The "Perfect" Persona – The Unacceptable Me

A Psychodynamic Exploration of Neurotic Perfectionism from the Perspective of the Experienced Clinician

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Table of Contents

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Abstract

With aetiological roots in obsessional neurosis, neurotic perfectionism is the self-destructive branch of the dichotomous perfectionism construct. The most distinguishing characteristics of this phenomenon include the persistent striving to achieve completely unattainable self-imposed standards, and relentless, most often cruel, punitive self-criticism. In this perpetual pursuit of perfection, it is psychopathology that is inevitably found around every corner. The primary research aim of this study is to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician. As extant psychotherapeutic research has long focused on quantitative methodological approaches, this study seeks to gain a fresh new insight into the qualitatively untapped area of neurotic perfectionism. A qualitative research study was therefore carried out using the data collection method of semi-structured interviews, with 5 extensively experienced Irish accredited psychotherapists, regarding their clinical work with neurotic perfectionists. Interview transcripts were analysed using thematic analysis to translate the participants' subjective experiences into objective qualitative data. Three prominent superordinate themes consequently emerged from this analysis: 1) The Unacceptable Me; 2) A Sick Destiny; 3) Therapy- The "Imperfect" Struggle. This research ultimately showed that neurotic perfectionism is a phony "perfect" persona that is unconsciously constructed, when the true self is rejected in childhood, as a defensive mask of survival to gain love and acceptance from significant others. Comorbidity was found to be positively associated between neurotic perfectionism and psychopathology, resulting from the continued repression of the true self. The therapeutic encounter was found to be an incredibly tempestuous, and pressurised, see-saw experience for the psychotherapist working with neurotic perfectionists, as it is littered with a multitude of obstructive negative transference and countertransference reactions. This qualitative study undoubtedly highlights the unequivocal destructive power of the phenomenon of neurotic perfectionism.

Chapter 1: Introduction

"Perfection does not exist. To understand it is the triumph of human intelligence; the desire to possess it is the most dangerous kind of madness"
- Alfred de Musset (1810-1857)

1.1 Introduction

The phenomenon of perfectionism has been extensively reviewed since its first psychoanalytic conceptualisation by Freud (1926) as being located within the realm of neurotic symptomatology. Perfectionism subsequently proceeded on a journey of reconceptualisation after reconceptualisation, as the more attention it received from various scholars, the more it grew in volume and complexity within the literature (Greenspon, 2008). This once budding area has consequently blossomed over the decades and evolved into the diverse and multifaceted field of perfectionism that is so robustly present in the burgeoning contemporary psychotherapeutic literature available today. Moreover, perfectionism has further branched out from its originating psychotherapeutic roots into mainstream psychological and psychiatric study.

Originally considered a unidimensional construct, it was Hamachek's (1978) seminal work that brought forth the transformation of perfectionism into the dichotomous constructs of normal and neurotic perfectionism that are still discussed to this day. One-dimensionality was exchanged for a fresh multidimensional theory of perfectionism, with interpersonal layers conceptualised by Frost, Marten, Lahart & Rosenblate (1990), and intrapersonal layers theorised by Hewitt & Flett (1990, 1991a, 1991b). A further revolutionary concept, the measurement of multidimensional perfectionism, was later conceived and a number of quantitative measurement tools were further developed (Sorotzkin, 1985; Halgin & Leahy, 1989; Shafran, Cooper, & Fairburn, 2002).

Some of the most common features associated with neurotic perfectionism in its earliest conceptual stages were; the incessant striving for impossible standards, relentless self-criticism, and a self-deprecatory obsession over making any kind of mistakes (Burns, 1980b). However, more relatively recent research has further concluded that the neurotic branch of perfectionism is positively associated with a broad spectrum of psychopathology (Flett & Hewitt, 2002), such as, depression (see Rice & Mirzadeh, 2000), eating disorders (see Halmi et al., 2000), anxiety disorders (see Flett & Hewitt, 2004), obsessive compulsive disorders (see Frost & Steketee, 1997), personality disorders (see Devens & Erichson, 1998), psychosomatic disorders (see Forman, Tosi, & Rudy, 1987), sexual dysfunction disorders (Quadland, 1980), and also suicidality (see Hewitt, Flett, & Turnbull-Donovan, 1992).

The current, and reclassified, psychiatric definition of maladaptive perfectionism, located in the recently revised diagnostic and statistical manual of mental disorders (DSM-5), is rigid perfectionism; a pathological personality trait within the core diagnostic criteria for obsessive-compulsive personality disorder (American Psychiatric Association, 2013). Arguably, this alludes to an obvious comorbidity between neurotic perfectionism and general obsessive compulsivity (Schweitzer & Hamilton, 2002). So, perfectionism has come a monumentally long way since Freud's (1924) deceptively simplistic original theory. A most noteworthy point to make is that ninety years, and five publications of the DSM later, Freud's (1924) concept of the link between perfectionism and obsessionality continues to live on, with particular support from the psychiatric community. Finally, one is left wondering about those who struggled with their own neurotic perfectionism related psychopathologies prior to our current understanding of what Blatt (1995) insisted is "the destructiveness of perfectionism" (p.1003).

1.2 Rationale

Extant psychotherapeutic knowledge of neurotic perfectionism has been built upon developing research predominantly conducted by the cognitive behavioural and psychoanalytic traditions. While this research has been responsible for the advancement of the neurotic perfectionism construct, there still remains a monumental dearth of study from the psychodynamic and object relations perspectives. Additionally, while the area of parent-child attachment has been clearly identified as a fundamental predisposing factor to neurotic perfectionism, apart from a very small body of published literature (see Rice & Mirzadeh, 2000; Andersson & Perris, 2000; Flett et al., 2001; Speirs-Neumeister & Finch, 2006), surprisingly little research has actually been directly carried out in this area.

Furthermore, in light of the vast amount of knowledge which has been gained through continued research in this field, most studies conducted, and published, regarding neurotic perfectionism favour a purely quantitative methodological approach. Research data is therefore generally established using a plethora of quantitative measurement tools, such as, self-reports, questionnaires, and scales. As a result, there is a noticeable paucity of any kind of rich subjective data which can only be appropriately obtained through qualitative methodological research. Additionally, no research has been located pertaining to the experiential understanding of the psychotherapist working with neurotic perfectionists in the clinic.

1.3 Research Aims & Objectives

1.3.1 Aims

- Bridge the gaps identified in the literature by conducting an in-depth psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician

- Focus qualitative exploration from a psychodynamic and object relations perspective.
- Broaden extant theoretical knowledge of the phenomenon of neurotic perfectionism, to provide further insight for clinicians working with neurotic perfectionists.

1.3.2 Objectives

- Assess the participants' theoretical interpretation of the construct of neurotic perfectionism.
- Examine the participants' views of the parent-child attachment styles of neurotic perfectionists.
- Investigate the existence of comorbidity between neurotic perfectionism and psychopathological disorders in accordance with the perceptions of the participants.
- Explore the rationale for any positive associations made by participants between neurotic perfectionism and psychopathology.
- Identify negative transference and negative countertransference issues experienced by the participants.
- Determine the participants' experience of the impact of neurotic perfectionism on the psychotherapeutic process.

Note: the terms "neurotic" and "maladaptive" are used interchangeably throughout the thesis as they denote the same concept.

Chapter 2: Literature Review

"The desire for perfection is the worst disease that ever afflicted the human mind"
- Marquis Louis Fontanes (1757-1821) to Napoleon 1 (in 1804)

2.1 Introduction

The literature review will begin with a discussion of the key developmental stages, and most prevalent characteristics, of neurotic perfectionism. The aetiology of neurotic perfectionism will next be expounded from the perspectives of psychoanalytic theory, and maladaptive parenting. Following this, psychodynamic literature will elaborate the dynamic processes of insecure attachment, and unconscious internalisations, in relation to the development of neurotic perfectionism. Unconscious defensive strategies will then be outlined in terms of the use of neurotic perfectionism as defence in itself. Next, the positive association between neurotic perfectionism and the development of psychopathology will be examined. To conclude, the transferential dynamic will be brought into focus to elucidate the obstructive nature of certain transferential phenomena that can hinder any psychotherapeutic relationship.

2.2 Theoretical Underpinnings of Perfectionism

A variety of theories regarding the construct of perfectionism have been put forward by leading theoreticians (Dickinson & Ashby 2005). Freud's (1926) description of perfectionism as a core symptom of obsessional neurosis was the earliest theory recorded in the literature. Hamachek (1978) conceptualised 2 opposing constructs of perfectionism, normal (adaptive) and neurotic (maladaptive), thus suggesting that perfectionism can either be useful, or destructive. Hewitt & Flett (1990) advanced the extant research with their conceptualisation of perfectionism as a multidimensional construct. On foot of this research, Frost et al. (1990) introduced an innovative quantitative measurement tool, the Frost Multidimensional Perfectionism Scale (FMPS), which measured various intrapersonal dimensions of

perfectionism (Lo & Abbott, 2013). Subsequently, Hewitt & Flett (1991a, 1991b) presented their own multidimensional perfectionism scale, the HMPS, which advanced the previous one-dimensional, self-directed, FMPS by adding two new interpersonal dimensions of perfectionism; social orientated perfectionism, and other oriented perfectionism (Crosby, Bates, & Twohig, 2011).

According to Hamacheck (1978), neurotic perfectionists set unattainably high standards, without any allowable margin for error, and therefore never achieve satisfaction or pleasure from their endeavours, because, "in their own eyes they never seem to do things good enough" (p.27). Wei, Mallinckrodt, Russell, & Abraham (2004) concluded that maladaptive perfectionism is usually comprised of excessive worrying about failure, and a deep underlying fear of rejection or abandonment. Rice, Lopez, & Vergara (2005) further ascribe debilitating self-criticism, self-doubt, and the relentless pursuit of achievement, as central characteristics of maladaptive perfectionism. Neurotic perfectionists are consequently plagued by anxiety related to their perceived imperfections (LoCicero & Ashby, 2000), laden with feelings of inferiority (Ashby & Kottman, 1996), and suffer greatly with very low self-esteem (Rice & Slaney, 2002). Neurotic perfectionism is thus most succinctly described as destructive (Blatt, 1995), and insidious (Pacht, 1984), thereby making psychotherapeutic treatment incredibly difficult (Nadler, 1983).

As part of Beck's (1967, 1976) cognitive model of psychopathology, the dysfunctional attitudes scale (DAS; Weissman & Beck, 1978; Weissman, 1979) was formulated to measure the cognitive content of various forms of psychopathology (Beck, Brown, Steer, & Weissman, 1991). In a study comparing three different treatments for depression, the DAS was completed by participants (Elkin, Parloff, Hadley, & Autry, 1985). An underlying self-

critical factor was determined in all participants, which was subsequently named perfectionism (Blatt, Quinlan, Pilkonis, & Shea, 1995). Additionally, several authors have reached the same conclusion as Blatt et al. (1995), that is, maladaptive perfectionism and self-criticism are one and the same concept (see Shahar, 2006; Beck, 1983; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Shahar, Blatt, & Zurofi, 2007; Ashby & Kottman, 1996).

Moreover, the term self-critical perfectionism was theorised to demonstrate the inextricability between self-criticism and neurotic perfectionism (Clara, Cox, & Enns, 2007; Dunkley, & Blankstein, 2000; Dunkley, Zuroff, & Blankstein, 2003; Powers, Zuroff, & Topciu, 2004; Terry-Short, Owens, Slade, & Dewey 1995; Robins et al. 1994). Some shared, and poignant, characteristics of self-criticism and neurotic perfectionism (self-critical perfectionism) include; the tendency to set unrealistically high standards, a punitive and demeaning attitude towards the self for any small personal failure (Shahar et al., 2007), a consuming preoccupation with the establishment of a worthy sense of self (Whelton, Paulson, & Marusiak, 2007), high levels of neuroticism, low levels of agreeableness (Zuroff,1994), severe interpersonal difficulties (Mongrain, Vettese, Shuster, & Kendal, 1998) , and social dysfunction (Aube & Whiffen, 1996).

2.3 Aetiological Conceptualisations of Neurotic Perfectionism

Freud (1926) postulated that neurotic perfectionism was at the root of obsessional neurosis. The danger of repressed oedipal impulses, and conflicts, returning to consciousness results in the ego and superego regressing to an anal fixation, while the id threatens to explode with aggressive impulses (Sorotzkin, 1985). However, Branfman & Bergler (1955) argued that neurotic perfectionists can also be orally regressed, that is, they are not all just anally regressed neurotics. The external symptomatology of obsessional neurosis is thus a compromise formation manifesting as unrelentingly punitive, obsessive-compulsive, self-

correcting tendencies (Fenichel, 1945) to disguise, and counteract, deep seated aggressive impulses (Sorotzkin, 1985). Furthermore, White & Watt (1981) asserted that extensive feelings of guilt penetrate the individual, which are experienced as almost inescapable. Therefore, neurotic perfectionism aims to fulfil a specific purpose as a self-protecting psychological mechanism (Hamachek, 1978), that is, to unconsciously avoid the criticism, blame, guilt, and rejection that is punitively imposed by the punitive superego (Dickinson & Ashby, 2005).

Freud (1926) stressed that in obsessional neurosis "the super-ego becomes exceptionally severe…and the ego…[*obediently*] produces strong reaction formations in the shape of conscientiousness, piety, and cleanliness" (p. 115). Both the classical cognitive behavioural and psychoanalytic orientations are united in the agreement that the characteristic low self-esteem experienced by the neurotic perfectionist, is a direct consequence of failure to meet the demands of the harsh superego (Sorotzkin, 1985; Beck, 1976). Sorotzkin (1985) further declared that it is the exacting pressures of the punitive superego, resulting from latent aggression and hostility, that are responsible for the defensive manifestation of neurotic perfectionism (Sandler & Rosenblatt, 1962), in protest to the demanding voice of the critical superego (Pacht, 1984).

