Perfectionism Is Multidimensional: a reply to Shafran, Cooper and Fairburn (2002)

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Abstract

Shafran et al. (2002) provided a cognitive-behavioural analysis of perfectionism that focused primarily on self-oriented perfectionism. They argued against studying perfectionism from a multidimensional perspective that they regard as inconsistent with prior work on perfectionism as a self-oriented phenomenon. We respond to Shafran et al. (2002) by offering historical, empirical, and theoretical support for the usefulness and the importance of a multidimensional model of perfectionism involving both intrapersonal processes and interpersonal dynamics. It is concluded that a multidimensional approach to the study of perfectionism is still warranted.
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1. Introduction

The recent paper by Shafran et al. (2002) on a cognitive-behavioural analysis of clinical perfectionism is a welcome addition to the literature in that the authors acknowledged the role of perfectionism in the etiology, maintenance, and course of clinical disorders. The authors also made some important points about certain features and characteristics that make perfectionists vulnerable to a wide range of adjustment problems, including a discussion of possible reasons for the persistence of perfection and an important point that perfectionism and striving for excellence are different constructs. Shafran et al. (2002) also provided some useful treatment suggestions and described

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ways in which perfectionism impedes treatment. Finally, the authors made some insightful comments about the role of perfectionism in eating disorders.

Unfortunately, this paper also has numerous fundamental problems, including an alarming failure to cite previous authors who have made similar observations. For instance, Shafran et al. (2002) outlined a theoretical model of the maintenance of perfectionism that bears a strong resemblance to earlier self-regulation models, yet previous models were not cited. This "new" model begins with the setting of personal standards and with the perfectionist's tendency for self-evaluation to be overly dependent on striving to meet these standards (see Shafran et al., 2002, p. 780). It is then suggested that perfectionists engage in hypervigilant monitoring of outcomes and that they selectively attend to failure. Failure to meet standards results in self-criticism, while temporarily meeting standards results in the reappraisal of standards as insufficiently demanding.

2. Cognitive-behavioural models from an expanded historical perspective

Most notably, in outlining their theoretical model, Shafran et al. (2002) failed to acknowledge the important contributions of such authors as Kanfer and Hagerman (1981), Rehm (1977), and Carver and associates (Carver & Ganellen, 1983; Carver & Scheier, 1986), and they did not outline the various ways in which their model is similar to these models. Kanfer and Hagerman's (1981) self-regulation model is quite explicit in stating that certain individuals are prone to adjustment problems because they pursue unrealistically high standards and then engage in excessive self-criticism and self-blame when these standards are not achieved. Rehm's (1977) behavioural model of self-control and depression also emphasizes the pursuit of unattainable standards and subsequent negative self-evaluations. Similarly, Carver and Ganellen (1983) examined the components of self-punitiveness and suggested that psychological distress reflects: (1) a tendency to hold high self-standards; (2) an inability to tolerate failure in meeting these standards; and (3) a tendency to generalize a single failure to all aspects of the self. Carver and Scheier's (1986) well-known model of self-regulatory processes goes further and includes a focus on whether standards are attained and the related notion that some individuals will continue to pursue unattained goals even when abandoning such goals is highly adaptive. Unfortunately, Shafran, Cooper and Fairburn (2002) did not address the similarities between their conceptualization and these earlier works.

Shafran et al. (2002) also made no mention of pertinent research on the cognitive aspects of perfectionism. Their conceptual analysis includes a number of cognitive biases (e.g., selective attention to failure) and allows for hypervigilant monitoring in clinical perfectionism, but this analysis is limited in that the authors did not incorporate other theoretical developments involving the role of ruminative processes in perfectionism. Cognitive rumination over mistakes and imperfections has been noted often in the perfectionism literature (e.g., Frost & Henderson, 1991; Frost et al., 1997; Guidano & Liotti, 1983) and research has focused on the assessment of individual differences in automatic, perfectionistic thoughts, as assessed by the Perfectionism Cognitions Inventory (PCI; Flett, Hewitt, Blankstein, & Gray, 1998). The PCI has been described as a measure that assesses perfectionism "…from a unique cognitive perspective" (Enns and Cox, 2002, p. 50). The PCI is based on the premise that individuals have an ideal self-schema that is engaged in cognitive processing (see Hewitt & Genest, 1990), and perfectionists who sense a discrepancy between their actual self and their ideal self, or their actual level of goal attainment and high

ideals, will tend to experience automatic thoughts that reflect perfectionistic themes. It is believed that perfectionists with high levels of perfectionism cognitions are especially susceptible to psychological distress because of cognitions regarding failure to attain perfection in the past or to attain perfection in the future (also see Ferrari, 1995). We feel strongly that any cognitive–behavioural model of perfectionism that addresses factors involved in the persistence of perfectionism should also include an emphasis on the role of frequent automatic thoughts about attaining perfection.

