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Comprehensive Assessment of Perfectionism in Clinical Practice

Priyanka Dang[1]*, Dr. Sandhya Gupta[2]

[1]PhD Research Scholar, Department of Psychology, Banasthali Vidyapith, Banasthali, Rajasthan, India
*Corresponding Email Id: priyanka.dang9@gmail.com
[2]Associate Professor, Department of Curriculum Studies and Development, National Council of Educational Research and Training, New Delhi, Delhi, India

ABSTRACT: Perfectionism is known as a transdiagnostic process which leads to the onset, persistence and resistance to treatment of various types of psychopathologies such as anxiety disorders, depression, eating disorders and obsessive-compulsive spectrum conditions. High perfectionism is often accompanied by shame, fear of negative judgment and defensiveness, which might slow down the help-seeking process and make it difficult to engage in therapy. With its ubiquitous presence in all forms of diagnosis, it is necessary to perform a functionally informed assessment of perfectionism that will be vital in clinical practice. In this paper, a multidimensional approach to the evaluation of perfectionism will be presented that will combine diagnostic assessment, functional analysis, psychometric assessment, and situational understanding. Based on cognitive-behavioural and Relational Frame Theory (RFT) approaches, it highlights the necessity to go beyond the measurement of traits to investigate the relational patterns, rule-based behaviour, and self-evaluation that maintain perfectionistic patterns. Extensive evaluation involves structured and semi-structured interviews, standardized perfectionism measures, broad-spectrum symptom measures and personality measures to detect comorbidities and measure general distress and functioning. Assessment objectives are not restricted to symptoms identification but informed collaborative case conceptualization, directed treatment planning, tracking the therapeutic progress, and outcomes assessment. Instead of removing the striving for high standards, the aim of intervention is to minimize strict self-assessment and cognitive fusion to perfectionistic rules, facilitating psychological flexibility and goal adaptive actions.

INTRODUCTION

Despite a growing acceptance of psychotherapy in society, many people continue to experience feelings of shame and embarrassment, and harbour fears of negative judgment if others discover that they are consulting a mental health professional. This is particularly true for perfectionists, who tend to view personal limitations as flaws that must be hidden at all costs thereby increasing their feelings of blame, shame and failure and also increasing the time it would take for them to reach out for mental health help when they need it. Because they anticipate being judged for being imperfect, they might react defensively to perceived criticism which they associate with suggestions of seeking help.

In clinical practice, perfectionism has been shown to be a strong transdiagnostic process in psychopathology that influences the emergence, maintenance and treatment of different psychopathologies (Egan et al. 2011), cutting across a range of disorders, including anxiety and related disorders, eating disorders, and depression, to name a few (Egan, Wade, & Shafran, 2011). Evidence shows its consistent elevation in disorders like, social anxiety disorder, obsessive compulsive disorder (OCD), panic disorder, generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), bipolar disorder, eating disorders, body dysmorphic disorder (BDD), depression, obsessive compulsive personality disorder (OCPD), and narcissistic personality

disorder (NPD). Targeting key, critical processes like perfectionism that maintain a range of disorders is likely to be more effective and efficient in dealing with comorbidity than multiple disorder- specific interventions.

What is perfectionism?

Perfectionism positions an absolute standard as the goal of functioning with the expectation that it would bring rewards like enhanced self-esteem; while effort is continuously mobilized, a sense of completion or self-acceptance remains persistently unattainable. The drive to excel becomes self-defeating. Clinical perfectionism is defined as "the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards in at least one highly salient domain, despite adverse consequences" (Shafran et al., 2002). Evidence also suggests perfectionism is best understood as a dimensional construct varying along a continuum of severity. Perfectionism is not conscientiousness. It differs meaningfully from the self-discipline, organization, and achievement striving that defines conscientiousness (Flett & Hewitt, 2006). In the DSM-V, (strict) perfectionism, stated as a pathological personality trait, is defined as insisting strictly that everything should be perfect, flawless, and error-free, believing that there is a single truth, difficulty in changing perspectives and thoughts, engaging in detail, organization, and sequencing (APA 2013). Perfectionism, according to Hewitt and Flett (1991), is a personality trait with three dimensions: self-oriented perfectionism (which characterizes a tendency to require perfection of the self), other-oriented perfectionism (characterizes a tendency to require perfection from other people), and socially prescribed perfectionism (characterizes a tendency to believe other people require perfection).