Greenspon (2002, 2008) theorised that neurotic perfectionism results from a developmental environment of conditional approval, where love and acceptance are only ever conditional rewards in exchange for meeting parental demands (Flett, Hewitt, Oliver, & MacDonald, 2002; Rice, Lopez, & Vergara, 2005; Missildine, 1963). These parentally imposed conditions of worth teach the child that the basic human needs of love, and acceptance, may only be attained through meeting the needs of others (Rogers, 1951). Self-worth becomes locked into

an other-oriented feedback loop of continually pleasing others, to gain acceptance, to feel worthy (Mearns & Thorne, 2007). Locus of evaluation becomes external, and the child grows into an individual living life in accordance with how others have deemed worthy of their love and acceptance (Thorne, 2008)…*"I will love you if…"* The individual is thus existing with a disconnected sense of self, and a self-concept that has been moulded into a way of being in the world that is guided by other peoples' belief systems, values, and attitudes (Rogers, 2004).

In addition, punitive parenting styles have been hypothesised as a precursor to the development of neurotic perfectionism (Rice, Ashby, & Preusser, 1996; Driscoll, 1982; Shafran & Mansell, 2001). These parents tend to be very harsh, critical, controlling and intimidating (Sullivan, 1953). As a result, these oppressed children are often controlled and humiliated by egotistical parents (Tziner & Tanami, 2013). Also, Tziner & Tanami (2013) asserted that it was the failure of children to meet the impossible standards set by their parents that ultimately led to inappropriate punishments. Rice, Lopez, & Vergara's (2005) quantitative study of parental influences on perfectionism found that maladaptive perfectionists held internalised beliefs that their parents were/are critical, and often dismissive of their personal successes. Neurotic perfectionism may therefore be considered a result of the child's continual striving for acceptance from parents who are excessively critical, seldom content with good performance, and fickle with their approval (Rice, Lopez, & Vergara, 2005).

2.4 The Psychodynamics of Neurotic Perfectionism

Problematic parent-child attachment has long been conjectured as a correlational factor in the genesis of neurotic perfectionism (Wei et al., 2004; Tziner & Tanami, 2013; Murray, Brian, & Ian, n.d), however a modicum of research has actually been conducted in this area.

Bowlby's (1969, 1979) attachment theory distinguished between two contrasting attachment styles, secure (safe) and insecure (unsafe). Insecure attachment is believed to result from misattuned, inconsistent, and punitive parenting (Bowlby, 1988). In Winnicottian terms, failure of adaptation by the parents to the child's basic needs for unconditional love, and acceptance, results in an environment that is deemed not good-enough (Winnicott, 1986, 1991) for the provision of a secure attachment, or for healthy psychological, and personality, development (Winnicott, 2005, 2006). As a result, the child can develop an external façade to adapt to the demands of the parents in the attempts of gaining the love, and approval, that is so desperately needed. Winnicott (1965) christened this external mask; the false self, as it takes the place of the self that was originally born into the world; the real self.

Among the handful of published studies available, Rice & Mirzadeh's (2000) ground-breaking quantitative study of attachment and perfectionism in college students, was the first to establish a direct correlation between insecure parental attachment and maladaptive perfectionism. Andersson & Perris's (2000) empirical study of attachment styles and dysfunctional assumptions provided substantial support for Rice & Mirzadeh's (2000) findings, by also reporting a positive association between insecure attachment and maladaptive perfectionism. Subsequent additional quantitative studies by Flett et al. (2001) and Speirs-Neumeister & Finch (2006) further echoed their predecessors' conclusions by asserting that insecure parental attachment is indeed firmly associated with maladaptive perfectionism.

As a result of this insecure parental attachment, the child unconsciously internalises the punitive attitudes and expectations of the parents (Rice & Mirzadeh, 2000; Kohut & Wolf, 1978). These hostile introjects (Whelton et al., 2007) become unconscious mental

representations, or internal working models, which are then destructively turned inwards towards the self (Wei, Heppner, Russell, & Young, 2006). Kleinian object relations theory explicated these unconscious processes as the identification with, and introjection of, internalised bad objects; the parents (Klein, 1984; Klein, Heimann, & Kyrle, 1985). Tremendous anxiety ensues thus setting the scene for maladaptive psychological development, and personality disintegration (Klein, Riviere, & Jones, 1989; Klein, Strachey, & Thorner, 1997). Consequently, a core belief system is set up that no level of accomplishment, or success, will ever be truly acceptable, sufficient, or good enough (Schweitzer & Hamilton, 2002).

Freud (1924) conceptualised the punitive superego as consisting of the conscience and the ego ideal. The ego ideal contains the introjected primary attachment objects/part-objects, the parents, into the ego, along with their punitive predispositions (Babikian, 1985). Hence, the superego symbolises an internalised parent, *the critical inner voice*, into whom the child has also projected his/her own punitive tendencies (Bateman & Holmes, 2002). Therefore, neurotic perfectionism involves a continual striving to become the same as the ego ideal, that is, identification with a critical parent (Asch, 1976). An endless internal cycle of rejection and criticism follows, where the neurotic perfectionist repeatedly rejects and criticises him/herself in the same way as the parents did (Frederickson, 2103). Bergler (1952) argued that this is a type of superego pathology, whereby the superego callously uses the ego ideals of neurotic perfectionists against them as a form of self-torture. Frederickson (2013) concluded that neurotic perfectionism is thus a form of self-hatred, reinforced by the unconscious belief that the individual is unlovable unless he/she becomes the unattainable ego ideal.

2.5 Necessity for Defensiveness

Wei et al. (2004) conceptualised maladaptive perfectionism as a defensive response to insecure parental attachment. Therefore, a significant deficit existed in attunement, dyadic emotional regulation, acceptance, and positive regard (Winnicott, 2006). In attempting to become overtly "perfect" to please the parents, the child thus discovers that being the "perfect child" is the only real way possible to gain parental love, affection, and acceptance; conditional though it may be. Accordingly, Harter (1998) maintained that the persistent neurotic pursuit of perfection was the child's unconscious defensive reaction to conceal latent feelings of worthlessness and unworthiness. Consequently, the neurotic perfectionist grows into adulthood with a negative and wholly inaccurate self- image, in addition to deeply engrained unconscious beliefs that his/her true self is not worthy of, being loved (Lapan & Patton, 1986; Robbins & Patton, 1985).

Furthermore, Frederickson's (2013) contemporary psychoanalytic research has theorised that neurotic perfectionism is a character defence that results from deeply unconscious anxiety, and fear of rejection. This is manifested by the individual treating him/herself in the same manner as the parents treated him/her in early childhood. Identification with a critical parent thus facilitates the development of an intensive self-directed criticism (Greenspon, 2008), as a defence against directing forbidden aggressions towards a parent (Frederickson, 2013). Arguably, Sorotzkin's (1985) definition of neurotic perfectionism as "a defense against intrapsychic conflict" (p.567) appears to fit quite naturally with Frederickson's (2013) concept. Similarly, in their empirical study, Rice & Mirzadeh (2000) found that this internalised self-criticism served the function of avoiding parental loss by enabling the individual to turn against him/herself, as opposed to directing aggression towards the parent.

Intra-psychic ego defence mechanisms are used to unconsciously defend against the anxiety associated with conflicts and ego threats (Flett, Hewitt, Oliver, & MacDonald, 2002; Valliant, 1977). These involuntary defences are thereby employed to protect the ego against this anxiety, whilst also maintaining an appropriate internal balance (Dickinson & Ashby, 2005). Defences have been categorised by various theorists as part of an overall hierarchy, from least to most complex, which reflects the adaptiveness of the defences (see Flett, Besser & Hewitt, 2005; Valliant & Valliant, 1992, Valliant, 1992, 1994;). Cramer (1987) outlined three specific categories of ego defence mechanisms which are unconsciously used by the individual. First, are neurotic defences, such as; repression, displacement, and reaction formation. Second, are immature/primitive defences, including; projection, projective identification, and denial. Last, are mature defences, including; suppression, humour, and sublimation.

2.6 Comorbidity – Neurotic Perfectionism & Psychopathology

Neurotic perfectionism is considered an insidious vulnerability factor associated with the aetiology of a multitude of psychopathologies (Dunn, Whelton, & Sharpe, 2006; Knutt, 2007; Flett & Hewitt, 2002, Shafran & Mansell, 2001; Valliant, 1994). To date, researchers have directly connected maladaptive perfectionism with eating disorders (see Halmi et al., 2000; Cash, & Szymanski, 1995; Minarik & Ahrens, 1996), anxiety disorders (see Flett & Hewitt, 2004; Flett, Hewitt, & Dyck, 1989; Antony, Purdon, Huta, & Swinson, 1998), and obsessive compulsive disorders (see Frost & Steketee, 1997; McFall & Wollersheim, 1979; Burns, 1980a). However, depression remains the most predominant, and widely discussed, subject throughout the literature (Flett, Besser, & Hewitt, 2005). Some of the most germane studies relating to maladaptive perfectionism as a largely pernicious factor in the development of depression include; Hewitt & Flett (1990, 199la, 1991b), Rice, Ashby, & Slaney (1998), Flett

et al. (2005), Blatt, Quinlan, Pilkonis, & Shea (1995), Blatt, Zuroff, Quinlan, & Pilkonis (1996), Hewitt & Dyck (1986), Hewitt, Flett, & Ediger (1996), and Cheng (2001).

Despite the obviously steadfast agreement of the existence of comorbidity between neurotic perfectionism and psychopathology, no such harmony exists when it comes to a rationale for the development of this exceptionally destructive relationship. Shafran, Cooper, & Fairburn's (2002) model of clinical, or maladaptive, perfectionism proposed that a predominant causal factor in the development of psychopathology was the self-directed pressure to incessantly strive for the unachievable. However, Hewitt et al. (2003) fervently argued that perfectionistic self-representation, which includes overt self-proclamation of perfection and self-concealment of imperfections, was the dimension primarily responsible for the associated deleterious psychological effects. Additionally, Kawamura & Frost's (2004) quantitative study provided further support for Hewitt et al.'s (2003) findings, by reporting that self-concealment was a core mediating factor between maladaptive perfectionism and psychological disturbances.

On the other hand, quantitative research studies by Bieling, Israeli, & Antony (2004), DiBartolo, Frost, Chang, LaSota, & Grills (2004), and DiBartolo, Li, & Frost (2008), in addition to articles from Bieling, Israeli, Smith, & Antony (2003) and Dunkley et al. (2006), all concluded that the maladaptive evaluative concerns (MEC) dimension of perfectionism was the most pernicious of all, and therefore the one ultimately responsible for the onset of psychopathology. MEC incorporates various negative self-evaluative elements, such as, negative self-talk, distress over making mistakes, anxiety surrounding criticism, and general self-doubt (ibid). Nevertheless, while these concepts may shed some light on the relationship between neurotic perfectionism and psychopathological disorders, no research has yet

ascertained why certain individuals will develop one disorder, say an eating disorder, while other individuals will develop a completely different disorder, OCD for example (Bieling, Summerfeldt, Israeli, & Antony, 2004).

The theories presented thus far to explicate the comorbidity between neurotic perfectionism and psychopathology have all been sourced from the very small body of existing research, primarily CBT, surrounding this phenomenon. This is a consequence of the noticeable paucity of research from any other psychotherapeutic orientation relating to this matter. As a result, these concepts all concentrate on specific dimensions of the construct of maladaptive perfectionism exclusively in accordance with CBT theory (Shafran et al., 2002; Hewitt et al., 2003; DiBartolo et al., 2004). However, in an attempt to move more towards a possible psychodynamic explanation, an inference could be made that, in psychoanalytic terms, psychopathology may be representative of Freud's (1896) theory of "the return of the repressed" (p. 169). Thus, specifically in terms of neurotic perfectionism, whatever has been repressed into the unconscious at an earlier developmental stage in childhood, may in fact be finding its way out, in a disguised form, via the psychopathological disorder.

2.7 Obstacles in the Transferential Dynamic

At the beating heart of psychodynamic theory and practice sits the transferential dynamic, consisting of the unconscious transference and countertransference phenomena, which pumps the transferential blood that circulates through every psychotherapeutic relationship (Jacobs, 2010). Transference, the unconscious projection of past experiences, attitudes, and strong feelings relating to significant others, from the client onto the therapist, is arguably one of Freud's (1905) most illustrious psychoanalytic concepts (Malan 1995). Negative transference, according to Guidi (1993), is the projection of intense feelings onto the

therapist, which in turn signifies a resistance on the client's part in doing the therapeutic work. Hence, the central theoretical point here surrounds the intensity of these transferred feelings responsible for obstructing the therapeutic alliance (Grinberg, 1997). Consequently, negative transference may result from intensely positive feelings, such as; love or idealisation, or from intensely negative feelings, such as; hostility, anger, or mistrust (ibid). Thus, Racker (1953) vehemently stressed the importance of cognisance of the law of Talion, that is, every negative transference reaction from the client will be naturally met with a corresponding negative countertransference reaction from the therapist.