3. Should researchers return to a unidimensional approach?

Perhaps the most troubling aspect of the Shafran et al. (2002) paper is that the authors argue strongly in favour of returning to a unidimensional approach to the study of perfectionism. This unidimensional approach is essentially an emphasis on self-oriented perfectionistic attitudes, and this was the focus of research in the perfectionism field prior to the 1990s (for discussions, see Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b).

In addition to self-oriented perfectionism that involved motivational, behavioural, and cognitive components, Hewitt & Flett (1991b) outlined two interpersonal dimensions of perfectionism known as other-oriented perfectionism (requiring perfection from others) and socially prescribed perfectionism (perfectionism imposed on the self by others). Shafran et al. (2002) suggested that the interpersonal dimensions described by Hewitt & Flett (1991b) should be regarded, at best, as mere correlates of perfectionism, and that they are not central to "clinical perfectionism" or to the perfectionism construct as defined by numerous authors (e.g., Burns, 1980; Hamachek, 1978; Hollender, 1965). Specifically, they claimed that:

> "…the additional dimensions do not assess perfectionism per se, but assess *related* constructs. Beliefs about other people's standards ('other-oriented perfectionism' [sic.]) and the perception that others have unrealistically high standards for the individual and that they exert pressure on them to be perfect ('socially-prescribed perfectionism') are both constructs that may be associated perfectionism [sic.] rather than integral elements of perfectionism." (p. 776).[1]

The authors claimed further that the multidimensional approach has not aided in the understanding or treatment of clinical phenomena.

Does empirical evidence or a careful reading of the literature they cite support these strong views? Unfortunately, empirical evidence to support a unidimensional approach with a central focus on self-oriented perfectionism was not offered nor cited by the authors. Instead, Shafran et al. (2002) relied on a limited set of arguments, including the observation that past descriptions of perfectionists by a number of authors are "remarkably consistent" (e.g., Burns, 1980; Hamachek, 1978; Hollender, 1965) in their focus on "…the self-imposed nature of standards that are

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[1] Although not acknowledged by Shafran et al. (2002), a strikingly similar critique was first offered by Rheaume, Freeston, Dugas, Letarte and Ladouceur (1995): "We believe that perfectionism may be essentially self-referent (Freeston, 1994, unpublished MS), and the socially-referent elements are derived from the more basic self-referent core" (p. 792).

personally demanding, and that self-evaluation is dependent upon success and achievement in people with perfectionism" (Shafran et al., 2002, p. 775).

In support of this, Shafran et al. (2002) emphasized what was said about self-oriented perfectionism, or the motivation for perfectionism being success or achievement, without also acknowledging what the authors had to say about interpersonal aspects of perfectionism. Below are several examples from these same authors that actually informed our early conceptualization of perfectionism as incorporating interpersonal features (e.g., Hewitt & Flett, 1990, 1991b). For example, Hamachek (1978) stated, "the mental connection between being perfect and being approved of are linked strongly together…. Neurotic perfectionism usually reflects a deep-seated sense of inferiority and is a learned way of reaching for approval and acceptance by setting standards for achievement or performance that are unrealistically high" (p. 30). Similarly, Hollender (1965), in discussing other-oriented perfectionism, stated that "the tendency of the perfectionist to demand perfection from others… is simply a matter of demanding that others perform as well as he expects himself to perform… some persons who do not demand perfection of themselves, demand it of others" (p. 100), and further that "many perfectionists must work on their own because their goading demands bring them into conflict with others" (p. 96). He also stated that the perfectionist is "…continually dependent on his performance for feelings of acceptability, adequacy, and goodness" (p. 99), and that "perfectionism is motivated by an effort to create a better self-feeling or self-image and to obtain certain responses or supplies from other people" (p. 99), indicating that a core feature of perfectionism involves concern over acceptance. Additionally, Pacht (1984) indicated although his perfectionistic patients came "from different backgrounds, the bottom line is always the same—to get love they have to perform in a perfect manner…. At other times, a parent is seen as a perfectionist, and in order to win approval, the patient also must be perfect. In almost all of these cases, there is a need to help patients achieve a separation from their parents and an individuation of self before they can modify the value system that demands that they be perfect" (p. 388). Lastly, Burns (1980) described a cognitive–behavioural treatment for perfectionism that underscores the core elements of perfectionism and stated, "we have developed a step-by-step program focusing on the motivational, cognitive, and interpersonal aspects of perfectionism" (p. 46), again underscoring the relevance of interpersonal issues.

