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THE QUEST FOR PERFECTION: AVOIDING GUILT OR AVOIDING SHAME?

BEN SOROTZKIN
Yeshiva University

The cognitive style of perfectionists is noted together with the emotional and behavioral outcome of their irrational thinking patterns. Perfectionism in narcissism is viewed as an attempt to avoid shame and humiliation for not living up to an archaic grandiose view of the self. In contrast, neurotic perfectionism is an attempt to avoid guilt for not living up to the demands of a harsh, internalized, and differentiated superego.

Cognitive researchers have found perfectionism to be a major feature in obsessive-compulsive and mood disorders (Beck, 1976; Burns, 1980; Burns & Beck, 1978; Ellis, 1962; Meichenbaum, 1974; McFall & Wollersheim, 1979). Several cognitive styles are characteristic of those who strive compulsively and unremittingly toward goals beyond reach and reason (in contrast to a healthy pursuit of excellence see Hamachek, 1978 and Pacht, 1984).

Dichotomous thinking. The perfectionist tends to view the world in a polarized fashion. Events are labeled "black or white," "wonderful or horrible," and underlying assumptions are likewise in absolute terms, such as "always or never" and "all or nothing" (Beck, 1976; Burns & Beck, 1978; Mahoney & Arnkoff, 1979).

Overgeneralization. The perfectionist illogically generalizes on the basis of a single incident (e.g., concluding from failing one test that one will fail all other tests) (Beck, 1976; Burns & Beck, 1978).

An overly active system of self-commands, termed by Karen Horney (1950) "the tyranny of the shoulds." Some of the common self-commands are: "I should be the perfect parent, friend, spouse, etc.," "I should never get angry," "I should always achieve my goals without any difficulty" (Beck, 1976; Mahoney & Arnkoff, 1979).

Overly moralistic self-evaluation. Perfectionists measure their self-worth in terms of unachievable goals of accomplishment and productivity, and thus any deviation from the perfectionistic goal is likely to be accompanied by moralistic self-criticism and lowered self-esteem (Burns & Beck, 1978; Mahoney & Arnkoff, 1979).

Many detrimental behavior patterns and emotional states have been attributed to perfectionistic tendencies. According to Beck (1976), perfectionists tend to have disturbed interpersonal relationships, related to anticipation of rejection when they inevitably fall short of their perfectionistic standards, and a concomitant hypersensitivity to criticism and/or withdrawal from meaningful social interaction. When they notice, in fact, that no one is interacting with them this is used as evidence of their own worthlessness and undesirability; thus establishing a self-perpetuating vicious cycle (Burns & Beck, 1978). As would be expected, a withdrawal from interpersonal relationships and the repeated recognition of a

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Requests for reprints should be sent to Ben Sorotzkin, 24 Tudor Terrace, Brooklyn NY 11224.

gap between performance and perfectionistic goals and grandiose expectations often leads to lowered self-esteem and depression (Beck, 1976; Burns & Beck, 1978).

Chess & Hassibi (1978) note that "for some children, fear of failure and an obsessional desire for perfection may act as an emotional block against learning" (p. 305). Burns (1980) reports that perfectionists tend to procrastinate, as they attempt to avoid the dreaded consequence of less than perfect performance. Likewise, Mahoney & Arnkoff (1979) assert that the dichotomous and overgeneralized thinking of the perfectionist is most detrimental to self-regulation of smoking, drinking, and eating habits. The first lapse in the perfectionist's typically overambitious program is viewed as indicating total failure which usually results in binge smoking, drinking, or eating (the "saint or sinner" syndrome).

The Etiology of Perfectionism

Beck (1976), using a learning theory approach, states that emotional disorders "are derived largely from certain distortions of reality based on erroneous premises and assumptions which originated in defective learning during the person's cognitive development" (p. 3).