Therefore, an inevitable part of psychotherapeutic work is the experiencing of negative feelings towards clients (Aviv & Springmann, 1990). Negative countertransference reactions may result from either the therapist's subjective, un-integrated, unconsciously lingering neurotic conflicts, or from the therapist's objective responses to a client's persistently destructive behaviours (Kiesler, 2001). Ligiéro & Gelso (2002) acknowledged that negative countertransference reactions, such as feelings and attitudes, become most damaging to therapy when they are inappropriately acted upon by the therapist. Kiesler (2001) noted the most common negative countertransference feelings include; anger, hatred, and anxiety. Friedman & Gelso (2000) insisted that the acting out of these feelings, or attitudes, constituted a cross over into what they conceptualised as negative countertransference behaviours, such as the therapist being; avoidant, punitive, rejecting, distancing, or psychologically absent. It is this layer of negative countertransference that impedes the therapeutic alliance, and obstructs the therapist's empathy for, and acceptance of, the client (Kahn, 2001).

Moreover, Racker (2007) observed that negative countertransference contains two significantly noteworthy sub phenomena. The first, entitled countertransference-depressive anxiety, is typified by a depressive disposition, and arises when depressive anxieties are elicited within the therapist, in response to the client's continued depressive state as a result of stuckness in the therapy. Conversely, the second sub phenomenon, termed countertransference-aggression, is somewhat an extension of countertransference-depressive anxiety. In this situation the therapist's desire for acceptance from the client, or to maintain an alliance, is frustrated by the client's aggression towards, or rejection of, the therapist, and by default the alliance. Consequently, the therapist's talionic internal response of aggression results from an "identification with the aggressor" (ibid, p.740), the vexing client. Furthermore, an additional phenomenon, more prevalent in contemporary psychotherapeutic literature, is somatic countertransference (Gubb, 2014; Athanasiadou & Halewood, 2011). Negative countertransference responses are thus somatised and therefore physically experienced/felt by the therapist in the body (Ross, 2000). This is in addition to the associated thoughts, feelings, and attitudes which have been exclusively discussed up to now (ibid).

As evidenced thus far, negative transference and negative countertransference responses are part of the very fabric of the therapeutic encounter. However, due to the virtually exclusive quantitative methodological approaches repeatedly employed within psychotherapeutic research and study of the neurotic perfectionism phenomenon, it has not been possible to locate the much needed literature specifically pertaining to the subjective transferential experience of the psychotherapist while in relationship with neurotic perfectionists. As a direct result of this most alluring gap within the extant psychotherapeutic literature, this study aims to make the participants' phenomenological experience of the negative transferential

dynamic, in their work with neurotic perfectionists, a chief focal point of its qualitative research approach.

2.8 Summary

Neurotic perfectionism has aetiological roots in obsessional neurosis and is characterised by the relentless striving to attain the unattainable. Maladaptive parenting styles, and insecure parent-child attachment, are considered as predisposing factors to the development of neurotic perfectionism. Subsequently, maladaptive parenting and attachment styles become internalised by the child, resulting in a punitive superego and a ruthless inner-critic. In addition, neurotic perfectionism, manifesting in the perpetual pursuit of perfection, becomes both a defence against unconscious feelings of worthlessness, and a desperate attempt to gain parental love and acceptance. Furthermore, psychopathology has been conceptualised as a have having a clear positive association with neurotic perfectionism. Finally, the therapeutic relationship becomes awash with negative transference and negative countertransference responses, which threaten to thwart any chance of a sustainable therapeutic working alliance.

Chapter 3: Methodology

"The thing that is really hard, and really amazing, is giving up on being perfect and beginning the work of becoming yourself"
-Anna Quindlen

3.1 Research Aim

The primary aim of this qualitative research study is to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician.

3.2 Rationale for a Qualitative Approach

Qualitative research is "a process of systematic enquiry into the meanings which people employ to make sense of their experience and guide their actions" (McLeod, 2003, p.73). Thus, at the heart of qualitative research is the fundamental goal of discovering subjective meanings. This consequently enables collection and analysis of the most covert, and quantitatively elusive, subjective and subtle data from each participant (Silverman, 2005). Hence, a qualitative approach facilitates the unearthing of hidden raw data which is subsequently translated into rich data via the processes of semi-structured interviews. It is this qualitative translation, from the subjectively implicit to the objectively explicit, that ultimately generates the previously indecipherable knowledge that bridges gaps in the understanding of phenomena; which in this case, is neurotic perfectionism.

This study demanded the excavation of the participants' subjective views, and experiences, of working in the clinic with neurotic perfectionists. Thus, an inductive qualitative methodological approach was chosen by the researcher as it was deemed the most suitable methodology to facilitate both the uncovering of hidden subjective data, and the further explication of the seldom understood phenomenon of neurotic perfectionism. As a result, the choice of a qualitative approach for this research fundamentally met with the suggestions of

Dallos & Vetere (2005, p.49), who maintained that qualitative research should be specifically carried out when "…the research question is orientated towards the exploration and understanding of [*subjective*] meaning"

3.3 The Sample

The sample for this research study was non-probable; therefore, participants were selected purposefully. This ensured all participants within the sample had the necessary knowledge, experience, and reflective capacity to fulfil the crucial requirement of talking in depthabout their experience of working with neurotic perfectionists in the clinical setting (Trochim, 2006). Predetermined inclusion criterion was devised in order to identify, and recruit, the most appropriate and robust sample possible. To qualify for participation, participants must have met the three core inclusion requirements. First, was accreditation with an Irish professional body, for example, the Irish Association for Counselling and Psychotherapy (IACP), or the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP). Second, was a minimum of five years post accreditation clinical experience. Third, was having the specific experience of working psychodynamically with neurotic perfectionists in the clinic. Hence, student psychotherapists, pre-accredited psychotherapists, and psychotherapists with less than five years post accreditation experience were excluded.

In accordance with the stipulated criteria surrounding the number of participants required for research purposes, this study was based upon five in-depth interviews with experienced accredited psychotherapists, all of whom had the required clinical experience of working neurotic perfectionists. Three of the participants were female and two were male, their average age was fifty-seven years, their mean time working as a psychotherapist was sixteen years, and four participants were supervisors. All participants principally worked within the

Humanistic/Integrative framework, and additional areas of focus included; psychodynamic, bioenergetics, gestalt, mindfulness, object relations, and body psychotherapy.

Demographics of the Sample *(Table 1)*

Code	Age	Pseudonym	Years as a Therapist	Years Accred	Accred Body	Qualification	Principal Orientation	Additional Areas of Focus
PA	62	Paul	23 yrs	22 yrs	IAHIP IACP	Dip. Counselling & Psychotherapy	Humanistic/ Integrative	Psychodynamic Bioenergetics
PB	56	Anne	13 yrs	12 yrs	IAHIP IACP	Dip. Counselling & Psychotherapy	Humanistic/ Integrative	Psychodynamic Gestalt
PC	55	Ed	11 yrs	7 yrs	IAHIP IACP	Dip. Counselling & Psychotherapy	Humanistic/ Integrative	Psychodynamic Mindfulness
PD	55	Helen	13 yrs	11 yrs	IAHIP IACP	B.A. Counselling & Psychotherapy	Humanistic/ Integrative	Psychodynamic Object Relations
PE	57	Niamh	18 yrs	16 yrs	IAHIP IACP	Dip. Counselling & Psychotherapy	Humanistic/ Integrative	Psychodynamic Body Psychotherapy

3.4 Recruitment of the Sample

The researcher first prepared a full information pack which included; an information sheet that provided an overview of the study, and also detailed what would be involved in participation (Appendix A), a consent form that was signed by participants at each interview (Appendix B), a demographic questionnaire that was completed by each participant in order to provide an anonymous biography, and holistic overview, of all participants (Appendix C), and semi-structured interview questions, that were used with all participants in each interview (Appendix D).

As this study was completely dependent upon interviewing experienced accredited psychotherapists, a first contact generic email (Appendix E) was initially sent out with the information sheet to all supervisors listed on the IACP website, who were working in the greater Dublin area, and included "psychodynamic" or "object relations" in their list of psychotherapeutic orientations. From a total of forty five potential participants emailed, four email responses were received, and all four declined participation. One potential participant was excluded from this initial email contact as she was the therapist of an immediate member of the researcher's family of origin. It was not possible to email the IAHIP website's list of supervisors as it omitted personal email addresses.

Of the five participants recruited for this study, three were Dublin Business School (DBS) lecturers, who were previous lecturers of the researcher's from 2010 to 2013. Two participants were skills trainers, one lectured on various psychotherapy academic modules, and all lectured on both BA and MA programs. Having retrieved telephone numbers from the IAHIP website, the researcher made telephone contact with all three participants, and they all agreed to partake in this study. The full information pack was then sent to each participant via email. One of the participants no longer worked for DBS at the time of first contact, and the subsequent interview.

The fourth participant was recommended through a psychotherapist friend of the researchers, who had interviewed this person as part of another qualitative research study a number of years previous. The researcher made telephone contact with this participant, sent the full information pack, and the participant agreed to partake in this research. Attempting to strike a gender balance, the researcher identified sixteen male supervisors from the IAHIP website

who were working in the greater Dublin area. From ten calls made, there were five no contacts, four refusals, and one possible agreement pending sight of documentation. Following receipt of the full information pack, via email, the fifth participant agreed to partake in this research.

3.5 Data Collection Methods

The predominant data collection method used for this study was in-depth semi-structured interviews. This method allowed for a flexible interview process which consequently enabled a thorough examination of each participant's subjective experience of working with neurotic perfectionists. A standardised interview guide was devised, informed by the researcher's extensive literature review, which incorporated pre-determined interview questions (Appendix D). As "the goal of any qualitative research interview is… to see the research topic from the perspective of the interviewee" (Cassell & Symon, 2006, p.11), interview questions were of open-ended design. Participants were therefore furnished with 'ample opportunity to express their feelings', and also empowered to "respond in their own words' (Polit & Hungler, 1999, p.334). Demographic questions were asked prior to the recorded interview (Appendix C). Interviews were digitally-recorded, lasted between forty and fifty minutes, and the consent form (Appendix B) was signed in each interview. All recordings were subsequently transcribed verbatim pending future analysis.

3.6 Data Analysis

Braun & Clarke (2006, p.79) maintained that thematic analysis is "a [*qualitative*] method for identifying, analysing and reporting patterns (themes) within data". Therefore, thematic analysis was chosen as the most practicable form of analysis to analyse the data collected from the semi-structured interviews. Each interview was then analysed using the thematic data analysis method delineated by Braun & Clarke (2006). First, each of the transcripts was read three times. This enabled the researcher to become immersed in, and scrutinise, these

data, to establish some preliminary ideas regarding the content and noteworthy features. Data were treated using a theory-driven coding system. Codes were thus generated by the coding of each data item in accordance with the theoretical features contained within each item. These coded data were then colour coded for ease of matching up with themes as they developed.

Additionally, a fresh review of these data was conducted to establish if any further coding was possible. This produced additional coding which was missed in the initial coding phase. Whilst all coding was being reviewed in its entirety, seven themes emerged, and codes were then collated in accordance with each of these themes. During the refining process of the established themes, it was identified that certain themes contained a lot of duplicated coded data items. Consequently, codes were reallocated and three final superordinate themes emerged. Next, while refining, and naming, these themes in order to encapsulate the whole picture of the analysis, two subordinate themes became apparent from within each theme. Subordinate themes provided extra layers of depth by demonstrating specific intriguing sub aspects present in each theme. Finally, a report was produced which included poignant vignettes from the semi-structured interviews which vividly brought each theme to life.

3.7 Ethical Considerations

Crucially, ethical approval was granted by the DBS ethics committee in advance of the commencement of this research. This study was categorised as low risk, and the sample was not considered to be a vulnerable sample, due to the fact that all participants were psychotherapists. Therefore, a power imbalance was not believed to exist. Additionally, the semi-structured interview questions, which were emailed to all participants at least one week prior to interview, did not ask, probe, nor seek disclosure of any sensitive personal information which may compromise any participant or client.

In accordance with McLeod's (2003) guidelines for obtaining informed consent, each participant received an information sheet and consent from via email at least one week prior to interview. Participants were therefore made aware, in writing, of the aims of this research, what would be involved in participation, and their right to withdraw without penalty at any time. All participants were also assured of anonymity in relation to their responses, both verbal and written. Thus, any identifiable information regarding the participants or their clients was changed using pseudonyms, or omitted completely. Moreover, the limitations to confidentiality were made explicit in both the information sheet and consent form.

Furthermore, confidentiality of all information gathered was also assured and detailed in both the information sheet and consent form. This outlined the particular safeguards which the researcher committed to undertaking in order to ensure confidentiality. These safeguards specifically included; de-identification procedures via pseudonyms and code numbers for all research materials, storage of all coded documentation in a locked file which is accessible by the researcher only, and the transferring of digital recordings to the researchers password protected personal computer.

Chapter 4: Results

"Complete and total perfection will come about only when we feel that our perfection is no perfections as long as the rest of humanity remains imperfect."
-Sri Chinmoy

4.1 Introduction

In accordance with the data collection method of semi-structured interviews, all participants were asked open ended questions in order to unearth, and ascertain, their subjective experience of working with clients who are neurotic perfectionists. This qualitative research method supported the primary research aim; to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician. The reflections, and responses, of the participants thus generated the necessary raw data required for thematic analysis. Three superordinate, and six subordinate, themes ultimately emerged (see table 2).

