School administrators – Attitudes Teacher-administrator relationships Student-administrator relationships

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Abstract
The construct of perfectionism is an important one for today's counselor. Perfectionism has been associated with a wide variety of psychopathologies, including anxiety (Flett, Hewitt, & Dyck, 1989), depression (Hewitt & Flett, 1990), and personality disorders (Broday, 1988; Hewitt & Flett, 1991 b). A number of theorists have connected perfectionism with unhealthy or pathological symptomatology (e.g. Adler, 1956; Burns, 1980b; Horney, 1950). Recently, however, perfectionism has been associated with both healthy and unhealthy characteristics (Slaney & Ashby, in press). Slaney, Ashby, and Trippi (in press) suggested that the component of high personal standards appeared to be an important aspect of the definition of perfectionism, but not always problematic.
Perfectionism:  
Conceptualizations and Implications for Treatment

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A Research Paper  
Presented to  
The Department of Educational Administration  
and Counseling  
University of Northern Iowa

________________________

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts

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by  
Donna L. Fisher  
May, 1995
This Research Paper by: Donna L. Fisher
Entitled: Perfectionism: Conceptualizations and Implications for Treatment

has been approved as meeting the research paper requirements for the Degree of Masters of Arts.

Date Approved

4/21/95

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4-25-95

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The construct of perfectionism is an important one for today's counselor. Perfectionism has been associated with a wide variety of psychopathologies, including anxiety (Flett, Hewitt, & Dyck, 1989), depression (Hewitt & Flett, 1990), and personality disorders (Broday, 1988; Hewitt & Flett, 1991b). A number of theorists have connected perfectionism with unhealthy or pathological symptomatology (e.g. Adler, 1956; Burns, 1980b; Horney, 1950). Recently, however, perfectionism has been associated with both healthy and unhealthy characteristics (Slaney & Ashby, in press). Slaney, Ashby, and Trippi (in press) suggested that the component of high personal standards appeared to be an important aspect of the definition of perfectionism, but not always problematic.

The construct of perfectionism in today's literature is markedly different than it was a decade ago. Early theorists such as Adler (1956) and Horney (1950) did not specifically discuss an individual construct called "perfectionism." In contrast, they discussed theories of personality development wherein perfectionism was a characteristic of pathological behavior.

In the time period between 1960 and 1980, ideas surrounding perfectionism began to be examined more closely. With the augmentation of new researchers like Burns (1980a), Hollender (1965), and Pacht (1984), a unidimensional and cognitive view of perfectionism which focused on negative and maladaptive characteristics emerged.
The central concept of this definition of perfectionism was the setting of unrealistically high standards.

In 1978, Hamachek introduced the concept that there can be both normal and neurotic perfectionistic behavior. According to Hamachek (1978), neurotic perfectionists are motivated by their fear of failure, while normal perfectionists are motivated by a desire for improvement. With Hamachek's distinction between normal and neurotic perfection, the question became, "How does one distinguish between the two groups?" A new wave of research and ideology originated from this question.

Theorists appear to agree that parts of this construct are connected to unhealthy characteristics (Burns, 1980a; Hewitt & Dyck, 1986; Hewitt & Flett, 1990; Hollender, 1965; Pacht, 1984) and consequently try and treat the perfectionism when it appears in their counseling caseload (Burns, 1980a). However, Ashby and Rice (1994) proposed that in order for perfectionism to be treated effectively, the counselor must better understand it. The purpose of this paper is to track the historical explanation of perfectionism and review current conceptualizations in order to facilitate more sophisticated understanding and frame interventions appropriately.

Early Theorists

Historically, early theorists noted perfectionistic behavior, but rarely studied the construct in isolation. Theorists such as Adler (1956) and Horney (1950) believed perfectionism to be a trait of one's
personality. They did not discuss a specific perfectionistic construct, but rather considered it to be one of many traits that made up the entire personality. In this early literature, perfectionistic personality traits were considered pathological.

Adler

Adler (1956) believed that all behavior is purposeful and goal-directed and that humans are all striving for some type of significance or perfection. He viewed perfection as an ideal which can never be reached, but can guide one in the right direction for improvement. Adler emphasized that people are primarily social creatures and motivated by social interests (Eckstein, Baruth, & Mahrer, 1992). He viewed perfectionism as a healthy attribute as long as it manifested itself within the range of common sense and with social interest (Lazarsfeld, 1991). Based on this idea, Adler proposed a difference between the sound striving for perfection and the neurotic wanting to be perfect (Adler, 1956).