In classical psychoanalytic theory, perfectionism is viewed as one of the common symptoms of obsessional neurosis (Freud, 1926/1959). The threatened return of repressed oedipal impulses and conflicts results in a defensive regression to anal fixation of the ego (resulting in an archaic mode of cognition), and superego (reviving sadistic superego forerunners), while the id threatens to erupt with sadistic impulses. The obsessive-compulsive symptoms are viewed as a compromise, masking aggressive impulses in the form of punitive and exhaustive self-corrective tendencies which testify to the individual's need to counteract and set right his or her aggressive tendencies (Fenichel, 1945). "Guilt feelings are almost constant companions . . . . A childish conception of evil joins battle with a childish conception of righteousness and punishment" (White & Watt, 1981, pp. 201-202).

The role of the superego in obsessional neurosis is emphasized by Freud (1926/1959), who states that "the super-ego becomes exceptionally severe and unkind, and the ego, in obedience to the super-ego, produces strong reaction formations in the shape of conscientiousness, pity and cleanliness" (p. 115).

The importance of the role of the superego in perfectionism is, in fact, also emphasized by the cognitive behaviorists who prefer to refer to an "overly moralistic self-evaluation" (Mahoney & Arnkoff, 1979), or to Horney's (1950) tyranny of the shoulds which Beck (1976) concedes has "much in common with Freud's conceptualization of the superego" (p. 257). Indeed, in both the cognitive approach and classical psychoanalytic conflict theory the perfectionist's lowered self-esteem is viewed as the *result* of a harsh superego.

The Narcissistic Striving for Perfection

Kohut's pioneering work on narcissism (1971, 1977), in which he contrasts neurotic disturbances with narcissistic personality disorders ("disorders of the self"), necessitates considering a different concept of perfectionism with a different "meaning" than the one discussed above.

The central pathology in neurosis relates to intrapsychic conflict over forbidden wishes "which emanate from a well-delimited, cohesive self and are directed toward childhood objects . . . fully differentiated from the self" (Kohut, 1971, p. 19). Anxiety results from the fear that giving expression to the wishes will result in punishment (castration anxiety) or losing the *love* of the object.

Since the self is differentiated, the feared loss of object love does not threaten the cohesiveness of the self and so any loss of self-esteem is only secondary. Likewise, since the superego is well developed, the threat of giving expression to the forbidden wishes is experienced as a transgression of a moral/ideal and therefore arouses feelings of *guilt*.

In contrast, the psychopathology of the *narcissistic* personality, according to Kohut (1971, 1977), concerns primarily the poorly differentiated self—its cohesiveness, stability, and affective coloring. The anxiety of a narcissistic personality is a result of a realistic appraisal of the vulnerability of the self to fragmentation ("disintegration anxiety") and/or intrusion of archaic forms of grandiosity. The narcissistic disturbance cripples the regulation of

self-esteem which may range from archaic grandiosity to severe shame.[1]

Since the objects in the narcissist's world are "selfobjects" (Kohut, 1971, p. 3), i.e., objects poorly differentiated from the self which serve to maintain the sense of self, the loss of their *admiration* (as opposed to love) can result in a serious blow to the cohesion of the self and/or to the sense of self-esteem. This may cause feelings of overpowering *shame*.

Kohut asserts that, in the normal course of development, a child establishes a grandiose image of the self, i.e., "I am perfect" and a grandiose image of the selfobject (idealized parent *imago*), i.e., "you are perfect and I am part of you." According to Kohut, this is done to replace the state of perfection enjoyed during the stage of *primary narcissism* when all love is directed toward the self and which is threatened by normal parental shortcomings (Kohut, 1971).

Stolorow & Lachmann (1980) point out that at this early stage of development, before *object constancy* is established, it makes little sense to speak of primary narcissism since love can neither be directed toward the self nor toward an object, since at this point they are undifferentiated from each other. In their view, these early grandiose and idealized images serve to consolidate the infant's rudimentary self-representation which is lacking in cohesiveness and stable boundaries.

When the parent's shortcomings are at an optimal level the child's perfect self-image is toned down and internalized as part of a psychic structure supplying ambition and motivation for activities while the idealized parent imago is internalized as ideals and morals (ego-ideal) which serves to regulate self-esteem, relatively independent of external factors. However, if the child experiences severe narcissistic trauma (e.g., a lack of *mirroring* of the child's grandiose needs because of the parent's own narcissism), the development of a mature, cohesive, and stable feeling of self is not achieved. As a result, the archaic grandiosity is not integrated into the adult personality structure and *the person continues to strive for ultimate perfection* or for merger with a perfect selfobject (Kohut, 1971).