Superordinate & Subordinate Themes (*Table 2*)

SUPERORDINATE THEMES	SUBORDINATE THEMES
THEME 1 **The "Perfect" Persona**	• **The Unacceptable Me** • **They Love Me, They Love *Me* Not!**
THEME 2 **A Sick Destiny**	• **A Sick Reason** • **Pot Luck?**
THEME 3 **Therapy- The "Imperfect" Struggle**	• **Working Under Pressure** • **The "Perfect" Therapist**

4.2 Theme 1: The "Perfect" Persona

All participants were unanimous in their belief that neurotic perfectionism is a defensive mask donned in childhood as a means of self-protection, in addition to a means of surviving the annihilation resulting from the rejection of the individual's true self:

> PB: **Anne:** "…that everything has to be perfect is, I think, very often hiding something that lurks beneath that they don't want to go near."

> PA: **Paul:** "…it becomes necessary for the person to be a perfected version of themselves. We develop characters, ways of being us, that keeps hidden those core elements that we were told were unbearable. The person is…um…caught in a suffering in what we're calling a neurosis…"I don't know how to be me safely." "

> PE: **Niamh**: "One particular client…she learned that the way to be and to be okay in the world…to be loved and accepted by others…was to get everything right…*perfect*."

Both Helen and Anne make explicit their thoughts of what neurotic perfectionism is defending against:

> PD: **Helen:** "The perfectionism is keeping them safe from really, whatever feelings or traumas that they can't bear. It's a protective mechanism that they've had to use to simply survive…"

> PB: **Anne:** "I think perfectionism keeps emotions and hurt and pain right out of the picture. It's a detachment away from feeling…away from being let down, away from being hurt."

Ed recognises how the "perfect" persona furnishes the child with the opportunity of artificially gaining the love and acceptance needed to survive:

> PC: **Ed:** "…when the parent sort of sees the child as being this type of person, this good girl, or this minding person, the child sees that this is what they need to do to be loved. And it sort of gets locked in a cycle then."

Another striking passage from Ed's transcript concisely illustrates the unconscious manoeuvring from the true self to the false self for self-preservation:

> PC: **Ed:** "Where people had to change their true self in some way to be acceptable…they had to change the person they were…and sort of sub-consciously move into some form of a perfection mode where they sort of have to be the best to be loved."

4.2.1 The Unacceptable Me

Each of the participants explicitly vocalised their belief that beneath the often impenetrable façade of neurotic perfectionism, at the very core of the individual, lays the true self:

> PA: **Paul:** "It, it's the person closing a door from the inside. You can't get in there. They've got to unlock it, trust you enough to unlock it and come out."

> PB: **Anne:** "…it's the hidden bit, which is actually in all of us, it's…um…it's an insecure attachment to the self. That's the hidden piece."

> PD: **Helen:** "I mean…it's always there, you know, that piece of them that was locked away. Locked behind a door, never to be seen again…well…perhaps until they come to therapy."

Most of the participants felt this true self was repressed in early childhood as a survival mechanism. Paul's excerpt describes the vulnerable child's unconscious internal dilemma:

> PA: **Paul:** "…I'm three. I'm unhappy. I'm told I should be happy and I can't be anything but happy. I'm a problem. I can't be me because that's a problem. So…I'll start copying. Oh, I'll be…John is popular. I'll be like *him!*"

Ed echoes Paul's sentiment, and further articulates the child's unconscious rationale for feeling so fundamentally flawed and "unacceptable" to the outside world:

> PC: **Ed:** "…it was then, in that early stage of development that it was deemed "it's unsafe to be me"…and rightly so, because you're telling me…in other words…"it's not *ok* to be you." "

4.2.2 They Love Me, They Love *Me* Not!

All transcripts were replete with strong views that neurotic perfectionists failed to have healthy relationships with their parents.

Niamh communicates her view, specifically highlighting an interruption, or breakdown, in parent-child relationships:

> PE: **Niamh:** "I would think it [*neurotic perfectionism*] very much comes from childhood and disrupted relationships with them [*the parents*]. The clients I'm thinking of…their early relationships just weren't secure."

Anne's extract demonstrates how the failure to establish a secure parent-child relationship leads to corresponding attachment difficulties in later adult life:

PB: **Anne:** "…it's all about attachment/detachment…security/insecurity. They never had attachment security with the parents. They still don't attach easily. People don't attach easily to them…"

Three participants asserted that a predominant deleterious consequence of these maladaptive parent-child relationships is the development of a punitive internalised critic.

In this vignette, Ed also emphasises the dominance of the critic:

PC: **Ed:** "…that harsh internal critic…the judge…that's in them all as a result of their childhood. In most perfectionists I would see it's the critic part of their personality that has really gotten all the attention…"

Helen further elucidates the tormenting nature of the critic, whilst also connecting the internalised parent with the superego:

PD: **Helen:** "…it's the critical piece…the super ego…the critical parent that they are so much in touch with. It's like this voice in their head that's always giving out to them for doing whatever they do because it's always wrong, it's never right…it could *never* be right."

4.3 Theme 2: A Sick Destiny

Emanating from all transcripts was the salient theme that neurotic perfectionism inevitably leads to severely degenerative effects on the psychological health of the individual in adulthood. The following vignettes explicate the participants' subjective thoughts as to the causes, or origins, of psychopathology:

Helen makes a seemingly linear, almost predetermined, link from the "perfect" persona to psychopathology:

PD: **Helen:** "I think they [*psychopathologies*] are all manifestations of the [*neurotic*] perfectionism. Like, the perfect body, the perfect mind…all different kinds of manifestations…"

In this intuitive passage, Paul poignantly connects the repression of the true self with the subsequent development of psychopathological disorders:

PA: **Paul:** "An awful lot of these [*psychopathologies*] are symptomatic of the basic neurosis…"it's not okay to be me". You're holding back the life urge, so that pressure to be other than you are…that energy…you lodge it in your system long enough, it will make you ill. It will become cellular…and it will express itself in various symptomatic ways."

Anne's excerpt indicates a sort of cause and effect to psychopathology; that which is defended will somehow find release:

PB: **Anne:** "…those unsafe feelings that had to be denied or protected…when they were smaller…the intense longing/fear/anger/anxiety…those feelings are still there, they *have to* come out somewhere."

Anne further makes an insightful correlation between neurotic perfectionism, defensiveness, and the development of psychopathology:

PB: **Anne:** "…it's great that they had the resources to put up those defence mechanisms [*the "perfect" persona*] but if the defence mechanisms eventually become the way of life…they are now serving an unhealthy purpose. It's like a pressure cooker, if you keep the lid very tightly pressed on, it's going to blow and it's going to do serious damage when it blows."

4.3.1 A Sick Reason

Most of the participants spoke of psychopathological disorders in terms of psychopathology serving a purpose, or having some sort of meaning. In this context, psychopathology is almost considered a "necessary evil" in neurotic perfectionism:

Here, Paul's fascinating perspective alludes to an actual need for psychopathology; as a medium to give expression to the inexpressible:

> PA: **Paul:** "Whatever the "disorder" is…it's symptomatic, symptomatic of this energy…this life energy…that's been held in…locked away. This constricting energy. So you see, even though it's still "locked away"…it still manages to find a way out". In what you're calling a "disorder." "

The following quote from Anne's transcript further reiterates Paul's belief:

> PB: **Anne:** "So there's a function of it [*psychopathology*]…a letting out of the shadow side…of what I can't bear to be seen…the unlovable, the unacceptable…that can't see the light of day in any normal circumstances. It's…*a way out*."

Ed and Helen's extracts are almost speaking in unison regarding their views of psychopathology serving a primary function in neurotic perfectionism:

> PC: **Ed:** "…they [*psychopathologies*] are ways of sort of hiding…keeping them away from their pain…or… numbing the pain. Sort of a by-product of the perfectionism…"

> PE: **Niamh:** "It's [*psychopathology*] always to do with having to negate any of the unacceptable parts of themselves."

4.3.2 Pot Luck?

Despite the collective agreement between all participants regarding the existence of psychopathology, there was a noticeable lack of harmony in relation to a specific type, or prevalence, of any one particular form of disorder being most associated with neurotic perfectionism:

The most prominent disorder, as mentioned by three of the participants, was eating disorders:

> PD: **Helen:** "…overeating…grossly overweight, dark colours, not wanting to be seen! Or…anorexia nervosa…having the perfect figure, the perfect look…"
>
> PE: **Niamh:** "…clients with eating disorders…particularly the anorexics. It's obvious in the body there is a "neurotic perfectionism"…when they are not in the place where they are recovering from it or able to contain it."

Addiction was stated by both Ann and Ed, with specific emphasis placed on alcoholism:

> PB: **Anne:** "When I think of a client I'm working with now, there's addiction there…he's drinking way too much at the moment…"
>
> PC: **Ed:** "Alcohol or addiction. Addiction I suppose would be one of the key ones."

Both Anne and Helen recognised an association between neurotic perfectionism and OCD:

> PB: **Anne:** "…OCD is another one, kind of like eating disorders…where it's also about control."
>
> PD: **Helen:** "I suppose sometimes I would see it associated with OCD. So for example somebody who is extremely neat and tidy so everything has a place, and if it's not in its place its wrong…"

Ed's insightful extract links the absence of a sense of the true self with personality disorders:

> PC: **Ed:** "…they lose [*in childhood*] their whole sense of themselves…so they could have any sort of personality disorder then, because they don't know who they are!"

Depression was indicated by three participants, but only in a secondary sense, arising on the back of another more primary disorder:

> PC: **Ed:** "Anxiety would be the main one that springs to mind and which then leads to depression."

> PD: **Helen:** "…when it [*OCD*] gets really bad, it can really throw them into a place of depression"

4.4 Theme 3: Therapy- The "Imperfect" Struggle

An overarching theme, attested to by all participants, related to the plethora of negative transference experiences which continually stand in the way of establishing, and maintaining, an effective therapeutic alliance with neurotic perfectionists:

> PB: **Anne:** "…a common thread I've seen is expecting results…"how long will this take?". They want "results" and they want them *now!*. They're looking for a short-term fix rather than a long-term process."

Here, Paul, Ed and Niamh are all undoubtedly aware of the toxic effects of projection:

> PA: **Paul:** "…they may try to please me or invest authority and expertise in me. There are all sorts of variations of how the person constructs the superego in order to project it onto you."

PC: **Ed:** "…they are often being the *perfect* client...telling me what I need to hear. Or…they would tend to sort of project onto me perfection, so that I would "know" everything."

PD: **Helen:** "…the projection out of the parts that they cannot bear, like a client who raved at me once for my imperfection. It was because she was so frightened of it. She was so frightened of being imperfect herself."

Both Anne and Niamh recounted their experiences of when therapy has either been cut short or appeared doomed:

PB: **Anne:** "Sometimes they'll just leave…go off to another therapist and, well… that will keep happening."

PC: **Ed:** "…when they come to a block or if they get stuck, it's a real dilemma and they can't move, so they are not *perfect*. It's sort of at that point either they leave or…um….the process gets quite stuck."

4.4.1 Working Under Pressure

All five participants professed to a wide variety of negative countertransference reactions in response to the weight of the pressure they felt throughout their work with neurotic perfectionists:

PB: **Anne:** "…I don't like feeling under pressure. I don't feel I work at my best when I'm under pressure like that. I feel I'm being judged…and I'm disliking the person!"

PD: **Helen:** "…it's the frustration…of the client not actually moving, and of course I'm meant to stay with the client, as we all know, but like I'm kind of wanting to go

on a little bit. So it's kind of the frustration that would build in me…I'm saying to myself "will they bloody ever get a move on here". "

In this arresting excerpt, Niamh reflects on how the intensity of the pressure she felt in one particular session subsequently led to an alarming daydream with shook her to her core:

PE: **Niamh:** "...I had this really fast this image of seeing a sniper shooting my client dead. That was really negative and I said "Oh God yeah…that would be such a relief wouldn't it!. It was a very powerful image, like…*take him out!*...he wouldn't even know it! And really sadistic. I felt um…almost psychopathic…because there was no feeling, you know, *take him out!* I was really shocked by the power of the image"

4.4.2 The "Perfect" Therapist

Intriguingly, three of the participants revealed how they have previously experienced intense, and at times overwhelming, feelings of "having" to be the "perfect" therapist for their clients:

PB: **Anne:** "…I would feel myself performing and not being myself and trying to be the perfect therapist…you know…"I have to be good enough", and, "I'd better be up to the mark here." "

PC: **Ed:** "I find myself maybe working that bit harder…trying to sort of be the perfect therapist and heal them in a way sort of, um….that is a danger around working with neurotic perfectionism…that you'll end up with it yourself sort of."

PE: **Niamh:** "…I am being pulled in to their need you know, for me to be the perfect therapist, whatever that is?"

This intense pressure, associated with feeling the stress of having to be the "perfect" therapist, took a very significant toll on all of these participants. Here, Niamh explains the consequence of her "imperfection" in one session:

PE: **Niamh:** "…in fact I came out of a session with her feeling completely destroyed. I felt that her rage was….I felt completely flittered by it because she was *so raging*."

Anne describes the somatic impact and physiological toll that she has experienced:

PB: **Anne:** "…that anxiety, to be the perfect therapist, I could feel it in my body…the speeding up. It induces a…a stress in me. The stress that I would feel…and, I'm even putting my hands to my chest here now, it's like…"Oh, I need to calm myself down." "

This extract captures the adverse psychophysiological effects that Ed has also suffered:

PC: **Ed:** "…I would feel anxiety, that physical sort of "Oh Jesus!". And maybe…that this will never change...or a feeling of hopelessness. The sort of feelings around not being perfect."

4.5 Summary

It is evident from these results that neurotic perfectionism is unconsciously used as a phony disguise for survival, following condemnation of the true self in childhood, to gain acceptance from parents and/or significant others. Consequently, the true self is kept hidden behind this perfectionistic people pleasing guise. Psychopathology ensues as a result of the individual living life inauthentically, and operating from this false veneer. Furthermore, the therapeutic alliance can become besieged by the sheer force of a multitude of negative transference, and negative countertransference reactions. As a result, deleterious effects can be seen in the psychotherapist, and the working alliance, due to the intense pressure associated with working in the clinic with neurotic perfectionism.

