Therapist's perfectionism as a target of clinical supervision. A case-study

Gianpaolo Salvatore[*,**], *Luisa Buonocore*[**], *Raffaella Marciano*[**], *Francesca Cavallo*[***], *Anna Rossi*[****]

Submitted: 29/11/24
Accepted: 13/12/24

Abstract

Perfectionism is characterized by beliefs and feelings that drive individuals to pursue unattainable standards of excellence and impeccability, often at the expense of their psychological and physical well-being. It correlates with many psychopathologies and a heightened suicide risk; and it can be also an aspect of a multiplicity of personality disorders. Perfectionism seems a common phenomenon among psychological practitioners too, and the very few studies that focus on it overall suggest that perfectionism in therapists is negatively correlated with therapy effectiveness, and positively correlated with therapist emotional distress (e.g., negative emotions toward patient characteristics or demands); but it is not clear the mechanism underlying these correlations. In this paper we present a hypothesis on the process underlying the relationship between therapist perfectionism, therapist

[*] Department of Social Sciences, University of Foggia. https://orcid.org/0000-0002-1781-6474
[**] Studio Maya, Psychiatry, Psychotherapy, Criminology, Research.
[***] Graduate School Integrated Psychotherapy (SPI), https://orcid.org/0000-0002-7394-5828
[****] Psychotherapist.

Corresponding Author: Gianpaolo Salvatore, Department of Social Sciences, University of Foggia, Via Alberto da Zara, 71121 Foggia (Italy). E-mail: gianpaolo.salvatore@unifg.it

emotional distress, and ineffectiveness of therapeutic interventions. Starting with a parallel analysis of a clinical case and supervision over it, we show that perfectionism may be part of an overall organization of the meaning of the experience that the therapist brings into the relationship, which we call Prototypical Adaptive Modality of Existence (PAME). We show how the therapist's perfectionist PAME functions as an automatic process that hinders intersubjective attunement with the patient; finally, we show how a supervisory process focused on the shared exploration of the therapist's perfectionist PAME, of its developmental genesis, and of its impact on the supervisory relationship can modulate the therapist's perfectionism, foster attunement with the patient, functionally modify the line of intervention, and foster a positive outcome.

Keywords: perfectionism, clinical supervision, supervisory relationship, therapeutic relationship, intersubjectivity.

Introduction

Perfectionism is a psychological construct characterized by a set of behaviors, beliefs and feelings that drive individuals to pursue unattainable standards of excellence and impeccability, often at the expense of their psychological and physical well-being (Frost *et al.*, 1990; Flett & Hewitt, 2002; Hewitt *et al.*, 2017). These characteristics deeply affect the whole life of persons and their subjective and intersubjective experience (Ayearst *et al.*, 2012; Flett *et al.*, 2022; Smith *et al.*, 2022). Following Frost and colleagues (Frost, Marten & Lahart, 1990), self-oriented perfectionism is multidimensional and comprises setting high standards for performance; fear of making mistakes; enhanced focus on parents' criticism; doubts about one's own performance, and finally a preference for organization and order. Hewitt and Flett (1991) add an interpersonal dimension to this definition, including other-oriented perfectionism (the setting of unrealistically high standards on others and the belief that others hold unrealistically high expectations about the self that one should meet). There is substantial evidence that maladaptive perfectionism correlates with many psychopathologies including eating disorders (Slof-Op't Landt, Claes, & van Furth, 2016), mood disturbance (Alloy, Abramson & Walshaw, 2009) and anxiety disorders (Frost & DiBartolo, 2002); and with heightened