Shame versus Guilt

The distinction between shame and guilt, elaborated upon by Piers & Singer (1953), Jacobson (1964), and Lewis (1971), is extremely relevant to our discussion.

Piers & Singer (1953) distinguish between guilt reactions to transgressions of prohibitions and feelings of shame resulting from the failure to reach goals or live up to expectations.

Lewis (1971) stresses that shame, in contrast to guilt, is more profoundly related to primitive feelings of the past and is more likely to disturb the sense of identity. Likewise, Jacobson (1964) asserts that shame has earlier infantile narcissistic origins and is related to fear of exposing one's defects (physical, emotional, or intellectual) to others. Shame is usually related to visible and concrete deficiencies rather than moral deficits. Therefore, shame and humiliation in relation to intellectual deficits would reflect the person's reaction to performance which does not live up to perfectionistic expectations.

The standards which are not being lived up to are related to pride and superiority and these deficiencies are felt to be beyond remediation and a threat to the self-representation.

In Jacobson's (1964) view, shame is an all-encompassing feeling with "a self-annihilating overwhelming effect" (p. 144). In contrast, guilt is a more developmentally advanced feeling related to verbal demands and moral prohibitions usually related to feelings of hostility to others.

The psychic structures involved in shame and guilt are also contrasted by Jacobson. *Shame* reactions arise from not living up to an ego-ideal according to which the *self* is evaluated in terms of archaic grandiose concepts of physical self-achievements, power and control. Kohut (1972) makes a similar point, that shame as a result of a "slip" is often related to a feeling of a defect in the omnipotent grandiose self and not to guilt over the unconscious impulses which are revealed. In contrast, *guilt* feelings arise from the more mature superego

[1] In *The Restoration of the Self* (1977), Kohut proposes doing away with the distinction between neurosis (conflict over impulses) and narcissistic disorders (archaic selfobject relations). Kohut suggests that impulses are a pathological *product* of deteriorated object relations. Mitchell (1979) asserts that this conceptualization resulted from Kohut's unfortunate attempt to reconcile his innovative approach with classical drive theory.

which has internalized the (differentiated) parent's moral demands and prohibitions and is related to transgression of these prohibitions.

Since narcissistic personalities have not developed an adequate superego structure they are not yet able to be affected by guilt feelings, although they often attempt to portray their shame reactions in terms of high moral ideals (Kohut, 1971).

Kohut (1971) refers to two forms of shame reactions prevalent in narcissistic personalities. One form of shame is a self-conscious reaction to a breakthrough of archaic aspects of the grandiose self accompanied by anticipation of faulty *mirroring* by significant others (where the shame may function as protection against the loss of self-boundaries implicit in grandiose fantasies). A second yet related form of shame is a reaction to not living up to the archaic grandiose image of the self. The narcissist's striving for perfection in this second case reflects the need to avoid the shame of not measuring up to grandiose standards.

Neurotic Perfectionism versus Narcissistic Perfectionism

Jacobson's distinction between shame and guilt and Kohut's distinction between neurotic and narcissistic disorders suggest that a differentiation between two forms of perfectionism would be useful.

Perfectionism in neurosis is a reaction to the demands of a harsh superego acquired as a result of learning and/or as a result of repressed hostility. As such, perfectionism is a defense against intrapsychic conflict (related to feelings of guilt around issues of morals and ideals) and an attempt to retain the love of differentiated objects in the individual's "representational world" (Sandler & Rosenblatt, 1962). The failure to live up to the superego's demands results in lowered self-esteem.

In contrast, perfectionism in the narcissistic personality is less related to morals and ideals. Rather it is an attempt by the individual to live up to a grandiose self-image in order to avoid humiliation and shame and the loss of the *admiration* of poorly differentiated selfobjects. The function of the perfectionism is to restore or maintain precarious self and object representations and not to defend against intrapsychic conflict (as in neurosis). This can be viewed as a "prestage of the defense" (Stolorow & Lachmann, 1980), i.e., a remnant of a developmental arrest at, or regression to, a stage where a perfectionistic view of self and selfobjects is necessary to develop a cohesive and stable sense of self. As such, the disturbance in self-esteem is the *cause* of the perfectionism and not the price.

