Group dynamic-relational therapy for perfectionism

Samuel F. Mikail,[1] Paul L. Hewitt,[2] Gordon L. Flett,[3] Sabrina Ge[2]

[1]Department of Psychology, University of Waterloo, Waterloo, ON, Canada; [2]Department of Psychology, University of British Columbia, Vancouver, BC, Canada; [3]Department of Psychology, York University, North York, ON, Canada

ABSTRACT

The interest in treating underlying core vulnerability factors or transdiagnostic processes has been a focus of much attention. In this paper we describe our application of group dynamic-relational psychotherapy to the treatment of perfectionism, a core personality vulnerability factor associated with various forms and types of dysfunction and disorders that have profound costs to the individual both socially and subjectively. Over the course of the past three decades, we developed an evidence-based integrative group treatment that targets the psychodynamic and relational underpinnings of perfectionism. The treatment is based on an integration of psychodynamic and interpersonal perspectives and therapeutic approaches. In this paper we present our model of perfectionism and describe our group dynamic-relational therapy for the treatment of its pernicious outcomes. By drawing on illustrative case material, we describe the approach as applied to one such group as it progresses through four phases of group development that we have termed engagement and pseudo attachment, pattern interruption, self-redefinition/painful authenticity, and termination. Finally, we present some of the accumulating evidence of the effectiveness and efficacy of dynamic-relational therapy.

Key words: Dynamic-relational therapy; perfectionism; group therapy.

Correspondence: Paul L. Hewitt, Department of Psychology, University of British Columbia, 2136 West Mall, Vancouver, BC, Canada V6T 1Z4.
E-mail: phewitt@psych.ubc.ca

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The genesis of group psychotherapy can be traced back to the turn of the 20th century when Joseph Pratt developed 'thought control classes' aimed at fostering treatment adherence among tuberculosis patients (Norcross, VandenBos, & Freedheim, 2011; Paquin, Abegunde, Hahn, & Fassinger, 2021). Today, group psychotherapy is applied to the treatment of numerous disorders and problems in living using a variety of theoretical orientations (*e.g.*, Armusewicz, Steele, Steele, & Murphy, 2022; Popolo *et al*., 2018; Qanbari Alaee *et al*., 2022). Norcross *et al*. (2011) define group therapy 'as the treatment of emotional or psychological disorders or problems of adjustment through the medium of a group setting, the focus point being the interpersonal (social), intrapersonal (psychological), or behavioural change of the participating clients or group members' (p. 505). In this paper we describe our application of group dynamic-relational therapy (DRT) to the treatment of perfectionism (Hewitt, Flett, & Mikail 2017; Hewitt, Mikail, Flett, Tasca, & Flynn, 2015; Hewitt *et al*., 2019) and provide a detailed description of

the group application of the DRT. We also describe in detail the integrative clinical formulation approach we developed in this treatment as well as provide clinical excerpts from various stages of the group process. Finally, we describe some of the clinical research we have conducted to ensure clinicians and researchers that the DRT is an evidence-based treatment.

We believe that group psychotherapy, and psychodynamically informed group psychotherapy in particular, may be effective in the treatment of all components of perfectionism[1] due to the crucial relational elements in the development of perfectionism and both the causal and maintenance factors involved in perfectionism's perniciousness (see Blatt, 1995; Flett & Hewitt, 2022; Hewitt *et al*., 2017). Perfectionism appears to develop from and be driven by powerful needs for safety, acceptance, belonging, and avoidance of rejection/abandonment as well as needs to feel and experience being good enough, and needs to have esteem and worth (see Cheek *et al*., 2018; Hewitt *et al*., 2017; Hollender, 1965; Horney, 1937; Miller, Hilsenroth, & Hewitt, 2017; Pacht, 1984). It is our contention that group psychotherapy approaches that emphasize these elements by focusing on felt security, cohesion, and acceptance by employing interpretative interventions, interpersonal and emotional exploration, and encouragement of and support for interpersonal risk taking in the here and now can contribute to a fundamental shift in one's experience of self and others. As such psychodynamically-informed group treatments may be particularly well suited and efficacious in targeting recurrent patterns of nonattunement and asynchronous interaction that we consider to be the building blocks of perfectionism (see Hewitt *et al*., in press).

Although there are numerous views of perfectionism, we have conceptualized perfectionism 'as a multifarious and multilevel personality construct' (Hewitt, Mikail, Flett, & Dang, 2018; p. 179) that is deeply ingrained and as having stylistic interpersonal, intrapersonal, motivational, and behavioural manifestations. More specifically, according to our Comprehensive Model of Perfectionistic Behaviour (CMPB; Hewitt *et al*., 2017), perfectionism comprises stable and enduring trait dimensions that drive and energize perfectionism. Hewitt and Flett (1991a, 1991b) identified three trait perfectionism dimensions: *self-oriented perfectionism* (*i.e*., the requirement of perfection for oneself), *other-oriented perfectionism* (*i.e*., the requirement of perfection for others), and *socially prescribed perfectionism* (*i.e*., the perception that others require perfection of oneself). In addition to trait perfectionism dimensions, Hewitt *et al*. (2003) also discussed perfectionistic self-presentational styles that capture the interpersonal expression and communication of one's purported perfection to others. These include *perfectionistic self-promotion* (*i.e*., promoting and proclaiming oneself as perfect), the *non-display of imperfection* (*i.e*., concealing overt displays of any imperfect behaviour), and the *non-disclosure of imperfection* (*i.e*., not disclosing or verbally revealing any imperfection). Finally, an intrapersonal or self-relational component of perfectionism that is reflected, in part, by an individual's internal dialogue with the self involves not only automatic perfectionistic self-statements and thoughts (Flett, Hewitt, Blankstein, & Gray, 1998) but also automatic critical self-recriminations (Hewitt, Smith, Molnar, & Flett, in prep). Moreover, we have also indicated that this component reflects a behavioural element involving neglect of the self in terms of limited self-care and self-denial.

