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Coming of age: A reflection of the first 21 years of cognitive behaviour therapy for perfectionism

Roz Shafran [a,*,1], Sarah J. Egan [b,c,1], Tracey D. Wade [d,1]

[a] UCL Great Ormond Street Institute of Child Health, University College London, United Kingdom
[b] EnAble Institute, Faculty of Health Sciences, Curtin University, Perth, Australia
[c] Discipline of Psychology, School of Population Health, Curtin University, Perth, Australia
[d] Blackbird Initiative, Flinders Institute for Mental Health and Wellbeing, Flinders University, South Australia, Australia

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ABSTRACT

It has been 21 years since the publication of the cognitive behavioural model of clinical perfectionism that underpins cognitive behaviour therapy (CBT) for perfectionism. The notion of clinical perfectionism and CBT for perfectionism has been controversial. Despite 15 randomised controlled trials which have demonstrated the efficacy of CBT for perfectionism in reducing perfectionism and symptoms of anxiety, depression and eating disorders, strong responses to this work continue to appear in the literature. In this article, we examine the evolution and controversy surrounding clinical perfectionism, the efficacy of CBT for perfectionism, and future directions for the concept of perfectionism and its treatment. Future research should aim to provide independent evaluations of treatment efficacy, compare CBT for perfectionism to active treatments, conduct dismantling trials to examine the effective components of treatment, and examine the causal processes involved in perfectionism. We provide recommendations for future pathways to support innovation in theory, understanding, and treatment of perfectionism with a view towards improving clinical outcomes.

1. Overview

This year marks the 21st anniversary of the cognitive behavioural model of clinical perfectionism published in Behaviour Research and Therapy (Shafran et al., 2002). Since its inception, clinical perfectionism has been dogged by controversy, discussion, and debate, despite the efficacy of cognitive behaviour therapy (CBT) based on the model (see Dunkley et al., 2006; Hewitt et al., 2003 and response by Shafran et al., 2003). This paper specifically aims to reflect on the first 21 years since publication with the goal of clarifying progress in the understanding and treatment of perfectionism, and considering future clinical research questions to improve outcome. It is not intended to provide a systematic review of the literature, or a detailed account of the historical development of the field of perfectionism research. We outline evidence for the efficacy of CBT for perfectionism and consider the history and current debate over clinical perfectionism and the evolution of the concept. We consider the strengths and limitations of the CBT approach and the alternative approaches. Suggested pathways are recommended to improve access to, and treatment of, perfectionism.

2. Defining clinical perfectionism

Perfectionism is a transdiagnostic risk and maintaining process across anxiety, depression, and eating disorders (Egan et al., 2011; Limburg et al., 2017). The construct of 'clinical perfectionism' was defined as self-worth based on striving, despite adverse consequences (e.g., symptoms of anxiety, depression, eating disorders, burnout) (Shafran et al., 2002). It was proposed to reflect the type of perfectionism that was typically being seen in clinical practice rather than 'healthy' perfectionism or other dimensions of perfectionism. The model was never intended to imply that other dimensions of perfectionism did not exist or could not present as clinical problems, nor did it infer that clinical perfectionism itself didn't have multiple dimensions (cognitive, affective, behavioural). However, it was considered that a focus on this specific form of perfectionism was needed to develop an efficacious treatment where none existed. In response to the controversy, it was boldly proposed that 'the most important test is its clinical utility, and specifically whether it yields advances in the treatment of Axis I psychopathology.' (Shafran et al., 2003, p.1220).

* Corresponding author. University College London Great Ormond Street Institute of Child Health, 30 Guilford Street, London, WC1N1EH, UK.
E-mail address: r.shafran@ucl.ac.uk (R. Shafran).

[1] All authors contributed equally to this manuscript.

