassionate increased their motivation to do more things in a more ‘rational’ manner, thus minimising the chance of making mistakes:

P8*: The more I became or tried to be compassionate with myself, the more I was able to relax and feel a comfort. And the more I relaxed the more I was able to think of things clearly and be rational (L304).*

Participant 7 gives a more detailed explanation of the processes occurring that minimised procrastination, due to a more compassionate attitude towards work and duties:

P7: *it was recognising or remembering that that was actually what used to happen yeah, so rather than fearing the worst, saying well hang on, from experience how often do they go badly these phone calls - very little, and if they do alright say ..if something crops up on a phone call say I’ll have to have a think about that and let you know. But the point was, it got it out the way so, you know, what I have done less....or what I am much better on now is, you know, I’ll have my telephone warnings so I’ll come in and I’ll say right I am going to make all my calls this morning and I’ll get them done and I am telling myself all the time, remember once it’s done, you’ve done it and you’re not worrying about it anymore (L531).*

Sub-theme: Not blaming self

Participants appeared to learn to challenge the concept of taking full blame over situations. They were now more able to depersonalise and recognise that certain attitudes and situations are not the direct outcome of a mistake they made, or because they are simply not good enough, but the responsibility lies in dynamics and factors that are beyond their control:

P1*: my friend, it’s not just me who she treats like that, sometimes she just does that sort of thing and at one point I know I would have taken it personally whereas now I think therapy has helped me realise that you know, people are just like that, it’s not necessarily a personal thing whereas before I would have ... internalised it, now I am just like - well no that’s not because I am bad or anything like that, that’s not tapping into those core beliefs that you have about yourself (L297).*

For participant 2, it was important to look at past experiences and rescript some of them using depersonalisation. She was able to recognise that the trauma she had experienced, in relation to rejection and disapproval, did not occur because she was not good enough. This was radical in terms of putting things into perspective and stopping her from blaming herself, not only in relation to her family, but with other people too:

P2*: I used to seek approval of my grandma in particular, all of the time and think nothing that I, personally, ever did was ever going to be good enough for her and that it was me that she personally had a problem with but being able to look at her as a person and her life, the other things that happened in her life before me or aside from me made me realise that it wasn’t just about me and I have, I guess I have used it with other people but just not to this greater extreme but it has enabled me to realise that it isn’t actually my problem, my issues that have made me feel the way that I feel, it was actually her issues (L383).*

Participant 5 went through the same process of re-scripting events in her life, however, she adapted an even more compassionate attitude than participant 2, by showing an understanding to her family, exactly the same way she showed compassion to herself. This appeared to be even more liberating as she was able to forgive and forget and, at the same time, maintain a non-blaming attitude towards herself and others:

P5*: And I know a lot of bad things have happened to me and I felt...should I have some blame, should I have.....no not just.....but you made me realise it was maybe the reason, but there wasn’t anybody to blame it was just that’s how it was and all those unfortunate things happened that made me a cautious person, an overly cautious person, but they just happened and they weren’t anybody’s deliberate faults and they weren’t anybody’s deliberate...you know, therefore I didn’t need to blame anybody....I had an understanding...and I really, really liked not having to blame anybody...(L287).*

Sub-theme: Disclosure of imperfections

It is proposed that for five participants disclosing imperfections was evidence that they were challenging their perfectionism and were more comfortable with themselves in terms of not worrying about negative evaluation. This is a sign that they are far more compassionate with themselves, since they have accepted their ‘human’ nature and protected themselves from this constant battle to hide their imperfections and appear perfect:

P3: *I now admit to people where, for want of a better word, my failings are so if I can’t do something or I have not got time to do something I will openly admit, if I have done something wrong I will openly admit, it’s ok now for people to see me…. (L219)*

P7: *… if he asks me something I genuinely don’t know it’s fine to say I’ll let you know, because I can always go back to the office and work it out (L314).*

Self- compassion relates to accepting vulnerability for oneself and not worrying if one appears weak in front of others. For participants 3 and 6 it was a revelation to ‘drop the barriers’ and open up to other people. They held strong beliefs of being in control, they did not want to show emotions and vulnerability as they believed that these would make them appear weak in front of others, resulting in negative evaluation. Therefore, the fact that they were now able to open up to others demonstrated that they were more compassionate towards the fact that they are emotional and vulnerable:

P6: *I have been very open to people so I have admitted rather than saying “oh you know, I’ve not been too good” or trying to cover it in any way whatsoever, I have just told people straight out what I have been diagnosed with and what I.....the process I am going through...so in many way it has made me drop a shield and ...you know, it’s ...one of my favourite albums of all time is Pink Floyd The Wall and you know, it’s like “tear down the wall, tear down the wall” (L185).*

It is apparent that the participants’ relationships benefitted as well, since they became more sociable and open towards others. Therefore, social gatherings have increased as the fear of negative evaluation decreased. This is the case for participant 3 and 4, who both had similar concerns with regards to keeping up appearances in the past:

P4: *I was much happier about inviting people in, you know, because I sort of realised that even if it’s not the perfect meal, the place doesn’t look perfect, then it doesn’t really matter and people aren’t always waiting to judge or criticise (L343).*

Seeking help used to be another sign of being weak and not good enough for participant 8. Following treatment she challenged this and now appeared to have a more relaxed work attitude. She additionally highlighted that she had became more assertive socially, by doing things for herself and not mainly for others:

P8*: I am also far more prone to ask for help from others as well, or to socialise with others when I feel like it, not always when they want to (L155) I respect that they have their own opinion, and I try and do things for myself, not to be perfect for others (L231).*

Sub-theme: Recognising achievement

Not being able to recognise achievement, either because perfectionistic clients were already preoccupied with achieving the next goal, or because they would undermine their abilities due to high standards and self-criticism, was a factor that undermined their confidence and reinforced unhelpful perfectionistic traits. Several participants identified that following the treatment protocol they were now able to recognise that they have done well. Participant 1 provided further evidence that she still remains a perfectionist, although her perfectionism appears to be functional and not problematic:

P1: *I want to do better but I guess the only thing is that I recognise it now whereas before I don’t think I was at all and it has made me think you know, I guess to accept that I've done well in certain things and be happy with that whereas before I didn’t accept that I did well in anything (L369)…. whereas now I think I realise that actually that’s just how I think and sometimes I'm just like “you know what that’s fine I've done an ok job there” and that’s it and just don’t dwell on the negatives(L124).*

Participant 3 described how much her confidence had increased and how she is now able to recognise her achievements. Not only that, but she was able to challenge the fear that she might appear big-headed for doing so. In addition participant 5 highlights that it helped her stop doubting herself, which in turn helped her minimise obsessive-compulsive activities:

P3: *I think for the first time in my life, I have not got low self-esteem and I know we talked about that sounding big-headed because that is how I felt before but to me if I’m good at something I’m good at it and I’ll take the praise for it (L330)*

P5: *It makes me enjoy it, I can do it and look at it and think “that’s nice” instead of do it and look at it and think “have I done it properly, have I got to do it again?” I can look at it and think, “I’ve done a good job there” (L235).*

Sub-theme: Accepting perfectionist traits

Even after the treatment protocol was implemented, several participants still portrayed perfectionistic tendencies. However, these were not interfering with their everyday activities; nor undermining their confidence. On the contrary, they were being utilised in ways where people could benefit from the positive side of perfectionism:

P8*: I am trying to utilise the perfectionism in me in a positive way, of trying to achieve things but not letting it overpower me (L189).*

The concept of recognising that perfectionism still exists but that it does not lead to excessive worry and undermining confidence is demonstrated by participants 2 and 6:

P2*: I am still like quite house proud really but I am not as concerned about it as I was, I am happy to leave things and I don’t kind of feel people are coming in and judging “oh that’s a bit dirty”...“how disgusting” (L196)*

P6: *I’m still a perfectionist, I still very definitely have....you know, I don’t think my standards have changed, I am more relaxed about things and I am less....I am more realistic about what I am trying to achieve and how I can achieve it (L157).*

Participant 7 appeared to be experiencing times, where he still had strong emotions and worrying thoughts in relation to perfectionistic traits, such, as the possibility of making a mistake, appearing not good enough, etc. However, these seemed not to be long and he was able to recognise them.

P7: *So although I do get nervous before I’ve got to go and see a client I now realise, or I tell myself, hang on this is perfectly normal to feel nervous before I am seeing a client …but just to recognise that as what it is, you know and not...so whereas before it was just a complete...totally in my cave....almost panic that I had got meetings....I’m not saying I am perfect on every one but, you know, it is a damn sight better than it used to be (L335)*

Participant 4 provides a very similar account:

P4: *again just for the sake of honesty, I think I do still have perfectionist traits and I worry, you know, probably excessively about negative things and I do still survey ....what I say and often worry that I am being boring and what have you, you know, so there are still elements of perfectionism there but I think I'm much...I find it much easier to tolerate them now and I look at things in a different way (L382).*

The same compassionate attitude was adapted by participants 1 and 2, who normalised certain traits, thus minimising discomfort with themselves:

P1: *I still think … in some ways I want to be the perfect like partner ....I want to kind of look, you know, good and stuff all the time, but I don’t think that’s such a bad thing (L421)*

P2: *I still worry a bit about things and will say oh I look fat today or ....I look a mess today or whatever but I don’t think its abnormal to think like that (L155).*

**5.2.4c Increased self-worth in relation to others**

There appeared to have been a remarkable change regarding individual’s sense of self-worth following the treatment protocol. Several participants underlined the changes in believing in themselves in areas, such as, work, the relationship with their bodies, and their relationships with others:

P1: *Work...I think I just believe in myself more ...and so I guess low self-esteem doesn’t show to myself or to other people as much (L241) I just seem to have gone on and on feeling better and better about myself and I just, I don’t know, my self-esteem has just improved dramatically really (L352) …Now I would say I am a lot more kind of self-reliant, I am a lot happier within myself (L231)*

P2: *just I would say that I am lot happier with my body image than I was. when I go out now I don’t tend to avoid mirrors or worry as much that I am not as good as other people or as nicely dressed as other people and things, I am happy to be myself (L216)*

P4: *it meant that I had a lot...sort of a lot more confidence, I wasn’t so needy anymore (L338) thinking that the sense of yeah people can value my friendship and I have got something to offer (L465).*

The above statements underlie several themes that will be analysed in the following sections. It is proposed that the subsequent themes identified are evidence that the participants no longer measured their self-worth based on what other people think, or others’ approval.

Sub-theme: Not seeking approval

Five participants identified a major change in their need to seek approval from others as a way of feeling accepted and valued. Participant 1 stated that she is able to not seek reassurance that her job is well done; she seems to have stopped worrying over people’s negative evaluation, especially in the working environment. The same accounts for participant 6 who commented that, especially at work, it was no longer necessary to feel accepted and liked:

P6: *my view is now very much it’s not about.....being seen...or being accepted by everybody, it’s being....it’s getting the job done and it doesn’t matter if you don’t go for a beer afterwards, you know, you don’t have to be liked to get the job done do you? (L291).*

Participant 8 stated that the process of not seeking reassurance had generated to personal and family relationships, which is in agreement with participant 2. She highlighted the fact that not seeking reassurance resulted in not avoiding people. She was able to normalise that, even if there were times where people disagree, this did not mean that she is rejected. By being able to recognise this she stopped feeling the need to seek reassurance:

*P2: I don’t avoid things anymore, I go out... loads really! I am out more than I am in…I don’t feel like I am not good enough for other people except that the people that are in my life want me to be there and obviously, you know, I probably get on their nerves from time to time but they get on mine so...and I just think I am happier because I’m not constantly worrying what other people think or are saying (L157).*

Participant 4 stated that the key to better self-esteem was that she can now receive the respect and validation she always sought from herself, thus, other people seem to respect her more.