The concrete outcome of a perfect performance in the narcissistic personaliy can be conceptualized as a "transitional selfobject" (Kohut, 1971) which, to paraphrase Atwood & Stolorow (1981, p. 204), gives the individual reassurance that while the sense of self may vanish on a temporary basis, it will not be permanently annihilated. The concrete nature of the performance provides a feeling of conviction and validity to the image of the grandiose self.

The obsessive redoing, characterisic of the perfectionist, may be the way a narcissistic personality assures himself or herself continued contact with the "almost-perfect" selfobject. Likewise, the tendency toward perfectionism may be more prevalent when a narcissistic personality is separated from those who normally function as his or her selfobjects (e.g., when leaving home for college.)

While the cognitive styles discussed at the beginning of this article (dichotomous thinking, overgeneralization, etc.) apply to all forms of perfectionism, the cognitive ideation involved depends on the the underlying etiology. For example, the "tyranny of the shoulds" of the narcissistic perfectionist focuses on the self ("I should be perfect"). The failure to live up to the dictates of the "shoulds" evokes thoughts of "I am worthless," "I am a nobody" (shame). In contrast, the focal point of the neurotic individual's "should" is the action to be done or not done ("I should *never get angry*"). The failure to live up to this expectation evokes thoughts of "I am bad" (guilt). As Lewis (1971) points out, while both guilt and shame may be evoked in the context of a moral transgression, the ideations involved are distinctly different. The shame-prone individual would be obsessed with the question "How could *I* have done that?" whereas the guilt-ridden person is more likely to wonder "How could I have *done that*?"

The way in which the need for perfection is *experienced* is also different in the various pathologies. A neurotic may be capable of ex-

periencing *some* satisfaction from a less-than-perfect performance (although feeling guilty for not performing better). In contrast, the narcissistic personality expects to control his or her performance (experienced as a selfobject not fully differentiated from the self) as he or she expects to control the parts of his or her body. The inevitable failure to live up to the perfectionistic standards results in profound shame and *narcissistic rage* (Kohut, 1972). This failure attacks the very fabric of the self and so is much more threatening than the neurotic's failure to live up to the demands of the superego.

Implications for Treatment

In real life, most perfectionists are likely to experience both neurotic and narcissistic elements of perfectionism. It is the therapist's task to assess the "motivational priority" (Stolorow & Lachmann, 1980, p. 174) of each need at any given stage of treatment.

When perfectionism is predominantly neurotic, atempting to diminish the power of the "harsh superego" or overly strong ideals would be a legitimate goal of treatment for analytically oriented therapists (Salzman, 1980) and especially with cognitively oriented therapists, (see McFall & Wollersheim, 1979).[2]

In contrast, this approach is *not* indicated when the perfectionism is predominantly narcissistic in its root, since it is the *lack* of strong internalized ideals capable of regulating self-esteem which is at the core of the disorder. Rather than being related to morals and ideals, the perfectionism is desperately needed for maintaining the sense of self. Questioning this grandiose belief system or suggesting that other people suffer from the same type of problem would be extremely threatening to the patient and would most likely be experienced as a severe narcissistic injury and may provoke the patient to leave therapy. On the contrary, one of the major goals of therapy would be to facilitate the development of moral ideals as part of a process of helping the patient develop differentiated and integrated self and object representations, by understanding and transforming the vulnerabilities that make the perfectionism necessary, and reinstating the thwarted developmental process (Stolorow & Lachmann, 1980).

The following clinical vignette illustrates the rupture of an incipient therapeutic alliance because of an empathic failure due to the therapist's failure to distinguish between the two forms of perfectionism.

Case History

Dan was a 16-year-old student in the tenth grade of a fairly exclusive Midwestern boarding school at the time of his referral to the author for biweekly psychoanalytically oriented psychotherapy.