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Over time, the terminology has evolved from discussion of 'CBT for clinical perfectionism' to 'CBT for perfectionism' which can map onto the broader literature regarding perfectionistic concerns and striving (e.g., Stoeber & Gaudreau, 2017) but the focus on the common type of perfectionism seen in clinical practice remains. The cognitive behavioural model of maintaining processes (Shafran et al., 2002), has guided the development of CBT for perfectionism (see Egan, Wade, Shafran, & Antony, 2014; Shafran et al., 2010; 2018), of which individualised cognitive behavioural formulation of the maintaining processes of clinical perfectionism is an integral component (Shafran et al., 2010; 2018; Egan, Wade, et al., 2014;).

3. Evolution of the theory and treatment

At the heart of CBT for perfectionism (CBT-P) is the view that the individual's self-evaluation is largely, or even exclusively, dependent on the pursuit and achievement of their standards for performance (Shafran et al., 2002). According to this cognitive behavioural account, a range of maintaining mechanisms accounts for the persistence of perfectionism, in particular counter-productive behaviours (such as checking and avoidance), and cognitive errors such as discounting the positive and dichotomous thinking operationalised as rigid rules. The highly focused, brief treatment was originally 10 individual sessions delivered over 8 weeks (Riley et al., 2007) and was one component of enhanced CBT for eating disorders (Fairburn, 2008). The original treatment had four components: (1) identifying perfectionism as a problem and establishing maintaining mechanisms (2) conducting behavioural experiments to learn more about the nature of perfectionism, and alternative ways of living (3) psychoeducation and cognitive restructuring (in combination with behavioural experiments) to modify personal standards, self-criticism, 'rules' and cognitive biases such as selective attention to perceived failure (4) broadening the individual's scheme for self-evaluation by examining existing methods of evaluating the self, and identifying and adopting alternative cognitions and behaviours. Importantly, the treatment has not remained static. The 2002 model was updated to emphasise the emotional and behavioural maintaining mechanisms, and tackling self-criticism was introduced as an additional important component (Egan et al., 2011; Shafran et al., 2010). In 2014, the therapist manual incorporated suggestions from Martin Antony's work as well as techniques such as evaluating the pros and cons of change in the context of self-evaluation (Egan, Wade, et al., 2014). It was further updated in 2018 (Shafran et al., 2018) to incorporate concepts and interventions derived from compassion-focused therapy (Gilbert, 2014) as well as clinical observations arising from working with patients (see Grieve et al., 2022 for a recent table of modules). Although the intervention is evolving, the key principles and interventions have remained the same with the primary focus being on re-evaluation of self-worth rather than lowering standards.

4. Clinical utility of CBT for perfectionism

After 21 years, it is timely to ask the question as to how well this approach has fared in terms of clinical utility. The short answer to this question is that it has fared well. CBT for perfectionism is undoubtedly the leading treatment for perfectionism and has been examined in 15 randomised controlled trials (RCTs), across a variety of groups (see Galloway et al., 2022). Early meta-analyses demonstrated the efficacy of CBT for perfectionism in reducing perfectionism, anxiety and depression (Lloyd et al., 2015; Suh et al., 2019). The most recent meta-analyses indicate when compared to waitlist control, CBT for perfectionism results in large effects for perfectionism ($g = 0.87$ to -1.27), medium effects for disordered eating ($g = 0.61$ to 0.64) and depressive symptoms ($g = -0.45$ to 0.60), and small to medium effects for anxiety ($g = -0.14$ to 0.42) (Galloway et al., 2022; Robinson & Wade, 2021).

CBT for perfectionism has been tested in both universal (whole of population) and selective (selected for a risk factor i.e., female gender), prevention studies in children and adolescents, aged 10–19 years. Prevention effects have been demonstrated for face-to-face and online programs at follow-up, including prevention of symptoms of anxiety, depression, and eating disorders (Nehmy & Wade, 2015; Shu et al., 2019; Vekas & Wade, 2017; Wilksch et al., 2008). School based, brief CBT for perfectionism early interventions have also been evaluated in children and young adolescents (mean age ranges 11–13 years), with positive impacts on perfectionism, wellbeing, anxiety, and emotional problems (Fairweather-Schmidt & Wade, 2015; Osenk et al., 2022).