suicide risk (Blatt, 1995; Flett, Hewitt & Heisel 2014; Hewitt, Flett, Sherry & Caelian 2006; O'Connor, 2007). Perfectionism can be also an aspect of personality disorders (PD; Lowyck, Luyten, Vermote *et al.*, 2016), not only obsessive-compulsive PD, where perfectionism is one of its main features (Riddle, Maher, Wang *et al.*, 2016), but also narcissistic (McCown & Carlson, 2004), depressive (Huprich, Porcerelli, Keaschuk *et al.*, 2008), borderline, avoidant and dependent PD's (Hewitt, Flettn & Turnbull-Donovan, 1992; Hewitt & Flett, 1991). Dimaggio and colleagues (Dimaggio *et al.*, 2016, 2018) have explored the associations of perfectionism with PD in clinical samples and reported that maladaptive perfectionism was correlated with number of PD criteria, to interpersonal problems, to the majority of PD symptomatology and to PD severity via number of SCID-II criteria met, to emotional inhibition. These data suggest that perfectionism is a transdiagnostic candidate mechanism underlying a broad array of psychiatric disorders (Egan, Wade & Shafran, 2011), so that the higher the perfectionism, the higher the psychological suffering (Dimaggio *et al.*, 2015, 2018; Hewitt & Flett, 1991, 1993; Hewitt *et al.*, 1992; Sherry *et al.*, 2007).

Perfectionism has been extensively studied in the context of clinical and non-clinical populations; but it seems a common phenomenon among psychological practitioners too. The latter is an almost neglected topic in the research literature, and there are few studies that focus on it. For example, high socially prescribed perfectionism negatively correlates with reduced enjoyment of conducting psychotherapy in doctoral-level, private-practice psychologists (Wittenberg & Norcross, 2001). Moreover, clinical psychologists who endorse higher levels of perfectionism are more prone to experience greater stress levels and professional burnout (D'Souza, Egan & Rees, 2011). Perfectionism can place great demand and distress on a therapist, and it could even disrupt his or her clinical effectiveness and compromise the patient's continuation of therapy (Presley, Jones & Newton, 2017). Coherently, starting from the assumption that therapists' emotional reactions to patients are related to psychotherapy outcomes (Hayes *et al.*, 2018), Pozza, Casale and D'Ettore (2022) found that specific dimensions of therapist's perfectionism are correlated to the quality of therapist's emotional responses to patient with obsessive compulsive disorder: therapists with higher parents' expectations/evaluation had

higher hostile or angry feelings toward patients; those with higher concerns over mistakes and doubts about actions had more intense criticised/devalued emotions, namely feelings of being unappreciated, devaluated or dismissed by the patient (Betan *et al.*, 2005); therapists with stronger concerns with precision, order and organization (healthy perfectionism) experienced lower disengagement reactions, namely feelings of being distracted, withdrawn, bored, annoyed during sessions (Betan *et al.*, 2005). Finally, in marriage and family therapy (MFT) higher levels of both self-oriented and socially oriented perfectionism are correlated with higher levels of both burnout and secondary traumatic stress (Holden & Jeanfreau, 2021).

In summary, the above data seem to converge on one conclusion: perfectionism in therapists is negatively correlated with therapy effectiveness, and positively correlated with therapist emotional distress (e.g., negative emotions toward patient characteristics or demands), which can even reach burn-out levels. As the above data are inferred from correlational studies, the causal link between these factors and the process underlying their correlation is unclear. For example, perfectionism may result in a predisposition to experience emotional distress in the face of the clinical difficulties posed by a complex case, and this emotional distress may in turn guide the therapist toward ineffective interventions or generate dysfunctional interpersonal cycles with the patient, which easily generate relationship ruptures and undermine the effectiveness of therapy (Safran & Segal, 1990; Safran & Kraus, 2014; Safran & Muran, 2000). But it may also be that other factors (e.g., intrinsic features of the patient's psychopathology, such as the devaluing attitude of a patient with severe narcissistic traits) may result in ruptures in the relationship, which the therapist, because of his perfectionism, may experience as his own failures that move him away from the perfectionistic standard; this may easily result in emotional distress, and the latter may lead to behavioral reactions of the therapist (e.g, a directive attitude toward the patient to counteract devaluation by restoring ranks, a hyper-available attitude to counteract devaluation by gratifying the patient) that exacerbate the ruptures.

