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Clinical Perfectionism as a Transdiagnostic Process: A Cognitive-Behavioural Conceptualisation

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Abstract

Aim: The aim of this article is to present clinical perfectionism as a transdiagnostic process within the cognitive-behavioural framework and to discuss its implications for the conceptualisation and treatment of mental disorders.

Theses: It is proposed that clinical perfectionism may function as a transdiagnostic process. Its presence is observed across a range of mental disorders, and elevated perfectionistic concerns are associated with greater symptom severity, comorbidity of psychological difficulties, and poorer treatment outcomes.

Conclusion: A review of empirical studies and systematic reviews indicates that clinical perfectionism constitutes a clinically significant element of cognitive-behavioural case conceptualisation. The article presents theoretical models of perfectionism, its developmental factors and maintenance mechanisms, as well as its associations with selected groups of mental disorders. Commonly used measures of perfectionism are described, and findings from research on the efficacy of therapeutic interventions targeting its reduction are reviewed. Incorporating perfectionism into diagnosis and case conceptualisation may support the planning of therapeutic interventions, particularly in cases involving comorbid psychological difficulties.

Keywords: clinical perfectionism, transdiagnostic processes, cognitive-behavioural therapy, psychopathology

In recent years, psychological research has devoted increasing attention to transdiagnostic processes, understood as psychological mechanisms common

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to multiple mental disorders that contribute to their onset and the maintenance of symptoms (Harvey et al., 2004). This approach focuses on identifying and modifying the processes underlying different disorders rather than analysing individual nosological categories. It enables a more integrated understanding of psychopathology and the design of more effective interventions that account for the co-occurrence of disorders (Mansell et al., 2009).

One process that has attracted particular interest among researchers and clinicians over the past two decades is perfectionism. It is most commonly defined as the tendency to set high, often rigid standards and to engage in harsh self-criticism when those standards are not met (Egan et al., 2011; Frost et al., 1990; Hewitt & Flett, 1991). Initially regarded as a relatively stable personality trait, more recent research suggests that it may also function as a process that maintains the symptoms of various disorders (Egan et al., 2011; Shafran et al., 2002).

Despite frequent reference to its transdiagnostic nature, questions remain about the scope and mechanism of this influence—particularly whether perfectionism functions as a risk factor, a maintenance mechanism, or whether it primarily amplifies other psychopathological processes. The aim of this article is to synthesise current knowledge on clinical perfectionism as a transdiagnostic process and to examine its significance within cognitive-behavioural case conceptualisation. The article takes the form of a narrative literature review and focuses on integrating theoretical models with empirical findings relevant to clinical practice.

Definitions and Models of Perfectionism

Perfectionism has been a subject of scholarly interest for several decades. Early conceptualisations framed it primarily as a relatively stable personality trait characterised by high standards and a critical orientation towards one's own achievements (Burns, 1980). Over time, the complexity and clinical significance of perfectionism came to be emphasised, with researchers highlighting its role in the development and maintenance of mental disorders (Frost et al., 1990; Hewitt & Flett, 1991).

The two most influential multidimensional models were proposed by Frost and colleagues (1990) and Hewitt and Flett (1991). Frost's model comprises six dimensions: concern over mistakes, doubts about actions, personal standards, parental expectations, parental criticism, and organisation. Hewitt and Flett distinguished self-oriented, other-oriented, and socially prescribed perfectionism, thereby emphasising the interpersonal dimension of the construct.

Factor analyses indicate that the dimensions from both models can be organised into two broader categories: perfectionistic strivings and perfectionistic concerns (Bieling et al., 2004; Stoeber & Otto, 2006). This distinction suggests that high standards do not necessarily produce adverse outcomes, provided they are not accompanied by excessive self-criticism and contingency of self-worth on achievement.

The distinction between adaptive and maladaptive perfectionism was, for a time, widely discussed in the literature. More recently, scholars have emphasised that the functional significance of perfectionism is determined not so much by

the level of standards per se as by the manner in which self-esteem is regulated and the context in which standards are pursued (Egan et al., 2012). High demands may facilitate engagement and achievement; however, when a sense of self-worth is contingent on meeting them, perfectionism is associated with greater psychopathological symptom severity (Bardone-Cone et al., 2007; Limburg et al., 2017).