A strength of the literature to date is that across the 15 randomised controlled trials of CBT for perfectionism, the treatment has been delivered in a variety of different modalities, age ranges and populations. The scalability of the treatment has been demonstrated; it has been evaluated as internet-delivered, including fully guided, guidance on demand, and unguided treatment (Arpin-Cribbie et al., 2012; Egan, Van Noort, et al., 2014; ; Grieve et al., 2022; Rozental et al., 2017; Shafran et al., 2017; Shu et al., 2019; Valentine et al., 2018; Wade et al., 2019), and in traditional book self-help formats (Hoiles et al., 2022; Lowndes et al., 2019; Steele & Wade, 2008). Indeed, the majority of RCTs have focused on scalable delivery, with a smaller number of studies evaluating the treatment in individual face-to-face (e.g., Egan, Van Noort, et al., 2014; Mahmoodi et al., 2021; Riley et al., 2007) and group treatment (Handley et al., 2015) formats. In addition to clinical populations with diagnoses of anxiety, depression and eating disorders demonstrating reductions in diagnoses and symptoms (Egan, Van Noort, et al., 2014; ; Handley et al., 2015; Hoiles et al., 2002; Riley et al., 2007; Steele & Wade, 2008), the treatment has been examined in community (Egan, Van Noort, et al., 2014; ; Handley et al., 2015; Hoiles et al., 2022; Rozental et al., 2017; Shafran et al., 2017; Valentine et al., 2018; Wade et al., 2019), highschool/university student populations (Arpin-Cribbie et al., 2012; Grieve et al., 2022; Shu et al., 2019), and other specific samples, for example, women in the perinatal period (Lowndes et al., 2019). For the treatment of perfectionism, the intervention has been shown to be superior to an active comparison, CBT for stress management (Shu et al., 2019) and the Unified Treatment Protocol (Mahmoodi et al., 2021). The efficacy of treatment has been demonstrated via statistical significance (all 15 RCTs included in the Galloway et al., 2022 meta-analysis), in addition to reliable and clinically significant change (e.g., Handley et al., 2015; Hoiles et al., 2022; Riley et al., 2007; Shu et al., 2019). Acceptability of CBT for perfectionism has been demonstrated in qualitative research, with studies reporting positive feedback and experiences (Larsson et al., 2018; Rozental et al., 2020).

In summary, CBT for perfectionism has been demonstrated to not only be efficacious as a transdiagnostic treatment for symptoms of anxiety, depression and eating disorders across the age range, but has a clear advantage of being tested as a highly accessible approach. CBT for perfectionism has demonstrated efficacy as a prevention, early intervention, and treatment program across the age range. The treatment is brief, scalable, easily disseminated, and acceptable. Durability of treatment effects have also been found: the effects of CBT for perfectionism on perfectionism and symptoms of anxiety, depression and eating disorders have been shown to be maintained at 6-month (e.g., Egan, Van Noort, et al., 2014; ; Handley et al., 2015; Shu et al., 2019), and 12-month follow-up (e.g., Rozental, Shafran et al., 2018).

4.1. Alternative interventions for perfectionism

Of course, there are approaches to perfectionism other than CBT. A literature search indicated at least 10 studies (Cheli et al., 2020; 2022; James & Rimes, 2018; Hewitt et al., 2015, 2020, Hewitt et al., in press; Ong et al., 2019; Redden et al., 2022; Visvalingam et al., 2022; Woodfin et al., 2021) across Dynamic Relational Therapy (a psychodynamically informed therapy), single technique approaches (habituation to making mistakes), Mindful Compassion for Perfectionism (an integrative intervention comprising Compassion Focused Therapy and Dynamic Relational Therapy), Mindfulness-Based Cognitive Therapy, and Acceptance

and Commitment therapy. Few approaches are informed by theories of perfectionism; where theory exists, it is typically broad in focus, for example Hewitt et al.'s (2017) Comprehensive Model of Perfectionistic Behavior which considers perfectionism as a multifaceted and multilevel personality style comprising interconnecting trait, self-presentational, relational and cognitive components (for further reading, please see Cheli et al. (2022); Hewitt et al. (2020), Hewitt et al. (in press), Mikail et al. (2022),