Sub-theme: Not pleasing others

Pleasing others was one of the behaviours that used to reinforce assumptions that would undermine people’s autonomy, since in order to feel approved they had to prioritise other people’s needs over theirs. Several participants identified that as their belief in their self-worth increased the need to please others decreased. Participant 1 commented that she felt more equal in her new relationship and, as a result, she would not try and please her partner. Furthermore, because she would not please him she felt accepted, irrelevant of their behaviour. It is interesting though that she uses the word ‘selfish’ to describe not pleasing others, which possibly indicates an element of guilt, however, not so powerful to overwhelm her:

P1*: it’s more of a level equal relationship...I am myself, I don’t try and please him, I am myself but he likes me the way I am so I don’t, we are quite similar (L327) I have mentioned this but I don’t try and please them I don’t try and do everything like right for them, you know I am myself but then again I think more so I kind of, I'm more selfish this time around and that’s not a bad thing (L423).*

Participants 2 and 8 continued to help others, however, not to the extent where their needs were not met. This is understandable as it would be unrealistic to shift 100% from a personality with this tendency towards someone who does not care about people’s needs:

P2: *now I just kind of rationalise it a lot better and think, I do what I can for people and do the things that I can when I can but I need a bit of time for myself as well (L227) again not striving to be better than anyone just thinking that people need to accept me for who and what I am as I do for them and not comparing to other people and not, not kind of trying to please everybody all of the time (L241).*

It appears that they were able to recognise that certain situations were not their responsibility, thus, they did not seem to experience guilt which is a common feeling which reinforces the need to please others. This was the case with participant 6.

P6: *I don’t sit in the room feeling like I’ve got to be the court jester anymore, I don’t feel.....if there’ s a silence, there’s a silence. It’s not my silence and it’s not really my job to fill it (L250).*

Sub-theme: Increased assertiveness

The previous sub-theme is related to this one. The assertiveness training component of the treatment protocol appeared very effective as the outcome was for participants to stop pleasing others; set boundaries; prioritise their needs; and being able to say no; without feeling guilty or engaging in self-criticism as they used to do. Participants 1, 2, 3 and 7 identified that they had become far more assertive at work. A major difference was that their ability to say no, setting boundaries, etc., resulted in managing overcompensation, not feeling exhausted and, above all, not feeling that they were used by others. In addition, in some cases, assertiveness was evident in terms of better communication skills. They would not communicate in a passive and/or aggressive way, thus reaching a point where they felt they were finally being heard by peers, family, and friends:

P1: *it has helped me be more assertive at work, I am definitely more assertive than I used to be obviously like I am a supervisor at work so it has helped me deal with other people a lot more. I am a lot more assertive with them and also I don’t kind of let them, like, upset me whereas before I maybe would have and now I don’t (L242) it has put things into perspective more when I am talking to my parents and I want to get my point of view across I think I do in a much better way (L263)*

P2*: I think I am more assertive at work, I am more confident to say what I think (L203). Just because I think I feel like I can say what I think a bit more but know how to say it in a nice way, so if someone had upset me for example, a friend had upset me, I would deal with it better instead of, you know.....I think sometimes you can inadvertently deal with it badly (L353).*

Becoming more assertive was not relevant only in the professional arena, but also in interpersonal relationships. Participants 3, 5, 6, and 8 reported that by becoming more assertive they had established a better lifestyle and quality time for themselves as they were able to refuse social gatherings when they did not want to go:

P5: *I go out when I want to go out, do what I want and I do enjoy it when I go. I am also happy that if I don’t go it’s because I don’t really want to go, it’s not because I am frightened so it’s a choice, it’s not a fear - should I? Shouldn’t I? It’s a choice, I don’t really want to so...you know, I’m not a particularly sociable person and I accept that so, yeah (L253)*

P6: *It doesn’t matter...you know...if somebody says “oh do you fancy going to the pub”, I would have always..”yeah lets go”...or I would have suggested it whereas now I’m like no I can’t, I’ve got other things to think about and do, other things that are more important (L273).*

Sub-theme: Increased autonomy/relying on self

It was apparent for several participants that as their self-esteem and assertiveness increased, their sense of autonomy also increased. Before they would call themselves ‘needy’ and ‘reliant’ on others, whilst post treatment it appeared that they were confident to rely on themselves as opposed to others. For participant 1 was the significant decision to leave the parental home, which she had postponed for years due to her fear of letting her mother down. Participant 7 took things much further as he decided to leave his marital home, because as his self-esteem increased he was able to recognise that he was experiencing a very unequal relationship with a controlling wife, who would reinforce unhelpful beliefs about himself and emotions of guilt. It is interesting once more the use of the word ‘selfish’ indicating that there is an element of guilt and self- criticism on his behalf for moving on. This is understandable as feeling guilty and being passive has been the way of coping up until the time for treatment, thus it is familiar to think this way, on the other hand this process is not so powerful to change his mind:

*P7: so now....I have moved out of the family home and living on my own, one part of me thinks that this is bloody selfish, you know, because I am actually......you know, I am doing something......I don’t know....I just feel like it’s slightly selfish but then again, I keep reminding myself that I have actually never felt as happy for a long time, you know..... that I don’t have this pressure when I go home in the evening(L438).*

Participant 2 commented that once her self-esteem increased she stopped feeling insecure when her husband was away for business trips. Believing in herself resulted in not perceiving her husband being away as a sign of personal rejection:

*P2: it doesn’t bother me at all now and in fact I quite like it sometimes and I keep myself busy like if my husband’s away then I tend to go out, most of the time I am out more than I am in when he is away but then recently I have just enjoyed having a bit of time to myself and it doesn’t bother me in the slightest whereas before I would get quite upset and annoyed almost about it (L257).*

A very interesting account is given by participant 6, who showed that dependency was generated in the therapeutic relationship as well. However, he was able to recognise it, and because of his increased belief in himself, he was able to challenge it and be compassionate and remind himself of his abilities to cope alone:

*P6: I came to see you last week and you said, you know, about discharging me, I went away and had a bit of a wobble and think oooh you know, and then I thought well no, only you can sort this, you have been given a massive ...amount of help and support and you can’t start using that as a crutch, now you’ve got to go and do it for yourself and you can always come back to it, it’s not that it’s disappearing, it’s not that it’s gone forever but ultimately I’ve got to do it in here without somebody holding my hand all the way (L362).*

**5.2.4d Better quality in relationships**

Sub-theme: Protecting self from unfulfilling relationships

Previous analyses of themes showed a great emphasis on interpersonal relationships. Very often participants would choose the ‘wrong’ type of people, who would validate and reinforce their unhelpful belief systems. Through the course of therapy they were able to recognise the unhelpful dynamics occurring with some of their choices in friends, partners and even in family members. As mentioned in the previous section several participants distanced themselves from unhelpful and unfulfilling relationships.

Participant 1 explains how it helped her recognise that she was having an unequal relationship with a particular friend and that now by becoming more assertive she is able to stay distant enough, in order to protect herself from energy draining encounters. This was not avoidance as she was not distancing herself out of fear of having a conflict, but was doing it in an assertive way by setting boundaries. Similarly participant 2 set boundaries with certain friends that she still sees, although in far less frequency than before:

*P1: I find that the friends that made me feel bad or whatever before or the controlling friends or the demanding friends, like there was one that you know, I talked about quite a bit in therapy and I find that really I don’t really see them that often now, I just see them at like social events (L400)*

*P2: I see less of certain ones and more of others...again because some of the friends that I had didn’t help with making me any more confident (L180).*

Participant 2 describes a similar, but more powerful process as it involves family members. For a very long time she tried hard to gain their approval, which unfortunately she never got. Instead, she would be the victim of emotional and often verbal abuse. She has learned to let go, and accepted that it is not her fault, however, she needs to protect herself from the toxic dynamics between herself and her family:

P2*: I don’t really see any of my family anymore because of how they used to make me feel but I am happy with that and I felt like I tried my best and tried to make amends where I could but it was not on my part that the problem existed so I have, through some of the techniques we used, I kind of looked at what to do in those situations and not having them as part of my life seemed like the right solution for me which again some people might disagree with but I think going back time and time again to be treated the same way would have just kept causing the same problems and it seems easier not be around it (L165).*

The same accounts for participant 8, who like participant 1, experienced a very toxic relationship with certain family members to the level of neglect and emotional abuse:

Sub-theme: Establishing fulfilling relationships

This relates to individuals making more helpful choices in interpersonal relationships, as well as establishing better interpersonal quality within existing relationships. Participants 1, 2 and 8 had a shared point of view, where they underline the importance of feeling equal in their relationships with people. As described above, in order to achieve this, there was distance with certain people, however, this gave space for new people to enter their lives as with participant 1. These people, despite being different from the ones they used to be involved with, had similar interests and attitudes in life, but above all, ‘they’ did not trigger the participants’ belief systems. Instead they would make them feel equal and fulfilled in a relationship that would make them feel good about themselves:

P2: *I don’t feel like I’m not good enough and I kind of know it’s two-sided, most of the relationships are completely two-sided, not just me wanting someone to be there for me and thinking that they are not, or not having to run around after everybody else, they just kind of leave me to my own devices I suppose (L249)*

P8: *I now find myself capable of forming a relationship where there is equality instead of undermining myself. I know what I can give in a relationship, and I also know what I want to get from a relationship more than anything. (L163) P8: I now look for people who are equally confident with themselves, and people who want to achieve certain things in their life, instead of people who want me to be a door mat. (L167).*

Participants 6 and 7 reported that their existing relationships had improved, following the course of treatment. For participant 6 it was the fact that he let go of his control to appear strong and perfect, which helped him establish relationships based on openness and honesty:

*P6: it’s all walks of life and you look at it and think well, the openness that I have shown has enabled me to find out more about these people because they have suddenly gone oh, so you know, it has opened up a better.....or a more honest level, not better, more honest level of communication rather than being “oh yes we’ll have a drink and that will be fine and have you heard the one about the.....” (L215).*

For participant 7 it was the fact that he decided to let go of his controlling marriage, which allowed him to be more relaxed and enjoy quality time with his children:

*P7:...and also with regard to the children it’s ended up meaning I have got a better relationship with the children because now I have moved out of the house, we actually make specific, you know, days out and we go out in the evening for a drink whereas when I was at home and in my cave, largely caused by work yes (L445).*

The following chapter will now look at the implications of the results.

**Chapter 6**

**Discussion**

In this chapter the findings of the research will be discussed in line with the aims and objectives of the study, and the existing literature. The first ‘aim’ of this study was to provide a detailed analysis of people’s experience of perfectionism and how this impacted on their daily lives - only the main findings that contribute to existing literature will be discussed. Some other findings, for example, overcompensation, and procrastination, will be briefly discussed as they have extensively been investigated in previous literature.

The second main aim was to evaluate a specifically designed treatment plan that targeted perfectionism (and low self-esteem) and its efficacy in reducing both perfectionism, and Axis I disorder symptoms. A detailed picture of participant’s experiences of the treatment protocol will be presented, thus contributing to clinician’s knowledge of interventions and therapeutic process issues when working with perfectionistic clients.

**6.1 Evidence of Perfectionism as a Trans-diagnostic Process**

There have been significant developments in the area of CBP for perfectionism, however, to-date there is little empirical research that explored the efficacy of a proposed treatment plan on perfectionism and it’s traits (Barrow & Moore, 1983; Ferguson & Rodway, 1994; Hirsch & Hayward, 1998; DiPartolo, Dixon, Almodovar & Frost, 2001; Shafran, Lee & Fairburn, 2004; Glover, Brown, Fairburn & Shafran, 2007; Pleva & Wade, 2007; Riley, Lee, Cooper, Fairburn & Shafran, 2007; Amster & Klein, 2008; Steele & Wade, 2008; Egan & Hine, 2011; Radhu, Daskalakis, Arpin-Cribbie, Irvine & Ritvo, 2012; Steele, Waite, Egan, Finnigan, Handley & Wade, 2013). One of the closest studies to the presenting research was that of Riley et al. (2007), however, their results did not provide strong evidence of the efficacy of the treatment plan, as there was little change on depression, anxiety and perfectionism. Furthermore, only 50% of the participants met the criteria for an Axis I disorder - the other 50% being a non-clinical sample. The present study involved participants, who all met the DSM-IV-TR (American Psychiatric Association, 2000) diagnostic criteria for anxiety and mood disorders and, who prior to the beginning of treatment, had significantly high scores both on the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI). Specifically, regarding the ABAC study (phase 1) all participants’ depression scores indicated severe, clinical depression prior to treatment. Likewise, the anxiety scores for eight out of thirteen of participants indicated severe, clinical anxiety pre-treatment. Regarding the second group of participants during the ABA study (phase 2), their depression and anxiety scores ranged between moderate to severe prior to treatment. This is in line with Egan & Hine (2011) suggestions that:

‘*To improve upon previous research, future studies should include a larger randomised controlled trial with participants who all meet criteria for an axis I disorder and have symptom scores within clinical ranges pre-treatment so that the impact of treatment on symptoms can be examined’ (p.256).*

Figures 2.1 to 2.13 (Phase 1) showed that the depression and anxiety scores significantly decreased following the shift of the treatment plan focusing on the Axis I disorder(s) to perfectionism and low self-esteem. The section that includes BDI and BAI Mid 2 scores indicate the baseline scores prior to starting the treatment on perfectionism. The reduction is significant and this is supported by the mean and standard deviation scores. The participants’ scores dropped to nominal/minimal levels of depression and anxiety post-treatment. These findings indicate that once the treatment plan focused on perfectionistic traits, this had an effect on anxiety and depression as well. However, it was unfortunate that in this study, the participants were not administered any perfectionism related scores, apart from the perfectionism sub-set in the Dysfunctional Attitudes Scale (DAS). It would have been interesting to have additional information related to perfectionism and which aspects of the same changed as well.