An important step towards a clinical conceptualisation was taken by Shafran and colleagues (2002), who introduced the construct of clinical perfectionism, defined as the persistent pursuit of excessively high standards despite their adverse consequences, and the contingency of self-evaluation on the ability to meet them. This formulation shifts the emphasis from the description of a personality trait to an analysis of the function perfectionism serves in maintaining psychological difficulties.

The clinical perfectionism model accounts for maintenance mechanisms such as inflexible standards, selective attention to errors, cognitive distortions, avoidance of situations involving potential failure, and repetitive checking behaviours (Egan et al., 2011; Shafran et al., 2002). Even when standards are met, the relief experienced is typically brief, followed by the imposition of yet higher demands, thereby generating a self-perpetuating cycle of escalating standards and increasing contingency of self-worth on achievement.

Contemporary perspectives suggest that perfectionism can be understood both as a relatively stable trait and as a psychological mechanism whose significance depends on the clinical context and the psychological processes with which it co-occurs.

Aetiology and Developmental Factors of Perfectionism

The role of the family environment in the development of perfectionism has long been recognised in the literature. Early accounts suggested a link with attachment style and with the manner in which a child experiences evaluation and acceptance from significant others (Hamachek, 1978; Pacht, 1984). Later formulations emphasised that what matters is not simply the level of parental standards but also how those standards are communicated and the emotional consequences of failing to meet them (Frost et al., 1990; Hewitt, 1991). Perceptions of parents as excessively evaluative and critical may foster a fragile sense of self-worth and heightened fear of mistakes and rejection (Frost et al., 1990; Hewitt, 1991). Under such conditions, the pursuit of perfection may serve as a strategy for regulating self-worth and minimising the risk of criticism. Internalisation of high standards promotes the linking of self-esteem to achievement, consolidating the belief that errors threaten relational bonds (Domocus & Damian, 2018; Neumeister, 2004; Stoeber & Otto, 2006). Contemporary analyses also highlight subtler forms of parental pressure, including conditional acceptance, psychological control, and excessive focus on the child's success (Curran & Hill, 2019; Flett et al., 2002; Hewitt et al., 2017).

Beyond family experiences, individual temperamental and biological predispositions may also influence the development of perfectionism (Egan et al., 2011;

cf. Kwarcińska et al., 2022). Temperament, understood as a relatively stable pattern of emotional reactivity and self-regulation, influences the way an individual responds to environmental demands (Rothbart, 2004; Strelau, 2008). Studies indicate a moderate genetic contribution to perfectionism, estimated at approximately 25–40% of variance across its various dimensions (Iranzo-Tatay et al., 2015; Kamakura et al., 2003; Wade & Bulik, 2007). At the same time, specific temperamental characteristics—such as high emotional reactivity, behavioural inhibition, and perseveration—may increase vulnerability to the development of maladaptive forms of perfectionism (Affrunti et al., 2016; Chęć et al., 2024; Hong et al., 2016). The development of perfectionism is therefore the product of an interaction between dispositional and environmental factors, with temperament potentially moderating the influence of family experiences (Oliveira et al., 2025).

Cognitive processes associated with the formation of beliefs about self-worth and the importance of achievement also play a significant role. The literature emphasises the central importance of linking self-worth to the attainment of high standards and to evaluation by others (Egan et al., 2011; Shafran et al., 2002). Under these conditions, achievement becomes the primary criterion of self-evaluation, and failure to meet demands may lead to intensified self-criticism and a sense of personal failure (Flett & Hewitt, 2002; Limburg et al., 2017). The manner in which mistakes and imperfections are interpreted is also important: individuals developing perfectionistic tendencies may perceive errors as evidence of personal incompetence or as threats to their sense of self-worth (Egan et al., 2011; Frost et al., 1990).

Perfectionism can also be understood in terms of learning processes. From this perspective, high standards and perfectionistic behaviours may become consolidated through experiences in which achievement or the absence of error leads to positive consequences, such as recognition or the avoidance of criticism (Flett & Hewitt, 2002; Shafran et al., 2002). Two complementary mechanisms have been described in the literature. The social expectations model proposes that perfectionism may develop in contexts of conditional approval and high demands from significant others (Flett et al., 2002). The social learning model, in turn, emphasises the role of modelling—that is, the observation and imitation of perfectionistic beliefs and behaviours displayed by people in one's environment (Damian et al., 2013; Flett et al., 2002). Additionally, negative reinforcement mechanisms may consolidate perfectionistic strategies when flawless performance enables the individual to avoid criticism or a sense of shame (Shafran et al., 2002).