What does a comprehensive assessment of perfectionism entail?

Because being a perfectionist is mostly served as a culturally and socially acceptable narrative to human beings, and is reinforced by the media, and our language patterns, it is easy to overlook its clinically impairing impact on an individual. From the perspective of Relational Frame Theory (RFT), we live in a world of verbally constructed meaning, not just a world of direct experience. So, perfectionism becomes a pattern of relational framing, specifically, rigid and excessive use of evaluative and comparative frames. The perfectionist constantly derives relations of comparison (better/worse, enough/not enough) between their current performance and an idealized standard. These frames become functionally dominant, meaning they govern behaviour even when doing so is costly. The person relationally frames their behaviour, output, or self against an abstract verbal standard ("perfect," "flawless," "the best").

The assessment process therefore involves more than compiling demographic, psychometric, formulaic, and diagnostic data. A comprehensive assessment of perfectionism begins with a functional analysis to establish the role of perfectionism in the development and maintenance of psychopathology in each individual client (Egan, Wade, and Shafran, 2012) which helps to derive an individualized formulation of the role of perfectionism for a particular client to establish the treatment plan. Perfectionism involves heavy fusion with self-evaluative content: "I am the kind of person who must not make mistakes," "If my work isn't perfect, I'm worthless." These are relationally derived rules that function as augmenters, they amplify the motivating properties of avoiding imperfection. Perfectionism can present as a primary presenting problem, as a predisposing factor, as an interfering factor and as a correlation and a consequence of psychopathology.

It is also imperative that the clinician be continually attentive to the emotional tone of the early interactions with the client. This requires vigilance in monitoring the client's reaction to the clinician, along with their subjective response to the experience of undergoing an assessment and their propensity for experiencing shame, even while simply sitting in the therapist's waiting room.

Goals of comprehensive assessment of perfectionism

In the context of clinical perfectionism, assessment typically focuses on assessing the presence, absence, or severity of particular symptoms or behaviours (e.g., procrastination, perfectionistic beliefs), to assess any associated problems such as depression, eating disorders, anxiety disorders, or OCD and related disorders, to assess the impact of perfectionism on functioning and quality of life at work or school, in relationships, and in other life domains, to facilitate the selection of symptoms or behaviours to target in treatment, to inform the process of collaborative case conceptualization, to facilitate the development of a treatment plan, to assess the effects of the intervention, both during treatment and after treatment has ended.

Components of Comprehensive Assessment of Perfectionism

It is important to remember that therapy begins at assessment, where the types of issues discussed, and the way that they are discussed, can already start to introduce the client to a slightly different perspective on the problems with which he or she has

been grappling. A comprehensive diagnostic assessment is helpful for identifying disorders that are often associated with perfectionism and developing an evidence- based assessment strategy.

The clinical interview focuses on perfectionism and related problems, their severity, impact, development course and treatment history, by understanding cues and triggers for perfectionistic beliefs and behaviours which can include interpersonal cues like receiving negative feedback from others, cognitive cues like intrusive thoughts that one is inadequate and emotional cues like low mood; behavioural cues (things that clients "do" because of their perfectionism) like avoidance behaviours (e.g., procrastinating on a project for work or school) and counterproductive safety behaviours (e.g., overpreparing for a presentation); physiological cues like panic attacks, headaches, palpitations, dizziness due to perceived inability to live up to their high standards). Semi structured interviews like Structured Clinical Interview for DSM-5 Disorders (SCID; First, Williams, Karg, & Spitzer, 2014) can provide a reliable and valid method for assessing the presence and absence of associated conditions and Interview for Perfectionistic Behaviour (IPB), which is a brief semi structured interview, assesses the perfectionism traits, perfectionistic self-presentational styles, and perfectionistic cognitions, and gives interviewer ratings of perfectionistic behaviour.