This information was provided in the second study (Phase 2) where relevant perfectionism measures were utilised, which will be discussed later. Looking at the depression and anxiety scores for these participants the BDI and BAI scores were very high during the baseline period and then significantly reduced following the treatment protocol indicating nominal and mild levels of depression and anxiety only. These lower scores were sustained and, in cases further reduced, after a month’s follow up session. A limitation here is that it would be more detailed and informative to administer all the measurements on a weekly basis to monitor progress, thus providing some indication as per when the changes occurred in terms of a) number of therapy sessions and b) the interventions utilised. However, a sound understanding with regards to the effectiveness of specific techniques and the pace of the progress has been provided from the qualitative results. Additionally, it would be informative to provide disorder specific measures that could clearly show the decrease in the presenting problem, thus supporting quantitatively that perfectionism can be treated on a trans-diagnostic basis. Therefore, a further limitation is that, whilst there is clear reduction in anxiety and depression, there is no quantitative evidence that shows a reduction on the presenting problem, for example, social phobia, OCD.

Despite the above limitations, the qualitative interviews and the results have provided substantial evidence that the presenting problem has indeed been eliminated, thus supporting the idea originally stated by Frost and Steketee (1996), and later on by Shafran and Mansell (2001), that perfectionism can be treated as a trans-diagnostic process. The findings of the present research showed evidence, which confirmed the argument that:

*‘Perfectionism can be viewed as a transdiagnostic issue, and targeting this maintaining mechanism may potentially provide symptom reduction across a range of disorders’* (Egan & Hine, 2008, p.245).

The findings derived from the present research add to the results of previous studies (Glover et al., 2007; Riley et al., 2007; Steele & Wade, 2008; Egan & Hine, 2011) none of which resulted in a significant reduction in anxiety and depression scores. The present research provides some insight as to the reasons why previous studies did not produce strong evidence of the efficacy of the treatment plan in reducing both perfectionism and Axis I disorder symptoms. A possible explanation could be that the previous studies utilised a brief treatment protocol (8 to 10 sessions), whilst the present study did not have an official limit regarding the number of sessions. In phase one, from the point where the treatment plan shifted to perfectionism, the participants had an average of 14.5 sessions (ranging from 5 to 23 sessions). In phase two, the participants had an average of 15.5 sessions overall (ranging from 10 to 21 sessions). This suggests that if a treatment protocol is provided for longer periods it may have a significant effect on the outcome regarding anxiety and depression scores. This is in line with Egan and Hine (2011) suggestions who state that *‘It would be useful to also examine the length of treatment that is required before symptoms may start to change’ (p.256).*

Another explanation is the fact that in previous studies perfectionism was treated as an intrapersonal issue with no reference to interpersonal relationships. In other words it was treated as a uni-dimensional construct where perfectionism manifests as setting unrealistic standards, engaging in self-criticism and as a result overcompensation and avoidance/procrastination. All these processes are self- induced. However, the findings of the present study advocates for a protocol that treats perfectionism as multidimensional construct, where the relationships with others play a significant role in perfectionism in many different ways.

**6.2 Evidence of Perfectionism as a Multidimensional Construct**

The present study contributes to the literature as further evidence that perfectionism is a multidimensional construct in line with the available literature (Frost et al., 1990; Hewitt & Flett, 1991; Terry-Short, Owens, Slade, & Dewey, 1995) and that once the maladaptive nature of it is treated, then it can function positively for the individual. The majority of studies to date have investigated the multidimensional nature of perfectionism from a quantitative perspective, mostly using non-clinical samples, thus resulting in very limited information with regards to the experience of perfectionism in depth. In addition it can be argued that the results with regards to the adaptive nature of perfectionism have been quite biased as the research to date focused on selective aspects of perfectionism, such as performance and motivation, on a very selective sample involving high achievers, sports athletes and gifted students. The present study has exclusively focused on a clinical population, where all the participants were meeting the criteria for Axis 1 disorders and, in certain cases comorbidity with other disorders was also present.

The results from phase 2 demonstrate the results in decreasing perfectionism. All participants had elevated scores on the Multidimensional Perfectionism Scale (MPS-F) and the Perfectionistic Self-presentation scales prior to treatment, however, post-treatment the ratings decreased significantly. The results showed that all participants, prior to treatment, scored high on personal standards, concern over mistakes, order and doubts about actions. Whilst post-treatment all the scores reduced significantly apart from the scores for personal standards - these decreased but still remained relatively high.

These findings draw attention to some interesting findings. According to literature it could be expected that holding high personal standards is unrelated to negative feelings such as depression and anxiety (Frost et al., 1993; Parker & Stumpf, 1995; Rice, Ashby & Slaney, 1998; Lynd-Stevenson & Hearne, 1999; Blankstein, Halsall, Williams, & Winkworth, 2000; Stumpf & Parker, 2000; Enns, Cox, Sareen, & Freeman, 2001; Suddarth & Slaney, 2001; Cox, Enns, & Clara, 2002; Bieling et al., 2003; Dunkley, Dunkley, Zuroff, & Blankstein, 2003; Bieling et al, 2004; Chang, Watkins, & Banks, 2004; Hill et al., 2004; Rice, Lopez & Vergara, 2005). Based on the definition of positive or adaptive perfectionism, high personal standards should make people experience positive effects with regards to achievement; elevated self-esteem and self-efficacy; increased motivation to succeed and gain greater satisfaction in life. However, the participants in this study did not; instead they experienced elevated levels of distress, anxiety and depression. All of the participants disclosed that they held high standards in different domains and for almost all of them those standards where imposed by themselves leading to maladaptive behaviours and emotional distress, thus validating the concept of self-oriented perfectionism, however, not as an adaptive construct.

A smaller number of participants (3 out of 8) disclosed that they held high expectations of others too, which often resulted in domineering behaviour, vindictiveness, and at times being judgemental towards others. This is in line with Habke and Flynn (2002) who argued that people with other-oriented perfectionism behave in this manner, resulting in interpersonal difficulties. This study provides a deeper understanding of this in that the tendency to have high expectations of others manifested differently according to different life domains. For example, in the work domain for one participant it meant that she would be overwhelming and domineering with co-workers and end up overcompensating out of fear of failure in line with Robinson (1998) and Porter (2001).

Interestingly, all participants believed that they were expected to meet other people’s standards as well, thus providing further evidence of socially-prescribed perfectionism. Meeting other’s standards had a major effect as it led people to engage in overcompensation and behaviours that undermined their self-confidence such as pleasing others and lacking assertiveness. The qualitative results provided further evidence that often self-oriented perfectionism and socially-prescribed perfectionism co-exist, which is again in line with others’ findings (Hewitt and Flett, 1991). Further support for the notion that perfectionism should be encountered as multidimensional, with a strong reference to interpersonal relationships, are the findings from the Perfectionistic Self-presentation scale. It is proposed that this adds to the evidence of socially-prescribed perfectionism, since they are very strongly linked.

**6.3.1 Perfectionistic Self-presentation as Evidence of Multidimensional Perfectionism**

What becomes apparent is that most participants scored very high on the perfectionistic self-promotion trait in relation to the other two traits. The second trait that they scored very high on is the non-disclosure of imperfection, and the least high is the non-display of imperfection (behavioural aspect of perfectionism). The reduction in the scores post-treatment is highly significant indicating the effectiveness of the proposed treatment protocol, when focused on the interpersonal element of perfectionism.

The findings with regards to perfectionistic self-presentation are quite important, as there is limited research investigating how perfectionists behave in social situations and in their interpersonal relationships. The present study provided extensive information in this area and is the only qualitative study that can provide evidence to Hewitt and Flett’s (2003) quantitative study of how perfectionistic self-presentation manifests interpersonally. From a quantitative point of view, the results indicate that individuals who score high on the Perfectionistic Self-presentation scale experience low self-esteem. This has been evident from the scores on the Rosenberg Self- esteem Scale. This is understandable as people lacking confidence would try to protect themselves from appearing ‘wrong’ and anything rather than perfect out of fear of rejection. Additionally, they would not have the confidence to disclose imperfections and would avoid disclosing weaknesses and mistakes, again as a way of preserving approval. Avoidance and ‘making up’ excuses was a defence mechanism to protect them from not appearing good enough, which is in line with Flett and Hewitt (2003) findings on facets of perfectionistic self-presentation.

**6.3.2 Maintaining Control**

The results revealed that an important area where perfectionism was manifested was the participants’ tendency to maintain control of their emotions, which included not disclosing information that could show to others their perceived ‘weaknesses’. No studies have been found that directly link perfectionism with issues of self-control, although Park, Heppner and Lee (2010) touched upon the issue, although utilising quantitative methods and a non-clinical population.

Studies have indicated that self-control is a protective mechanism linked to positive outcomes as it helps people attain their high goals; regulate emotions; manage unhelpful behaviours such as procrastination; and have high interpersonal skills, thus experience positive relationships (Tangney et al, 2004; Duckworth & Seligman, 2005; Schmidt et al, 2007; Achtziger & Bayer, 2012) and also adaptive work styles (Accordino et al, 2000; Mills & Blankstein, 2000; Achtziger & Bayer, 2012). The results of the present study show a different picture. Whilst the majority of participants had high self-control, they were unable to manage worry effectively; their tendencies to maintain control led to overcompensation and avoidance; which would eventually lead to psychological distress and increased levels of guilt and shame. This further increased self-blame and self-criticism as supported by Ashby, Rice and Martin (2006).

An area, which was mostly affected, was that of the relationships with others as people would not disclose how they felt, nor display emotions, and this affected their sense of belonging and elevated their distress. This supports Park, Heppner and Lee’s (2010) study, which showed that self-control was a maladaptive coping strategy that caused distress and affected interpersonal relationships. The majority of participants in Phase 2 of this research (6 out of 8) reported that they would avoid people and engage in withdrawal behaviours, because they did not want people to see them not being in control:

* Participant 7 experienced frequent conflicts in the marital environment and withdrawal from his children,
* Participants 4 & 8 experienced isolation as this factor prevented them from forming relationships,
* Participants 3, 2 & 5 would have extremely limited social life.

These results further support Flett, Hewitt and DeRosa’s (1996) findings, that is, people with perfectionistic concerns and control issues would engage in isolation, avoidance and withdrawal as a way of coping. Once again, the present study showed that a strong influence of avoidance and withdrawal had a link to interpersonal factors.

The results also revealed that on certain occasions, control issues affected the therapeutic process as people would avoid ‘sensitive issues’ out of fear of losing control and appearing vulnerable and weak, at least at the beginning of treatment. This may validate previous findings that perfectionistic self-presentation is the perfectionism dimension that could be responsible for the difficulties posed in psychotherapy by perfectionists (Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998). These findings have important clinical implications indicating that treatment protocols should include interventions to address issues of control, as the present one did. For example, interventions would include a cost and benefit analysis; challenging of beliefs such as ‘always appearing in control’, ‘if I show emotions, people will think I am weak’; and behavioural experiments, that is, ‘opening up’ to people and testing whether they will be judged or rejected for ‘appearing weak’.