The development of perfectionism is also analysed within a broader sociocultural context that shapes norms regarding achievement and success. Contemporary societies place strong emphasis on competition and the necessity of continuous self-improvement, which may facilitate the internalisation of high and often unattainable standards (Curran & Hill, 2019; Flett & Hewitt, 2014). Cross-cohort analyses further indicate that the intensity of perfectionism among young adults has increased over recent decades, which has been interpreted as a consequence of growing achievement pressure and heightened social comparison (Curran & Hill, 2019). Contemporary media environments may further amplify such comparisons through exposure to idealised standards of appearance

and success (Fardouly & Vartanian, 2016; Vogel et al., 2014). Research also indicates that perfectionism—particularly its self-critical dimension—may heighten sensitivity to social comparison and be associated with greater depressive symptom severity and lower body image satisfaction (Etherson et al., 2022).

Perfectionism as a Transdiagnostic Process

The concept of transdiagnostic processes holds that certain psychological mechanisms are not specific to individual diagnostic categories but may play a role in the development and maintenance of various mental disorders, as well as in the co-occurrence of symptoms (Harvey et al., 2004; Mansell et al., 2009). Accumulated research suggests that perfectionism may satisfy many of the criteria for a process so conceived, given that it is observed across a range of mental disorders and may be associated with both their onset and the maintenance of symptoms (Egan et al., 2012; Limburg et al., 2017).

Elevated levels of perfectionism have been observed across various clinical populations, including individuals with eating disorders, mood disorders, and anxiety disorders (Egan et al., 2012; Limburg et al., 2017). Research also indicates that perfectionism may be associated with greater symptom severity and poorer treatment outcomes, in part through heightened self-criticism and cognitive rigidity (Egan et al., 2011). Furthermore, a greater number of co-occurring diagnoses may be associated with elevated perfectionistic concerns, suggesting a possible role for perfectionism in the phenomenon of comorbidity in psychopathology (Bieling et al., 2004; Harvey et al., 2004).

At the same time, the role of perfectionism is not uniform across all mental disorders. Depending on the clinical context, it may function as a risk factor, a symptom maintenance mechanism, or a consequence of experiences of failure and heightened self-criticism. A further limitation is the heterogeneity of the perfectionism construct itself. Research indicates that its different dimensions—particularly perfectionistic concerns and perfectionistic strivings—may relate to psychological functioning in distinct ways (Limburg et al., 2017; Stoeber & Otto, 2006).

Maintenance Mechanisms of Perfectionism

In the clinical perfectionism model, a central role is played by the contingency of self-worth on the attainment of high standards (Shafran et al., 2002). This means that an individual's sense of worth becomes conditional and dependent on achievement, productivity, or the avoidance of errors. As a result, meeting high standards becomes the primary means of regulating self-esteem.

The clinical perfectionism model also describes the cognitive and behavioural mechanisms that promote the consolidation of this pattern. These include selective attention to errors and imperfections, rigid performance standards, and the tendency to interpret mistakes as evidence of personal incompetence (Egan et al., 2011; Shafran et al., 2002). In response to these beliefs, individuals may

engage in strategies such as excessive preparation, repetitive checking of their own actions, and avoidance of situations associated with the risk of evaluation.

These strategies often produce short-term reductions in tension or help the individual avoid criticism, thereby reinforcing the belief that maintaining high standards is necessary. Over time, this fosters a self-perpetuating cycle in which high demands, intensified self-criticism, and error-controlling strategies mutually reinforce one another (Egan et al., 2011; Shafran et al., 2002).

Interpersonal processes also play a significant role in maintaining perfectionism. Individuals with high levels of perfectionism may seek external validation of their achievements or avoid social situations in which they risk negative evaluation. Although such strategies provide short-term relief, they reinforce the belief that high standards must be met and impede the disconfirmation of distorted beliefs about self-worth (Flett & Hewitt, 2002; Hewitt et al., 2006).