The reason given for referral was "problems with interpersonal relations which affects his motivation for academic achievement." The teacher indicated that Dan had an extraordinarily strong motivation for a high level of academic success, which had recently been disrupted by frequent squabbles with his peers. Dan frequently accused the other youngsters of ridiculing him, an accusation that the teachers asserted was often "made up." In fact, Dan often "makes fun of himself" and "verbally abuses his peers" and then cried when they reacted.

Dan's relationship with his parents was described as "good." Both parents worked their way up from lower socioeconomic backgrounds. The father attained a college degree and held a responsible position in a social welfare agency in the small town where the family lived. The mother was described as "cultured" in the referral form.

From the beginning of therapy, Dan made it clear that he agreed to accept treatment only out of compliance with his teacher's wishes. He displayed a great deal of nervousness and made a mostly successful attempt to remain at a distant and intellectualizing level. One of the first things that struck my eye when Dan walked in was his slightly deformed arm. He "announced" his name, grade, and problem: "I have interpersonal problems and the teacher thinks it is worthwhile for me to come and get advice." Nonetheless, Dan took some tenta-

[2]See Salzman (1980) for an extensive discussion of the difficulties involved in treating the perfectionist. In this author's opinion, many of these problems result from not distinguishing between neurotic and narcissistic perfection. It is also interesting to note, in this context, Coleman's (1968) comment about *therapists* who "cherish an exaggerated ideal of personality structure and function and deplore anything less than perfect" (p. 1).

tive steps during the first months of therapy toward presenting some interrelated areas of his subjective world, as if to test for my reaction.

He spoke a great deal of his father, always in idealized terms, and never mentioned his mother. For example, he described his father as having worked his way up the socioeconomic ladder to become a "director of research," as "super-orderly" and "super-sociable," and as a harsh disciplinarian intolerant of weakness: "By my father there is no such thing as fear."

Dan was only willing to hint at all the ways he imagined he disappointed his father (especially since he was the only male child). The first act of disappointment was being born with a defective arm. This was a taboo topic in Dan's house and he had no idea what exactly was wrong with his arm. At times the father served as a guide during nature hikes in which Dan's class participated and he insisted that Dan participate regardless of his handicap. Given the prevailing emotional attitude of his father, Dan experienced this as a denial of his defect and his related fears, rather than as encouragement to overcome a handicap. Dan felt compelled to prove himself by fully participating in all the physical activities his classmates were involved in, yet was terrified of failing and thus "humiliating himself." When he inevitably failed to perform at the same level as his peers he concluded that he was "a zero."

Dan also spoke of other areas of endeavor where his imperfections stood in contrast to his idealized father, such as being extremely disorderly and nonsociable. Even his academic achievements were experienced as worthless, in the light of paternal comments such as, "Someone who gets a 90% can surely get 100%!"

These defects were perceived as humiliating and unpardonable. Dan felt that he *should* succeed and thus achieve social status. He *should* be *very* sociable and loved by everyone. His failure to achieve perfection was perceived to be glaring proof of his worthlessness. His shame at not achieving these "minimal" goals was especially glaring since he was "spoiled" as a child, i.e., he was given every opportunity. Dan also clearly indicated that he felt loved by his parents. It was his father's longed-for admiration that he failed to merit.

Dan's interpersonal problems were also related to his feelings of being defective. His peers were perceived by him as exemplifying perfect, nondefective (especially nondeformed) human beings. In his subjective world these people were constantly "ridiculing him" for his imperfections, and so he was only retaliating when he verbally abused them. Likewise, if he allowed himself to be close to them his deficits would be highlighted.

As indicated above, these feelings of being defective and disappointing to his father were only hinted at and were usually denied. In fact, at one point he asserted that "I do not fear anything, except for a while when I was afraid of heights."[3]

One of the striking features in the therapy was the almost total lack of affective expression. I misinterpreted this as a repression of resentment and hostility toward his father (for rejecting him) in order to avoid the feelings of guilt and anxiety associated with the expression of hostility (i.e., intrapsychic conflict). His resistance to the transference was interpreted as a conflict over hostility and guilt. The self-demand for perfection was misunderstood as being a result of an internalization of the father's harsh superego (as a resolution of the oedipal conflict).

