The Perfectionist Constellation: How Perfectionists Describe, Understand, Experience and Imagine Relationships

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3. Abstract

In this qualitative Counselling Psychology study, I interviewed twelve self-identified perfectionists to explore how they describe, understand, experience and imagine relationships. Nine female and three male interviewees aged between 33 and 67 were recruited through a purpose-built website, social media, press advertising and word-of-mouth. The interviews were qualitative, semi-structured and relational.

The interview transcripts were inductively analysed from a critical realist perspective using Braun and Clarke's guide for thematic analysis (Braun & Clarke 2013). The study sought to give voice to perfectionist relationship experience and illuminate the possible impacts of this for relating and relationships (including therapeutic relationships). The analysis produced three main themes: i. Challenging relationship experiences from the past, ii. Feeling unpleasant sensations and emotions in the past and present and iii. Ongoing habits impacting on relationships.

This study considers the interviewees relational experiences in depth and how well available theory applies to, or accounts for these experiences. It also identifies areas of their experience that current theory does not account for. It recommends pragmatic, limited and plural use of the theories considered and suggests the addition of Interpersonal Discrepancy to concepts worth considering with perfectionist clients. Amongst the conclusions of the study are that perfectionism is seen as pathological and conceptualised over-negatively. This may discursively disenfranchise the majority of those experiencing it and obstruct participation in therapeutic alliance.

The study suggests Interpersonal Discrepancy as an area for further research and that a mix of methods may facilitate the collection of better quality, more comprehensive data from perfectionists thus avoiding data distorted or obscured by emotional reserve and the tendency to self-conceal.

Overall, this study supports a field-wide shift of focus from efforts to define perfectionism towards efforts to give voice to the experience of it. It concludes that, in keeping with the importance of understanding subjective experience to Counselling Psychology, the findings support the possible benefits and efficacy of giving voice to perfectionists in particular. Also, interventions seeking to resolve perfectionism
directly, or which encourage relinquishing parts of the self, may be misguided because they do not acknowledge its fluctuating nature, its basis in relational trauma or how profoundly integral perfectionism can feel to the self. The study recommends that therapy focus on resilience, management, understanding individual perfectionism, relating and Interpersonal Discrepancy and the resolution of relational trauma.

**Keywords:** Perfectionism, Relationships, Interpersonal Discrepancy, Therapeutic Relationship, Therapeutic Alliance
4. Introduction

My interest in perfectionism began during a first-year placement in a drugs and alcohol rehabilitation service. I saw many newly sober clients begin to struggle with their own and others’ perceived high standards and with urges to be perfect. Four clients struggled with feelings of worthlessness when they ceased drinking. They believed they needed to improve and, once sober, they began cleaning their homes, grooming themselves, criticising themselves and thinking a lot about how others perceived them.

The women also tried to alter the attitudes and behaviours of family members or began avoiding them. They felt lonely, isolated and ashamed and this put pressure on them and their sobriety. They began to feel addicted to other things, e.g. Radio 4, sexual encounters, and building a successful business. The numbing effect of alcohol was irresistible at times and one woman could not reduce her drinking. She said she could not bear how she felt about herself when sober. The women became more distant and self-critical in sessions. They made fewer personal disclosures and for some time were angrier, sadder and more anxious than when they arrived.

All had perfectionistic thoughts and often became stuck in ruminative, black and white cycles of thinking which proved difficult to disrupt. Their perfectionism was pervasive, and it fluctuated. They had to work hard to overcome it. I began noticing my own discomfort at not being able to help them to effectively relieve their distress and became preoccupied with improving my skills and knowledge. I found many professional resources addressing perfectionistic cognitions but few addressing the interpersonal effects of the perfectionism I was seeing in my client's relationships and in the therapy itself. I began reading about perfectionism and realising that I too had a highly evaluative approach to life, work and anything that felt like a performance. Like my clients, I noticed times when I did not feel perfectionistic and wondered why those moments differed from those when I did. I concluded my perfection-seeking could be all-encompassing, paralysing and personally uncomfortable as well as productive, calming and satisfying.
There is little qualitative research available about perfectionists’ experience of relationships or therapy in their own words and I have found no qualitative or processual studies about perfectionists’ perceptions and experiences of relationships across the lifespan or which consider their capacity to benefit from therapy.

Perfectionism, as it is clinically understood, is linked with psychological disorder and it appears in psychological autopsy studies of suicide victims. Research has established that it makes depression difficult to alleviate and that perfectionism and its disadvantages can, and should, be improved through psychotherapy. Authors have acknowledged perfectionist difficulty with therapeutic alliance (Brustein 2014) and called for improvements to the outcome of therapy with perfectionists (Blatt, Zuroff & Shahar 2002).

Perfectionistic clients’ beliefs and attitudes about themselves and relationships may routinely affect therapeutic outcomes and experiences of therapy itself both for the client and therapist. A lack of knowledge about individual perceptions, expectations and preferences may be obscuring the nature of any barriers to therapy for perfectionist clients. Barriers which could be overcome or removed.

To make the situation more complex, perfectionism is also a widely understood popular psychology reference and habits associated with it are often both encouraged as productive and socially desirable and discouraged as obsessive and unhealthy in western societies. Conflicting cultural and social messages like these may also affect relational experience.

Considering the relative absence of qualitative and Counselling Psychology literature around perfectionism and relationships, this study aims to provide insight into perfectionists’ relational experiences and so potentially their capacity to benefit from therapy. It aims to produce therapeutically relevant information about perfectionists, their perceptions and the impact of these on therapy.
Twelve self-identified perfectionists were interviewed over a two-year period for the study. The study considers their relational experiences and perceptions in a thematic analysis of the transcripts of those interviews.

5. Literature Review

This review considers and summarises currently available psychological literature which offers understanding of perfectionist relating. To do this it is helpful to summarise the effects of perfectionism and the difficulties associated with it. It also outlines conceptualisations of perfectionism and how it is understood from the perspectives of: Cognitive Behavioural Therapy; Psychoanalysis; trauma; attachment; Cognitive Analytic Therapy and Schema Therapy. These shed light on perfectionist relating where they account for it. The review also critically considers therapeutic outcomes with perfectionists, and what they tell us about their relationship constellations.

The literature was gathered through searches of online journal articles and library catalogues focussing on perfectionism, relationships, interpersonal effects, explanations and models of perfectionism, therapeutic outcome studies and efficacy studies

a) Definition and Effects of Perfectionism

In the clinical literature, perfectionism is associated with psychological distress but there is still little agreement about what comprises perfectionism, so the effects outlined here are drawn from studies that measure and conceive of perfectionism in different but similar ways.

Definitions vary as to whether perfectionism is unidimensional, bi-dimensional or multidimensional and a personality trait. Two early unidimensional definitions (now considered simplistic) are: “The practice of demanding of oneself or others a higher quality of performance than is required by the situation” (Hollender 1978) and “active striving to be flawless” (Blatt 1995). A more recent unidimensional clinical definition is “the overdependence of self-evaluation on the determined pursuit of personally demanding
Self-imposed standards in at least one highly salient domain despite adverse consequences” (Shafran, Cooper & Fairburn 2002).

Early bi-dimensional concepts described perfectionism as adaptive and maladaptive or healthy and unhealthy which were dichotomous in nature. To Hamachek, maladaptive perfectionism involved high standards which are rarely met or achievable and a lack of enjoyment of completed projects. Conversely adaptive perfectionists meet their standards and enjoy completed projects more (Hamachek 1978). More recently perfectionism has been considered a multidimensional personality trait, conceptualisations of which have been developed through the testing and revision of psychometric self-report and clinical instruments. Bieling, Israeli and Anthony point out that most now agree that core aspects of perfectionism are: striving for high personal standards of achievement and concerns over mistakes and failure to achieve (Bieling, Israeli & Antony 2004)

Three instruments dominate the field. Frost, Marten, Lahart and Rosenblate’s Multidimensional Perfectionism Scale (FMPS) (Frost, Marten, Lahart & Rosenblate 1990) comprises six factors: Personal Standards, Organisation, Concern about Mistakes, Doubt about Action, Parental Expectation and Parental Criticism. Some factors are more strongly associated with maladaptive perfectionism than others as are high scores across the scale and are considered more likely to lead to distress (Frost et al. 1990).

The second is Hewitt and Flett’s Multidimensional Perfectionism Scale (HMPS) (Hewitt & Flett, 1991). The HMPS comprises 3 types of perfectionism which are intrapersonal and interpersonal in nature. They are: Self-Oriented, Other-Oriented and Socially-Prescribed perfectionism. Self-Oriented involves the tendency to set high standards for oneself, Other-Oriented involves setting high standards for others and Socially-Prescribed involves the belief that others expect high standards from the self (Hewitt & Flett 1991).

The third instrument, the Almost Perfect Scale – Revised (APS-R) was developed by Counselling Psychologists Slaney, Rice, Mobley, Trippi and Ashby (Slaney, Rice, Mobley, Trippi & Ashby 2001). The APS-R subscales are High Standards, Order and Discrepancy.
Discrepancy measures the degree of self-critical evaluation relating to one’s perceived ability to achieve one’s own standards. The researchers found a high association between High Standards and Order but a weaker association between High Standards and Discrepancy. The authors indicate that the APS-R may measure two types of perfectionism with high Discrepancy indicating the more distressing type (Slaney et al. 2001).

Psychologists have tried to simplify and clarify all these constructs. Stairs’ factorial analysis of 15 established measures of perfectionism concluded that the most valid and reliable factors in existing measures could be loaded on to higher Ego-Syntonic and Ego-Dystonic factors. Ego-Dystonic includes Dissatisfaction, Concern over Mistakes, and Details and Checking (Stairs 2009) (Stairs, Smith, Zapolski, Combs & Settles 2012). Alternately, Sirois and Molnar loaded factors on to higher Perfectionistic Striving and Perfectionistic Concerns factors. Perfectionistic Striving includes high standards and Perfectionistic Concerns includes critical self-appraisal and scrutiny, preoccupation with others evaluation, expectation and criticism, and inability to gain satisfaction (Sirois & Molnar 2016). Measures continue to identify positive and negative aspects of perfectionism.

**b) Interpersonal Effects of Perfectionism**

In terms of relating, the Perfectionism captured in these measures has been associated with several interpersonal effects which may be valuable for understanding perfectionist relationship experience. Hill, Zrull and Turlington linked Self-Oriented perfectionism (Hewitt & Flett 1991) to relatively positive or successful interpersonal characteristics in women; Other-Oriented perfectionism (Hewitt & Flett 1991) to negative interpersonal characteristics and lack of interpersonal distress; and Socially-Prescribed perfectionism (Hewitt & Flett 1991) to interpersonal maladjustment and distress. They linked perfectionism to characteristics including: problems with controlling, manipulating, aggression, trying to change others, distrust, low empathy, emotional distance, over-nurturance, over-trusting, permissiveness, eagerness to please, social anxiety, embarrassment, anger, gullibility, over-generosity, attention-seeking, over self-disclosing and problems being alone. These characteristics varied
between male and female and Self-Oriented, Other-Oriented and Socially-Prescribed perfectionists (Hill, Zrull & Turlington 1997).

Stairs and colleagues linked Reactivity to Mistakes to anxiety, anger, hostility, depression, self-consciousness, vulnerability and maladaptive competence, dutifulness, achievement striving, self-discipline and deliberation. Perceiving Pressure from Others, Dissatisfaction and Reactivity to Mistakes was linked to low trust (Stairs, Smith, Zapolski, Combs & Settles 2012). Perfectionism has also been linked to hypersensitivity to perceived external standards (Dunkley, Zuroff & Blankstein 2003) and distress from interpersonal rumination after negative feedback (Nepon, Flett, Hewitt & Molnar 2011). Kumari, Sudhir & Mariamma linked Socially-Prescribed perfectionism (Hewitt & Flett 1991) to fragile inner self, separation anxiety and Concern over Mistakes and Order subscales (Frost et al 1990) (Kumari, Sudhir & Mariamma 2012). Others found increases in depressive affect in interaction with low friendship intimacy in student autobiographical narratives (Mackinnon, Sherry, Pratt & Smith 2014).

Many of the mood and interpersonal associations made in research may have relationship impacts because they impact on interpersonal interacting and comfort around other people. For example; neurosis, low positive emotion, low trust, low competence, anhedonia, general anxiety and anxious arousal (Dunkley, Blankstein & Berg 2012), aggressive behaviour and self-harm (Chester, Merwin & Dewall 2015), low self-esteem, emotional reactivity and attachment fears of dependency, closeness and loss (Dunkley, Berg & Zuroff 2012), and shame (Wyatt & Gilbert 1998) (Lutwak & Ferrari 1996).

Illness has been found to co-occur with perfectionist high-stress reactivity, 'pressure personality', particular coping styles and poor self-care (Sirois & Molner 2016). Perfectionism has been associated with: colitis, ulcers, migraine, hypertension, cardiovascular illness, arthritis, stroke, hernia, lumbar conditions and chronic fatigue (Hewitt, Flett & Molnar 2016). This suggests that perfectionists may be more vulnerable to these types of physical ill health than others.
In research specific to perfectionist relationships, Lopez and colleagues found dyadic perfectionism in perfectionists' romantic relationships and that this predicted relationship continuity and distress over a three-month period in 116 heterosexual university students (Lopez, Fons-Scheyd, Morúa & Chaliman 2006). Dyadic perfectionism in students also; ‘put(s) pressure on the partner and negatively affects the perception of the quality of the relationship regarding satisfaction and long-term commitment’ (Stoeber 2012). Concern over Mistakes and Parental Criticism scores (Frost et al. 1990) have been negatively associated with dyadic adjustment but less so than neuroticism and agreeableness (Costa & McCrae 1992) according to Egan, Vinciguerra and Mazzucchelli (Egan, Vinciguerra & Mazzucchelli 2015).

Overall, mainstream literature gives an uncomfortable picture of perfectionists in interpersonal contexts, suggesting that perfectionists' interpersonal traits do not facilitate or easily support interpersonal relationships. This provides some information about perfectionism and relationships but does not describe the process or experience of this or how and in what contexts these occur.

c) Mental Illness and Perfectionism

Clinical perfectionism is also frequently linked to mental health difficulty and illness and as Shafran and Mansell's exhaustive clinical review identified research has established statistical associations between perfectionism and those meeting diagnostic criteria for: depression, anxiety, eating disorder, social anxiety, obsessive compulsive disorder, panic and obsessive compulsive and borderline personality disorder. The HMPS (Hewitt & Flett 1991) is the most used measure it's Socially-Prescribed perfectionism has been associated to Avoidant, Schizoid, Passive-Aggressive, Schizotypal and Borderline personality disorders and Other-Oriented perfectionism to histrionic, narcissistic, and anti-social personality disorders (Shafran & Mansell 2001). Socially-Prescribed perfectionism is associated with depression, external locus of control, need for approval and fear of negative evaluation (Hewitt & Flett 1991).

Perfectionism has been regularly associated with depression. Again Socially-Prescribed perfectionism (Hewitt & Flett 1991) was found to predict increased levels of depression
in a longitudinal study (Hewitt, Flett & Ediger 1996). Depressed patients were found to have higher levels of Self-Oriented perfectionism than anxiety patients, although the level of Self-Oriented perfectionism did not differ greatly from that in the non-disordered control group (Hewitt, Flett & Ediger 1996). Self-Oriented perfectionism was also found not to predict depression in a student population but interacted with achievement stress and predicted depression 4 months later (Hewitt, Flett & De Rosa 1996). Self-Oriented perfectionism predicted depression in those with unipolar depression or mixed psychiatric diagnoses in the context of achievement stress (Hewitt & Flett 1993). Chang and Rand found achievement stress interacted with Socially-Prescribed perfectionism but not Self-Oriented perfectionism, to predict depression (Chang & Rand 2000).

Measurement scales have proliferated and specialised. For example, the Perfectionistic Self Presentation Scale (PSPS) developed for Social Anxiety measures tendency toward defensive self-concealment and self-promotion (Hewitt, Flett, Sherry, Habke, Parkin, Lam & Stein 2003). The Perfectionistic Cognitions Inventory (PCI) aims to measure the severity of OCD symptoms (Flett, Hewitt, Blankstein & Gray 1998).

Many studies link psychopathology and perfectionism (Shafran & Mansell 2001) but most were not repeated and relied heavily on self-report using established instruments and small numbers of white, traditionally, academically educated students or patients diagnosed with clinical disorders under medical care. Factors beyond perfectionism and distress were rarely observed, controlled for or considered. Consequently, the studies disregard life context and the nuanced experiences of participants and potentially the individual nature of their distress and perfectionism.

A further point here is that studies associating perfectionism with specific diagnoses are hampered by the fact that diagnosis itself, especially where it relies on DSM-V criteria, is a similarly blunt tool to perfectionism measures. According to The Dana Foundation “The DSM is a poor mirror of clinical and biological realities; a fundamentally new approach to diagnostic classification is needed and researchers must uncover novel ways to study and understand mental illness” (Danaorg 2016). To the US National Institute of Mental Health “… the DSM diagnoses are based on consensus about clusters of clinical
symptoms, not any objective laboratory measure…. The weakness is its lack of validity” (Nimhgov 2016). Debate about ‘incorrect subjugation” of perfectionism to merely a lower order facet of many personality disorders in the DSM-V (Ayearst, Flett & Hewitt 2012) and its omission from DSM-V highlights the arbitrary and politicised nature of what appears in DSM publications, despite their authoritative and empirical overtones.

Perhaps more important for this discussion, is that psychological distress is evident in some perfectionists and that perfectionism has often been associated to psychological discomfort and as the literature below shows, to an increased risk of harm to self.

**d) Suicidality and Perfectionism**

The UK suicide prevention charity, The Samaritans reported 6,233 suicides in the UK in 2013. The report cited UK Office of National Statistics (ONS) figures and stated that the suicide rate was 11.9 per 100,000 in adults and 25.1 per 100,000 for men aged 45 to 59 (The Samaritans Annual Report 2015).

Clarke Carlisle, former chairman of the Professional Footballers Association made the documentary ‘Football's Suicide Secret’ which described the vulnerability of professional footballers to suicidal feelings and the pressure of perfect performance (BBC One 2013, August 13th). Carlisle described himself as prone to depression and distress about his ability, performance and injury. Likewise, the BBC report on the unexpected suicide of Welsh Football Manager Gary Speed revealed his high standards and fear of failure (BBC Sports Bulletin 2012).

In the mainstream quantitative literature, Socially-Prescribed and Self-Oriented perfectionism have been linked to suicidal ideation (Hewitt, Flett & Weber 1994) (Hewitt, Newton, Flett & Callender 1997) and to suicide attempting in alcoholics with Socially-Prescribed perfectionism (Hewitt, Norton, Flett, Callender & Cowan 1998).

Qualitative suicide and death studies research reveals perfectionism often contributes to the decision to die, Bell, Stanley, Mallon and Manthorpe interviewed relatives and
significant others of three male suicide victims and concluded that perfectionism and related distress, despair, fear of failure and unachievable or unsustainable standards were influential in victim’s decisions (Bell, Stanley, Mallon & Manthorpe 2010).

A psychological autopsy study by Kiamanesh and colleagues of 41 male Norwegian suicide victims to gain phenomenological understanding linked the deaths to maladaptive perfectionism, concluding they were unable to cope with self-perceived inability to meet their own high expectations. The four themes were: Striving for success; Fear of failure; Keeping up the façade; and Rigidity. The researchers found the group difficult to identify, especially when the deceased had been regarded as successful (Kiamanesh, Dyregrov, Haavind & Dieserud 2014). Their subsequent IPA study interviewed 5 - 9 informants for each of 6 male suicide victims and concluded all the deaths related to irreversible, shameful defeat and loss of ability to handle this. The themes were: A cracked façade; Loss of coping ability and Total escape (Kiamanesh, Dieserud & Haavind 2015).

The methodological and contextual validity issues with the concepts of perfectionism, mental health diagnoses and suicidality are considerable and lack agreement about what they are and how they should be measured. Although firmly associating perfectionism with specific diagnoses is problematic, repeated findings relate perfectionism to distress, suicidality and interpersonal difficulty and indicate perfectionism causes difficulty and vulnerability to these - although most of the research reviewed does not illuminate subjective experience of this.

Blatt considered the suicides of three perfectionists - Vince Foster, Alastair Clayre and Denny Hansen (Blatt 1995). All had performance standards which were difficult to maintain and were highly self-critical perfectionists – vulnerable to introjective depression according to Blatt. Introjective depression is triggered by threat to self-esteem and self-worth, where Anaclitic depression is triggered by disruption to interpersonal relations (Blatt 1995). Blatt considers perfectionists more vulnerable to introjective events but also to anaclitic events where perfectionism impacts negatively on interpersonal relating (Blatt 1995) (Blatt, Shahar & Zuroff 2002)
Distress, mental illness and suicidality are relationship disrupting. Those experiencing them also experience social stigmatization, distancing, prejudice (Corrigan & Lundin 2001) and self-stigmatization (Corrigan & Watson 2002) and this impacts negatively on help-seeking behaviour (Corrigan, Druss & Perlick 2014). Prejudice and discrimination - real or perceived – leads to feeling shame. To Shahar, shame erodes personal ties and delays and extends recovery from depression (Shahar 2001). It seems mental health difficulty and distress make relating and relationship forming difficult generally and may exacerbate pre-existing difficulty with this.

**e) Early Experience of Perfectionists**

Developmental context may also profoundly affect how perfectionists experience relationships. Psychotherapy generally is based on an understanding that relationships play a role in shaping daily experience and perception and that personal understanding and awareness of our experience is helpful.

The presence of the Parental Criticism and Parental Expectation subscales of the FMPS (Frost et al. 1990) indicates the importance of early experience to psychological understanding of perfectionism prior to the psychometric direction the field has since taken. Missildine suggested parents of perfectionists subtly convey disapproval using disappointment, urge children to do better and approve only when the child’s performance improves (Missildine 1963) and Burns suggested parents of perfectionists withhold affection (Burns 1980).

Since then, Quantitative research has found highly self-critical adults recall parents as less warm, nurturant and affectionate (Blatt, Wein, Chevron & Quinlan 1979) and recall poor relationships with their parents (Brewin, Firth-Cozens, Furnham & McManus 1992). Harsh parenting styles and disciplinary shame were associated with higher levels of maladaptive perfectionism (Soenens, Elliot, Goossens, Vansteenkiste, Luyten & Duriez 2005). The same researchers associated Maladaptive perfectionism and depressive affect to higher parental psychological control at age 15 (Soenens, Luyckx, Vansteenkiste, Duriez & Goessens 2008).
Hibbard and Walton found “Authoritarian parenting style was associated with more maladaptive aspects of perfectionism” e.g. Concerns about Mistakes (Frost et al. 1990), whereas Authoritative parenting buffered individuals from maladaptive aspects. Indulgent parenting was associated with fewer feelings of criticism and Neglectful parenting was related to more feelings of criticism. None were related to adaptive perfectionism (Hibbard & Walton 2014).

In a prior qualitative study, Hibbard and Walton interviewed rather than measured 36 students and found perfectionists experience of their parents differed from non-perfectionists. Whilst similar in terms of achievement motivation, belief in hard work and frustration when thwarted; perfectionists were more likely to say they felt family pressure and that parents were critical of mistakes (Hibbard & Walton 2012).

The FMPS (Frost et al. 1990) has been criticised by other researchers because its parent experience items are deemed to cloud a clear construct of perfectionism. This pressure to divorce perfectionism from developmental context (despite high validity\(^1\)) seems bizarre, given the hoped-for therapeutic applications of both MPS measures (Frost et al. 1990) (Hewitt & Flett 1991). The persistence of contextual, experiential items suggests the day to day relevance of this to the experience of perfectionism and relationships.

This also shows up a pivotal paradigmatic issue - if including and excluding developmental items is problematic, then perhaps generalised clinical measurement is not the best way to understand and research relational and/or formative experiences of perfectionists because it records only limited information about potentially clinically relevant experiences. Research excluding relational experience is less useful to Counselling Psychology because the profession focusses on subjective experience (BPS 2009). Pressure to reach a marketable or diagnosable definition of perfectionism may have distracted many researchers from the experiences central to it and its resolution.

**Psychotherapeutic Models and Theories applied to Perfectionism**

\(^1\) The coefficient alphas for the 6 subscales range between .77 and .93 with an overall average of .90 and are generally cited as being correlated i.e. occurring together and as having good concurrent validity (Frost 2011)
Where multidimensional conceptualisations seek to describe perfectionism, the models examined below seek to account for or explain it and can shed light on the relationship experience of perfectionists

f) Cognitive Behavioural Model

In Cognitive Behavioural Therapy, Shafran, Egan and Wade, proponents of a unidimensional clinical definition of perfectionism describe three main elements: a) demanding standards and self-criticism; b) striving to meet demanding standards despite negative effects; and c) basing self-evaluation on high standards. To them, perfectionists try to escape or decrease anxiety by; avoiding activities, procrastinating, checking and testing performance (sometimes repeatedly), comparing themselves to others, seeking reassurance, and engaging in other counterproductive behaviours, e.g. overpreparation (Shafran, Egan & Wade 2010). CBT now favours a transdiagnostic approach to perfectionism (Fairburn, Cooper & Shafran 2003), recognising that it can apply to a variety of diagnoses. Their definition is clinical and most CBT research using this, has been conducted with eating disordered clients (Egan, Wade & Shafran 2011).
CBT seeks to understand thoughts and the model is predicated on an assumption that thoughts lead to feelings which lead to behaviours. CBT itself aims to interrupt this loop and bring swift relief, sustainable by the client once they have left therapy. The model (Fig. 1) illustrates the process of perfectionism, captures its intractable and looping nature and illustrates why perfectionism persists.

Perfectionists set themselves unyielding standards kept in place by cognitive biases which affect how they perceive the world. Their perceptions impact on behaviour, leading to striving and/or avoiding. Perfectionists either avoid, fail to meet, only temporarily meet their standards and counterproductively reappraise and raise standards. Other counterproductive safety behaviours may lead to avoiding evidence which would disprove biased perceptions. These patterns are potentially precursors to disorders including eating disorder and social anxiety. Overall perfectionists are locked into a negative thought-behaviour cycle (Shafran, Egan & Wade 2010). The authors encourage individuals to draw up a personalised version of the model and do cognitive restructuring exercises to reduce the effects of the different aspects of perfectionism shown in the model (Shafran, Egan & Wade 2010). Whilst not explicitly relational, the model indicates perfectionists have a predisposition to focus on achievement, seek recognition and approval and this informs their social and relationship behaviours.

g) Psychoanalytic Theory

Psychoanalytic thinkers most often conceptualised perfectionism as a complex defense against a hidden fear of shame and shame is integral to a psychoanalytic understanding of perfectionism. To Lewis, shame evolves through infancy and childhood, as trust in attachment figures is betrayed and children may experience shame when events do not proceed as they expect or hope (Lewis 1987). Shame takes on psychological meaning about the self when experienced repeatedly and this results in adult shame. Shame relates to separation anxiety because it separates us from others psychically, causing instant insecurity (Nathanson 1987). It is not known if shame is innate or develops from experience but Schore suggests early interpersonal interacting with caretakers is fundamental to how shame is subsequently experienced (Schore 2003). Childhood shame has been related to condemnation, hostility, not recognising positive behaviour,
lack of discipline, neglect, over-protectiveness, parentifying the child, conditional approval, withdrawal of love as discipline, self-focused or public humiliation discipline from parents (Lewis 1987) (Nathanson 1987). The upshot of excessive shaming is attachment difficulty. Smith writes “For children with attachment difficulties, ordinary discipline and being given directions is a reliable trigger for a shame reaction.” (Smith 2016:2). Indeed, attachment theory was originally a pragmatic application of psychoanalytic and object-relations concepts.

Psychoanalysis uses the concept of defense to describe the impact of shame on the self. Defenses are stable, distorting forces which maintain inconsistent inner models of relational experience. They are understood by some, like Lemma as a developmental achievement or attempts at overcoming deficits. In this sense they not only resist awareness as traditionally understood but also lead to resolution (Lemma 2003). To Cooper, defenses maintain internal equilibrium, protect the individual from becoming conscious of thoughts and ideas that would cause anxiety and are part of cognitive, relational patterns which protect self-esteem and reduce and control conflict (Cooper 1998). By this definition, a perfectionist defense is an effort to overcome a deficit in unmet early needs and to keep anxiety out of awareness.

Malan’s two triangles provide a useful representation of defenses in relation to the self and for understanding their action and impact. The Triangle of Conflict represents phenomena intrapersonally (Malan 1979) and the Triangle of Persons represents them interpersonally (Malan 1979) (Fig.2).

Ultimately psychoanalysis sees perfectionistic defense as compensating for feelings of inferiority stemming from childhood. To Burgo, this is a defense against unconscious shame from a shame-driven superego which manifests itself in seeking perfect results, seeking to appear perfect and avoiding appearing imperfect (Burgo 2012: 171).
Fig. 2 - Triangle of Conflict and Triangle of Persons
(Malan: 1979: 80)

Inferiority feelings represent the hidden feeling (of defense/anxiety/hidden feeling) point of the Triangle of Conflict (Malan 1979) and may present as an impulse to persevere or avoid. Perfectionism can be understood as superego pathology where unconscious memories of childhood relationships are organized into representations of the self and of others and the emotions linking the two. The Triangle of Persons shows these representations (or unconscious memories) may be enacted in interpersonal situations in three ways. For example, as an inner character defense where the individual behaves toward their self as their parent did (Parent); as transference resistance where the individual behaves toward the other as their parent did toward the self and avoids criticism of the self (Therapist) and; as projection where the individual perceives other’s intentions towards the self as if they are the critical parent (Others). This triangle demonstrates how perfectionists are self-critical, other-critical and perceive criticism from others and this results from interpersonal experience. These are similar to Self-Oriented, Other-Oriented and Socially-Prescribed perfectionism (Hewitt & Flett 1991) although Malan’s Triangles perhaps allow for a more relational, transactional and state-based process occurring inside the individual rather than simply a permanent trait.

In Object-Relations, Klein described a primitive, infantile Superego which must resolve crises in life and death instincts and fear of annihilation (Lemma: 2003: 202). Pathology results when our senses of badness, annihilation or aggression become dominant. The first of Klein’s pathological positions is Paranoid-Schizoid where we use a splitting
defense to manage tension and see the self and others as either all good or all bad. Our worldview develops from whichever fantasies – good or bad - are affirmed. Those whose good fantasies are affirmed or whose bad fantasies do not overwhelm them, come to rely less on splitting. A Kleinian perspective could describe perfectionism as a pathology reliant on splitting, exemplified by black and white thinking. Splitting manages fear and uncertainty and manifests as self and other judgement. The second pathological position is the Depressive Position; individuals realise they also love those they feel envy or hatred for. They feel guilt and shame and become helpful and compelled to repair relationships (Brustein 2014) (Barnett 2007). In a controversial extension of this, Bion suggested that psychosis results from becoming dominated by envy or aggression in the Depressive or Paranoid-Schizoid positions. This corrupts normal superego morality and ‘attacks the linking’ between people (Barnett: 2007: 101). This may explain how highly distressing perfectionism isolates sufferers and undermines relationships.

To Klein, envy was a defense against pain or hopelessness felt, if goodness from good experiences felt unattainable to the self. We envy the good object (person) to protect ourselves if the person then abandons or rejects us. By devaluing the person, the loss is lessened. Perfectionists envy, judge or devalue others and their own goodness and accomplishments like this and so strive on for goodness which they then spoil for themselves. (Lemma 2003) (Brustein 2014)

In Self Psychology, Kohut conceptualised pathology as developing from unmet self-object needs for: affirmation through mirroring to gain self-esteem and sustain sense of self in hard times; strong care figures to look up to through idealising to feel safe and to set realistic goals; and affiliation and to be on the same level as others through twinship (Kohut 1971). Consequently, Brustein conceptualises perfectionists as having unmet affirmation needs because they are driven to seek affirmation through approval and mirroring. They fear rejection because of this and so may avoid others. Those with unmet idealising needs may idealise and admire others to feel safe or look to others to develop realistic goals (Brustein 2014). In this understanding, individuals who have also been singled out, isolated, or neglected may also have unmet affiliation needs
To Kohut, all pathology, including personality disorder develops from insufficient mirroring, idealising and twinship (Kohut 1971). Johnson suggested that perfectionism in those with narcissistic, histrionic and obsessive disorders results from insufficient resolution of early crises. In narcissism insufficiently resolved infantile grandiosity (through mirroring in toddlerhood) leads to developmental arrest. In Obsessive Compulsive Personality Disorder (OCPD) insufficient resolution of the child’s oedipal love for their opposite sex parent by optimal frustration leads to OCPD. Instead the child is used to flatter the parent or is rejected by the parent (Johnson 1994).

h) Trauma Theory

Trauma focussed psychotherapeutic literature often considers perfectionism as symptomatic of trauma. Walker, a therapist focussed on Complex Post Traumatic Stress Disorder (CPTSD) addresses the felt experience of relational trauma. He describes attacks of perfectionism, the inner critic (criticising the self) and the outer critic (criticising others) as responses to relational trauma- itself usually due to poorly attuned and/or abusive parenting and care. Individuals whose main trauma responses are flight (characterised by ‘busy-ness’) and fawn (characterised by enabling styles of relating) are prone to perfectionism (Walker 2014).

Webb conceptualises perfectionism as resulting from Childhood Emotional Neglect (CEN). Poor parental feedback results in an over-authoritative, moralistic, critical and essentially childlike inner voice. Perfectionism also results from narcissistic parenting which lacks emotional attunement and where the child is perceived as less-than-perfect by the parent. This is experienced as personally humiliating to the parent who is punitive as a result (Webb 2012).

Judith Herman’s aetiology of CPTSD includes subjection to totalitarian control over a prolonged period, possible in domestic life. Symptoms include; dysphoria, self-injury, suicidality, amnesia, dissociation, reliving, ruminative preoccupation, helplessness and paralysis, shame, guilt, self-blame, sense of defilement, sense of difference from others, preoccupation with the perpetrator including attribution of total power, paradoxical gratitude, feelings of specialness, acceptance of their belief system, avoidance,
withdrawal, disrupted intimate relationships, distrust, lost faith, hopelessness and despair (Herman 1992).

i) Attachment Theory

Attachment theory describes how individuals learn to relate to and perceive others through efforts in infancy to gain physical proximity, emotional regulation and protection from caregivers. Main proposed that infant attachments and internal working models become adult attachment styles later in life (Main, Kaplan & Cassidy 1985). Attachment is now grounded in empirical research and provides a lens for psychology professionals to view client experience and understand responses. Mikulincer and Shaver summarise four attachment styles which articulate individual’s responses to perceived internal or external threat. These responses result from conscious and unconscious ‘decisions’ or appraisal and are often beyond the awareness of the individual. Appraisal of threat involves accessing internal representations and implicit memories of past threats. Where threat is associated with proximity, safety, love and relief, it will be dealt with differently to when it is associated with separation, abandonment and rejection.

In adult attachment, mental representations of soothing attachment figures become available at times of threat and when not available, may result in proximity-seeking or avoiding behaviours. Adults have internalised attachment figures and so seek proximity less than children. Mental representations affect perception, likelihood of, and style of, help or proximity-seeking and beliefs about whether this will reduce distress (Mikulincer & Shaver 2010). They cause individuals to treat themselves as early caregivers did. The Attachment-Secure may show themselves kindness and comfort where the Attachment-Insecure may treat themselves harshly, talk critically to themselves and ignore pain. This is how unresponsive, insensitive or absent attachment figure’s messages can subsequently a child’s capacity to self-soothe.