Disappointingly, however, such approaches do not yet appear to have yielded much in the way of clinical impact. Indeed, in their reflection of 30 years of multidimensional perfectionism (Smith et al., 2022) that inspired this current paper, the single paragraph dedicated to treatment research stated that 'research on the impact of multidimensional perfectionism on treatment-seeking behaviors and treatment outcomes is needed' (p.25). Although we certainly agree with that, it is important to also consider the existing treatment research that has been conducted on alternative approaches and it is clear they are wide and varied. Unlike other areas of psychopathology, such as depression, where there are distinct but coherent approaches that are evaluated, the studies of perfectionism do not consistently evaluate a single leading treatment that presents an agreed credible alternative approach to CBT although they do show efficacy (e.g., Hewitt et al., (in press)). While some may consider the multiplicity of suggested interventions a strength and necessity given the breadth and comprehension of alternative theoretical approaches, the result is lack of a single, strongly evidence-based alternative to CBT for perfectionism at the present time.

5. Empirical tests of the cognitive behavioural theory

RCTs can be viewed as a form of experiment that has implications for theory. The effectiveness of CBT-P provides indirect empirical support for the theory underlying the treatment, but it does not provide direct support for the specific maintaining mechanisms. Mediational analyses in the RCTs have been limited although those that have been conducted are consistent with centrality of reduction of concerns over mistakes (related to self-criticism and self-evaluation) rather than high standards (Handley et al., 2015). Other experimental analyses provide more direct support of the theory. For example, the theory proposed that individuals with self-imposed perfectionism raise their standards after they successfully meet them and this was found to be the case (Kobori et al., 2009) although the reasons for resetting standards may be multifaceted (Krause et al., 2018). It has proven difficult to experimentally induce perfectionism under laboratory conditions as inductions invariably confound perfectionism with responsibility and importance (Bouchard et al., 1999); efforts to do so indicate that inducing perfectionism increases symptoms of anxiety, depression and eating disorders (Boone et al., 2012; Yiend et al., 2011). Recent experimental studies have successfully induced perfectionistic concerns and indicated a causal relationship from perfectionistic concerns to negative affect in students with high levels of perfectionism (Hummel et al., 2023). The work of Stoeber and colleagues supports the view that perfectionistic standards are associated with counter-productive behaviours that reduce task efficiency (Stoeber, 2011; Stoeber & Eysenck, 2008). Other experimental studies using attention and interpretation bias paradigms have also found support for the cognitive behavioural model of perfectionism (Howell et al., 2016, 2019; Tonta et al., 2019). Although not experimental analyses manipulating a single variable of interest, qualitative studies can also contribute to the understanding of maintaining mechanisms with a meta-synthesis indicating that self-worth dependent on achievement and cognitive- behavioural maintaining factors were consistent themes across 37 qualitative studies (Egan et al., 2022).

6. Limitations of CBT for perfectionism

The development of complex interventions is seen as an iterative and ongoing process (Skivington et al., 2021) across the following phases: developing the intervention, assessing feasibility and acceptability, evaluating effectiveness, and working towards implementation. Six core elements are considered important across all phases of development, and the limitations of CBT for perfectionism are addressed against these elements below.

6.1. Consider context

The first issue to consider is that the initial terminology of 'clinical perfectionism' was unhelpful, leading to arguments about the construct of perfectionism rather than furthering the cause of developing interventions with clinical utility. The term 'perfectionism' is also misunderstood across different contexts, given some confusion over the meaning and desirability of the construct in common language. The stress inherent in managing one's own expectations and finding constructive rather than destructive pathways to achievement forms a central understanding of the perfectionism construct which informs treatment development.