It is proposed that another major clinical implication to be taken in account is that perfectionistic clients may experience great difficulty in dealing with vulnerable issues, at least at the beginning of treatment. Therefore, clinicians should address these issues and relate it back to the client’s perfectionistic formulation and utilise the specific techniques previously described. Additionally, the clinician needs to be particularly empathic and normalising of the client’s difficulties throughout. This is how issues of control were addressed and treated in this study, which is an area that previous protocols have not addressed, as they did not address control issues as being a part of perfectionism. These findings provide some good evidence that reply to Flett, Besser, Hewitt and Davis’s (2007) suggestion for research where they argued that:

‘*Related research should focus on the possibility that certain perfectionists do not express negative emotions…self-silencing may result in engaging publicly in perfectionistic self-presentation’ (p1220).*

**6.4 Developmental Factors**

Whilst the aim of the present study was not to focus on developmental factors of perfectionism, from the accounts of four participants there was some insight revealed with regards to developmental factors affecting the adaptation of high standards. It became apparent that in some cases, parental expectations were the contributing factor to the development of perfectionistic striving. This provides some qualitative evidence that supports previous research (Rice, Lopez, and Vergara, 2005; McArdle & Duda, 2008) and especially evidence for the Social Expectation Model as proposed by Flett, Hewitt, Oliver & Macdonald (2002). Two participants (p 1 & 2) disclosed that they perceived their parents/carers always holding high expectations of them. Additionally to parental expectations, participant 1 provided some evidence with regards to parental criticism and controlling behaviour over her - unfortunately this was not further explored in the interviews. However, it was known throughout the treatment course that she was an only child resulting in her feeling very lonely and controlled and that all the demands to succeed were down to her, continuing into adulthood. Her parents, especially her mother, would often use controlling behaviours such as guilt-inducing behaviours, criticism, and intrusive behaviour, thus providing some qualitative evidence in line with previous research (Soenens, Elliot, Goossens, Vansteenkiste, Luyten, & Duriez, 2005; Soenens, Vansteenkiste, Luyten, Duriez & Goossens, 2005) to support that parents’ controlling behaviour can affect a child’s perfectionism. This may also add support to research (Frost, Lahart, & Rosenblate, 1991; Vieth & Trull, 1999) that suggests that same sex parents can be more influential in the development of their child’s perfectionism. Indeed, with this participant the influential figure she identified that affected her tendencies to doubt herself, be self-critical and experiencing low self-esteem, is her mother.

A similar case was participant 2, where the influential figure was her grandmother, who she often referred to in her treatment as being a very hostile, critical and demanding woman, who would often portray controlling behaviours marked by withdrawal of love and guilt-inducing behaviours. Once again, this provides qualitative evidence in line with previous research that looked at the issue from a quantitative perspective (Frost, Lahart, & Rosenblate, 1991; Vieth & Trull, 1999; Soenens et al., 2004; Soenens, Elliot, et al., 2005). It also provides evidence supporting that the lack of maternal care and affection (in this case grandmother) has an effect on perfectionism, in line with Enns, Cox & Larsen (2000).

The Social Expectation Model generalised to other influences aside from parental expectations and this was confirmed by one participant (p 7) who argued that his wife was a reinforcing factor of his socially-prescribed thought processes. It is unfortunate that this participant did not mention in the actual interview how his early experiences affected the development of his perfectionism, however, through the treatment course he mentioned on several occasion that his father, in particular held high expectations of him.

The qualitative results provided some evidence with regards to the Social Learning Model (Flett, Hewitt, Oliver & Macdonald, 2002) as one participant (p 4) disclosed that a reinforcing factor of her high standards was that all family members were high-achievers. She used to compare herself to these role models and she grew up admiring them and wanting to imitate them. It is important to explain that this participant’s parents were overall very caring and attentive towards their children. Previous studies (Frost, Lahart & Rosenblate, 1991; Chang, 2000; Flynn, Hewitt, Flett & Caelian, 2001) showed quantitatively that there was a relation between children’s perfectionism and their parent’s perfectionism, as they both scored highly on the relevant measures. However, these studies did not explicitly highlight the role of modelling, as parent’s perfectionism could manifest in behaviours such as being critical and demanding that could lead to the child’s perfectionism. The current study shows some evidence of a direct link between perfectionism and the role of modelling.

An interesting finding derived from the statements of another participant (p 8) was that she ‘argued’ that her perfectionistic beliefs were reinforced due to the absence of inspiring role models. This could still be viewed as support for the Social Reaction Model (Flett, Hewitt, Oliver & Macdonald, 2002) and findings on the effect of insufficient supervision (Barber, 1996; Gray & Steinberg, 1999), since this person was a perfectionist in order to cope with neglect and lack of attention from the family environment. She was an only child and it is a limitation of the study that this factor was not further discussed in the interviews. It would be interesting to identify how being an only child could have affected this person’s perfectionism. That was the case for another participant too (p 5), who, whilst she did not mention in the interviews anything regarding early experiences, from assessment it was revealed that she had to take the role of the carer, being from a single parent family, where her mother was absent most of the day due to work.

The present study showed some evidence of longitudinal factors influencing perfectionism. The above information was used in the psycho-educational phase of treatment when the participants were shown the formulation. Most studies to date explain perfectionism in treatment from a cross-sectional point of view. It is only in the self-help book ‘Treating Perfectionism’ (Shafran, Egan & Wade, 2010), where developmental factors are referred to. As it will be discussed later, including developmental factors in the formulation of perfectionism appeared very helpful for all participants. This appears to be an important omission of previous treatment protocols.

**6.5.1 Doubting Self and Self-criticism**

The quantitative results indicate that when high standards are accompanied by doubts about actions and concern over mistakes they hinder the potentially positive effect of setting high standards, which is in line with other literature (Hill, Huelsman, & Araujo, 2010; Stoeber & Otto, 2006, Stoeber, 2012). As suggested by Stoeber & Otto (2006) individuals scoring high on perfectionistic striving (i.e. personal standards) and high on perfectionistic concerns (i.e. concern over mistakes and doubts about actions) are experiencing the maladaptive side of perfectionism. From the quantitative results from this research, this is the case for the participants prior to treatment, which was validated further by the qualitative analysis.

Seven out of eight participants engaged in self-doubt beliefs linked to concern over mistakes and five out of eight would engage in thought processes linked to doubts about actions. This resulted in overcompensation with detrimental consequences, mainly affecting their lifestyles, as they had to sacrifice pleasurable activities over work and their wellbeing. The majority of the participants eventually experienced burn-out, exhaustion and depression. The proposed treatment plan addressed the issue of overcompensation slightly differently from other treatment protocols. Overcompensation here was linked with lack of assertiveness and the need to gain approval, because it became apparent from several participants that their inability to say no to other people often resulted in overcompensation. The latter would ensure approval, thus people would fall into a vicious circle that often resulted in a self-fulfilling prophecy as described by Flett & Hewitt (2003). Thus, the treatment protocol focussed on assertiveness training; inclusion of pleasurable activities via activity scheduling; reduction of working hours; and compassionate mind training in order to deal with guilty emotions and self-blame/criticism beliefs as proposed by Gilbert & Irons (2005).

It appeared clear that the participants’ need to attain their goals was motivated by increased levels of shame and guilt as proposed by several other previous studies (Hewitt & Flett, 1991; Lutwak & Ferrari, 1996; Tangney, 2002; Klibert, Langhinrichsen-Rohling, & Saito, 2005). Several participants disclosed often experiencing emotions of guilt and shame, which would manifest in the form of self-blame and self-criticism. The present study validated qualitatively several studies that underlined the process of self-criticism and self-blame and this is the main area where the treatment protocol as suggested by Shafran et al (2002, 2004, 2007, 2010) is similar to this current treatment protocol. However, the qualitative results revealed a manifestation of self-criticism that has not been addressed by previous treatment protocols.

**6.5.2. Unfair Comparisons**

In line with previous quantitative studies (Flett, Besser, Davis & Hewitt, 2003; Thompson and Zuroff, 2004; Neumeister & Finch, 2006; Trumpeter et al, 2006; Hill, Hall & Appleton, 2011) it was found that high standards were reinforced by the participant’s tendency to make unfair comparisons with others. These comparisons would provide a sense of how people should be in order to gain acceptance and approval by others, however, they were not objective in a sense that the perfectionistic person would put others on ‘a pedestal’ even if this was not the case. At the same time the participants would ‘put themselves down’ as they failed to compare adequately to people who they considered superior.

This study showed qualitative evidence that supported Thompson & Zuroff (2004) findings that perfectionists tend to engage in comparative self-criticism which is ‘the unfavourable comparison of the self with others, who are seen as superior’ (p.421). In addition it provides further evidence as per the multidimensional nature of perfectionism. Five out of eight participants gave significant support that unfair comparisons was one way to criticise themselves, which in turn reinforced perfectionistic striving. This is in line with Gilbert (1992) who argued that unfair social comparisons would reinforce submissive behaviour, which in turn would reinforce perfectionistic traits, thus underlining the necessity to address this in treatment.

The concept of self-comparison has not been addressed in previous treatment plans, certainly not as an aspect of self-criticism. The concept of self-criticism has been addressed in treatment protocols, however, unfair comparisons with others hasn’t; the present study shows that this is a major omission. Therefore, clinical implications underline that comparative self-criticism should be addressed in treatment. The proposed treatment protocol has addressed this issue by the use of thought challenging techniques and, specifically, cost/benefit analysis of comparing self to others and additionally by the use of continuum technique. Further work on comparative self-criticism utilised compassion training.

Once self-criticism and overall perfectionistic concerns were addressed, the picture changed post-treatment showing that people were still able to have high standards, without experiencing anxiety and depression. Six out of eight participants agreed that they still held perfectionistic traits, however, they were not affecting their wellbeing anymore. Therefore, this study provides qualitative evidence supporting the positive nature of perfectionism. This again is in line with Stoeber & Otto (2006) who argued that high perfectionistic striving and low perfectionistic concerns can lead to adaptive and positive perfectionism.

The present study replicates the findings of previous research (Bieling, Israeli, Smith, & Anthony, 2003; Bieling, Israeli, & Anthony, 2004), which demonstrated that positive striving as suggested by Frost et al. (1993), is indeed related to both negative as well as positive characteristics. This provides further evidence of the multidimensional nature of perfectionism and the existence of what is called positive perfectionism. These results are in contradiction with Shafran, Cooper & Fairburn’s work (2002) who proposed that perfectionism is a uni-dimensional construct, where high personal standards, and the maladaptive behaviours that accompany them, should be focus of treatment. It could be argued that the reason why previous studies (Glover et al., Riley et al., 2007) did not show strong efficacy of the treatment plans in the significant reduction of perfectionism, anxiety and depression, is due to the fact that perfectionism was treated as a uni-dimensional construct. It is proposed that the success of the proposed treatment plan in this study is due to the fact that perfectionism was treated as a multidimensional construct with a strong link to interpersonal factors.

**6.6 The Importance of Addressing Lacking Assertiveness and Pleasing Others**

The quantitative results on the Perfectionistic Self-presentation are in agreement with previous research (Flett, Hewitt, Blankstein, & O’Brien, 1991; Baumeister & Leary, 1995; Leary, Tambor, Terdal, & Downs, 1995; Crocker & Wolfe, 2001;Hewitt & Flett, 2003) where it was found that the driving force of perfectionistic self-presentation is the need for love, approval, acceptance and belonging. This suggestion has been validated by the scores on the DAS where, prior to treatment, individual’s scores showed great vulnerability especially in issues of Love, Approval, Achievement and Perfectionism. Additionally, qualitative evidence is provided by the lengthy accounts that showed the participants’ need to gain approval and acceptance resulting in overcompensation that took the form of pleasing others, lacking assertiveness and seeking reassurance. As Flett, Besser, Hewitt & Davis (2007) argued:

*‘Both self-silencing and perfectionistic self-presentation reflects defensiveness and an unwillingness to reveal negative aspects that could potentially result in a loss of approval of significant others’ (p.1220).*

All participants provided accounts that underlined the fact that they were lacking assertiveness resulting in significant problems in their interpersonal relationships. The qualitative results provided significant evidence to support Hewitt and Flett (1991) that socially-prescribed perfectionists engage in excessive pleasing of others type behaviours; lack autonomy (Deci & Ryan, 2002); experience shame and guilt (Wyatt & Gilbert, 1998) and lack of assertiveness in the form of ‘self- silencing’ where the individual would avoid saying no, expressing personal needs and opinions (Drew, Heesacker, Frost & Oelke, 2004; Flett, Besser, Hewitt & Davis, 2007). An important finding here is that all the above are driven by the need to be approved and accepted and not by the need to appear perfect. For example, participants would feel shame and guilt, not because they made a mistake per se, but because a mistake would mean that he/she had let people down, resulting in appearing as ‘not good enough’ in different interpersonal domains, such as, friendships, love life, etc., and of course resulting in not gaining approval. Likewise, overcompensation was often related to pleasing others so to gain a sense of belonging, not simply out of fear of failing.

