

# Guided self-help versus pure self-help for perfectionism: A randomised controlled trial

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Received 20 April 2006; received in revised form 7 August 2006; accepted 9 August 2006

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## Abstract

Perfectionism is known to be a risk factor for the development and maintenance of obsessive–compulsive (OC) and depressive symptoms. The purpose of the present study was to test the effectiveness of a cognitive-behavioural self-help therapy for perfectionism, and to examine the effect of such treatment on OC and depressive symptomatology. The study compares the effectiveness of guided self-help (GSH,  $n = 24$ ) with pure self-help (PSH,  $n = 25$ ) therapy. Both GSH and PSH were found to be effective in reducing perfectionism, and also in reducing OC and depressive symptomatology. Overall, participants in the GSH condition experienced greater symptom improvement than participants in the PSH condition, and treatment gains for both groups were largely maintained at 3-month follow-up. Twenty percent of PSH participants experienced clinically significant increases in depressive symptoms over the treatment and follow-up period (compared to 0% in the GSH condition), suggesting that PSH may be a less suitable strategy than GSH in treating this population. Overall, the findings suggest that self-help for perfectionism is effective in reducing OC and depressive symptomatology in non-clinical individuals, with GSH being superior to PSH.

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*Keywords:* Perfectionism; Obsessive–compulsive disorder; Depression; Cognitive-behavioural therapy; Self-help; Treatment

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## Introduction

Research findings suggest that specifically targeting perfectionism in treatment may enhance therapeutic outcomes across a range of psychological disorders. Blatt and Zuroff (2005) found that pre-treatment perfectionism interfered significantly with the reduction of depressive symptoms, both post-treatment and at follow-up, and that patients with high levels of perfectionism tended to make less therapeutic progress toward the later stages of therapy as they begin to approach termination, compared to patients with lower levels of perfectionism. Blatt and Zuroff further reported that pre- and post-treatment perfectionism reduced patients' capacity to adapt to stressful life events in the 18 months following termination of treatment. It has also been suggested that perfectionism may impede the treatment of obsessive–compulsive disorder (OCD), by interfering with the ability of OCD patients to endure typical exposure and response prevention (ERP)

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procedures and to examine evidence regarding their beliefs about intrusive thoughts (Frost, Novara, & Rhéaume, 2002). Furthermore, studies involving eating disorder populations (Bastiani, Rao, Weltzin, & Kaye, 1995) and depressed patients (Blatt, 1995) suggest that specifically addressing perfectionistic thinking may be an important component of treatment, and Bastiani et al. (1995) have suggested that perfectionism may contribute to treatment resistance and relapse in anorexia nervosa.

A handful of studies have indicated that use of cognitive-behavioural therapy (CBT) principles may reduce perfectionism. First, Ferguson and Rodway (1994) conducted an exploratory study aimed at evaluating an intervention that identified automatic thoughts and restructured cognitive distortions into positive coping statements. They found that the intervention was successful in reducing perfectionism levels in nine clients. However, because no control group was employed, it is impossible to determine whether improvements were the result of the specific CBT intervention or merely the result of non-specific factors such as demand characteristics, clients' expectations about treatment and general support offered by the therapist. Changes in perfectionistic behaviours were assessed using a subjective "self-anchored scale" and conclusions were based solely on "visual analysis" of the data, with no formal statistical analyses or calculations of effect size.

Second, some preliminary findings on the effectiveness of cognitive restructuring in the treatment of perfectionism were provided by DiBartolo, Frost, Dixon, and Almodovar (2001). In this study, a group of 60 female undergraduate students (of either high or low concern over mistakes) received either a brief cognitive restructuring intervention or a distraction intervention prior to delivering a speech in front of a small audience. Each intervention lasted a total of 8 min. The cognitive restructuring intervention was successful in reducing evaluative threat concerns for individuals with high concern over mistakes. Furthermore, these cognitive changes were associated with lower self-reported anxiety compared to participants in the distraction condition.

The only other published accounts of CBT for perfectionism are two single-case studies. The first case study was conducted by Hirsch and Hayward (1998) and describes the case of a 40-year-old man undergoing CBT for anxiety and depression, which seemed to be perpetuated by his perfectionistic thoughts and assumptions. Moreover, the authors noted that his perfectionism impeded successful treatment of the anxiety and depression, as "setbacks were exacerbated because of a perfectionistic belief that anything but rapid progress was a failure" (p. 363). Specific interventions were therefore devised in order to address the client's perfectionistic assumptions, and once the client's perfectionism decreased he also began to make progress in reducing his anxiety and depression symptoms. Another case study (Shafran, Lee, & Fairburn, 2004) described the case of a 26-year-old woman with binge eating disorder, whose perfectionism appeared to be contributing to the maintenance of the eating disorder. The treatment consisted of eight sessions aimed at reducing the client's "clinical perfectionism" (Shafran, Cooper, & Fairburn, 2002), and was successful in reducing both the client's clinical perfectionism as well as her eating disorder symptoms, with improvements maintained at 5-month follow-up. Furthermore, a recent study by Shafran, Lee, Payne, and Fairburn (2006) has also demonstrated that experimental manipulations of personal standards (PS, one aspect of clinical perfectionism) result in changes in eating behaviours in non-clinical individuals, with higher PS being associated with increased restraint and regret after eating.

Whilst the studies described above suggest that perfectionism is treatable, and that the treatment of perfectionism may lead to improvements in various forms of psychopathology, the treatment of perfectionism is yet to be examined in any randomised controlled trials. The purpose of the present study was therefore to test the effectiveness of the cognitive-behavioural self-help strategies developed by Antony and Swinson (1998) for the treatment of perfectionism. The aim was not only to examine whether this treatment leads to a significant reduction in perfectionism, but also to test whether the treatment of perfectionism leads to a reduction in associated psychopathology, including depression, anxiety, and obsessive-compulsive (OC) symptomatology.

Given that the strategies outlined by Antony and Swinson (1998) are presented in the form of a self-help book, the effectiveness of this treatment was evaluated both as a pure self-help (PSH) and a guided self-help (GSH) program. In recent years, there has been increasing interest in self-help therapies for a variety of psychological disorders, including eating disorders (Carter & Fairburn, 1998; Palmer, Birchall, McGrain, & Sullivan, 2002), depression (Landreville & Bissonnette, 1997), panic disorder (Lidren et al., 1994), specific phobias (Öst, Stridh, & Wolf, 1998), and OCD (Bachofen et al., 1999; Clark, Kirkby, Daniels, & Marks,

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