In retrospect, it is clear that Dan made repeated subtle attempts to reveal *his* subjective experiencing of these issues. Dan's description of his family life revealed a father who demanded total success from Dan as a means of validating his own worth. Dan's relationship with his father was symbioticlike, where the father would constantly instruct Dan on how to maintain a socially acceptable facade. This suggests that Dan's father related to him as a selfobject necessary for the regulation of his own self-esteem. Therefore, Dan never experienced himself as totally differentiated from his father. Since successful children in Dan's town went on to exclusive boarding schools, Dan's father felt compelled to send him also. While at first Dan enjoyed the reflected glory (thus allowing himself to feel more acceptable to his father), any evidence of being less per-

[3]Kohut (1971) asserts that acrophobia in the narcissistic personality is caused by the reality ego's anxiety reaction to the grandiose belief in one's ability to fly.

fect than his idealized peers was experienced as a severe blow to his self-esteem. His defects became his father's defects and highlighted his humiliation and shame. As the cause of his father's imperfection, how could he be worthy of his admiration?

The "dread to repeat" (Ornstein, 1974) the rejection experienced at home and the necessity of not showing weakness was clearly the major motivational force behind the resistance and not the defense against intrapsychic conflict. Already in the first session Dan tried to make clear his fear of treatment; "nothing will come from it and then I will just give up" (i.e., being rejected again will be too much to bear).

When discussing his perfectionistic tendency I again mistakenly attributed this to conflict involving hostility and a harsh superego. When I questioned the need for perfection and interpreted it as a defense against hostile feelings toward his father, he exhibited emotion for the first time. His mood turned depressive, and he indicated that he experienced my suggestion as criticism, as I was insinuating that he was not worthy of being perfect. Likewise, he clearly felt threatened by an expression of hostility against the selfobject (father), and at this point the patient terminated treatment.

In retrospect, it is clear that encouraging the awareness of hostility against a person experienced as a selfobject is contraindicated. As Stolorow & Lachmann (1980) point out:

> To promote the emergence of hostility while the self representation is still insufficiently structured, vulnerable, and in need of selfobjects for the maintenance of its cohesion and stability places the patient in an intolerable dilemma. In effect, the patient is encouraged to bite the hand that sustains him (p. 165).

While Dan's relationship with his father was a mostly selfobject one, enough differentiation had developed to have allowed a "prestage of therapeutic alliance" (Stolorow & Lachmann, 1980) to progress rapidly to a therapeutic alliance proper had there been correct empathic understanding of his need for perfection as a narcissistic avoidance of shame rather than interpreting it as a neurotic avoidance of guilt. Unfortunately, I fell victim to "a specific failure in empathy, wherein the analyst misunderstands and misinterprets the meaning of the patient's archaic states by amalgamating them to his own much more differentiated and integrated world of self and object representations" (Stolorow & Lachmann, 1980, p. 190).

Had I correctly recognized and clarified the patient's *developmental* need for perfectionistic strivings, a stable "selfobject transference" most likely would have developed. According to Stolorow & Lachmann (1984) a selfobject transference facilitates the reinstating of the developmental process of self–object differentiation that had been aborted or arrested during the patient's formative years. This transference relationship can, therefore, promote the process of psychic structure formation.

While the therapist attempts to avoid repeating the trauma that caused the developmental arrest, there will inevitably occur ruptures in the selfobject transference relationship. It is of utmost importance to clarify the patient's experience of this rupture, thus reestablishing the selfobject tie and permitting the resumption of the developmental process. (For a detailed exploration of the treatment of developmental arrests, see Stolorow & Lachmann, 1980, Chapter 9, Stolorow & Lachmann, 1984).

In this case, the constant, incorrect interpretation of Dan's perfectionistic strivings as a defense against intrapsychic conflict while remaining unaware of its developmental significance led to an obstruction of his attempt to develop a selfobject transference relationship and consequently to his leaving treatment. This experience underscores the critical importance of understanding the specific meanings of perfectionism for the unfolding therapeutic process.

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