Chapter 5: Discussion

"The essence of being human is that one does not seek perfection."
-George Orwell

5.1 Introduction

The principal aim of this research study was to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician. The qualitative methodological approach included semi-structured interviews to collect experiential data from participants, and thematic analysis was used in order to extrapolate specific themes from the resulting subjective data. In combination, the three themes that emerged from this study provided a concentrated view of the profoundly destructive nature of the neurotic perfectionism construct. This chapter will discuss each one of the themes individually, in accordance with the corresponding psychotherapeutic literature.

5.2 The "Perfect" Persona

The most striking result in this study was the emphatic nature of all participants' assertions that neurotic perfectionism is a fake façade constructed in childhood. The "perfect" persona was viewed as an unconscious defensive strategy, used to gain parental love and acceptance, following rejection of the child's true self. This perspective is extensively supported throughout the literature in various forms. Greenspon (2002, 2008) considered the development of neurotic perfectionism a fundamental consequence of parents' inability to show unconditional love for their children…*"you're a "good" boy when..."*. Similarly, Rogers (1951) argued that these callous conditions of worth cause the child to incessantly strive to meet their parents' inappropriate demands, to gain their love and acceptance. The child, naturally, comes to a realisation that being him/herself is not good-enough (Winnicott, 1965), and continues putting the needs of others first in frantic attempts to be accepted, liked, and loved. Mearns & Thorne (2007) aptly described this despairing situation; "…so great is

their need for positive approval that they accept this straightjacket [*of conditions of worth*] rather than risk rejection by trespassing against the conditions set for their acceptability".

Hence, the "perfect" persona undoubtedly provides a desperately needed sense of stability, and protection, which helps the child to survive these sustained threats of rejection. This fake external mask of fear, with its associated maladaptive perfectionistic attitudes, and behaviours, is thus consistent with Winnicott's (1965) false self, or Roger's (1951) self-concept. The results fittingly included significant focus on the defensive purpose for which this false self was adopted, thus hiding the organismic (ibid) or true self (Winnicottt, 1965), as succinctly put by Helen: "The perfectionism is keeping them safe…from whatever feelings or traumas that they can't bear. It's a protective mechanism that they've had to use to simply survive…". This poignant perspective resonates with Hatter's (1998) clinical writings, who stressed that the ruinous, abnormal, quest for perfection in early childhood is very much a defensive strategy employed to cope with incapacitating unconscious feelings of worthlessness. Frederickson (2013) provides further psychoanalytic support, maintaining that neurotic perfectionism is an unconscious character defence that protects against unbearable latent feelings, such as, anxiety and rejection.

Another central finding was that neurotic perfectionists universally have some form of unsafe, or insecure, attachment to either one, or both, parents. In light of the clinical opinions, and literature, presented thus far relating to the aetiology of the neurotic perfectionism construct, this finding consequently appears to have a somewhat "natural fit" in regards to the development of the "perfect" persona. Furthermore, the small body of psychotherapeutic literature pertaining to the association between parent-child attachment and the subsequent development of neurotic perfectionism lends additional scholarly credibility to this finding

(Wei et al., 2004; Tziner et al., 2013). More specifically, four independent quantitative research studies were published on this matter, and all 4 reported, thus confirming, a positive correlation between neurotic perfectionism and an insecure parental attachment in childhood (Rice & Mirzadeh, 2000; Andersson & Perris, 2000; Flett et al., 2001; Speirs-Neumeister & Finch, 2006). In Winnicottian terms, the parents, therefore, did not provide a good-enough facilitating environment to sufficiently adapt to the most fundamental needs of their developing child (Winnicott, 1986).

Additionally, three of the participants articulated how the adverse effects of insecure parental attachment, rejection of the child's true self, and formation of the "perfect" persona, unsurprisingly have the most severely destructive psychological effects on the vulnerable developing child. The combined negative impact is therefore seen to manifest in a very harsh self-critic, or severely punitive superego. Helen's vignette provides further elucidation: "…it's the critical piece…the super ego…the critical parent that they are so much in touch with. It's like this voice in their head that's always giving out to them for doing whatever they do because it's always wrong, it's never right…it could *never* be right." This finding is concurrent with the psychotherapeutic literature concerning unconscious parental internalisations (Rice & Mirzadeh, 2000). Thus, the child introjects the pejorative attitudes of the parents, which quickly become self-directed, and are then rigidly cemented as a maladaptive unconscious psychological construct (Whelton et al., 2007; Klein, 1984). Consequently, the internalised critical parent, or punitive superego, becomes established as the hostile, and abusive, inner critical voice (Babikian, 1985; Freud, 1924), which is likely to be unrelentingly heard by every neurotic perfectionist.

5.3 A Sick Destiny

Explicit in the results of this study, as attested to by all participants, was the prevalence of some form of psychopathology across all neurotic perfectionists, with whom the participants have worked with in their average experience of sixteen years practicing. This finding thus accurately reflects the literature, and the fundamental principle of this theme, that is, comorbidity unquestionably exists between neurotic perfectionism and psychopathology (Dunn et al., 2006; Flett & Hewitt, 2002, Shafran & Mansell, 2001). It is therefore apparent that neurotic perfectionism is a largely malignant, and predisposing, factor leading to the later onset of psychopathology. Eating disorders was the most common psychopathological disorder to appear in the results, as disclosed by three of the participants. However, this is inconsistent with the available quantitative research that suggests depression is the most predominant disorder associated with neurotic perfectionism (Flett et al., 2005; Cheng 2001). In fact, depression was only identified by three participants, and only occurring secondarily when a more primary psychopathology worsened, for example OCD.

Furthermore, consistently asserted across the most relevant psychotherapeutic research, the CBT paradigm has proposed various theories in its attempts to provide a rationale for the now qualitatively ratified association between psychopathology and neurotic perfectionism (DiBartolo et al., 2004). The most germane concepts include; the self-oriented obdurate pursuit to achieve the unachievable (Shafran et al., 2003), negative self-representation-centring around the maintenance of a flawless mask of perfection by means of the interminable conscious suppression of any infinitesimal imperfection (Hewitt et al., 2003; Kawamura & Frost, 2004), and maladaptive evaluative concerns (MEC)- including concerns over making any mistakes, reservations around actions, and intense worry regarding external criticism (Dunkley et al., 2006; DiBartolo et al., 2008). The results are thus consistent with

the basic tenet presented in the literature, that is, there has to be *some* reason for the existence of psychopathology. However, as these quantitative studies are wholly deficient in providing any psychodynamic insight, it is here that the qualitative results of this research diverge from the literature.

A missing psychodynamic piece of the neurotic perfectionism-psychopathology puzzle has therefore been located in this study. All participants were adamant that all psychopathology results from the repression of the individual's true self. As emphasised by Paul: "an awful lot of these [*psychopathologies*] are symptomatic of the basic neurosis…"it's not okay to be me". Furthermore, participants asserted that the relentless maintenance of the "perfect" persona causes the repressed to leak out. Anne pithily sums this up: "so there's a function of it [*psychopathology*]…a letting out of the shadow side…of what I can't bear to be seen". This "letting out" of the unbearable is consistent with the psychoanalytic concept of the return of the repressed; "the re-activated [*repressed*] memories…never re-emerge into consciousness unchanged: what become conscious as obsessional ideas and affects…takes the place of the pathogenic memories" (Freud, 1896, pp. 169-170).

Hence, Bieling et al. (2004) contended that "[*neurotic*] perfectionism is not associated with a single disorder, or type of disorder, but may be an underlying factor across several disorders and categories of psychopathology" (p.194). In this study, there were a variety of opposing views as to the different types, or categories, of psychopathologies associated with neurotic perfectionism, including; eating disorders, OCD, personality disorders, addiction, and depression. Therefore, the results did not find one particular disorder to be most prevalent. A concurring perspective thus exists between the academic literature and all participants in this study, that is, no one single psychopathological disorder, or group of disorders, can be

exclusively ascribed to, or associated with, neurotic perfectionism. As it now appears largely conclusive that there is no "one size fits all" psychopathology when it comes to neurotic perfectionism, perhaps it is just pot luck?

5.4 Therapy- The "Imperfect Struggle"

A resounding discovery of this research was the extent to which all participants suffered the obstructive, and forceful, pressures of unconscious projections manifesting via the medium of negative transference. This finding corresponds with Freud's (1905) assertions that negative projections onto the therapist can psychologically test the therapist, and often bring the therapeutic work to a standstill. Racker (1953) warned of projections where the neurosis specifically related to unconscious conflicts with an introjected punitive parent. These projections transform the therapist into the oppressive father/mother, and the client interacts accordingly (ibid). A range of negative transference issues were witnessed in clients who were; demanding, impatient, results focused, expecting a "cure", dismissive or critical of the therapist, hostile, aggressive, passive, investing authority in the therapist, pleasing the therapist, and trying to be the "perfect" client. The epitome of all negative transference reactions arose in clients who abruptly terminated therapy. Both Gudi (1993) and Grinberg (1997) provide substantiation of these experiences on the premise that it is the intensity of the emotions that causes the obstruction, therefore these emotions can be both "negative" and "positive".

Another overwhelmingly prominent finding from this research was the extent, and intensity, of the negative countertransference reactions that all participants experienced as a relatively "expected" part of their turbulent work with neurotic perfectionists. This particular phenomenon is reflected in the psychoanalytic literature, illustrated by Talion law (Racker, 1953), which maintains that negative countertransference reactions will always follow

experiences of negative transference reactions (Racker, 2007). Thus, the therapist must maintain awareness of this destructive negative transferential cycle in order to avoid getting caught in, or perpetuating, the client's neurosis, and thereby further hindering therapy (ibid). Kiesler (2001) identified that negative countertransference may result from either a triggering of the therapist's own unresolved unconscious issues, which does not relate to the client, or from a more objective position whereby these responses directly relate to what the client's maladaptive behaviours genuinely provoke within the therapist, and others. The results therefore parallel Kiesler's (2001) claims on both fronts, as some participant's cited their negative countertransference related to their "own stuff", while others observed their responses as being exclusively relating to their client.

Hence, Ligiéro & Gelso (2002) contended that due to the sheer psychological force of the negative transferential dynamic, therapists will often experience, in their negative countertransference reactions, a wide range of perturbing negative thoughts, feelings and attitudes towards their clients. This phenomenon firmly resonates with the results, as all transcripts revealed a variety of negative emotions elicited towards clients in the heat of the many negative countertransference moments, including; frustration, impatience, anger, irritation, and annoyance. While these internal feelings were rarely inappropriately externalised, they are likely to lead to negative countertransference behaviours, such as, distancing or psychological absence (Friedman & Gelso, 2000). It is at this point when this obstructive countertransference can inadvertently impede the therapist's clarity and empathy (Kahn, 2001). Additionally, and concurring with Gubb's (2014) research into the somatisation of negative countertransference, two of the participants admitted to suffering the ill effects of somatic countertransference. These experiences, felt in the body, included;

anxiety, tension, increased heat rate and respiration, chest pain, and a general feeling of "stress".

Furthermore, psychoanalytic writings have emphasised that when the client plateaus in therapy without hope of improvement, depressive anxieties can be provoked in the therapist resulting in an almost desperate wish to heal the client (Racker, 2007). Fascinatingly, and in accordance with the literature, three participants divulged specific times when they felt under pressure to be the "perfect" therapist, thus feeling the need to "do more" or "perform" for their clients. Ed's vignette provides a fitting illustration: "I find myself maybe working that bit harder…trying to sort of be the perfect therapist and heal them in a way…". Additionally, countertransference-aggression may ensue in response to a client who is aggressive towards, or rejecting of, the therapist/ therapeutic alliance (ibid). While the results did not lend much support to the literature in this instance, Niamh's fascinating reverie does provides one most extraordinary example of this phenomenon at work: "...I had this really fast this image of seeing a sniper shooting my client dead….Oh God yeah…that would be such a relief wouldn't it!... *take him out!*...he wouldn't even know it!...really sadistic"

5.5 Conclusion

This study facilitated a rare opportunity to take a qualitative glimpse behind the very abstract concept of neurotic perfectionism. The findings of this research, engendered from the participants' clinical experiences, thus signified the holy grail of qualitative study, as they essentially provided the subjective knowledge required for a substantially robust qualitative elucidation of all aims and objectives of this research. Neurotic perfectionism has consequently been established, within the framework of this study, as an unconsciously constructed mask of survival, which is worn in direct response to, the often implicit, rejection

of the child's true self in early childhood development. The basis for the cruel refusal of this innocent child, who was born into this world, imperfections and all, has been found to sit within the realm of parentally imposed conditions of worth. The child thus learns at a very early age that love and acceptance are not given freely, and consequently enters an unconscious bartering system; relinquishment of the true self, and self-worth, in exchange for conditional approval.

Therefore, it is this fake façade, the perfectionist scaffolding upon which neurotic perfectionism is so rigidly attached, that fundamentally provides the anxious child with the means of burying the true self, in pursuit of the most basic needs of parental love and acceptance. The "perfect" persona has now been born to mediate this insecure parent-child attachment, and from now on, no more mistakes are allowed, no spontaneity is permitted, and no real congruence can ever truly be felt. Hence, it is painfully apparent that the "perfect" persona provides the only means possible for the child to find a way of surviving in the world, of attaining some kind of homeostasis, in the cold face of this perpetual fear of rejection from his/her "protectors". This early experience thus sets the stage for the maladaptive show that will be continually performed, often for the rest of this child's life, in the desperate attempts to find love, acceptance, and approval from others, no matter what the personal cost. So, even though this child may be slowly disintegrating inside, the "perfect" show must go on.