Perfectionism develops and is maintained within a relational context that has its foundation in early interactions with primary caregivers and other significant figures and is further developed and ingrained within the individual through other relational contexts (Hewitt *et al*., 2017). Specifically, recurrent asynchronous responses between parent and child contribute to felt insecurity within the child that serves as the foundation for experiencing the self as not good enough to be accepted, loved, and not rejected or punished and an understanding of the self as flawed, defective, and not deserving of mattering. The developing child in turn is propelled toward a pattern of perfectionism, having as its basis two fundamental needs: a need for connection and belonging and a need for self-esteem. Accompanying this is an intense inner experience of self-censure and self-punishment, feelings of inadequacy, and a deep fear of being revealed as deeply flawed and defective. Thus, the perfectionist harbours an internal and tortuous conflict between being or appearing perfect for the external world and an internal experience and view of self as profoundly defective (see Hewitt *et al*., 2017). Fredtoft *et al*. (1996) posit that the unrelenting expectations of parents contribute an internal pressure felt by the emerging perfectionist to attain a level of accomplishment that allows their parents to feel they are good parents. The emphasis in our model is somewhat different: We understand the nature of this relationship[2] and resulting perfectionism as an attempt to secure a sense of belonging, mattering and being acceptable to others as well as an internal sense of being worthy and acceptable to the self. The developmental trajectory that follows is one of trying

[1] We would also suggest that DRT will be effective in other personality styles that are transdiagnostic and core vulnerability factors such as dependency or narcissism. All these styles have relational and attachment-based aetiologies and the focus on such aetiologies may be particularly effective.

[2] As we have stated, we do not wish to assert that perfectionism arises from poor parenting or pathological parents only. Certainly, there are neglectful and abusive parents whose behaviours can contribute to the development of perfectionism; however, we suggest that there is an asynchrony that can ensue between caregiver and the perfectionism-prone person whereby the needs the child have are not met or are missed. This can be due to circumstance and environment, a child's idiosyncratic understanding of caregiver's behaviours, temperament, or personality or to parents attempting to do their best in trying or stressful family circumstances.

to both appease and please others in the hope of becoming worthy of love and acceptance from those others and to repair the sense of defectiveness of the self; a stance that contributes to perfectionists becoming increasingly disconnected from their own feelings and needs, and in turn making authenticity and intimacy elusive (see Cheek *et al*., 2018; Hewitt *et al*., 2017).

Hewitt *et al*. (2006) extended these ideas in their Perfectionism Social Disconnection Model (PSDM) as a means of explicating the developmental roots of perfectionism and its interpersonal consequences. Hewitt *et al*. (2017) extended an original model but retained the core premise that perfectionism is driven by an excessive need for acceptance and the avoidance of rejection that bespeaks a deep and unfulfilled need for social connection. Thus, perfectionism in its various forms becomes the primary vehicle for securing a sense of belonging and the esteem of others and of the self. Yet, the pervasive rigidity of the perfectionist in which outcomes and appearances trump collaboration, coupled with limited awareness and acceptance of one's fallibility and the fallibility of others, contributes to an interpersonal presentation that others experience as cold, distant, uncaring, and, at times, hostile and aggressive. The understandable reticence others may experience when interacting with the perfectionist in turn serves to perpetuate the perfectionist's view of the self as defective, unworthy, and desperately alone in the world. The PSDM provides a comprehensive and empirically based conceptualization of the interpersonal, intrapersonal, and behavioural elements of perfectionism both in terms of development and in terms of its role in producing and maintaining distress and dysfunctions. Work by Hewitt and his colleagues has demonstrated that meaningful and sustained psychotherapeutic change requires addressing each of these elements (see Cheek *et al*., 2018; Hewitt *et al*., 2017; Hewitt, Mikail, Dang, Kealy, & Flett, 2020).

Group psychotherapy has been shown to be an effective means of treating perfectionism and the various forms of maladjustment that accompany it (Hewitt *et al*., 2015, 2018, 2019). Over the course of the past two decades we developed an empirically supported treatment, DRT, that integrates psychodynamic and interpersonal theory with the expressed intent of addressing the interpersonal, intrapsychic, and behavioural manifestations of perfectionism. In our experience, successful treatment of perfectionism begins with an appreciation of the subjective experience of the perfectionistic individual, particularly as it relates to the decision to pursue treatment. Most patients we treat embark on psychotherapy at a point when they are feeling utterly tortured by their perfectionism. Yet the dilemma they face is an awareness that psychotherapy requires revealing one's needs, limitations, and shortcomings; a prospect that evokes a complex mix of apprehension, fear, self-loathing, anger, and despair. The patient's distress is further magnified when group psychotherapy is recommended. Fear of judgement and rejection stemming from a lifetime of unmet relational and emotional needs make the prospect of exposing one's self to strangers nearly paralyzing. This precarious terrain has to be traversed gently by the clinician who must be prepared to see beyond the patient's ambivalence and recognize deeper layers of contained affect concealed by well-honed defenses that have served to push others away.