An Attachment-Anxious style is characterised by preoccupation and hypervigilance around attachment cues. The Attachment-Anxious adults often give often incoherent
emotional accounts of original caregivers (Main, Kaplan & Cassidy 1985). This is an: “overdependence on a relationship partner for comfort, excessive demands for attention and care, strong desire for enmeshment or merger, attempts to minimise cognitive, emotional and physical distance from a partner; and clinging and controlling behaviour designed to guarantee a partner’s attention and support” (Mikulincer & Shaver 2010:40).

Attachment-Avoidant style is characterised by distancing from threat, control and denial of attachment needs. Adults often give normalised, over-general, brief or contradictory accounts of their relationships with original caregivers (Main, Kaplan & Cassidy 1985). Avoidant style involves attempts to control and maximise psychological distance from relationship partners and avoid emotional involvement, intimacy, disclosure, interdependence, partner desire for intimacy or security, thinking about personal weakness and relational tension. The Attachment-Avoidant also deny and suppress attachment related thoughts, feelings and fears related to rejection, separation, abandonment or loss. It diverts cognitive attention from threatening thoughts which lead to disrupted processing and memory and failure to deal with negative experiences (Mikulincer & Shaver 2010).

Attachment Fearful-Avoidant style is a mix of both characterised by haphazard, confused and chaotic responses. It leads to contradictory, abortive attempts at proximity, paralysed inaction and withdrawal. Individuals may withdraw and experience anxiety being “caught in a cycle of conflict-ridden attempts to meet personal needs while avoiding rejection or mishandling”. This has been likened to the experience of PTSD (Mikulincer & Shaver 2010:43) and is reminiscent of CPTSD descriptions (Walker 2014) (Herman 1992).

Recently attachment has been considered as more state-based than trait-based. To Wallin, we are securely attached in some respects and calm and flexible in some situations but not in others. He encourages a tailored consideration of client history and experience to address this (Wallin 2007).
j) Attachment and Perfectionism

A small number of studies consider perfectionism and attachment which may indicate and describe aspects of perfectionists’ experience of relationships. Rice and Mirzadeh linked less adaptive perfectionism (in goal setting) to insecure attachment styles and more adaptive perfectionism to secure attachment styles. Maladaptive perfectionism here – signified by less-adaptive goal setting - was indicated by high, unachievable personal standards and high scores on all FMPS subscales particularly Doubt about Action, and Concern Over Mistakes (Frost et al. 1990). Secure attachment was associated with emotionally accessible, nurturing parents who provided a sense of comfort, predictability and encouraged children to approach others and approach difficulty. This early emotional regulation had subsequent interpersonal relationship benefits. Conversely, insecure attachment styles were associated with harsh, unpredictable or unsupportive parent-child interactions, difficulty with developmental challenges and subsequent personal and interpersonal adjustment problems (Rice & Mirzadeh 2000).

The parents of more adaptive perfectionists (i.e. those able to enjoy completed projects and whose standards were achievable) were described as positive, encouraging and supportive with participants viewing themselves as worthy and confident and others as trustworthy and responsible. Parents of less adaptive perfectionists were non- or inconsistently approving, objectified the child, expected suitable performances and showed little interest in or sensitivity to their child’s subjective experience. Participants reported suppressing negative emotion to maintain connection (Rice & Mirzadeh 2000).

Unsurprisingly, less adaptive perfectionism negatively affected self-esteem but less so in Attachment-Secure individuals whose self-worth was more stable irrespective of their standards (Rice & Lopez 2004). Rice, Lopez and Vergara associated appraisals of parental criticism to Attachment-Avoidance and suggested that internalizing a critical parent determined self-worth in the Attachment-Avoidant. They associated Attachment-Anxiety to appraisal of high parental criticism and low parental expectation. They concluded that combination was particularly detrimental to self-esteem (Rice, Lopez & Vergara 2005).
Rice and Mirzadeh found less adaptive perfectionists reported more depression in the clinical range and attachment style predicted adaptive perfectionism more reliably than it predicted less adaptive perfectionism. Notably, there were securely attached individuals in the less adaptive perfectionist group and non-perfectionist attachment was not analysed (Rice & Mirzadeh 2000). Overall, only 30 less adaptive perfectionists participated, and the complexity of the findings and the conclusions drawn suggest that statistical relationships are unclear.

However, these studies do reveal connection between attachment experience, and perfectionist experience and suggest childhood relationship experiences are important for emotional regulation and inform the experiences of adult perfectionists going forward in life.

CBT, psychoanalysis, trauma and attachment models and theories all contribute to the understanding of perfectionist relationship experience and it is worth considering two therapeutic approaches which synthesise main elements of the four considered so far

**k) Cognitive Analytic Therapy**

Anthony Ryle characterises CAT as an actively collaborative integration of cognitive, psychoanalytic and Vygotskian ideas developed to treat personality disorder in a public health setting (Ryle & Kerr 2002). CAT acknowledges CBT needs to take better account of the key role of human relationships in development, pathology and therapy and uses CBT to analyse and describe sequences of behaviour and connect them to outcome and belief. It recognises psychoanalytic ways to understand life patterns which derive from early experience and focuses on how these repeat and on modification of them. Within this framework, CAT accepts the role of temperament, genetically inherited reactivity, trauma and age in altering and reducing neural plasticity in the development of distress. Within this it rejects Kleinian ideas about splitting, preferring to see black-and-white thinking as resulting from trauma and due to the biological importance to humans of being able to differentiate friend from foe (Ryle & Kerr 2002). CAT is also sympathetic to attachment theory although perhaps more radical and narrative in its approach to its
understanding of the impact of early relationships. These experiences constitute us rather than simply being internalised by us (Ryle & Kerr 2002).

CAT uses Sequential Diagrammatic Reformulation to capture these patterns and Reciprocal Role Procedures to understand relationship patterns and how we learn our role from others (Potter 2010). It suggests we are likely to operate learned roles internally; from self to self and externally; from self to other. Projection is understood as an exaggerated Reciprocal Role response and dissociated Reciprocal Roles are what lead individuals to powerfully identify with or forcefully seek reciprocation from others. CAT is procedural, sequential and relational and prefers ‘coping strategy’ where other therapies use ‘defense’ to describe responding (Jenaway & Rattigan 2011) (Ryle & Kerr 2012).

Within CAT, perfectionistic behaviours and thoughts represent Dilemmas, Traps and Snags. They are a Dilemma because, to the individual, only being perfect is acceptable to others. Wilde McCormick provides useful worked examples of the dilemma; one patient feels either perfect or guilty; another feels in perfect control or in a mess. (Wilde McCormick: 2012: 91). Perfectionism is a Trap because despite intentions, it results in unwanted consequences e.g. placating, depressed thinking. Finally, it is a Snag when it results in avoiding situations and opportunities altogether and leads to isolation, reduced self-esteem and feeling worthless.

In addition, CAT acknowledges cultural context, and that some coping strategies are more culturally accepted than others e.g. soldiering on versus expressing feelings. Perfectionism is a culturally acceptable mode of responding to adversity despite leading to internalisation of avoidant, defensive, symptomatic Reciprocal Role Procedures which accompany disruption or failure of integrated self-process and may lead to always feeling bad, not feeling at all or feeling too intensely. Specifically, to CAT, perfectionism is a persistent negative role pattern; “the child of a parent offering critical, conditional care may be critical of self, and expecting criticism from others, manifest in perfectionistic striving or placation and depression, and may also be critical of others” (Ryle and Kerr:2002: 51)
1) Schema Therapy

Schema Therapy (ST) is a second hybrid approach developed by Young, Klosko and Weishaar. It was developed in response to the CBT relapse rate for depression Barlow found- 60% of patients were successful, 30% relapsed after one year (Barlow 2001). Schema therapy was intended to treat the personality and characterological issues which make depression more intractable for some. It addresses CBT’s assumption of motivation to recover in patients, desire to comply and that change is possible simply through cognition of thinking patterns. To Young, Klosko and Weishaar many characterological issues involve lack of personal flexibility and giving up trusted problems can feel like death if they are central to personal identity. Schema therapy aims to solve chronic, vague and pervasive problems and hints at the philosophical stoicism which underpins it, relating loosely to Inference Schema (Nussbaum 1994) to describe broad, pervasive themes in memory, emotion, cognition and sensation which concern self to self and self to other relations. Schemas arrive in adolescence, are often dysfunctional and go on to be elaborated in individuals’ lifestyles (Young, Klosko & Weishaar 2003).

There are unconditional core childhood schemas and more conditional schemas which develop in adulthood – not all from traumatic experience. Humans prefer consistency and these structures render our experience consistent. They reflect the tone and the severity of early experience. Severe schemas being those triggered by a greater number of situations. Young, Klosko and Weishaar suggest we are drawn to experiences that trigger us, in paradoxical, inadvertent recreation of the crucible of experience in which a schema formed. We form positive schemas too. Later, conditional schemas involve more hope and develop as attempts to gain relief from the unconditional schemas already operating. This is not necessarily effective and may just forestall core schemas.

We need core needs for secure attachment, autonomy, competence, identity, expression of need and emotion, spontaneity, play, realistic limits and self-control to be met. Schema therapy considers that we need to resolve each of Erickson’s Psychosocial stages and that we can develop a new schema with each of these resolutions or crises. Early maladaptive schemas come from toxic frustration of needs, traumatization,
victimization, over-indulgence, over-involvement, selective internalization and identification with others – this includes seeing oneself as victim or becoming abusive like an abuser.

Like CAT, Schema Therapy acknowledges that temperament affects the style of schemas which develop, and it varies across axes of; lability/non-reactivity, dysthymia/optimism, anxious/calm, obsessive/distractible, passive/aggressive, irritable/cheerful and shy/sociable. Favourable or aversive experience can override temperament to some extent and vice-versa. The model also acknowledges the role of trauma and its neurological impact in the development of schemas and the authors cite LeDoux (1996). To LeDoux, trauma affects memory storage and the fast, automatic, unconscious amygdala system produces emotion before higher cortices have time to become cognizant of the situation at hand. This speed is thought to be due to its survival value and it produces permanent traumatic memory with no fine discrimination. Schemas are often also preverbal (formed prior to language acquisition) which makes the experience of these memories difficult to articulate.

Schemas fall in to five domains. Domain 1 disconnection and rejection schemas characterised by difficulty establishing relationships include; i) Social isolation/alienation, ii) Abandonment/instability iii) Mistrust/abuse, iv) Emotional deprivation and v) Defectiveness/shame. Domain 2 impaired autonomy and performance schemas are characterised by struggle to separate, survive independently and can be enmeshed with their first family. They include; vi) Dependence/incompetence, vii) Vulnerability to harm or illness, viii) Enmeshment/underdeveloped self and ix) Failure. Domain 3 impaired limits and reciprocity schemas are characterised by inability to respect others, cooperate, communicate, set long-term goals or follow rules. These include; x) Entitlement/grandiosity and xi) Insufficient self-control/self-discipline. Domain 4 schemas are characterised by other-directedness, excessive focus on others and suppression of self-awareness to maintain approval, connection and avoid retaliation. They include; xii) Subjugation, xiii) Self-sacrifice and xiv) Approval-seeking/recognition-seeking. Lastly Domain 5 over-vigilance and inhibition schemas are characterised by self-denial, grimness, restriction and rigidity. They include; xv)

Unrelenting standards/hypercriticality in Domain 5 outlines how Schema Therapy understands perfectionism. It presents as; “a) perfectionism, inordinate attention to detail, or an underestimate of how good one’s own performance is relative the norm; b) rigid rules and ‘shoulds’ in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or c) preoccupation with time and efficiency, the need to accomplish more.” (Young, Klosko & Weishaar 2003: 17). To be considered an early schema Unrelenting standards/hypercriticality must present with significant difficulty with health, self-esteem, relationships or experience of pleasure. If it occurs later, it develops to mitigate early core schemas already at work. As a result, one might expect to see relationship difficulty characteristic of early schemas in some with Unrelenting standards/hypercriticality i.e. disconnection, rejection, enmeshment, entitlement or compliance.

CAT and Schema both emphasise relational difficulty and apperceptive distortion because they were designed for character based and intractable mood difficulty.

**m) Therapy with Perfectionists**

What happens in therapy with perfectionist clients may also be of use in understanding perfectionist relating. Therapeutic outcome research literature documents aspects of relationship experience and indicates what works and what does not work in therapy or seeks to. Most is quantitative and selects participants based on perfectionism and distress scores and measures improvement using distress scores. There is some qualitative research.

The largest available analysed data set comes from 162 participants collected by the National Institute for Mental Health Treatment of Depression Collaborative Research Programme (NIMH TDCRP) (Elkin et al. 1989). The TDCRP delivered brief CBT, Interpersonal therapy and drug treatment to depressed perfectionist patients and is cited evidence that CBT is an empirically supported therapy for depression. The TDCRP
used the Dysfunctional Attitudes Scale (DAS) (Weissman & Beck 1978) to measure perfectionism and the Barrett-Lennard Relationship Inventory (B-L RI) to measure Empathic Understanding, Level of Regard, Unconditionality of Regard and Congruence of the therapists (Barrett-Lennard 1965). Elkin and colleagues found that higher B-L RI scores at the end of session two significantly reduced the negative effects of perfectionism on treatment outcome in mid-range perfectionists but that negative effects were not reduced low and high scoring perfectionists (Elkin et al. 1989).

Blatt, Zuroff, Quinlan and Pilkonis compared the date for More-effective, Moderately-effective and Less-effective therapists. More-effective therapists reported psychological rather than biological understandings of depression and were more likely to use psychotherapy as opposed to drugs or electro-convulsive therapy (ECT). They used psychotherapy alone 73.8% of the time, in combination with medication 19.6% of the time and with non-therapy methods 6.6% of the time. They expected therapy to require more sessions, had less variability in outcome across patients and had lower dropout rates than other therapists. Moderately-effective therapists used psychotherapy alone 29.4% of the time, psychotherapy and medication combined 56.1% of the time and medication alone 14.4% of the time (Blatt, Zuroff, Quinlan & Pilkonis 1996).

Blatt, Zuroff and Hawley concluded that relationship factors in the TDCRP accounted for 22% of outcome variance. Pre-treatment self-critical perfectionism accounted for 9%, level of pre-treatment symptoms for 4%, patients’ contribution to the working alliance in the 3rd session for 4% and pre-treatment social network for 4% of variance in outcome (Blatt, Zuroff & Hawley 2009). Relationship factors appear important for alleviation of perfectionist distress and how well the therapy relationship works, the strength of the alliance, patient contribution and their existing relationships potentially all play a role in improving distress.

Blatt, Shahar and Zuroff suggested enhanced capacity to cope is a more efficacy discriminating measure than symptom reduction and that: “Pre-treatment level of perfectionism impacted on therapeutic outcome primarily by disrupting the patient’s quality of interpersonal relations both in the treatment process and in social relationships outside of treatment” (Blatt, Shahar & Zuroff 2002: 322). Overall, capacity to benefit and
outcome were significantly influenced by interpersonal aspects of life and treatment and the personal qualities of therapists and patients because of their impact on the forming of therapeutic relationships (Blatt, Shahar & Zuroff 2002).

Zuroff and Blatt found that perfectionist patients had greater interpersonal difficulty, poorer therapeutic alliance, more limited social networks during treatment and were more vulnerable to stressful life events in the 18-month follow-up period than non-perfectionists. The increased depressive affect in these patients was, to Zuroff and Blatt, because they had not developed the capacity to cope with stressful life events during treatment (Zuroff & Blatt 2002).

Blatt concluded that short-term treatment for depressed perfectionists was relatively ineffective. An average of 4 sessions per week over of 15 months was considerably more effective for disturbed introjectively depressed patients (Blatt 1995). Again, in The Menninger Psychotherapy Research Project, introjectively depressed patients made greater therapeutic gain in 5 sessions of psychoanalysis per week than in twice weekly psychotherapy (Blatt 1995).

Overall, the TDCRP data confirms the need to find out what is happening in perfectionist relationships especially given the apparently important role of relationships in alleviating distress.

In a smaller scale study, Pleva and Wade used CBT in Australia. 24 participants completed Anthony and Swinson’s CBT protocol in Guided condition (with a helper) and reported clinically significant improvement in perfectionism. Improvements were in Concern Over Mistakes, Personal Standards (Frost et al. 1990), Obsessionality (29%), Depression (38%) and Feelings of Responsibility (54%) (Pleva & Wade 2007). A 3-month follow up indicated therapeutic gains were maintained but it is not clear if improvements were maintained beyond that. 20% of those in the Unguided condition (without a helper) reported increased depressive symptoms throughout treatment and follow up. Depression also increased in the Guided condition participants by follow up (Pleva & Wade 2007). Depression levels remained below pre-treatment levels but these changes may not have held over time.
Riley, Lee, Cooper, Fairburn and Shafran gave 8 participants 8 sessions of manualised CBT using their own measures and protocol. The protocol included: psychoeducation; cognitive restructuring of thoughts, standards and rules; and broadening schemes for self-evaluation and was adapted from an eating disorder protocol. Reduced clinical perfectionism and depression (BDI-II) was observed and maintained through 8 and 16 week follow ups. The authors concluded the therapy was clinically significant in reducing psychopathology co-occurring with perfectionism and see perfectionism as unidimensional and so did not expect the therapy to reduce trait measures (Riley, Lee, Cooper, Fairburn & Shafran 2006).

Riley, Lee, Cooper, Fairburn and Shafran carried out a randomized controlled trial of CBT with 20 clinical perfectionist participants, providing 10 CBT sessions in 8 weeks. 18 completed the trial and 15 were significantly improved (effect size of 1.8) and treatment gains were maintained at 8-week and 16-week follow-up (Riley, Lee, Cooper, Fairburn & Shafran 2007). Again, these studies were short-term and did not address the therapeutic relationships involved.

Kutlesa and Arthur conducted a group CBT study involving cognitive restructuring, role-modelling, self-reinforcement and stress reduction techniques, and aimed to convert negative perfectionism into positive perfectionism (Kutlesa & Arthur 2008). This was effective for aspects of perfectionism measured by the HMPS (Hewitt & Flett 1991). It is not known if participants maintained treatment gains following the treatment (Kutlesa & Arthur 2008). The study raised a useful question about the typicality of perfectionists who self-select for group therapy, as perfectionist self-concealment may make revealing activities undesirable to typical perfectionists (Kutlesa & Arthur 2008).

Radhu, Daskalakis, Arpin-Cribbie, Irvine, and Ritvo studied 47 maladaptive perfectionist students using the Perfectionist Cognitions Inventory (Flett, Hewitt, Blankstein & Gray 1998), APS-R (Slaney et al 2002) and HMPS (Hewitt & Flett 1991) and found that participants in a 12-week online CBT course demonstrated significant decreases in anxiety sensitivity and negative automatic thoughts compared to the control group. Reductions in perfectionism scores significantly correlated with positive changes in
depression, anxiety, stress and automatic thoughts (Radhu, Daskalakis, Arpin-Cribbie, Irvine, and Ritvo 2012).

In contrast there are a much smaller number of non-CBT studies. It appears that despite the findings of the TDCRP, subsequent outcome studies have focused on short term, low contact treatments, not on the therapeutic relationship. This suggests TDCRP findings have been overlooked. This may be for number of mainly political reasons which have involved: misuse of research design, economic pressure in health care systems, power dynamics affecting research funding and straightforward misrepresentation of the results of the TDCRP.

Perhaps an example of this, is the widely disseminated but reductive meta-analysis of interventions by Lloyd, Schmidt, Khondoker and Tchanturia. Targeting perfectionism in individuals with psychiatric disorders, it reduced 1183 studies in peer reviewed journals to 8 studies which used CBT online, in person or as self-help and suited its method of statistical analysis. Participants had HMPS Socially-Prescribed scores of 59+, Self-Oriented scores of 70+ (Hewitt & Flett 1991), high FMPS Personal Standards, Concern over Mistakes and Doubt about Actions subscale scores (Frost et al. 1990) and APS-R Discrepancy subscale scores of 42+ (Slaney et al. 2002) and it used PCI and Clinical Perfectionism Scale (CPS) (Fairburn, Cooper & Shafran, unpublished) to establish perfectionism and a variety of measures for distress. The conclusions were “There is some support that it is possible to significantly reduce perfectionism in individuals with clinical disorders associated with perfectionism and/or clinical levels of perfectionism. There is also some evidence that such interventions are associated with decreases in anxiety, depression, eating disorder and obsessive-compulsive symptoms. Further research is needed in order to investigate the optimal dosage and format of such interventions as well as into specific disorders where there is a lack of evidence for their effectiveness“ (Lloyd, Schmidt, Khondoker & Tchanturia 2014).

To Shedler, TDCRP data misrepresents the efficacy of CBT, Manualised Interpersonal Therapy and Psychoactive Drugs. The positive effect of CBT for depressed participants was statistically significant but less well reported was that this effect was only a 1.2 improvement on the 54-point Hamilton Depression Rating Scale. Although statistically
significant, this is not clinically significant. Shedler cites the conclusion on the original project “There was limited evidence for the specific effectiveness of interpersonal psychotherapy and none for the cognitive behaviour therapy.” (Elkin et al. 1989 in Shedler 2015). Shedler suggests that the phrase ‘evidence-based’ has been commandeered by a dominant master narrative which labels any therapy not ‘scientifically proven’ (by RCT or EST) as antiquated and ineffective irrespective of its actual efficacy.

Non-CBT studies which have reached completion include Rice, Neimeyer and Taylor. They documented the efficacy of 20 Coherence Therapy sessions with 18 perfectionist participants and self-help with 19 other participants. All were screened for APS-R perfectionism (Slaney et al. 2002) and procrastination. Coherence therapy is a targeted brief therapy which explores the deeper emotional truth of symptoms, stays focussed on the presenting symptoms and without seeking to counteract them. They concluded it worked well for maladaptive perfectionism (APS-R Discrepancy subscale) and the improvement continued after therapy. Discrepancy scores reduced further in the 6 months after. Conversely the benefits of self-help quickly diminished and mean APS-R Discrepancy score was higher at 6 months than at pre-test for those in the self-help condition. This small study with US undergraduates had a high attrition rate by follow up but nevertheless indicates that emotional understanding and integration is helpful for treatment gain (Rice, Neimeyer & Taylor 2011).

In Italy, Dimaggio and Attina carried out long-term relational therapy with a man in his early 20s. This involved 2.5 years of Metacognitive Interpersonal Therapy (MIT) and he no longer met diagnostic criteria for Narcissistic Personality Disorder (NPD), Antisocial Personality Disorder (APD) and Personality Disorder Non-Specified (PD-NOS) after therapy. He reported less social phobia, fewer depressive feelings and higher functioning (Dimaggio & Attina 2012). It is not known if these treatment gains held over time.
Case study and non-CBT therapy studies like this are difficult to find where those like Lloyd et al. are easily accessible and widely disseminated despite being problematic. The quantitative studies based on self-report scores for distress and perfectionism and fail to recognise bias or confounding variables. For example, reporting improvement to please or support a therapist or be good client. This is pertinent to perfectionists who are sensitive to failure and tend to self-concealment. They also do not consider life context and shed little light on what is efficacious about the interventions they describe. Indeed, to Blatt, Shahar and Zuroff; “Efforts to identify empirically supported treatments (ESTs) are often seriously flawed for two fundamental reasons: 1) They focus on differences in the techniques of treatment and ignore interpersonal dimensions of the treatment process and 2) they focus on symptom reduction and neglect change in vulnerability as a primary criteria of therapeutic gain” (Blatt, Shahar & Zuroff 2002 in Norcross 2010: 315).

In fact, the available evidence base for therapies with depressed perfectionists is insubstantial and may misrepresent the experience of perfectionists in psychotherapy and their experiences of the relationships. Evidence for relational and interpersonal therapies is scant partly because non-EST or RCT qualitative methods are effortful to conduct and easily dismissed as anecdotal or not rigorous (Shedler 2015). Consequently, outcome studies account poorly, if at all, for how perfectionists experience relationships. The literature reviewed above also indicates that perfectionists may be being excluded from quantitative representation though narrow selection methods and that they often do not fare well in their unassisted conditions. Subjective experience of therapy is not well documented, and the over emphasis of EST appears to be a wrong turn (Blatt, Shahar & Zuroff 2002). Because of this, perfectionists considering or entering therapy may encounter therapy poorly attuned to their needs. If this is so, their own investment and commitment may reflect that, particularly if they tend towards avoidance and self-reliance.

**n) Missing Perfectionist Voices**
The voices of perfectionists are most often represented by scores on psychometric measures. This is problematic because it does not capture the subjective nuanced experience of perfectionism and instead sets experience into generalised reductive statements. It also does not allow that perfectionism may fluctuate or apply to a greater or lesser extent over time.

Measures may further distort this picture e.g. describing an individual as ‘Self-Oriented perfectionist’ (Hewitt & Flett 1991) ignores that they may also score highly for Socially-Prescribed perfectionism (Hewitt & Flett 1991) and interaction between subscales is not well researched. The psychoanalytic, trauma and attachment literatures all suggest perfectionism is dynamic i.e. individuals may be self-oriented in some situations and not in others and fluctuations may be triggered by specific vulnerabilities and at specific times.

Lundh, Saboonchi and Wangby emphasise that associating one factor e.g. High Standards, to adaptive perfectionism is misleading if this co-occurs with other factors e.g. High Concern over Mistakes or Doubt about Actions (Frost et al. 1990) (Lundh, Saboonchi & Wangby 2008). This has significant implications for variable centred research seeking to isolate perfectionistic dimensions, but which may effectively decontextualize experience and ignore those who score highly on all counts (Lundh, Saboonchi & Wangby 2008).

The voices of perfectionists themselves are conspicuously absent from the clinical literature, and thus, so is rich description and first-person narrative about the nature of their relationships. The available qualitative research appears to be about gifted students, athletes and performers i.e. the voices of conventionally valued and impressive individuals are disseminated through mainstream channels. In the case of suicide studies, it is worth noting that only research about the deaths of men in western cultures is widely available.

The themes found in non-clinical research may indicate something about the nature of perfectionist relating. Sport Psychologists Hill, Witcher, Gokwals and Leyland
interviewed 15 participants. They were self-identified, undiagnosed perfectionists and the researchers used thematic analysis to identify themes of Drive, Accomplishment and Strain. They capture the dichotomous nature of being perfectionist. On the one hand, participants had ever-increasing standards, obsessiveness, rigid and dichotomous thinking and dissatisfaction. On the other, they had greater capacity for success in their respective domains accompanied by personal and interpersonal difficulty (Hill, Witcher, Gokwals & Leyland 2015).

A qualitative interview study by Speirs Neumeister with gifted perfectionist college students looked at factors contributing to Socially-Prescribed and Self-Oriented perfectionism (Hewitt & Flett 1991). She found evidence of parental perfectionism and authoritarian parenting which led to themes of: Perception of stringent expectations; Self-worth tied to achievement and; Fear of disappointing others contributing to development of Socially-Prescribed perfectionism. Themes contributing to the development of Self-Oriented perfectionism were: Mastery of early academic experiences without effort; No previous experience with academic failure and; Modelling of parental perfectionism (Speirs Neumeister 2004).

These two studies reflect their participants experience and provide a depth of information which could be helpful for understanding perfectionist’s relationships. Specifically, that they are prone to rigidity, strain, fear of other evaluation, approval seeking, personal and interpersonal difficulty etc. However, they represent only a narrow, well-regarded and highly successful selection of perfectionists.

6. Rationale

My desire as a Counselling Psychologist is to act in the best interest of my clients and to do what works to alleviate distress. In seeking a deeper understanding of the relationship dynamics at work in perfectionists (and in myself) a dearth of current qualitative research about relational work with perfectionists and about relationships more generally became clear. The literature reveals that not only does therapy appear to be negatively influenced by perfectionism but that relatively little is known about
why this is. To Habke and Flynn; “Questions remain regarding why perfectionists experience this difficulty [in engaging in therapy] and how they avoid increasing intimacy in therapy” (Habke & Flynn 2002).

The reviewed literature Psychoanalytic, Cognitive Analytic and Schema Therapy literatures all construct accounts of perfectionism which suggest that perfectionism affects relationships (e.g. disruption and mistrust). However, there are no qualitative studies about relationships. Given how often perfectionism is described as a pervasive, therapy interfering and distressing, this is surprising.

Counselling psychology is well poised to explore whether perfectionists first-person accounts of their relational lives correlate which what is both in and suggested by the literatures considered and what is missing from the literature and how to improve the offering for perfectionists.

The why of this project is to provide information about perfectionist relating because despite relationship-based therapy achieving good results with perfectionists where good alliances are achieved, there is an historic and ongoing difficulty in reaching and retaining perfectionistic clients and sustaining their gains. This is evident in recovery and relapse rates of depression (Barlow 2001), low ratings of alliance by perfectionist clients (Brustein 2014), and most tragically by the perfectionism retrospectively evident in the lives of suicide victims (Kiamanesh, Dyregrov, Haavind & Dieserud 2014) (Bell, Stanley, Mallon & Manthorpe 2010).

What is known about perfectionist relating in a therapeutic setting has been gleaned from predominantly quantitative sources and, whilst useful, a large portion of the research literature is, or has been, subject to distorting political and economic forces. These have potentially obfuscated relational information about perfectionists (Shedler 2015). According to the Division of Counselling Psychology of the British Psychological Society, Counselling Psychologists: “understand diagnosis and the medical context to mental health problems and work with individuals’ unique subjective psychological experience to empower their recovery and alleviate distress” (BPS 2017). Arguably, we have a duty of care not to be recruited to political agendas which side-line or fail to
consider the best outcomes for our clients. Furthermore, Counselling Psychologists are faced with negotiating paradigmatic divides between the sometimes-competing priorities of therapeutic models, medical diagnoses, economic concerns and the proper subjective understanding of the experience of the client which is certainly the case with perfectionists as a client group. In addition, because Counselling Psychologists spend longer in training than psychotherapists, often having more therapeutic experience on qualification than Clinical Psychologists, they can find themselves seeing highly distressed individuals early in their careers. This makes knowing ‘what works’ important for all concerned.

In 2007, O’Connor wrote “To date, only one peer reviewed study has successfully developed an intervention to modify perfectionism as a problem trait itself. The dearth in the literature may be due to the lack of clarity about the nature of the relationship between perfectionism and distress.” (O’Connor 2007). As with Zuroff and Blatt, this suggests that researchers in the field may have been missing the point and as a result, the therapeutic professions are not being very helpful. Ten years on, CBT treatment protocols have been developed and more outcome studies have been carried out, but these have not truly shed light on what is effective therapy. Neither have continued efforts to capture perfectionist experience in self-report instruments. The statistical correlations between perfectionism and distress remain unclear. Seeking to understand the impact of perfectionism on relationships and so on the means of distress alleviation is a more apposite and humane use of our professional resources.

The silencing, isolating and destructive nature of some perfectionism is evident. Its constituent beliefs probably contribute to perfectionists delaying entering therapy, entering when highly distressed or not entering at all. This last has potentially lethal consequences as The Samaritans report and the death studies reviewed, describe. (The Samaritans Annual Report 2015).

A study looking at expressive writing in perfectionists saw many participants become visibly distressed and tearful during the exercises. The themes and categories included; Stress (academic, relational), Relationships (family, social support, interpersonal strife), Coping (avoidance, interactions, physical activity, drinking), Expectations (self-imposed,
parental, unmet, self-critical), Perfectionism (identity, definition) and Academic and Professional Goals (commitment, uncertainty). Despite their distress and the breadth of struggling experienced, the researchers concluded that participants were unlikely to seek help for distressing perfectionism, preferring to see it in terms of its positive aspects. (Merrell, Hannah, Van Arsdale, Buman & Rice 2007).

Lundt concluded, that categorising and defining perfectionism as problematic is off-putting to perfectionists (Lundt 2004) and the findings of the expressive writing study echo this (Merrell, Hannah, Van Arsdale, Buman & Rice 2007). Very few perfectionists wish to abandon their perfectionism i.e. part of their identity. Understanding this paradox, inner conflict and any related distress and finding ways to normalise, de-pathologise and improve the experience of it may be more fruitful than seeking to capture, label and eradicate it.

In short, it is our duty to listen to clients both individually and collectively. To Morrow, good quality research must consider trustworthiness, quality, subjectivity, adequacy of data and adequacy of interpretation in order to be of value to the field (Morrow 2005). Since there remains a near total absence of useful, qualitative, experience-valid, discursively-enfranchising and therapy minded literature about perfectionist relating, it is the intention of this study to remedy that gap.

7. Aim

This study seeks to understand perfectionists and their relationship experiences more deeply than those reviewed. Given the importance of early relationship experience, capacity for personal resilience and the centrality of the therapeutic relationship to the efficacy of psychotherapy, I believe this study is a timely contribution to the field. Coming from within Counselling Psychology, this study seeks to provide a voice to interviewees identifying as perfectionist and to offer a fuller understanding of how perfectionists describe, understand, experience, and imagine relationships and the possible impacts of this for support and therapeutic relationships.
8. Methodology

a) Research Philosophy

Philosophically, epistemologically and according to Scott, I am a realist “because it is asserted that there are objects in the world, including social objects, whether the observer or researcher can know them or not” and critical because I understand “any attempts at describing and explaining the world are bound to be fallible, and also because those ways of ordering the world, its categorisations and the relationships between them, cannot be justified in any absolute sense, and are always open to critique and their replacement by a different set of categories and relationships” (Scott 2005:635).

I believe there are large shared independent realities mediated by power relations and shaped by social, political, cultural, economic and ethnic values over time. In this respect, I am a Critical Realist as Ponterotto defines it. I subscribe to a belief that there may be more than one independent reality (Ponterotto 2004) and that the data research gathers may not provide direct access to these (Willig 2008: 13).

Critical Realism suggests that there may be discoverable truths about the psychological world which we are unlikely to find scientifically provable and replicable. Any ways of discovering and observing these are imperfect because these phenomena are too complex and changeable. However, all discoveries may have pragmatic value for the practice of psychology in the resolution of distress. This is philosophical pragmatism (James 1907) and seeks to avoid reifying theory beyond its useful value. As such my research philosophy is best described as a pragmatic critical realism which ‘differentiates the essence of phenomenon from their appearance’ (Losch 2009) and can accommodate individual understandings or constructions and that these are how we come to know external realities.

My understanding of how we learn socially and psychologically (consciously or unconsciously), fits most closely with Vygotsky's concept of internalization. He saw human cognitive development as a process of internalization mediated through practical activity in shared environments. This is culturally mediated and informed by interpersonal communication. Vygotsky revised this with his Zone of Proximal
Development. The lower limit of the zone is what the child can do alone, drawing on prior experience and the upper limit is what they can do with the help of a capable other (Vygotsky 1978). This means others significantly influence and alter what we internalise, achieve and learn.

Cottone’s description of ‘consensuality’ specifies that within a community shared truth can be held as absolute whereas to others it is held as relative to other truths. This describes my understanding of psychotherapy. A psychotherapy client describes their life and experience to their therapist, sharing truths they hold to be absolute and formed in communities and relationships. Therapists hold this truth as relative which can be essential to the process of therapy. The client and therapist construct some consensualities together about the client’s life and experience, to help the client.

My understanding of power relations can be summarized as Foucauldian in nature. This informs my view of how individuals act and think regarding structure and agency. For example, science has dominated western understanding about the best ways to know, discover, learn and think. Within this the medical discourse dictates how most people understand, illness, health, madness and sanity. Dominance continues to increase the power of a discourse and the power of its subscribers as it confers legitimacy and justification. Historically, religion has had this power in western society and continues to in some places. Dominant discourses suppress other discourses or explanations about phenomena and subscribers may be unaware of other explanations (Gutting 2005). Critical Realism fits with an understanding of power relations in Foucauldian discourse terms. According to Guba and Lincoln these positions share similar axiomatic elements i.e. bases for truth and “fit together comfortably.” (1994: 117).

b) Reflexive Statement

In respect of perfectionism I have occupied insider and outsider positions at different times in my life. I consider I am generally inside the experience of perfectionistic thought and fantasy but outside the compulsion to be perfect, inside the experience of perception that others expect me to be perfect but outside the experience of expecting it from myself. Being an insider researcher is beneficial in some ways but not others. Hayfield and Huxley observe that insider researchers’ familiarity with interviewee
experience strengthens their capacity for focussed, ethical research. It can also create problems e.g. high expectations of the researcher and erosion of boundaries between the researcher and the researched, with the researched treating the researcher as a friend or counsellor (Hayfield & Huxley 2015).