Adler saw personality as heavily influenced by the quality of early social relationships (Way, 1950). He suggested that poor social relationships and other handicaps would cause individuals to lose confidence in their capacity to reach the goals they had set for themselves and use perfectionism as an illusion of fulfillment (Lazarsfeld, 1991).
Horney (1950) agreed with Adler in that she saw adult personality as being largely shaped by childhood experiences. Horney focused on social relationships, especially with parents. In particular, Horney argued that when parents' behaviors toward a child are indifferent or inconsistent, the child feels helpless and insecure. Horney called this feeling "basic anxiety." She believed that the child who develops this "basic anxiety" tries to establish a sense of security later in life. This is accomplished by the continuous striving toward an image of the "perfect" self. The child tries to achieve a close fit between his or her desired self and perceived self. According to Horney, when such perfectionistic or idealized standards come to dominate a person's life, he or she becomes driven to obtain the impossible. For the perfectionistic individual, no amount of accomplishment will ever be enough.

The perfectionist is also extremely sensitive to criticism (Horney, 1950). Even the slightest negative feedback will be seen as evidence that there is a huge gap between the real self and the idealized self (Horney, 1950). Horney also stated that the perfectionist is deeply vulnerable. Because the gap between the perceived self and idealized self is so large, low self-esteem is inevitable (Horney, 1950).

Horney (1950) viewed this process of molding oneself into an idealized image of perfection as a neurotic process. She believed that a child facilitated this neurotic process by creating an irrational thought
process called "the tyranny of the shoulds." According to Horney (1950), the child unconsciously tells himself or herself: "Forget about the disgraceful creature you actually are; this is how you should be; and to be this idealized self is all that matters. You should be able to endure everything, to understand everything, to like everybody, to be always productive" (p.65). These demands on the self are extremely difficult and rigid. Horney (1950) believed that the child will usually add that it is better to expect too much of himself or herself than too little. According to Horney (1950), as soon as these inner dictates are exposed to critical thinking, the individual is usually able to see that they are not feasible. Yet, "the tyranny of the shoulds" is still in control, and the individual believes that he or she should be able to adjust his or her idealized image.

Later Theorists

Early theorists, Adler (1956) and Horney (1950), viewed perfectionism as pathological. Several later theorists (1960s -1980s) such as Hollender (1965), Burns (1980a), and Pacht (1984) continued with this line of thinking. Like the early theorists, these individuals viewed perfectionism as a negative and maladaptive concept (Burns, 1980; Hollender, 1965; Pacht, 1984). However, Hamachek (1978) conceptualized perfectionism somewhat differently. Hamachek (1978) viewed perfectionistic behavior as having both normal and neurotic characteristics.
Hollender

Hollender (1965) defined perfectionism differently than earlier theorists, but continued to conceptualize it in a similar way. For instance, Horney (1950) defined the perfectionist as one who works to mold himself or herself into a perfect idealized image. In contrast, Hollender (1965) defined perfectionism as being a manner in which a person performs, rather than how he or she thinks or sees him or herself. Hollender (1965) perceived perfectionism as a personality trait gained during childhood through insecurity. The continuous goal throughout childhood, Hollender (1965) believed, is to perform in a manner that will gain approval and acceptance from others. While struggling for acceptance, the child may hear messages from his or her parents that the performance does not meet their standards. According to Hollender, this increases the child's insecurity and pushes the child to work harder.

Hollender (1965), like Horney, placed great importance on the child's relationship with parents. Hollender argued that parents who are hard to please may equate adequate or even above average performances as failures and reject the child. As time goes by, the child's need to please the parents becomes internalized. No longer does someone else require perfection. The child requires perfection from himself or herself. The purpose of the perfectionistic behavior is to raise the child's self-image and gain acceptance, approval, and attention from others (Hollender, 1965).
Hamachek (1978) agreed with Horney (1950) and Hollender (1965) that perfectionism has its origin in early childhood. In 1978, he published a paper that marked a turning point in the conceptualization of perfectionism. Hamachek introduced the concept that both neurotic and normal perfectionistic behavior can exist. Neurotic perfectionists do not allow themselves any imperfection (Hamachek, 1978). They never achieve satisfaction from their work because their goals are unattainable. By having extremely high expectations of themselves, neurotic perfectionists sabotage their efforts to increase their self-esteem.