Dynamic-relational therapy: an evidence-based approach

The therapeutic approach

Over the past 30 years we have developed, practiced, and researched the DRT in an attempt to refine the treatment and to determine its utility, effectiveness, and efficacy for perfectionistic individuals. In keeping with Norcross *et al*. (2011)'s definition of group psychotherapy and Hewitt *et al*. (2017)'s PSDM, our treatment of perfectionism emphasizes targeting the self-limiting aspects of the patient's interpersonal patterns as expressed in group treatment, with an emphasis placed on the here-and-now (see Yalom & Leszcz, 2020) using interpretative, exploratory, and rupture/repair interventions. For many patients there are at least four distinct but somewhat related patterns in the group context: the patient's relationship with the therapists, with the self, with other group individual members, and with the group as an entity. The patient's relationship with the group therapist reflects features of a patient's experience with authority figures and other significant attachment figures. Similarly, relationship with self, or the manner in which the patient treats the self (*i.e*., as expressed through self-statements, risk taking behaviour *vs* inhibition, self-neglect, or self-harm *vs* self-indulgence, *etc*.) is an internalization of the patient's perception of how they were treated by significant attachment figures. A member's manner of engaging with other group members reflects key aspects of the individual's relational style more broadly in day-to-day interactions. In some instances, a patient's manner of relating to other members of the group may vary depending on the sex, age, ethnicity, race, or sexual identity of the person the patient is interacting with. The fourth relational pattern is the individual's relationship with the group as a whole in which the entire group is viewed as a single entity. Individuals possessing a more fragile and rigidly organized self-concept who are prone to greater degrees of interpersonal distortion may respond to all members of the group in an undifferentiated manner. A similar pattern can be seen in more well-adjustment members at times of heightened distress or perceived threat that are overwhelming the individual's coping capacity.

Critical to our treatment approach is the development of a case formulation that draws on the tenets of attachment theory, interpersonal theory, and contemporary psychodynamic principals (Hewitt *et al*., 2017; 2020; Tasca, Mikail,

& Hewitt, 2021). The clinical formulation serves as the roadmap for the therapists and in determining specific interventions for the group. Effective treatment relies on establishing a coherent understanding of an individual's patterns of relating to both others (interpersonal) and to the self (intrapersonal) and the manner in which those patterns are likely to manifest in group interactions (behavioural). The initial consultation session focuses on identifying the individual's reasons for seeking treatment, their unique needs and challenges, past experiences with psychotherapy, and hopes for treatment. The assessment proper begins with an exploration of the patient's developmental and attachment history. Emphasis is placed on the nature and quality of the patient's relationships with significant figures including parents, extended family, teachers, coaches, and childhood peers. These formative relationships serve as the foundation for the patient's personality development including the individual's self-concept, the ability to express and regulate emotions, the capacity to express needs and the associated expectations of how others will respond, as well as the capacity to explore one's world and take risks. We refer to this constellation of psychological functions as the individual's cyclical relational pattern[3] (CRP; see Hewitt *et al*., 2017; Strupp & Binder, 1984; Tasca *et al*., 2021). The CRP comprises four inter-related facets: i) *Acts of Self*, which includes prototypic behaviours, cognitions, affective states, and perceptions; ii) *Expectations of Others* that capture the individual's view of how others will act, feel and think in response to the Acts of Self; iii) *Acts of Others* or the actual observed reactions of others to the individual's Acts of Self; and iv) *Introject*, which encompasses the patient's feelings, thoughts and behaviours toward self that are typically an internalization of the ways in which significant others have treated the individual. The CRP is immensely helpful when assessing an individual's suitability for placement in a particular group as it allows the clinician to anticipate ways the individual is likely to relate to other group members. The CRP represents a first step in the development of the clinical formulation for the patient but it should also incorporate a means of positioning the patient's treatment goals within the broader context of their attachment history and dynamic functioning. We accomplish this by using two additional heuristics: the Triangle of Adaptation and the Triangle of Object Relationships (Hewitt *et al*., 2017; Tasca *et al*., 2021). The Triangle of Adaptation summarizes the individual's unfulfilled attachment needs, the associated affective states when attachment needs are activated yet remain frustrated, and the prototypic defenses and coping mechanisms that are triggered in order to quell or discharge unpleasant affect. The Triangle of Object Relations is a deeper extension of the CRP that is specific to the expected transference dynamic enacted when the individual experiences frustration of a core attachment need. Its vertices include a description of the nature and quality of significant past relationships, current extra-group relationships, and expected relationships with group members, the group leader, and/or the group as a whole. The main goal is to identify consistent interpersonal patterns that reflect attempts to have one's needs met. The case conceptualization is derived through integration of results obtained from a combination of clinical interviewing and psychometric testing (see Hewitt *et al.*, 2017 for a full description). The outcome is shared with the client in the form of a concise narrative describing their CRP and associated dynamics and alerts them to ways these are likely to be enacted in treatment. This is a critical aspect of pre-group preparation as it serves as a means of helping the patient tolerate junctures in treatment that could otherwise contribute to premature termination.