Both issues arose in this study. I discovered in my pilot interview, and subsequent interviews that my disclosed perfectionism was important to the interviewees. It was important for their faith in me as a person and as an interviewer. For some, it guided whether they felt I would understand them. I began to wonder if this impacted in other ways and if interviewees' perceptions of my personal presentation, orderliness, time-keeping or commitment for example affected the interviews, rapport or results. I tried to maintain consistency and similarity about what I disclosed to each interviewee.

Counsellor and perfectionist are two of my statuses or memberships. These might also be described as consensualities to which I am connected. I also identify as cisgender, white, female, British, able-bodied, in my 30s, in training, a postgraduate student, conventionally educated, middle class and from a white, wealthy and provincial city in England. I am therefore comparatively privileged and, other than sexism and gender discrimination, I have not faced discrimination regarding race, disability, pregnancy, sexuality or on visible difference grounds. I see the world through a lens informed by these experiences and memberships and others may see this about me.

This has important consequences for interviewees' perceptions of me, particularly that I shared more memberships with some than with others and that this is likely to affect rapport, disclosure and trust. The interviewees had experienced divorce, parenthood, being male, cancer diagnosis, cancer recovery and being American. Our differences were useful because interviewees tried hard to explain experience they perceived I did not share. It was less useful when they presumed I shared their experience.

My interests include oppression, relational trauma, relating ability, discrimination on mental health grounds, experience of distress and resolution of this. My interest in perfectionism heightened after I carried out a grounded theory-lite qualitative survey study of the processes of perfectionism. That study concluded that perfectionism could
cause distress experienced as being *Trapped in a Cycle of Negative Evaluation*. It affected health, confidence and relationships according to the participants. Many felt it was integral to their self and desirable, despite causing distress and exhaustion. I wondered if it was possible to get the benefits of perfectionism without its disadvantages.

Historically my assumptions have been that perfectionism: has positive and negative consequences; is societally and culturally encouraged; has personal disadvantages which are disregarded; is often treated as a joke; involves varied experiences; is widespread; is part of the self and so has emotional, cognitive, behavioural, attitudinal, physical and possibly other manifestations.

My agenda with regards to perfectionism was to investigate and understand relational barriers to benefitting from therapy, having experienced the discomfort of perfectionism myself and being pragmatic and committed to alleviation of distress, the efficacy of Counselling Psychology and the value of the profession more generally. I also prefer to avoid recruitment to conceptualisations of problems, particularly reductive or simplistic ones which do not appear to contribute to proper understanding of them or to their long-term resolution and I increasingly suspected that perfectionists and perfectionism were subject to this given how often the therapy in the literature appeared to be ineffective, unattractive or missing the point.

I was concerned about the risk of insider status leading me to making assumptions and overlook important aspects of the data (Kanuha 2000). To address this, I kept a personal journal and took opportunities to talk about the study, the interviews and the analysis with colleagues and supervisors. These conversations widened my thinking and challenged my assumptions. This lead me to consider Critical Language Awareness and avoid relying on pathologising or mainstream language (Fairclough 1995) at least without caveat. I used ‘perfection-seeking’ in communications and interviews where possible, asked interviewees for their own definitions and disclosed my uncertainty about popular and clinical definitions of the term.

Throughout this study, I have continued to reflect on my own desire to be perfect and the effects of this. My fantasies of perfectionism contributed to performance anxiety about the interviews and some retrospective rumination about their quality. The
anxiety related to any negative emotional effect the interviews may have had on interviewees. The fantasies contributed to a struggle with procrastination. I recognise my perfectionism relates to productivity and I find it difficult to say no to other commitments and accept that I have finite resources. This is exacerbated because I have Chronic Fatigue Syndrome and a belief that I may be less productive than in the past.

c) Methodological Considerations

The aim of this study was to talk to and listen to interviewees describe their experiences, understandings and imaginings. Semi-structured one-to-one relational interviews (Josselson 2013) offered the best opportunity to gather the rich data needed and an opportunity to clarify and deepen exploration of interviewees’ ideas and experiences at the time of interview. Josselson describes the aim of interview as to “document people’s experience of self-understanding and working models of the world they live in so we may later attempt to make meaning of these phenomena on levels of analysis beyond simple description of what we heard.” (Josselson 2013: 2). Perfectionism and relationships are sensitive, personal subjects and relational interviewing has benefits for building rapport with interviewees. Interviews are also desirable because personal narratives are “the most internally consistent presentation of presently understood past, experienced-present and anticipated future.” (Cohler 1982 in Josselson 2013: 4). In my view, relational interviewing can be contrasted with non-relationship focussed interviewing e.g. identical structured questions, asked in the same order to every participant irrespective of the interview relationship which allows the interviewee less autonomy in directing the interview.

Initially I considered Interpretative Phenomenological Analysis as a research method but selected Thematic analysis (TA) because it offers a theoretically flexible qualitative research method, free of methodological associations with specific research paradigms. IPA was attractive for the depth of exploration it allows but I wanted to consider the broadest number of relationships and individuals possible within the scope of the study. IPA also restricts the researcher to experiential and descriptive data and potentially precludes consideration of power relations, discourse or behavioural or relational aspects of the interviewees lives whereas TA does not. TA provides opportunity and
freedom to look at data collected in a wide-ranging way (Braun, Moller & Rance 2013). This privileges the ‘what’ of the research over the ‘how’ and follows Kvale’s logic that methods are ‘the way to the goal’ (Kvale: 1996: 278). TA allows inductive, theoretical and experiential analysis (Braun & Clarke 2013). The research question seeks data about patterns in interviewees understanding, perception and experience. TA fits with this and allows the opportunity to seek semantic meaning (what they say), latent meaning (why they say it) and – to a lesser extent for the purposes of this study - discursive or narrative meaning (how they say it). Braun, Clarke and Rance's account of how to use thematic analysis with interview data was useful (Braun, Clarke and Rance 2013) and led to adopting Braun and Clarke's guide to Thematic Analysis (Braun & Clarke 2013).

Subjective experience and therapeutic relevance are intrinsic to the aims of this study and the multimethod style of coding was adopted to reflect this (Hesse-Biber & Johnson 2015). Specifically, I sought out descriptions related to intrapersonal and interpersonal experience and internal psychological processes including emotions, beliefs, attitudes and attributions.

The design of the analysis was in keeping with Creswell, i.e. the flow of logic in qualitative study begins with the purpose of the study, moves through the research questions discussed as data is collected from a small group and then voices how they will be analysed. Following this logic, this study looked at what, in the interviewees descriptions, relates to relationships, perfectionism and therapeutic change. It sought to capture this through inductive TA and document themes and patterns that arose. The study followed a coding process much like that in Creswell (Creswell 2012).
Fig. 3 - Data Analysis Spiral
Taken from 'Qualitative inquiry & research design: choosing among five approaches. Third Edition' and used with permission of the author R.W. Creswell and acknowledgement to SAGE Publications.

In line with Morrow’s thorough-going assessment of quality and trustworthiness in qualitative inquiry in Counselling Psychology, this study was concerned with: fairness, educative, ontological and catalytic authenticity, dependability, researcher reflexivity, praxis, 

verstehen  and particularity (Lincoln, Lynham and Guba 2011). Morrow also indicates that sample size is important and throughout the literature ‘

the magic 12’ interviews are considered to produce data sufficient to reach what Guba and Lincoln called redundancy and others call saturation (Guba & Lincoln 1994). This means that themes or explanations can be generated from twelve interviews providing they are of sufficient length, depth and quality (Morrow 2005).

Themes developed from twelve interview transcripts are likely to have the cumulative explanatory and informative weight desirable to critical and relativist inquiry i.e. enough to describe and interpret the experiences of interviewees and be useful to therapeutic professionals. With this in mind, I adopted a 15-point criteria for good thematic analysis (Braun & Clarke 2013: 287) (See Appendix 2).
d) Research Design and Strategy
This is an inductive qualitative thematic analysis study of interview data using one-to-one relational semi-structured interviews with twelve interviewees. It focusses on the relational experiences of interviewees self-identifying as perfectionist or perfection-seeking.

e) Research Ethics
The study has been designed to adhere to BPS ethical guidelines for Counselling Psychology (BPS 2009) and this study was granted ethics approval by the University of the West of England Research Governance Department (See Appendix 3). Pseudonyms were used to preserve the anonymity of the interviewees.

f) Interviewee Recruitment
Twelve interviewees were recruited through word of mouth, email, LinkedIn, Facebook, press advert and a website. I designed and built the website to recruit interviewees and host the research sheets and information (See Appendices 8, 9 & 10). The website featured a description of the study and of perfectionism (see Appendix 6).

This was a snowballing recruitment strategy and the only inclusion criterion was that interviewees identified themselves as perfectionist. This was intended to achieve a random purposive sample of interviewees from a range of cultural backgrounds, ages, nationalities, and avoid a homogenous interviewee group comprised of only university students.

- Facebook recruitment through public status updates linked to the website and posted on the researcher's profile. It advised that all information would be anonymised. This was shared and then shared by others (see Appendix 7).
- LinkedIn recruitment comprised an update describing the study and linked to the website, posted on the researcher’s profile and shared to others who also shared this (see Appendix 7).
- Email recruitment was through two circular emails which outlined the study and contained links to the website. These were forwarded to all contacts and re-forwarded by others, to their contacts.
• Direct and word-of-mouth recruitment came from talking to people about the study at several events and interviewees contacted me having heard about it.

• Press advert recruitment - the study was advertised in the Local Look, a free magazine distributed to 8,900 homes and businesses in Bath and Wiltshire. The publishers estimate that the publication reaches 20,000 people or more. It is distributed in rural and urban communities which vary in socio-economic profile (see Appendix 5).

One interviewee came from Facebook, one from LinkedIn, two via viral email, three from word of mouth, three via the press advert and three from direct opportunist face-to-face recruitment. Recruitment was carried out over a 2-year period.

**g) Interviewee Demographics**

The interviewees comprised three men and nine women and included nine who identified themselves as white and English (3 men, 6 women), one who identified as a white Latin American of German descent (now a UK resident), one who identified as an Australian born Chinese person resident in the UK and one who identified as a white American resident in the US. This study attracted a nearly entirely white group of interviewees – who Braun and Clarke characterised as the ‘usual suspects’ and all of whom identified as heterosexual and cisgender male or female (Braun & Clarke 2013).

English was the first language of eleven of the interviewees and Spanish was the first language of the twelfth. Care was taken not to assume any individuals were ‘without language’ or not ‘mother-tongued’ with English and so decolonise the research process (Al-Hardan 2014).

The interviewee ages ranged between 33 and 67 and their occupations included: student, teacher, electrical engineer, therapist, senior executive, care home manager, psychologist, social worker, project manager, training manager, finance copywriter and retiree.

Eleven had been married or cohabited with a long-term partner, six were married at the time of interview and six had been divorced. Seven of the interviewees were parents
and some had experience of step-parenting and blended families. All interviewees were raised by at least one of their own parents. Ten of the interviewees had had psychotherapy at some stage and of these, six had seen more than one therapist.

Interviews were conducted between December 2014 and September 2016. Nine were conducted face to face in the southwest of England, one in the southeast and two over Skype.

**h) Data Collection**

Interviewees were invited to look at the website and all were sent the Research Information Sheet (see Appendix 10) detailing the purpose of the study, their role in it, and how to withdraw from it. They were also sent the Participant Information Form (see Appendix 9) and Participant Consent Form (see Appendix 8) and Further Information about perfectionism and where to get support (see Appendix 11). On receipt of consent, interviewees were contacted, and interviews were scheduled in person where possible or on Skype.

All questions about the study and their participation were answered and they were reminded of their right to withdraw their data at any time. Interviewees were asked where they’d like to be interviewed and advised to allow 2 hours to be interviewed. Refreshments were provided at the interview and interviewees were given Further Information sheets and reminded of their right to withdraw.

The interviews took place in interviewees’ homes, the interviewer's home and in rooms borrowed for the purpose. The interviewees were asked to ensure - where the venue was their home – that it was empty at the time of interview to ensure minimal interruption.

**i) The Interviews**

A pilot interview with a volunteer and experienced interviewer was carried out and it provided valuable information. Following this, I allowed more time for interviews,
double-checked power supplies in venues, carried back up equipment, revised questions to produce more open and wide-ranging answers, scheduled breaks and increased the level of personal disclosure to build rapport.

The interviews were open, relational and semi-structured. The questions and statements in the interview schedule (See Appendix 4) were designed using Braun and Clarke and Josselson’s Relational Interviewing to keep the interviewees talking and focussed on areas of interest. They covered all key life relationships. Further, more detailed questions were asked spontaneously in interview where they were helpful in opening up a topic (Braun & Clarke 2013) (Josselson 2013). I described the interview process to interviewees prior to and during interviews. Interviewees were asked to talk about and describe their lives and relationships and the questions aimed to help interviewees to express their experience. I focussed on creating a comfortable environment for the interviewees and tried to deliver questions sensitively.

Personal disclosure covered my research background, interests, interest in perfectionism, my own perfectionism and offered a little information freely in response to interviewee questions. I avoided over-disclosing personal details because creating false intimacy through personal disclosure is ethically inappropriate (Braun & Clarke 2013).

When interviewees asked for more information about perfectionism, and therapy recommendations, I offered this after the interview and tried to avoid discussion during the interviews, to avoid taking an ‘expert’ position and thus diverting the focus. This sometimes proved difficult.

Interviews were conducted in a spirit of empathic interviewing. Integral to this is providing what Bion called ‘containment’ (Bion 1962). Josselson suggests paraphrasing, summarising, checking and mirroring interviewees’ responses where possible. I sought to remain aware of the process, the content and my own impact on the interviews. Interview relationships require attention to ensure they are functioning. The interviewee’s and interviewer’s perception of the interview relationship affects the
content and process of the interview, making interview data very context and perception-sensitive (Josselson 2013).

The intent was to follow and not lead the interviewees. Success at this varied and depended on the rapport and possibly the interviewee’s degree of confidence. To this end, I adopted a relaxed style, assured the interviewees that all experiences are normal and understandable, and stated that it was not possible to ‘get the interview wrong.’ Some interviewees were nervous and it was important to build trust and rapport with them prior to the interview. This took place by phone, email and in person.

‘Experience-near’ prompt questions were used and generally interviewees were encouraged to recount and describe relational experiences with specific people in their lives and their feelings about these. This approach allows more access to ‘markers’ i.e. what the experience meant to the person and accessed experience directly rather than via interviewees’ evaluations of their experience (Labov & Waletzky 1967). In practice, the interviewees tended to focus on experiences and evaluation of them. This appeared integral to the interviewees approach to their experience and to relating to me as the interviewer.

Some interviewees preferred to be questioned and waited at the end of each answer. Others preferred to talk more widely with only occasional prompts from me. These differences may have related to rapport, personal style and/or the power dynamics at work in the interviews. As a result, the interviews varied in style.

Three interviewees became tearful during their interviews when describing memories. I offered to pause at these times and tried to listen and encourage the interviewee to do what they needed to, and to handle their feelings sensitively. Some interviewees appeared to use the interview and the companionship as an opportunity to work through that distress. I allowed interviewees to continue whilst remaining gently focussed on the purpose of the interview and returning to that in due course. This has consequences for any hoped-for objectivity of the interviews. Ultimately it became increasingly clear that not only were many interviewees potentially constructing their accounts based on their interpretation of the questions and my desires but that these
interpretations and quality of the rapport overall with each individual made them highly subjective in all areas.

I was vigilant about rapport and about inadvertently or unintentionally shutting down interviewee responses. I sought to recap, repair or improve rapport where necessary and maintain a supportive, facilitative atmosphere.

At times, I was aware of following particular threads of the narrative at the expense of others. I tried to maintain a friendly permissiveness and to allow interviewees to speak freely and offer them opportunities to return to topics. In addition, I noted occasionally being shut down by interviewees, avoided, evaded, assisted, intimidated, entertained and impressed by interviewees as well as being disagreed with, making interviewees laugh, feeling empathy, feeling accepted and feeling cared about by them.

After the interviews, the interviewees were encouraged to reflect on their experience and contact me by phone or email if they had more to say about the interview, or if they had questions about the study or wanted to withdraw their data. Those that requested information about perfectionism and about therapy were sent further signposting information by email.

According to research, perfectionists can experience regret and retrospective negative evaluation of themselves and this may result in distress. For this reason, I encouraged contact after the interviews and assured them of the value of their contribution. I was careful to explicitly thank them for their time and effort at the time and to follow up with a thank you in writing. In the event, three interviewees emailed me following their interview. They wanted to wish me luck with the study and to let me know their thoughts after the interview.

j) Data Analysis

The interviews ranged from 61 to 117 minutes in length, lasting 82 minutes on average and were recorded on two digital Dictaphone devices. The files were uploaded to an encrypted back up service and transcribed via audiotyping. The transcripts exclude
‘ums’ and ‘ahs’, false starts, non-important interruptions, pauses but include all idiomatic noise words e.g. ‘you know’, ‘like’, ‘well’. Incorrect grammar is also included. The transcripts were all time stamped and typed using MS Word, Windows Media Player and headphones.

The transcribed interviews were checked against the recordings and read and re-read for familiarisation. The first reading was to compare the transcripts to their recordings for accuracy whilst listening to the recordings and making corrections. The second and third readings were to refamiliarise me with the interviews.

The transcripts were uploaded to NVivo 10, coded within the program. These codes (known as nodes in Nvivo) were later organised into folders. The codes sought to describe what was happening in the interviews including emotion, descriptions of events, people, relationships, perceptions, understandings, how the interviewee was relating to the interviewer and if their words or tone performed additional functions to what was said.

In the first stage, the data was coded with placeholder codes for how it related to life relationships. For example, Keith’s description of his father: “He is impatient but he’s an ill man he’s been ill for the last, he’s been ill since he was 53, 54 so he’s been battling cancer for a lot of years. He’s had a lot going on in his adult life from the early 50’s really but then he’s had quite a difficult upbringing he didn’t have a lot of love in his life” was initially coded with the placeholder code ‘Father-Child’. This was to record in Nvivo that it was about the nature of a parent-child relationship. In the second stage, I re-coded the placeholder codes with detailed codes to capture the content of each description. For example, the second half of Keith’s description was detailed coded with Parent-Father endured hardship (See Appendix 12 (i)). (The first half was detail coded as Parent-father with long term illness (not shown)).

Where possible I split utterances such as Keith’s where one part was relevant to one code and another was relevant to a second. However, sometimes, doing this risked compromising the meaning and context of an interviewees descriptions and so I elected to code these examples twice.
There were detailed codes relating to every type of relationship described or referenced including the interview relationship. Appendix 12(i) shows four examples of detailed coded utterances included under one detailed code; *Parent – Father endured hardship*. This was created from the placeholder code ‘Father-child’ including the description of Keith’s father above. Appendix 12(ii) shows four examples of detailed coded utterances from detailed code; *Parent– Father private, unemotional* also created from the Placeholder ‘Father-child’. Appendix 12(iii) shows a number of detailed code parent-related codes which were created.

The detailed coding aimed to capture content including both what the interviewees said (how they described relationship experience), what they described doing in relationships and what, if anything, they did in the interviews (relationship affecting behaviours) e.g. evading a question using tone of voice to indicate dislike or discomfort.

In the third stage, detailed codes were moved or merged into consolidated codes. *Parent- father endured hardship* became a consolidated code in that other detailed code were merged into it. The consolidated codes gathered similar descriptions of experiences together and reduced some twice coded examples when merged, e.g. when two detailed codes referring to the same example were merged in the same consolidated code, that example would then be coded only once with the consolidated code, not twice.

During the fourth stage, *Parent - Father-ended hardship* (which includes Keith’s description) was put into the *Difficult to reach parent* subtheme node, along with *Parent – Father private unemotional* (from Appendix 12 (ii)). Appendix 12(iv) shows the list of detailed and consolidated codes which were gathered into the *Difficult to reach parent* subtheme node. Appendix 12(v) shows all the subtheme nodes created, which by this stage contain most of the detailed and consolidated codes. In a fifth stage, these subtheme nodes were gathered into three main theme groups. The *Difficult to reach parent* subtheme node was gathered into the *Challenging relationships in the past* main theme.
The coding was reviewed during each stage for oversights. This was productive and showed when examples were overlooked, e.g. I initially overlook interviewees’ desire to help others as it seemed normal, possibly because I am in a helping profession. This process swept up omissions. I also looked for and retained outlying examples or non-sequiturs to ensure that they were not lost. Henwood and Pidgeon’s checklist for negative case analysis was useful for checking the comprehensiveness and consistency of coding in this respect (Henwood & Pidgeon 1992).

The whole process involved sorting codes, recording my thoughts, considering how various code groups hung together, moving nodes and both merging and unmerging them. This loosely reflected Cresswell’s data analysis spiral (See Fig. 3) but was less linear and with some backwards steps and reversals.

9. Analysis and Discussion

Analysis of the interview transcripts produced three main themes and thirteen subthemes in the interviewees’ descriptions of their relationship experience. Together they capture the interviewee’s experience of relationships and how they conduct them. The themes and subthemes summarise the topics and descriptions which occurred most regularly and appeared most significant to the interviewees.

The table below outlines these themes and subthemes (See Fig. 4) and the diagram which follows later in the discussion (See Fig. 5) shows how the themes interact and the relationship outcomes of this.
<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Subtheme</th>
<th>Illustrative examples of coded utterances in the subtheme</th>
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</table>
| Challenging relationship experiences from the past | Parents in conflict with one another | “...they used to have huge arguments, screaming shouting arguments. No violence or anything but a lot of screaming and shouting and my mother, well I came home from school one day when I was 14 and my mother had cleared the house full of furniture and we were moving out and she did it while my father was away on a course.” (Mary)  
“miserable marriage, absolutely miserable. They fought physically when I was a child. I had to break them up. Not punching but like throwing things at each other and shoving and stuff like that. We used to go to the neighbours to break them up. They married oh fifty years but they went through divorce proceedings three times.” (Sarah)  
“...they would argue so it was quite traumatic scenes which I wasn’t supposed to see but I’d dipped out onto the landing and at least listen and it was quite unpleasant.” (Olga) |
| Challenging relationship experiences from the past | Difficult to understand parent | “She’s a bit of a puzzle, difficult to describe. She was an only child and well I suppose looking back on it was kind of obvious but I think she was gay but I’m not sure. ...” (Mary)  
“She had a lot of issues because she had me young, so I think she just maybe resented me? I don’t get a lot of support from her. (Rita)  
“he didn’t play (the piano) with emotion, he was very technical and he had this song, he told my piano teacher it was in the wrong key so he had re-written it in the right key and he showed it to her and she just thought he was completely bonkers.” (Sarah) |
<p>| Challenging relationship experiences from the past | Difficult to please parent | “…I still remember her getting so mad at me about writing transitions in my papers and I was like come on, nobody else is gonna care. It is like ‘I care. You have to do it right and it has to be perfect according to me. I don’t care if you’re going to get an A anyway’” (Emma) |</p>
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<tr>
<th>Main Theme</th>
<th>Subtheme</th>
<th>Illustrative examples of coded utterances in the subtheme</th>
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<td></td>
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<td>“... if I came home with an A+ on my project he’d be like, ‘where’s the other A, where’s the other plus’...so it always felt like I was being, I always felt like I was failing because I wasn’t meeting the absolute 100% best score all the time”. (Rita)</td>
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<td>‘always do everything you can and the best and make sure you give 100%, if you’re not happy if you’ve got a problem just go back on it and sort it out’ but he said ‘doing things right is correct, little things like cleaning up after you with a dustpan or brush ....’”. (Phil)</td>
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<tr>
<td>Challenging relationship experiences from the past</td>
<td>Difficult to reach parent</td>
<td>“My dad adored me but the drinking obviously got in the way of proper close family relationships really.” “I’m afraid your dad’s in his cups dear. He’s in his cups.”” (Olga)</td>
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<td>“...they didn’t really think about what was happening to me... because I was the oldest from about the age of maybe 9 they used to leave me in charge of everyone and they’d go off to movies and then like wouldn’t tell me when they were coming back”. (Rita)</td>
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<td>“…then she devoted her entire attention to this relationship and we were taken care by a maid.” (Katrina)</td>
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<tr>
<td>Challenging relationship experiences from the past</td>
<td>Traumatic events in relationships</td>
<td>“My mom had this kind of fabulous of ‘well you know it’s very common in the Jewish community’. He was Jewish, in the Jewish community it’s very common they have this over sexual way to approach things just don’t take it and I just heard the answer.” (Katrina)</td>
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<td>“...we had a happy home, it was all very stable and when that happened it was like opening a massive window and a gust of cold air coming in and all of a sudden, yeah it could happen to anybody .... made me realize that everybody is fallible but I don’t think I’ll ever really forgive him for what he did to mum” (Sue)</td>
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<td>“He pretty well died in front of me, well just round the corner by his mother’s flat. I was down on the ground floor, he was going down the stairs to see his mum, my gran, and I worked for Dad so when you see something like that happen and you know, your dad dying say about 10 yards on the other side of the door...” (Phil)</td>
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<td>Main Theme</td>
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<td>Feeling unpleasant sensations and emotions in</td>
<td>Feeling disappointed, misunderstood and</td>
<td>“I can judge other people by my standards so where I would go out of my way for friends and it doesn’t, that’s not returned I can take it really hard…” (Kate)</td>
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<tr>
<td>the past and present</td>
<td>not listened to by others</td>
<td>“…then when they didn’t do it you were disappointed and frustrated with them, felt bitter toward them.” (Lee)</td>
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<td></td>
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<td>“people quite often say I’m very competitive but actually I don’t think I’m competitive I think I’m a perfectionist and I think there’s a subtle difference” (Mary)</td>
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<td>“she was jumping to conclusions about me about things she thought were wrong that I thought weren’t an issue”. (Mary)</td>
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<tr>
<td>Feeling unpleasant</td>
<td>Angry, hurt, sad and vulnerable because of</td>
<td>“it pisses me off royally when people aren’t trained enough to do it right because this is what we’re supposed to be doing…” (Emma)</td>
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<td>sensations and emotions in the past and</td>
<td>others</td>
<td>“It was really tiring and sad. I would come home and cry every day.” (Emma)</td>
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<td>present</td>
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<td>“whenever ... we meet, she always wants to tell me what I should be eating, what exercise I should be doing should be doing even though I’m a health care professional and that really irritates me.” (Jennifer)</td>
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<td>“Yeah you can’t, everything you do just seems to matter so much and that feedback that you get from your teachers is, it hurts, like it goes straight to the bone right... (tapping on chest).” (Rita)</td>
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<td>“the anxiety that ensues from those standards debilitates you and you can’t do them, you’re kind of”</td>
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<td>Main Theme</td>
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<td>Illustrative examples of coded utterances in the subtheme</td>
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<tr>
<td>Feeling unpleasant sensations and emotions in the past and present</td>
<td>Feeling anxiety and fear for, or of, others</td>
<td>“immobilized.” (Kate)</td>
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<td></td>
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<td>“…I really kind of wound myself up about it.” (Mary)</td>
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<td>“What all happens is I start not sleeping, I started getting to where I couldn’t make the most simple decision like what to wear or starting to do that and when you work event management you have to make decisions 20 times a day and I couldn’t do it anymore.” (Sarah)</td>
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<td>“a downward spiral”, “I just wind myself up tighter and tighter and I stop sleeping which makes it worse…” (Sue)</td>
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<td>“I think if I spend too much time with her, my son might also die, sort of irrational.” (Jennifer) ‘Overwhelmed’ (Keith)</td>
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<td>“I think, like the force, it could be strong within me. I’m so glad that I didn’t have the chance to ruin somebody’s life. I think it’s so much better to be slightly detached and supportive or whatever.” (Emma)</td>
</tr>
<tr>
<td>Feeling unpleasant sensations and emotions in the past and present</td>
<td>Feeling distress and being in crisis</td>
<td>“I’ve just had enough. I don’t want to live my life like this anymore. I just want a rest. It’s just too difficult. That personal pain, you know, just never being satisfied, it’s just hurting you is the main thing.” (Lee)</td>
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<td>“…that I’ve done something really wrong and if I don’t know their birthdate then how on earth can I be good friends with them? It’s such a stupid thought to have, like lots of people forget peoples’ birthday.” (Rita)</td>
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<td>“I had really a stomach pain and I was crying and so I think I had these years of incredible need of mum’s care.” (Katrina)</td>
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<td>“it just all came to a head and I couldn’t stop crying and everything felt too much and I couldn’t really even articulate what was going on” (Sue)</td>
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### Main Theme

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<th>Subtheme</th>
<th>Illustrative examples of coded utterances in the subtheme</th>
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</table>
| **Ongoing habits impacting on relationships** | “...it’s because I’ve had bad experiences with people in the past and I thought ok, never the twain are going to meet anymore so I’ve never been particularly close to anybody at work.”  
(Jennifer)                                       |
| Expecting disappointment and feeling suspicious of others | “...Sometimes I’m kind of like, the phone is ringing before he’s answered it and I’m thinking I know I’m not going to get what I need but I still do it. I’m still doing it and it’s like vague hope that it might result in...”  
(Kate)                                                  |
|                                             | “...she suggested I went to Al-Ateen when I was a teenager but I never did go. Not a great joiner really. They wouldn’t do things well enough for me would they? [Laughing]”  
(Olga)                                                 |
| **Ongoing habits impacting on relationships** | “I’m very list-oriented and I have to make sure the list is complete and then you have to finish the list and the list is important which drives my husband crazy and if something’s not perfect like, we renovated our place and it’s like well, it’s not perfect.”  
(Emma)                                                  |
| Exasperating others through striving                  | “But I think it drives him mad as well because of the way I stack the dishwasher, it’s got to be pretty well done the way I want it and then if there’s not space I’ll wash up by hand and he hates me washing it by hand.”  
(Olga)                                                  |
|                                             | “...I said ‘well you should have just told me, don’t worry it’s fine’ and he said ‘I did, I did say that’ but I was obviously so focused on him not doing it right, me needing to be there to do that, that I couldn’t even hear him say those words.”  
(Sue)                                                   |
|                                             | “I am really controlling I print my bank statements out every week and I go through them with a fine-toothed comb.”  
(Sarah)                                                 |
| **Ongoing habits impacting on relationships** | “...I haven’t explained things and that’s caused me to be misunderstood and then when I’m misunderstood I go, well wasn’t… that act wasn’t selfish, that was this. But then I don’t (explain), ... I’m a bit of a backroom guy in the sense, that I don’t want the limelight.”  
(Lee)                                                   |
| Avoiding others                                    | “I know what they’re doing, they’re trying to control me and the problem is I don’t lie down and take it so I...”  
<pre><code>                                                    |
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<tr>
<th>Main Theme</th>
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<th>Illustrative examples of coded utterances in the subtheme</th>
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<td>quite often end up I have a few male enemies where I’ve probably been a bit too direct in saying I wasn’t going to stand for something.” (Mary)</td>
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<td>“I need to keep her at an emotional distance and if I let her in too much then it gets warped for me and I get too drawn into her dramas and I get too recruited into parenting her basically” (Kate)</td>
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<td>“And really I wouldn’t choose her for a friend, really I wouldn’t choose any of them particularly as friends, because they’re all older, not that that makes them less worthy of being a friend, but we’ve got less in common.” (Olga)</td>
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<td>“My husband serves all my needs, but I think other than him, my sister is the one where she knows so much and it’s still ok.” (Emma)</td>
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<tr>
<td>Ongoing habits impacting on relationships</td>
<td>Evaluating, comparing and criticising self and others</td>
<td>“So everyone in our family was really smart and I followed three people who were super smart so I had to be super smart so all of us in high school were either in our senior class we were either ranked number 1 or number 2 ...but if I hadn’t been in the top 2, I hate to think, because our family was never average, never normal.” (Emma)</td>
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<td>“He auditioned for this advert and he was like oh I went for that and I said oh, I’m sorry. He said, it’s all right I’m not him am I? And I just thought ‘yes’. Whereas I’d be like, ‘what’s he got that I haven’t got and why’ that kind of thing...” (Kate)</td>
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<td>“We were so different from everyone in our class pretty much whether it was how we dressed or the car or the academics or whatever.” (Emma)</td>
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<td>“I never really particularly felt that I was in any clique or fitted in. I had friends and I would go to friends and friends would come to me but it was difficult with friends coming to me in case my dad was drunk.” (Olga)</td>
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<td></td>
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<td>“…he’s a wheeler dealer my brother. He’s got this business, he’s an eBay business on the side, to me it sounds dodgy but he’s good at that kind of stuff.” (Sarah)</td>
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<td>Main Theme</td>
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<td>“they’re both leeches and I don’t assume it, I know it”. (Phil)</td>
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</table>
i. **Challenging relationship experiences from the past**

This theme predominantly describes the interviewees' relationships with their parents. The interviewees noticed, assessed and recounted many negative rather than positive aspects of their relationships.

All the interviewees described difficulty in their parental relationships in childhood or early adulthood. Some were ongoing issues which dominated their early years and other difficulties developed later. Some were sudden and associated with a traumatic event.

The interviewees described experiencing parents as negative, critical, authoritarian and demanding. They also described distress, reactivity, addiction, illness, physical and emotional absence, neglect, attitudinal rigidity and marital relationship distress in their parents.

**a) Parents in conflict with one another**

Almost all the interviewees described parents in conflict, arguing, separating or divorcing.

Mary said her parents often argued and their marriage ended suddenly when her mother cleared out the house and left one day: “...they used to have huge arguments, screaming shouting arguments. No violence or anything but a lot of screaming and shouting and my mother, well I came home from school one day when I was 14 and my mother had cleared the house full of furniture and we were moving out and she did it while my father was away on a course.”

Sarah described her parents': “miserable marriage, absolutely miserable. They fought physically when I was a child. I had to break them up. Not punching but like throwing things at each other and shoving and stuff like that. We used to go to the neighbours to break them up. They married oh fifty years but they went through divorce proceedings three times.”
Although Rita’s parents remained married, the relationship struggled. She said: “...they’ve threatened to divorce several times which was awful”. She and her siblings were drawn into this: “I had to fly back home, sit them all down and have a round table discussion like ‘This is what we’re thinking. You guys are hurting us all continuing like this, telling one sister one thing, one sister another thing and it’s got nothing to do with us, it’s everything to do with you two.’ ”

Olga’s father was an alcoholic. Of her parents, she said: “…they would argue so it was quite traumatic scenes which I wasn’t supposed to see but I’d dipped out onto the landing and at least listen and it was quite unpleasant.”

Kate’s parents separated when she was a teenager and Kate was often caught in the middle: “… every time I was with my dad he’d be like, has your mum got a job yet, has your mum got a job yet and she actually at one point did have a job but I wasn’t allowed to tell my dad because then he would stop paying her so I had to lie and I was always in the middle.”