Perfectionism in Selected Groups of Mental Disorders

Perfectionism is increasingly examined in the context of a range of mental disorders. Meta-analyses indicate that both perfectionistic strivings and perfectionistic concerns are associated with symptoms of depression, anxiety disorders, and obsessive-compulsive disorder (OCD) (Callaghan et al., 2024; Claus et al., 2025; Limburg et al., 2017). These findings suggest that perfectionism may function as a process present across broad domains of psychopathology (Egan et al., 2011).

The strongest associations between perfectionism and eating disorders have been documented particularly in the context of anorexia nervosa and bulimia nervosa (Fairburn et al., 2003). Individuals with these disorders obtain higher perfectionism scores than non-clinical controls, and elevated perfectionism frequently persists following symptom remission, thereby increasing the risk of relapse (Bardone-Cone et al., 2007). Within the transdiagnostic model of eating disorders, clinical perfectionism is regarded as one of the mechanisms maintaining symptoms, associated with cognitive rigidity, excessive weight and shape control, and chronic dissatisfaction with the self (Fairburn et al., 2003; Reivan Ortiz et al., 2022).

Perfectionism also plays a significant role in mood disorders. Research indicates particularly strong associations with the dimensions of socially prescribed perfectionism and concern over mistakes (Dunkley et al., 2006). Negative aspects of perfectionism may predict the persistence of depressive symptoms over time (Dunkley et al., 2009). It has also been proposed that the relationship between perfectionism and depression is partially accounted for by heightened self-criticism and rumination, which contribute to the consolidation of a negative self-concept (De Rosa & Keegan, 2024; De Rosa et al., 2021).

Elevated perfectionism has also been observed in anxiety disorders, particularly OCD and social phobia (Frost & DiBartolo, 2002). In OCD, it is associated with difficulties tolerating errors, excessive checking behaviours, and high standards of control. In social phobia, it is linked to heightened fear of negative evaluation and avoidance of social situations (Heimberg et al., 1995).

Conceptualisation of Perfectionism Within the CBT Framework

In cognitive-behavioural therapy, case conceptualisation forms the foundation for planning therapeutic interventions. It represents an attempt to answer three fundamental questions: what problem the patient presents, which mechanisms maintain their difficulties, and which factors contributed to their development (Popiel & Pragłowska, 2022). Within this framework, perfectionism may be understood as one of the significant processes incorporated into case conceptualisation. Because maladaptive perfectionism may function both as a risk factor and as a maintenance mechanism for various forms of psychopathology, it is frequently identified as an important target for therapeutic intervention. In the cognitive-behavioural approach, such interventions are grounded in case conceptualisation based on the clinical perfectionism model (Keegan, 2024; Egan et al., 2024).

The model proposed by Shafran and colleagues (2002) describes perfectionism as a pattern of functioning in which self-worth is excessively contingent on the ability to meet demanding standards in at least one important domain of life. The problem does not lie in high standards per se, but in the linking of self-evaluation to their attainment. As a result, achievement becomes the primary criterion by which the self is judged.

Within cognitive-behavioural case conceptualisation, perfectionism can be analysed at the level of cognitive mechanisms—such as core beliefs, schemas, and rigid rules for living—as well as in terms of the behavioural strategies that maintain the problem. These mechanisms are typically shaped through learning processes and constitute an important element of individual case formulation.

In clinical practice, this means that perfectionism may be incorporated into case conceptualisation at several levels of the patient's functioning. It may be linked to core beliefs concerning self-worth (e.g., "I am incompetent", "I am unworthy of love"), from which conditional beliefs and cognitive distortions derive (e.g., "If I don't do something perfectly, it's better not to do it at all", "If I make a mistake, it means I am incompetent"). These beliefs give rise to specific behavioural strategies, including excessive preparation, checking, social comparison, and avoidance of situations involving the risk of error. Although these strategies may provide short-term relief, over time they maintain self-criticism and reinforce the contingency of self-worth on achievement. In this formulation, perfectionism becomes a clinically significant element of individual case conceptualisation and may constitute an important target for therapeutic interventions within cognitive-behavioural therapy.