Our group DRT has relied on the use of time-limited homogenous groups of 12 weeks in duration. This length of time was not determined by specific theoretical considerations but rather by the practical requirement of conducting research that needs to have a defined start and end point. Our data suggests that most members achieved meaningful sustained change within this time frame; however, it is our impression that a longer duration, or perhaps an open-ended group with rolling admission, may be a preferred option. Although our groups have comprised individuals exhibiting high levels of perfectionism, composition has been heterogenous with respect to the manner in which members manifest their particular form of perfectionism (see Hewitt *et al.*, 2017 for a description of the various forms of perfectionism). Criteria employed in member selection included being over the age of 18 and having at least one significant long-standing relationship that indicates the capacity to connect relationally with another person. Members were excluded if they presented with active psychotic symptoms or suicidality, unmanaged bipolar disorder, or a confirmed diagnosis of schizoid or antisocial personality disorder. Groups comprise up to ten participants and two co-leaders. Therapist interventions are guided by the emotional and task demands of the group as it progresses through four phases of group development. Phase one, referred to as 'engagement and pseudo attachment', is marked by heightened anxiety and feelings of uncertainty. On the one hand, members enter the group harbouring an inner longing for connection and acceptance. Yet, they also fear and are quick to defend against any hint of disapproval, whether real or perceived. A particular challenge for the therapist during this phase is managing the demanding and hostile relational style of other-oriented perfectionists and the reticence, hesitation, and distancing behaviours of those with other forms of perfectionism. The primary tasks of the therapist include establishing adaptive norms, building cohesion by highlighting universal themes and struggles, and, perhaps most importantly, creating a safe environ-

[3] In Tasca, Mikail, & Hewitt (2021) the CRP is referred to as the Cyclical Maladaptive Interpersonal Pattern.

ment that makes it possible for members to begin to take the risks necessary to achieve growth. A preponderance of group-as-a-whole interventions are employed when offering observations, interpretations, and summary statements as a means of underscoring the shared experiences of group members. The predominant emphasis during phase one is on the encouragement of and support for patients telling their story. Although these historical and contextual accounts are essential to understanding others and building universality, the therapist aims to encourage members to be curious about each other, note when members identify with what another member has shared, and normalize signs of ambivalence and caution that members may be feeling.

John: *I really think my perfectionism stems from all those years of playing competitive hockey. I had it coming from every direction. My parents weren't that well off and it cost a lot to register and equip me. Sure, they wanted me to be involved in something productive rather than hanging out at the corner store. But, I always felt they expected me to be drafted into a professional league because that would be the family's ticket out of struggling financially. And of course, there was added pressure from my coach. He pushed and pushed, always expecting better - good was never good enough. I had to execute perfectly at every turn.*

Jane: *For me it was growing up in a house of over achievers. My father had a PhD in biochemistry and my mother was a paediatrician. Getting anything less than an A+ average in school was not an option, and certainly would have been met with disapproval and a lot of shaming. I liked how it felt when I achieved those grades and the attention I got from my parents. It seems those were the only times they paid attention to me. If I was upset because of a falling out with a friend or felt left out because boys weren't interested in me, they'd say, 'there will be plenty of time for friends and dating. Just focus on your studies for now. That's what will get you ahead in this world.'*

Therapist: *Both of you have been carrying a lot of pain. It seems you grew up feeling that the significant people in your lives placed a lot of pressure on you to perform and didn't always recognize your needs. I wonder if what John and Jane have shared resonates with others in the room?*

During this stage there can be a tendency for some members to idealize group leaders and the group experience, particularly those who score high on self-oriented and socially prescribed perfectionism. Such idealization captures a complex set of dynamics including an inflated sense of hope, a need to feel one has made a choice that is flawless, and a longing - perhaps even an insistence - that authority figures be perfect. Given this complexity, idealization of the group and its leaders should not be interpreted at this point, but rather incorporated within the overall case conceptualization and addressed during the next phase of treatment.

In phase two, which we term 'pattern interruption', the over-riding objective is that of disrupting or unbalancing perfectionistic defenses and the self-limiting aspects of the individual's relational pattern. This phase typically targets the intrapersonal and behavioural aspects of perfectionism. At their core, perfectionistic behaviours are defenses reflecting an internalized means of garnering acceptance, belonging, and self-worth that are intended to make one tolerable or acceptable to others and to oneself. Note that defenses remain dormant until an individual's self-concept and felt security are threatened. During this phase the therapist focuses on aiding members relinquish established ways of relating to both self and others that have been considered essential to guarding against loneliness and a view of self as insignificant yet that have had the effect of pushing others away. Interventions aim to encourage member-to-member interactions and deepen affective experience. The former serves as a vehicle for making available the feedback necessary to expand group members' awareness of their interpersonal impact on others, whereas the latter is a means of uncovering unmet attachment needs. Moreover, identification of ruptures in interconnectedness and the encouragement of repairing those ruptures is crucial. Resistance is at its highest level during this period, as is the level of activity of the therapist who must function in much the same way as does the conductor of an orchestra. At times, this may require interrupting an exchange between members and inviting participants to attend to what they are feeling and the self-referent meaning they are attaching to the exchange that has occurred.