In this paper we present a hypothesis on the process underlying the relationship between therapist perfectionism, therapist emotional distress, and ineffectiveness of therapeutic interventions. Starting with a parallel analysis of a clinical case and supervision over it, we show

that perfectionism may be part of an overall organization of the meaning of the experience that the therapist brings into the relationship, which we call Prototypical Adaptive Modality of Existence (PAME). We show how the therapist's PAME, and the perfectionism that constitutes its instantiation in the therapeutic relationship, functions as an automatic process that hinders intersubjective attunement with the patient and guides the therapist in an autarkic way toward a line of intervention that is ineffective and likely to generate ruptures in the therapeutic relationship; finally, we show how a supervisory process focused on the shared exploration of the therapist's perfectionist PAME, of its developmental genesis, and of its impact on the supervisory relationship can modulate the therapist's perfectionism, foster attunement with the patient, functionally modify the line of intervention, and foster a positive outcome.

The process of supervision

Case presentation

A 43-year-old cognitivist-oriented therapist with more than a decade of experience, whom we will call Luise, seeks the help of group supervision for the case of a patient, whom we will call Judy. A few years before meeting Luise, Judy – thirty-two years old and a secretary – had made her only attempt to get help. She was experiencing a period of severe depression. She had met for a while with a psychiatrist who prescribed a high-dose antidepressant. Judy had derived partial and momentary benefit from it, and after a couple of months she had arbitrarily stopped the treatment and never saw him again; but the symptomatology had recurred after about a month. Judy sought help from Luise not only for her depression, but also because she was prey to intense states of anxiety punctuated by brooding over the possibility that colleagues and superiors would notice her incompetence; these states alternated with moments of shutdown and abulia, which at their peak marked her entry into a state of depersonalization in which she felt "out of herself". Judy lives with a partner who emerges from her stories as tyrannical, critical, controlling. This seems to echo the style of familiar male figures – father and brother – always aggressive,

humiliating and invalidating. For example, when Judy was a teenager, it had happened that her brother would ask her with a "devilish" facial expression the question "Are you sure you are my sister...are you sure you are really mommy and daddy's daughter, too?"; or "Have you looked at yourself! Look at what a big ass you have, what a crooked nose, you are so ugly, you suck, you shouldn't even exist". Judy describes her mother as passive, insubstantial; her father as very much like her brother. When, for example, Judy had reacted to her brother's verbal assaults by running to her parents in tears, her mother's response had been a sigh and a glazed expression; her father's: "That sucks! You're always complaining". When she was eight years old and struggling to sleep alone, her father would become furious and threaten her physically or humiliate her by saying phrases like, "You never grow up, look at your brother, who was already sleeping alone at your age". Thus, Judy had learned to pretend to sleep.

The supervision

The difficulty that Luise expressed to the supervisor and the group is that she felt that the therapy, which she had started about six months before, had stalled. During her case report, Luise's eyes glided feverishly over her notes. She looked as someone who has painstakingly prepared the case. The supervisor was very impressed by the manualistic accuracy and *impeccability* of her account. Moreover, throughout the account, the supervisor had felt somewhat *rejected*; that is, he had perceived Luise to be somewhat cold, distant, and out of tune with the sincere attitude of the supervisor and the group to provide her with help. In this affective context, the supervisor's mind was reminded of some scenes related to when he used to present clinical cases during professional training classes. He recalled his tendency to tell a lot of factual details about the case and to use very technical and theory-rich language as a strategy to control his fear of being judged negatively by the supervisor and the group, and of being "exposed" as an inadequate therapist.

Monitoring this internal experience led the supervisor to hypothesize that Luise was entering the supervisory relationship with a fear of judgment and performance anxiety similar to those felt by the

supervisor in the experiences he had recalled. At the same time, the supervisor understood that – similar to what happened to him when he was in Luise's shoes – the fear of receiving a negative judgment about one's value as a therapist was associated with a representation of the other as an "enemy", which prevented him from tuning in to the benevolent intention of the other. The supervisor let himself be guided by these elements of his internal experience, focusing first on exploring the *hic et nunc* declination of the supervisory relationship. What follows is a fragment of the video recording of the supervision bearing this phase of the exploration:

Supervisor: well Luise, thank you. All very clear. If you allow, I would like to gather first of all a round of impressions...I would like to ask one thing to the colleagues in the group; try to tell me for a moment, who wants to, what did you feel while Luise was narrating this case? Without making analytical digressions about the patient, though. What did you feel as you listened to the case narrative?