The excerpts suggest that interpersonal aspects of perfectionism are core features and that the most consistent component in all of the writing seems to be that the self-evaluation evident in both self-oriented and socially prescribed perfectionism is dependent upon acceptance by others rather than simply on success or achievement.

In their enthusiasm to minimize the interpersonal aspects of perfectionism, Shafran et al. (2002) also failed to acknowledge the highly insightful descriptions of clinical perfectionism provided long ago by such classic theorists as Adler (1956, 1998) and Horney (1950) and by more contemporary accounts (e.g., Bruch, 1971; Bruch, 1981a; Humphrey, 1989; Lesse, 1983; Missildine, 1963; Sorotzkin, 1985, 1998). Adler and Horney were cited by Hewitt & Flett (1991b) since both theorists indicated clearly that perfectionism has a salient interpersonal aspect that often takes the form of other-oriented perfectionism, and both theorists suggested that perfectionism becomes more insidious and difficult to treat when it has engaged the social network. Horney (1950) was most explicit about the interpersonal aspects of perfectionism. Regarding other-oriented perfectionism, she noted that:

"…a person may primarily impose his standards upon others and make relentless demands as to *their* perfection. The more he feels himself to be the measure of all things, the more he

insists—not upon general perfection but upon his particular norms being measured up to. The failure of others to do so arouses his contempt or anger" (Horney, 1950, p. 78).

Indeed, research suggests that exposure to other-oriented perfectionism has a deleterious impact on family and marital adjustment (Habke, Hewitt, & Flett, 1999).

Horney (1950) not only addressed the issue of other-oriented perfectionism, she also described an overconcern with meeting social expectations that closely resembles the concept of socially prescribed perfectionism, as part of her broader discussion of the tyranny of the shoulds. Specifically, Horney (1950) observed that:

"…when he is not the perfect lover, or is caught in a lie, he may turn angrily against those he failed and build up a case against them. Again he may primarily experience his expectations of himself as coming from others. And, whether these others actually do expect something or whether he merely thinks they do, their expectations then turn into demands to be fulfilled. In analysis he feels that the analyst expects the impossible from him" (Horney, 1950, p. 78).

The passage outlined above is just a small portion of Horney's (1950) extensive description of perfectionists as people who perceive others as providing the impetus for perfectionistic behaviour. At present, research has not addressed the important question of whether socially prescribed perfectionism is a veridical assessment of perfectionistic demands imposed on the self, or is merely how the perfectionist comes to view his or her interpersonal world. However, contrary to the Shafran et al. (2002) assertion that little knowledge has been gained by including interpersonal components of perfectionism, extensive evidence indicates that socially prescribed perfectionism is implicated directly in a variety of clinical disorders including borderline personality (Hewitt, Flett, & Turnbull-Donovan, 1994), affective disorders (Antony, Purdon, Huta, & Swinson, 1998; Bieling & Alden, 1997; Enns & Cox, 1999; Hewitt & Flett, 1991a), and eating disorders (Bastiani, Rao, Weltzin, & Kaye, 1995; Cockell et al., 2002). Moreover, socially prescribed perfectionism is a factor associated with suicide ideation, risk, and attempts even after taking into account other important factors associated with suicidality, such as depression and hopelessness (Chang, 1998; Hewitt, Flett, & Weber, 1994; Hewitt, Newton, Flett, & Callander, 1997; Hewitt, Norton, Flett, Callander, & Cowan, 1998).

Shafran et al. (2002) offer clinical examples to support their claims. Extant empirical research on the interpersonal aspects of perfectionism has been supplemented by case studies that further demonstrate the need to consider the interpersonal dimensions of perfectionism. For instance, Ellis (2002) provided a case description of a man named John who was set for a "double divorce" because both his wife and his business partners had experienced enough of John's perfectionistic demands. Ellis recounted that:

"John, however, was equally perfectionistic about his wife, Sally, and his two accounting partners. They, too, had to—yes, had to—perform well, dress well, and even play tennis well. And often they didn't, those laggards! John, of course, couldn't control others as he strove for his own perfection, so he was frequently enraged against his "careless" wife and partners and much more than he was anxious about his own performances" (Ellis, 2002, p. 255).