Jane: *(crying and exasperated). I'm tired of having nothing else in my life except publications, speaking engagements, and academic awards. Sure, my department head loves the recognition it brings to the department, but that does nothing for the loneliness I feel when I get home. You know why I've got a list of journal articles and books as long as both my arms put together - because in the evenings and weekends I have nothing else to fill my time with except researching and writing. My parents said there would be time for friends and dates once I finished my studies - well, where are they?*

Mark: *Jane, you're a handsome woman and very bright. Don't get down on yourself. I think we should all put our heads together and help you create a killer dating profile. Then you'll see, men will be trying to knock down your door.*

John: *That's a great idea. Count me in. We can even give you the inside scoop on the male perspective; what men are really looking for when they get on those dating apps. You know, perhaps you can get some trendier frames for your glasses and a new hair style. I bet some of the women in the group could offer suggestions on make-up and stuff like that.*

Therapist: *Jane's sadness seems to have compelled Mark and John into action. I wonder what each of you felt as you listened to her.*

Each person expressed feeling helpless yet wanting to take Jane's pain away. At this juncture the therapist would encourage Mark and John to verbalize what it is like to be fully present to Jane's pain and in turn, explore how Jane feels as she listens to what John and Mark are feeling.

As the group approaches the mid-point of the agreed upon number of sessions, members begin to exhibit a growing sense of urgency. This marks entry into phase three, which we refer to as 'self-redefinition/painful authenticity'. Initial preoccupation with trust, belonging, and acceptance shifts to a focus on efforts to establish new ways of relating. From the therapist's vantage point this is a particularly rewarding period in treatment rife with promise. Yet, for patients it feels awkward, confusing, and deeply threatening. Attachment theory reminds us that for insecurely attached individuals, venturing into unfamiliar territory evokes one of several responses depending on the particular attachment style: anxiety that inhibits exploration through indecision and internal confusion, forging ahead with apparent indifference to risk yet being too aroused internally to profit from one's experience, or paralysis (Fonagy, 2001). It is at this juncture that members who are on the threshold of significant change become increasingly focused on confronting unwanted parts of self, be it with respect to self-concept or their manner of relating to others. This reflects the intersection between interpersonal, intrapersonal, and behavioural aspects of perfectionism. The prior tendency to externalize blame and/or engage in self-condemnation begins to shift toward one's longing for intimacy, authenticity, and greater acceptance of self. Therapist interventions are more heavily weighted toward here-and-now interactions that target dynamics on the vertex of current relationships in the Triangle of Object Relations but also to connect to past ways of relating to important others. Much of the therapist's activity involves encouraging member-to-member feedback that emphasizes an individual's subjective experience of another's actions or inaction. It's critical to invite members to express how they are impacted by another member's behaviour and the subjective meaning they attach to it while moving them away from judging, evaluating, or correcting the behaviour of others. When done effectively, the therapist simply sets this process in motion and allows it to unfold, necessitating fewer interventions than what was required during earlier phases in the group's life. Most interventions by the leader will involve some form of metacommunication, be it a group-as-a-whole statement identifying the interpersonal dynamic being enacted, making overt the implied meaning that members have drawn from another's comments, underscoring the relational intention and longing reflected in a member's comments to another member, or highlighting a member's subtle ways of devaluing the self and guarding against intimacy. In the treatment of perfectionism, therapists' readiness to acknowledge their mistakes and limitations, while inviting group members to express their reactions to those errors can be a powerful source of modelling that offers a corrective albeit unsettling experience for many individuals who struggle with perfectionism. This is a particularly potent means of addressing the defensive use of idealization that underscores the humanness of the group leaders and in turn serves as a testament to the reality that being fallible and limited is at the core of why each of us needs others in our lives.

Jane: *I'm realizing that all these years I've hidden behind my achievements. All the research and writing - that was my shield. It protected me from having to experience the pain of being rejected. Like all those times in school when none of the boys seemed to even notice that I existed - unless of course they needed help with an assignment. I realize now that with each publication and award I feel like someone is noticing and appreciating me. That's filled the void, but I know now that's it's not enough.*

Mark: *What you just shared makes me feel a lot closer to you. You know Jane, I admire and respect you a great deal but up until now I've found it difficult to get close to you. I've always experienced you as someone who has a good heart but when you've shared in here, it's mostly been you offering a solution by telling me what I should do. I think I've done that to you as well because it's what I thought you expected and how you connect - by solving problems and coming up with an action plan. I regret having done that now.*