Therapist 1: May I have my say? I couldn't get into the situation, in the sense that it's as if I was a bit detached from the story....

Therapist 2: I was there at the beginning, then after that I got lost; I started brooding, picking up the phone, a part of me was following Luise however emotionally I felt distant.

Therapist 3: I kind of like (therapist 2), I was in and out however I get a confusion...So much stuff, so many things, so many dramatic events...I felt a bit inundated by all these situations.

Therapist 4: I, on the other hand, felt quite detached at first, I was even getting a little distracted. Then when she told the part more about her father's aggression it acted as a trigger for some things from my childhood...my own scenes came to mind and I kind of went with it.

Therapist 5: I…an alternation of also very different emotional states, that is, from distancing at the beginning, I would get distracted and I couldn't follow, to moments also of fear, fear, others of humiliation and anger also very strong and then I would come back, maybe, again distracted. It was very strange, that's it.

Supervisor: there recurs this element of detachment...a...not feeling involved, which can also manifest itself in the tendency to get distracted. Some of you then came out of this state of non-involvement because you were captured by the dimension of aggressiveness, which awakened personal content...and that kept the focus more alive. But it seems to me there was this common note of the difficulty in engaging in the narrative....

(*colleagues nod*)

S.: I felt the same sense of distance from Luise. Shall we try to work on that? The way of telling the case is a way of relating to the other. With myself and the group. The first thing we have to ask ourselves, Luise, is: what were you feeling while you were presenting the case? What is going on inside Luise that generates this way of telling, which in turn contributes to distancing the listener?"

Luise: (reflects) I can't say...I was very focused on telling everything (pause)...I had prepared the case well...

S.: as I listened, I was reminded of the scenes when I used to present clinical cases during training. I remember that I tended to intellectualize a lot. It was like taking an exam. But really it was a kind of strategy against the fear of not knowing quite what to do, and especially that supervisor and colleagues would notice.

(*all smiling or nodding*)

L.: (smiles): it can fit...it's my "hyper precise mode" mode, while in fact I too...don't feel confident.

S.: in fact, I had it too, this underlying fear of that all the right things to do were somewhere else, always out of my reach, and that everyone would notice...

L.: ...and in the meantime we miss the patient.

S.: exactly! The distance...which is then the same distance we put between us and those who listen to us talk about the patient. Caught up in the performance of the session, we don't really connect with the patient. Similarly, even when we talk about the patient, caught up in the performance of the exposition and the sense of being evaluated, we don't really have the patient in mind. We describe the clinical case, not the patient or our relationship with him. We hardly present the patient with slides.

V.: (laughter, Luise smiles relieved) that's right!

(*other group members also smile, comment with joking phrases and reassure Luise. A colleague shares an experience similar to Luise's in interacting with one of her patients*).

In this tranche of the session of supervision we observe how the supervisor and the group promote the therapist's to have insight about her perfectionist part of herself (the "hyper precise mode") and how this part is guiding the therapist in the supervision relationship. This insight results in a change in the quality of the supervisory relationship and the affective atmosphere in the group. There emerges a part of Luise capable of observing her own perfectionism from a critical

position and jokingly tuning in to the supervisor and the group itself. In the following exploration we will see how the supervisor – on the basis of this relational shift – investigates the impact of her perfectionism on the therapeutic relationship.

S.: Can you think of a time with the patient when there was your "hyper precise mode", which was committed to not making mistakes with the patient?

V.: (pause) I'm reminded of the last session...the patient is telling me about these parents who, in addition to never standing up for her, criticized her harshly. For example, they would go out for the weekend and she would go out of her way to make sure they found the house in order. She tells me this episode in which her father just entered the house and looked around and said to her angrily 'what is that CD doing there?' That is, the patient makes me understand that he found the one object out of place and used it to scold her. I ask her, "What did she say to him". She says, "I tried to tell him, 'Dad but look around the house is all tidy, all clean,' and the father is like, 'No, if this CD is out of place....'" At that point I didn't know how to continue; the only thing I could think of was to comment on how fussy the father was, and she said, "Yes, absolutely!" but I didn't feel like we were doing anything really helpful....