This has major clinical implications as treatment focused on what was really feeding perfectionism - not the concept of failing but the concept of gaining disapproval. The treatment plan focused on:

* Cost/benefit of being approved by others at all times
* Continuum work on always pleasing others and other aspects that would make them the perfect person
* Response prevention techniques on seeking reassurance
* Lengthy sessions on assertiveness training paired with psycho-education, role plays and real life experiments of saying no and being assertive in certain situations.

In addition activity scheduling involving spending time alone was utilised with the rationale of increasing a participant’s autonomy.

It is proposed that this is a highly significant, and the most effective, part of treatment as it provided participants with greater sense of autonomy, self-esteem and directly challenged their perfectionistic beliefs as they realised that they did not need to be the perfect person in order to gain approval.

Existing literature (Flett, Hewitt, Garshowitz, & Martin, 1997; Zuroff, Blatt., Sotsky, Krupnick, Martin, Sanislow & Simmens, 2000; Zuroff & Duncan, 1999; Zuroff & Fitzpatrick, 1995; Zuroff, Stotland, Sweetman, Craig, & Koestner, 1995), suggested that perfectionists fail to establish satisfying relationships, due to their self-criticism and perfectionism. However, these studies did not provide an in-depth picture as to how self-criticism and perfectionism interfered with relationships. A very interesting finding in this study, regarding unfulfilling relationships, was that several participants had formed relationships with people who would actually reinforce and validate their unhelpful belief systems. This is in line with Young’s concept of ‘schema attraction’ (2003) and there were several examples where participants would be drawn to the ‘wrong’ people. They chose friends and partners who would be demanding, critical and possessive; who would reinforce emotions of guilt and shame; thus validating their belief system that they are good enough unless they please others.

Seven out of eight participants validated that, at some point in their life, they had engaged in unfulfilling relationships with people who made them feel bad about themselves, frequently seeking reassurance and approval from people where they were unlikely to receive it. Additionally, they would have perfectionistic concerns linked to their interpersonal relationships in the form of self-criticism and self-blame, which in turn reinforced perfectionistic striving in the form of lacking assertiveness and pleasing others.

This draws attention to another clinical implication, that is, clinicians should undertake a thorough assessment of relationships - looking at common features in choice of partners and friends, in order to increase the person’s awareness of how certain dynamics in relationships reinforce self-doubt and perfectionistic beliefs. It is interesting that, to date, research showed that perfectionistic striving was not related to relationship problems (Stoeber & Otto, 2006; Ashby, Rice & Kutchins, 2008).

The present study, though, showed different results as perfectionistic striving prevented participants from establishing boundaries, thus protecting themselves from unfulfilling relationships. Several participants would strive to become the perfect daughter/ partner/ lover, which that led to overcompensation and lack of assertiveness. This was also the reason why many of the participants would experience high distress being in relationships that increased and reinforced their perfectionistic concerns, thus validating some very recent studies (Mackinnon, Sherry, Antony, Stewart, Sherry & Hartling, 2012; Stoeber, 2012).

The current study is the only one known that provides some qualitative reports that give light to how perfectionism affects relationships, and how treatment can have a positive effect in relationships.

Going back to the quantitative results of DAS, Perfectionistic Self-promotion and the Rosenberg Self-esteem scale, it is evident that the proposed treatment plan is not only effective in reducing perfectionism and psychological distress, but also attitudes and behaviours that are associated with interpersonal relationships, thus leading to a better sense of self-worth (as indicated by the elevated scores in the Rosenberg scale and the positive scores on the DAS). Both qualitative and quantitative results showed that perfectionism manifests strongly in interpersonal relationships as suggested by recent studies (Hill, Hall & Appleton, 2011; Mackinnon et al, 2012; Stoeber, 2012) and overlooking this aspect in any proposed treatment plan could lead to lack of effectiveness.

**6.7 Domains of Perfectionism**

Despite the number of studies investigating perfectionism, the majority of them utilised a quantitative methodology, thus calling for further research that could provide rich information as per the experience of perfectionism. The present study is one of the very few (Slaney & Ashby, 1996; Sloat, 2002; Rice, Bair, Castro, Cohen & Hood, 2003; Neumeister, 2004a-b-c) that provides a detailed picture of how perfectionism manifests in several areas of people’s lives; how it affects those domains; and how is linked to low self-esteem and psychopathology. With regards to which domains people become perfectionists in, Hewitt and Flett (1991) argued that perfectionism affects all domains. A few research studies emphasised that perfectionism is generated mainly in the occupation/educational arena (Mitchelson & Burns, 1998; Dunn, Gotwals, & Dunn, 2005), on the other hand others (Slaney & Ashby, 1996) suggested that perfectionism affects several different domains. The present research did not evidence that perfectionism affected all the domains in people’s lives to the same degree as suggested by Hewitt & Flett (1991); however, it showed that several domains were strongly affected in different ways.

It was evident that same people wanted to achieve perfection as employees; and then as fathers/mothers; and then as family members; and as partners; and so on. The results revealed that there are several domains where perfectionism manifests replicating the results of previous studies (Slaney & Ashby, 1996; Coles, Frost, Heimberg, & Rhéaume, 2003; Stoeber, 2009) and these are work/occupation and education; domestic as in cleaning, tidying, etc.; personal interests and hobbies; beauty and appearance; social skills; and a major area that appeared to be affected is that of relationships.

The conclusion that one can draw from these findings is that perfectionism manifests in different ways according to the circumstances. Therefore, it appears to be ineffective to treat perfectionism as a constant and stable manifestation of behaviours and attitudes as has been done so far. This is a point that clinicians should take into account as it appeared from the results that holding high standards changes according to everyday circumstances and different domains. Therefore, an idiosyncratic formulation would be appropriate, instead of a ‘fixed’ one that focuses on the process of attaining high standards on oneself alone, as proposed in previous studies.

As mentioned previously, this study is the only qualitative one known that demonstrates how perfectionism has such a strong link to relationships with others. The areas identified are the selection of partners; autonomy and dependency on others; expectations of others; how people should appear in front of others; and dynamics within friendships; love life, marital relationships and family. This study provided sound information as to how these domains are affected, thus contributing to existing literature and contributing towards answering Stoeber’s (2009) suggestion that:

*‘Unfortunately, very little is known about what domains of life are most frequently affected by perfectionism - even though the measures to find out have been available for some time’ ( p.4).*

The strong indication that perfectionism is manifesting and generating in interpersonal relationships underlines the necessity to shift existing treatment plans, from the intrapersonal perspective, where attaining high standards is the main focus, towards an interpersonal perspective where the focus is on how these perfectionistic standards affect the behaviours and attitudes of people in relation to others and likewise, how others respond to perfectionists. This was the focus of the present treatment protocol; hence the positive results in terms of treatment perfectionism and emotional distress.

**6.8 The Effectiveness of the Treatment Protocol**

Whilst some aspects of the treatment protocol have already been referred to, specific interventions will now be discussed in greater detail.

**6.8.1 Formulation and Psycho-education**

Almost all participants (7 out of 8) stated that they gained greater awareness and insight; indicating that they benefited from an idiosyncratic, longitudinal formulation, which explained why they developed perfectionistic traits and how perfectionism manifested in everyday life resulting in symptoms related to their presenting problem. The majority of participants (5 out of 8) were intrigued by the explanation of schemas and early life experiences in relation to perfectionism and low self-esteem. It became very clear that gaining awareness provided the participants with a sense of control as they started recognising which processes were occurring when they felt unhelpful emotions and behaved in unhelpful ways. The experience of schemas being activated became a conscious process and they started recognising it and it gave them a sense of understanding regarding which areas they could work on in order to feel better.

Additionally, it was apparent, ‘exploring’ early experiences resulted in becoming more compassionate towards themselves, as it became clear that holding certain beliefs about themselves was not their fault and, likewise, there was a reason why they behaved the way they did. Additionally, one participant mentioned that it helped her become more compassionate towards others, as through the formulation and education on schemas, she was able to understand and empathise with other people’s attitudes, thus challenging her attitudes towards others that related to ‘other-oriented perfectionism’.

Finally, almost everybody (7 out of 8) experienced a sense of ‘normalisation’ of their difficulties, which affected them positively and gave them a sense of hope that increased motivation to engage in therapy and comply with the treatment plan. These findings are in line with Finn and Tonsager (1992) and Aldea, Rice and Rojas (2010) whose findings indicated that ‘perfectionists’ benefit from learning about their perfectionism and receiving feedback regarding their perfectionistic attitudes, and that this has a positive effect in the reduction of their psychological distress.

This draws further attention to the necessity of including a longitudinal, and not a cross-sectional, formulation which clinicians should frequently refer back to throughout therapy in order to increase the client’s awareness. Additionally a multidimensional rather than a single model of formulation appears to be a more complete and established way of explaining perfectionism, since it appears that several factors from early life experiences, attention, schemas, reasoning, behaviours, interpersonal and sociocultural factors can influence perfectionism. Therefore, a formulation following the guidelines by Townend and Grant (2008) and Grant & Townend (2008) appears more effective and relevant, rather than a uni-dimensional, cross-sectional formulation of clinical perfectionism as proposed by Shafran, Cooper and Fairburn (2002).

**6.8.2 Cognitive Techniques**

All participants had positive comments to make with regards to their experience of cognitive work. Overall, six out of eight participants (p1-p2-p3-p4-p6-p8) argued that the cognitive work helped them balance their dichotomous thinking and to recognise that their standards are unrealistic; to convert to a more rational way of thinking; to depersonalise and challenge personalising errors (p1-p2-p7-p8); and to stop comparing themselves unfairly towards others and/or an unrealistic ‘model of perfection’ (p4-p8). The cognitive techniques appeared to be very helpful in reducing perfectionistic concerns and in increasing self-acceptance, satisfaction and wellbeing, thus validating qualitatively the findings on positive reframing in perfectionism by Stoeber and Janssen (2011).

However, the findings provide some evidence that does not support Longmore and Worrel’s work (2007). Following their review of several studies, they came to the conclusion that cognitive interventions do not add to the value of psychotherapy and that they are not necessary components of treatment. A possible explanation could be that the studies reviewed did not focus on perfectionistic concerns and perfectionism overall, but to the reduction of Axis I disorders symptomatology. This could mean that a very important maintaining factor, that of perfectionism, was not subject to treatment at all, hence the unsatisfying treatment outcome.

From all the cognitive techniques one of the most helpful and effective appeared to be the positive log, which was identified by six out of eight (p2-p3-p4-p5-p6-p8) participants as very helpful. The continuum work was identified by five participants (p1-p2-p3-p4-p7) as being very effective; and the cost and benefit analysis, which was identified by four out of eight participants (p2-p4-p5-p6).

Continuum work

This appeared to be one of the most effective techniques in challenging dichotomous thinking, as suggested by Padesky (1994), and James and Barton (2004). It helped the participants recognise that being on the extreme end of being totally successful held as many costs and negative consequences, as being on the extreme of being a total failure. In addition, defining what a failure is helped the participants to recognise that they did not meet the criteria they identified as evidence of being a failure. In other words the continuum appeared helpful in challenging selective attention errors, that is, the participants’ tendency to focus on limited evidence to support a global result and dichotomous thinking. There was one participant (p1) who reported that the continuum did not appear helpful, however, they did not participate in this technique fully, arguing that it felt irrelevant and that she had more important issues to deal with at the time. A limitation regarding the interview process was that this issue was not further explored. It was assumed, however, that this participant did not want to relinquish her tendency to think in dichotomous terms and setting high standards, out of fear that this could lead to a potential failure. This assumption required further investigation.