According to Hamachek (1978), neurotic perfectionists concentrate on their inability to meet their high standards, while normal perfectionists concentrate on how to increase their current ability to achieve more. Hamachek explained this by introducing the concept that neurotic perfectionists are motivated by their fear of failure, while normal perfectionists are motivated by a desire for improvement.

Unlike neurotic perfectionists, normal perfectionists do not equate an unsatisfactory performance with their self-worth. According to Hamachek (1978), a normal perfectionist takes pleasure in working towards high standards, but does not have high standards in every aspect of his or her life. The normal perfectionist allows himself or herself imperfection as the situation permits. Hamachek (1978) believed that normal perfectionists use the good feelings that they receive from striving
towards high standards to feel good about themselves. These good feelings, on top of preexisting good feelings and adequate self-esteem, motivate people to improve their work or reward themselves for a job well done.

Hamachek (1978) stated that perfection refers to not only behavior, but also to the way one thinks about behavior. Hamachek (1978) argued that neurotic perfectionists have childhoods filled with disapproval or inconsistent approval. He expounded on this idea by explaining that children may gain their idea of self by their performance. A message with unconditional approval states that love will be given no matter what. A message with conditional approval is dependent on a satisfactory performance. With this type of approval, children equate their self-worth by their performance and become neurotic perfectionists (Hamachek, 1978).

Burns

Like Hamachek (1978), Burns (1980b) believed that there is a difference between a healthy pursuit of excellence and an unhealthy pursuit of impossibly high standards. He would see Hamachek's "normal" perfectionist as healthy, and as a result, would not label the individual a perfectionist at all.

Burns (1980b) came from a cognitive perspective and theorized that the perfectionist is trapped in a thought structure that includes all-or-nothing thinking, over generalizations, and "should" statements. This
perfectionistic mind-set produces feelings of guilt, shame, and depression.

Consistent with Adler (1956), Horney (1950), and Hamachek (1978), Burns (1980b) believed that perfectionism is learned during childhood. He maintained that a perfectionistic thought structure and behavior forms in the child’s early years through the modeling of perfectionistic parents. His hypothesis was that once the child engages in the perfectionistic mind-set, the cycle perpetuates itself. The internal, cognitive messages and the emotional consequences never allow the child to achieve perfection no matter how well he or she performs. Burns (1980b) surmised that the cycle also perpetuates itself through intermittent reinforcement. Infrequent and unpredictable reinforcement allow the perfectionistic child to continue the unrealistic thinking and behaving even though the pain drastically outweighs the rewards.

Pacht

Consistent with the theory of Burns (1980b), Pacht (1984) described perfectionism as a cognitive script that places an individual in a self-destructive double bind. Unlike Hamachek (1978), Pacht (1984) believed that there is no such thing as a “normal” perfectionist. He reserved the use of the term to label individuals who take perfectionism to the extreme ends of a continuum and who can see no middle ground. This is similar to Burns’s idea of all-or-nothing thought distortions. Pacht stated that perfectionists are doomed to a miserable life if they can not
unlearn distorted thinking patterns and let go of their rigid goals.

These later theorists (1960s-1980s) contributed many theoretical ideas to the literature on perfectionism. Hollender (1965), Hamachek (1978), Burns (1980), and Pacht (1984) believed perfectionism to be a unidimensional, cognitive construct. These authors stressed that the central concept of perfectionism was the setting of unrealistically high personal standards. With this conceptualization in mind, contemporary researchers began to contemplate a new question: How was one to determine the distinction between individuals who set unrealistically high standards and those who are highly proficient and successful?

Research on Perfectionism

Hamachek (1978), who proposed the idea of both normal and neurotic perfectionism, suggested that perfectionism was a combination of unrealistically high standards and critical self-evaluation. Therefore, one might think that pathological perfectionism has more to do with critical self-evaluation than with high standards. The preceding idea was only one of many hypotheses generated during the late 1980s and early 1990s. Out of this multitude of hypotheses came a number of scales, developed to measure the distinct components of perfectionism.

Frost

Frost, Marten, Lahart, and Rosenblate (1990) reviewed the literature and suggested that there were five common areas where perfectionistic behavior was thought to be problematic. These five areas
include perfectionists' unrealistic personal standards, high level of concern over their mistakes, vague sense of doubt over the quality of their work, perception of extremely high parental expectations, and overemphasis on organization and order.