In time-limited groups, preparing members for the final phase of *termination* is part of every session from the moment treatment begins. Periodically reminding participants of the number of weeks remaining underscores not only the importance of making each session count but also to acknowledge the impending loss of what has become a place of safety and acceptance. A task not unique to termination in the treatment of perfectionism, but perhaps one that's particularly relevant to this population, is acknowledging and facilitating members' tolerance of the reality that at the end of treatment the needs of each participant will not be fully met and some of their initial concerns and struggles will remain unresolved. Hence, underscoring the incompleteness and imperfection inherent in life's journey that each must continue to tolerate in the absence of disillusionment, blame of self and blame of others. The final few weeks of group sessions often surface memories of previous unresolved endings and experiences of loss. The challenge for the leader is to achieve a balance between allowing members to share their accounts of these experiences while placing emphasis on ending their time in the group without repeating missteps of the past. A means of helping members consolidate change that has been realized while remaining cognizant of the need for continued growth can be facilitated by hav-

ing them reflect on critical moments and interactions as well as identifying regrets and missed opportunities; a process that can also be modelled by the leader's own statement of saying goodbye to the group.

Subjective experience of the leader

It has been our experience that these groups can be exceedingly challenging for group leaders (see Hewitt *et al*., 2018). The need of the perfectionist to do things right manifests in patients' insistence on getting concrete answers, direction or being given specific exercises that will ease their angst. Other oriented perfectionists often lead the charge in these efforts, expressed in a tone that is challenging and hostile. The perfection's history of social disconnection and the pain associated with anticipated rejection or criticism leads some members to question their membership and whether to continue in the group. This can contribute to leaders feeling ineffective and may lead to a need to demonstrate their relevance and the value of the group and in so doing, losing sight of self-limiting interpersonal patterns that need to be identified and worked through.

Empirical support for dynamic-relational therapy

In addition to developing and refining the DRT, we also conducted research to assess its effectiveness and efficacy. The research has allowed us to determine elements of the treatment that are particularly effective and elements that have needed to be changed or enhanced as well as evaluate overall the effectiveness and efficacy of the DRT for perfectionism. Below we present some of the research we have conducted so clinicians who are entertaining using such an approach have some assurance of its effectiveness and efficacy. Overall, we have demonstrated the effectiveness and efficacy of DRT assessing the changes, not only in psychiatric symptoms, life satisfaction, interpersonal problems and functioning, but also in the deeply ingrained perfectionism traits, self-presentational facets, and self-relational components of the Comprehensive Model of Perfectionistic Behaviour (CMPB, Hewitt *et al*., 2017).

In a large group psychotherapy project, known as the UBC Treatment of Perfectionism Study (UBC-TPS), we (Hewitt, *et al*., 2015) reported on 60 patients who were initially screened for extreme scores on our extensively validated multidimensional measures of trait perfectionism (Hewitt & Flett, 1991), perfectionistic self-presentation (Hewitt *et al*., 2003), and perfectionistic automatic thoughts (Flett *et al*., 1998). Patients also completed a clinical interview, other measures of psychological and interpersonal functioning, and met specific inclusion and exclusion criteria for acceptance into the treatment study. The findings revealed that, following 10 sessions of DRT (Hewitt *et al*., 2017), all components of trait, self-presentation, and self-relational cognitive elements of perfectionism significantly improved post-treatment (with 92% showing clinically significant improvements, based on the Reliable Change Index [Jacobson & Truax, 1991] on at least one perfectionism measure and 82% reporting clinically significant improvements on two or more perfectionism measures). Clinically significant improvements were also seen in depression, anxiety, social anxiety, and interpersonal problems. Moreover, at the 4-month follow-up, perfectionism and symptoms continued to improve, a result often found with psychodynamic treatments (see Shedler, 2010). Lastly, the changes in all measures differed significantly from a waitlist control group.

In the UBC-TPS we also included informant ratings of perfectionism traits and self-presentational styles. Significant or close others provided ratings of the three perfectionism traits and the three perfectionistic self-presentational styles at pre- and post-treatment as well as at the 4-month follow-up. It was found that close other measures of patients' self-oriented and other-oriented perfectionism, and all three facets of perfectionistic self-presentation were significantly reduced at posttreatment and follow-up (Hewitt *et al*., 2019). Close other measures of patients' socially prescribed perfectionism did not show change over the course of treatment and follow-up, likely due to socially prescribed perfectionism being more internal than other measures and not directly observable. In this study, we also calculated RCIs and found that 67% of participants showed clinically significant improvement on at least one perfectionism subscale measure. Overall, the findings of close other ratings support the effectiveness of the DRT and corroborate earlier results using self-reports of patients (Hewitt *et al*., 2015).

The findings of these two studies from the UBC-TPS suggest that a treatment that focuses on the underlying relational elements of perfectionism reduces trait perfectionism and associated symptoms. We recently completed a randomized control trial evaluating our DRT in comparison to a psychodynamic supportive psychotherapy (PST) control (the UBC-TPS II; Hewitt *et al*., in press).