Ellis (2002) also recounted that he provided treatment to both John and Sally because Sally found

it difficult to cope with the unrealistic expectancies imposed on her (i.e., socially prescribed perfectionism).

Another comprehensive account of a perfectionist with socially prescribed perfectionism was provided by Reilly (1998), who used cognitive therapy to treat a 28-year-old woman with the pseudonym "Jane." Jane attempted suicide by drug overdose on at least two occasions, including during the course of treatment. She was diagnosed with major depressive disorder and generalized anxiety disorder. Reilly (1998) reported that Jane suffered from perfectionistic dysfunctional attitudes, self-criticism, and a preponderance of automatic thoughts about her inability to live up to socially prescribed pressures to be perfect.[2] Jane's socially prescribed perfectionism was also accompanied by high levels of interpersonal sensitivity, hopelessness, and perceived deficits in coping.

These case studies illustrate how perfectionism has a salient interpersonal component. We would suggest that much is to be gained from an interpersonal approach that includes an emphasis on the self in relation to significant others (see Baldwin, 1992; Westen, 1991), and an explicit emphasis on the interpersonal behaviours expressed by perfectionists (Habke & Flynn, 2002). Failure to examine the interpersonal dimensions of perfectionism may result in an underappreciation of the role of perfectionism in a variety of disorders, suicidal behaviour, and in marital and family distress.

More broadly, there is a long-standing tradition of viewing human behaviour as encompassing two over-arching organizing principles: agency and communion. This is reflected in all manner of writing (e.g., Bakan, 1966; Guisinger & Blatt, 1995; Sullivan, 1953; Wiggins, 1991). Shafran et al. (2002) focused on the self's relation to the self (e.g., stringent self-evaluation), and thus offered a simplified, purely agentic model of perfectionism wherein the perfectionist is represented as a self-contained unit divorced from his/her social context. In contrast, our emphasis on other-oriented and socially prescribed perfectionism recognizes the importance of communal concerns as fundamental aspects of human experience.

The most relevant way of addressing the issue of the unidimensionality versus multi-dimensionality of perfectionism is to examine the empirical evidence on this issue. Clearly, factor analyses of responses to the Multidimensional Perfectionism Scale (MPS) show strong evidence of multidimensionality (see Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b). Moreover, recent research on the nature of perfectionism in children and adolescents is particularly informative. Using the Child-Adolescent Perfectionism Scale (CAPS), a measure of self-oriented and socially prescribed perfectionism (see Flett, Hewitt, Besser, Boucher, & Davidson, 2002, MS in preparation), confirmatory factor analyses (CFA) indicate that a single factor solution does not fit the data and that a two-factor solution that distinguishes self-oriented and socially prescribed perfectionism provides an excellent fit to the data for both children and adolescents (Flett, Hewitt, et al., 2002, MS in preparation).

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[2] Additionally, although the perfectionism subscale of the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978) is consistently misidentified as a measure of perfectionism with an exclusively self-oriented focus (Sherry, Hewitt, Flett, & Harvey, 2002), it nonetheless has a strong interpersonal component with at least one third of the item content reflecting a perfectionistic preoccupation with "obtaining and maintaining [others'] approval" (Barnett and Gotlib, 1990, p. 56; Whisman & Friedman, 1998). Recent research has determined that the perfectionism subscale of the DAS is more a measure of socially prescribed perfectionism than a measure of self-oriented perfectionism (Sherry et al., 2002). As with the EDI perfectionism subscale, the perfectionism subscale of the DAS is best thought of as a measure that both captures and confounds self-oriented perfectionism and socially prescribed perfectionism.

Additional evidence of multidimensionality involves data showing that certain findings obtained with one dimension of perfectionism are simply not obtained with other perfectionism dimensions (Hewitt & Flett, 1993), and there are even some instances when perfectionism dimensions are associated in opposite directions with outcome measures, even though the perfectionism dimensions are positively intercorrelated (see Flett, Hewitt, & Martin, 1995). Other research shows that the multiple dimensions of perfectionism may operate as unique predictors of significant variance in maladjustment when dimensions of perfectionism are simultaneously considered (Hewitt & Flett, 1990; Hewitt, Flett, Ediger, Norton, & Flynn, 1998). For instance, discriminant function analyses have shown that both self-oriented and socially prescribed perfectionism are significant factors in individual differences in suicide ideation (Hewitt, Flett, & Turnbull-Donovan, 1992; Hewitt, Flett, & Weber, 1994).