It is important to underline that the participant’s comments support the efficacy of the continuum technique as it was carried out and modified from the researcher/clinician (refer to appendix 1 re the treatment plan). This step by step guide of utilizing the continuum is not evident in any other book or paper.

Positive data logging

Six out of eight participants (p1-p3-p4-p5-p7-p8) stated that this helped them identify and recognise their achievements, thus challenging their tendency to focus on the negatives. Half of the participants (p2-p3-p5-p8) reported that it not only helped them focus on positives, but also helped them eliminate self-criticism, thus making positive logging an effective technique in eliminating perfectionistic concerns and self-criticism. Only one participant (p6) stated that it was not helpful to him, however, from his accounts it appeared that the process of focusing on the positives was already occurring mentally, thus putting things in writing appeared unnecessary.

The findings show that certain process issues emerged. One was the difficulty in identifying positives. For example, two participants (p3-p8) found the process of identifying positives very challenging as their natural tendency was to focus on the negatives since that was familiar to them. This process draws attention to the necessity for the clinician to frequently check the entries in the positive log, especially at the beginning, so to address negative entries and also help the client to recognise positives. Another issue was that logging positives reinforced critical self-talk for certain participants (p2-p5). For example, participant 5 commented that it felt ‘stupid’ to write down simple tasks and consider them achievements, and participant 2 believed that this potentially could lead to them becoming ‘big-headed’. It is unfortunate that there are not many accounts reported in the interviews regarding the process issues that can emerge when doing the positive logging, but from the researcher’s clinical experience it was apparent on several occasions that positive logging would also promote shame as participants would feel ashamed to write down positives about themselves. It can be argued that this is a limitation of the interview not to explore further what sort of emotions and difficulties people experienced when writing positives. The above findings indicate certain clinical implications, that clinicians should focus on how positive logging reinforces critical self-talk and utilise techniques such as compassionate mind training and cognitive restructuring in order to eliminate the client’s difficulties in positive data logging (as in line with the current treatment protocol).

The above findings provide sound guidelines with regards to the usefulness of the intervention not only in increasing positive self-talk and challenging self-criticism, but also in providing material in relation to perfectionism, which a clinician can work with. Additionally, this is the only known study that provided qualitative evidence and insight as per the functionality and process issues that emerge with an intervention that is used widely.

Compassionate mind training

This appeared to be one of the most influential techniques in challenging self-criticism and in increasing self-acceptance and self-esteem. All eight participants provided positive comments as per the efficacy and usefulness of the technique. Seven out of eight participants (p1-p2-p3-p4-p5-p6-p7) reported that this intervention helped them to increase self-acceptance, thus minimising perfectionistic concerns. Similarly, seven out of eight participants (p2-p3-p4-p5-p6-p7-p8) stated that they became far less critical with themselves, meaning that once again perfectionistic concerns were decreased. Five out of eight participants (p2-p4-p5-p7-p8) commented that by becoming more compassionate they stopped blaming themselves, managed to undertake mental re-scripting of past events, thus resulting in depersonalising (p1-p2) and feeling more compassionate towards people who did not treat them well (p5). Two participants (p5-p8) stated that this intervention increased calmness and helped them manage stressful emotions. Three participants (p1-p2-p5) found that self-compassion shifted the unhelpful emotions of guilt and shame. The result of that was to manage non-disclosure of imperfections - six out of eight participants (p2-p3-p4-p6-p7-p8) argued that being more self-compassionate freed them from the worries of appearing perfect towards others by disclosing imperfections.

In addition compassionate mind training, helped the above participants to challenge control issues, in relation to perfectionistic self-presentation. These findings are in line with an increasing amount of research (Neff, 2003b; Neff, Hsieh & Dejitterat, 2005; Neff, Rude & Kirkpatrick, 2007a-b; Neff & Vonk, 2009; Neff, 2011; Leary, Tate, Adams, Allen & Hancock, 2007) which found that self-compassion is associated with wellbeing, higher self-esteem and adaptive coping strategies, as well as negatively associated with self-criticism.

For three participants (p6-p7-p8) it helped them manage procrastination and avoidance, by increasing their motivation to do things without experiencing perfectionistic concerns, thus supporting the findings by Neff, Hsieh and Dejitterat (2005) and Iskender (2011). In addition, five participants (p2-p3-p5-p6-p7) found that it helped them manage overcompensation and they identified that becoming more self-compassionate helped them to balance perfectionistic concerns, which in return decreased overcompensation and in one case (p.8) it helped her to ask for help, therefore, decrease overcompensation and ensure a more relaxed work attitude. Finally, two participants (p3-p4) increased their social life and sense of connectivity with others, thus supporting the findings of Neff (2003a).

Whilst, for the majority of participants, compassionate mind training was easy to master and helpful, for two participants (p5-p8) it appeared challenging as, similarly to positive logging, it triggered self-criticism, at least in the initial stages when the intervention was introduced. Once again, this process holds clinical implications as it draws the attention for clinicians to be aware of the power of self-criticism and to utilise specific techniques such as cognitive restructuring and cost/benefit analysis, in order to address further self-criticism, otherwise the effectiveness of the technique might be jeopardised.

An interesting finding that emerged from the work done on self-compassion was that being more compassionate assisted people to use their perfectionism in an adaptive way. All participants reported that once they became compassionate with themselves, they were able to accept perfectionistic traits and utilise them in a positive way in terms of continuing achieving, but without the experience of distress that is brought by perfectionistic concerns. This provides further evidence for Stoeber & Otto (2006) arguments on positive perfectionism as discussed previously.

**6.8.3 Behavioural Techniques**

Behavioural experiments

Four participants (p4-p5-p6-p7) mentioned the behavioural experiments as being an effective strategy to challenge cognitions and increase self-esteem. There are two issues to be discussed here - the first one relates to the fact that the behavioural experiments were all related to interpersonal issues and on several occasions they were related to assertiveness training, thus underlining the importance to address interpersonal issues once again. The other one is the fact that out of eight participants only half the participants referred to behavioural experiments.

A possible explanation could be that other techniques had a more significant impact for the participants, such as, compassionate mind training; or other techniques were more challenging, such as, assertiveness training. Whilst some of the experiments were designed in order to increase assertiveness, it appears that the participants were able to differentiate between behavioural experiments and assertiveness training as two different interventions. Some evidence to support this is that far more participants commented on assertiveness training, process issues and difficulties they encountered with it.

Assertiveness Training

All eight participants commented on the assertiveness training. Six out of eight participants (p1-p2-p3-p5-p6-p8) reported that it helped improve their communication skills in relation to arguments, and stating effectively their point of view, thus improving socialising and their relationships and lifestyle - spending quality time not in order to please others but because they truly enjoyed it. Seven participants (p2-p3-p4-p5-p6-p7-p8) commented on certain process issues they experienced with assertiveness as being challenging and difficult for a variety of reasons. Four participants (p1-p2-p7-p8) underlined that this intervention was the most difficult one and the most challenging as it actively involved other people and that it transformed their relationships.

One of the most challenging processes with assertiveness training was the realisation that these participants were involved in potentially abusive relationships as they were being controlled by significant others. The participants who ended unhelpful relationships (p1-p2-p8) were able to establish new ones where they felt equal towards others, or gained a sense of autonomy, which in turn benefited existing relationships (p7). They also commented that it is a continuing process and that they recognised that they need to continue to apply the principles of assertiveness.

From the participants’ accounts what appears to be a very important clinical implication arises. That is, clinicians may face an ethical dilemma, where once apparent that the client is being ‘used and abused’ by significant others, whether they are friends, colleagues, partners and family, should he/she bring this to the client’s attention. The results from the interviews support that, despite how difficult the process of letting go of certain situations was, the end result was very beneficial for the participants. P7 ended his marriage and, according to his accounts, for the first time in years felt autonomous, with greater self-esteem and established a warmer relationship with his children; participant 8 left a stressful job and found a new, far more rewarding one in a different area. She felt more valued overall and, additionally she distanced herself from certain family members who would often criticise her and undermine her self-esteem, resulting in her feeling more independent and happier within herself. This was also the outcome for participant 2, who distanced herself both from family members and friends, because she realised that she would never feel fulfilled in certain relationships with controlling people. Finally, that was the case for participant 1, who decided to become more independent by moving out of her parents’ house and by distancing herself from friends, who engaged in antagonistic behaviours.

The interviews were very revealing regarding the outcome of becoming more assertive and provided evidence very encouraging regarding building a better life for people. Thus, it is proposed that it may be more unethical not to address issues of being controlled and ‘abused’ by others, and this is in line with non-maleficence and beneficence of the people who attend therapy and the therapist’s duty to address those issues (Etherington, 2007). It is important to note that the therapist should encourage the client to make their own connections, instead of being direct and this was ensured in the present treatment protocol by the use of:

* Socratic questioning
* Cost/benefit analysis of staying in the relationship/job/seeking approval
* Psycho-education regarding ‘schema attraction’ and the dynamics of the relationship, thus underlining issues of being controlled by others
* Assertiveness training – role plays/behavioural experiments
* Compassionate mind training.

In fact, assertiveness training was often combined with compassionate mind training especially when significant others would react negatively towards the participant who was becoming more assertive, thus reinforcing self-blame and self-criticism.

From the results it was apparent that assertiveness training resulted in a greater sense of autonomy marked by a reduced need to please others and seek approval. Five participants (p1-p2-p4-p6-p8) commented on the fact that they did not feel the need to seek approval from others, and four participants (p1-p2-p6-p8) stated that they no longer felt the need to please others. All participants reported that they had become more autonomous; these findings have been validated and confirmed by the quantitative data, specifically the aspect of DAS that measured autonomy and approval. The scores on these aspects indicated a shift towards more positive attitudes regarding autonomy and approval.

The overall result of becoming autonomous was the establishment of more fulfilling relationships where people would feel equal towards others and experience respect both within them, as well as from others. This was confirmed by five participants (p1-p2-p6-p7-p8). In addition it was apparent that by the combination of assertiveness training and compassionate mind training, overcompensation was adequately addressed and managed, resulting in a more satisfying lifestyle as was mentioned by six participants (p2-p3-p4-p6-p7-p8).

Before moving on, it is important to highlight that the present study is the only one that provides qualitative evidence as per the process issues that occur with the application of specific techniques. This holds important clinical implications as to-date there is very little written on process issues in the field of CBP. More process issues will be discussed further in the following sections.

**6.8.4 Organised/educational Nature of CBP**

With regards to non-technical factors that appeared helpful in this study was the organised and educational nature of CBP, which actually agrees with the nature of perfectionism. However, the participants’ perfectionism was utilised in a beneficial way in treatment, thus giving support to the notion that therapy should not strive to eliminate perfectionism completely, but utilise it in an adaptive way.

More specifically, similar to self- esteem, perfectionism is a life-long trait that can fluctuate and be influenced by numerous factors i.e. a loss of a job, a rejection by a partner etc.

It appears from the findings that a perfectionist will always be a perfectionist. Therefore, therapy should focus on client’s acceptance of perfectionism and provide the client with tools to eliminate its maladaptive manifestation and promote the more adaptive and functional traits of the construct.

Writing

Six participants (p1-p3-p4-p5-p7-p8) reported that writing things down appeared very helpful in terms of:

* Keeping a record and refreshing their memory;
* Putting things in perspective and reinforcing the intellectual/rational reasoning over the emotional reasoning;
* Increasing reflection.

Overall it appeared that writing things down fitted the participants’ way of learning, through an educational model. However, two participants (p4-p5) stated that writing was not helpful, in fact it reinforced unhelpful emotions as it drew their focus to the problem at the time. However, writing appeared unhelpful only in the case of filling in records. This draws the attention to a process issue that clinicians should be aware of, that is, how helpful is it to actually ask clients to fill in records as homework? Specifically with perfectionism, it can appear counterproductive as it can reinforce perfectionistic traits, which was explained clearly by participant 4. Clinicians need to be mindful that the organised and structured nature of CBP can often collude with the client’s perfectionistic traits. This is further discussed below.