Keith believed that his mother would had left in different circumstances: “Mum probably would have left the day after he left (Keith’s’ younger brother) .... I think my mum would have left my dad. She’s not been particularly happy with him.” He described their relationship: “my parents have always been (clashing grinding sound effect) so they’re very much strong-minded both of them. My dad is exceedingly opinionated for a man and he rams it and mum will say what she’s gotta say so…”

Parents in conflict with one another describes the atmosphere of the interviewees childhoods and that they were having to cope with this. Some were mostly kept away from parental conflict (Olga, Keith and Lee). Some were drawn into it (Sarah, Phil, Jennifer, Kate and Rita). Others described witnessing it and associated distress (Sue, Mary and Katrina). Between them they describe witnessing fighting, arguing, anger, distress, avoidance and relationship breakdown. They described awareness of their parent’s difficulties, preoccupation and the dynamics between them and some were drawn into the parents’ relationships as mediators, peacemakers and/or caretakers of parents or other children.
There is little in the literature about perfectionism which indicates that parental discord is an experience common to perfectionists, but it was common to eleven of the twelve in this study. Coping with adult conflict as a child or even with an atmosphere of conflict has relationship implications.

Adult conflict can be beyond the capacity of children to understand and cope with and family members may also be overwhelmed which may result in emotional neglect of children involved. Also significant is that children may not differentiate the quality of parent-parent relationships from parent-child relationships. Children may then interpret all family relationships as conflicted (Cummings & Davies 2002). Childhood Emotional Neglect can occur in many ways, often unintentionally as a side effect of life events or the emotional lives of the adults involved (Webb 2012). This can be traumatic, and children may assemble a strategies to deal with anxiety caused by it. Walker describes this as trauma with a small ‘t’ i.e. small, traumatic, cumulative, everyday experiences which lead to Complex PTSD, as opposed to PTSD – usually triggered by a discrete event (Walker 2013). According to Walker, Complex PTSD symptoms include emotional flashbacks, tyrannical inner and outer critics, toxic shame, self-abandonment, social anxiety, loneliness, fragile self-esteem, attachment disorder, developmental arrest, relationship difficulty, mood vacillation, dissociation through distracting activity or mental processes, hair-triggered fight and flight responses, oversensitivity to stress and suicidal ideation (Walker 2013). Psychiatrist Lenore Terr differentiated single blow PTSD trauma from repeated blow CPTSD trauma (Terr 1991). Wortman, Battle and Lemkau highlight that psychological trauma effects are likely to be more severe if the trauma is human caused, repeated, unpredictable, multifaceted, sadistic, undergone in childhood and perpetrated by a caregiver (Wortman, Battle & Lemkau 1997).

Perfectionistic strategies or defenses may then develop in response to cumulative traumatic experience. Without the cognitive ability of adults. - children are likely to draw simplistic, polarised, black-and-white conclusions about themselves under emotionally misattuned or difficult circumstances - particularly where they have little contrasting or validating experience of others outside the family. Of the eleven participants with this experience, eight of them were the eldest child in their family.
Whilst this may be unremarkable, it is worth considering the impact of being the first or only born in a difficult family environment. Similarly, all the participants were raised in western style nuclear families which can socially isolate their members (Parsons 1951). This may heighten the chances of children drawing a conclusion about themselves that they are somehow central to the problems being experienced and leave these conclusions unchallenged. Butterworth and Harris describe this as an inability to distinguish between the subjective and objective (Butterworth & Harris 1994). To Jean Piaget, it was centration or egocentrism – children can only contemplate the world from their own point of view (Pronin & Olivola 2006). If they conclude that they are the cause of a problem and that a caregiver is unhappy, they may try to alleviate this by helping and being good, better or perfect. If this doesn’t work, they may simply try harder because they have few other acceptable strategies available to them.

Perfectionism also offers children a chance to get some control over situations where powerlessness distresses them. Good, helpful behaviour is encouraged and rewarded in children which makes trying to be good or perfect more likely. Perfectionism is a strategy which can be applied to several childhood problems and may offer children a way to get needed positive feedback from a challenging environment.

Interviewees Katrina and Sue acknowledged their perfectionism developed when they experienced feeling abandoned or profoundly disappointed by a parent and that they become more perfectionistic to cope with situations in life which produce anxiety.

The interviewees valued helping behaviours and being helpful highly and being helpful was what motivated some to volunteer for the study. They strive to understand and help others and described helping friends and family members. They value being helped also and described liking being helped by friends, wanting help from therapists as well as feeling unhelped by others. Many described being helpful throughout their lives and described awareness of both needing help and other’s need for help. Early atmospheres of relational conflict may contribute to a tendency like this because children are praised for helpfulness and in a conflict atmosphere, getting the right kind of emotional attention is difficult.
Cognitive Analytic Therapy, particularly its understanding of Reciprocal Role Procedures can elaborate on this point. Emotionally neglected, deprived or stressed children may feel they need help more often than children being regularly helped or those in more equable environments. Children with parents in need of help or emotional support may become conditioned to see need of help in others more clearly than those without. Help then, may take on great significance for these individuals and focus on helping, being helped or avoiding helplessness may follow.

b) Difficult to understand parent

This subtheme captures the interviewees descriptions of parents or aspects of experience of them which made them difficult to understand. Mary found her mother difficult to understand. To Mary, her mother was angry and confusing: “She’s a bit of a puzzle, difficult to describe. She was an only child and well I suppose looking back on it was kind of obvious but I think she was gay but I’m not sure. …” She said “I think I’m stretching a point to call it a relationship” and “I think it’s quite difficult to understand someone when you don’t, when you don’t know anything about them.”

Rita described a lack of relationship with her mother and a cultural divide in the relationship: “She had a lot of issues because she had me young, so I think she just maybe resented me? I don’t get a lot of support from her. It’s also the collision of cultures right, so Chinese people tend to be very focused on academics and I still haven’t quite figured out what Europeans are really focused on really.”

Kate’s mother had unrealistic standards about appearance. She remembered her saying: “… ‘but you’re prettier than Cindy Crawford’. I was like, what? And then you know I obviously corrected her and she got pissed off because she couldn’t, I don’t know, she couldn’t sort of handle that we’re not the best-looking people in the world or something. It was really strange.”

Sarah described her father as eccentric, obsessed and doing unusual things. Of She said: “he didn’t play (the piano) with emotion, he was very technical and he had this song, he
told my piano teacher it was in the wrong key so he had re-written it in the right key and he showed it to her and she just thought he was completely bonkers.”

To Lee, his mother: “got more and more extreme and pretty much unbearable and no one could stand being with her really.”. Lee sought to understand her: “they really had no money they lived in a caravan with her mother and her sister that had like nothing and I think stemmed from that everything’s really important like, don’t waste that, don’t do that”.

Like Lee, the interviewees with Difficult to understand parent experiences described trying to make sense of their parent’s actions and questioned and analysed parents’ behaviour during the interviews. They felt they did not know or did not understand the parent. They described parents who were crazy, unintelligible, unrealistic, culturally different and emotionally reactive for reasons they could not properly comprehend. Where the parent was distressed interviewees described taking responsibility for calming or helping parents.

The descriptions in this subtheme are striking for the unfamiliarity interviewees conveyed about their parents’ words or actions. This is reminiscent of Kohut’s description of how the failure to meet selfobject needs for mirroring, idealising and twinship occurs. The idealising selfobject need involves a desire to rely on or merge with an idealized other (the parent) in times of stress, similar to a desire to seek the resources of a secure attachment figure. When met, this need fosters healthy ideals, internal values, self-soothing and emotion regulation. We need idealising and for others to explain about themselves and their thoughts to feel safe and to set realistic goals for ourselves (Kohut 1971). These interviewees had not experienced idealising and had parents who it would have been unsafe or undesirable to merge with because they perceived that they did not know or understand the parent. It also likely that these parents did not mirror their children well or give them sense of twinship or affiliation; a feeling of being the same as the parent for the same reasons.

In keeping with Webb’s’ Childhood Emotional Neglect schematic (Webb 2012) the experiences interviewees described suggest they were lacking important and realistic feedback from parents as they could not understand their responses, perhaps because
those responses were unrelated or irrelevant to the children witnessing them. This is significant because children are apt to invent and internalise childish and simplistic standards for themselves because they lack an available moderate adult voice to internalise which helps to navigate life (Webb 2012), and so perfection can become their standard. The interviewees described the vulnerability and difficulty in setting realistic standards which Kohut would expect to see in those with poorly met idealising selfobject needs (Kohut 1971).

Cognitive Analytic Therapy expects to see patterns in individuals’ Reciprocal Role Procedures (Ryle & Kerr 2002). For example, CAT might expect adults with this experience to find others or find themselves unfathomable and that they may develop analytical and/or vigilant strategies to help them fathom out others. Alternately, individuals may experience themselves as undesirable, difficult to build relationships with, or untrustworthy as a result, and experience others in this way too. Reciprocal Role understanding can also explain avoiding and distancing behaviours some interviewees described as well as their questioning and struggling to understand others.

The language and questioning in the descriptions is also reminiscent of group 1 schemas outlined in Schema Therapy. These include: Social isolation/alienation; Abandonment/instability; Mistrust/abuse; Emotional deprivation and; Defectiveness/shame. Some perfectionists could be described as having some of these schemas or cognitive and emotional patterns of understanding. (Young Klosko & Weishaar 2003).

In attachment theory, having a **Difficult to understand parent** could be expected to lead to attachment insecurity and hyperactivation of the attachment system both as children and as adults because it denies the opportunity to internalise secure mental representations of others and the self (Main, Kaplan & Cassidy 1985). Hyperactivation in children is likely to show up in difficulty self-soothing, vulnerability to perceiving attachment threat and anxiety as anxious clinging, excessive self-reliance, ambivalence or dismissiveness about parents and significant other people. Attachment theorists Mikulincer and Shaver would expect attachment insecurity in individuals with **Difficult to understand parent** experience (Mikulincer & Shaver 2010). The interviewees went
on to express some emotional experiences that attachment theorists might expect them to have.

All interviewees had a second more emotionally reliable or available parent either at the time they described or later which may have mitigated the emotional effect of a *Difficult to understand parent*.

c.) Difficult to please parent

Interviewees described *Difficult to please parent* experiences. Parents had high standards and/or strong preferences for order. The standards usually related to personal appearance, conduct and academic performance and manifested in questioning, negativity, criticism, attention to detail and negative judgment.

Emma described her mother as demanding and angry when she perceived Emma had failed to reach her standards. She said “...I still remember her getting so mad at me about writing transitions in my papers and I was like come on, nobody else is gonna care. It is like ‘I care. You have to do it right and it has to be perfect according to me. I don’t care if you’re going to get an A anyway’”. Emma described her parents as: “withholding of the approval at the key moments of life…”

Rita’s father would make his disappointment clear. She said “… if I came home with an A+ on my project he’d be like, ‘where’s the other A, where’s the other plus’...so it always felt like I was being, I always felt like I was failing because I wasn’t meeting the absolute 100% best score all the time”.

Phil recalled his father explicitly instructing him how to do things: “always do everything you can and the best and make sure you give 100%, if you’re not happy if you’ve got a problem just go back on it and sort it out’ but he said, ‘doing things right is correct, little things like cleaning up after you with a dustpan or brush …””. Phil thinks there is no excuse for being poorly prepared.
Mary’s mother and grandmother were critical: “… grandmother would say, you’re putting on weight but it was direct. My mother would be more there would be a nastier side to it. ‘Ooh, that doesn’t suit you, you shouldn’t be wearing that’, there was a mean streak to it.” Mary said of her mother: “So she’d do a lot of that kind of stuff but it was more really just constant undermining. ‘You can’t…’, ‘What are you doing?’, ‘He’s not suitable.’ ‘Where do you think you’re going?’, ‘You can’t go out at this time’ that kind of stuff.”

Lee described his mother as authoritarian, perfectionist and harsh. Lee described her scrutiny: “It’s like a hawk. You do or say anything she’ll swoop down and wop! ‘What have you done?’ ‘You alright?’… I’d phone her up and say all right only me and she’d say ‘oh yeah’. And she’d say, ‘what’s wrong with you?’ ‘No I’m fine’. ‘You sound awful’. ‘No’. ‘This voice’. ‘There’s nothing wrong with my voice’. ‘Are you sure?’ ‘What’s wrong with you?’ Making you feel, you start to think no there is nothing wrong with me, there’s nothing and it’s that, even if there’s nothing to pick up on she’ll still pick up on something…”

Many of the interviewees described a parent as rigidly orderly or moral. Both Sue’s parents were orderly and procedure oriented. Her father; “always had a military, methodical approach to things.” Mary’s father was “not so much a perfectionist as meticulous. He would write down every mile he did in his car in a book…”

Keith described his father as morally-upstanding: “…a very honest man. My dad has never got a ticket or anything he’s never broken the law he’s as honest as they come. He’s also very old-fashioned he’s got real values he’s never so much as looked at another woman in all his life.”

Descriptions like these suggest approval was difficult to get for the interviewees. Their parents’ standards varied in what they applied to and overall could be rigid and onerous to live up to. Interviewees described parents as intolerant, critical or negative in response to things which did not fit with standards or expectations. The data in this subtheme includes descriptions of experiencing parents as critical, mocking, nagging, negative, undermining, unkind and passive-aggressive. A number described situations that could be considered as verbally abusive.
The descriptions are reminiscent of earlier clinical mainstream literature about perfectionism and its aetiology. They mirror the findings of Blatt: that parental relationships are disrupted in perfectionists (Blatt 1995); Blatt, Wein, Chevron and Quinlan, that perfectionists recall parents as less warm and nurturant than non-perfectionists (Blatt, Wein, Chevron & Quinlan 1979); and that some perfectionists experience high parental control over the self in teenage years (Soenens, Luyckx, Vansteenkiste, Duriez & Goessens 2008). The Difficult to please parent subtheme captures experience common to many in the study and that high standards and preference for order may transmit down through generations of a family. Many of the parents appeared perfectionist in some aspect and this supports the body of literature on the heritability of perfectionism which is well summarized by Flett, Hewitt, Oliver and Macdonald (Flett, Hewitt, Oliver & Macdonald 2002).

The psychology literature addresses the experience of perfectionists getting approval less clearly. Interviewees described achieving validation and approval from their parents, conditional upon achieving their standards. There was variation between interviewee experiences about how easy approval was to get. For example, Emma and Olga both described a parent as loving, approving and affectionate whereas Lee and Phil described being cared for physically or ‘looked after’ but not in warm and affectionate ways.

In Kohutian terms this subtheme suggests interviewees selfobject needs for mirroring (affirmation) and twinship (affiliation) were inconsistently met. Psychoanalysts Marmorosh and Mann researched the parallels between Kohutian Self-Psychology theory and Attachment theory and would expect to see ‘mirror hunger’ or a craving or need for approval later in life in individuals with this experience (Marmorosh & Mann 2014).

In attachment terms, interviewees with Difficult to please parent experience, may have internalized mental representations of others as critical or insatiable and unmet attachment needs and not being emotionally regulated may have led to shame. Shame is an adaptive emotion which breaks the self-other connection and serves to keep us safe from immediate threat. It can cause separation anxiety in children and repeated feelings
of shame may lead to internalising a negative, insecure mental representation of the self, characterised by feeling anxious or unsafe. Representations of others may be characterised by anxiety, mistrust and ambivalence which is created by repeatedly experiencing others as non-soothing (Mikulincer & Shaver 2010). Inconsistency in meeting these needs would be considered to produce a vulnerability in the individual to perceiving attachment threat (Mikulincer & Shaver 2010). This leads to hyperactivation of attachment systems and behaviours like approval-seeking. (Bowlby 1969). Shame is also instrumental in resolving inevitable early betrayal by parents and having to recognise that we must and are separate from them (Lewis 1987).

In trauma terms, inconsistency, depending on its severity and how it is experienced, is considered a form of Childhood Emotional Neglect (Webb 2012) or as cumulative small ‘t’ trauma which contributes to Complex PTSD (Walker 2013). Herman’s definition of Complex PTSD suggests it can result from being hostage to a ‘totalitarian’ family or possibly school environment (Herman 1992) which might have been the case for some of the interviewees who described pressured and onerous environments.

d) Difficult to reach parent

In the Difficult to reach parent subtheme, Kate described her mother as retaliatory and abandoning in response to criticism. She said: “I definitely have the message from my mum as a child that you can’t criticise her, you can’t tell her you’re pissed off ‘cause she’ll just come back with something bigger or she might not be there”. Kate’s mother was a heavy drinker and Kate said: “(she) just doesn’t deal with stress very well ....and my mum she’s always been a drinker but she hit the bottle very... [big time] big time yeah” Kate also described seeing less of her father when he found a new partner and finding both parents difficult to reach for a time.

Olga’s father also drank. She said: “my dad adored me but the drinking obviously got in the way of proper close family relationships really.” She remembered her mother saying “I’m afraid your dad’s in his cups dear. He’s in his cups.”

Rita described feelings of stress and responsibility from the burden of caring for her younger siblings alone: “…they didn’t really think about what was happening to me...
because I was the oldest from about the age of maybe 9 they used to leave me in charge of everyone and they’d go off to movies and then like wouldn’t tell me when they were coming back”.

Katrina’s mother remarried. She said “...then she devoted her entire attention to this relationship and we were taken care by a maid.”

Mary described her father as consumed by work: “his job really was his life and unfortunately when he retired, he died a year later so he kind of poured all his life into the gas board and then he died”.

Keith described his father as very private. He said: “he’s a typical man of that generation born in ‘34 very private man, not demonstrative in his emotions, is in his own world of Walter Mitty wherever that may be” Keith went on to say “He is impatient but he’s an ill man, he’s been ill for the last, he’s been ill since he was 53, 54 so he’s been battling cancer for a lot of years.”.

Many interviewees described a distracted, unavailable Difficult to reach parent. There was difficulty in making or maintaining emotional connection or intimacy and getting attention and help from these parents. The interviewees described parents distracted by; alcohol, work, illness, caring for others, marital conflict, avoiding their spouses, living elsewhere, new partners, their own distress and emotions, enduring hardship, postnatal depression and being emotionally unavailable due to temperament, parenting style or cultural styles of the time.

As with the previous subthemes in Challenging relationship experiences from the past, there is a sense of powerlessness in the descriptions, many had to accept less than desired parental attention and access and some (including Rita, Sue and Keith), felt they must cope without help as a result.

Again, experience like this be cumulatively traumatic (Walker 2013) and early environments like these may have made secure attachments difficult to make (Bowlby 1969) (Mikulincer & Shaver 2010). The organising force of affective attunement is
comparatively less available in these environments and this can lead to feelings of isolation and aloneness (Applebaum 1994). This is neglectful from an attachment viewpoint and attachment theorists would expect to see deactivating and avoidance strategies developing because of this experience (Mikulincer & Shaver 2010). Most interviewees described a **Difficult to reach parent** and a **Difficult to please parent**, suggesting that interviewees may respond to threat with hyperactivating (e.g. vigilance, approval-seeking) and deactivating (e.g. avoidant) strategies. Interviewees described overcompensating or undercompensating behaviours which fits this and makes attachment style worth considering with perfectionists in a psychotherapeutic setting. However, as David Wallin suggests, a state-based, fluid conception of perfectionists’ perceptions of attachment threat and attachment behaviours when triggered acknowledges that it is dynamic, and this is probably a more useful, less pathologizing, less iatrogenic conception of attachment than a traditional trait-based diagnosis of ‘insecurely attached’ for example (Wallin 1997).

Cognitive Analytic therapy might expect to see individuals with a **Difficult to reach parent** doing to themselves and others, what was done to them as Reciprocal Role Procedures. e.g. if they have been avoided, they may avoid their own emotions and those of others and not share their emotional life or information with others. In fact, this could account for the tendency to self-conceal found in many perfectionists (Hewitt, Flett, Sherry, Habke, Parkin, Lam & Stein 2003).

Psychoanalysis generally sees self-concealment as a defense mechanism against shame. For example, where the hidden feeling in Malan’s’ Triangle of Conflict is shame, the compulsion may be to conceal aspects of self felt to be offensive and which may be integral to perfectionistic defenses (Malan 1979). Interviewees described feelings of distress which are explored in the next main theme **Feeling unpleasant sensations and emotions in the past and present** but only one interviewee used the word shame. It is possible that interviewees simply did not mention feeling shame to hide the feeling or because they are unaware of it. Shame is agonising to acknowledge because it is experienced as a disorientating loss of self-cohesion (Lewis 1988) and remembering it can trigger the feeling again.
Shame-driven self-concealment could also be a learned or avoidant behaviour (Vygotsky 1978) (Bandura 1977). Avoidance makes it difficult to cognitively process emotions and interpersonal dynamics and those with avoidant strategies or who are dismissively, avoidantly or ambivalently attached are unlikely to behave in emotionally revealing ways (Mikulincer & Shaver 2010) (Levine & Heller 2011). Emotionally speaking, unavailability or tendency to conceal could result from shame and from learned behavioural strategies transmitted by care-givers.

**e) Traumatic events in relationship**

Many interviewees described discrete events that had shocked them. These included the perception of betrayal through: parental infidelity; a parent not believing or acting on a disclosure of abuse or a parent becoming unavailable due to illness in themselves or another. The sudden death of a parent was also traumatic. In addition, interviewees described traumatic experiences with other students, teachers and in other relationships.

Katrina’s stepfather sexually abused her, and her mother only minimally acknowledged this: “My mom had this kind of fabulous of ‘well you know it’s very common in the Jewish community’. He was Jewish, in the Jewish community it’s very common they have this over sexual way to approach things just don’t take it and I just heard the answer.” This dismissal felt like a betrayal.

Sue’s father was unfaithful to her mother and it deeply shocked Sue. She said: “...we had a happy home, it was all very stable and when that happened it was like opening a massive window and a gust of cold air coming in and all of a sudden, yeah it could happen to anybody .... made me realize that everybody is fallible but I don’t think I’ll ever really forgive him for what he did to mum”. It damaged Sue’s trust in her father. She remembered the moments after the news: “he drove away in the car, my mum just collapsed in a heap and started crying and then rang my sister, um, her sister and said ‘He doesn’t love me anymore, he doesn’t love me anymore.’ She came over and there were lots of tears, it was horrible”.

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Phil’s father died suddenly while Phil was nearby. It deeply shocked him: “He pretty well died in front of me, well just ‘round the corner by his mother’s flat. I was down on the ground floor, he was going down the stairs to see his mum, my gran, and I worked for Dad so when you see something like that happen and you know, your dad dying say about 10 yards on the other side of the door then obviously I had to be on my own since I was 21 and a quarter I was. My dad died and my dad was only 47.”

Sue, Keith and Mary’s lives changed with the swift onset of illness in a family member. Sue’s mother had to care for her father and both became less available. Sue now find it difficult to relate to her parents as well as feeling that her own family are disadvantaged by it. She said: “the knock-on effect of that is she hasn’t been around to help me with the boys at all.” Keith’s brother became seriously ill: “There was always a tremendous amount of pressure on us, the other three children, my brother was ill so we kind of got pushed out” and “it almost felt like as if we weren’t really disowned but then mum’s main priority was her son.” Mary witnessed her husband’s life-threatening fall, a traumatic experience.

Interviewees experienced traumatic events elsewhere too. Keith described a threatening school environment and was held at knifepoint by an attacker; Emma described feeling bullied at school; Lee and Sarah described teachers who were bullying; and Katrina described being exposed to sexually inappropriate situations with adults as a child. Jennifer, Mary and Phil experienced bullying or feeling harassed at work. Jennifer recalled being banned from using a phone or car by a step-parent when due to give birth. Interviewees also appeared to have felt betrayed by infidelity, recognising their partner did not love them, co-workers not taking phone messages properly or not following work protocol properly.

The events experienced as traumatic were perceived as threats to the self or others and accompanied by feelings of not being cared about or that care had been withdrawn. The events disrupted relationships and these often continued in a ruptured state. Interviewees were prone to feeling insufficiently cared for and distressed when others did not do as expected or did not meet their standards. They described hurt and being
affected by the actions of employers, colleagues, teenage sons, former partners, siblings, friends and parents.

The examples in this subtheme show that a thorough consideration of the role of trauma, particularly interpersonal trauma in relationship experiences could be central and significant to how the interviewees experience relationships more generally. What was felt as traumatizing varied a lot between individuals. For example, near fatal accidents and sudden disabling illness in a loved one was experienced by three interviewees and would be understood by conventional psychology to have a high chance of leading to PTSD. The failure of a colleague to take a phone message correctly, to follow work protocol properly or criticism from a colleague were arguably experienced by three interviewees as traumatic. These interviewees had been preoccupied, angry and hurt and potentially overwhelmed by these incidents which could have contributed to pre-existing complex relational trauma. Trauma occurs when an individual’s ability to integrate his or her emotional experience is overwhelmed, or they experience (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995, p. 60). Trauma also begets trauma and past trauma primes us for future trauma (Walker 2013) (Herman 1992) which means that what is traumatic, is subjective, cumulative and context dependent.

It is likely that almost all people have had potentially traumatizing experiences. For example, all of us must overcome the attachment betrayal of our parents when we realise that we are separate (Lewis 1988). Much relational trauma could be considered an ordinary experience.

ii. Feeling unpleasant sensations and emotions in the past and present

This main theme captures interviewees descriptions of emotions related to experiences with people or perceptions of people and the world. The feelings described included feeling: disappointed, anxious, misunderstood, irritated, betrayed, not listened to, angry, obligated, hurt and regretful. Positive feelings were described in relation to others but not often. Of the subthemes, two include descriptions of direct emotional reactions to
other people and three capture aspects of interviewees perceptions of people more generally.

a) Feeling disappointed, misunderstood and not listened to by others

Kate also often felt disappointed by others: “I can judge other people by my standards so where I would go out of my way for friends and it doesn’t, that’s not returned I can take it really hard…” Lee also described feeling disappointed in others and even betrayed “…then when they didn’t do it you were disappointed and frustrated with them, felt bitter toward them.” Lee also easily felt misunderstood by others: “When I was like 20, 25 people used to say to me, you’re the most laidback guy I know, I thought, yeah you don’t know me”.

Like Lee, Mary described people misunderstanding her: “people quite often say I’m very competitive but actually I don’t think I’m competitive I think I’m a perfectionist and I think there’s a subtle difference”. She felt others could underestimate her as “mild” and that perhaps her appearance is deceptive.

Mary also experienced feeling not listened to in therapy and doubting her therapist’s competence “she was jumping to conclusions about me about things she thought were wrong that I thought weren’t an issue”.

Like Mary, Rita felt not listened to in therapy: “…and then every time I kind of said I think I need to stop this she’d be like oh I’m a bit concerned for you if I just pull this rug out from underneath you and I said ok, that’s a valid point. I think I tried to leave three times and she made the same point and I’m like hold on I’m free to leave…”

Sue felt not listened to by her doctor: “…and she went ‘oh well normally breast feeding mums we give this drug and la la la and it’s fine your sex drive might go down but it will come back’ and she was all very light hearted about it, gave me prescription, off you go, and I came home and I was thinking something doesn’t feel quite right here I was, I sort of just want somebody to talk to.”
The interviewees also described experiences in therapy including therapists; *failing to understand, missing the point, not doing what was needed* and *jumping to conclusions*. The tone of these therapy experiences was reminiscent of the interviewees experiences of others in their lives. Almost all the interviewees described moments of misunderstanding and disappointment with others and this theme captures this as something of the nature of the conclusions they often drew from interactions with others.

Cognitive Analytic Therapy would describe these cognitions as interviewees’ Reciprocal Role Procedures. Specifically, people who have often been let down, disappointed or disregarded may come to expect this of other people (Ryle & Kerr 2002). Cognitive Analytic Therapy describes how this happens in childhood e.g. Katrina’s traumatic event - being abandoned by her mother - happened in childhood and perhaps changed her expectations and triggered her perfectionism. She began trying to ensure parental attention with perfect performances. Trauma theory suggests this can happen at any time because traumatic events can happen at any time. E.g. Sue’s trauma – aged 19 - and subsequent loss of trust and new feelings of suspicion which occurred when her father was unfaithful.

Relational trauma disrupts relationships and leads to toxic shame and self-esteem problems more generally (Walker 2013). Van der Kolk suggests trauma can manifest itself in a pervasive experience of disappointment and this can indicate a history of trauma which would fit with interviewee experiences (van der Kolk 2015).

**b) Feeling angry, hurt, sad and vulnerable because of others**

This subtheme captures descriptions of interviewees emotional reactions to others. Emma described anger at others’ incompetence: “*it pisses me off royally when people aren’t trained enough to do it right because this is what we’re supposed to be doing*...” Of her school experience, Emma said: “*It was really tiring and sad. I would come home and cry every day.*”
Jennifer felt irritated and patronised by a family member “whenever … we meet, she always wants to tell me what I should be eating, what exercise I should be doing should be doing even though I’m a health care professional and that really irritates me.”

Rita described the pain of criticism: “Yeah you can’t, everything you do just seems to matter so much and that feedback that you get from your teachers is, it hurts, like it goes straight to the bone right… (tapping on chest).”

Keith described feeling hurt by his decision to end a friendship after a friend criticised him: “I did have a friend but I ended the 30-year friendship so I cut it, I cut it which hurt me initially. I had a very close friend for many years and in the end I decided even though it hurt me initially to pull the plug on it I pulled the plug on a relationship with a close male friend.”

Others described the sensation and discomfort of feeling vulnerable. Katrina described: “Attention that is not nice because you’re always on the spot”. Olga remembered family gatherings: “You really didn’t have much option it wasn’t something you could not do and I always thought everybody else was better than me and I was really the poor relation.” Others, including Emma and Sue, were worried about feeling vulnerable during their interviews with me and were particularly concerned that they might cry.

Phil felt irritated by being analysed at work. He said: “he’s always kind of analyzing and assessing and treating us as though we’re idiots, so yeah the manager, but we all find that, we find him quite irritating.” Phil’s irritation was perhaps a reaction to feeling vulnerable.

It perhaps follows experiences of feeling disregarded, scrutinised and ultimately hurt by this that interviewees described feeling uncomfortable, disliking intimacy and disliking painful conversations in therapy.

The descriptions in the last two subthemes capture a sense of being emotionally disregarded, misunderstood and let down by others and the impact of this. Many experienced negative emotion, emotional pain, vulnerability, anger and powerlessness.
as a result. Feelings like these were memorable and perhaps overwhelming and shaming and interviewees appeared wary of them. They also appeared wary of others, whose actions may lead to these feelings. People the interviewees were wary of included work colleagues who they saw everyday but who they did not have close relationships with.

c) Feelings of anxiety and fear for and of others

The interviewees described anxious feelings, often stemming from concern over the way they do things or the standards they can reach.

Olga remembered past anxiety as a physical sensation. “Very butterflies and having to rush to the loo and that stuff; yes I think that was… but it wasn’t necessarily to be perfect but it was to achieve the best I could.”

Kate described anxiety about standards: “the anxiety that ensues from those standards debilitates you and you can’t do them, you’re kind of immobilized.”. Mary, whilst not immobilised, described ruminating retrospectively about interview feedback at work and if the interview was good enough, saying: “…I really kind of wound myself up about it.”

Sarah and Sue described patterns of anxiety. Sarah said: “What all happens is I start not sleeping, I started getting to where I couldn’t make the most simple decision like what to wear or starting to do that and when you work event management you have to make decisions 20 times a day and I couldn’t do it anymore.” Sue described: “a downward spiral”, “I just wind myself up tighter and tighter and I stop sleeping which makes it worse…”

It was mostly female interviewees who described anxiety, fear and agitation and often in relation to their perception of others’ expectations. Interviewees described tendencies which in themselves involve anxiety. Sarah was ‘obsessive’, Olga described herself as ‘OCD’ and Jennifer described intrusive thoughts about others e.g. “I think if I
spend too much time with her, my son might also die, sort of irrational.”. Of the men, only Keith described becoming ‘overwhelmed’ and the remaining two described behaving in controlled and self-disciplined ways e.g. making efforts to ‘optimize’ every experience for fear of not getting the best out of it (Lee). These ways are captured more clearly in the next main theme and may be strategies adopted to avoid or manage anxiety.

Interviewees experienced and described several fears. Emma feared being destructive to children. She does not have children and concluded about herself; “I think, like the force, it could be strong within me. I’m so glad that I didn’t have the chance to ruin somebody’s life. I think it’s so much better to be slightly detached and supportive or whatever.”

Jennifer feared passing anxiety or perfectionism to her children; “I was thinking just now, have I passed on any of my perfectionist tendencies to my children?”

Rita feared not being good enough for others after her divorce. She said: “you have this whole division of friends thing that occurs and for a long time I was a bit scared of being friends with people because I didn’t think I was good enough.” Kate struggles with a fear of relationship rupture. “Being able to tell the person when you’re really pissed off at them as well... There’s not many other people I can without fear of it rupturing”. Jennifer fears abandonment and worries about coping alone “I do worry about that as well as about how I would it be emotionally if anything bad happened to him.”

Olga described how she feared damaging her son by saying no to him or addressing his bad behavior. She said, “I wasn’t very receptive to the message that everyone was saying ‘come on that just isn’t realistic you shouldn’t be tolerating this and just because you say no’ like God says no to teddies,’ just because you say no, it doesn’t mean you don’t love them’.”

The interviewees shared past and present fears about; parenting, being damaging to others, failing, not being good enough, losing people, public speaking, emotional dependency, other’s responses to them and feeling disappointment in themselves. Overall, this subtheme describes anxiety on concluding that their actions or something
inherent about themselves was not good enough or not right. The interviewees rarely mentioned who might be judging their efforts and described fears that their efforts would not be good enough for other people. In psychoanalytic terms, anxiety responses like these suggest that interviewees may have internalised the standards of a difficult to please other and they compare their efforts to what they anticipate that other might require and then project those standards on to those around them. Unpleasable or unpredictable others make it difficult to feel assured that one’s actions are sufficient.

The Cognitive Behavioural Therapy model which describes how perfectionism is maintained usefully described this experience. CBT expects to see anxiety in perfectionists, treating it basically as an anxiety disorder. Like CAT (a hybrid successor of CBT), CBT offers a sequential understanding of perfectionism as involving constant negative evaluation of one’s own performance and over-reliance on the approval of others (Shafran, Egan and & Wade 2010). CBT considers perfectionism transdiagnostically and perfectionists to have cognitive bias which keeps rigid standards in place. This leads to counterproductive behaviour and appraisal - precursors to more serious problems. Whilst not specifically relational, the CBT conception outlines a cyclical and isolating anxiety driven process which individuals become locked into (Shafran, Egan & Wade 2010). If perfectionism is cognitively trapping and potentially addictive this indicates how intractable it can be. This aspect is supported by its established links to OCD (Shafran & Mansell 2001).

Interviewees’ interpersonal fears suggest difficulty trusting themselves to do the correct thing with others, particularly children. This could be because earlier relationship experiences left them feeling ill-equipped to resolve difficulties in newer relationships. Their confidence when dealing with others and taking responsibility for them may be undermined easily by negative core beliefs, a critical internal voice parent and/or inadequate early feedback about activities involving others. In Kohutian terms, the shortfall in mirroring, idealising and twinship which, when adequate, lead to affirmation, realistic standards and limits and feeling of affiliation (Kohut 1971) may show up more clearly for the interviewees in pressured interpersonal situations like workplaces and parenting. For interviewees with parents who were inconsistent, addicted, difficult to understand and/or in volatile relationships, shame was also likely
to be a regular risk. Perceptions of helplessness, objectification, being scrutinised and powerlessness appeared to have been regular experiences for the interviewees, which Mollon cites as integral to the constellation of shame (Mollon 1993).

Shame is relevant to the experiences of interviewees in interpersonal relationships although very few explicitly described feeling it. This could be due to the excruciating nature of shame and memories of it. People can be both aware and unaware of shame for this reason so in psychoanalysis it can be a ‘hidden feeling’ (Malan 1979). Interviewees described working hard at tasks which gain approval and thus avoid shame. They were diligent in answering questions but some avoided answering by: interpreting a question in superficial ways; answering in generalities; keeping answers short and speculative; opting not to comment; and two interviewees appeared angered by a question and fixed me (the interviewer) with a hard stare to discourage the line of questioning. This occurred on the topics of therapy and parent’s relationships with one another.

