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Review

# Perfectionism in obsessive-compulsive disorder and related disorders: What should treating clinicians know?

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ABSTRACT

Perfectionism is known to be highly prevalent in obsessive-compulsive disorder (OCD). This review seeks to explore perfectionism in OCD and related disorders, particularly in relation to treatment, in order to inform treating clinicians. We also evaluate the potential role of perfectionism in the maintenance of OCD. Evidence supports perfectionism as a transdiagnostic process central to the psychopathology of OCD and other mental illnesses. Treatment outcomes in EX/RP for OCD are diminished in the presence of perfectionism, which is thought to be due to inherent treatment interfering features of perfectionism. Successful OCD treatment has been shown to decrease perfectionistic thinking, though data are mixed on whether reducing perfectionism mediates subsequent reductions in OCD symptoms. Short-term cognitive behavioral protocols for perfectionism are reviewed here and recommendations are made for the treatment of perfectionism in the context of OCD and related disorders.

## 1. Introduction

Obsessive compulsive disorder (OCD) is characterized by recurrent, intrusive, and distressing thoughts, images, or impulses (obsessions) and repetitive mental or behavioral acts that the individual feels driven to perform (compulsions) to prevent or reduce distress (APA, 2013). OCD produces substantial impairment in social, family, and work functioning (Koran, Leventhal, Fireman, & Jacobson, 2000). Obsessions and compulsions are diverse and can be expressed with great variability both within and across patients over time (Eisen et al., 1998). Patients with OCD also differ in their course of illness, point of onset, and comorbid clinical conditions. This heterogeneity in the OCD clinical phenotype complicates research, possibly obscuring findings and reducing power in studies of pathophysiology, course, and treatment outcome. Dissecting the heterogeneous phenotype into less complex, more homogeneous components could lead to the identification of discrete mechanisms and the development of tailored treatment strategies.

Categorical and dimensional symptom approaches have been applied in research aimed at refining the phenotype of OCD (Miguel et al., 2005). The use of symptom categories has been disputed, as most patients with OCD are not monosymptomatic and typically present with overlapping symptom clusters (Rufer, Frike, Moritz, Kloss, & Hand, 2006). OCD symptom dimensions are also debated, due in part to differences in clinical ascertainment, scoring, and statistical methods across studies which have sometimes resulted in varying structures (Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008).

While symptom subtyping remains unclear, there has been interest in understanding the role of personality functioning in the psychopathology of OCD, including comorbid personality disorders. Although results are equivocal from studies that predate the DSM-IV (e.g., Baer et al., 1990), most recent studies have suggested a strong link between OCD and obsessive-compulsive personality disorder (OCPD). Studies using DSM-IV criteria have consistently found elevated rates of OCPD in OCD, with estimates ranging from 23% to 34% (Albert, Maina, Forner, & Bogetto, 2004; Garyfallos et al., 2010; Lochner et al., 2011; Pinto, Liebowitz, Foa, & Simpson, 2011; Samuels et al., 2000; Tenney, Schotte, Denys, van Megen, & Westenberg, 2003) in comparison to rates of OCPD in community samples. OCPD involves a chronic

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maladaptive pattern of excessive perfectionism, preoccupation with orderliness and detail, and need for control over one's environment that leads to significant distress or impairment, particularly in areas of interpersonal functioning. Individuals with this disorder are often characterized as rigid and overly controlling; they find relaxing difficult, feel obligated to plan out their activities to the minute, and find unstructured time unbearable (Pinto, Eisen, Mancebo, & Rasmussen, 2008). While evidence remains mixed (Gordon, Salkovskis, & Bream, 2015), OCPD has been associated with poor treatment response to both exposure and response prevention (EX/RP) (Pinto, Liebowitz, Foa, & Simpson, 2011) and SRI medications (Cavedini, Erzegovesi, Ronchi, & Bellodi, 1997).

Due to limitations in categorical definitions of personality disorders (Clark, 2007), a dimensional approach to personality, reflecting a comprehensive explanatory model, may be more informative. Determining the nature of the relationship between personality traits and OCD may prove helpful in clarifying the disorder's etiology, based on the theoretical view that certain personality traits may make individuals vulnerable to the onset of the disorder. As personality and psychopathology have a pathoplastic relationship (Widiger, 2011), in which they can influence the presentation of each other, relating personality dimensions to OCD symptoms may provide a means of identifying more homogeneous phenotypes of the disorder (i.e., subtyping OCD based on the presence or absence of key personality traits), relevant given recent work suggesting perfectionism may have a genetic component (Di Nocera, Colazingari, Trabalza, Mamazza, & Bevilacqua, 2014). Identifying homogenous subtypes of OCD with a genetic component might enable individualized treatment recommendations, in line with the goals of personalized medicine.