Under these conditions, Frost et al. (1990) developed the Multidimensional Perfectionism Scale (MPS). Frost and his colleagues gathered items from existing measures of perfection and created other items to draw upon their hypothesized dimensions of perfectionism. All of the items were placed into one of these five categories: Personal Standards, Concern Over Mistakes, Parental Expectations, Doubting of Actions, and Organization. The MPS developed by Frost et al. (1990) correlated significantly with the Burns Perfectionism Scale (Burns, 1980b) and the Perfectionism Scale of the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983).

Along with the MPS development, Frost et al. (1990) wanted to identify the features of perfectionism that were most relevant to pathology. Frost and his colleagues had identified the major dimension of perfectionism to be excessive concern over mistakes. They hypothesized that certain dimensions of perfectionism (i.e. concern over mistakes) would correlate more highly with psychopathology than other dimensions. Frost et al. (1990) hypothesized that the MPS measures what Hamachek calls neurotic perfectionism, but reported there appear to be dimensions of perfectionism that are positive and promote a healthy
orientation towards life rather than complete pathological thinking. Specifically, Frost et al. stated that the Personal Standards subscale contains items that may be related to positive self-concept.

Overall, findings by Frost et al. (1990) included preliminary evidence suggesting the reliability and validity of the MPS and the multiple dimensions of perfectionism. Frost et al. (1990) also suggested that the central concept in perfectionism was concern over mistakes (CM) and that this trait was most closely associated with symptoms of psychopathology.

**Hewitt and Flett**

At the same time, other contemporary theorists began researching perfectionism under this multidimensional aspect (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b; Slaney & Ashby, in press). Hewitt and Flett (1991b) proposed that perfectionism incorporated both personal and social factors. They suggested that perfectionism consists of three components: self-orientated perfectionism, other-orientated perfectionism, and socially-prescribed perfectionism. Self-orientated perfectionism is directed towards the self. This component of perfectionism is thought to reflect the discrepancy between the real self and the ideal self. Other-orientated perfectionism is directed towards others. This component suggests that some perfectionists hold unrealistically high standards for others. Socially-prescribed perfectionism incorporates the perception that others project
unrealistically high standards on the perfectionist or will evaluate him or her harshly.

Hewitt and Flett (1991b) conducted research to test their hypothesis that perfectionism is a multidimensional trait. Their scale, also termed the Multidimensional Perfectionism Scale (MPS), was created and found to have adequate internal consistency, internal validity, and subscale validity with clinical samples. Hewitt and Flett found that both self-orientated perfectionism and socially-prescribed perfectionism contributed to depressive symptomatology. Using their Multidimensional Perfectionism Scale, Hewitt and Flett (1994) investigated possible connections between the dimensions of perfection and depression and found that self-orientated perfectionism, perfectionistic motivation and other-orientated perfectionism were correlated positively with severity of depression. These results suggest that the different dimensions of perfectionism play a unique role in clinical cases.

Even with the new concept of perfectionism as a multidimensional construct, researchers continued to view perfectionism as a primarily maladaptive construct contributing to clinical problems such as depression (Hewitt & Dyck, 1986; Hewitt & Flett, 1991a) and personality disorders (Broday, 1988; Hewitt & Flett, 1991b). However, similar to Frost et al. (1990), Hewitt and Flett (1990) commented on the possible positive components of perfectionism. They briefly commented that self-
orientated perfectionism appears to contain a positive aspect related to self-confidence that has previously gone undetected and unresearched. Slaney, Ashby, Johnson, and Trippi

While Hewitt and Flett (1990) and Frost et al. (1990) mentioned possible positive aspects of perfectionism, they continued to focus on its negative consequences in their research. Slaney, Ashby, and Trippi (in press) conducted a review of the research on multidimensional perfectionism. Slaney et al. (in press) proposed that when studying perfectionism, the existing literature was biased towards pathology. As a result of their research, Slaney et al. (in press) also suggested that the component of high personal standards appeared to be an important aspect of the definition of perfectionism but not always problematic. This suggestion was consistent with Hamachek (1978) in that it proposed a healthy or adaptive aspect of perfectionism.