Hence, it has also been found that as a result of the introjection of these punitive parental attitudes and beliefs, an incredibly harsh superego becomes firmly established which then dominates the life of the neurotic perfectionist. It is this hostile voice of the internalised critical parent, or the internal "self-critic", that incessantly reinforces completely erroneous beliefs that this person will never be *good-enough*. As a result, psychopathology becomes an almost natural fate, ultimately stemming from this individual living an inauthentic life,

completely out of touch with the true self, and therefore exclusively operating from this false exterior. Consequently, the psychopathological disorder serves as a disguised way out for these unbearable traumas, and emotions, that are so unsafe to feel in what would be considered as the conscious cold light of day.

It is evident that no client will ever present for therapy as a "neurotic perfectionist", in fact, it is apparent that what will often bring this individual into therapy is the psychological atrophy caused by sustained exposure to any one of the many psychopathological disorders associated with neurotic perfectionism. Therapists should thus be mindful of what may really be lurking beneath the "disorder" that is so often predominantly presented in the clinic. Furthermore, therapists should also expect, as attested to by this study, excessive amounts of negative transference, and negative countertransference issues, as potential exacerbating difficulties in the working alliance. Thus, it is these recurring obstructions, resulting from the negative transferential dynamic, that can lead to the therapist feeling extremely pressurised to be something that is completely impossible, the absolute antithesis of the psychotherapist; the "perfect" therapist.

5.6 Limitations

The greatest limitation of this study was the most fundamental limitation of all limitations possible, the exploration of the obscure phenomenon of "neurotic perfectionism", as none of the participants had ever heard of the concept. While this represented a genuinely spontaneous qualitative research opportunity, it also engendered equally spontaneous limitations in terms of some participants struggling to engage fully, and confidently, prior to, and during, the interviews. At times, some participants were hesitant, questioned themselves, and became apologetic for not "knowing enough". This presented a significant issue that had to be managed and, in consultation with the researcher's academic supervisor, elaboration

was given in certain circumstances so participants could feel reasonably comfortable, and competent, answering the interview questions. Due care and attention was therefore given in advance of providing any elaboration to ensure the ethos of the study was not polluted, and the participant's responses were not inadvertently biased.

5.7 Recommendations for Future Research

As demonstrated by this study, the field of neurotic perfectionism is relatively untouched in terms of qualitative research. It is therefore immensely ripe for all kinds of further qualitative harvesting, especially if that research is conducted with a psychodynamic plough. Therefore, each one of the three superordinate themes identified in this study consequently provides a platform for further in-depth research into the area of neurotic perfectionism.

Theme 1 revealed repression of the real self and the construction of a false "perfect" persona to survive in the world. Data resulted from participants working with adult clients, and consequently, their client's retrospective reflections of childhood. By conducting a similar study with child psychotherapists actively working with young children, the earliest stages of the development of the neurotic perfectionism construct could thus be explored. A unique opportunity would also exist to include the parents' invaluable experiences within the remit of data collection. This rich data would undoubtedly assist in producing a better understanding of the phenomenon of neurotic perfectionism.

Theme 2 provided extensive qualitative support for the previously quantitatively hypothesised existence of comorbidity between neurotic perfectionism and psychopathology. Psychopathology was identified as a consequence of the continued repression of the true self, and as an outlet for the return of the repressed. Also, no single disorder was identified as being exclusive to neurotic perfectionism. Scope therefore exists to take this theme forward

as a primary research aim, with the view of deeper exploration into the origins, and functions, of psychopathology as a comorbid phenomenon. Further exploration of why different psychopathologies affect different individual's deemed "neurotic perfectionists" would also appear an enticing research opportunity.

Theme 3 uncovered the obstructive nature of negative transference and negative countertransference reactions, and their deleterious effects on both the therapeutic alliance, and the psychotherapist working under pressure. Morel (1992, p.90) poignantly describes these negative countertransferences as "thorns in the analyst's side". As the subjective experience of the psychotherapist is a relatively untapped area in the research pertaining to neurotic perfectionism, this presents an excellent opportunity to carry out further study. Focal points of the research might include; how the therapist manages these reactions, the impact on the therapist's psychological health, and also dedicated study of somatic countertransference reactions.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Andersson, P., & Perris, C. (2000). Attachment styles and dysfunctional assumptions in adults. *Clinical Psychology & Psychotherapy, 7*(1), 47-53. doi:10.1002/(SICI)1099-0879(200002)7:1<47::AID-CPP225>3.0.CO;2-F.

Antony,M.M., Purdon, C.L., Huta, V., & Swinson, R.P. (1998). Dimensions of perfectionism across anxiety disorders. *Behavior Research and Therapy, 36*, 1143–1154. doi:10.1016/S0005-7967(98)00083-7.

Asch, S. S. (1976). Varieties of negative therapeutic reaction and problems of technique. *Journal Of The American Psychoanalytic Association, 24*(2), 383-407. doi:10.1177/000306517602400209.

Ashby, J. S., & Kottman, T. (1996). Inferiority as a distinction between normal and neurotic perfectionism. *Individual Psychology: Journal Of Adlerian Theory, Research & Practice, 52*(3), 237-245.

Athanasiadou, C., & Halewood, A. (2011). A grounded theory exploration of therapists' experiences of somatic phenomena in the countertransference. *European Journal Of Psychotherapy And Counselling, 13*(3), 247-262. doi:10.1080/13642537.2011.596724.

Aviv, A., & Springmann, R. R. (1990). Negative countertransference and negative therapeutic reactions: Prognostic indicators in the analysis of severe psychopathology. *Contemporary Psychoanalysis, 26*(4), 692-715.

Aube, J., & Whiffen, V. E. (1996). Depressive styles and social acuity: Further evidence for distinct interpersonal correlates of dependency and self-criticism. *Communication Research, 23*(4), 407-424. doi:10.1177/009365096023004004.

Babikian, H. M. (1985). The psychoanalytic treatment of the performing artist: Superego aspects. *Journal Of The American Academy Of Psychoanalysis, 13*(1), 139-148.

Basco, M.R. (1999). *Never good enough: Freeing yourself from the chains of perfectionism.* New York: The Free Press.

Bateman, A., & Holmes, J. (2002). *Introduction to Psychoanalysis: Contemporary Theory and Practice*. London: Routledge.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects.* New York: Harper and Row.

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.

Beck, A. T. (1983). Cognitive therapy for depression: New perspectives. In P. J. Clayton, & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches*. New York: Raven Press.

Beck, A. T., Brown, G., Steer, R. A., & Weissman, A. N. (1991). Factor analysis of the Dysfunctional Attitude Scale in a clinical population. *Psychological Assessment: A Journal Of Consulting And Clinical Psychology, 3*(3), 478-483. doi:10.1037/1040-3590.3.3.478.

Bergler, E. (1952). *The superego: Unconscious conscience: The key to the theory and therapy of neurosis*. Madison, CT US: International Universities Press, Inc.

Bieling, P. J., Israeli, A., Smith, J., & Antony, M. M. (2003). Making the grade: The behavioural consequences of perfectionism in the classroom. *Personality And Individual Differences, 35*(1), 163-178. doi:10.1016/S0191-8869(02)00173-3.

Bieling, P. J., Israeli, A. L., & Antony, M. M. (2004). Is perfectionism good, bad, or both? Examining models of the perfectionism construct. *Personality And Individual Differences, 36*(6), 1373-1385. doi:10.1016/S0191-8869(03)00235-6.

Bieling, P. J., Summerfeldt, L. J., Israeli, A. L., & Antony, M. M. (2004). Perfectionism as an explanatory construct in comorbidity of axis I disorders. *Journal Of Psychopathology And BehavioralAssessment, 26*(3),193-201.doi:10.1023/B:JOBA.0000022112.27186.98.

Blatt, S. J. (1992). The Differential Effect of Psychotherapy and Psychoanalysis on Anaclitic and Introjective Patients: The Menninger Psychotherapy Research Project Revisited. *Journal of the American Psychoanalytic Association, 40*(3), 691-724.

Blatt, S. J. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. *AmericanPsychologist, 50*(12),1003-1020.doi:10.1037/0003-066X.50.12.1003.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical and research perspectives*. Washington, DC: APA Press.

Blatt, S. J., Quinlan, D. M., Chevron, E. S., McDonald, C., & Zuroff, D. (1982). Dependency and self-criticism: Psychological dimensions of depression. *Journal Of Consulting And Clinical Psychology, 50*(1), 113-124. doi:10.1037/0022-006X.50.1.113.

Blatt, S. J., & Shichman, S. (1983). Two primary configurations of psychopathology. *Psychoanalysis and Contemporary Thought, 6*(2), 187-254.

Blatt, S. J., Quinlan, D. M., Pilkonis, P. A., & Shea, M. (1995). Impact of perfectionism and need for approval on the brief treatment of depression: The National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *Journal Of Consulting And Clinical Psychology, 63*(1), 125-132. doi:10.1037/0022-006X.63.1.125.

Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal Of Consulting And Clinical Psychology, 64*(1),162-171. doi:10.1037/0022-006X.64.1.162.

Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Branfman, T., & Bergler, E. (1955). Psychology of "Perfectionism". *American Imago, 12*(1), 9-15.

Burns, D.D. (1980a). *Feeling Good: The New Mood Therapy.* New York: Morrow.

Burns, D. D. (1980b). The perfectionist's script for self-defeat. *Psychology Today, 13*, 34–52.

Cash, T. F., & Szymanski, M. L. (1995). The development and validation of the body-image ideals questionnaire. *Journal Of Personality Assessment, 64*(3), 466-477. doi:10.1207/s15327752jpa6403_6.

Cheng, S. K. (2001). Life stress, problem solving, perfectionism, and depressive symptoms in Chinese. *Cognitive Therapy And Research, 25*(3), 303-333. doi:10.1023/A:1010788513083.

Clara, I. P., Cox, B. J., & Enns, M. W. (2007). Assessing Self-Critical Perfectionism in Clinical Depression. *Journal Of Personality Assessment, 88*(3), 309-316. doi:10.1080/00223890701317046.

Cramer, P. (1987). The Development of Defense Mechanisms. *Journal Of Personality, 55*(4), 597-614. doi:10.1111/1467-6494.ep8970918.

Cassell, C., & Symon G. (2006). *Essential Guide to Qualitative Methods in Organizational Research*. London, UK: SAGE Publications Ltd.

Crosby, J. M., Bates, S. C., & Twohig, M. P. (2011). Examination of the relationship between perfectionism and religiosity as mediated by psychological inflexibility. *Current Psychology: A Journal For Diverse Perspectives On Diverse Psychological Issues, 30*(2), 117-129. doi:10.1007/s12144-011-9104-3.

Dallos, R., & Vetere, A. (2005). *Researching psychotherapy and counselling*. UK: Bell & Bain.

Devens, M., & Erickson, M. T. (1998). The relationship between defense styles and personalitydisorders. *Journal of Personality Disorders, 12*(1),86-93. doi:10.1521/pedi.1998.12.1.86.

Di Bartolo, P., Frost, R. O., Chang, P., LaSota, M., & Grills, A. E. (2004). Shedding light on the relationship between personal standards and psychopathology: The case for contingent self-worth. *Journal Of Rational-Emotive & Cognitive Behavior Therapy, 22*(4), 241-254. doi:10.1023/B:JORE.0000047310.94044.ac.

DiBartolo, P., Li, C., & Frost, R. O. (2008). How do the dimensions of perfectionism relate to mental health?.*Cognitive Therapy And Research, 32*(3), 401-417. doi:10.1007/s10608-007-9157-7.

Dickinson, W. L., & Ashby, J. S. (2005). Multidimensional Perfectionism and Ego Defenses. *Journal Of College Student Psychotherapy, 19*(3), 41-54. doi:10.1300/J035v19n03_05.

Driscoll, R. (1982). Their own worst enemies. *Psychology Today,* 45-49.

Dunkley, D. M., & Blankstein, K. R. (2000). Self-critical perfectionism, coping, hassles, and current distress: A structural equation modeling approach. *Cognitive Therapy And Research, 24*(6), 713-730. doi:10.1023/A:1005543529245.

Dunkley, D. M., Zuroff, D. C., & Blankstein, K. R. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal Of Personality And Social Psychology, 84*(1), 234-252. doi:10.1037/0022-3514.84.1.234.

Dunkley, D. M., Blankstein, K. R., Masheb, R. M., & Grilo, C. M. (2006). Personal standards and evaluative concerns dimensions of 'clinical' perfectionism: A reply to Shafran et al. (2002, 2003) and Hewitt et al. (2003). *Behaviour Research And Therapy, 44*(1), 63-84. doi:10.1016/j.brat.2004.12.004.

Dunn, J. C., Whelton, W. J., & Sharpe, D. (2006). Maladaptive perfectionism, hassles, coping, and psychological distress in university professors. *Journal Of Counseling Psychology, 53*(4), 511-523. doi:10.1037/0022-0167.53.4.511.

Elkin, I., Parloff, M. B., Hadley, S. W., & Autry, J. H. (1985). NIMH treatment of Depression Collaborative Research Program: Background and research plan. *Archives Of General Psychiatry, 42*(3), 305-316. doi:10.1001/archpsyc.1985.01790260103013

Enns, M. W., Cox, B. J., & Clara, I. (2002). Adaptive and maladaptive perfectionism: Developmental origins and association with depression proneness. *Personality And Individual Differences, 33*(6), 921-935. doi:10.1016/S0191-8869(01)00202-1.