S.: clear...it occurs to me that your "hyper precise mode" which just now was guiding your way of being in supervision and exposing the case, somewhat resembles a "hyper precise mode" that the father, perhaps the environment in which the patient lives, asks the patient to embody. What do you think about that? What comes to mind as you are with the patient in that scene where she is in a sense forced to be so "precise" and still fails to meet that expectation?

V.: (long pause) now I realize that I am practically activated by things that are the same as what the patient experiences....

S.: what scene, for example, came to your mind? Or that has come to you now, that you feel in common with the patient?

V.: this thing about the house being in order...

S.: do you feel like telling me about it?

V.: ...yes...This episode brings me back to the different situations I experienced not only in my adolescence but also when I was younger. I always thought of myself that I grew up before my time, in the sense that when I was six, seven, eight years old, I already felt that I had to do services in the house, that I had to help my mother, that I had to do something to be considered and loved. This is something that is also activated for me on other episodes of the patient; when she also tells me episodes where she was doing

things like this the mother was calmer, with a more serene face, a face that was sending back to her, "How good you are, how good a daughter you are", and therefore feeling connected to her. This is what happened and happened in my childhood and still happens now in regard to my mother. Because my mother has always been...when I was doing things that maybe she wanted me to do, like helping her around the house because she worked all day, then I was an only child, total indifference with my sister, so for quite a long time I was alone, so if I did things around the house, if I made her find everything in order, if I acted like a daughter who helps, who obeys above all, she had a different facial expression than when I for example 'these things I didn't feel like doing them simply, they weren't things that... she wasn't saying big things, it was the expression, she wasn't scolding me, it was an expression like...of someone who is pouting, she was showing disappointment...So there was this mode... "Only that I do something I am seen, only if I do something I am worthy of attention, of love" and that's the anxiety that the patient constantly feels through even intrusive thoughts, right? She is constantly trying in a desperate attempt to be effective, to be good, to do things well (*she look down*).

S.: ...What are you feeling?

V.: ...emptiness (pause).

S.: where?

V.: here (she points to her chest)

S.: pain...

V.: yes...I'm surprised because I'm working on it in therapy too, but I hadn't seen how it presented itself with the patient...Now that I think about it, while it was happening to me, I didn't feel it...I was detached. I only catch it now (she smiles sadly). I didn't feel anything there. I was just focused on what I had to do...I was thinking about following the procedure....

S.: you were somewhat cerebral about the patient's functioning, but not with her

V.: I was thinking about what I had to say, how to put the pieces together....

S.: maybe it was again on the scene Luise who has to be "the good, precise little girl" with her parents; and that was also happening here with us. That good little girl who puts everything in order, she can't allow suffering to show since she has to constantly mask it, and she has to be approved.

V.: maybe a little bit yes....

(*pause*)

S.: Luise, how do you feel?

V.: better...welcomed, understood....

S.: imagine you are now in front of the patient? She is telling you about

her mother, her brother, how she is traumatized What do you wish to tell her, what do you tell her?

V.: (*she nods*) ...that I know what it's like to grow up with the idea of having to struggle with love.

The supervision seems to succeed in promoting the therapist's dominance of the therapist's perfectionist part in both the supervisory and therapeutic relationship. In both cases, this awareness makes it possible to modulate perfectionism and results in a change in the quality and affective register of the relationship. In the supervisory relationship-with the supervisor and with the group-this shift consists metaphorically in the expression of a part of the therapist's self that is eager to share its insecurities and vulnerabilities; the latter is thus able to experience acceptance in an emotionally warm and playful relational climate. At the same time, the therapist's representation of the therapeutic relationship also changes: the part of the therapist's that is able to intersubjectively attune with the supervisor and the group is able to experience the same attunement to the patient's internal painful experience.