Second, a lack of epidemiological data relating to perfectionism inhibits our understanding of how to best place the intervention across different settings. Data on college students from Britain, Canada and the USA suggest perfectionism has increased over time (Curran & Hill, 2019). Data from Norway indicate that there are twice as many students in ordinary versus elite secondary schools experience debilitating perfectionism, 40% versus 20% (Stornæs et al., 2019). A further study of adolescents from the same country suggests significantly more girls than boys score higher than the 90th percentile on perfectionism and that a better perceived economic wellbeing was associated with higher perfectionism, but parental education was not (Sand et al., 2021).

6.2. Limitations of RCTs to date

Although the model has a pivotal role in the perfectionism literature and CBT-P certainly has more evidence than other existing treatments, there are important limitations. Much of research showing effectiveness includes studies without an active treatment control group. The lack of control group means it is not possible to determine the specificity of the intervention. It also means that it is not possible to test the cognitive behavioural theory by comparing whether targeting the specific behaviours and beliefs in CBT leads to greater reductions in these mechanisms than alternative interventions. The few published articles comparing active treatments have various biases, for example the study of Mahmoodi et al. (2021) was not registered, there was no expert training or supervision for the interventions and the sample size was limited. A benefit of the Mahoodi et al. study, however, is that it was conducted independently of those with any allegiance, and much of the existing research on CBT-P has been conducted by the authors. The potential for allegiance biases to influence the findings needs to be considered as an important limitation. The lack of mediational analyses and consistent predictors of outcome with CBT-P should also be considered as limitations (Rozental et al., 2017).

6.3. Refine theory

Two issues need to be considered. First, the major issue that causes confusion in the field is the numerous measures of perfectionism, accompanied by a multitude of factor analyses, giving slightly different interpretations of the core dimensions of perfectionism. The clear distinction between perfectionism and a focus on adaptive but high levels of achievement also remains elusive. Adoption of core perfectionism measures that are informative but not an onerous burden on respondents is required, allowing for the inclusion of other measures that reflect the important transdiagnostic effects that CBT for perfectionism has on other constructs, namely disordered eating, depression, anxiety, self-esteem, pursuit of important goals, self-compassion, and

stress.

Second, the rise of perfectionism in youth (Curran & Hill, 2019) is in part attributed to external factors such as an increasingly competitive society focused on achievement, pressures from (well-meaning) schools, parents, and teachers, and the pressures from peers and social media. The current model is silent on these "other" factors and needs to evolve to inform development of a treatment that can help individuals recognise and manage these pressures.

6.4. Engage stakeholders

Some recent progress has been made in this area, with greater attention paid to qualitative feedback ((Egan et al., 2022), and incorporation of lived experience into informing model development (Wade et al., 2021). More, however, needs to be done in this area, especially with respect to the use of co-design to refine and evaluate the intervention. Recent developments have focused on adolescents co-designing unguided CBT for perfectionism in the website development phase (O'Brien et al., 2022), and parents/carers co-designing a parent supported version of CBT for perfectionism in adolescents with eating disorders. Further work is required however where young people are engaged in a co-design process throughout the entire research project in addition to parents/carers.

6.5. Key uncertainties

Efficacy trials of interventions in tightly controlled conditions, where research questions can be answered with some certainty, are important. To this end, more rigorous evaluation of CBT for perfectionism is required, notably: greater use of attention control and plausible alternative treatments such as Dynamic Relational Therapy as comparisons rather than reliance on waitlist controls; independent replication; longer term follow-up; reporting of reliable change indices for both improvement and deterioration. If CBT for perfectionism is to be considered for use in healthcare and educational settings, then greater priority should be given to mixed methods, and systems evaluation that can inform implementation.