Perfectionism, as a maladaptive trait dimension, has been implicated in understanding OCD since it is highly prevalent in patients with OCD (Pinto et al., 2006) and has been shown to impede OCD treatment (Pinto et al., 2011). Perfectionism is defined as the tendency to set and pursue unrealistically high standards and to employ overly critical self-evaluations (Frost, Marten, Lahart, & Rosenblate, 1990). While a prominent feature of OCPD, perfectionism is also a distinct clinical presentation. The Obsessive Compulsive Cognitions Working Group (OCCWG, 1997) considers perfectionism to be a risk factor for the development of OCD, and others consider it to be a necessary, but insufficient, predisposing trait for the disorder (Rhéaume, Freeston, Dugas, Letarte, & Ladoucer, 1995).

Some theoretical and empirical work suggests that perfectionism may be a maintaining factor in OCD symptoms. This view is based on several lines of evidence that will be reviewed here, including perfectionism as a transdiagnostic process driving various pathologies (Egan, Wade, & Shafran, 2011), the correlation between obsessive compulsive symptoms and perfectionism in both clinical and non-clinical samples, and the positive effect of explicitly treating perfectionism on comorbidities. Considering the impact of perfectionism on OCD treatment outcome provides a new direction for research into evidence based approaches for this population, including adapting evidence based treatments for clinical perfectionism, which are reviewed here. Although perfectionism itself has been increasingly researched and recently reviewed (Egan et al., 2011), the present paper focused on the co-occurrence of perfectionism within OCD. In particular, we sought to review recent empirical work with implications for clinicians treating OCD. We feel that this is an important endeavour for several reasons. Based on high rates of co-occurrence, treating clinicians are highly likely to encounter patients with OCD (and OCD-related disorders) who demonstrate clinically significant perfectionism. The nature of OCD symptoms can make it difficult to disentangle what is OCD and what is best conceptualized as a separate issue with perfectionism; thus reviewing the current conceptualization of perfectionism could help clinicians make diagnostic determinations. In addition, recent data suggests that perfectionism may represent a complicating factor in OCD treatment, which treating clinicians should be aware of. Finally, evidence supports specifically-tailored CBT to target perfectionism, perhaps offering clinicians an additional treatment option in such cases.

To identify relevant empirical reports, we conducted a search of the electronic databases PsycINFO, PsycARTICLES, Medline, ScienceDirect and PubMed using the following key words: Obsessive-Compulsive Disorder or OCD and perfectionism; Obsessive-Compulsive Personality Disorder or OCPD and perfectionism; OCD, perfectionism and treatment; perfectionism, treatment and outcome. Article relevance was determined by screening titles and abstracts. Reference lists of relevant articles were further screened for potentially relevant studies. This review begins by defining perfectionism as both a construct and transdiagnostic process. We then organized the results of our literature review to focus on empirical studies of perfectionism in OCD and OCD-related disorders, followed by the impact of perfectionism on treatment of these conditions. Next, we discuss treatments focusing on perfectionism itself and how these may be incorporated into OCD treatment. Finally, we review conclusions and offer directions for future research in this area.

### 1.1. Perfectionism as a construct

While there has been increasing interest in the role perfectionism plays in the etiology, maintenance, and treatment of a variety of disorders, considerable debate continues regarding how perfectionism should be defined. The multidimensional perspective (Frost et al., 1990; Hewitt & Flett, 1991) considers perfectionism as being comprised of various intrapersonal and interpersonal domains. Hewitt and Flett (1991) developed a multidimensional perfectionism scale, the Hewitt-Flett Multidimensional Perfectionism Scale (HMPS), composed of three dimensions: self-oriented perfectionism, in which one sets stringent standards for oneself and focuses on perceived failures; socially-prescribed perfectionism, or the perception that others have unrealistically high standards for them; and other-oriented perfectionism, wherein one's own demanding standards and stern evaluations are reflected onto others. Frost et al. (1990) developed another measure of multidimensional perfectionism, the Frost Multidimensional Perfectionism Scale (FMPS), which encompassed five dimensions: concern over mistakes, setting high personal standards, perceiving high parental expectations, parental criticism, and doubting the quality of one's performance or actions. A comparison of these scales showed that the FMPS global measure of perfectionism correlated highly with the HMPS self-oriented and socially-prescribed subscales, and to a lesser extent, the other-oriented scale (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993). Moreover, a factor analysis of the nine subscales between the two questionnaires parsed out two distinct factors: maladaptive evaluative concerns and positive striving, with only the former contributing to perfectionism-associated psychopathology (Frost et al., 1993).

Shafran, Cooper, and Fairburn (2002) proposed an alternative construct informed by a cognitive-behavioral view of perfectionism: clinical perfectionism is “the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards despite adverse consequences” (p. 778). In emphasizing the valuation of self-worth being tied to striving and success as the central tenet of clinical perfectionism and proposing distinct cognitive mechanisms that maintain this schema, they identify potential domains for treatment focus (Riley & Shafran, 2005; Shafran et al., 2002). In response, the Clinical Perfectionism Questionnaire (CPQ; Shafran et al., 2002) was developed to measure perfectionism through striving for achievement and the effect of perceived success or failure on self-evaluation. The CPQ is correlated with the personal standards and concern over mistakes subscales of the FMPS (Egan, Piek, Dyck, Rees, & Hagger, 2013; Chang & Sanna, 2012; Egan et al., 2015), indicating notable overlap between definitions of perfectionism.