**6.8.5 Process Issues**

The perfectionist client

A review of the literature suggested that people’s perfectionism would interfere with the treatment plan and outcome for a variety of disorders, especially depression (Blatt, Quinlan, Pilkonis, & Shea, 1995; Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998). The results of the present study have revealed a significant process issue - it is important to address perfectionism in relation to the treatment process, otherwise perfectionism can have an impact on the therapeutic process of perfectionism. For four participants (p1-p3-p4-p6) there was a risk that the therapy could collude negatively with their perfectionistic traits. Participant 1 often was characterised by impatience and a sense of persistence in remaining a perfectionist, additionally she would refuse to engage in interventions as they appeared too ‘simplistic’. This process needs to be addressed early on in treatment and a client’s high expectations and unrealistic standards should be challenged in relation to treatment outcome and efficacy of interventions per se. Otherwise there is a risk of ‘drop out’ once the client feels disappointed because they do not reach the desired outcome at the desired pace. This is in line with Shafran and Mansell’s (2001) suggestions, who state that ‘*the beliefs of people with perfectionism are held rigidly and it is the rigidity of assumptions and beliefs that interferes with treatment progress’* (p.899).

Participants 3, 4 & 6 had the tendency to give 100% to the therapy process and this presents the risk of a) being the ‘perfect’ client in order to please the therapist, which is in line with Blatt, Quinlan, Pilkonis and Shea (1995), who identified that perfectionistic clients would need approval and seek reassurance in treatment, which was a factor affecting the therapeutic process; b) complying with homework only in order to gain a sense of achievement; and c) overcompensation in order to achieve the perfect result. These issues collude with perfectionism and reinforce it instead of shifting it in an adaptive way. This process needs to be addressed from the start of the treatment plan, otherwise it can lead to what Blatt, Zuroff, Bondi, Sanislow and Pilkoni (1998) identified as an issue, which was that the participant might experience a significant sense of failure, once close to the termination of therapy. In fact, participant 6 mentioned that he experienced anxiety when he was told that the therapy was close to an end, which indicated that he had established a form of ‘dependency’ towards the therapist and also, that the termination of therapy triggered a fear of failure to cope without the help of a therapist. Fortunately, he was able to challenge this and accept the termination. However, his reports highlight the importance of addressing this process throughout the course of treatment.

The above processes have been addressed in the protocol and actually used as material to challenge dichotomous thinking and perfectionistic traits. For example, the therapist would avoid using ‘perfect’ forms as in organised, neat thought records, she would make deliberate mistakes to model a less rigid way of working; she would directly address the client’s tendency to please the therapist and implement thought challenging on this and utilise techniques to focus on the therapeutic process directly. Therefore, it is proposed that clinicians should be aware that these processes need to be addressed immediately in treatment otherwise the effectiveness of treatment may be compromised.

Therapeutic alliance

Shafran and Mansell (2001) stated that frequently perfectionistic clients fail to establish strong therapeutic alliance. In addition, Blatt, Zuroff, Quinlan, and Pilkonis (1996) argued that perfectionism would affect negatively client’s perceptions of the quality of the therapeutic relationship. The results of the present study do not appear to support these findings. Five out of eight participants (p1-p3-p4-p5-p6) commented on the importance of the therapeutic alliance and how this actually helped them to progress with treatment, thus providing evidence that perfectionistic clients can establish positive therapeutic relationships. Participant 5 underlined the importance of collaboration, which increased her confidence in therapy as she experienced that there was an equal input and a shared goal. Three participants (p1-p3-p6) underlined the importance of feeling that there was rapport with the therapist, that is, there was warmth, lack of judgemental attitude and trust.

These interpersonal factors, in line with the main humanistic principles (Rogers, 1957) are a significant variable that affects the therapeutic process. Of particular interest are participant 3 comments, which show how perfectionism can affect the client’s intention to participate with therapy in the initial stages - she was reluctant to attend treatment during the initial assessment, which is in line with Blatt et al (1996) findings. However, once she started therapy the evidence is exactly the opposite as she was able to establish a strong therapeutic alliance and engage fully in the therapy process, thus going against the findings of Blatt et al (1996), and Zuroff, Blatt, Sotsky, Krupnick, Sanislow and Simmens (2000). They argued that perfectionists do not fully engage in treatment and, if they do so it will take an extended period of time.

What appeared to be very effective was the fact that the therapist demonstrated warmth, empathy and positive reinforcement from the very beginning and also the actual work on perfectionism that was done, which was in agreement with Zuroff et al (2000) who stated that: *‘therapists may need to use therapeutic strategies specifically designed to reduce perfectionism and to encourage the patient's active involvement in the therapeutic process’* (p121).

Another factor which appeared to increase participation with the therapeutic process, and benefitted the therapeutic alliance, was highlighted by participant 4 who commented that self-disclosure was very helpful to her and a valuable variable in establishing a positive therapeutic alliance. This is in line with Hill & Knox (2001) who noticed that therapist’s self-disclosure ‘*led to client insight and made the therapist seem more real and human’* (p.3). To date there are very few empirical studies investigating how self-disclosure can be beneficial, especially in the CBP field. A limitation of this study was the missed opportunity to investigate further the impact of self-disclosure with all the participants in the interviews.

**6.9 The Shift of Perfectionism and Low-self Esteem (post-treatment)**

Some of these issues have been addressed previously, however, one of the main effects post-treatment was that the participants’ standards were more balanced. As mentioned before, all participants still held personal standards, however, not in an unrealistic manner and not in a way where those standards would produce distressing emotions. Seven out of eight participants (p1-p3-p4-p5-p6-p7-p8) balanced their dichotomous thinking and had more realistic standards. Six out of eight participants (p1-p3-p4-p5-p6-p7) reported that their tendency to doubt themselves and be concerned over their mistakes had decreased significantly, resulting in increased socialising; better relationships; managing overcompensation; and decreased self-criticism. With regards to overcompensation, six out of eight participants (p2-p3-p4-p6-p7-p8) disclosed that they did not engage in this anymore, thus resulting in effective prioritising, better lifestyle, increased pleasure, increased relaxation, and calmer emotions.

**6.10 Strengths and Limitations of the Present Study and Suggestions for Future Research**

It is proposed that this study has made an important contribution to knowledge about experiences of perfectionism and its treatment. The use of mixed methods, as in quantitative and qualitative data collection and analysis, constitute a significant strength of methodology, as they provide a detailed and in-depth understanding of the experiences of perfectionism in different domains. Furthermore, they made a significant contribution about the participants’ experiences of a treatment protocol and showed substantial evidence with regards to the efficacy of the same. The use of mixed methodology permitted the development of arguments and greater depth of knowledge in the field of perfectionism and its treatment by underlining the strengths of each method as suggested by Creswell and Clark (2007). This study reviewed perfectionism and its treatment from a longitudinal perspective, which is an advantage over the existing cross-sectional studies. Additionally, compared to mono-method research in isolation, the use of mixed methods made the present study quite unique and novel in the field of perfectionism.

The strength of IPA was that it provided a rich account of the experience of perfectionism for the participants interviewed that is consistent with existing literature, but adds to it by bringing in the perspective of the client and by providing a longitudinal, detailed and in-depth exploration that goes beyond the data any quantitative method could provide. Additionally, this study gave rich information as to how participants experienced the treatment and how it benefitted them post-treatment. It is further proposed that the information gained in relation to the participants’ experiences contributes to theory on treatment of perfectionism; increases the understanding of what aspects of therapy are useful and efficacious; and also identifies some areas where theory may be improved by further research into clients’ experience and therapy interventions. The analysis of the interviews was carried out in great detail, thus improving the soundness of the study and ensuring that the participants’ experiences were captured in a way that indicated dedication and an interpretative engagement to the text.

As with any research, the current study has several limitations. Other than those already mentioned, further limitations are as follows. One limitation of the study refers to inter-rater reliability. It can be argued that the quality and transparency of the results could be challenged, since no external validation was obtained in an official manner. Additionally it could be argued that the validity of the results could be biased by the interpreter’s personal, social and cultural contexts and schemas, which can affect the interpretations of the research texts (Denzin, 1997; Christians, 2000; Edwards & Mauthner, 2002). In order to ensure the consistency of the findings in the interviews interpretation, ‘triangulation’ and inter rater liability was necessary as suggested by Armstrong (2007) and Christians (2000). The difference between researchers in identifying themes and generally interpreting the interviews could have led to a greater understanding of the participants’ experiences and potentially ensuring a sense of scientific validation (Hammersely, 1991). This was partially achieved since two people were asked to review a sample of the interviews and see if they agree with the themes identified. These were the researcher’s clinical supervisor (former CBP lecturer and accredited psychotherapist) and the researcher’s academic supervisor. However, in order to achieve the best validity and reliability of the results, one of the two supervisors should be asked to formally review one or two interviews and identify their own themes and then compare and contrast with the researcher’s findings. That would be a more thorough approach to inter rater liability.

An alternative view on this argues that it is unrealistic to expect an external researcher to have exactly the same insights and also the same knowledge in order to interpret data and that different interpreters would offer a different reality (Tyler, 1986; Morse, 1994).

Furthermore, in line with the main principle of IPA (which argues that there is a double hermeneutic that involves the researcher to make sense of the participants making sense of their experience), it was deemed that this was not an absolute necessity as per the guidelines by Stiles (1993) and Smith and Osborn (2003). However, future research that replicates the results would be strengthened by including a second researcher trained in qualitative methods, who could audit formaly, the qualitative data, thus ensuring greater reliability of the results.

Following Patton’s (2005) and Guba & Lincoln’s (1994) guidelines, validity and reliability of the results was further ensured by:

* The checking and rechecking of the data from the researcher, in order to ensure that they make sense.
* Asking the participants of their opinion as per how their accounts have been accurately reflected (this happened with 3 participants).
* Thick detailed description that occurred with the inclusion of lengthy and detailed narrative.
* The use of validated measures that were administered following a long period, hence ensuring that the participants did not remember their previous responses.
* The measures showed a significant reduction that was replicated amongst cases.

Another limitation of this study is the small sample size, which limits the extent of external validity, as it can be argued that the results cannot be generalised to the rest of the population as the sample size consisted of only 8 people. Whilst this is a limitation, it could also be seen as a strength, because the small number of interviews allowed the in-depth analysis necessary to ensure that the participants’ experiences were carefully examined, thus meeting the idiographic obligation of IPA as proposed by Smith & Osborn (2003). A larger sample size holds the risk of losing important information and missing complexities in specific cases (Morse, 2000).

A further strength of the study was that the sample consisted of a clinical population with a variety of Axis I diagnosis and, in some cases, comorbidity. The findings indicated that there were several themes consistent between the participants’ accounts and provided sound evidence of the efficacy of trans-diagnostic processes in treatment. However, the sample mainly consisted of females (only two males involved). Once again, this limits the external validity of this study. There is a possibility that if more males were involved in the study, some different, gender based experiences of perfectionism and its treatment could be identified. To account for this, future studies would benefit from including an equal number of males and females.

Additionally, the sample predominantly consisted of western, white, relatively wealthy, and educated individuals from the United Kingdom (participant 8 is Greek and the treatment took place in Greece). The use of such samples has been criticised as limiting external validity (Mitchell, 2012). This means that the results cannot be generalised to people from different cultures and ethnic backgrounds. From participant 8’s account, there is very little difference in terms of how perfectionism is experienced within the Greek society and there is consistency of themes if compared to the participants from the UK. The same stands as per the experiences of treatment and its outcome. However, one participant’s accounts do not constitute enough evidence regarding the generalisation of the results to populations from a different culture. This supports that future research should be cross-cultural; duplicating the results in other countries; and studying different societies. Despite this, it is important to highlight that IPA is an idiographic approach, therefore, this study does not expect to be generalised to all participants’ experience of perfectionism and therapy, but aims to provide a contribution to a gradually developing knowledge base (Smith & Osborn, 2008).