Slaney and Johnson (1992) developed the Almost Perfect Scale (APS) which attempted to measure high personal standards and orderliness without a negative bias towards pathology. Support for this scale was found by Slaney, Ashby, and Trippi (in press). After factor analysis and comparison with existing measures of perfectionism, Slaney et al. (in press) concluded that there appeared to be support for the multi dimensional aspect of perfectionism along with the construct having both adaptive and maladaptive factors.
Implications for Treatment

Both individual (Halgin & Leahy, 1989) and group (Barrow & Moore, 1983; Broday, 1989; King, 1986) treatment approaches have been proposed for perfectionistic clients. The existing literature on treatment of perfectionism directly reflects Burns' (1980a) ideology that perfectionism results from cognitive scripts. Interventions following this ideology include the unlearning of destructive perfectionistic cognitive patterns and the relearning of a productive cognitive style through such techniques as modeling, feedback, practice, and increasing cognitive coping skills or positive self-talk (Barrow & Moore, 1983; King, 1986).

Burns (1980a) stated that the perfectionist must change his or her thought structure. Concerning treatment, he suggested that it was not sufficient to be aware of perfectionistic tendencies or trace its etiology back into childhood. Burns (1980a) developed a series of cognitive strategies to combat perfectionistic tendencies. The first step that he implemented with his perfectionistic clients was to have them make a list of the advantages and disadvantages of being perfectionistic. With this list it became clear to clients that perfectionism was working against them. This was done to increase the motivation of the clients. The second step employed by Burns was to analyze the clients' distorted thinking patterns. For example, if the clients engaged in all-or-nothing thinking, they were asked to put this notion towards everything and everyone for one day. This included looking at another person and trying
to decide if he or she is totally ugly or irresistible. Clients usually realized that the world was not meaningful when one employed such dichotomous thinking. The clients’ next step was to substitute a more realistic thought for the unrealistic one when it occurred. Burns (1980a) stated that it is important to communicate that this process will take considerable time and energy. The clients may have spent the last 10-20 years involved in perfectionistic thinking, and it can not be corrected in 2-3 therapy sessions. The perfectionists will undoubtedly try and tell themselves that they “should” be able to master this just like they should be able to master everything else in their lives.

Future Implications

This paper charted the development of the ideology surrounding perfectionism. Throughout the last half of this century, there was a steady increase in the research on perfectionism. As clinicians began to identify more perfectionists in their caseloads, they began to focus more attention on the construct in the literature. Most of the research before 1990 indicated that perfectionism was a unidimensional construct having maladaptive or pathological consequences with a central concept of setting unrealistically high personal standards (Burns, 1980; Hollender, 1965; Pacht, 1984).

As a result of this new literature, individuals began to look at perfectionism more closely and question this ideology. Out of this close scrutiny of the literature came the notion of perfectionism as a

In the late 1980s and early 1990s, perfectionism evolved from a unidimensional construct to a multidimensional construct, but its pathological characteristics or consequences persisted. In only one instance (Flett, Hewitt, Blankstein, & O'Brien, 1991) was it mentioned that perfectionism may have positive aspects. These concepts were challenged when Slaney, Ashby, and Trippi (in press) reviewed the literature on multidimensional perfectionism and questioned earlier research methods. Slaney et al. (in press) stated that previous research appeared to be both biased towards pathology and focused narrowly on problematic high personal standards. In fact, Slaney et al. (in press) found the opposite to be true. Just as Hamachek (1978) helped researchers turn the corner into the new realm of multidimensional
aspects of perfectionism, Slaney and Ashby (in press) will help turn the corner into the new realm of healthy aspects of perfectionism. Their research contradicted the previous association between high standards and pathology. According to Slaney and his colleagues, it is imperative that counselors think about and redefine perfectionism to facilitate more sophisticated understanding of and frame interventions appropriately.

In terms of treatment of perfectionism, the existing literature trails the current conceptualizations. When perfectionism was thought to be a unidimensional construct, several theorists (Barrow & Moore, 1983; Broday, 1989; King, 1986) suggested group cognitive treatment techniques. With this new conceptualization, is this treatment still appropriate? Ashby and Rice (1994) proposed that different types of perfectionists (i.e. normal and neurotic) need different types of interventions. Following the old model of perfectionism could be decreasing the client's healthy aspects of perfectionism during therapy. Obviously further research needs to be done in the area of treatment of the different dimensions and aspects of perfectionism.
References