4. Dimensions of perfectionism and fear of failure

Research on the fear of failure is quite useful in terms of illustrating the benefits of a multidimensional approach. Shafran et al. (2002) placed great emphasis on the role of fear of failure in clinical perfectionism and concluded that "the core psychopathology of perfectionism is expressed as a morbid fear of failure and relentless pursuit of success" (p. 779).

As noted by Shafran et al. (2002), self-oriented perfectionism has been linked empirically with an inability to tolerate failure (Flett, Hewitt, Blankstein, & Mosher, 1991) and fear of failure (Flett, Blankstein, Hewitt, & Koledin, 1992). However, these same studies and more recent research (e.g., Onwuegbuzie, 2000) indicate that socially prescribed perfectionism is the dimension of the MPS (Hewitt & Flett, 1991b) that has the strongest link with fear of failure. Presumably, socially prescribed perfectionists are concerned about criticism and censure from others in the event that their behaviours fail to meet performance expectations.

Fig. 1 outlines the results of a new study on perfectionism, fear of failure, and distress that further illustrates this point. This study involved the administration of the MPS, the Performance Failure Appraisal Inventory (PFAI; Conroy, 2001), and the CES-D Depression Scale (Radloff, 1977) to a sample of 94 undergraduates (see Flett, Besser, Davis, & Hewitt, MS in preparation). The PFAI assesses fear of failure in five areas: (1) fear of shame and guilt due to inadequate performance; (2) fear of loss of self (i.e., devaluing one's self-estimate); (3) fear of loss of plans for the future; (4) fear of loss of social influence and upsetting important others; and (5) fear of having an uncertain future. A confirmatory factor analysis demonstrated the acceptability of a latent factor defined by the five scales.

Our initial analyses showed that self-oriented perfectionism ($r = 0.23$, $p < 0.05$), other-oriented perfectionism ($r = 0.19$, $p < 0.09$), and socially prescribed perfectionism ($r = 0.60$, $p < 0.001$) are all associated with the Fear of Failure latent construct defined by the five PFAI factors as its indicators. A CFA evaluated the possibility that self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism are all indicators of Fear of Failure, and did not fit the data, thereby demonstrating that perfectionism and Fear of Failure are correlated but separate constructs. A structural equation analysis shows that when the correlations among the three MPS dimensions are taken into account, only socially prescribed perfectionism continues to have a link with the Fear of Failure construct, and Fear of Failure mediates the link between
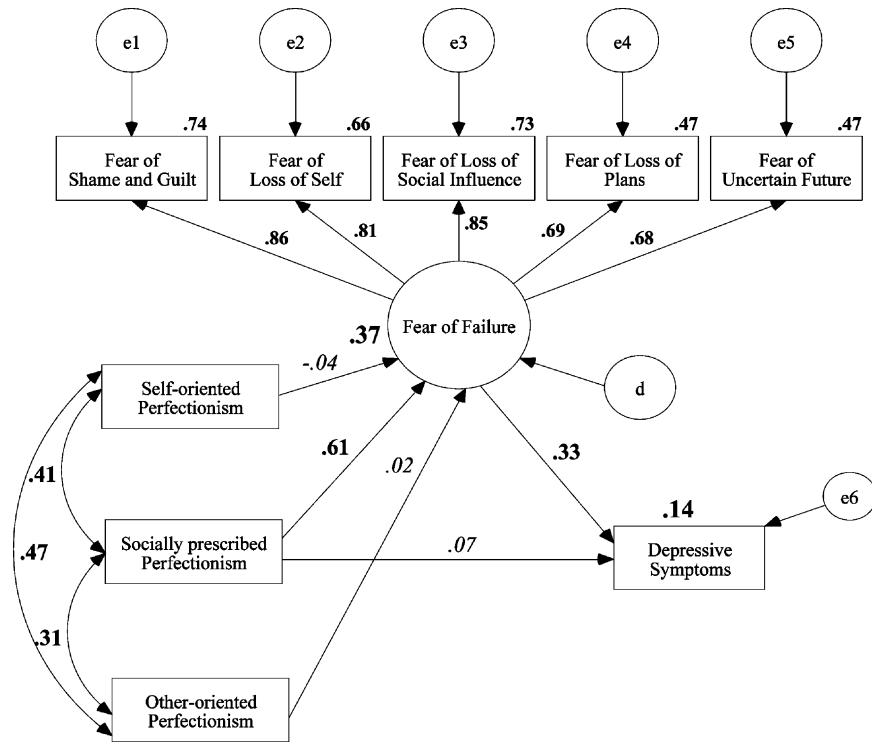
Fig. 1. Rectangles indicate measured variables, the large circle represents a latent construct, and the small circles reflect residual (d) or disturbance variances (e1-e6). The numbers on paths from the latent construct to its indicators represent factor loading coefficients and numbers above indicators and exogenous variables represent the amount of variance explained (R^2). Standardized maximum likelihood parameters are used. Bold estimates are statistically significant as determined by critical ratios.