A further limitation refers to the sampling process. This study used a nonprobability method of sampling, thus the participants’ selection was not done randomly. The sample consisted of participants, whose treatment for perfectionism appeared to be successful, initially, based on their outcome measures. This holds the risk that the participant selection was purposely, in order to compliment the results of the study, which would provide a rather biased picture of the efficacy of the treatment plan. On the other hand, the quantitative results from the study in phase one provide some good evidence as per the efficacy of the treatment protocol, once shifted to targeting perfectionism and, at that stage the criteria for participants’ selection was not based on the successful outcome of the treatment on perfectionism, but on the unsuccessful outcome of traditional CBP on the presenting problem.

The researcher included participants for whom the treatment plan was focused on perfectionism and was concisted throughout. In line with Smith (2007) this type of sampling is relevant to the nature of IPA, as a homogenous sample should be recruited in order to answer the research questions. Thus, people who dropped out; did not complete the treatment and post-treatment measures were not obtained; or did not receive an explicit treatment protocol for perfectionism, but one that is a mix of both CBP for the presenting problem and perfectionism, they would not form a homogenous group. However, future studies could interview people who did not complete the treatment protocol or dropped out as this would provide accounts of participants’ different experiences that could potentially improve the treatment protocol.

The previous limitation highlights the necessity to address another issue - two out of eight of the clients participated in an additional technique, that is, Eye Movement Desensitisation and Reprocessing (EMDR). The reason for the application of EMDR was that these participants met the diagnostic criteria for Post-traumatic Stress Disorder (PTSD) and it was an absolute necessity to utilise EMDR in order to eliminate the distress accompanying ‘flashbacks’ and reliving of the accident they had experienced. Therefore, some caution should be considered in that they had an additional technique. On the other hand, it would appear unethical not to utilise a technique (EMDR) that is very effective in the treatment of PTSD (Van Etten & Taylor, 1998; Davidson & Parker, 2001; Seidler & Wagner, 2006) and purely work on the perfectionism. Indeed perfectionistic traits appear to have a significant effect in the maintenance of the trauma, since the participants’ belief system interfered with it, supporting the effect of the Schematic Mode Level on the Propositional Level as proposed by SPAARS- Schematic Propositional Associative & Analogical Representational System (Power & Dalgleish, 1999).

It was also apparent that working on core beliefs, in this case perfectionistic traits, was very relevant as supported by Grant, Townend and Cockx (2008), however not utilising EMDR, would appear extremely unethical, as it would delay the treatment of ‘flashbacks’ and there was no rationale in not doing so in the present study. This study though, provided some evidence of the occurrence of perfectionism with people suffering from PTSD - there is almost no research to date, apart from Kawamura, Hunt, Frost and DiBartolo (2001) looking at the relationship of perfectionism with emotional and anxiety disorders including PTSD.

Another limitation is that the researcher who carried out the interviews, was actually the therapist who conducted treatment with all the participants. Being the therapist and the researcher imposes a common ethical challenge in qualitative research (Hart & Crawford-Wright, 1999; Christians, 2000; Meyers & Sylvester, 2006; Haverkamp, 2005). It can be argued that holding a dual relationship in research holds the risk of exploitation and decreased level of objectivity from the researcher’s point of view (Hart & Crawford-Wright, 1999).

In this research it could be argued that the therapy was designed in such way to compliment the purposes of the research and not in order to meet the client’s needs. A further argument could be made in reference to the client’s participation in the interviews - that they participated and provided an informed consent in order not to let the therapist down and also out of fear of not receiving the best possible treatment if they refused (Hart & Crawford-Wright, 1999; Christians, 2000). However, it is evident from the first phase of the study that the researcher had shifted the treatment plan with all her clients towards targeting perfectionism, long before the conduct of the present study. This means that the clients’ treatment in the second study was based on the proposed treatment protocol, irrespective of the present research. In addition, informed consent regarding their participation was sought on the follow-up session where treatment had already come to an end. Thus, there is no reason why the clients felt obliged to agree out of fear of not receiving the best possible treatment. Indeed there is a chance that the participants did not want to let the therapist down, however, this is always a risk when asking ex-clients to participate in a study and is irrelevant to whether the therapist is the interviewer or not.

It could be argued that there are greater risks with regards to the participants’ responses if the interviewer is a stranger and these risks were taken into serious consideration, resulting in the therapist being the interviewer too. Firstly, in terms of the application of methodology, critical evaluation of IPA indicates that it is frequently difficult to deeply understand a participant's experience without background information about the origin of the experience in question (Willing, 2001). This problem was addressed as the interviewer, being the therapist, already had enough information to comprehend what the participant was saying. Additionally, she was able to understand as to which interventions and process issues the participant was referring to, even when the former could not remember the terminology and the details of the intervention in question. It has been argued that an important feature of the success of the interview with participants lies in the strength of the participant- interviewer relationship, since the quality of this relationship can affect the level of disclosure and the depth of the information shared (Warren, 2002; Adler, 2002).

Additionally it is not unknown for participants to experience strong emotional affect, especially when they recall past experiences. This was definitely the case with some participants, who became emotional during the interview (i.e. p3-p5). If there is no sound relationship developed with the interviewer, the participant can experience strong emotions of shame and fear for disclosing personal information (Birch & Miller, 2000, 2002; Sinding & Aronson, 2003), which can be further strengthened by the fear that the interviewer may be judgemental towards the participant (Adler, 2002). The above was completely avoided as the participants felt secure since a sound therapeutic relationship has been established prior to the interviews. It appeared that the therapist also being the researcher would, in fact, protect the participant from exploitation and ensured that in-depth information was elicited. However, future studies attempting to replicate the results of the present study, could involve a third-party to carry out the interviews. It would be interesting to compare and contrast the findings and identify any significant differences in the participants’ responses, both verbal and non-verbal, as well as the level of depth in the information disclosed.

A further consideration, and a proposal for future studies, refers to the belief modification following the proposed treatment protocol. It was apparent that core beliefs and schemas in relation to perfectionism and low self-esteem, have been modified in a relatively short period of time, that is, approximately 15 sessions. There appears to be very little published research with regards to the optimum number of sessions when focusing on belief modification. There is more literature available with regards to such work with Axis II disorders, particularly Borderline Personality Disorder, proposing a length of up to 3 or 4 years (Young, 1994; Kellogg & Young, (2006); Young, Klosko & Weishaar, 2003) or 65-120 sessions (Nordahl & Nysaeter, 2005). This may explain why, in the case of participant 1, her perfectionistic beliefs showed lesser modification in comparison to the other participants, indicating that longer treatment may have been necessary for greater modification. Results of the present study would be strengthened if longer term follow-up to monitor maintenance of the improvement was carried out. Future studies could examine whether gains have been sustained on a longer follow-up of 2-3 years following the treatment on perfectionism, which would give stronger evidence of the efficacy of the treatment protocol proposed.

**Conclusion:**

Despite the construct of perfectionism having been recognised as a phenomenon since the 1950’s, it is only over the last decade that it has been investigated in greater depth and, even now, it is still not clearly defined or understood. There appears to be some consistent agreement that perfectionism can be both helpful and unhelpful (examples: Ashby & Kottman, 1996; Rice et al, 1998; Cox et al, 2002; Stoeber et al, 2009; Verner-Filion & Gaudreau, 2010). This study is the only one that provided substantial qualitative evidence as per the nature of perfectionism and its impact on different life domains, thus giving a clearer picture of its manifestation.

To-date, there continue to be disagreements as to whether it is a unidimensional (Shafran et al, 2002; Shafran et al, 2010) or a multidimensional construct (Frost et al, 1990; Flett & Hewitt, 1991). It is proposed that the findings from this study support that perfectionism is multidimensional in nature. This is because the findings demonstrated that it is not only standards that are imposed on self but also on others, amongst other aspects. It concurs with the findings of Frost et al (1990) and Hewitt et al (1991) that there are social and interpersonal components.

It appeared that perfectionism does affect relationships and the way the person behaves within a relationship. Overcompensation and high standards appeared to be relevant not only in achieving success in work/ task domains but also in relationships. Further behaviours included lack of assertiveness, avoidance and comparative self-criticism.

There is a growing wealth of material which has looked at the construct of perfectionism and its link with Axis I disorders (DSM-IV-TR; APA, 2000), in particular eating disorders and obsessive-compulsive disorder. However, there appears to be little literature focusing on the treatment of perfectionism and low self-esteem and the consequent effect on Axis I disorders. The main treatment protocol for perfectionism (clinical perfectionism) in the area of cognitive therapy is that by Fairburn, Cooper, and Shafran (2003); as mentioned it approaches perfectionism from a unidimensional perspective. It consists of 4 elements, that is, conceptualisation of perfectionism, in particular the maintenance factors; behavioural experiments related to the nature of perfectionism; psycho-educational and cognitive re-structuring; and identifying and modifying the individual’s self-evaluation methods. The current treatment protocol included these elements but, in addition, also focused on multidimensional aspects of perfectionism and low self-esteem by including additional cognitive-behavioural interventions, such as, the use of an idiosyncratic formulation emphasising early life experiences; assertiveness training; and compassionate mind training.

To date most of the research conducted on the construct of perfectionism and its treatment has been of a quantitative nature. Whilst some argue that mixed methodology is not appropriate (for example Leininger, 1994) this study approached the matter from both quantitative and qualitative methods. The reasoning behind this was to ensure that a greater and more in-depth understanding was reached, which is in line with Creswell & Clark (2007). Another reason to take a mixed methodology approach was to identify if the participants’ self-reports were supported by a quantifiable change in the nature of their presenting problems, that is, the Axis I disorders they met diagnostic criteria for.

The findings from this research supported that focusing on perfectionism and low self-esteem not only resulted in a helpful change to the majority of the participants’ belief systems, but also in a reduction of the symptoms related to the Axis I disorder(s). This is supported by the results from both quantitative and qualitative perspectives. With regard to the latter the Interpretative Phenomenological Approach analysis identified a Master Theme, that is, experiences of treatment (technical and non-technical factors). This helped identify which specific components of the proposed treatment protocol were most helpful. Almost all participants, in response to questions related to which techniques were useful and which ones were not so useful, stated that that nothing had appeared unhelpful.

The majority of participants found the longitudinal idiosyncratic formulation and understanding of schemas very intriguing and helpful. In relation to cognitive restructuring techniques, the majority of the participants found the strategies, such as thought challenging and positive data logging, to be very useful, although a few participants found some techniques not as helpful as others. For example, participants 4 and 5 found the process of keeping thought records not particularly helpful as it drew their attention to their problem(s) further, although they benefitted from therapist assisted thought challenging.

With regards to the addition of compassionate mind training it is suggested that this was important, as it addressed the powerful trait of self-criticism in perfectionism and low self-esteem. Some individuals commented on how valuable this technique was, however, others found it triggered further self-criticism. From a behavioural perspective, exposure and behavioural experiments, were found to be helpful and this concurs with Shafran et al’s (2010) findings.

The addition of assertiveness training was a crucial part of the treatment protocol because the majority of the participants, due to fear of rejection and negative evaluation, were lacking assertiveness. The majority of the participants reported ‘positive’ changes as a result of this intervention, although many of them found becoming assertive was one of the most challenging aspects of the treatment protocol.

With regards to non-technical factors, as might be expected, the therapeutic alliance appeared to be the most important factor affecting the therapeutic outcome. Almost all individuals, commented on the importance of establishing a positive relationship based on trust, warmth and collaboration.

With regards to process issues it needs to be recognised that the nature of being a perfectionist could have an impact on the treatment if not managed appropriately. It was found that the organised nature of the therapy colluded with the participants’ perfectionism and that perfectionist tendencies would generate in treatment. However, there was only one participant where this had a negative impact on the treatment process.

It is proposed that the aims/objectives of the study were met in that a greater understanding of the concept of perfectionism was gained; the participants’ overall experiences of the treatment protocol were identified and specific techniques were identified that appeared more helpful than others. The inclusion of interventions such as compassionate mind training appeared to complement existing treatment protocols. The quantitative and qualitative results appear to support that the treatment protocol is efficacious. However, there were limitations to the study, for example, there was lack of inter-rater reliability; the sample size could be viewed as small. Finally, research in this area is still in its infancy, and further research which explores the subject further, and addresses the limitations of this study, would certainly enhance the work carried out to date.

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