A problem with psychoanalytic explanations is that shame defenses can be difficult to discern in interviewees’ descriptions. This is partly because shame defenses co-occur with desire to re-establish relationship experienced as lost through feeling the shame and because many of us learn to conceal shame. This obscures how shame manifests itself relationally in the moment (Hahn 2000). Hahn described shame defenses which include projection of shame on to others via; externalising the devaluing introject (and so experiencing others as condemning) and; externalising the devalued self (and so condemning others and expressing contempt, envy or rage). These defenses avoid the feeling of inadequacy associated with shame (Hahn 2000). As interviewer, I experienced interviewee withdrawal, a sense of being evaded and a feeling that interview rapport had ruptured – indicated by broken eye contact and irritable responses. A close processual and visual analysis of the interviews might have revealed more about the shame experience of the interviewees.

Perception of attachment threat and associated shame explain how perfectionism is self-involving i.e. perfectionists experience threat of shame or separation from disapproving criticism or feelings of failure which influence their perception of self and
others. Interviewees’ fears included loss, dependency, of being perceived as failing, deficient or personally damaging to others which all involve negative judgement by others and so threaten attachment. Early attachment threat in the form of rejection, abandonment or separation is experienced as existence threat. This may be why negative judgement can be experienced as annihilating.

It is worth noting that ten of the twelve interviewees had undergone interpersonal therapy and the remaining two expressed a strong interest in it. This is unsurprising given that the researcher was a trainee Counselling Psychologist. Many of the interviewees had worked through feelings about others and the world and were articulate. Some seemed able to resolve distress or had overcome it. Some did not articulate emotions. This study benefits from the therapeutic work the interviewees have done, their openness and understanding of their lives. It may also have attracted interviewees who want to talk about their lives and relationships and were beginning or continuing to work through their experiences.

At this point the imbalance of emotional talk between male and female interviewees is worth considering further. Given gender norms in the UK and the age of the male participants it’s possible that discussion of distressing feelings may have been uncomfortable and possibly threatening to the masculine identity of male interviewees. This is particularly concerning as inability to express emotions is considered to increase risk of suicide in distressed men and perfectionists. However, perhaps the men did not experience anxiety in the same ways as the women. For example, women are more likely to experience powerlessness in patriarchal western society and be considered less perfect or not as good as men by society at large because of their gender. This may contribute to distress.

This also suggests that the experience and expression of emotion and relational trauma in more marginalized perfectionists and those with complex intersectional identities may be affected by their relative and subjective positions in society in relation to mainstream societal norms and experiences of oppression and discrimination. If perfectionism can result from totalitarianism (Herman 1992) (Walker 2013) and difficulty gaining approval, then being black and discriminated against in white
dominated societies may be relevant to how likely one is to experience relational trauma - especially as racism is traumatizing, institutional and internalized. Racism has an established link to PTSD in its victims (Carter 2007) (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquilin 2007). This study mainly represents subjective experiences of middle class, white, culturally western, mainly female, conventionally successful, working age and older perfectionists and in this, it attracted mostly the ‘usual suspects’ (Braun & Clarke 2013). This lack of diversity is limiting because it includes few who have life experiences which vary from those typical of white, middle class individuals.

**d) Feelings of distress and being in crisis**

This subtheme captures descriptions of distress including loneliness, pain, shame, sadness, longing, emptiness, unhappiness, guilt and misery. These feelings stemmed from experiences of feeling abandoned, unloved, disliked, invaded, not good enough or mocked by others.

Lee described personal pain: “I’ve just had enough. I don’t want to live my life like this anymore. I just want a rest. It’s just too difficult. That personal pain, you know, just never being satisfied, it’s just hurting you is the main thing.”

Rita described feeling wrong and like an imposter friend if she forgets a friend’s birthday: “...that I’ve done something really wrong and if I don’t know their birthdate then how on earth can I be good friends with them? It’s such a stupid thought to have, like lots of people forget peoples’ birthday.” Rita described wrong feelings like this as shame at other points in her interview.

Katrina remembered past longing for her mother; “I had really a stomach pain and I was crying and so I think I had these years of incredible need of mum’s care.”

Sue described distress and overwhelm when a plan went wrong “it just all came to a head and I couldn’t stop crying and everything felt too much and I couldn’t really even articulate what was going on”.


The interviewees described past, every day and one-off crises. Many, like Lees ‘personal pain’ were interpersonal and involved other people and/or seeing themselves as problematic in the eyes of others. Interviewees also described crises involving illness, depression, infidelity, separation, difficulties with children and parenting, work stress, divorce and life dissatisfaction. The interviewees described common threads of having felt emotionally overwhelmed, disregarded, rejected or betrayed.

About the end of his marriage, Keith said “I was devastated that my then wife went and did what she did and stuff so I was really I was a mess I would say I was emotionally, I was just a mess really I suppose.”. After her marriage Katrina “fell into a physical stress crisis”. She said “It was really horrible but then I had a really, I think a breakdown and just thinking after this scene of punishment it just hit me, the betrayal...”.

Sarah said, “I ended up in therapy for two years because I just got so stressed with it all, the work, that I started to edge towards a nervous breakdown because I just couldn’t cope with it all”.

Interviewees also experienced crises relating to; dismissal from work on competency grounds, trying to find the right relationship, and coping with the challenging behavior of teenage children. The experience of distress was common and easily recalled.

Interpersonally triggered anxiety and distress was common to many of these interviewees. Some appeared to be more vulnerable to anxiety and distress than others and had experienced more of it. All those interviewees had described potentially traumatic interpersonal experiences in childhood or later with authority figures and remembered them clearly. Given that “trauma occurs when the individual’s ability to integrate his/her emotional experience is overwhelmed, or they experience (subjectively) a threat to life, bodily integrity, or sanity” (Pearlman & Saakvitne, 1995, p. 60), it appears interviewees who were overwhelmed in childhood by others’ critical, incomprehensible or bullying responses to them or by lack of help at times of stress have been likely to experience those sensations again later in life. In attachment terms they may have struggled to acquire the ability to self-soothe due a lack of affective attunement (Mikulincer & Shaver 2010) (Applebaum 1994).
Some interviewees did not describe anxiety but had had potentially traumatic or neglectful early experience and disclosed medical conditions which could be considered somatic in nature (McDougall 1989). These included ulcerative colitis, irritable bowel syndrome, food allergies, heart condition and high blood pressure. Some interviewees disclosed no physical health information at all either prior to or during interviews. These four interviewees (male and female) tended toward guarded, emotionless or alexithymic expression. They were matter-of-fact, used fewer feeling words, had had the least therapy and had found it difficult to benefit from therapy.

McDougall describes alexithymia as ‘deficiency in symbolic thinking’ and diminished capacity to form symbols due to curtailment of, or neglect during, a critical developmental phase. Rather than dealing with preverbal experiences by symbolizing and rendering them safe through verbalization or fantasy formation, the alexithymic may have lost touch with these archaic experiences, and consequently the experiences have no access to preconscious or conscious thought and cannot express them (McDougall 1989). To McDougall, alexithymic patients tend to somatise and to chronic or acute disturbances in self-regulation which produce somatic disorders of hyperarousal (e.g., migraine, hypertension, coronary artery disease) or dependency nurturing frustration (e.g., asthma, gastric ulcer, colitis, dermatitis) in susceptible individuals (McDougall 1989). This is contentious, but some of the less expressive interviewees in the study were experiencing potentially somatic conditions which may result from somatised reactions to early trauma.

Kohut and Wolf considered whether the body itself is a selfobject (Kohut & Wolf 1978) and psychoanalyst William Rickles argued that a detailed understanding of the selfobject quality and vicissitudes of body-self relationships would aid understanding and treatment of psychosomatic illness. This includes chronic pain, physical mutilation, accident proneness, suicide, addictions, noncompliance in medical treatment, eating disorders, sports injuries and clumsiness (Rickles 1986).

Interviewees could be described as addicted to perfectionism, cleaning, planning, sport and achievement. The idea that failures in mirroring, idealising and twinship can affect
the relationship of the body and mind and become embodied appears interesting and possible. Herman (1992) and Walker (2012) support embodied trauma and it is central to Sensorimotor Psychotherapy for trauma (Minton, Ogden, Pain, Siegel & van der Kolk 2006). It seems likely that perfectionists are prone to embodied trauma and their physical health may indicate something about their relational life.

Adverse Childhood Experience test researchers have found that those with higher scores have a higher likelihood of developing damaging health behaviours and of early death (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks 1998). The ACE assessment includes relational questions about feeling humiliated, not special, abandoned, witnessing violence, having parents with active addictions, parents struggling with mental illness or parents who have died. The interviewees in this study would score in the mid-range for ACE. This makes a compelling argument for considering the physical health of perfectionists in assessing perfectionism for psychotherapy.

There are other explanations for apparently alexithymic presentation. Emotionless expression may be learned behavior (Vygotsky 1978) (Bandura 1977) or due to active shame defenses and concealment (Hahn 2000). Talking about anxiety without emotion could be a form of shamelessness, what Hahn calls countershame defenses (Hahn 2000). If feeling anxiety is a source of shame, then evasive or matter-of-factness about topics relating to it avoids shame. Generally, male, older female and less therapy-aware interviewees adopted a matter-of-fact tone or evaded emotion questions. They may simply not have learned to talk about their emotions easily and matter-of-factness sometimes co-occurred with physical indications of anxiety in the interviews - including motor tension, disorganized and rapid speech - and discomfort with emotional topics. Further understanding interviewee’s metacognitions (Wells 2011) could reveal much about how some feelings trigger shame but in this study the interviewees were not asked for their thoughts and feelings about their thoughts and feelings. An Emotion Focused interview approach based on Emotion Focused Therapy (Greenberg 2002) might reveal if interviewees awareness of what they feel and their metacognitions. However, this risks creating false intimacy (Braun & Clarke 2013) (Josselson 2012).
which is potentially unethically and unattractively invasive. Interviewing at emotional depth may also be difficult to achieve full consent for.

In attachment terms, the ambivalent, reserved, matter-of-factness of some interviewees’ descriptions could be characterised as avoidant or dismissive attachment style (Mikulincer & Shaver 2010). Some appeared attentive and vigilant and so potentially anxiously attached. Many interviewees had parents who were overwhelmed, addicted, stressed and/or had high standards. These parents may have responded positively to competence or self-reliance in their children and if productivity, problem-solving and achievement were valued, the children may have learned to strive in response. Perhaps perfectionism offers an attachment securing strategy which enabled them to gain secure or consistent relating relationship attunement and which continues to be deployed later in life. This fits with interviewee descriptions of experiencing striving as calming and explains its addictive quality for some.

Interviewees described a wide range of negative emotions, perceptions and feeling states including; anxiety, disappointment, feeling misunderstood, feeling not listened to, anger, hurt, vulnerability, distress, and a variety of interpersonal fears. They experienced reactivity in the form of fear, sadness and anger about their experiences.

It is relevant to consider temperament here. Both Schema Therapy (Young, Klosko & Weishaar 2003) and Cognitive Analytic Therapy (Ryle & Kerr 2002) consider the role of temperament in distress. The emotions and reactions described in this subtheme suggest the interviewees can be reactive and prone to drawing conclusions in interpersonal situations which may cause them to feel strong emotions including shame. It may be that, temperamentally, perfectionists are more reactive or interpersonally sensitised than non-perfectionists. This being the case it would be difficult to say if this is temperamental or results from repeated exposure to non-ideal nurture which produces hypervigilance to attachment threat, perfectionism and hypersensitivity to slights or disregard for example. To Young, Klosko and Weishaar, temperament affects and motivates the likelihood and style of schemas which develop, and it varies across; lability/ non-reactivity, dysthymia/ optimism, anxious/ calm,
obsessive/distractible, passive/aggressive, irritable/cheerful and shy/sociable (Young, Klosko and Weishaar 2003).

On balance, the interviewees appeared to tend, and described tending, toward lability, optimism, anxiety, obsessiveness and irritability. They varied in the impression they gave of passivity/aggressiveness, compliance/dominance and extroversion/introversion. LeDoux considers favourable or aversive experience can override temperament to some extent and vice-versa (LeDoux 1996). Over time, trauma and perfectionism may alter the effect of temperament and temperament plays a role in who is likely to develop perfectionistic survival strategies in response to adverse experience to begin with. According to LeDoux, trauma affects memory storage and the amygdala. This means that schemas can be preverbal and form prior to the development of speech (LeDoux 1996). This too might explain why some perfectionists are perfectionist from early in life and less able to articulate feelings than others. Schema therapy acknowledges that an Unrelenting Standards/Hypercriticalness schema (Overvigilance and Inhibition Group 5) can emerge as a response to (or defense against) the early maladaptive and highly disorganising Rejection and Disconnection schemas (Group 1) (Young, Klosko & Weishaar 2003). This suggests a symbiotic, evolving, transactional relationship between trauma, schemas and temperament which impacts on the cognitions, strategies, emotional responses and expectations those schemas contain.

Interviewees described positive emotions they had experienced in their best and safest relationships. These were not described in as much depth, but they described feeling accepted, appreciated, close, understood, safe and lucky. The descriptions related most to their partners. Many had had close and trusting long term relationships and described these as the best, most helpful and happiest (and sometimes the only close) relationships in their lives. There were also examples given of close, trusting, and supportive bonds with friends, siblings and teachers and two described this with one parent. A valid methodological observation is that interviewees were talking to a trainee Counselling Psychologist and their perceived role expectations may have motivated them to talk more about their negative experiences. Perhaps, they felt I understood distress and am more interested in that than in positive experiences. Many may also have come with a desire to share and perhaps resolve some of their more negative
experiences. In addition to this there is a popular perception that perfectionism is problematic, and that counselling psychology is interested in problems and so it is very likely that this contributed to an increased focus on negative experience and perhaps the study even attracted those who felt they have had negative experiences because of these aspects of its design. One impact is that it may have allowed interviewees to be particularly honest about their emotions, particularly as the study was subsequently anonymised.

iii. Ongoing habits impacting on relationships

The interviewees described several perceptual and behavioural habits which impacted on their relationships and the following subthemes reflect these. These habits can be interpersonally disrupting and may be both intentional and unintentional.

a) Expecting disappointment and feeling suspicious of others

Jennifer described not expecting to develop friendships with work colleagues “...it’s because I’ve had bad experiences with people in the past and I thought ok, never the twain are going to meet anymore so I’ve never been particularly close to anybody at work.”.

Kate described phoning her father and expecting to feel disappointed: “...Sometimes I’m kind of like, the phone is ringing before he’s answered it and I’m thinking I know I’m not going to get what I need but I still do it. I’m still doing it and it’s like vague hope that it might result in...”.

Other people disappoint Olga by not doing things well enough. She said: “...she suggested I went to Al-Ateen when I was a teenager but I never did go. Not a great joiner really. They wouldn’t do things well enough for me would they? [Laughing]”
Sue also described struggling to adjust when her expectations are not met “She didn’t really ask me the questions I expected to be asked given my knowledge of what GPs should ask in those situations.”

Lee described not being good enough for others and recognised it had an effect: “that then affects the way you deal with people because you always kind of, what you do, you don’t think is good enough for them…”

The interviewees often had low expectations of others and these made them suspicious and led them to question others motives and intentions.

Emma wondered about her mother: “I feel like well if she really feels this way about people like him and our relationship is she just using him because he’s useful?” and Sue questioned what her mothers’ opinion of her: “I don’t know if it’s necessarily to do with my perfection seeking but sometimes I feel like she’s maybe mocking me a little bit or…”

Jennifer wondered about her ex-husbands desire to marry her: “I got pregnant with my daughter so we got married. So there was always that in the back of my mind, did he marry me because we had a little girl.”

Many described suspicion or caution about other people more generally. Kate expected a negative atmosphere in National Childbirth Trust antenatal classes saying, “I know that when you do NCT classes and that kind of stuff there’s often competition and bitchiness between new mothers about how well their child’s doing.”

Keith expects manipulation: “You see when I’m with people and sometimes people will try and sort of like not necessarily directly deliberately manipulate but some people try things on and they think because I’m an easygoing kind of guy that I’m a pushover but that couldn’t be farther from the truth”. Like Mary and Lee, Keith appeared to feel others misunderstood him and perhaps considered that I might be manipulating him in the interview. He said: “For example, let’s you and I are having a conversation and you’re wanting me to do something or react a certain way. I will hold onto the silence to the point where you might start to feel really uncomfortable.”
Phil described seeing through people “Oh yeah I could see straight through her. I mean, fairly pretty lady and such like but there was something going on up here (pointing to head) that wasn’t right and I was proven to be right. Because he got really mixed up with her and mentally it was a little bit destroying to him when he was 18.”

Mary and Rita had felt suspicious of therapists. Mary suspected incompetence “…it just wasn’t working for me and it really, with her I felt I’m not sure how long she’d been doing it but I wasn’t comfortable that she knew what she was doing…”. Rita said “I tried to leave three times and she made the same point and I’m like, hold on, I’m free to leave… [Interviewer: So you began to feel a little bit… held onto?] Yeah almost like I was being manipulated?”

In therapists, the interviewees described disliking; fakeness, suggesting deceit as a course of action, unfriendliness, judgment, manipulation and seeming unknowable.

The interviewees described situations where they expected to be disappointed, let down, threatened, manipulated or duped by others. They questioned others motivation and integrity and suspected others of controlling and manipulating them. Many expressed wariness, concern and disapproval about others and several appeared wary during the interviews.

These wary expectations of others may affect their relationships and cause interviewees to appear unpleasable or unsympathetic towards others at times. This may affect the depth, variety, longevity and quality of their relationships. These expectations also suggest the kind of watchfulness or caution that one might expect to see in those with relational trauma. Again, from a CAT, Schema or CBT core beliefs perspective these represent of a set of cognitions about others which interfere with relating.

b) Exasperating others through striving

Interviewees described that they exasperated others.
For example, Emma said: “I’m very list-oriented and I have to make sure the list is complete and then you have to finish the list and the list is important which drives my husband crazy and if something’s not perfect like, we renovated our place and it’s like well, it’s not perfect”.

Of her husband, Olga said: “But I think it drives him mad as well because of the way I stack the dishwasher, it’s got to be pretty well done the way I want it and then if there’s not space I’ll wash up by hand and he hates me washing it by hand.”

Sue described that her conviction that others will not do things as she would distracts her and she mishears her husband: “...I said ‘well you should have just told me, don’t worry it’s fine’ and he said ‘I did, I did say that’ but I was obviously so focused on him not doing it right, me needing to be there to do that, that I couldn’t even hear him say those words.”

Some noticed tension in their relationships.

Sue said of her mother: “She doesn’t understand sort of the way I think or the way I do things ...oh, the frustration shows”, and of a friend: “often she will say ‘can we just stop planning everything, can we just not go and just see what happens’...”

How the interviewees described exasperating others varied. Some frustrated others with tendencies to act on urges toward orderliness, getting things right, doing things well and striving. They described; having systems, planning, controlling, reconnoitering situations and immersing themselves in projects and persisting.

For example, Olga described redoing tasks: “I like to do things in an orderly way and if they’re not orderly sometimes I’ll redo them ‘til they are- folding towels is a bit of a, bit of a thing.”

Emma described persisting despite herself: “you just keep trying and keep trying even if you don’t believe it, you don’t believe that you should have to or you don’t agree with what they want, you still keep trying.”
Sarah described being controlling: “I am really controlling I print my bank statements out every week and I go through them with a fine-toothed comb.”

Rita described not knowing when to stop: “This idea of having to like, stop doing a task or try to finish something. I still struggle with that a bit ...I stay awake until really late and then wonder why I’m having a meltdown.”

Some, like Sue, recognized that these systems were ways of coping: “I’m feeling a bit all over the place and maybe can’t even explain why I just, lets, some people feel emotional or moody I tend to take comfort in that list making and again it just gets a bit frantic.”

Within this, fatigue was a regular side effect and itself potentially exasperating to others. Trauma theorists recognise this as a form of self-sabotage. Poor self-care through keeping oneself in a less than optimal physical state, impedes relationships and performance (Walker 2013). Fennell points out that self-sabotage helps to maintain low self-esteem because it leads to missed opportunity, avoiding challenges and spoiling relationships, pleasure and achievements (Fennell 2016).

Keith’s wife noticed when he was losing balance: “It’s like my wife’s like ‘oh no Keith!’ sometimes I’m up at 5:50 sometimes I’ll work 7 ‘til 6 and then on the weekend I’m up at 5:50 and I’m in at 10 at night and it’s like oh god. She’s like ‘oh no, oh dear. [Laughing] What happened? Not back there again!’ ”

Katrina described: “... (it’s) exhausting because you are always, as it is insurmountable and it will be because perfection doesn’t exist you’re always exhausted because you’re always trying to get a thing that’s not achievable.”

Sue described: “... it takes a huge amount of energy and it’s actually quite exhausting because I sort of impose these ways of doing things on myself and I sort of can’t allow myself to deviate from that so I can’t just um...”

Kate described the risk of “grinding myself into dust”
Rita described her partner saying to her: ‘stop putting so much undue pressure on yourself.’

Interviewees described situations both specifically and generally when they may have been exasperating to others due to their method of approach.

Phil described correcting others; “And some people, the dodgy ones, I can actually change them by talking to them, from being irate, and sometimes they say, listen what was that all about and I’ll say what do you mean and they’ll say well you talked to me in a rather an officious manner and (I’ll say) I don’t think you’re going to get the best from me, my friend, talking to me in that way”.

Emma pushes others: “If I really want to achieve something I have to push him a lot but then I sort of think why am I pushing this just because I want to have it done or is it because it really needs to be done and so I sort of back up a little bit so it works pretty well.”

For Lee, described interpersonal persistence as a way of life: “That’s the way I live my life. I will find a way. You trap me underground or whatever I’ll find a way of getting out and that certainly when I was younger to the point, in a relationship or something, someone’s going, we just got to give to this guy because he’s, I’m not a strong guy but if you got in a fight with me you’d have to kill me because I just keep getting up.”

Olga persisted at work: “I think I was a complete nightmare because I wanted everybody to achieve the best they could and I don’t necessarily think that’s a bad thing but er, it puts quite a lot of pressure on people.”.

Interviewees rarely described past goals as involving high quality interpersonal relationships. More often, they described wants and needs. These included wanting to be right and lacked interpersonal focus, e.g. Jennifer: “I don’t it’s not so much I have problems with people telling me what to do it’s that I always think my way of doing things
is best”. Interviewees also wanted to be the best, e.g. Emma: "I’m the best, why am I not getting this award”.

Others had fantasies of perfection which were rarely collaborative efforts. For example, Sue envisioned perfect decorating results and Katrina imagined being the greatest mother. The existence of fantasies supports the idea that perfection feels like a solution to all problems for perfectionists.

Interviewees described; working to exhaustion, driving others crazy, pushing others and acting in competitive ways, being controlling and/or correcting toward others when in pursuit of a goal and descriptions of the strategies they adopted to achieve their goals. They strove towards goals in a committed and rigid manner, almost irrespective of the cost. Striving was underpinned by their values and standards about doing things well. Ceasing to strive was described as difficult and undesirable although many also described strategies they had used to mitigate negative effects of striving. Ironically these included further striving: to be selective about the tasks they took on; to maintain perspective; to avoid becoming obsessed and to be flexible, grateful and to ‘let go’ more. Interviewees were both aware and expected that others found them difficult to understand and a source of frustration and concern. Many appeared addicted to striving.

Overall, interviewees described struggling with; tiredness, overwhelm, dissatisfaction, decisions, change, and maintaining balance. They acknowledged that their striving and its consequences were often misunderstood, disagreed with, and judged negatively by others and this caused strain in relationships. It is difficult to say to what extent striving is conscious i.e. whether the relational consequences of it are known yet discounted, or if it simply compulsive. It appears interviewees disregard others and favour progress of the task at hand and so prioritise relationships less highly than others might or than they might at other times. Most prioritised close family relationships and tried to deviate from striving for family members when necessary.

Perfection fantasies and striving itself have neurological implications. Imagining fantastical conclusions to life circumstances may trigger dopamine release in the brains’
mesolimbic pathway and a sensation of reward. Fantasy about perfection could account for perfectionism’s addictive quality and for how difficult it is to relinquish. Dopamine is associated with reward, addiction, lust, motivation, attention and what we pay attention to. Neuropsychiatric Genetics has linked perfectionism to the D4 dopamine receptor which suggests that some individuals are genetically predisposed to Anorexia Nervosa and perfectionism because of this (Bachner-Melman, Lerer, Zohar, Kremer, Elizur, Nemanov, Golan, Blank, Gitsenko & Ebstein 2006). The presence of perfectionism addiction may also detract from relationships and exasperate others in their lives.

Addiction is often associated with unresolved (and existential) grief and loss (Frankl 1985) (Rogers 2011) and unresolved loss is considered to contribute to depression (Leader 2009). Many researchers have linked perfectionism with depression (Shafran and Mansell 2001) (Elkin et al. 1989) (Blatt 1995) and the therapeutic community commonly understands that abuse or neglect in childhood can lead to lifelong feelings of grief and loss which could, to some extent, explain the frequency of depression experienced by perfectionists.

Striving is a powerful strategy which avoids uncomfortable emotions and wins approval or mirroring (Kohut 1971). Psychoanalysis sees it as a compulsion in Malan’s Triangle of Conflict (Malan 1979). Blatt suggested that perfectionists are prone to introjective depression i.e. triggered by feelings about the self and anaclitic depression i.e. caused by loss of relationship, and that depressed perfectionists appeared to be vulnerable to both types of trigger. The interviewees described behaviour that potentially neglects relationships which may mean they are more likely – through striving – to trigger anaclitic events (Blatt 1995). CAT would see it as a childhood strategy to resolve childhood feelings, but which works relatively ineffectively in adulthood and which has relationship damaging side effects (Ryle & Kerr 2002). Schema Therapy might see it as the enactment of an Unrelenting Standards schema (Young Klosko and Weisharr 2003) Trauma therapy might see it as distracting, overcompensating activity and evidence of a flight response (Walker 2014).

According to Zuroff and Blatt, the depressed perfectionist vulnerability is a reduced capacity for relating, using and feeling the benefits of social resources and connection
(Zuroff & Blatt 2002). Brustein described this as ‘reduced capacity to benefit from therapy’ (Brustein 2014). If perfectionists perceive and experience regular- and traumatising - attachment threat, they may not find other people, including therapists, to be safe sources of help. This could account for some interviewees’ reservations about therapy, their less than successful experiences of it and their tendency towards a mode of behaviour that prioritises achievement of a task over relationships for example. The impact of perfectionism on relations may be an unfortunate side effect and a manifestation of perfectionist’s ambivalent feelings about relationships – that they are disappointing and do not yield benefits hence ultimately favouring tasks over relationships to a greater or lesser extent. When interviewees described making great effort in friendships e.g. driving a long distance, organising a birthday party, or helping with advice and money, they often described feeling unrewarded and angry as a result.

c) Avoiding others

This subtheme captures interviewee descriptions of distancing themselves, keeping quiet, ending relationships, avoiding relationships, being self-reliant and avoiding the need for others, as well as taking care choosing friends and trying to elude the control of others.

Lee described avoiding communicating with others: “…I haven't explained things and that’s caused me to be misunderstood and then when I’m misunderstood I go, well wasn’t... that act wasn’t selfish, that was this. But then I don’t (explain), ... I'm a bit of a backroom guy in the sense, that I don’t want the limelight.” Lee has lost contact with others: “…because I, they didn’t meet that standard so I never bothered calling them back, whereas now, I wouldn't look at things that way.”

Sue described becoming less reliant on other people: “I think I yeah I’ve had to just sort of get on with it. I’ve had to leave them to it”

Mary described eluding the control of others following suspicion that others want to control her: “I know what they’re doing, they’re trying to control me and the problem is I


Kate avoids her mother. She said: “I need to keep her at an emotional distance and if I let her in too much then it gets warped for me and I get too drawn into her dramas and I get too recruited into parenting her basically”

Olga described avoiding friendships with others: “And really I wouldn’t choose her for a friend, really I wouldn’t choose any of them particularly as friends, because they’re all older, not that that makes them less worthy of being a friend, but we’ve got less in common.” Olga remarked that she hasn’t been good at cherishing friendships.

Emma feels she doesn’t need others. She said: “I don’t have that many really close friendships just because my husband serves all my needs, but I think other than him, my sister is the one where she knows so much and it’s still ok.”

Interviewees had avoided friendships at work, been careful about friendships and many focused on their partners. The three male interviewees had few close supportive relationships and one had no close relationships. He drew support from a football refereeing hobby.

All described relationships they had avoided, ended or reduced because the contact made them feel uncomfortable. This fits with their experiences and expectations of disappointment and/or of feeling they had been found to be disappointing by others. They were wary and ready for relationship rupture and may be familiar with the emotions of rupture and some perhaps even pre-empt it. As with striving, avoidance or distancing may be one unintended side effect of perfectionism because it is tiring and time-consuming.

In attachment terms the relationship behaviour of interviewees in this study appears to be more self-reliant and avoidant in style than close and dependent. This seemed less the case with a trusted partner who was the main support relationship. Some seemed dependent on partners and three became tearful when describing their partners
importance to them. Interviewees described long, stable romantic relationships and had sought long term, secure attachments to a trustworthy other who understood them. Many focussed on this rather than on friendships. Of the twelve interviewees, six had been divorced and four were still married. Of the divorced, three had remarried, one was cohabiting and two were single and living alone. Of the two never-married interviewees, one lived with a partner and the other described herself as long-term single.

**Avoiding others** alongside these long-term safe relationships, supports a state rather than trait-based conception of attachment i.e. attachment style varies depending who the relationship is with and over time. Many interviewees had built up a small number of long-term, committed partnerships and friendships and avoided relationships in the first instance or ended hurtful relationships perhaps because this minimises attachment threat and exposure to both anaclitic (relationship loss-related) and introjective (self-value related) triggers to low mood or anxiety (Blatt 1995).

Interviewees also described positive experiences of parents, friends, siblings, mentors, teachers and therapists. These mostly occurred in adulthood and were ongoing except for the positive experiences of two male interviewees of school teachers. This included descriptions of therapy as: helpful, creating new bedrock, bringing new perception and helping in bad times. Positive experiences included feeling cared about, helped by others, understood, accepted and close to others.

Mikulincer and Shaver suggest that developing secure attachments allows us to ‘broaden and build’ in our lives and relationships. i.e. we become more relationally and generally flexible and relaxed if we achieve this. (Mikulincer & Shaver 2010). Stern characterised attachment security as coming from a responsive ‘To-and-Fro’ between parent and child, resulting in the internalization of a secure base. In keeping with this, Fonagy and colleagues describe it as ‘emotional resilience’ and ‘a psychological immune system against trauma-induced psychopathology in both children and adults’ (Brownescombe Heller 2010). Allan Schore’s findings that parents regulate their children's emotions and so furnish them with the ability to regulate their own, supports this (Schore 2003). Psychotherapists have argued that both therapy and long-term
relationships can change attachment style stable long-term relationships because they can provide restitutive experiences which moderate attachment-insecurity and lead to more secure feelings and relating (Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target & Gerber 1996). They found that psychotherapy has couched change from Insecure Dismissing (Attachment-Avoidant) to Attachment-Secure styles in 14 of 35 people with personality disorder (Fonagy et al 1996). Travis, Binder, Bliwise and Herne-Meyer found 7 of 29 clients to be Attachment-Secure after therapy, where none were before and concluded that those securely attached after therapy benefitted more from it in terms of functioning and symptomology than those insecurely attached (Travis, Binder, Bliwise & Herne-Meyer 2001). Overall, improving attachment security improves resiliency and capacity to use social support.

Interviewees in this study who had trusted partner, therapist and friend relationships may have been assisted and helped by them to loosen rigidity and day-to-day grip and conviction about how the world should be in this way. The interviewees also talked a lot about how to do this.

d) Evaluating, comparing and criticising the self and others

The interviewees frequently compared themselves to others, others to one another and sometimes, others to themselves. They regularly judged, criticized and analysed others negatively, did this to themselves and perceived others to be judging and criticizing them.

Emma described active comparison in her family and the pressure to be better: “So everyone in our family was really smart and I followed three people who were super smart so I had to be super smart so all of us in high school were either in our senior class we were either ranked number 1 or number 2 ...but if I hadn’t been in the top 2, I hate to think, because our family was never average, never normal.”

Some, comparison took the form of noticing difference. Kate noticed differences between herself and her partner “he auditioned for this advert and he was like oh I went
Keith and Emma described family cultures which seemed different from other families. Emma said: "We were so different from everyone in our class pretty much whether it was how we dressed or the car or the academics or whatever."

Olga remembered about school: "I never really particularly felt that I was in any clique or fitted in. I had friends and I would go to friends and friends would come to me but it was difficult with friends coming to me in case my dad was drunk."

Emma criticised her brothers’ integrity for signing a document dishonestly “He signed that to make my parents happy even though he had no intention and it's like a promise officially before God and you are doing this to make my parents happy. What the heck are you doing?” Sarah said of her brother “...he’s a wheeler dealer my brother. He’s got this business, he’s an eBay business on the side, to me it sounds dodgy but he’s good at that kind of stuff.”

Phil criticised his younger brother “he’s hung onto mum, he’s a bit, but apparently with younger children, the youngest child sometimes that does happen doesn’t it, where they cling on” saying of him and his older sister “they’re both leeches and I don’t assume it, I know it”.

Rita described judging her family and her distance from them: “...sometimes I think I’m judging them too harshly as well and that’s tainting my view of them and I know that affects the way I speak to them. We don’t speak very often either but when you know we do, I haven’t really spoken to them about the divorce or anything like that but I mean equally they haven’t asked so...”

Lee said more generally: “I don’t like people around me making mistakes. I don’t like to be exposed to ignorance and unfairness and stuff and over you know over the years I find ways of dealing with it but like I said I still feel unhappy.”
Olga can find others unpleasantly dependent. She said: “I’m a member of a group and two of the members of the group, three, have latched onto me in a different way.”

Kate described past boyfriends as ‘a bit thick’, ‘a bit of an arsehole’, ‘a bit of a wet blanket’ and said ‘it’s important to have a bit of banter and be able to take a piss at each other and stuff bit of a laugh and not take it too seriously and whenever I took a piss out of him he would stick his bottom lip out at me and do big doe eyes and it was repugnant’.

Jennifer criticized a family member saying; “I don’t think she breastfed them and he was always like the mother figure in lots of ways when they were little and still is to a certain extent she’s quite a cold woman”

Interviewees had evaluated and disliked things about therapists too. These included; inexperience, an untailored approach, clumsy interventions, passivity, being directed away from important issues, and having an irritating voice.

Interviewees described being criticised by others. Emma said, “I think my parents already thought I wasn’t making all the right choices”. Jennifer felt: “I wasn’t slim enough for my first husband and I felt I always had to be on a diet because he wanted a woman who was size 12 not size 14.”. Katrina felt she disappointed her mother and described the “fake illusion of putting me always as the perfect bit until I disappointed her and then all went to the trash”. Lee described criticism of his character “I think…the stubbornness, someone said to me a little while ago, you’re very tenacious. Well that’s very complimentary but what you actually mean which is really stubborn and awkward.

Conversely, Emma remarked how ‘nice’ she found me during the interview and was visibly relieved by some of my responses to her. She appeared to anticipate criticism and I reassured her regularly that her experiences were valid, answers correct and of my good opinion of her in order that she could continue.