6.6. Intervention refinement

CBT for perfectionism would benefit from dismantling studies in order to highlight the aspects of treatment that are essential and those that may not be necessary. For example, exposure to making mistakes produced large between-group effect size differences from the control group on perfectionism and depression at post-intervention (Redden et al., 2022). It also produced moderate effect size differences for anxiety-related conditions, and a small effect size difference for disordered eating. Longer term follow-up and comparison of effect sizes against the full protocol of CBT for perfectionism will be important to inform implementation of the approach more widely. Dismantling studies are especially important in promoting use of the intervention in educational settings, where the current 8-session protocol is likely to be too long. Additionally, an understanding of which elements of the treatment protocol have most impact on which disorder and are causal processes underpinning treatment efficacy, will be important for the transdiagnostic application of the therapy across different mental health settings.

6.7. Economic considerations

Given the primary focus of the intervention on re-evaluation of self-worth in terms of over-reliance on achievement rather than lowering standards, economic analyses of the impact of perfectionism and the impact of the intervention will be important to conduct. We would predict that higher levels of perfectionism are associated with less goal directed activity and therefore valued output, and that the intervention would somewhat obviate this effect.

7. Future development of CBT for perfectionism

As the cognitive behavioural approach to perfectionism matures into adulthood, what are the important next steps? One of these should be to conduct research that overcomes the limitations described above. Dismantling studies, more rigorous, independent evaluation with active treatment comparisons, mediational analyses, empirical tests of the theory, longer-term follow up, independent replication, consistent measurement, continued refinement of theory, epidemiological studies, economic evaluations, greater use of co-design and implementation studies, and careful consideration of terminology are all areas for improvement. There are alternative, non-cognitive conceptualizations of perfectionism such as error-related negativity (e.g., Perrone-McGovern et al., 2017) that suggest perfectionism may have a neural basis and it would be of interest to rigorously evaluate and compare these different perspectives. Another is to consider future priorities within two areas – increasing access to the intervention and improving clinical outcomes.

7.1. Increasing access to effective intervention

It is undeniable that the first place that people turn when experiencing difficulties is the internet. Our realist synthesis of websites containing content on perfectionism resulted in the conclusion that only one website could be considered as 'excellent' (and that was actually a TED talk by a CBT clinical researcher), most contained some empirically supported information but that overall the quality needed improvement (Wade et al., 2021). What doesn't happen when someone conducts an internet search for 'perfectionism effective treatment' is that they are given access to the intervention shown to be effective in the RCTs. This is not limited to the area of perfectionism research and there are a number of explanations for this. One explanation is that the science hasn't yet been conducted – we don't know how effective the intervention is without any type of guidance and freely available to anyone that wants it. Such science is needed as it cannot be assumed that the intervention does no harm (Rozental, Castonguay et al., 2018) and it is important to conduct a full evaluation. Another explanation is that providing a free resource requires some funding behind it and perfectionism research has typically been under-funded. However, it is not only the funding since effective interventions more generally largely remain in the domain of academia rather than freely accessible. Complexities around intellectual property, long-term maintenance and collaboration with industry all need to be resolved to make such interventions freely available. There is a model for such interventions for single-session interventions (Schleider, 2022) that could usefully be used to increase access to longer forms of CBT, including perfectionism.

Building on the notion of single-session intervention, a 'one-at-a-time' therapy approach has been proposed (Dryden, 2022). It has been argued that given the modal number of sessions attended in clinical services can be as low as one (Moller et al., 2019) which makes it necessary to rethink our model of treatment delivery. The existing data from the RCTs show that one session of treatment is going to be insufficient for reducing perfectionism and associated psychopathology, but multiple, inter-connected single sessions that build on each other is a model that may suit some individuals who would otherwise be deemed drop-outs and non-completers. Such a 'one-at-a-time' approach lends itself well to the modular version of CBT for perfectionism which has been developed with preliminary evidence of efficacy (Grieve et al., 2022). Interestingly, this study allowed participants to choose which modules they wanted to complete and the order in which to complete them (after an initial module) which personalises the intervention, takes into consideration patient preference (a key part of evidence-based practice) and reflects a genuine collaboration between the patient and therapist.