socially prescribed perfectionism and depression (see Fig. 1). These data confirm the importance of considering the association between fear of failure and perfectionism, but they also show clearly that fear of failure is much more relevant to an understanding of socially prescribed perfectionism rather than self-oriented perfectionism. Thus, it can be argued that if, as Shafran et al. (2002) suggest, a "morbid fear of failure" is a critical component in perfectionism and psychopathology, then it follows that socially prescribed perfectionism is more relevant when focusing on fear of failure and clinical perfectionism.

5. Perfectionism as a generalizable trait

Another point raised by Shafran et al. (2002) that must be qualified is their definition of clinical perfectionism as involving "...*the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences*" (p. 778). Although concerns about being imperfect in just one life domain can be quite distressing for individuals, we believe that even greater dysfunction is likely among people who strive for perfection in

multiple domains, despite negative consequences. By definition, the study of perfectionism as a personality trait implies generalization across situations and life domains (see Hewitt & Flett, 1991b). That is, extreme self-oriented perfectionists are focused globally on perfecting the entire self, and, as we have demonstrated empirically, this may be exacerbated by a cognitive tendency to overgeneralize a single mistake to all aspects of the self (see Flett et al., 1998; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).

Horney (1950) also addressed this issue as part of her discussion of the "appeal of mastery." She observed that:

> "When speaking of perfectionistic people, we often think merely of those who keep meticulous order, are overly punctilious and punctual, have to find just the right word, or must wear just the right necktie or hat. But these are only the superficial aspects of their need to attain the highest degree of excellence. What really matters is not those petty details but the flawless excellence of the whole conduct of life" (Horney, 1950, p. 196).

Unfortunately, issues such as perfecting the global self and the generalizability of perfectionism across life domains and situations have seldom been the subject of empirical investigation. However, it has been demonstrated empirically that individuals with a high level of commitment to one perfectionistic goal also tend to have elevated levels of commitment to a wide range of other perfectionistic goals (see Flett, Sawatzky, & Hewitt, 1995) and that the greater the importance placed on being perfect in many domains, the greater the depressive symptomatology in perfectionists (Hewitt, Mittelstaedt, & Flett, 1990). We believe that this is a critical point. Although it is possible and desirable to identify the one area of greatest importance to perfectionists, one defining feature of extreme perfectionism is a tendency to want to be perfect in many life domains because flaws and failures of any sort indicate that the self is not perfect. That is, people are especially prone to psychopathology to the extent that they have become overly focused on a generalized sense of the perfect self (Hewitt, Mittelstaedt & Flett, 1990).

6. Perfectionism and self-worth as separate components

Shafran et al. (2002) suggested that the critical component in perfectionism is the impact of imperfections on self-evaluation. We believe that self-evaluative processes are essential and must be included in any model of perfectionism and psychopathology, and the authors are to be commended for incorporating this focus. However, we believe it is vital to retain a clear distinction (both empirically and conceptually) between the perfectionism construct and the self-evaluative reactions to achievement outcomes. Similarly, we believe that measures purporting to assess perfectionism should not be contaminated by content that refers to reactions to failure or success.

The need to distinguish perfectionism and self-evaluative processes is clearly evident in research and theory on perfectionism and self-efficacy. Experimental investigations of standard setting and self-efficacy are based on the premise that it is both desirable and meaningful to distinguish standards and an individual's perceived ability to meet these standards (Wallace & Alden, 1991). Indeed, the two-factor model of social anxiety outlined by Alden, Ryder and Mellings (2002) maintains this distinction between perfectionism and self-efficacy judgments. Empirical research

also highlights the usefulness of distinguishing perfectionism and self-efficacy judgments (see Martin, Flett, Hewitt, Krames, & Szantos, 1996; Wallace & Alden, 1991). A distinction between perfectionism and self-judgments is incorporated in research on perfectionism, self-esteem, and distress that has provided some support for the notion that self-esteem mediates the link between perfectionism and depression (Preusser, Rice, & Ashby, 1994; Rice, Ashby, & Slaney, 1998).