Assessment of Perfectionism

The assessment of perfectionism in research and clinical practice draws primarily on psychometric instruments reflecting different theoretical conceptualisations of the construct. The most widely used measures are two multidimensional scales: the *Frost Multidimensional Perfectionism Scale* (FMPS) and the

Hewitt and Flett Multidimensional Perfectionism Scale (HMPS). The FMPS comprises six dimensions, including personal standards, concern over mistakes, and doubts about actions (Frost et al., 1990), whereas the HMPS distinguishes three forms of perfectionism: self-oriented, other-oriented, and socially prescribed (Hewitt & Flett, 1991). Research indicates that the dimensions associated with concern over mistakes and socially prescribed perfectionism show particularly strong associations with psychopathology (Enns & Cox, 2002; Hewitt et al., 2006).

Factor analyses of both scales have led to the identification of two broader perfectionism categories: perfectionistic strivings and perfectionistic concerns (Bieling et al., 2004; Stoeber & Otto, 2006). This distinction has proved especially useful in psychopathology research, as it suggests that concerns related to errors and evaluation are more strongly associated with mental disorders than high standards alone (Stoeber & Otto, 2006).

In clinical practice, instruments targeting more specific aspects of perfectionism are also employed. One example is the *Clinical Perfectionism Questionnaire* (CPQ), developed by Fairburn and colleagues (2003), which measures clinical perfectionism understood as the persistent pursuit of high standards despite their negative consequences and the contingency of self-evaluation on their attainment (Shafran et al., 2002). Other questionnaires have also been developed, including the *Almost Perfect Scale – Revised* (APS-R) and the *Perfectionism Cognitions Inventory* (PCI), which assess respectively the discrepancy between standards and achievement and the frequency of perfectionistic thoughts (Flett et al., 1998; Slaney et al., 2001).

Perfectionism and Treatment Efficacy

The significance of perfectionism as a transdiagnostic process is further supported by treatment outcome research. Cognitive-behavioural protocols designed specifically to reduce perfectionism (*Cognitive Behavioural Therapy for Perfectionism*; CBT-P) lead to reductions in the intensity of perfectionism and decreases in the severity of depressive, anxiety, and eating disorder symptoms (Egan et al., 2024; Shafran et al., 2010; Suh et al., 2019). Meta-analyses indicate that perfectionism-focused interventions are effective in both individual and group therapy formats, and that their effects extend to symptoms that were not the direct targets of treatment (Galloway et al., 2021; Robinson & Wade, 2021).

Studies examining various forms of psychotherapy, including cognitive-behavioural therapy and mindfulness-based approaches, confirm that reductions in perfectionism are achievable, although effects in clinical populations tend to be less consistent and may require longer interventions (Smith et al., 2023). Existing findings underscore the value of a process-focused approach targeting mechanisms common to multiple disorders, such as clinical perfectionism, whose incorporation into CBT protocols may support more accurate case conceptualisation in patients presenting with multiple comorbid difficulties (Egan et al., 2012).

Conclusions

Accumulated research indicates that perfectionism plays a significant role in eating disorders, mood disorders, and anxiety disorders, influencing both symptom severity and the course of treatment (Egan et al., 2012; Limburg et al., 2017). At the same time, available evidence suggests that perfectionism does not constitute a universal core of psychopathology. Its significance depends on the clinical context and the psychological processes with which it co-occurs, with perfectionistic concerns associated with self-criticism and fear of negative evaluation playing a particularly prominent role.

From a cognitive-behavioural perspective, perfectionism may constitute an important element of case conceptualisation and a meaningful target for therapeutic intervention. Research demonstrates that interventions targeting its reduction lead to decreases in perfectionism intensity and in the symptoms of comorbid disorders (Galloway et al., 2021; Robinson & Wade, 2021).

Future research may focus on the role of specific perfectionism dimensions and on the durability of treatment effects. Despite these limitations, clinical perfectionism remains a construct of considerable theoretical and practical significance, particularly within the cognitive-behavioural therapy context.

Declarations

Declaration of conflict of interest
The author declares no potential conflict of interest with respect to the research, authorship, or publication of this article. The author has no significant financial or non-financial interests requiring disclosure, and no competing interests related to the content of this article. The author also confirms that she is not affiliated with or involved in any organization or entity that might have a financial or non-financial interest in the subject matter or materials discussed in this manuscript.

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Anna Ussorowska-Krokosz: Conceptualisation, Formal analysis, Project management, Writing – first draft, Writing – review and editing.

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