In the next section I will develop the main theoretical and clinical implications of the material presented.

Discussion

In this section we will articulate the theoretical and clinical implications according to the following aspects:

1. perfectionism as part of a prototypical mode of existence;
2. the impact of the therapist perfectionism on therapeutic intervention;
3. the supervisory relationship as a preferred tool of intervention on the therapist's perfectionism.

Perfectionism as part of a prototypical mode of existence. The literature analyzes perfectionism as a trait in its own right, characteristically ubiquitous in personality disorders, which can also be found in the therapist, although therapists' perfectionism has been little studied (see introduction). The case we have analyzed allows us to speculate

that in a more complex view perfectionism may be part of an overall organization of the meaning of the experience. We call this organization *Prototypical Adaptive Modality of Existence (PAME)*. We define PAME in the following way: *a prevailing mode of relating to self and the world, necessitated by traumatic adaptation to the developmental relational environment, and resulting in a) a oversimplification of the implicit affective processes of attributing meaning to experience and b) a dissociation of large portions of the self.* For example, perfectionism; workaholism; Machiavellianism aimed at the pursuit of grandiose goals; active pursuit of admiration through performative effort; enforced self-sufficiency; avoidance of intimacy; distrust in interpersonal situations in which there is no certainty of receiving appreciation; and a tendency toward compulsive seduction as a means of confirming one's special worth may converge in a patient. Perfectionism and these other aspects of functioning can be subsumed by a single PAME: (a) based on a totalizing way of relating to oneself and to the world whose organizing principle is that in order to maintain a bond with the relational environment (and feel lovable) it is necessary to be superior to others in terms of performative value; (b) necessitated by traumatic adaptation to a narcissistically structured developmental relational environment that has exalted and desired-because rewarding-the subject's special qualities and manifestations of superiority; (c) resulting in a oversimplification of the implicit affective processes of attribution of meaning to experience, with prevalence of affects – positive and negative – correlated with personal prestige and self-esteem; (d) resulting in the systematic dissociation of portions of the self incompatible with that oversimplification (e. g., parts of the self in need of nurturing, playfulness, cooperation). Another example is that of a patient who may exhibit perfectionism in the service of the compulsive tendency to anticipate and gratify the other's needs; in other words, a tendency to want to appear perfect to the other (especially in the nurturing function exercised toward the other himself or herself), so as to foster a positive self-image that will ensure the bond is maintained; but also forced self-sufficiency coupled with sacrificial availability; systematic inhibition of emotions whose manifestation may threaten meaningful bonds (e.g., irritation, anger); *assertiveness*. Taken together, these aspects may be part of a PAME: (a) based on a prevailing way of relating to oneself and the world whose organizing principle is

that in order to maintain a connection with the relational environment (and feel lovable) it is necessary not to engage the resources of that environment with demands for attention; (b) necessitated by traumatic adaptation to a developmental relational environment that is excessively self-centered, hyper-focused on one's own performative goals and/or frailties and/or conflicts, and demanding of the subject-early adulthood-attention and caretaking and/or not "making too much noise" with one's own needs and subjectivity; (c) resulting in oversimplification of implicit affective processes of attribution of meaning to experience, with prevalence of affects – positive and negative – correlated with ready ability to care for others; (d) resulting in systematic dissociation of portions of the self incompatible with that oversimplification (e. g., parts of the self in need of exploratory autonomy or caretaking).

It emerges from these examples that perfectionism pursues different goals depending on the PAME of which it is a part. It is therefore necessary – in order to understand the function of perfectionism in both patient and therapist – to investigate perfectionism in light of the specific developmental trajectory that made a peculiar PAME necessary. In this perspective, consistently with Wachtel (2023) we hypothesize that PAME is the result of adaptation to a relational environment teaches us what we should be but also what we cannot afford to be. This is due to the inevitable selectivity of the love and attention of caregivers; selectivity to which we are particularly sensitive. The peculiar behaviors or characteristics that are preferred or rejected vary according to the specifics of the evolutionary environment. But selectivity itself, the preference-sometimes conscious but often unconscious-of the environment for certain ways in which the child behaves, feels, experiences the world, is inevitable and universal. As a consequence, in order to adapt, we perform a kind of unconscious self-betrayal: we develop and negotiate versions of ourselves that gratify the relational environment, while pushing into the background important parts of us that tend to be unpleasant to that environment. As a result, the subject will unconsciously shape his or her own PAME, gradually constructing a prevailing self that fits with the relational reality in which he or she lives (Putnam, 1997, 2016). When parents disapprove of parts of the child's personality, those parts are dissociated from personal consciousness; only those experiences that parents or significant