Interviewees were self-critical both about day to day things and larger life events. Phil judged his conduct “I have been known to swear but that’s one thing when someone points out, what was the swearing all about? And then you think, well why did I swear? That was stupid.” Sarah judges her tidiness “I’m untidy and it annoys me that I’m untidy but I will
leave newspapers lying around and all that kind of stuff then I’ll chastise myself for doing that”. Sue judged her social behavior “I think god I wasn’t really engaged with that I was just sort of saying words and I wasn’t really thinking about it and it was almost like an out of body experience like I wasn’t really there.” For Emma, her decision not to work overseas and subsequent return to a same-level position in the US 8 years later was a source of shame. She was tearful in the interview and said, “I was just so embarrassed that I hadn’t been recognized or gotten a better job or a better title”. Interviewees questioned themselves, their decisions and often struggled to trust their own judgement.

This subtheme captures a habit of, and preoccupation with, monitoring their own (and others) progress, performance and efforts. Interviewee evaluations were often critical and negative or occasionally admiring but mostly emphasised differences between themselves and others. Some praised others’ achievements and lifestyles often expressed this by comparing the self to the person praised either directly or obliquely. Some interviewees, like Keith, valued being different, where others, like Emma and Sue valued being the same. Descriptions varied across interviewees, some were more critical of self and some more critical of others. The severity of the criticism varied.

In psychoanalytic terms, perfectionism is a complex defense and involves several other defenses. For example, Introjection of high standards and rules for living; Projection of feelings of anxiety or insecurity on to others; Splitting of the self and others into ‘all good’ or ‘all bad’ (i.e. successes or failures); and Projective Identification, that is the projection of an unwanted identity on to others.

There may have been Splitting in interviewees’ descriptions, with people described as either admirable or reprehensible. e.g. Rita was bad, a failure, who was not good enough for friends after her divorce whereas Mary was good as demonstrated by her strong sense of being a success. In general, interviewees were emphatic and evaluative about themselves and others. There were many examples of the internalization or introjection of the standards of their parents and parents’ world views. For example, Phil was often preoccupied with correctness.
In the Triangle of Conflict (Malan 1979), perfectionism fits as a defense against a hidden feeling of shame and the related impulse to strive toward being better. This fits with interviewee descriptions about how they conduct their lives. The subtheme captures aspects of interviewee fears and feelings about failure, disapproval, not mattering, being disappointed and being misunderstood. These could represent the anxiety in the Triangle, which they seek to escape through perfectionism. The Triangle of Persons illustrates the relationship between a person’s parents’ attitudes and how they treat themselves, therapists and others (Malan 1979). Interviewees described and used the dismissive and negative self-talk one might expect from those with a negative or critical parent. Some interviewee anxiety about the interviews may have been due to expecting condemnation or imagining my criticism of their contributions.

Cognitive Analytic Therapy understands patterns of relating as Reciprocal Role Procedures (Ryle & Kerr 2002) i.e. if a person perceives themselves as criticised or disapproved of in early care environments, they may develop a tendency to criticise or disapprove of the self and/or of others, because this is how they learned to relate. They may then develop a strategy to combat this if it produces distressing feelings – perfectionism being one such strategy.

Perfectionism, or at least perfection itself, is relative and this is important given the evaluative behaviour of many interviewees. They looked to others and compared progress with others when evaluating. Evaluating can be thought of as vertical relating or a tendency to see others in terms of difference or superiority rather than as similar or equal. This suggests that equitable relationships may be difficult for interviewees to forge. That evaluation is intrinsic to perfectionism suggests perfectionism obstructs relating by undermining trust and feelings of acceptance.

There may also be an unacknowledged role for envy within evaluative behaviour. Object-Relations theorist Melanie Klein would expect to see envy and self-envy in perfectionists (Brustein 2014) and interviewee comparing, evaluating, admiring and desiring to emulate others suggests envy. Again, in relative terms, experience is only negative when imagining or envying something comparatively better. Interviewees may have perceived others to be having more positive early (or later) experiences than
they were, especially if their own experience involved misattunement, upheaval or neglect. Klein also described self-envy which involves feeling underwhelmed by one’s own achievements even when knowing objectively and relatively, that these are successes. Interviewees rarely described successes in any detail. Although this may also represent a British cultural belief that this would be conceited behaviour and so rude.

Interviewees descriptions of evaluating and comparing and their condemnation, disapproval or criticism of themselves and sometimes others also fit with Walker’s descriptions of the Inner and Outer Critic (symptoms of CPTSD) (Walker 2013). Many interviewees described themselves and their mistakes and judgements as stupid or ridiculous.

A thread underpinning many of the descriptions in the main theme Ongoing habits impacting on relationships is that much of what the interviewees describe has a psychic effect of distancing, removing or dividing them from others and so from emotional intimacy with others. Whether consciously or not, this is perhaps because they perceive threat from others.

The subthemes within this theme suggest interpersonally triggered shame being avoided by: moderating expectations of others and feeling suspicious; predicting and so avoiding shame in interpersonal interactions; striving (including planning and persevering); disregarding of others which accompanies this i.e. driving others crazy, frustrating others; vigilantly evaluating and comparing the self and others; and avoiding relationships. Developing attachment fears also leads to avoidance of interpersonal situations where shame is a risk, e.g. the fears of letting others down, dependency and performance described by interviewees. Criticism and disapproval also avoids the shame of being wrong or making an incorrect judgement, allowing the individual to be right. In psychoanalytic terms this is a projective identification defense which identifies wrongness (and associated shame) within the other person rather than within the self (Hahn 2000).

The purpose of this study is to learn more about how perfectionists describe, understand, experience and imagine relationships and so it is useful to look at all the
themes together. Together they shed light on the perfectionist constellation. In this context constellation refers to both their relational constellation (or the landscape of the relationships in their lives) but also to whether these experiences themselves constellate or cluster together. This study effectively asks: Is there clustering together of these self-identified perfectionists relational experiences? Have they had similar experiences or not? Are any similar relational experiences integral to perfectionism? These are ambitious questions. It is not possible answer this last question fully from a sample of this size or generalize from the experiences of twelve interviewees about all perfectionists. That would be creating a map from a very small territory, but it may enhance our understanding to consider it.

These twelve individuals appear to describe, understand, experience and imagine relationships in some similar ways as illustrated below.

As the diagram in Figure 5 illustrates, the first main theme, Challenging relationship* experiences in the past* and its subthemes: Parents in conflict with one another; Difficult to understand parent; Difficult to please parent; Difficult to reach parent and; Traumatic events in relationships illuminate much about the early relationship experience of the interviewees. Fundamentally, interviewees experienced some of their care-giving as potentially traumatic and emotionally misattuned to their childhood needs. The descriptions in Challenging relationship experiences in the past reflect and resemble many aspects of Webb’s work on Childhood Emotional Neglect (Webb 2012), Walkers conception Complex PTSD (Walker 2013), Herman’s conception of Complex PTSD (Herman 1992) and arguably van der Kolk’s Developmental Trauma Disorder (van der Kolk 2015). There were clear traumatic experiences e.g. betrayal, death, bullying in the descriptions of the interviewees. Alongside this there is scope for considering that there are unmet selfobject needs (Kohut 1971) and ‘mirrorhunger’ (Marmarosh & Mann 2014) in interviewees early experience of parents who were difficult to understand, please or reach. In Kohut’s view, this leads to pathology due to lack of mirroring, idealising and twinship feedback. There is also scope for recognising the attachment difficulty that their experiences presented them with and how this may have led to relatively insecure attachment styles (Bowlby 1969) (Mikulincer & Shaver 2010) and feelings of isolation and aloneness (Applebaum 1994). Malan’s Triangle of
Fig. 5 Interaction of Themes and Relationship Outcomes
Conflict and Triangle of Persons suggest experiences like many of those described may lead to shame, shame defenses and impulses and behaviours being deployed, consciously or not, to avoid this (Malan 1979). Ultimately all these theories suggest potential behavioural and relational consequences and adaptations including striving to be good, preoccupation with helping, striving to relate to a parent or resolve conflict - which children can feel as undifferentiated from themselves (Cummings & Davies 2002) – or learning to somehow do without that parent emotionally. It is possible to see in this how environments experienced like this may feel like totalitarian regimes to the children in them. In fact, all the subthemes indicate emotional obstacles between the interviewees and their parents which the interviewees may have required strategies to cope with.

In the second main theme - **Feeling unpleasant sensations and emotions in the past and present** - the subthemes were: **Feeling disappointed, misunderstood and not listened to by others; Feeling angry hurt sad and vulnerable because of others; Feeling anxiety and fear for or of others** and; **Feeling distress and being in crisis**. These feelings, most often about others or in relation to how interviewees are perceived by others suggest the interviewees struggle with negative emotions and appraisals of their interactions with others. These experiences reflect what Kohut would expect to see in individuals with unmet selfobject needs - preoccupation with others approval and struggling with anxiety to a greater or lesser degree. Cognitive Analytic Therapy (Ryle & Kerr 2002) and Schema Therapy (Young, Klosko & Weishaar 2003) indicate how perfectionism may impact on cognitive appraisal. Experience like this can result in a cognitive or apperceptive habit of interpreting others as having negative beliefs about the self or negative intentions toward the self and feeling persecuted by the experience of this. Similarly, trauma theorists like Walker argue that the experience of relational trauma erodes self-esteem, creates hypervigilance and a predisposition for seeing others in terms of ‘friend or foe’ – itself a black-and-white thought habit (Walker 2014). There is also a tendency toward disappointment (van der Kolk 2015). Psychoanalysts might see a ‘friend or foe’ habit as splitting where Cognitive Behavioural Therorists would see it as a cognitive distortion and indicative of harmful or undermining core beliefs. In both CAT and Schema
Therapy, experience leads to expectation i.e. how the interviewees might imagine relationships – e.g. as difficult, frightening and overwhelming.

Interviewees who did not describe anxiety but whose behaviour seems designed to avoid it, might be considered as alexithymic by psychoanalytic embodiment theorists (McDougall 1989) and trauma theorists. Alternately they might be understood as avoidant or self-concealing where they demonstrate anxiety but do not describe it e.g. motor tension in the interview or behaviours like striving assiduously to avoid the shame of failure. Shame, a social emotion, alluded to by interviewees was rarely discussed directly. It appears relevant to their experiences and it is also understood as integral to trauma, betrayal, resolving attachment crises and psychoanalytic understandings of perfectionism as a defense mechanism. Temperament is also relevant to their experience and any thorough going consideration of perfectionist relating needs to consider it. Overall the interviewees struck me as generally tending toward lability, anxiety, obsessiveness, irritability and optimism (despite the often-negative focus of the interview material). They were also noticeably helpful and conscientious.

The third and final theme – **Ongoing habits impacting on relationships** – has subthemes of: *Expecting disappointment and feeling suspicious of others; Exasperating others through striving; Avoiding others* and; *Evaluating, comparing and criticising the self and others*. These subthemes are essentially descriptions of behaviour that interviewees described regularly doing and/or that I observed them doing. Psychoanalytic and Cognitive Analytic theorists would expect to see behaviours of these types in individuals with the relationship experiences these interviewees described e.g. individuals struggling to make and maintain supportive, attuned relationships in childhood are likely to experience disappointment and anxiety. CAT Reciprocal Role Procedures suggest this could manifest as feeling pre-emptive disappointment or a strategy of predicting disappointment in others. Struggling to gain approval, subsequent anxiety and striving to overcome this or achieve approval later in life is another example of how early relational experience may manifest later. This is a cyclical aspect of interviewee relating that both CAT and CBT’s sequential diagrammatic models capture well (Ryle & Kerr 2002) (Shafran, Egan & Wade 2010). It is also reflected in self-psychology: to Kohut, repetitious behaviour seeks to gain affirmation,
idealisation and affiliation which were missed earlier in life (Kohut 1971). More recent psychoanalytic conceptualisations of defenses see them not merely as attempts to keep shame, for example, out of awareness but as evolving efforts to solve and overcome a problem (Lemma 2003).

For the interviewees the experience of those relationships, was variously confusing, frightening, insufficient, disappointing and on some level hurtful and appeared to lay them open to experiencing those feelings again with others later in life. This potentially leads to behaviour (and sometimes compulsions) which avoid unpleasant feelings and to being unable to relinquish these behaviours, despite any associated costs. This illustrates a relationship constellation where interviewees – consciously or not – feel easily hurt by others and so understand relationships as potentially harmful, hurtful or disappointing. Some appeared to find good relational experience surprising and difficult to assimilate. Imagining relationships as harmful, viewing them with caution and seeking to avoid or maintain a level of self-reliance within them and so manage relationships using avoidance, analysis, evaluation, striving, pre-emptive assumption and vigilance (to avoid further hurt and disappointment) is understandable in this light. Obviously, this carries a risk of loneliness and a tendency to relate either inequitably or only partially and so perhaps undermines trust further.

Attachment, Kohutian, CAT and Schema therapeutic theories all indicate how individuals may devise a strategy to alleviate feelings by being perfect. They also account for the finding that the self-identified individuals interviewed can be described as having experienced early difficulty in relationships or relational trauma which affected their self-image and causes feelings of shame and anxiety. However, these theories, often decontextualize the experience they seek to explain and pathologise it and those it is applied to.

These twelve interviewees varied enormously in the strength of their disappointment or hurt and their predictions of it. Their experiences of anxiety and their response to it also varied – some described severe immobilising anxiety and others did not. Crises also varied considerably in severity and in what triggered them.
A problem with general theories is that even when effort is made to acknowledge the multiple causes and effects of a phenomenon, they decontextualize individual experience. For example, trauma theory may categorize a perfectionistic response to anxiety and feelings of uncertainty in a person who attended boarding school from a young age as the same as perfectionism in a person who is vigilant, has low self-esteem and was neglected by an alcoholic parent. Both may be viewed as perfectionism from CPTSD but the experiences, the individuals, any consequences and their manifestations may differ significantly – even the nature of the perfectionism, what it applies to and whether the individuals themselves view it as perfectionism may differ.

A further example of decontextualisation is that very little in the literature reviewed accounts for interviewee partnering preferences. The descriptions of these interviewees do not fit well with research findings that perfectionism increases dyadic perfectionism and relationship distress and that perfectionists are potentially demanding and unsatisfied regardless of attachment style (Lopez, Fons-Scheyd, Morúa & Chaliman 2006). This may perhaps be because Lopez et al. focussed on relationships of only 3-month duration and their participants were also from a limited age group. The interviewees in this study were on average 20 years older. Unfortunately, there are few other studies which focus on the nature of perfectionist relating.

Where depressed perfectionists having been described as not easily able to use and maintain social connections as a coping resource (Blatt & Zuroff 2002), these interviewees did have social support and secure connections. Some less so than others and the level of intimacy and support was not always clear but nevertheless, eleven had support from partners, family and friends and one from an involving sporting hobby and a pet. There is a lack of information about the life context of perfectionists in other studies which is not so in this study. The information about these interviewees may indicate something about the apparently good mental health and resilience of the interviewees in comparison to the patients in the NIMH TRDRP (Elkin et al 1989) who coped poorly according to Blatt and Zuroff (Blatt & Zuroff 2002).

The decontextualizing nature of much quantitative research means where it does not look directly at relationship dynamics, they often get ignored along with factors that
may mediate and affect them. These findings suggest that individual perfectionism and relationship experiences interact with many aspects of the life context and identity, as shown in pink in the diagram (See Fig 6). These life context aspects are numerous, and this interaction is shown by the circular arrows. The interviewees described realizations they had had e.g. Lee’s ‘personal pain’ and need to change which suggest that aspects of perfectionism, relationship approach and identity are subject to revision.

Interviewees described themselves as ‘ex-perfectionist’ or of having been ‘declawed’ (of exacting high standards of others). These descriptions echo those of participants elsewhere i.e. ‘rehabilitated perfectionist’ (Slaney & Ashby 1996). This group were highly therapeutically educated and focussed on personal change and to some extent have overcome perfectionism or the distress causing aspects of it which suggests it is subject to revision. This is not accounted for in perfectionist literature.

Interviewees had also experienced positive benefits of perfectionism which they valued. These included wealth, variety in careers and career satisfaction, interesting hobbies and sporting achievements. It had provided opportunities they may not have had without it and appeared to improve self-value and life chances over time.

The experience of these interviewees differs from that collected from participants in quantitative studies. It is not known whether this study attracted self-identified perfectionists who had gained self-esteem due to: pre-existing positive competency beliefs; relationship and career commitment; psychotherapy; or through self-awareness and the desire for peace and connection. What is clear is that there were positives which were common to many interviewees (long-term relationships, career success) some of which they attributed to perfectionism which quantitative studies of perfectionism do not capture. If these positives are common, continued use of instruments conceptualising perfectionism as pathological is inaccurate and overlooks positive experience which may obscure important protective factors, exceptions or personal resources which perfectionists use.
Fig 6. Life context mediates relationship experience and response

Interviewee descriptions essentially support a conceptualisation of perfectionism as a deficit overcoming defense which may help to achieve feelings of security through career or relationship success. The defense may remedy deficits in mirroring. This does
not solve some aspects of experience and their impacts however. The **Unpleasant sensations and emotions in the past and present** and the **Ongoing habits impacting on relationships** themes still indicate that interviewees may not easily be able to regulate negative emotions and they may not be well attuned to others, even in long term relationships. Perfectionism and associated striving may help perfectionists overcome relating issues but only in some respects. Andrew Shea’s concept of Dyadic Discrepancy is useful here (Shea 1999). He found it to be a good predictor of relationship distress. It could be that persevering in relationships helps perfectionists to overcome romantic dyadic discrepancy and improves relating capability. Likewise, interviewees who no longer consider themselves perfectionist but remain orderly with high standards and perhaps controlling may indicate that perfectionism can have a recovery trajectory or a lifespan, becoming obsolete as a defense. We could imagine this as perfectionists passing through extended stages of change from Pre-contemplation to Contemplation to Action (Prochaska & Diclemente 1993) which contribute to it improving the core vulnerability beneath it and reducing associated distress. However again, it does not appear to wholly remedy lack of trust and resolve feelings of emotional vulnerability around others. This was evident in the subthemes of **Feeling disappointed, misunderstood and not listened to by others** and **Feeling angry, hurt, sad and vulnerable because of others** still being experienced by interviewees. This perfectionism may be less negative than current clinical and quantitative psychology explanations allow perhaps because most of the interviewees had left behind traumatic relationships of the past which, in itself, may reduce the need for perfectionism as a defense.

Slaney and Ashby noted that perfectionism has often been deemed as extreme, excessive or pathological (Slaney & Ashby 1996). They suggest the pathological association came from anecdotal information based on non-representative samples of clients of various US psychology professionals. High standards and orderliness, although consistently held to be central to perfectionism, are not consistently related to distress, relationship problems, procrastination or even to perfectionism itself. They cited studies which refuted these claims and concluded there is a tendency to overemphasise its negative qualities (Slaney & Ashby 1996). For example, much of the quantitative research conducted uses either HMPS (Hewitt & Flett 1991) or FMPS (Frost
et al. 1990) as its definitional basis and these both measure pathology and help to rule out 'sub-clinical', low scoring perfectionists. This research has then sought associations between maladaptive perfectionist traits and psychopathology including depression, anxiety, OCD, eating disorder, personality disorder, negative interpersonal traits and negative social perception.

Whilst the interviewees in this study described experiencing low mood, anxious feelings and obsessive thoughts, they did not appear to think this pathological or central to their life experience. They more often revealed social caution, and similar styles of interpersonal apperception and attribution regarding other people’s intentions and meanings. These styles were not strictly ‘negative’ but they have potential to complicate and derail interviewee relating. Many described negative perfectionism experience which made life harder but not that perfectionism was the resoundingly negative or distressing experience which some quantitative conceptualizations imply. Quantitative research also relates High Standards and Order to self-esteem (Ashby & Rice 2002) this may indicate why perfectionists have positive experience, are reluctant or unable to relinquish perfectionism and why many do not seek help for perfectionism despite experiencing distress (Merrell et al. 2011). i.e. they have the felt sense that aspects of perfectionism are protective. The decontextualizing nature of quantitative conceptualizations also does not acknowledge that interviewees may experience low mood due to events unrelated or only indirectly related to perfectionism. Decontextualising distress in this way is misleading because it implies that perfectionism is a problem rather than a symptom, that it is a central problem and that it can only be pathological in nature.

Slaney and Ashby’s observation that conceptualizations privilege the negatives of perfectionism (Slaney & Ashby 1996) prompted a rethink of the negative aspects of perfectionism and revision of the APS. It was succeeded by the APS-R (Slaney, Rice & Ashby 2002) which included the Discrepancy subscale. Discrepancy measures a perception of consistently failing to meet standards one has set for oneself and has been associated with distress (Slaney et al. 1996). Discrepancy is independent of High Standards and Order and is significantly correlated to DAS perfectionism (Slaney, Rice & Ashby 2002). The interviewees described how others do not meet their standards and
more rarely their sense that they do not meet the standards of others. The described an awareness or even fear of not doing things well enough for others. Some feared disappointing others at work (Lee, Mary), friends (Rita), experiences of disappointing others or being found to be disappointing (Olga, Jennifer, Emma).

It appears that Interpersonal Discrepancy can go both ways. They also described feeling disappointed by friends (Lee, Kate, Sue, Sarah) family members (Mary, Emma, Jennifer, Phil, Rita, Sue, Sarah, Katrina) groups, co-workers, professionals, organisations and therapists (Olga, Sarah, Kate, Lee). The interviewees experience Interpersonal Discrepancy and project this experience on to others i.e. expecting others to be disappointed in them.

Interpersonal Discrepancy could account for many relational experiences described in this study and interviewees wariness of others, who they imagined would misunderstand or disappoint them or who had disappointed them in the past. It also accounts for their descriptions of themselves as likely to disappoint and in turn for many of the behaviours they described in the Ongoing habits impacting on relationships theme i.e. suspecting, avoiding, striving to exhaustion, evaluating, comparing and criticising. The descriptions and potentially the patterns described in the Challenging relationship experiences in the past theme capture how Interpersonal Discrepancy came about. CAT Reciprocal Roles (Ryle & Kerr 2002) are useful for understanding perfectionist interpersonal experience more generally because they offer a mechanism which can capture the experience and impact of interpersonal discrepancy without dictating its precise nature and so decontextualizing the individual.

The example relational narrative script for Interpersonal Discrepancy below shows how might be reminiscent of the ‘tyranny of the shoulds’ (Horney 1952) and potentially cognitively tiring and disorientating to experience.

*I am not as I should be (because I do not do as I should)*

*You are not as you should be (because you do not do as you should)*

*The world is not as it should be (because it is not as I think it should be)*

There are real consequences of pathologising perfectionism both in this study and outside it. In the study, the four interviewees in psychology-related professions asserted
their ex-perfectionism most strongly. This may be because they had been helped by therapy and long-term relationships but given that they described still behaving compulsively and two described ongoing attitudinal rigidity, perhaps as psychology-aware interviewees, they rejected the perfectionist label because they are aware of its ‘pathological’, ‘clinical’ and so shaming connotations. Consequently, individuals committed to self-reliance or with dismissive or avoidant attachment styles - may avoid therapy and acknowledging associated behaviours and feelings for this reason. This may increase the potential of perfectionistic clients entering therapy when already in crisis, experiencing high discrepancy in many areas of life and subsequently finding alleviation harder to achieve through psychotherapy.

Outside the study, the consequences of pathologising perfectionism include that perfectionists participating in unguided self-help conditions in two CBT outcome studies were recorded as being more distressed after the interventions than before (Pleva & Wade 2007) (Rice, Neimeyer & Taylor 2011). It appears that using psychoeducation style self-help based on a CBT model as an intervention which characterises perfectionism as wrong or problematic delivered without supporting or mediating relationships may worsen distress. These use manualised CBT protocols rather than tailored approaches and may make participants feel generally problematic and potentially disregarded the level of personal experience. The interviewees’ descriptions in this study of feeling disappointed, misunderstood and not listened to suggest this. Secondly the tasks and topics of the unguided conditions may have been triggering and provoked negative self-evaluation. CBT can focus on unhelpful thought patterns and distortions which may lead perfectionists to feel they are doing something wrong. This educational and corrective stance may collude with or reconfirm negative self-beliefs about being personally defective and trigger achievement related fear. There is a high risk of negative self-evaluation appraisal of failure and/or fear of failure. Whilst feeling corrected may be familiar or acceptable to perfectionists, it can also re-wound self-esteem in the absence of a containing, regulating relationship. This may explain increased distress in unguided condition participants. The damage potential of a pathologising perspective and therapy approaches adopting this and axiomatically, conceptualising it as a defect is highly problematic, wounding, disempowering and
potentially iatrogenic to those who already feel defective. Containment and emotional safety are pivotal for recovery.

The interviewees were responsible, conscientious with a tendency to analyse and evaluate. There is a strong possibility that current definitions of perfectionism confer responsibility for an individuals’ apperceptive ‘distorted’ style on that individual which may isolate them and effectively blame them for their own distress and which perfectionistic individuals are disproportionately vulnerable to feeling responsible for and perhaps ashamed of.

The perfectionists I interviewed were also sensitized to power dynamics in relationships due to their life experiences – witnessing conflict between parents, struggling to understand, please or reach a parent, relational trauma, feeling disappointed, misunderstood and not listened to by others, feeling angry, hurt, sad or vulnerable because of others and feelings of anxiety and fear for and of others for example. These experiences were not empowering to the interviewees as children and they expressed wariness of oppressive people and circumstances. Perfectionists perceiving an unequal power dynamic between therapist and client may be wary of therapy and struggle to engage in the working alliance fully. This may be enhanced by diagnostic labelling, medical style referral routes and authority laden therapy style and could suggest how ‘reduced capacity to benefit from therapy’ might come about for those with similar experience to the interviewees (Brustein 2014) and potentially both ‘how and why’ they struggle to engage with therapy (Habke & Flynn 2002). They may approach relationships with a tendency towards experiencing and projecting Interpersonal Discrepancy and experiencing impaired safety and trust as a result. Many therapy-aware interviewees talked retrospectively and articulately about their emotional experiences and this suggests therapy helped them to construct and convey their experience.

In considering how the interviewees describe, understand and imagine therapeutic relationships, some described hating therapy and finding it uncomfortable which is in keeping with experiences of Feeling disappointed, misunderstood and not listened to, Feeling angry, hurt, sad and vulnerable, Expecting disappointment and feeling
suspicious of others and Evaluating, comparing and criticising the self and others. Despite this, ten interviewees had persevered at it, with five describing it as successful. Three did not comment on its success and the two remaining suggested it was unsuccessful but gained benefit in terms of perspective which led to other more successful - less relational, more trauma focussed - therapies including hypnosis and Eye Movement Desensitization and Reprogramming (EMDR). Two others simply described it unsuccessful and they had disengaged from therapy.

Regarding therapists, interviewees valued; someone they could trust, someone they could believe in, authenticity, communication about therapy process, like-mindedness, lateral thinking, cognitive challenging, making progress, awareness of language, new perspectives, doing what was needed, righteous anger, clear-sightedness, therapeutic flexibility, tailoring, risk-taking, experience, youth, assertiveness, courage, honesty, availability, safety, strength, competency, making a plan, not being able to leave and value for money. In this, the interviewees differed from more general samples about which personal attributes they found to positively impact on alliance in other studies (Ackerman & Hilsenroth 2003).

The interviewees valued rationality, effectiveness and trustworthiness more than the warmth, friendliness, facilitating of feelings and general supportiveness valued by a large general sample whose perfectionism was not known (Ackerman & Hilsenroth 2003). Only interviewees with long-term therapy experience described valuing trust, warmth, acceptance and containment. This may indicate that interviewees initially value alliance enhancing or maintaining qualities less than a general sample. As a result, interviewees may have preferred (and been habituated to) avoiding emotional affect and so been more comfortable with cognition-focussed rather than emotion-focussed therapies.

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2 The durations of therapy for these five ranged from a few months to several years.
3 EMDR and hypnotherapy may have benefitted these individuals more than talking therapy if working alliance could not be reached.
Preference for cognition-focus and potential for avoidant or dismissive attachment suggest the possibility of therapist collusion with perfectionistic clients and psychotherapists may be unconsciously drawn into colluding with clients avoiding shame or distress for example. This may be in the form of structural collusion, where clients choose cognition-focused models like CBT or simple collusion where they avoid emotion and so potentially is addressing core shame vulnerability directly. This may render therapy ineffective. Clients high in openness and attachment security have been found to be less averse to self-exploration (Petronzi & Masciale 2015) and observing client openness or willingness in the assessment phase may indicate attachment security and potential for collusion and so help to resolve barriers to efficacy.

Another observation from this study is that, of the interviewees, the most relentless strivers were those with a **Difficult to understand parent**. They valued achievement and success the most highly and those with two parents like this, who they found unfathomable and/or emotionally unknown described the most rigid and difficult-to-cease striving, higher levels of suspicion and questioning of others and demonstrated that suspicion in the interviews. It may be that lack of feedback (Webb 2012) or inadequate mirroring (Kohut 1971) leaves a deficit in standards to introject and so mainstream cultural standards about success and achievement are introjected in their place and more wholly and inflexibly than in others in order that these individuals have ways to meet these needs.

Unfathomable parent experience may make relating and trusting others difficult. At interview, allowing myself to be interviewed, answering questions and being vouched for or recommended by trusted others all facilitated rapport. Allowing space for interviewees to assert their credentials and appreciating their strengths increased trust and the quality of the interview relationship. It follows that doing this in therapy as well as talking explicitly with clients about how to deal (together) with feelings of suspicion or perception of unfathomableness may also improve alliance, and the chance of restitutive attachment experience (Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon et al 1996). This may help to level the perception of unequal power dynamics implicit in the client-therapist relationship which have the potential to damage the alliance. Acknowledgement of the progress of prior therapy is known to improve therapeutic
alliance (Norcross 2012) but for the reasons above, may be particularly important for perfectionists. Improvement in working alliance has been found to lead to improvement in social resources and greater symptom relief in clients (Mallinckrodt 1996). Blatt and Zuroff suggested depressed perfectionists’ ability to make use of social connections and resources was pivotal to reducing their vulnerability to distress and isolation (Blatt & Zuroff 2002). This takes time and careful, attuned effort hence depressed perfectionists do comparatively better in therapy which is longer in duration and higher in per week session frequency (Blatt 1995) and delivered by psychologically minded therapists (Blatt & Zuroff 2002). This all leads to the conclusion that an open, intensive, attuned approach is better for those with greater relational barriers to surmount. Attunement was necessary in the interviews. I paid close attention to how interviewees perceived me and tried to address any sense I got that interviewees were experiencing me as suspicious or threatening. The findings of this study support the view that a client’s inner representations can limit their capacity to benefit in therapy and that acute sensitivity to interpersonal process is important (Blatt, Shahar & Zuroff 2002).

Perfectionists may benefit from therapist recognition of shame transference and countertransference, therapist ability to reflect how the client is experiencing the therapist and vice versa, and the creation of a ‘sense of reunion’ to ‘assuage feelings of abandonment and emptiness’ (Hahn 2000). Some focus on shame and addressing how to manage it has been found to be preferable to non-therapy clients rather than withdrawal or over-focus on shame (Dorahy, Gorgas, Hanna & Wiinggaard 2014). The interviewees recognised that therapists who recognised, differentiated and contained their experiences were most helpful. It may also be helpful to overtly acknowledge possible pitfalls in relating because interviewees who discussed their client-therapist relationship and trusted the therapist’s intentions reported more success. Rennie has described the benefits of metacommunication in therapy (Rennie 2000). Communicating about experience of disappointment, Interpersonal Discrepancy, expectations and the trajectory, atmosphere and culture of therapy could be highly beneficial to clients with experience like these interviewees.

Perfectionism or rigidity in therapists may be unhelpful. Interviewees gave examples of therapists insisting on addressing their relationships with alcohol or their in-laws at the
expense of the interviewees own priorities and described them as ‘missing the point’. A study of 170 counselling supervisees found relationship rupture was a risk where supervisees were perfectionistic about work performance, experiencing discrepancy and identified as Attachment-Anxious (Gnilka, Rice, Ashby & Moate 2016). Therapists awareness of their own triggers, attachment styles and perfectionism may be important for perfectionist clients. Holmes outlines specific attachment-related consequences of collusion; controlling therapists may end too early with attachment-avoidant clients (Holmes 1997) i.e. before the work is complete and the client has internalized the view of ‘someone who understands me’ and truly learned to self-reflect (Fonagy et al. 1996). Conversely, over-empathic therapists with attachment-anxious clients may end too late i.e. long after the therapy benefit ceases (Holmes 1997). To attachment theorists, therapy provides the adult equivalent of a child’s internal world being organised by caretaker attunement and empathic translation of their thoughts, feelings and actions that is shared by both child and caretaker (Hahn 2000).

The interviewees were concerned with knowing what the interview would involve and who I was. This may be a sign of attachment related anxiety and they may have wanted to establish if I was friend or foe. For example, Lee conducted a short interview of me prior to my interview of him. Understanding interviewee expectations and managing them to avoid disappointment and misunderstanding was necessary in the interviews as was some self-disclosure and a friendly, warm, open demeanour. Knowing something about the interviewer was important to some interviewees and so I disclosed information about my perfectionism, my interest in it, my intended career, my training, my academic and cultural background, my understanding of perfectionism and my experience or recognition of it in family, friends and others. I also disclosed my single and non-parent statuses to some interviewees.

This disclosure may have affected interviewee disclosure in some respects. Many became more relaxed when they knew more about me and my intentions toward them and for the study. This may also be due to poor cultural perception of perfectionism and its association with being uncool, fastidious, pedantic and puritanical. Most wanted to know if I was perfectionist. I responded that I am and that I have perfectionistic thoughts. This may have had the effect of the interviewees assuming I shared their
experience and so explaining less about their own perfectionism to me, a danger Hayfield and Huxley have pointed out (Hayfield & Huxley 2015). This may not be problematic for this study because they tried hard to explain their relationships and feelings to me which was its focus. My disclosure may have provoked evaluation of me and comparison although most interviewees took it positively and showed interest in it. Many asked my opinions about perfectionism and I often needed to refocus interviews on to their experiences. This may have been a sign of some interviewees wanting to avoid personal or emotional territory but also of genuine interest in if others shared their emotional experience and perhaps a desire for kinship with these others.

The interview format attracted mostly articulate, therapy-aware, self-aware, white women aged 35-65. For the less articulate individuals, talking about themselves was more effortful and the interview appeared to be a demanding exercise. I tried to temper this by avoiding jargon and a performance atmosphere, but the medium of interviewing is limiting and may be unattractive to perfectionists with performance anxieties or those who prefer to self-conceal.

These observations give rise to a methodological point about objectivity. The intention was that the interviews were relaxed, non-invasive, avoided disrupting the world view of interviewees and collected objective data from them. However, as described the interviews did become emotion regulating and cognitively restructuring at times simply because interviewees answered questions they had not considered before. Many remarked on the experience and the way it made them think about their lives. There is tension here between the hoped-for objectivity and the reality that interviewees’ accounts were changed by the interview itself e.g. some expressed relief that others including me, might share their experiences suggesting that their personal realities were perhaps more sensitive to revision than I first considered. Secondly this required acknowledgement of the difference between therapy and research in the interview. Ultimately it was necessary to remind interviewees as soon as appropriate when interviews began straying in a therapeutic direction. Research is ultimately to the benefit of the researcher, researcher led and focused on the researcher’s chosen question. As such there is no agreement with the interviewee to work with them towards change and no contract or transactions to this effect. The intent is data
collection. I found that subtle, directive unspoken gestures like consulting the interview schedule, picking up a pen or glancing at the audio equipment at a suitable moment as well as asking if they wanted to go on with the interview worked well to refocus interviewees. I also addressed how we would handle strong emotion in the interviews to those expressing concern, prior to starting them. I think it would be difficult to achieve this level of rapport and disclosure without handling distress in some way and I think avoiding it might have an impact on the richness or depth of the data collected. Researchers using expressive writing also found that participants used it to work through distress so perhaps it is difficult to avoid in this topic (Merrell, Hannah, Van Arsdale, Buman & Rice 2011).