Through the assessment process, clients can also be encouraged to distinguish between standards that cause distress and impairment versus standards that are potentially helpful (Antony and Swinson (2009).

Different scales can also be used for measuring perfectionism and two general perfectionism scales that have been researched the most are the Hewitt and Flett Multidimensional Perfectionism Scale (HMPS; Hewitt & Flett, 1991) and the Frost et al. Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990). The Almost Perfect Scale-Revised (APS-R; Slaney, Rice, Mobley, Trippi, & Ashby, 2001) is also widely used in perfectionism research. Perfectionism scale for Indian adults (Anand & Nagle, 2016), Clinical Perfectionism Questionnaire (CPQ; Fairburn et al., 2003), Consequences of Perfectionism Scale (COPS; Kim, 2010) are some of other scales available. These measures are intended to be used not only for pretreatment assessment but also throughout the course of treatment in order to provide ongoing monitoring of progress consistent with evidence-based practice.

Other psychometrically based instruments can be used to ensure a comprehensive assessment of symptoms and an indication of overall distress which include common symptom measures like the Symptom Checklist 90-Revised [SCL-90-R]; Derogatis, 1975) and interpersonal measures like the Inventory of Interpersonal Problems [IIP] (Horowitz et al., 1988) to provide levels and types of distress. To fill out the symptom picture, clinically relevant personality characteristics, vulnerabilities, strengths, and diagnostic considerations, measures such as the Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 2001), the Millon Clinical Multiaxial Inventory–III, or the Personality Assessment Inventory (PAI) can be used.

Assessing perfectionism from an RFT perspective focuses on moving away from measuring traits or beliefs and instead mapping out the relational networks, their functions, and the contexts that control them for the client. The clinician should understand what kinds of relating are driving the client's perfectionistic behaviour. This entails listening for the specific frames that dominate their verbal repertoire, like comparisons "not good enough," "worse than" "behind," "falling short"; conditionality (if-then) "If I make a mistake, then people will reject me" which link performance to catastrophic consequences; temporal frames like "If I fail this exam, my career is over" which show that the client is living in verbally constructed futures and pasts rather than responding to present contingencies. (Hayes et al. 2001).

From an RFT standpoint, the pathological element in perfectionism is not just the content of perfectionistic thoughts but the degree to which the person is fused with them, meaning the derived relational network dominates behaviour as though it were literal reality (Hayes et al. 2012). The clinical question is, how insensitive has the client's behaviour become to direct experience? A client who continues perfectionistic behaviour despite clear evidence that it is damaging their health, relationships, and enjoyment is showing rigid rule-governance indicating that their behaviour is strongly influenced by verbal relations, not by the actual contingencies of their life (Törneke et al. 2008).

Findings from the assessment help the clinician to gain a more refined understanding of the patient's unique defensive structure and coping mechanisms. It is important to remember that perfectionism and its various components (interpersonal, cognitive, and behavioural) are understood by clients to constitute a solution to a perceived problem; helping clients understand that they serve as a defense guarding against a perceived threat to the self and that the defenses have served a purpose that may have

been adaptive at one point in time but is now no longer adaptive can offer the clients a new understanding of his or her difficulties, educating them about symptoms and the treatment process, and working collaboratively to define individual treatment goals and tasks.

The aim of treatment is not to remove striving for personal standards or lowering standards, rather to remove self-evaluation being exclusively based on meeting personal standards, and criticism when the standards are not met. Consequently, we might consider someone to be recovered from clinical perfectionism when they are able to still strive towards goals that are attainable, to not judge themselves adversely if the goals are not met, to invest energy in goals that are not performance related, and to be able to shift focus and effort away from unattainable goals.

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