others react to and pay attention to can then become part of the self; ignored experiences, those that significant others do not emphasize, to which they do not respond, are dissociated and become part of the not-me (Bromberg, 2011; Sullivan, 1953), undifferentiated processes inexpressible by the conscious self (Semerari, 2022).

Viewed from this perspective, PAME echoes the concept of the false self (Winnicott, 1960; see also Coltart, 1996), which represents a compliant shield of conformity to environmental expectations, for example in response to a mother unable to attune to the child's needs because of her depressive functioning; the latter's inability to recognize the child is associated with the implicit need for the child to recognize the mother's depressive state and to adapt to it. He will adapt by masking expressions of liveliness because they are incompatible with the mother's devitalization; it is likely that the child will feel forced to reassure the mother by giving up the need to be recognized by her. The current function of the false self should not be overlooked, which is to build protection in the face of an environment that has many times been found to be inadequate to anticipate the child's need, forcing the child to endure a frustrating external reality. The false self is reminiscent of the snail shell. The latter is capable of extracting calcium from soil and food and turning calcium carbonate into calcium carbonate. As with the snail, the false self (the PAME) is constructed from the raw affective material provided by the environment, and naturally acquires the protective function with respect to the environment itself. This function is exercised in parallel toward the developmental environment, and then in later stages of life toward the interpersonal environment; but throughout the life cycle this function is also exercised toward the "internal environment", that is, toward often large portions of the subject's affectivity. It protects the subject from the negative affects connected with the parts of the self that have not been validated and accepted; it also acts as a "shield" toward otherness-that is, it prevents the other from approaching the traumatic core and awakening its negative affective load. According to Donnel Stern (1983, 2015), dissociation defends the patient from the intolerable psychic pain associated with the experience of aspects of the self whose negotiation is procedurally associated with the expectation of rejection by the relational environment; the affective experience of these dissociated parts of the self is "unformulated", not consciously representable,

but present in the potential state and susceptible to being reactivated by relevant interpersonal triggers, including the therapeutic relationship.

There are several points of divergence between the concept of false self and that of PAME. The first is that the conceptual circumference of PAME is wider than that of the false self: the psychopathological dimension of PAME is inscribed in the existential one. In other words, the reality of PAME affects all of us, while the false self is a psychopathological construct that describes peculiar clinical realities. A second difference is that the clinical and existential problem posed by PAMEs is that they are "false". They represent potentially very "real" modes of negotiation with self and the world; fields of experience in which spontaneity, creativity, and expressiveness can take shape. Think of a child's excitement in experiencing and sharing with his parents the satisfaction of a good grade, which he may have received only in his class. What makes these parts of the self a potential factor in suffering is, if anything, their cumbersome predominance in shaping existence, making some registers of meaning hypersalient and excluding others: PAMEs behave like speculators aiming for a monopoly of the psychic economy, taking away affective market space from other dimensions of meaning. The criticality lies in the disproportion between the form of experience they generate and other levels of experience. It is this disproportion that generates a caricature effect that lends a kind of "falseness" to being in the world. What is "false", that is, inauthentic, is an existence lived "as if" there were no other possible forms of attributing meaning to experience, where in fact these exist in a dissociative limbo from which comes a faint echo[1].