A model that fails to consider perfectionism and self-evaluative reactions as related but distinct constructs would find it difficult to account for the salient differences between people who have been described as neurotic perfectionists (i.e., people who see themselves falling short of perfection) versus people described as narcissistic perfectionists. These highly narcissistic individuals often demand perfection from the self and others; they differ from neurotic perfectionists in that they evaluate themselves as being close to perfect or at least more capable of perfection than other people, and they become deflated when others do not recognize their accomplishments (see Akhtar & Thompson, 1982; Sorotzkin, 1985). The cognitive-behavioural model outlined by Shafran et al. (2002) does not include a mechanism that allows for the existence of narcissistic perfectionists who have inflated but fragile self-views that may contribute directly to profound interpersonal difficulties due to a tendency to alienate others.

7. Perfectionism and the special case of eating disorders

Shafran et al. (2002) indicate that perfectionism plays a critical role in eating disorders and we believe that this point is beyond dispute. Treatment programmes should include an explicit focus on perfectionism, and Shafran et al. (2002) should be applauded for including this emphasis. However, they imply that only self-oriented perfectionism is relevant in eating disorders. We take issue with their decision to focus solely on self-oriented perfectionism on conceptual, psychometric, and empirical grounds.

First, the role of interpersonal aspects of perfectionism has been incorporated in numerous models of eating disorder behaviours (e.g., Heatherton & Baumeister, 1991). As one example, Hilde Bruch, in numerous writings, has indicated that interpersonal components of perfectionism play important etiological roles. Bruch (1981b) argued that anorexic individuals experience "a paralyzing sense of ineffectiveness. This sense of ineffectiveness, pervasive of all thought and action, is connected with the perception of the self as acting only in response to the demands of others" (p. 212). Similarly, Bruch, 1981b) maintained, "people suffering from eating disorders experience themselves as acting *only in response to demands* coming from others, and as *not doing anything because they want to*" (p. 216). Bruch (1971) described several case studies that further support her contention that perfectionism in anorexia nervosa involves perfection that is demanded by others. At a more global level, perfectionistic standards imposed externally on the self could be a reflection of cultural pressures to attain unrealistic body image ideals.

In terms of psychometric grounds, Shafran et al. (2002) stated that perfectionism is so central to eating disorders that it is included as a subscale in the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983) and that a measure designed specifically to assess perfectionism in eating disorders (the Neurotic Perfectionism Questionnaire; NPQ) has been developed (Mitzman,

Slade, & Dewey, 1994). The authors failed to mention that in the EDI,[3] half of the perfectionism items reflect socially prescribed perfectionism (e.g., "Only outstanding performance is good enough in my family") and approximately one fourth of the items in the NPQ tap socially prescribed perfectionism (e.g., "It often feels as if people make impossible/excessive demands of me"). In fact, Joiner and Schmidt (1995), using confirmatory factor analysis with college students, demonstrated that the EDI perfectionism subscale contains two factors, self-oriented and socially prescribed perfectionism. Moreover, in a re-analysis of data from 124 bulimic patients (Tasca & Bissada, 2002), we replicated Joiner and Schmidt's (1995) findings showing with CFA that a two-factor solution with self and social items respectively, is a better fit than a one-factor solution. In terms of empirical evidence of the importance of self and interpersonal components of perfectionism in eating disorders, Joiner, Heatherton, Rudd and Schmidt (1997) found that in using the separate perfectionism subscales from the EDI, both factors were similar in predicting bulimia symptoms. Likewise, in a sample of 57 female gym members, Sherry, Hewitt, Besser, McGee and Flett (in press) found that both the self-oriented and the socially prescribed dimensions of the EDI perfectionism scale uniquely predicted scores on the Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982). Additionally, Pratt, Telch, Labouvie, Wilson and Agras (2001) used structural equation modeling to test models of the maintenance of Binge Eating Disorder (BED) found that only socially prescribed perfectionism was associated with the eating disorder variables related to BED. In re-analyzing data from Cockell et al. (2002), we found that both self-oriented and socially prescribed perfectionism significantly discriminated anorexic, psychiatric control, and normal control patients. These data have some important practical implications. We would predict that to the extent that perfectionism contributes to eating disorders, patients are more likely to benefit from a multi-faceted intervention that recognizes the personal and interpersonal dimensions of this construct. That is, eating disorders will be less treatment-resistant if a more complex intervention approach is adopted.