In this study, a sample of extremely perfectionistic patients were randomly assigned to 12 group therapy sessions of either DRT (initially n=41, with 37 completers) or a psychodynamic supportive treatment (PST, Winston *et al*., 2019; initially n=39, with 33 completers). Analyses revealed significant changes in all elements of perfectionism as well as psychiatric symptoms, increased life satisfaction, and work and social adjustment for patients receiving DRT and for those receiving PST indicating that psychodynamically-informed treatments seem to be very effective in reducing perfectionism and related outcomes. Furthermore, of the 37 individuals who completed the DRT, 36 individuals (97%) showed clinically significant improvement (*i.e*., RCI>1.96) on at least one perfectionism measure, and of

the 33 individuals completing the PST, 28 (90%) individuals showed clinically significant improvement on two or more perfectionism measures. In comparing DRT to PST, analyses showed significant differences between the treatments indicating that patients in the DRT condition showed greater changes in self-oriented perfectionism, all facets of perfectionistic self-presentation, as well as life satisfaction and work and social functioning. This provides strong evidence of the efficacy of DRT and a uniquely powerful treatment for particularly ingrained elements of perfectionism. This is important as meta analytic evidence indicates that other treatments of perfectionism that have been studied (*e.g.*, CBT) show that changes seem to be evident only in some cognitive features of perfectionism and not the more deeply ingrained trait and relational features (see Smith *et al*., under review).

Finally, adding to the accumulating evidence for DRT, Hewitt *et al*. (2020) presented an evidence-based case study illustrating a 27-year-old patient, Azure, undergoing DRT for perfectionism. The patient presented with extreme levels of trait, self-presentational and self-relational perfectionism as well as elevated anxiety. Azure associated the attainment of perfection with her worthiness of love from others, frequently engaged in excessive self-censure and harsh self-recriminations, and experienced intense sadness, anxiety, and self-loathing, especially in her relationships with others. Over the course of treatment, Azure learned how her perfectionistic behaviours and self-criticalness did not garner the connection she sought, but rather led to further alienation from others. As she began to understand the connection between her relational needs, emotional experiences, and her relationships, Azure was able to shift away from her harsh, self-critical internal dialogue and towards greater self-compassion. By the end of treatment, Azure reported clinically significant lower scores, based on Jacobson and Truax's (1991) Reliable Change Index, on all components of perfectionism as well as anxiety, suggesting that treatment focusing on her relational needs and patterns effectively improved her perfectionism and associated dysfunctions.

Overall, there appears to be accumulating evidence for effectiveness and efficacy of our DRT in a group psychotherapy context. The DRT in particular appears to offer significant benefit to individuals with perfectionism by effecting changes not only in perfectionism traits, self-presentation, self-relational, and attitudinal elements but also in symptoms, life satisfaction, and social and work functioning.

Concluding comments

In this paper, we described an evidence-based group psychodynamic dynamic-relational therapy for perfectionism and provided case examples to illustrate its use in a clinical context. DRT is grounded in attachment, interpersonal and contemporary psychodynamic theories and begins with a detailed idiosyncratic case formulation for each patient. Over the course of group DRT, patients undergo several phases of change, beginning with the development of group cohesion and safety through emphasizing shared experiences, followed by the gradual shifting of self-limiting relational patterns toward better ways of connecting and relating to others. This paper illustrates how focusing treatment on deeper, underlying relational dynamics of individuals with perfectionism leads to clinically significant improvements in trait, interpersonal, intrapersonal, and cognitive components of perfectionism as well as in symptoms of anxiety, life satisfaction and interpersonal and occupational functioning.

References

Armusewicz, K., Steele, M., Steele, H., & Murphy, A. (2022). Assessing therapist and clinician competency in parent-infant psychotherapy: The REARING coding system (RCS) for the group attachment based intervention (GABI). *Research in Psychotherapy: Psychopathology, Process and Outcome, 25*(1), 23-37. doi:10.4081/ripppo.2022.562.

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

Bruch, H. (1988). *Conversations with anorexics* (D. Czyzewski & M. A. Suhr, Eds.). New York: Basic Books.

Cheek, J., Kealy, D., Hewitt, P. L., Mikail, S. F., Flett, G. L., Ko, A., & Jia, M. (2018). Addressing the complexity of perfectionism in clinical practice. *Psychodynamic Psychiatry, 46*(4), 457-489. doi:10.1521/pdps.2018.46.4.457.

Flett, G. L., & Hewitt, P. L. (2022). *Perfectionism in childhood and adolescence: A developmental approach*. American Psychological Association. doi:10.1037/0000289-000.

Flett, G. L., Hewitt, P. L., Blankstein, K. R., & Gray, L. (1998). Psychological distress and the frequency of perfectionistic thinking. *Journal of Personality and Social Psychology, 75*(5), 1363-1381. doi:10.1037/0022-3514.75.5.1363.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.

Fredtoft, T., Poulsen, S., Bauer, M., & Malm, M. (1996). Dependency and perfectionism: Short-term dynamic group psychotherapy for university students. *Psychodynamic Counselling*, 2.4 (November), 476-497. doi:10.1080/1353333 9608402472.

Handley, A. K., Egan, S. J., Kane, R. T., & Rees, C. S. (2015). A randomized controlled trial of group cognitive behavioural therapy for perfectionism. *Behaviour Research and Therapy,* 68, 37-47. doi:10.1016/j.brat.2015.02.006.

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

Hewitt, P. L., Flett, G. L., & Mikail, S. F. (2017). *Perfectionism: A relational approach to conceptualization, assessment, and treatment.* New York: Guilford Press.