Fenichel, O. (1945). *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton.

Flett, G. L., Hewitt, P. L., & Dyck, D. G. (1989). Self-oriented perfectionism, neuroticism and anxiety. *Personality And Individual Differences, 10*(7), 731-735. doi:10.1016/0191-8869(89)90119-0.

Flett, G. L., Hewitt, P. L., Mosher, S. W., Sherry, S. B., Macdonald, S., & Sawatzky, D. L. (2001). *Dimensions of perfectionism and attachment style.* Paper presented at the annual meeting of the American Psychological Society, Toronto, Ontario, Canada.

Flett, G.L., & Hewitt, P. L. (2002). Perfectionism and maladjustment: An overview of theoretical, definitional and treatment issues. In G.L. Flett, P.L. Hewitt (Eds.), *Perfectionism: Theory, research and treatment*. Washington, DC US: American Psychological Association.

Flett, G.L., Hewitt, P.L., Oliver, J.M., & Macdonald, S. (2002). Perfectionism in children and their parents: A developmental analysis. In: Flett, G.L., & Hewitt, P.L.(Eds.), *Perfectionism: Theory, research, and treatment*. Washington, DC US: American Psychological Association.

Flett, G. L., Greene, A., & Hewitt, P. L. (2004). Dimensions of Perfectionism and Anxiety Sensitivity. *Journal Of Rational-Emotive & Cognitive Behavior Therapy, 22*(1), 39-57. doi:10.1023/B:JORE.0000011576.18538.8e.

Flett, G. L., Besser, A., & Hewitt, P. L. (2005). Perfectionism, Ego Defense Styles, and Depression: A Comparison of Self-Reports Versus Informant Ratings. *Journal Of Personality, 73*(5), 1355-1396. doi:10.1111/j.1467-6494.2005.00352.x.

Forman, M. A., Tosi, D. J., & Rudy, D. R. (1987). Common irrational beliefs associated with the psychophysiological conditions of low back pain, peptic ulcers and migraine headache: A multivariate study. *Journal Of Rational-Emotive Therapy, 5*(4), 255-265. doi:10.1007/BF01073816.

Frederickson, J. (2013). *Co-Creating Change: Effective Dynamic Therapy Techniques*. Kansas City, MO: Seven Leaves Press LLC.

Freud, S. (2001). Fragments of an analysis of a case of hysteria. In J. Strachey (Ed. & Trans.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 1, pp.3-122). London: Hogarth Press. (Original work published 1905).

Freud, S. (2001). Further remarks on the neuro-psychoses of defence. In J. Strachey (Ed. & Trans.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 3, pp. 159-185). London: Hogarth Press. (Original work published 1896).

Freud , S. (2001). The economic problem of masochism. In J. Strachey (Ed. & Trans.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 19, pp. 157-173**)**. London: Hogarth Press. (Original work published 1924).

Freud, S. (2001). Inhibitions, symptoms, and anxiety. In J. Strachey (Ed. and Trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20, pp. 87-86). London: Hogarth Press. (Original work published 1926).

Friedman, S., & Gelso, C. J. (2000). The development of the Inventory of Countertransference Behavior. *Journal Of Clinical Psychology, 56*(9), 1221-1235. doi:10.1002/1097-4679(200009)56:9<1221::AID-JCLP8>3.0.CO;2-W.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy And Research, 14*(5), 449-468. doi:10.1007/BF01172967.

Frost, R. O., Lahart, C. M., & Rosenblate, R. (1991). The development of perfectionism: A study of daughters and their parents. *Cognitive Therapy And Research, 15*(6), 469-489. doi:10.1007/BF01175730.

Frost, R. O., & Steketee, G. (1997). Perfectionism in obsessive-compulsive disorder patients. *Behaviour Research And Therapy, 35*(4), 291-296. doi:10.1016/S0005-7967(96)00108-8.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: APA Press.

Greenspon, T.S. (2002). *Freeing our families from perfectionism*. Minneapolis: Free Spirit Publishing.

Greenspon, T. S. (2008). Making sense of error: A view of the origins and treatment of perfectionism. *American Journal Of Psychotherapy, 62*(3), 263-282.

Grinberg, L. (1997). Is the transference feared by the psychoanalyst*?*. *The International Journal Of Psychoanalysis,78*(1), 1-14.

Gubb, K. (2014). Craving interpretation: A case of somatic countertransference. *British Journal Of Psychotherapy,30*(1), 51-67. doi:10.1111/bjp.12062.

Guidi, N. (1993). Unobjectionable negative transference. *The Annual Of Psychoanalysis, 2* (1), 107-121.

Halgin, R. P., & Leahy, P. M. (1989). Understanding and treating perfectionistic college students. *Journal Of Counseling & Development, 68*(2), 222-225. doi:10.1002/j.1556-6676.1989.tb01362.x.

Halmi, K.A., Sunday, S.P., Strober, M., Kaplan, A., Woodside, D.B., Fichter, M., Kaye, W.H. (2000). Perfectionism in anorexia nervosa: Variation by clinical subtype, obsessionality, and pathological eating behavior. *American Journal of Psychiatry, 157*, 1799–1805. doi:0.1176/appi.ajp.157.11.1799.

Hamachek, D. E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology: A Journal of Human Behavior, 15*(1), 27–33.

Hatter, S. (1998). The development of self-representations. In W. Damon & N. Eisenberg (Eds.), *Handbook of child psychology: Vol. 3.* New York: Wiley.

Hewitt, P. L., & Dyck, D. G. (1986). Perfectionism, stress, and vulnerability to depression. *Cognitive Therapy And Research, 10*(1), 137-142. doi:10.1007/BF01173389.

Hewitt, P. L., & Flett G. L. (1990). Perfectionism and depression: A multidimensional analysis. *Journal of Social Behavior and Personality. 5*(5), 423-438.

Hewitt, P. L., & Flett, G. L. (1991a). Dimensions of perfectionism in unipolar depression. *Journal Of Abnormal Psychology, 100*(1), 98-101. doi:10.1037/0021843X.100.1.98.

Hewitt, P. L., & Flett, G. L. (1991b). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal Of Personality And Social Psychology, 60*(3), 456-470. doi:10.1037/0022-3514.60.3.456.

Hewitt, P. L., Flett, G. L., & Turnbull-Donovan, W. (1992). Perfectionism and suicide potential. *British Journal Of Clinical Psychology, 31*(2), 181-190. doi:10.1111/j.2044-8260.1992.tb00982.x.

Hewitt, P. L., Flett, G. L., & Ediger, E. (1996). Perfectionism and depression: Longitudinal assessment of a specific vulnerability hypothesis. *Journal Of Abnormal Psychology, 105*(2), 276-280. doi:10.1037/0021-843X.105.2.276.

Hewitt, P. L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., & ... Stein, M. B. (2003). The interpersonal expression of perfection: Perfectionistic self-presentation and psychological distress. *Journal Of Personality And Social Psychology, 84*(6), 1303-1325. doi:10.1037/0022-3514.84.6.1303.

Hewitt, P. L., & Flett, G.L. (2007). When does conscientiousness become perfectionism? *Current Psychiatry, 6*(7), 49-59.

Jacobs, M. (2010). *Psychodynamic counselling in action*. 4th edn. London: SAGE.

Kahn, M. (2001). *Between therapist and client: the new relationship*. Rev. edn. New York: Henry Holt and Company, LLS.

Kawamura, K. Y., & Frost, R. O. (2004). Self-Concealment as a Mediator in the Relationship Between Perfectionism and Psychological Distress. *Cognitive Therapy And Research, 28*(2), 183-191. doi:10.1023/B:COTR.0000021539.48926.c1.

Kennedy, B. L., Schwab, J. J., & Hyde, J. A. (2001). Defense styles and personality dimensions of research subjects with anxiety and depressive disorders. *Psychiatric Quarterly, 72*(3), 251-262. doi:10.1023/A:1010353116016.

Kiesler, D. J. (2001). Therapist countertransference: In search of common themes and empirical referents. *Journal Of Clinical Psychology, 57*(8), 1053-1063. doi:10.1002/jclp.1073.

Klein, M. (1984). *Love, guilt, and reparation, and other works, 1921-1945*. New York: Free Press.

Klein, M., Heimann, P. & Kyrle, R. (1985). *New directions in psycho-analysis the significance of infant conflict in the pattern of adult behaviour*. London: Karnac.

Klein, M., Riviere, J. & Jones, E. (1989). *Developments in psycho-analysis*. London New York: Karnac.

Klein, M., Strachey, A. & Thorner, H. (1997). *The psycho-analysis of children*. London: Vintage.

Kneepkens, R., & Oakley, L. (1996). Rapid improvement in the defense style of depressed women and men. *The Journal Of Nervous And Mental Disease, 184*(6), 358-361.

Knutt, A. D. (2007). Pathological perfectionism: Implications for the treatment of depression, eating disorders, and obsessive-compulsive disorder in suicide prevention (Doctoral dissertation, University of Hartford). *Dissertation Abstracts International, 68*, 1930.

Kohut, H., & Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *The International Journal Of Psychoanalysis, 59*(4), 413-425.

Lapan, R., & Patton, M. J. (1986). Self-psychology and the adolescent process: Measures of pseudoautonomy and peer-group dependence. *Journal Of Counseling Psychology, 33*(2), 136-142. doi:10.1037/0022-0167.33.2.136.

Ligiéro, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, Research, Practice, Training,39*(1), 3-11. doi:10.1037/0033-3204.39.1.3.

Lo, A., & Abbott, M. J. (2013). Review of the theoretical, empirical, and clinical status of adaptive and maladaptive perfectionism. *Behaviour Change, 30*(2), 96-116. doi:10.1017/bec.2013.9.

LoCicero, K. A., & Ashby, J. S. (2000). Multidimensional Perfectionism in Middle School Age Gifted Students: A Comparison to Peers from the General Cohort. *Roeper Review, 22*(3), 182-85.

Malan, D.H. (1995). *Individual psychotherapy. and the science of psychodynamics*. (2nd ed.). Oxford: Butterworth Heinemann.

McFall, M. E., & Wollersheim, J. P. (1979). Obsessive-compulsive neurosis: A cognitive-behavioral formulation and approach to treatment. *Cognitive Therapy And Research, 3*(4), 333-348. doi:10.1007/BF01184447.

McLeod, J. (2003). *Doing Counselling Research.* (2nd ed.). London: Sage Publications Ltd.

Mearns, D. and Thorne, B. (2007). *Person-centred Counselling in Action*. (3rd ed.). London: Sage.

Minarik, M. L., & Ahrens, A. H. (1996). Relations of eating behaviour and symptoms of depression and anxiety to the dimensions of perfectionism among undergraduate women. *Cognitive Therapy & Research, 20*(2), 155-169.

Missildine, W.H. (1963). *Your inner child of the past.* New York: Simon and Schuster.

Mongrain, M., Vettese, L. C., Shuster, B., & Kendal, N. (1998). Perceptual biases, affect, and behavior in the relationships of dependents and self-critics. *Journal Of Personality And Social Psychology, 75*(1), 230-241. doi:10.1037/0022-3514.75.1.230.

Morrel, A. (1992). Countertransference and the Analyst's Response to It: Feelings About Feelings. *Modern Psychoanalysis, 17*(1), 85-99.

Nadler, A. (1983). Personal characteristics and help-seeking. In B. M. Depaulo, A. Nadler, & J. D. Fisher (Eds.),*New directions in help-seeking: Vol. 2 Help-seeking*. San Diego, CA: Academic Press.

Pacht, A. R. (1984). Reflections on perfection. *American Psychologist, 39(*4), 386-390. doi:10.1037/0003-066X.39.4.386.

Polit, F.D., & Hungler, B.P. (1999). *Nursing research: principles and methods*. (5th ed.). Baltimore: Lippincott.

Powers, T. A., Zuroff, D. C., & Topciu, R. A. (2004). Covert and overt expressions of self-criticism and perfectionism and their relation to depression. *European Journal Of Personality, 18*(1), 61-72. doi:10.1002/per.499.

Quadland, M. C. (1980). Private self-consciousness, attribution of responsibility, and perfectionistic thinking in secondary erectile dysfunction. *Journal Of Sex & Marital Therapy, 6*(1), 47-55. doi:10.1080/00926238008404245.

Racker, H. (1953). A Contribution to the Problem of Counter-Transference. *International Journal Of Psycho-Analysis, 3*(4), 313-324.

Racker, H. (2007). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 76*(3), 725.

Rice, K. G., Ashby, J. S., & Preusser, K. J. (1996). Perfectionism, relationships with parents, and self-esteem. *Individual Psychology: Journal Of Adlerian Theory, Research & Practice, 52*(3), 246-260.

Rice, K. G., Ashby, J. S., & Slaney, R. B. (1998). Self-esteem as a mediator between perfectionism and depression: A structural equations analysis. *Journal Of Counseling Psychology, 45*(3), 304-314. doi:10.1037/0022-0167.45.3.304.

Rice, K. G., & Mirzadeh, S. (2000). Perfectionism, attachment, and adjustment. *Journal Of Counseling Psychology,47*(2), 238-250. doi:10.1037/0022-0167.47.2.238.

Rice, K. G., & Slaney, R. B. (2002). Clusters of Perfectionists: Two Studies of Emotional Adjustment and Academic Achievement. *Measurement And Evaluation In Counseling And Development, 35*(1), 35-48.