Finally, Shafran et al. (2002) suggested that eating disorders represent the *expression* of perfectionism. This is an interesting observation because work in the personality literature is beginning to demonstrate that the levels of traits and expression of traits are both important in clinical outcomes (Wachtel, 1994). In this particular instance, we have found that the perfectionism construct has an expressive component in the form of perfectionistic self-presentation (i.e., an unwillingness to appear imperfect). Moreover, we have shown in several studies that the interpersonal expression of perfection is associated not only with trait perfectionism but also predicts a variety of psychopathological outcomes including eating disorder symptoms, depression, anxiety, fears of psychotherapy, and help-seeking beyond not only self-oriented perfectionism, but also other-oriented and socially prescribed perfectionism (Hewitt et al., 2002; Hewitt, Flett, & Ediger, 1995). This again highlights the relevance of interpersonal facets of the perfectionism construct to clinical phenomena.

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[3] Interestingly, two of the three items of the EDI perfectionism subscale are contained in the parental subscale of the Frost Multidimensional Perfectionism Scale (Frost et al., 1990).

8. Conclusion

As we noted, Shafran et al. (2002) are to be applauded for focusing additional attention on perfectionism as a significant problem with clinical implications. However, as is evident from our analysis, we must take issue with certain conclusions reached by Shafran et al. (2002), most notably their suggestion that the interpersonal dimensions of perfectionism are tangential and not central to an understanding of clinical perfectionism. Overall, we see little reason to dispense with the interpersonal components of perfectionism. There is a lengthy and consistent history of descriptions of perfectionism incorporating both self-related and interpersonal facets. The incorporation of these elements into current models of perfectionism has not only increased our understanding of the construct, but also allowed us to more accurately quantify the multiple facets, increase our understanding of the construct, and clarify how perfectionism might actually function in various clinical disorders (see Hewitt & Flett, 1993).

We believe that the interpersonal aspects of perfectionism are involved in clinical dysfunction and that the interpersonal complexities of the perfectionism construct have significant clinical implications in terms of the role of perfectionism in undermining the therapy process. Interpersonal behaviours play a major role and are a focal point in various approaches to psychotherapy (Benjamin, 1996; Tasca, Mikail, & Hewitt, 2002), including cognitive therapy. Young, Beck and Weinberger (1993) usefully distinguish between the "symptom-reduction phase" (p. 258) of treatment and the "schema-focused phase" (p. 268) of treatment. In the symptom-reduction phase of treatment, transient, surface-level cognitions are modified in an effort to reduce symptomatology, whereas, in the schema-focused phase of treatment, enduring, depth-level schemas based on interpersonal patterns, developmental origins, and traumatic experiences are addressed in an attempt to prevent relapse. Shafran et al. (2002), considering only the self-related components of perfectionism and ignoring the interpersonal/personological features of perfectionism, offer a treatment model directed more toward temporary relief than a treatment model oriented around lasting change.

Finally, we have argued (Hewitt et al., 2002) that clients who either demand perfection from others or who perceive that others are imposing perfectionistic demands on them will likely have a poor alliance with their therapists. Thus, it is not at all surprising that evidence provided by authors such as Blatt and Zuroff (2002) is beginning to show that the therapy process is very challenging, not only for perfectionists, but also for their treatment providers.

In conclusion, Shafran et al. (2002) have proposed a self-contained unidimensional model of perfectionism that emphasizes the primacy of cognition, downplays the importance of relational dynamics, and ignores the fullness of experience. Conversely, because we believe "that a living organism must be regarded as a nodal point in an extremely complex network of interactions, relations and transactions" (Bruch, 1970, p. 504), we have constructed a dynamic, multidimensional model of perfectionism wherein multiple forces involving developmental processes, self-presentational styles, environmental variables, physiological responses, interpersonal dynamics, cognitive patterns, and personality traits act independently and combine interactively to influence psychological difficulties (for a review see Flett & Hewitt, 2002b; Hewitt & Flett, 1991b, 2002; Hewitt et al., 2002).

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