Hewitt, P. L., Flett, G. L., Mikail, S. F., Kealy, D., & Zhang, L. (2018). Perfectionism in the therapeutic context: the perfectionism social disconnection model and clinical process and

outcome. In J. Stoeber (Ed.), *The Psychology of Perfectionism: Theory, Research, Applications*. New York: Routledge.

Hewitt, P. L., Flett, G. L., Sherry, S.B., & Caelian, C. (2006). Trait perfectionism dimensions and suicidal behaviour. In T.E. Ellis (Ed.). *Cognition and suicide: Therapy, research, and therapy* (pp. 215-235). Washington, DC: American Psychological Association. doi:10.1037/11377-010.

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

Hewitt, P. L., Flett, G. L., Turnbull-Donovan, W., & Mikail, S. F. (1991b). The multidimensional perfectionism scale: Reliability, validity, and psychometric properties in psychiatric samples. *Psychological Assessment, 3*(3), 464-468. doi:10.1037/1040-3590.3.3.464.

Hewitt, P. L., Kealy, D., Mikail, S. F., Smith, M. M., Ge, S., Chen, C., Sochting, I., Tasca, G. A., Flett, G. L., & Ko, A. (in press). The efficacy of group psychotherapy for adults with perfectionism: a randomized controlled trial of dynamic relational versus psychodynamic supportive treatment. *Journal of Consulting and Clinical Psychology*.

Hewitt, P. L., Mikail, S. F., Dang, S. S., Kealy, D., & Flett, G. L. (2020). Dynamic-relational treatment of perfectionism: An illustrative case study. *Journal of Clinical Psychology, 76*(11), 2028-2040. doi:10.1002/jclp.23040.

Hewitt, P. L., Mikail, S. F., Flett, G. L., & Dang, S. S. (2018). Specific formulation feedback in Dynamic-relational group psychotherapy of perfectionism. *Psychotherapy*, *55*(2), 179-185. doi:10.1037/pst0000137.

Hewitt, P. L., Mikail, S. F., Flett, G. L., Tasca, G. A., & Flynn, C. A. (2015). Psychodynamic and Interpersonal Group Psychotherapy for Perfectionism: Evaluating the Effectiveness of a Short-Term Treatment. *Psychotherapy*, *52*(2), 205-217. doi:10.1037/pst0000016.

Hewitt, P. L., Qiu, T., Flynn, C. A., Flett, G. L., Wiebe, S. A., Tasca, G. A., & Mikail, S. F. (2019). Dynamic-relational group treatment for perfectionism: Informant ratings of patient change. *Psychotherapy (Chicago, Ill.), 57*(2), 197-205. doi:10.1037/pst0000229.

Hollender, M. H. (1965). Perfectionism. *Comprehensive Psychiatry*, 6, 94-103.

Horney, K. (1950). *Neurosis and human growth*. New York, NY: Norton.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19. doi:10.1037/0022-006X.59.1.12.

Miller, R., Hilsenroth, M. J., & Hewitt, P. L. (2017). Perfectionism and therapeutic alliance: A review of the clinical research. *Research in Psychotherapy: Psychopathology, Process and Outcome, 20*(1), 19-29. doi:10.4081/ripppo.2017.264.

Norcross, J. C., VandenBos, G. R., Freedheim, D. K. (Eds.). (2011). *History of psychotherapy: Continuity and change* (2nd ed). American Psychological Association. doi:10.1037/12353-000.

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

Paquin, J. D., Abegunde, C., Hahn, A., & Fassinger, R. E. (2021). A brief history of group therapy as a field and the representation of women in its development. *International Journal of Group Psychotherapy*, *71*(1), 13-80. doi:10.1080/00207284.2020.1798176.

Popolo, R., MacBeth, A., Brunello, S., Canfora, F., Ozdemir, E., Rebecchi, D., Toselli, C., Venturelli, G., Salvatore, G., & Dimaggio, G. (2018). Metacognitive interpersonal therapy in group: A feasibility study. *Research in Psychotherapy: Psychopathology, Process and Outcome, 21*(3), 155-163. doi:10.4081/ripppo.2018.338.

Qanbari Alaee, E., Saed, O., Khakpoor, S., Ahmadi, R., Ali Mohammadi, M., Yoosefi Afrashteh, M., & Morovati, Z. (2022). The efficacy of transdiagnostic cognitive behavioural therapy on reducing negative affect, anxiety sensitivity and improving perceived control in children with emotional disorders - a randomized controlled trial. *Research in Psychotherapy: Psychopathology, Process and Outcome, 25*(1), 127-144. doi:10.4081/ripppo.2022.588.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *The American Psychologist, 65*(2), 98-109. doi:10.1037/a0018378.

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

Strupp, H. H., Binder, J. L. (1984). *Psychotherapy In A New Key.* New York: Basic Books.

Tasca. G. A, Mikail, S. F., & Hewitt, P. L. (2021). *Group Psychodynamic Interpersonal Psychotherapy*. Washington, D.C.: American Psychological Association.

Winston, A., Rosenthal, R. N., & Roberts, L. W. (2019). *Learning supportive psychotherapy: An illustrated guide.* American Psychiatric Association Publishing.

Yalom, I. D., & Leszcz, M. (2020). *The Theory and Practice of Group Psychotherapy.* New York: Basic Books.