Rice, K. G., & Lopez, F. G. (2004). Maladaptive Perfectionism, Adult Attachment, and Self-Esteem in College Students. *Journal Of College Counseling, 7*(2), 118-128. doi:10.1002/j.2161-1882.2004.tb00243.x.

Rice, K. G., Lopez, F. G., & Vergara, D. (2005). Parental/social influences on perfectionism and adult attachment orientations. *Journal Of Social And Clinical Psychology, 24(*4), 580-605. doi:10.1521/jscp.2005.24.4.580.

Robbins, S. B., & Patton, M. J. (1985). Self-psychology and career development: Construction of the Superiority and Goal Instability scales. *Journal Of Counseling Psychology, 32*(2), 221-231. doi:10.1037/0022-0167.32.2.221.

Robins, C. J., Ladd, J., Welkowitz, J., & Blaney, P. H. (1994). The Personal Style Inventory: Preliminary validation studies of new measures of sociotropy and autonomy. *Journal Of Psychopathology And Behavioral Assessment,16*(4), 277-300. doi:10.1007/BF02239408.

Rogers, C.R. (2004). *On Becoming a Person: A therapist's view of psychotherapy*. London: Constable.

Rogers, C.R. (1951). *Client-Centered Therapy*. Boston: Houghton Mifflin.

Ross, M. (2000). Body talk: Somatic countertransference. *Psychodynamic Counselling, 6*(4), 451-467. doi:10.1080/13533330050197089.

Sandler, J., & Rosenblatt, B. (1962). The Concept of the Representational World. *Psychoanalytic Study Of The Child,17,*128-145.

Schweitzer, R. D., & Hamilton, T. K. (2002). Perfectionism and Mental Health in Australian University Students: Is There a Relationship?. *Journal Of College Student development, 43*(5), 684-695.

Shafran, R., & Mansell, W. (2001). Perfectionism and psychopathology: A review of research and treatment. *Clinical Psychology Review, 21*(6), 879-906. doi:10.1016/S0272-7358(00)00072.

Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive-behavioural analysis. *Behaviour Research And Therapy, 40*(7), 773-791. doi:10.1016/S0005-7967(01)00059-6.

Shahar, G., Blatt, S. J., & Zuroff, D. C. (2007). Satisfaction with social relations buffers the adverse effect of (mid-level) self-critical perfectionism in brief treatment for depression. *Journal Of Social And Clinical Psychology, 26*(5), 540-555. doi:10.1521/jscp.2007.26.5.540.

Silverman, D. (2005). *Doing Qualitative Research.* (2nd ed.) London: Sage Publications.

Sorotzkin, B. (1985). The quest for perfection: Avoiding guilt or avoiding shame? *Psychotherapy: Theory, Research, Practice, Training, 22*(3), 564-571.doi:10.1037/h0085541.

Speirs Neumeister, K. L., & Finch, H. (2006). Perfectionism in High-Ability Students: Relational Precursors and Influences on Achievement Motivation. *Gifted Child Quarterly, 50*(3), 238-251.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.

Terry-Short, L. A., Glynn Owens, R. R., Slade, P. D., & Dewey, M. E. (1995). Positive and negative perfectionism. *Personality And Individual Differences, 18*(5), 663-668. doi:10.1016/0191-8869(94)00192-U.

Thorne, B. (2008). *Carl Rogers.* (2nd ed.). London: SAGE.

Trochim, W. (2006). 'Nonprobability Sampling'. *Research Methods Knowledge Base,* Retrieved March 17, 2014, from http://www.socialresearchmethods.net/kb/sampnon.php

Tziner, A., & Tanami, M. (2013). Examining the links between attachment, perfectionism, and job motivation potential with job engagement and workaholism. *Revista De Psicologia Del Trabajo Y De Las Organizaciones, 29*(2), 65-74. doi:10.5093/tr2013a10.

Vaillant, G. E. (1994). Ego mechanisms of defense and personality psychopathology. *Journal Of Abnormal Psychology, 103*(1), 44-50. doi:10.1037/0021-843X.103.1.44.

Valliant, G. E. (1992). *Ego mechanisms of defense: A guide for clinicians and researchers*. Washington, DC: American Psychiatric Press.

Valliant, G. E., & Valliant, C. O. (1992). A cross-validation of two methods of investigating defenses. In G. E. Valliant (Ed.), *Ego mechanisms of defense: A guide for clinicians and researchers*. Washington, DC: American Psychiatric Press.

Valliant, G. E. (1977). *Adaptation to life*. Boston: Little and Brown.

Wei, M., Mallinckrodt, B., Russell, D. W., & Abraham, W. (2004). Maladaptive Perfectionism as a Mediator and Moderator Between Adult Attachment and Depressive Mood. *Journal Of Counseling Psychology, 51*(2), 201-212. doi:10.1037/0022-0167.51.2.201.

Wei, M., Heppner, P., Russell, D. W., & Young, S. K. (2006). Maladaptive perfectionism and ineffective coping as mediators between attachment and future depression: A prospective analysis. *Journal Of Counseling Psychology,53*(1), 67-79. doi:10.1037/0022-0167.53.1.67.

Weissman, A. N. (1979). The Dysfunctional Attitude Scale: A validation study (Doctoral dissertation, University of Pennsylvania). *Dissertation Abstracts International, 40*(3), 1389-1390.

Weissman, A. N., & Beck, A. T. (1978). *Development and validation of the Dysfunctional Attitude Scale: A preliminary investigation.* Paper presented at the 86th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

Whelton, W. J., Paulson, B., & Marusiak, C. W. (2007). Self-criticism and the therapeutic relationship. Counselling Psychology Quarterly, 20(2), 135-148. doi:10.1080/09515070701412423.

White, R. W. & Watt, N. F. (1981). *The Abnormal Personality* (5th ed.). New York: John Wiley.

Winnicott, D.W., Winnicott, C., Shepherd, R. & Davis, M. (1986). *Home is where we start from: essays by a psychoanalyst*. New York: Norton.

Winnicott, D.W.(1965). *The Maturational Process and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Hogarth Press.

Winnicott, D.W. (1991). *The child, the family, and the outside world*. London: Penguin.

Winnicott, D.W. (2005). *Playing and reality*. London New York: Routledge.

Winnicott, D.W.(2006). *The family and individual development*. London New York: Routledge.

Zuroff, D. C. (1994). Depressive personality styles and the five-factor model of personality. *Journal Of Personality Assessment, 63*(3), 453-472. doi:10.1207/s15327752jpa6303_5.

Appendices

Appendix A – Participant Information Sheet

Title of this study:

"A Psychodynamic Exploration of Neurotic Perfectionism from the Perspective of the Experienced Clinician"

Researcher: Ciarán McMahon (Dublin Business School)

Researcher's contact details: 087-2672475 and ciaranmcmahon2014@gmail.com

Research Supervisor: Cathal O'Keeffe (Dublin Business School)

About the researcher:
My name is Ciarán McMahon and I am a final year student on the BA (Hons) Counselling & Psychotherapy at Dublin Business School. I am currently in the process of carrying out a qualitative research study.

The purpose of this study
The aim of this study is to understand the experience of Irish accredited (IACP/IAHIP) psychotherapists, who are experienced clinicians, working psychodynamically with clients who are neurotic perfectionists (i.e. clients living with maladaptive or very unhealthy levels of perfectionism). This study also aims to help further psychotherapy research in the field of neurotic perfectionism by means of qualitative exploration. If you decide to participate, I will ask you specific questions about your experience in this area to date.

Criteria for participation in this study
1. Accredited with an Irish professional body (IACP/IAHIP)
2. A minimum of 5 years post accreditation clinical experience
3. Experience of working psychodynamically with clients who are neurotic perfectionists (i.e. clients living with maladaptive or very unhealthy levels of perfectionism)

What involvement in this study will require
Participation in this study will include attending a face-to-face interview with me, which will be audio-taped then later transcribed. **The interview will take approximately 40 minutes**. During this time you will be asked about your experience in relation to the research question. The interview will be conducted at a venue of your choosing, at a date and time that suits you best. Additionally, I will ask you to answer some demographic questions by email, in advance of the interview, about yourself and your experience. This will enable me to include a short anonymous biography of you as a participant in my study for contextualisation purposes.

Anonymity
Your decision to participate is completely voluntary and all of the information you provide

will remain completely anonymous. A code number will identify all forms used in this research. Any names or other identifying information that you provide during the course of the interview will be removed during transcription. Audio recordings will be transferred to the researcher's personal computer and password protected. Transcripts will be made of the interview which will subsequently be coded by number and kept in a secure location. Excerpts from the interview may be made part of the final research project for contextualisation purposes.

Limitations to confidentiality:
It is important for you to know that there are naturally some appropriate limits to confidentiality. This applies even if you withdraw from this study after disclosing such information. The only times when confidentiality cannot be kept is if you tell me that children are at risk of harm or any form of abuse, or if I believe that you are at risk of harming yourself or others.

Freedom of Information and the right to withdraw from this study:
If you initially decide to take part you can subsequently change your mind and withdraw from this study without prejudice, and request to have your data removed from this study. Additionally, under the Freedom of Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.

Appendix B – Participant Consent Form

BACKGROUND INFORMATION

The aim of this study is: **to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician**. I am therefore incredibly interested to hear about the clinical experience of psychotherapists working psychodynamically with clients who are neurotic perfectionists (i.e. clients living with maladaptive or very unhealthy levels of perfectionism). I intend to explore the experience and opinions of experienced clinicians like you, all of whom work as Irish accredited (IACP/IAHIP) psychotherapists with a minimum of 5 years post accreditation clinical experience. I am therefore inviting you to participate in this research.

WHAT IS INVOLVED?

If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, at a date and time that suits you best. **The interview will take approximately 40 minutes.** During the interview I will ask you a series of questions relating to the research question and specifically in relation to your experience of working with clients who are neurotic perfectionists (i.e. clients living with maladaptive or very unhealthy levels of perfectionism). After completion of the interview, with your permission, I may request to contact you by telephone or email if I have any follow-up questions.

ANONYMITY

All information obtained from you during the research will be completely anonymous. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. All data stored will be de-identified. Audio recordings will be transferred to the researcher's personal computer and password protected. Transcripts will be made of the interview which will be subsequently coded by number and kept in a secure location. Excerpts from the interview may be made part of the final research project. Your decision to participate in this research study is completely voluntary. You are free to withdraw from this study at any point without any disadvantage.

Thank you very much for your time,

Ciarán McMahon

Contact details: 087-2672475 and ciaranmcmahon2014@gmail.com

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date / /

Appendix C – Demographic Questionnaire

I would be very grateful if you could please take a few minutes to answer these important demographic questions prior to interview and return to me by e-mail at: ciaranmcmahon2014@gmail.com

1. Name: (Reference Code:_____)

2. Age:

3. How long have you been practicing as a psychotherapist?

4. What qualification(s) do you hold?

5. How would you best describe your practicing theoretical orientation?

6. Please note any other any other psychotherapy specializations or any specific areas of focus in your psychotherapeutic work?

7. Who are you accredited with?

8. How long are you accredited?

9. Do you work in private practice?

10. Do you work as a psychotherapist outside of private practice? If so, where?

11. How many clients do you see per week (on average)?

Appendix D – Semi-Structured Interview Questions

1. What thoughts, if any, come to your mind when you hear the term neurotic perfectionism?

2. What body sensations, if any, do you feel when you think of neurotic perfectionism?

3. How would you theoretically define the concept of neurotic perfectionism?

4. Can you describe how neurotic perfectionism manifests in clients in the clinic?

5. Can you tell me, in as much detail as possible, how you work with clients who are neurotic perfectionists?

6. A study relating to parent-child attachment styles and neurotic perfectionism stated "Maladaptive [*neurotic*] perfectionists reported insecure relationships to [*their*] parents". What is your opinion of this statement?

7. In your experience, what effect does neurotic perfectionism have on the psychotherapeutic process?

8. What negative transference issues, if any, have you experienced while working with clients who are neurotic perfectionists?

9. What negative countertransference issues, if any, have you experienced while working with clients who are neurotic perfectionists?

10. What would you say are the most common ego defence mechanisms employed by neurotic perfectionists?

11. In your experience, what additional psychopathological disorders, if any, are associated with clients who are neurotic perfectionists?

12. In your opinion, is it possible for clients with neurotic perfectionism to experience positive change during the therapeutic process?

13. What therapeutic interventions have you found to be most effective while working with clients who are neurotic perfectionists?

14. Is there anything else, which you feel is important, that you would like to add?

Appendix E – First Contact Email

Dear (insert first name),

I found your contact details on the IACP website. I hope you do not mind me contacting you by email.

My name is Ciarán McMahon and I am a final year student on the BA (Hons) Counselling and Psychotherapy at Dublin Business School. I am currently in the process of carrying out a qualitative research project. The aim of my study is to conduct a psychodynamic exploration of neurotic perfectionism from the perspective of the experienced clinician.

I am therefore interested in researching the experience of Irish accredited (IACH/IAHIP) psychotherapists working psychodynamically with neurotic perfectionists (i.e. clients living with maladaptive or very unhealthy levels of perfectionism).

Please find attached, also, an information sheet which explains more about my study and what would be involved should you decide to participate.

I would appreciate if you could take a few minutes to consider whether you would like to participate in my study. Your participation would be vital to this gap in research surrounding neurotic perfectionism and the field of psychotherapy.

If you wish to participate, I would greatly appreciate you responding by email at ciaranmcmahon2014@gmail.com or alternatively please feel free to do so via phone call at 087-2672475.

Kind regards,

Ciarán

Appendix F – List of Tables