Such a genuine collaborative relationship between the patient and

therapist is a hallmark of good CBT, but as lower intensity interventions are developed with paraprofessionals as guides, supporters and coaches, the nature of the relationship between the guide and patient needs to be re-examined. In a systematic review of six studies of therapeutic alliance in guided internet therapy programs for depression and anxiety (Pihlaja et al., 2018), a high level of client-therapist alliance was reported and in the three most recent studies, the alliance was directly associated with outcome. The guidance in the review was via email. The ingredients of such an alliance and, more broadly, what makes a successful guide who can balance fidelity with flexibility (Kendall, 2021) whatever the mode of delivery of the guidance warrants further exploration. It is important to understand both whether such an association between therapist alliance and outcome remains when the guidance is delivered in a different format, and also the nature of the direction of the relationship since greater early symptom reduction has been shown to predict a strong therapeutic alliance (Turner et al., 2015). Guidance-on-demand has great potential to achieve the benefits of scalability without sacrificing the benefits of having guidance compared to pure self-help. Such guidance-on-demand appears to be as effective as weekly scheduled guidance but with significantly less input (e.g., Dahlin et al., 2022). Such guides should have ready access to training to optimise therapeutic outcomes, to balance fidelity to the protocol with flexibility and to prevent 'drift' into therapy or away from the protocol. For children and young people, who currently have little access to interventions, consideration of using parent-delivered CBT for perfectionism and using parents as guides has the potential to ensure access at the earliest stage of need.

7.2. Improving clinical outcomes

Although CBT for perfectionism has achieved much in the last 21 years, it is clear there is much that remains to be done. Those interested in effective treatments for perfectionism should be encouraged to follow the principles of Open Science/Open Intervention so that the data can be independently scrutinised and explored. Interrogating and replicating datasets will not just be of benefit to understanding processes responsible for therapeutic change but may also lead to a consensus with regard to common metrics. It is ironic that in this field there are so many different measures of perfectionism, each of which assesses a highly specific, detailed component of perfectionism, arguably at the expense of the 'big picture'. Such measures must also be made freely available. Combining datasets would allow the benefits of 'big data' to be applied to perfectionism, including treatment matching. Although a recent study concluded that perfectionism did not impede outcome of the Unified Protocol for anxiety and depression (Mahmoodi et al., 2021), the literature on the impact of perfectionism on treatment outcome is mixed and sharing datasets may expedite reaching an answer to this important question. Would it improve clinical outcomes if there was not such a division of theoretical approaches with CBT being pitted against a relational approach? Possibly. It is certainly the case that in treatment, boundaries often become blurred with clients describing how their self-worth is dependent on striving and achievement because of the influence of others. Extending a modular intervention to include both CBT techniques and elements from other approaches is a pragmatic, rather than theoretical or mechanisms approach to improving outcomes, but one that is worthy of consideration.

7.3. Final comment

The past 21 years have been fruitful. There is now an efficacious treatment for perfectionism based on the cognitive behavioural analysis published in *Behaviour Research and Therapy*. It is not a perfect treatment, and mistakes have been made along the way, in terms of both the initial model and naming of the construct which was misconstrued. However, we continue to strive for improvement with what we consider to be achievable goals, notably improved flexibility, studies on mechanisms to improve efficiency, increased patient choice with modular and 'one-at-a-time' approaches, free access to the intervention when searching on the internet and better outcomes. We conclude that the CBT approach to perfectionism has certainly passed the test with regard to clinical utility. It's a good beginning.

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Data sharing

n/a.

Author contribution statement

RS, SE and TW wrote the manuscript and contributed equally.

Data availability

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