The interviews also highlighted boundary and expectation issues that Hayfield and Huxley suggest are likely with insider research (Hayfield & Huxley 2015). To affirm the research purpose of the interviews I also found it useful to end some topic areas where boundaries were becoming pressured for example when an interview asked for advice and pause and consult my interview sheet before starting a new line of relationship-oriented questions. I remained vigilant as boundaries remained an issue with some interviewees who slightly commandeered the interview or sought control over it and others who could be reticent and sometimes say little. I consider that these are traits and so interviewees may be experienced like this by others in their lives.

At a personal level, as Counselling Psychology is predicated on confidentiality, I found it difficult to disclose my thoughts and conclusions about the interviewee’s processes and descriptions during the writing up process because it seemed disloyal. My discomfort was heightened by interviewee’s discomfort with some subjects and when I detected desire to conceal aspects of themselves, possibly because I experience this desire myself. The line between research and betrayal is a fine one and I managed this tension by reminding myself that interviewees gave their informed consent and wanted to participate despite personal discomfort because they believe the subject is important. My focus became to do justice to their efforts and I remained aware of a desire not betray them or humiliate them and vigilant for desire to collude in self-concealment and protect them from scrutiny.
Following this project, I understand the research process as more transactional and intersubjective that I did, and I have become more philosophically constructivist in light of it. Pragmatic critical realism can accommodate this paradoxical state because it can tolerate constructivism in a weaker sense – that there was construction and personal narrative in their accounts. Critical realism and constructivism are axiomatic, i.e. commensurable as epistemological philosophies and do not negate one another (Lincoln, Lynham & Guba 2011).

The interviewees shared similar experience, contexts, cultures and understanding of perfectionism, relationships and some ways of talking about these. Their relative homogeneity as a group suggested that similar realities were being experienced but this does not describe a shared global perfectionist experience like those inferred in the mainstream literature.

Given how the complexity of perfectionist relationship perception may affect research, future studies may benefit from mixed method or multimethod approaches. These could include expressive writing, self-interview, interview by multiple interviewers, video observation and process study of the intersubjective processes could reveal considerable detail and information about what happens in perfectionist relating moment to moment and may do much to avoid perfectionist interpersonal wariness interfering with data collection (Hesse-Biber & Johnson 2015).

Also, questions focussed on information which can enhance therapeutic alliance including stage of change (Prochaska & Diclemente 1992), level of functioning (Norcross 2012), the life and trauma histories of family members and experience of Interpersonal Discrepancy could establish more about if and exactly how relating capacity might vary across these experiences. For example, the interviewees described hardships their parents had endured, their own compassion and understanding of these experiences and described them as potential sources of their own difficulties. As a group, the interviewees were highly responsible and sensitive to distress in others and had parents who had experienced abandonment, poverty, emotional hardship and
gender oppression.\(^4\) This kind of information could significantly contribute to a therapeutic knowledge base about the relational impacts of perfectionism.

Future qualitative relational research also might seek those with a wider diversity of life, cultural and occupational experience than this study reached e.g. black perfectionists living in majority white cultures, perfectionists in perfection-seeking professions, those descended from misplaced peoples, ex-perfectionists, transgender, physically-challenged or older-aged perfectionists for example.

10. Conclusions

The strengths of this study lie in that it is a thoroughgoing exploration of how these self-identified perfectionists describe, understand, experience and imagine relationships. Imagining takes the form of expectations and predictions about others. The main themes were: *Challenging relationship experiences from the past*, *Feeling unpleasant sensations and emotions in the past and present* and *Ongoing habits impacting on relationships*.

The descriptions these themes and their subthemes encompass show how and why it may be difficult or undesirable for self-identified perfectionists to form and maintain therapeutic alliance. Their experience of relational trauma may contribute to further distressing experiences of others and mistrust of others. This could lead to feelings of abandonment and rejection and difficulty with internalising positive validating messages about the self and others. These experiences may have lead the individual to adopt strategies to avoid rejection and abandonment – such as trying to be perfect.

As a strategy, perfectionism becomes self-perpetuating and can maintain difficulties, distress and perceptions which fuel it. Between them, the Cognitive Behavioural, Cognitive Analytic, Schema, Psychoanalysis, Trauma and Attachment theories considered in the study allow for an understanding of perfectionism as a sequential,

\(^4\) Several interviewees’ mothers were described as prevented from achieving career success or financial independence by circumstances or societal expectations.
transactional result of misattuned interpersonal experiences. In this way, these theories account for some of the findings in this study and indicate that perfectionism is fundamentally relational in origin. Ignoring these origins risks decontextualizing perfectionism and may render therapeutic practices which ignore it, less effective in the long-term e.g. the unassisted CBT based self-help protocols where participants reported more distress after participation.

The study identifies that Discrepancy (Slaney et al. 2001) is experienced interpersonally i.e. the interviewees perceived themselves as failing to meet the standards of others and perceived others as failing to meet the interviewee’s standards. This indicates that where perfectionism is relational in origin, it is also relational in manifestation. Interpersonal Discrepancy informed the day-to-day interpersonal experience of the interviewees and so warrants further research. Whilst a committed approach to romantic relationships appeared common to many interviewees and could confer long-term relationship benefits, it did not resolve the wider Interpersonal Discrepancy they still experienced characterised by their disappointment, vulnerability and suspicion about others. Interpersonal Discrepancy affected how all interviewees described, understood, experienced and imagined relationships and sometimes how they behaved in the interviews. It also indicated that interviewees tended toward a characteristic relational perceptual style. This style, although mediated by many other forces in the individuals life context, can be regarded as a vulnerability or risk factor because it appears to be relationship disrupting and may interfere with the ability to use relationships as a coping resource.

Importantly, early experience of relational misattunement and cumulative trauma was common to the interviewees and it suggests a template for later difficulty with relationships. All had experienced disappointment and Interpersonal Discrepancy as a result. This suggests that perfectionism itself is an adaptation that some adopt to deal with difficulties of this type. A disappointed, discrepant, suspicious interpersonal attitude was described by all interviewees at some stage in their accounts. This may indicate conscious or unconscious traumatic memory of misattunement triggered by suspicions that they are not being listened to, understood, cared about or that they are not good enough. Overall, they had interpersonal styles, behaviours and beliefs which
indicate they value self-sufficiency and conscientiousness or believe these to be necessary for living. In turn, this apparent self-sufficiency may foster a perception in others that perfectionists do not especially need to be listened to, understood, cared for or validated. This may make it more likely that they will interpret others as falling short, be triggered by this and thus experience consequent negative feelings and/or social isolation.

A unique finding of this study is that all the interviewees described emotional misattunement and ongoing reservations, relational habits and Interpersonal Discrepancy which made relationships difficult for them to trust and easily maintain. Given that they all experienced this, it perfectionistic strategy has potential to be common to all individuals who suffer early misattunement, especially where perfectionism is culturally acceptable and encouraged response for the most part. In these terms, the number of people with perfectionistic strategies may be vast, even making up a majority in some populations. This implies than perfectionism is a very normal experience.

The relational experiences, emotions and habits described in this study constitute the perfectionist constellation described in the title. This constellation, which includes Interpersonal Discrepancy, is perhaps the most important and central facet of perfectionism for psychologists to understand in order to facilitate the alleviation of distress and to understand its interpersonal effects and impacts. This study offers an account of the interviewees perceptions and behaviours about relationships. It describes, with some immediacy, the action (and consequence) of what they think, and feel is happening in moments of relationship disruption or Interpersonal Discrepancy. This provides insight into how wary perceptual styles manifest themselves interpersonally.

In addition, the study suggests that these articulate, self-aware, older perfectionists have progressed through some of the impacts of early trauma, perhaps using aspects of perfectionism itself. Furthermore, they have achieved increasingly intimate and trusting relationships and have learned that they had relational blind spots. Most appreciated and were sometimes frustrated by the subtle and contradictory nature of their
perfectionism. Despite their experiences many had achieved considerable self-acceptance. Therapy with a small focus had been experienced as reductive and/or insulting by more than one interviewee. This indicates there is little benefit to perfectionist individuals in researchers trying to achieve a narrow, pathology-based, prescriptive and commercialisable definition of perfectionism. Especially if it is iatrogenic because it individualises problems, leads perfectionists to conclude that they are not good enough, inadvertently declares useful aspects of perfectionist experience to be pathological (e.g. order and high standards) and in effect pushes them back down a shaming path.

Overall, their relationship experience was far-reaching with cognitive, behavioural, emotional, intrapersonal and interpersonal manifestations. Given how profoundly integral perfectionism is to self, a therapeutic focus on healing trauma, building resilience, self-management, subjective understanding, Interpersonal Discrepancy and relationship building is likely to be effective and empowering for individuals with experience like this. In this light, a pragmatic and theoretically plural, normalising, non-diagnostic therapeutic approach which does not individualise the problem, pathologise the individual or decontextualize experience is desirable. Pluralism itself allows explanation of, and approach to, complex phenomena with complex and differing causes (Cooper & McLeod 2007).

The findings of this study are similar to the findings of earlier research focussed on parental relationships and gathered most often via case study. These earlier studies often found perception and experience of a lack of warmth and validation in parents (Sorotzkin 1985, 1998) (Burns 1980) (Missildine 1965). Later, quantitative studies increasingly reinforced these findings about lack of warmth and validation (Blatt 1995) (Blatt, Wein, Chevron & Quinlan 1979) (Brewin, Firth-Cozens, Furnham & McManus 1992). Research also found harshness (Soenens, Elliot, Goossens, Vansteenkiste, Luyten & Duriez 2005), control (Soenens, Luyckx, Vansteenkiste, Duriez & Goossens 2008), authoritarianism, neglect, (Hibbard & Walton 2014), family pressure and criticism (Hibbard & Walton 2012) in perfectionist’s experience of parents. Also, despite being anecdotal, the writings of trauma therapists are reminiscent of the childhood atmospheres that interviewees described (Miller 1979). However, this study does not
reflect the findings of the quantitative research of the 1990s and early 2000s as strongly. Research in the 1990s often sought to define and measure clinical perfectionism and the complexity of the interviewees descriptions of interactions with others here, are not reflected in the statements offered by the instruments used in that quantitative research. Perfectionism is generally understood to be damaging to relationships and, to some extent, this study supports that conclusion because it finds cautious social perception in the interviewees which can obstruct relating.

The interviewees were generally positive in outlook. They did not describe themselves as mainly distressed and did not see their perfectionism as wholly negative. Many valued it. This attitude may be the basis of their apparent resilience. A unique aspect of this study is that it echoes research findings that perfectionists have relational difficulties. It goes deeper in that it describes the nature of the relational difficulties and how they manifest in life as thoughts, feelings and behaviours. The interviewees did not necessarily think perfectionism was problematic and often accepted it as the status quo and this perhaps allowed them to talk freely about their relationships and themselves.

Perhaps surprisingly, and contrary to the popular psychology stereotype, the perfectionists in this study were not only task-obsessed or excessively rigid; many were sensitive, reflective, relationally aware, aware of ruptures and they even appeared aware of what they did not know. One described a ‘blind spot’ about relationships and another described realising her need for a new ‘bedrock’ about relationships. Many alluded to relational things they had not understood in the past and still did not. They appeared aware and alluded to a figurative unseeingness, unhearingness or unknowingness towards others, and perhaps even towards themselves which they had noticed over time. They asked rhetorical questions, declared ignorance and described sensations of not knowing or understanding past situations and relationships. Some expressed resignation. Many appeared to be processing, mourning and ruminating over past relationships and missed opportunities. The interviewees described participating in the study in order to contribute to the field but also to widen their self-knowledge. Perhaps they hoped to learn about relating and to get more joy and peace from life, which many of them desired.
These interviewees may offer insight into the recovery trajectory for perfectionism through being older, less distressed than quantitative clinical samples and having overcome substantial crises. They described what they grapple with, their efforts to overcome difficulty and distress, to reach resolution, to change and to accept themselves and they risked reliving feelings of shame or failure to do this. This study contributes information about the depth and complexity of the interviewees experience of themselves and others in the shape of its subthemes, to the fields of perfectionism and Counselling Psychology.

On a personal level I understand that my pragmatic critical realism has been motivated by a desire to understand the constellation and obstructions to relating experienced by perfectionists. I have found that my own relationships are harder and less rewarding when I am perfectionistic and that relationships are more difficult and complex with perfectionistic others than with non-perfectionists generally. I found the process of this research deeply affecting and was initially saddened by the relational trauma experience in this group. However, the more I explored the nuances and detail of their descriptions, the more optimistic I felt. They described exceptions, positive experience, personal revelations and resilience as well as difficulty and they showed unexpected awareness and openness. This suggested they have some power over their perception of relationships and that their relating styles may be dynamic and open to revision. That so many had benefitted from therapy challenged what appears to be a (potentially damaging) accepted wisdom that perfectionists are therapy-resistant.

These findings suggest that psychological therapists must take care not to further injure, discredit or ignore people who experience Interpersonal Discrepancy. Disempowering those who have historically experienced a degree of powerlessness may further damage self-esteem and self-belief in vulnerable individuals and potentially manifest in difficulty with decisions, standards, judgement and internalised messages and representations of others. Exploring Interpersonal Discrepancy experiences is useful for subjective understanding.

To Dorothy Rowe, power is the right to have your definition of reality prevail over that of others (Rowe 1989) and restoring personal power to perfectionists through
respecting their current reality is potentially the main avenue to therapeutic relationship and healing relational trauma in perfectionists. It may also be the first time many have experienced subjective understanding. Trauma informed practices like bearing witness to the self and focussing (Gendlin 2010) i.e. acknowledging one’s felt emotional reality, may be pivotal for many perfectionists. Regarding the ethical duties of Counselling Psychologists, Chris Newnes makes the point that “Personal experiences of distress, survival and connectedness and attention to the real lives of our clients should lead us to speak out about suffering and the cause of suffering, especially when we believe that our disciplines may be part of the problem.” (Newnes 2002). I understand this as a need to avoid pathologising clients since this directly contradicts our capacity to empower and assist them. Both Lucy Johnstone (Johnstone 2015) and Chris Newnes (Newnes 2002) have pointed out that it is our duty as a profession to radicalise and locate ourselves outside of conventional societal structures – including conventional psychiatric diagnoses and to shake off ideas and discourses which ultimately hurt our clients.

A bold idea for addressing oppressive pathologising and decontextualizing of problems may be to distance Counselling Psychology from medicalised psychology and to do this publicly. There is a compelling argument for therapy as ‘personal consultancy’ (Popovic & Boniwell 2007) which may help equalize the historically unequal power dynamics of therapy. Through this, Counselling Psychology could promote itself as a valid and empowering alternative, differing in attitude from current medical model based mental health care practices. This may also help to challenge views that psychology professions are intrinsically hurtful, paternalistic or oppressive, and so reduce perception barriers to therapy for those in need.

Counselling Psychology is ethically and philosophically well-placed to assist perfectionists because it can accommodate wholistic and plural approaches and its values coincide with what appears to work for perfectionists more generally and for these interviewees specifically. Generally perfectionists have benefitted more in assisted collaborative conditions (Pleva & Wade 2007), in 20 session coherence therapy (Rice, Neimeyer & Taylor 2011), in long-term interpersonal therapy (Blatt, Shahar & Zuroff 2010) (The Menninger Project cited in Blatt 1995) (Dimaggio & Attina 2012),
with psychologically minded therapists (Blatt, Zuroff Quinlan & Pilkonis 1996) and potentially in group settings (Kutlesa & Arthur 2008). Interviewees in this study felt they had benefitted from trustworthiness, transparency, authenticity, flexibility, tailoring, risk-taking, assertiveness, courage, honesty, safety, strength and competence in therapists. This echoes Blatt, Shahar and Zuroff’s emphasis on the importance of perfectionistic client’s perception of the therapists as ‘empathic, open and available’ for the success of therapy (Blatt Shahar and Zuroff 2002: 327).

In terms of which therapeutic model might be most desirable, the hybrid nature of both Schema Therapy (Young, Klosko & Weishaar 2003) and Cognitive Analytic Therapy (Ryle 1990) (Wilde McCormick 2012) allow therapists to offer dynamic accounts of problems, recognise trauma, address shame-related cognition and tailor approach to the individual. These all enhance alliance and subjective understanding. However, both were developed with characterological pathology in mind and within a medical framework, so they may need to be used sensitively to maintain maximum benefit and minimise harm.

Common factors research indicates that sensitive or altered use of therapeutic models like this allows them to retain their usefulness and efficacy. To Hubble, Duncan, Miller & Wampold activation of placebo effect, hope and expectancy and the facilitation of alliance through therapist use of cogent and believable rationales, explanations and procedures benefits efficacy the most (Hubble, Duncan, Miller & Wampold 2011). Rationale itself can be myth, as opposed to scientific truth, because it need only be accepted by the client and lead to adaptive responses in order to be effective (Imel & Wampold 2008). A ritual of meeting to explore self-understanding is also vital to alliance and efficacy, as is the avoidance of demoralising maladaptive explanations of problems (Frank & Frank 1991). This last suggests that solution-focus (de Shazer 1985) may increase attractiveness of therapy and client retention.
The fact that, within common factors research, therapist factors are the most robustly researched and account for 8-9% of variance in outcome\(^5\) (Hubble, Duncan, Miller & Wampold 2011) only emphasises the importance of therapist personal qualities and relational approach for perfectionist clients. The interviewees descriptions and experiences of what they found valuable in therapists echo this, and the advice of pluralists; that therapists should do more to ensure they help their clients to benefit from therapy seems wise (Cooper & McLeod 2007).

On balance, this study shifts the research focus from defining perfectionism to giving voice to the experience of it and its relationship related findings show this is revealing and apposite. It was intended to provide trustworthy, useful and experience-valid (Morrow 2005) qualitative contribution to practitioner psychology and to avoid recruitment to damaging discourses, disempowering narratives and discursively disenfranchising perfectionists in the process. The shifted focus pre-empted and now mirrors a conclusion Hewitt, Flett and Mikhail reached in “Perfectionism: A Relational Approach to Conceptualization, Assessment, and Treatment”; that there is a need for relationship in order to recover from perfectionism (Hewitt, Flett & Mikhail 2017).

Further qualitative research into the experience of Interpersonal Discrepancy, its manifestation and its potential for relationship disruption may shed a lot of light on perfectionism’s apparent intractability and perhaps help to resolve it. This may be particularly helpful if it is carried out using mixed methods to ensure some triangulation. This would avoid the effects of self-concealment. If the research also targeted wider and less well-accessed ethnic, professional and age populations, this would make it more useful and valid. It is perhaps more pertinent than ever if – as Curran and Hill suggest - young people are experiencing more mental health difficulties and becoming more perfectionistic towards themselves and others due to increasingly demanding social and economic parameters over the last three decades (Curran & Hill 2018).

\(^5\) Therapist factors account for 8-9% of variance in outcome which is potentially more than model (0-1%), alliance (5%) and superiority to a placebo treatment (0-4%) together (Hubble, Duncan, Miller & Wampold 2011).
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Appendices

Appendix 1 – Journal Article

The perfectionist constellation: an inductive thematic analysis of how perfectionists describe, experience and imagine relationships

Abstract

Aims: This study seeks to provide a voice to interviewees identifying as perfectionist and to offer a fuller account of how perfectionists describe, understand, experience, and imagine relationships. This is to enhance our understanding of perfectionism, including its interpersonal aspects, and improve perfectionist therapeutic relationships.

Method: This Critical Realist study thematically analysed the transcripts of twelve semi-structured interviews with nine female and three male self-identified perfectionists aged between 33 and 67. The transcripts were analysed inductively for semantic and latent meaning.

Results: Three main themes became evident from the analysis including: Challenging early parental experience, Feeling unpleasant sensations and emotions and Habits impacting on relationships. The findings reflect that current conceptualizations of, and theories applicable to, perfectionism do not fully account for the interpersonal experience of the interviewees or acknowledge its importance.

Discussion: The results offer rich description of interviewees’ relationship. Theoretical implications include that a plural, more inclusive, less pathological, less individualising approach to perfectionism is needed. In therapy, focusing on sensitive assessment and subjective understanding is more helpful than defining perfectionism. For individual therapists, knowledge about perfectionist relating may significantly benefit therapeutic relationships.

Keywords: Self-Identified Perfectionism, Relationships, Interpersonal Discrepancy, Therapeutic Relationship, Therapeutic Alliance
There are many quantitative studies linking psychopathology (including eating disorders, depression, OCD and personality disorders) with perfectionism (Shafran & Mansell 2001). The majority were not repeated and relied on self-report using established psychometric instruments which conceptualise perfectionism as multidimensional. These include the HMPS (Hewitt & Flett 1991), FMPS (Frost, Marten, Lahart & Rosenblate 1990) and the APS-R (Slaney, Rice, Mobley, Trippi & Ashby 2001). These instruments have superseded most of the earlier unidimensional and bidimensional definitions. Quantitative studies often involve small numbers of, usually white, academically educated, young adult students or medical patients diagnosed with clinical disorders. Factors beyond perfectionism and distress are rarely observed, controlled for or considered. Consequently, the research disregards the life context and nuanced experience of perfectionists. Perfectionism often features in psychological autopsy studies of suicide victims (Kiamanesh, Dyregrov, Haavind & Dieserud 2014) (Bell, Stanley, Mallon & Manthorpe 2010) and research has concluded that it makes depression difficult to alleviate (Blatt, Zuroff, Quinlan & Pilkonis 1996) (Brustein 2014).

The literature acknowledges that perfectionism can, and should be, be improved through psychotherapy but also that perfectionists have difficulty with the therapeutic alliance (Brustein 2014). Others have called for improvements to the outcome of therapy with perfectionists (Blatt, Shahar & Zuroff 2002) and more information about the nature of barriers to therapy (Habke & Flynn 2002).

There is little qualitative research available about perfectionists’ experience and perceptions of relationships in their own words and few studies consider their capacity to benefit from therapy.

The available quantitative research about perfectionist relationships has often focussed on attachment style and therapeutic outcome and does not comment directly on relationship experience.

**Rationale**
Counselling Psychologists are ethically bound to act in the best interest of their clients. Specifically: “They understand diagnosis and the medical context to mental health problems and work with individuals’ unique subjective psychological experience to empower their recovery and alleviate distress” (BPS 2017). We must negotiate paradigmatic divides between sometimes competing priorities of therapeutic models, medical diagnoses, economic concerns and the proper subjective understanding of the experience of the client. It is desirable to avoid pathologising clients and recruitment to damaging narratives which may compromise our capacity to empower and discursively enfranchise the client.

The silencing, isolating and destructive nature of perfectionism which co-occurs with distress is evident from the literature and it probably delays, prevents, hinders and curtails therapy for perfectionists. This can have lethal consequences as The Samaritans report and psychological autopsy studies reveal (The Samaritans 2015).

This study seeks to understand perfectionist experience more deeply, including early relationship experience and capacity for personal resilience, with the hope of supplying trustworthy, qualitative research (Morrow 2005) and answers to “why perfectionists experience this difficulty [in engaging in therapy] and how they avoid increasing intimacy in therapy” (Habke & Flynn 2002). The study adopts a ‘client-first’ lens to provide a voice to interviewees identifying as perfectionist and to better comprehend how they describe, understand, experience, and imagine relationships.

**Method**

Given the researcher’s Critical Realist research philosophy, thematic analysis (TA) offered a theoretically flexible qualitative research method, free of methodological associations with specific research paradigms. It provides an opportunity and freedom to look at data collected in a wide-ranging way (Braun, Clarke & Rance 2013). Semi-structured one-to-one relational interviews (Josselson 2013) offered the best opportunity to gather rich data and to acquire a clear, deep exploration of interviewees’ ideas and experiences.

**Reflective Statement**
My interest in perfectionism began during a first-year placement working in an alcohol rehabilitation service, where I saw newly sober clients struggle with the urge to be perfect. In respect of perfectionism, I occupy both insider and outsider positions. Insider researchers’ familiarity with interviewee experience strengthens their capacity for focussed, ethical research (Hayfield & Huxley 2015). I kept a personal journal and discussed findings with others to address the risk of my insider status leading me to make assumptions or overlook aspects of the data (Kanuha 2000).

**Participants**

A purposive snowballing recruitment strategy was adopted and sought self-identified perfectionist interviewees through internet, press and word-of-mouth. The three male and nine female interviewees recruited were aged 33-67. Nine identified as English (3 men, 6 women), one as Latin American-German, one as Australian born-Chinese and one as American. The study attracted the ‘usual suspects’ (Braun & Clarke 2013). Eleven had married or cohabited with a long-term partner. Six were married and six were divorced at the time of the interview. Seven were parents. All interviewees were raised by at least one of their own parents. Ten had had psychotherapy and many had seen more than one therapist.

**Ethical Considerations**

The study was designed to adhere to BPS ethical guidelines for Counselling Psychology (BPS 2009) and was granted ethics approval by the University of the West of England Research Ethics Committee. Pseudonyms were used and identifying information changed to preserve the anonymity of interviewees.

**Procedure**

Interviewees were invited to look at the website, sent a Research Information Sheet detailing the purpose of the study and their role in it and they completed and returned a Participant Consent form. The interviews were open, relational and semi-structured. I described the interview process to them prior to interview and they were asked to talk
about and describe various aspects of their lives and relationships. The questions prompted interviewees to express their experiences and were designed to keep the interviewees talking and focused on life relationships. More detailed spontaneous questions were asked where they were helpful in opening up a topic (Braun & Clarke 2013) (Josselson 2013). Interviewees were encouraged to keep in touch if desired and reminded of their right to withdraw their data at any time.

Data Analysis

The twelve interviews, ranging between 61 to 117 minutes, were transcribed verbatim using audiotyping. They excluded ‘ums’ and ‘ahs’, false starts and non-important interruptions but include all idiomatic noise words and incorrect grammar. The first reading and listening was to check transcripts for accuracy and make corrections. Subsequent readings were to refamiliarize and immerse me in the interview data.

The transcripts were inductively coded in NVivo 10 and organised into folders. The analysis process followed Creswell’s Data Analysis Spiral (Creswell 2012). The codes sought to reflect how interviewees described emotions, events, people, relationships, perceptions, and their understandings (as well as how they related to the interviewer) and whether their words performed latent functions as well as semantic functions.

Results & Analysis

Analysis of the interview transcripts revealed three main themes and fourteen subthemes in the interviewees’ descriptions of their perfectionism and relationships shown below:

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Subthemes</th>
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<tr>
<td>1) Challenging parental relationship experiences</td>
<td>a. Parents in conflict with one another</td>
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<td></td>
<td>b. Difficult to understand</td>
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<td>c. Difficult to please</td>
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1) **Challenging parental relationship experiences**

   a. *Parents in conflict with one another*

Mary said her parents often argued and their marriage ended suddenly when her mother cleared out the house and left one day:

“...they used to have huge arguments, screaming shouting arguments. No violence or anything but a lot of screaming and shouting and my mother, well I came home from school one day when I was 14 and my mother had cleared the house full of furniture and we were moving out and she did it while my father was away on a course.”

To Sarah, her parents had a:

“miserable marriage, absolutely miserable. They fought physically when I was a child. I had to break them up...They married oh fifty years but they went through divorce proceedings three times.”
Almost all the interviewees had parents in conflict with one another during their childhoods. Various they were coping with disruption and conflict at home and understood their parents were struggling, anxious or unhappy. They witnessed fighting, arguing, emotional reacting, avoidance, full relationship breakdown, with their own lives changing as a result.

**b. Difficult to understand parent**

To Mary, her mother was angry and confusing:

“She’s a bit of a puzzle, difficult to describe. She was an only child and well I suppose looking back on it was kind of obvious but I think she was gay but I’m not sure.”

“I think I’m stretching a point to call it a relationship.”, “I think it’s quite difficult to understand someone when you don’t, when you don’t know anything about them.”

Rita had difficulty connecting with her mother, detecting resentment and a cultural divide:

“... so I think she just maybe resented me? I don’t get a lot of support from her. It’s also the collision of cultures right, so Chinese people tend to be very focused on academics and I still haven’t quite figured out what Europeans are really focused on really.”

Lee described his mother saying:

“it just got more and more extreme and pretty much unbearable and no one could stand being with her really. She’s always been like that to some degree”.

Those with Difficult to understand parent tried to make sense of their parent’s actions and desires and questioned their parents’ behaviour during the interviews. They felt they did not know or did not understand the parent and suggested they were crazy, unintelligible, unrealistic, culturally different and/or emotionally reactive.

**c. Difficult to please parent**

Many experienced either or both parents as difficult to please, due to their high standards and/or preference for order.
Emma’s mother could be critical, demanding and angry toward Emma for failing to achieve her standards:

“...I still remember her getting so mad at me about writing transitions in my papers and I was like come on, nobody else is gonna care. It’s like ‘I care. You have to do it right and it has to be perfect according to me. I don’t care if you’re going to get an A anyway’.”

Lee described his mother as authoritarian, perfectionist and harsh in response to bad behaviour:

“It’s like a hawk. You do or say anything she’ll swoop down and wop! What have you done? You alright?... I’d phone her up and say all right only me and she’d say oh yeah. And she’d say, what’s wrong with you? ...What’s wrong with you? Making you feel, you start to think no there is nothing wrong with me, there’s nothing and it’s that, even if there’s nothing to pick up on she’ll still pick up on something...”

Many of the interviewees described one rigidly orderly or morally upright parent.

Sue’s father: “always had a military, methodical approach to things.” Mary’s father was “not so much a perfectionist as meticulous. He would write down every mile he did in his car in a book...”

Keith’s father was:

“...a very honest man. My dad has never got a ticket or anything he’s never broken the law he’s as honest as they come. He’s also very old-fashioned, he’s got real values, he’s never so much as looked at another woman in all his life.”

The descriptions of those with difficult to please parent experiences indicated struggle to imagine what might please a parent and suggested interviewees found parents could be critical, harsh, angry, unrelenting, dismissive, authoritarian, perfectionistic, inflexible and ambitious.

\[d. \text{Difficult to reach parent}\]
Kate found her mother reactive to criticism and that she could become hurtful, retaliatory and abandoning in response:

“I definitely have the message from my mum as a child that you can’t criticise her, you can’t tell her you’re pissed off ’cause she’ll just come back with something bigger or she might not be there”.

Katrina’s mother remarried and was less available:

“…then she devoted her entire attention to this relationship and we were taken care by a maid.”

Olga’s father was unavailable because he was often drunk:

“my dad adored me but the drinking obviously got in the way of proper close family relationships really.”

Mary described her father as consumed by work:

“his job really was his life and unfortunately when he retired he died a year later so he kind of poured all his life into the gas board and then he died”.

Keith’s father was very private:

“he’s a typical man of that generation born in ’34 very private man, not demonstrative in his emotions”.

Those with Difficult to reach parents described difficulty in maintaining emotional connection or intimacy and getting attention. Most of the interviewees appeared to be accepting or resigned to this. They described parents as not present in specific emotional and/or physical ways. Interviewees suggested parents were preoccupied with: alcohol, work, illness, caring for others, marital conflict, avoiding their spouses, living elsewhere, new partners, distress or simply perceived they were emotionally unavailable.

**e. Traumatic event in relationship**

Many of the interviewees described events that they had felt shocked or shaken by.
Sue’s father was unfaithful to her mother and this deeply shocked Sue:
“...we had a happy home, it was all very stable and when that happened it was like opening a massive window and a gust of cold air coming in and all of a sudden, yeah it could happen to anybody ....”

Phil’s father died suddenly while Phil was nearby:
“He pretty well died in front of me, well just round the corner by his mother’s flat. I was down on the ground floor, he was going down the stairs to see his mum, my gran, and I worked for Dad so when you see something like that happen...”

Keith and Sue’s lives both changed with the swift onset of illness in a family member and some interviewees experienced traumatic events elsewhere, e.g. bullying at school.

Interviewees were prone to feeling insufficiently cared for, distressed or betrayed due to traumatic events. Including when others did not do as expected or did not meet their standards. Descriptions included feeling hurt by employers, colleagues, teenage sons, former partners, siblings, friends and parents.

2) Feeling unpleasant sensations and emotions

   a. Anxiety

Olga remembered anxiety as physical when she was young:
“Very butterflies and having to rush to the loo and that stuff, yes I think that was... but it wasn’t necessarily to be perfect but it was to achieve the best I could.”

Sue described a pattern of anxiety:
“it’s almost like a downward spiral and I just wind myself up tighter and tighter and I stop sleeping which makes it worse...”

Many of the interviewees described anxious feelings, fear and agitation. Some had patterns of anxiety which were familiar to them and others described behaving in tightly controlled ways, possibly to manage anxiety.
b. Disappointment, misunderstood and not listened to

Kate often felt disappointed by others:
“I can judge other people by my standards so where I would go out of my way for friends and it doesn’t, that’s not returned I can take it really hard…”

Lee described feeling disappointed in others and even betrayed
“…then when they didn’t do it you were disappointed and frustrated with them, felt bitter toward them.”

Rita felt not listened to in therapy:
“…I think I tried to leave three times and she made the same point and I’m like hold on I’m free to leave…”

Interviewees described moments of misunderstanding and disappointment with others. Many appeared to have felt alone and some, trapped by other people’s misunderstanding of them.

c. Anger, hurt and vulnerable

Emma described anger at other’s incompetence:
“it pisses me off royally when people aren’t trained enough to do it right because this is what we’re supposed to be doing…”

Rita described feeling hurt:
“…everything you do just seems to matter so much and that feedback that you get from your teachers is, it hurts, like it goes straight to the bone right.”

Katrina described feeling vulnerable:
“Attention that is not nice because you’re always on the spot”.

Others, including Emma and Sue, were worried about feeling vulnerable during their interviews with me and were particularly concerned that they might cry.
The interviewees described and analysed discomfort they had experienced with others. Many had experienced negative emotion, emotional pain, vulnerability, anger and powerlessness and often simultaneously.

**d. Distress and crisis**

Of school, Emma said:

“It was really tiring and sad. I would come home and cry every day.”

Lee described personal pain:

“I’ve just had enough. I don’t want to live my life like this anymore. I just want a rest. It’s just too difficult. That personal pain, you know, just never being satisfied, it’s just hurting you is the main thing.”

Interviewees described experiencing crises. Crises were interpersonal in that they often involved having problems with other people or seeing themselves as problematic in the eyes of others.

Sarah became overwhelmed and anxious at work:

“When I let it go a bit I let it go a bit and that’s why I had on my form now I ended up in therapy for two years because I just got so stressed with it all the work that I started to edge towards a nervous breakdown because I just couldn’t cope with it all, so it...”

The experience of distress was common to many of the interviewees and many easily recalled past distress.

**e. Interpersonal fear**

Emma feared damaging others:

“I think, like the force it could be strong within me. I’m so glad that I didn’t have the chance to ruin somebody’s life. I think it’s so much better to be slightly detached and supportive or whatever.”

Rita feared not being good enough for others:
“you have this whole division of friends thing that occurs and for a long time I was a bit scared of being friends with people because I didn’t think I was good enough.”

The interviewees shared fears about; parenting, being damaging to others, failing, not being good enough, losing people, public speaking, emotional dependency and fearing others responses to and disappointment in themselves.
Many appeared to have experienced reactivity to their own negative feelings in the form of fear, sadness and anger.

3) Habits impacting on relationships

a. Expecting disappointment and feeling suspicious of others

Jennifer described not expecting to develop friendships with work colleagues:
“...it’s because I’ve had bad experiences with people in the past and I thought ok, never the twain are going to meet anymore so I’ve never been particularly close to anybody at work.”.

Kate described phoning her father with the expectation that she would feel disappointed:
“...Sometimes I’m kind of like the phone is ringing before he’s answered it and I’m thinking I know I’m not going to get what I need but I still do it.”

Other people had disappointed Olga by not doing things well enough:
“...she suggested I went to Al-Ateen when I was a teenager but I never did go. Not a great joiner really. They wouldn’t do things well enough for me would they? [Laughing]”

Sue described struggling to adjust when her expectations were not met:
“She didn’t really ask me the questions I expected to be asked given my knowledge of what GPs should ask in those situations.”
Lee described expecting to disappoint others: “the way that then affects the way you deal with people because you always kind of, what you do, you don’t think is good enough for them…”

Many questioned others motives and intentions. Sue questioned what her mother thought of her:
“ I don’t know if it’s necessarily to do with my perfection seeking but sometimes I feel like she’s maybe mocking me a little bit or…”

Kate expected a negative atmosphere in NCT classes:
“I know that when you do NCT classes and that kind of stuff there’s often competition and bitchiness between new mothers about how well their child’s doing.”

Phil described seeing through people:
“Oh yeah I could see straight through her. I mean, fairly pretty lady and such like but there was something going on up here (pointing to head) that wasn’t right…”

Mary began to suspect a therapist of incompetence:
“…I’m not sure how long she’d been doing it but I wasn’t comfortable that she knew what she was doing…”

The interviewees described situations where they expected to be disappointed, let down, threatened, manipulated or duped by others. They questioned others motivation and integrity and suspected others of manipulation. Many expressed wariness, concern and disapproval about others and were wary during the interview.

b. Exasperating others through striving

Emma said:
“I’m very list-oriented and I have to make sure the list is complete and then you have to finish the list and the list is important which drives my husband crazy…”

Of her husband, Olga said:
“But I think it drives him mad as well because of the way I stack the dishwasher, it’s got to be pretty well done the way I want it....”

Sue noticed tension in her relationships:
“*She doesn’t understand sort of the way I think or the way I do things ...oh, the frustration shows*”

How the interviewees described exasperating others varied. Olga described redoing tasks:
“I like to do things in an orderly way and if they’re not orderly sometimes I’ll redo them ’til they are- folding towels is a bit of a, bit of a thing.”

Emma described persisting despite herself:
“*you just keep trying and keep trying even if you don’t believe it, you don’t believe that you should have to or you don’t agree with what they want, you still keep trying.*”

Fatigue could be a side effect of the way many approached life. This could prove exasperating to others.

Keith said of his wife:
“...sometimes I’m up at 5:50, sometimes I’ll work 7 ’til 6 and then on the weekend I’m up at 5:50 and I’m in at 10 at night and it’s like oh god. She’s like ‘oh no, oh dear. [Laughing] What happened? Not back there again!’ ”

Kate described:
“*grinding myself into dust*”

Some described situations when their interpersonal approach could exasperate others.
Lee described persistence as a way of life:
“That’s the way I live my life. I will find a way. You trap me underground or whatever I’ll find a way of getting out and that certainly when I was younger to the point...I’m not a strong guy but if you got in a fight with me you’d have to kill me because I just keep getting up.”
Olga did this at work:

“I think I was a complete nightmare because I wanted everybody to achieve the best they could and I don’t necessarily think that’s a bad thing but, er, it puts quite a lot of pressure on people.”.

In addition, interviewees rarely described goals as involving high quality interpersonal relationships. More often they described wants and needs.

Jennifer said:

“I don’t, it’s not so much I have problems with people telling me what to do it’s that I always think my way of doing things is best”

Exasperating others through striving included working to exhaustion, driving others crazy and pushing others. They were competitive, controlling and correcting when in pursuit of a goal. Many were aware and expected that others found this difficult to deal with.

c. Avoiding others

Lee described avoiding communication with others and losing contact:

“...I haven’t explained things and that’s caused me to be misunderstood and then when I’m misunderstood I go, well wasn’t... that act wasn’t selfish, that was this. But then I don’t (explain), ... I’m a bit of a backroom guy in the sense, that I don’t want the limelight.”

“...I’ve lost contact with because I, they didn’t meet that standard so I never bothered calling them back, whereas now, I wouldn’t look at things that way.”

Emma seemed to avoid friendships:

“I don’t have that many really close friendships just because my husband serves all my needs, but I think other than him, my sister is the one where she knows so much and it’s still ok.”

Overall, many interviewees described avoiding others, ending relationships, distancing themselves, reducing contact and avoiding communication.

d. Evaluating and comparing to others

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Lee said:

“I don’t like people around me making mistakes. I don’t like to be exposed to ignorance and unfairness and stuff and over you know over the years I find ways of dealing with it but like I said I still feel unhappy.”

Kate noticed differences between herself and her partner:

“he auditioned for this advert and he was like ‘oh I went for that’ and I said ‘oh, I’m sorry’. He said, ‘it’s all right, I’m not him am I?’ And I just thought yes., whereas I’d be like, ‘what’s he got that I haven’t got and why that kind of thing…”

Keith and Emma described family cultures which seemed different from other families. Emma said:

“We were so different from everyone in our class pretty much whether it was how we dressed or the car or the academics or whatever.”

Evaluating and comparing highlights an overarching manner of monitoring the self and others. Evaluations were often critical and negative in tone. Interviewees noted differences between themselves and others from early in life. They often admired, wanted to emulate and talked about the achievements and lifestyles of others. Some talked about wanting to be different from, or better than, others.

In summary, the interviewees experienced their early parental relationships as challenging which resulted in some form of emotional misattunement by parents (as perceived by the interviewees). They described their adult relationships as relatively less challenging although some remained uncomfortable, with negative expectations of others. They described frustrating and avoiding other and fears relating to others, which indicates that they imagine relationships to be difficult and can assume that they will be misunderstood. This goes some way to explaining the apparently distant, reserved and wary approach to others that interviewees described. However, many had established close trusting relationships in adulthood and expected that these would remain trusting. They were not wary of these individuals.
Discussion

The discussion considers the strengths and weaknesses of current theories applicable to perfectionism. These include cognitive behavioural, psychoanalytic, trauma and attachment perspectives on perfectionism. It highlights fundamental issues with their central tenets in light of the subjective relationship experiences of the interviewees. The overarching themes of *Challenging parental relationships experience, Feeling unpleasant sensations and emotions* and *Habits impacting on relationships* capture how these self-identified perfectionists describe, experience, understand and imagine relationships and these findings have theoretical and therapeutic implications for working with self-identified perfectionists.

The cognitive behavioural model highlights perfectionism’s repetitious, ensnaring nature and the types of thoughts and conclusions it produces but excludes these perfectionists by defining perfectionism too narrowly and ignoring their interpersonal experience. The model does not recognise interviewees’ experience of perfectionism as dynamic, synergistic and purposeful and it pathologises perfectionism.

Psychoanalytic theory more fully accommodates the developmental contexts, depth and purpose of perfectionism in overcoming deficits, in protecting and repairing the self and as a cyclical and unconscious attempt to gain affirmation, idealization and affiliation. It fits with interviewees’ experience. It also requires interpretation of experience and so risks misrepresenting it. Psychoanalytic theory neglects the cognitive aspects of the interviewees’ perfectionism, considering these to be axiomatic to the description of deficit and defense. However, deficit and defense account well for the interpersonal experience, behaviours and perceptions described by the interviewees.

Trauma theory locates the development of perfectionism in early chronic, cumulative, relational trauma or larger more acute relationship affecting traumas. Both types may cause shame and necessitate coping with it. This overtly recognises that perfectionism is triggerable and so dynamic, and that it is symptomatic of a core vulnerability. Again, trauma somewhat pathologises the individual, being a loaded term and like psychoanalytic explanations it does not describe the cognitive or behavioural aspects of the experiences that interviewees described.
Attachment theory accounts for the developmental context and cumulative impacts of shame and misattunement on the inner relational representations of individuals. Many of the descriptions of the interviewees appear to indicate insecure style mental representations of others. The theory provides an understanding of their experience but like psychoanalytic explanations it requires interpretation of the experiences and attribution of these to a typological style and may be reductive.

The theoretical implications were that none of the cognitive, psychoanalytic, trauma and attachment theories considered adequately reflect the experience of the interviewees, but all had relevant strengths. Overall, the aspects that these theories did not address how and why interpersonal experiences had been both positive (reliable, supportive) on the one hand, and negative (leading to vulnerability and wariness) on the other; that interviewees had positive experiences of perfectionism itself; and some considered themselves rehabilitated from perfectionism.

Also, although these theories apply to perfectionist pathology, the negative interpersonal experiences they do not account for include those captured in the subthemes: Disappointment, misunderstood and not listened to; Anger, hurt and vulnerable; Evaluating and comparing to others; and Expecting disappointment and feeling suspicious of others. These experiences are more accurately explained by Discrepancy (a sense of consistently failing to meet the standards one has set for oneself) (Slaney, et al. 2001), particularly if it is applied interpersonally, i.e. these individuals experience others as failing to meet their relationship expectations and vice versa, in the ways the subthemes describe.

Shea’s concept of dyadic discrepancy described perfectionist experience in romantic relationships and could provide a useful template for this (Shea 1999). Therapeutic implications of these findings include recommendations that Counselling Psychology as a profession consider how current treatment and definitions of perfectionism pathologise and isolate clients, how the power dynamics at work in therapy may impact on them as clients and how the experiences described by this group in particular may influence therapy dynamics. The findings suggest that individual therapists working with self-identified perfectionists should consider: the importance of
managing interpersonal discrepancy; the risk and impacts of collusion with perfectionist clients; the importance of subjective understanding of their experience; and a recommendation to recognise, deal with and manage their own shame, attachment and perfectionism experiences. This avoids collusion and unnecessary transference and countertransference issues in the therapy.

The strengths of the theories and the relevance of shame and interpersonal discrepancy suggest that a theoretically plural therapeutic approach is desirable. Theoretical pluralism allows both explanation and approach to complex phenomena which have complex and differing causes (Cooper & McLeod 2007). Perfectionism is a profoundly conflated and confused area and many definitions and conceptualisations include aspects which may not be essential components of it. These include high standards and order which may actually provide a means of moderating the negative effects of perfectionism. In addition, there are conceptualisations of perfectionism which do not account for experiences that are central to it e.g. the cognitive model ignores shame and other explanations omit its dynamic nature.

Limitations

Overall, the self-selected group of interviewees that the study attracted favours the accounts of women and those of white, middle class, heterosexual, cisgender individuals, e.g. it may neglect the experiences of men and those with more varied ethnic and cultural backgrounds. It also attracted therapy-aware and non-seriously distressed individuals.

Despite hoped-for objectivity, the interviews appeared to have some affect-regulating and cognitively restructuring impacts on the interviewees. The study acknowledges this tension and considers that Critical Realism can accommodate this.

The study attracted articulate, self-aware individuals who were willing to disclose their experience in interviews. That said, under-emphasis of shame experience was noted and some interviewees were guarded and wary at times. Future studies could consider increased rapport building prior to interview and mixed or multimethod approaches including; expressive writing, self-interview, a sequence of interviews (possibly by
multiple interviewers), and observation of intersubjective processes through process study. These methods could reveal more about what happens in perfectionist relating moment-to-moment and more depth about their experiences (Hesse-Biber & Johnson 2015).

Conclusion
This study shifts the focus from defining perfectionism to giving voice to the experience of it. In doing this, I believe it provides trustworthy, useful and experience-valid qualitative research (Morrow 2005). It emphasises that interventions seeking to resolve perfectionism as a problem may be misdirected because they do not take into account its synergistic nature and they pathologise it. Rather than seeking definition, Counselling Psychology clients may benefit more from a comprehensive, normalising, non-diagnostic, plural method of approach which locates perfectionism as a response to life context rather than an individual pathology. The discrepancy experienced was multifaceted and far-reaching in its manifestation i.e. cognitive, behavioural, emotional, intrapersonal and interpersonal.

Given how profoundly integral perfectionism is to self, therapy goals which focus on resilience, management, understanding individual perfectionism and discrepancy, and relationship building appear to be more effective and empowering for clients than those which encourage perfectionists to relinquish parts of the self.

Wordcount: 5502

References


## Appendix 2 – 15-point Criteria for Good Thematic Analysis

<table>
<thead>
<tr>
<th>Process</th>
<th>No. &amp; Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transcription</strong></td>
<td>1) The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the recording for ‘accuracy’.</td>
</tr>
<tr>
<td><strong>Coding</strong></td>
<td>2) Each data item has been given equal attention in the coding process.</td>
</tr>
</tbody>
</table>
| **Analysis**   | 3) Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.  
4) All relevant extracts for each theme have been collated.  
5) Themes have been checked against each other and back to the original data set.  
6) Themes are internally coherent, consistent, and distinctive.                                                                                                           |
| **Overall**    | 7) Data have been analysed – interpreted, made sense of rather than just paraphrased or described.  
8) Analysis and data match each other – the extracts illustrate the analytic claims.  
9) Analysis tells a convincing and well-organised story about the data and topic.  
10) A good balance between analytic narrative and illustrative extracts is provided.  
11) Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.                                                                                          |
| **Written Report** | 12) The assumptions about, and specific approach to, thematic analysis are clearly explicated.  
13) There is a good fit between what you claim you do,                                                                                                                                                                                                                                     |
and what you show you have done.

14) The language and concepts used in the report are consistent with the epistemological position of the analysis.

15) The researcher is positioned as active in the research process: themes do not just 'emerge'.

Cited in Braun & Clarke 2013: 287, taken from Using Thematic Analysis in Psychology (Braun & Clarke 2006) in Qualitative Research in Psychology Vol.3 Issue. 2 and used with the permission of the authors and acknowledgement to Taylor & Francis, UK.
Appendix 3 – Ethical Approval

UWE REC REF No: HAS/14/06/93

Date: 8th August 2014

Dear Alice

Application title: The Perfectionist Constellation: How Perfectionists Describe, Understand, Experience and Imagine Relationships and the implications of this for therapy

Thank you for resubmitting your ethics application, this was considered by the Committee and based on the information provided was given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/hsresearch/researchethicsandgovernance.aspx

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

The following standards conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;

UREC/FREC Standard Approval Letter Version 1 1/8/2013

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3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely

[Signature]

Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c Zoe Thomas
Appendix 4 – Interview Schedule

- How are you?
- How’ve you been feeling of thinking about this interview in the run up to it?
- Any worries?
- Any hopes and fears?
- I thought we might start by talking about how you think about or talk about your perfectionism. This is about your experience of yourself so you can’t get it wrong.
- What do you call it? Do you talk about it?
- In terms of how this interview might go I thought we might talk about your relationships and perfectionism (or substituting their phrase) in the day-to-day and then about relationships of all types in the past, the present and possibly the future? How does that sound?
- I have a few questions in case we get stuck.
- Can I ask a bit about your background?
- Where did you grow up?
- With who?
- Brothers and sisters?
- Can you tell me a bit about your mum/ your relationship with your mum?
- And your dad?
- Brothers and sisters
- Difficult experiences
- Early perfectionistic thoughts or memories
- What school was like?
- What about friends?
- What about colleagues?
- And your romantic relationships?
- What is difficult in relationships?
- What is easy?
- What have been your best relationships? The ones that felt the best? What was it about them that you liked or disliked?
- And the worst?
• Have you had thoughts about changing or altering your desire for perfection?
• Have you ever had or considered having therapy? What sort was it?
• How did it go? How did you find it?
• What were they like?
• What holds you back or makes you uninterested in it?
• What do you think or do you want and not want in a therapist?
• Do you have plans for the future?
• What are you doing this weekend?
Appendix 5 – Local Look Participant Recruitment Advert

Perfectionist?
Has it always got to be perfect?

I’d like to hear about it!
I am a student psychologist at UWE in Bristol looking for people from all walks of life to interview about their feelings of perfectionism, their lives and their relationships for my doctoral research project.
To take part please give me a call on 07966 058328. My name is Alice, I am friendly!

Thank you!

Go to: almarsh.wix.com/perfectionism
Confidentiality Guaranteed
Appendix 6 – Participant Recruitment Website Screenshots

The Perfectionist Constellation Research Project

Hello Perfection-Seekers!

You are invited to take part in a research study about perfection seekers experiences of all types of relationship and the possible implications of this experience for the effectiveness of therapy.

By talking to you about perfectionism and relationships, I hope to discover what you have experienced, what you might expect from relationships and your feelings or opinions about therapy generally.

You don’t need to know anything about counselling or psychotherapy to take part and there is no expectation that you have had therapy or will have therapy as a result of participating. Equally, if you have had therapy I would be interested to hear anything about these experiences that you would like to share.

Before deciding whether or not to take part, it is important for you to understand why the research is being carried out and what it involves. Please click on The Research.

Please contact me if you have any questions.

Home  Perfectionist?  The Research  Participate!  Contact

The Perfectionist Constellation Research Project

Are you a Perfection-Seeker?

If the following statements sound like you then you might be...

- I feel great when I do well at something.
- I rarely feel that what I have done is good enough.
- No matter how well I do I still feel that I could’ve done better.
- When I make a mistake I feel really bad.
- I really don’t like to see people close to me make mistakes.
- I won’t do things if I can’t expect to do them perfectly.
- I definitely have high standards.
- I like to be orderly in the way I do things.
- I become very frustrated or have other strong feelings when I don’t do something perfectly.
- When I look over something, I often check over the small details.
- People expect a lot from me.

Perfectionism and perfection seeking thoughts are common and you can be perfectionistic or perfection seeking in one area of life or in many. This could include work, study, appearance, personal hygiene, athletic performance, social life, domestic life and parenting for example.
The Perfectionist Constellation Research Project

What is this research for?

This research improves the information about perfection seekers and the support available from Psychotherapists and Counselling Psychologist for perfection seeker who experience distress. I will submit it as the main research component of the counselling psychology doctorate I am studying for and hope it will make a useful contribution to the field.

This extract from the research proposal says more about this.

The research aim is to investigate how people who have perfection seeking thoughts experience relationships and how they relate to other people and to learn through analysing the transcripts of interviews and reviewing the relevant literature - how to improve therapy for perfection seekers. This includes improving the ease with which perfection seekers enter, complete and benefit from therapy.

Further intentions of this research are to:

• Improve the likelihood and ability of distressed perfection seekers to use psychological resources like social relationships, resilience and coping.
• Learn about any patterns in interpersonal relating specific that are common to perfection seekers.
• Understand more about any barriers to therapy, trust and change experienced by perfection seekers and learn about necessary conditions for therapy, therapist needs, the mechanisms of therapeutic change and about how to mitigate any relating difficulties.
• Provide comprehensive and explicit information about the dynamics at work in therapeutic relationships with

The Perfectionist Constellation Research Project

What will happen if you take part and what will you have to do?

I hope to interview 12 people for this project. The interview will be in an informal talk with some questions and answers which I will audio record.

The interviews will be between 1 and 2.5 hours long depending on how much you have to say! The interview will be carried out at an agreed place. This will be quiet, safe room organized for purpose of the interview and there is likely to be some drinks and small snacks. You can bring someone to wait for you if you like. Interviews can happen in a place of your choosing provided it is suitable. This will need to be a quiet, pet and family free room with any headphones and devices turned off for the duration of the interview. I will need access to powerpoints/electrical outlets to plug in my audio recorder.

You may or may not experience some feelings about perfectionism and relationships during and after the interview. This is normal. I am sensitive to this and the interview can be stopped at any time. You are completely free to decide not to participate at any time during this process.

What will I ask you about?

I will ask you about your life, your friends, family, partners, other people, your experience of relationships, the feelings

Home Perfectionist? The Research Participate! Contact
The Perfectionist Constellation Research Project

This is informal. I ask questions to help the interview can be stopped at any time. You are completely free to decide not to participate at any time during this process.

What will I ask you about?

I will ask you about your life, your friends, family, partners, other people, your experience of relationships, the feelings your perfectionism causes and what you consider you might want or need from a therapist if you decide to start therapy either due to a crisis or for personal development OR about the reasons you think you would not start therapy.

My hope is that we will get on well and you will be able to talk freely about your experiences.

I have prompt questions in case we get stuck.

What happens to the data collected and will it be confidential?

The recorded interviews will be transferred to a computer, encrypted digitally and stored on a password protected online filing service until they have been transcribed. The interviews will be transcribed and information about you including your name, age, workplace, names of others and any other identifying information you may have mentioned during the interview will be removed or substituted for other names. My supervisor Zoe Thomas at UWE and I will have access to these transcripts as will the examiners of the project if they request them. This information will be held securely by me for 3 years until it is destroyed.

Personal information about you which I collect in order to communicate with you including your name, telephone numbers, address, postcode age, postcode and email address will be stored separately to your questionnaires and recordings so no one except me will know who you are.

All records of the study including research notes, supervision notes, working copies of surveys, drafts and the final report will be kept securely at my home office on completion of the study until it is destroyed.

As per the Data Protection Act 1998, no identifying information will be kept beyond that which is required to enable you to participate. Your information will not be duplicated or circulated.

What happens to the data collected and will it be confidential?

The recorded interviews will be transferred to a computer, encrypted digitally and stored on a password protected online filing service until they have been transcribed. The interviews will be transcribed and information about you including your name, age, workplace, names of others and any other identifying information you may have mentioned during the interview will be removed or substituted for other names. My supervisor Zoe Thomas at UWE and I will have access to these transcripts as will the examiners of the project if they request them. This information will be held securely by me for 3 years until it is destroyed.

Personal information about you which I collect in order to communicate with you including your name, telephone numbers, address, postcode age, postcode and email address will be stored separately to your questionnaires and recordings so no one except me will know who you are.

All records of the study including research notes, supervision notes, working copies of surveys, drafts and the final report will be kept securely at my home office on completion of the study until it is destroyed.

As per the Data Protection Act 1998, no identifying information will be kept beyond that which is required to enable you to participate. Your information will not be duplicated or circulated.
Appendix 7 – Facebook & LinkedIn Messages

![Facebook & LinkedIn Message Image]

## Interviewing Perfection Seekers!

Published on May 27, 2015

Are you a perfectionist? If you think you are, I'd like to hear about it!

I am a postgraduate student psychologist at the University of the West of England in Bristol and I am looking for people from all walks of life to interview about their feelings of perfectionism, their lives and their relationships for my doctoral research project.

If you are interested and you would like to know more, go to [http://almarsh.wix.com/perfectionism](http://almarsh.wix.com/perfectionism) to read about the project and please contact me if you think you'd like to participate! I am friendly!

Not sure if you are a perfection seeker? Try this: [http://almarsh.wix.com/perfectionism#/perfectionist/cjg9](http://almarsh.wix.com/perfectionism#/perfectionist/cjg9)

Confidentiality Guaranteed

Thank you!

PS Are you international? If so I can interview you on Skype.
PARTICIPANT CONSENT FORM

Current Title of the Project: The Perfectionist Constellation: How Perfectionists Describe, Understand, Experience and Imagine Relationships

Researcher: Alice Marsh
Trainee Counselling Psychologist
Psychology - Health and Life Sciences
University of the West of England
Frenchay, Bristol
BS16 1QY

Research Supervisor: Zoe Thomas
Senior Lecturer - Counselling Psychology
Psychology - Health and Life Sciences
University of the West of England
Frenchay, Bristol
BS16 1QY

Please tick

1. I confirm that I have read and understand the Information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

3. I agree to take part in the above study.

4. I understand that if researcher considers that I am at risk of harming myself or others that this will be disclosed to the GP named on my participant information form.

Please tick

5. I agree to the interview.

6. I agree to the use of anonymised quotes in publications.

7. I understand that my interview material will kept confidentially after this project is complete and after the relevant time period that it will be destroyed.

Name of Participant __________________________ Date __________ Signature __________________________
Appendix 9 - Participant Personal Information Form

PERSONAL INFORMATION FORM

This data will be kept securely and disposed of in accordance with the Data Protection Act. Please see the Research Information about this. Please inform me on this form of any mental or physical health diagnoses or history that you think or feel is relevant or important.

Your Details

Full Name ____________________________________________

Address ____________________________________________

__________________________________________________________________________

Postcode ____________________________________________

Date of Birth ____________________________ Sex: Male / Female / Other

Email address _______________________________________

Preferred Telephone Number ____________________________________________

Medical Information

Are there any mental or physical health conditions, past or present, that you’d like to mention or that you feel are relevant or important for the researcher? If yes, please use this space to describe these.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Appendix 10 – Participant Research Project Information Sheet

Research Project Information

Current title: The Perfectionist Constellation: How Perfectionists Describe, Understand, Experience and Imagine Relationships

Do you find you agree with some of these statements?

- I feel great when I do well at something.
- I rarely feel that what I have done is good enough.
- No matter how well I do I still feel that I could’ve done better.
- When I make a mistake I feel really bad.
- I really don’t like to see people close to me make mistakes.
- I won’t do things if I can’t expect to do them perfectly.
- I definitely have high standards.
- I like to be orderly in the way I do things.
- I become very frustrated or have other strong feelings when I don’t do something perfectly.
- When I look over something, I often check over the small details.
- People expect a lot from me.

If you do, you might be perfection-seeking!

You can be perfectionist in one area of life or in many including work, study, appearance, personal hygiene, athletic performance, social life, domestic life and parenting.

If this does sound like you, you are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or would you like more information. Take time to decide whether or not to take part. Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to find out about your experience of relationships of all types and to use this information to learn more about how counsellors and psychotherapists can work better with people who struggle with perfectionism. Through us talking about relationships I hope to find out what you might have experienced, what you might expect and what the barriers to entering or staying in therapy might be.
You do not need to know anything about therapy to participate and there is no expectation that you have had therapy or will have therapy as a result of participating.

What will happen to me if I take part and what do I have to do?

I am looking for 12 people to interview. The interviews will be informal and I will carry them out. You can find out more about me at the end of this document.

If you would like to take part, please read the whole of this document. Complete the consent form and personal information forms and return them in the post. Once I receive these I will be in contact with you about the interview. I will call you to ask you if you’d still like to be interviewed, answer any questions you have and then we’ll organize to meet.

From experience, the interviews will between 1 and 2.5 hours depending on how much you feel you have to share. The interview will be carried out at an agreed place. This will be quiet, safe room and there is likely to be some refreshment and small snacks but you can also bring your own if you like. I can carry out the interview in your home provided it is suitable. The room will need to be quiet and peaceful, and family free with any television and devices turned off for the time of the interview. I will record the interviews with two audio recorders.

You may experience feelings about perfectionism and relationships during and after the interview. This is normal. The interview can be stopped at any time and you are completely free to decide not to participate at any time during this process. Please think carefully about participating particularly if you have any mental or physical health issues that might be affected by talking about your perfectionism or relationships. If you have any doubts it may be an idea to discuss participating with a friend or write a list of pros and cons about it, if this will help you to decide what is best for you. Please inform me on the personal information form of any mental or physical health diagnoses or history that you think relevant or important.

I will be available to answer any questions you have about your participation and I will supply further information about resources and things that can help with perfectionism if you want this.

What happens to the data collected and will it be confidential?

The interview recordings will be transferred to a computer and encrypted digitally and stored on a password protected filing service. The interviews will be transcribed and all identify information including your name, age, work place, names of others and any other identifying information will be removed, changed or substituted for other names. I and my supervisor will have access to these transcripts as well as the examiners of this project if they request them. They will then be held securely for 3 years until they can be destroyed.

Any personal information about you that is collected including your name, telephone numbers, address, postcode, age, postcode and email address will be stored separately to your questionnaires and recording so no one will know who you are.
All records of the study including research notes, supervision notes, questionnaires, drafts and the final report will be kept securely at my home office on completion of the study. As per the Data Protection Act 1998, no identifying information will be kept beyond that which is required to enable you to participate. Your information will not be duplicated or circulated.

**What will happen to the results of the study?**

This study will be submitted to the University of the West of England as my doctoral thesis and if it is suitable this report may be written up for journal publication.

**What are the possible disadvantages of taking part?**

Should you decide to take part, there is a possible risk that if you may find talking about perfectionism, relationships or distress to be difficult subjects and you may experience some distress when reflecting on these.

**What are the possible benefits of taking part?**

You may find reflecting on your personal experiences helpful and that talking about yourself increases your self-awareness. You may find that completing the screening questionnaires, prior to participating also has this effect. The research benefit is that you will be contributing to an under-researched area.

**Do I have to participate and if I do, can I withdraw my data?**

No, you don't have to participate. It is up to you to decide whether or not to take part. If you do decide to take part you will sign the consent form and if you take part you are still free to withdraw at any time, without giving a reason. You can do this by text, email or phone.

**What is something goes wrong?**

If you have any concerns then do please raise them with me, or if you prefer with my research supervisor, Zoe Thomas.

**Who is organizing the research and doing the interviews?**

My name is Alice Marsh and I am a student on the part time Professional Doctorate in Counselling Psychology at the University of the West of England. As part of this training I work as a therapist practising relational psychotherapy and CBT and I also run a support group. I will be interviewing the participants. The interviews are research interviews so I will not be able to offer therapy to interviewees however I can direct participants toward help and information where needed and make referrals.

I've worked in a number of settings prior to this training and I have had both a personal and professional interest in perfectionism for some time. I conducted a previous project about ‘Understanding the Processes of Perfectionism’ in 2013.

I am perfection-seeking in some respects myself 😄

Contact for further information
Alice Marsh at: almash@hotmail.co.uk or on 07966 058328

Zoe Thomas (Research supervisor) at: zoe2.thomas@uwe.ac.uk or on 0117 32 83794

Thank you for taking the time to read this information.
Appendix 11 – Further Information about Perfectionism

Further Information About Perfectionism

Perfectionist thinking is very common. It can make us feel good but can also make us feel frustrated or distressed if it takes over. This research project is about those feelings and this information sheet is about where to find further help and support for perfectionist thoughts and their consequences.

Books and Reading Information

- The Gift of Imperfection – Brene Brown
- When Perfect Isn’t Good Enough – Anthony and Swinson (This book has exercises to help reduce perfectionist thinking.)
- Overcoming Perfectionism – Shafran, Egan and Wade (This book has exercises to help reduce perfectionist thinking.)
- The Mindful Path to Self-Compassion – Charles Germer

Online Reading and Resources

- Finding the Right Therapist http://www.bacp.co.uk/seeking_therapist/right_therapist.php

One to One Support

The British Association for Counselling and Psychotherapy www.bacp.org.uk have a section on their website which can help you find accredited counsellors in your area. It can be useful to see a therapist for support, personal development and to have someone non-judgemental and accepting to talk to. There are many different types of therapy so please see the online guides above to find out more. If you are not in the UK, your country is likely to have a professional accrediting body for psychotherapists – they will usually have a list of practitioners.

Doctors – you can consult your doctor if you have having problems with your feelings and they can often offer further help and sometimes access to free therapy.

The Samaritans - If you need support, feel alone or have suicidal thoughts, the Samaritans are available 24 hours a day on 08457 90 90 90 and you can visit their branches.

Other Support

Mindfulness Based Cognitive Therapy (MBCT) and similar Mindfulness Based Stress Reduction (MBSR) courses teach meditation practice to groups and individuals which can bring relief and a sense of balance.
Appendix 12 – Examples of the Coding Process

i. NVivo screen shot of examples coded with detailed code: Parent - Father endured hardship in the second stage

<table>
<thead>
<tr>
<th>Reference 1 - 0.65% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>He is impatient but he’s an ill man he’s been ill for the last, he’s been ill since he was 53, 54 so he’s been battling cancer for a lot of years. He’s had a lot going on in his adult life from the early 50’s really but then he’s had quite a difficult upbringing he didn’t have a lot of love in his life. I think his parents split when he was 12 so I think in 1946 roundabout then. He was one of five and it split the whole family and oh dear your know so if you can imagine a 12 year old and mum going north and dad going south and where do the five children go, mess and of course in the forties divorce wasn’t common.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference 2 - 0.25% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>So dad was kind of like I think he was more or less brought up by he had brothers and one sister so the sister picked up the role of mum and she would have only been about 4 years older than him so that was probably difficult for him.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference 1 - 0.65% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think he had quite a difficult life he was the oldest boy of three children and his mother died when he was about 14 or 15 I think, and also he came from a Catholic family and when he married my mother his family disowned him so he was carrying quite a lot of baggage and I think when my mother left him that was the last straw really and you know he got quite depressed after that.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference 1 - 0.52% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>They were much more middle class than my mum’s family and he did do well because they were very flash but his father was an alcoholic and never gave him much attention whatsoever. He used to stand at the pub waiting for his dad to come out and give him to give him sixpence so it’s quite a tough upbringing.</td>
</tr>
</tbody>
</table>
ii. NVivo screen shot of examples coded with detailed code: Parent - Father private unemotional in the second stage

Reference 1 - 0.28% Coverage

It's a good relationship but it's a very he's a typical man of that generation born in '34 very private man not demonstrative in his emotions is in his own world of Walter Mitty wherever that may be. I love my dad tremendously he's a very kind of fiery kind of guy.

Reference 1 - 0.81% Coverage

My father was a typical sort of 1950s you know I was born in 1956 so he was a typical man of that time, didn’t, and he was in a family of three women and I think he wasn’t really a woman’s kind of a man [Ok yeah] and also he wasn’t very emotional. There was nothing unkind about him or anything like that but he was kind of typical of the time I would say with very controlled emotions with the occasional explosion but most of the time very kind of controlled and self-contained.

Reference 1 - 0.09% Coverage

My father’s quite cold, very closed off kind of person

Reference 2 - 0.31% Coverage

I’m sure he had problems with his emotions but he does have emotions. He’s not really upset. He’s better at doing all that so he was doing all of the practical stuff and running around.
iii. NVivo screenshot of detailed codes from recoding of placeholder codes about parents in the second stage

<table>
<thead>
<tr>
<th>Code</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent - Mother postnatal depression</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Mother tiptoeing around self</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Mother trapped by financial dependency</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Mother traumatized by divorce and struggling</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Mothers Expectations of self</td>
<td>5</td>
</tr>
<tr>
<td>Parent - Nagging mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Nitpicking negative mother</td>
<td>2</td>
</tr>
<tr>
<td>Parent - No pressure from mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Not dealing with stress well</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Not listening mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Off limits subjects</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Office out of bounds</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Orderly</td>
<td>4</td>
</tr>
<tr>
<td>Parent - Passive aggressive mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Perfectionist father</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Perfectionist mother</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Playful engaged father</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Provocative mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Reactive mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Reliable</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Religious inflexible</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Resentful culturally different mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Scrutinising critical mother</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Shocked by fathers infidelity</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Stepfather angry about father relationship</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Stepfathers Expectations of self (Nodes)</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Strongminded rigid father</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Struggling to achieve relationship</td>
<td>1</td>
</tr>
</tbody>
</table>
iv. Nvivo screen shot of work in progress showing detailed and consolidated codes gathered into the *Difficult to reach parent* subtheme node by the end of the third stage

<table>
<thead>
<tr>
<th>Name</th>
<th>Sources</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood - Boarding school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Childhood - Not close to either parent</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Abandoning mother</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Absent father</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Absorbed in work</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Parent - Alcoholic Drinking a Lot Father</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Parent - Alcoholic Mother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Caring for spouse or child long term</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Causing them anxiety</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Cold closed off father</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Death of Father</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Parent - Death of Mother</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Parent - Depressed mother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Father endured hardship</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Parent - Father focus of his parents life</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Father leaving</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Parent - Father not dealing with emotional stuff</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Father off living the good life</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Father one way street emotionally</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Parent - Father private unemotional</strong></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Parent - Father with long term illness</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Feeling disowned by mother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Hardworking Father</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Hardworking Mother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent - Insecure mother</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parent - Longing for mother</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
v. Work in progress on subtheme nodes in the fourth and fifth stages

By the fifth stage subthemes Aa. to Ae. made up Challenging relationships in the past, subthemes Af. to Aj. made up Feeling Unpleasant Sensations and Emotions in the past and present, and subthemes Ak. to Ao. made up Ongoing Habits Impacting on Relationships.