[1] In this regard, it should be pointed out that the concept of PAME also echoes Karen Horney's theorizing. According to the author, the developing subject may suffer from "basic distress" derived, from the inability of the relational environment to provide sufficient security, often due to the neuroses of its constituent actors; such distress would consist of the child's feeling of being isolated and powerless in a potentially hostile world (1950). In the face of such distress, the child learns to put in place "solution attempts" (Horney, 1945), which consist essentially of relational tactics. These are three distinct ways of posing in the relationship with the other, that is, going toward, against or away from the other. The mode toward the other is expressed in the form of excessive submissiveness aimed at gaining the perception of being loved; the mode against the other is expressed in the effort to gain power and control over the environment, functional to nurture a perception of superiority; and

PAME also resonates with Wilhelm Reich's (1949) concept of *character armor*. According to the author, such armor represents a mode of being that fulfills the function of a container for anguish, a defensive mode elaborated by the ego to cope with the conflicting impulses of the id and external reality. The armor allows for a detour and absorption of anguish related to the repressed childhood conflict. According to Reich, therefore, the character armor represents a true survival strategy in the everyday (Carotenuto, 1991; Reich, 1949;). Particularly interesting for understanding one aspect of PAME is the Reichian characterization of the somatic declination of character armor. The author postulated that it had a somatic counterpart in the muscular armor, consisting of peculiar patterns of posture, mimic expression, and muscle tension. In this regard, Reich stated that every muscular stiffening contains the history and meaning of its origin (Reich, 1942).

There is an obvious difference about the "origin" of PAME from what Reich postulates regarding the origin of character armor; where PAME has a relational derivation, the armor has an intrapsychic origin; more specifically from a conflict between ego and id. But – in line with the suggestions of the sensory-motor theory Ogden and Fisher (2016), we fully agree to see the armor, like PAME, as a mode of existence (and survival) in the everyday that bears a powerful trace in the body.

The impact of the therapist's perfectionism on therapeutic intervention. The case we analyzed seems to corroborate the theoretical strand that whereby the therapist's personal history shapes, and limits, the therapist's capacity for empathic introspective understanding. According to this line, not only the patient's transferential projections acquire relevance, but also the developmental conflicts and unresolved issues that the therapist brings into the relationship; these can potentially address in a helpful or negative way with respect to the therapeutic

the mode away from the other is expressed in an excessive search for independence functional to establish a condition of unassailability by the environment. According to Horney, these tendencies – more precisely, a harmonious mixture among the three – are almost inevitable for each of us; as is a certain share of basic anxiety. What determines psychopathology would be the imbalance between these different ways of relating.

process (Aron, 1995; Atwood & Stolorow, 1984; Cornell, 2019; Epstein & Feiner, 1988; Gabbard, 2001; Gelso & Hayes, 2002; Orange *et al.*, 1997; Stolorow *et al.*, 1987, 1992). A recent meta-analysis by Cruciani, Liotti and Lingiardi (2024) suggests that underlying the very choice of the psychotherapeutic profession are painful experiences in developmental history and modes of existence developed to operate a control over those experiences, consistent with the function of PAME described above. The therapist brings into the relationship, with her PAME, which may include a peculiar form of perfectionism.

To fully understand the impact of the therapist's perfectionist PAME on therapeutic intervention, we need to analyze more comprehensively how PAME creates the conditions for the generation of psychological suffering. Schematically, there are two mechanisms, and they are coexistent. The first is what we call *subtraction of potential dimensions of meaning of experience*. PAME generates on the field of interpretation of the meaning of experience an effect similar to that generated by negative scotomas on the visual field. Negative scotomas are dark spots that reduce or reset perceptual efficiency to zero, sectorially blinding certain portions of the visual field. Negative scotomas thus prevent certain aspects of reality from being seen, resulting in a loss of information.

Similarly, PAME allows only certain aspects of the meaning of events to be discerned, because it emphasizes – pertinentizes (for a comprehensive discussion of the concept of pertinentization see Salvatore, Palmieri, De Luca Picione *et al.*, 2024) – certain affective dimensions of those events, reducing others to the background. In fact, therefore, PAME leaks information in the sense that it prevents aspects of meaning other than those encoded by PAME itself from being captured. The uniqueness of the trajectory of interpretation of experience severely limits the possibility of experiencing the multiple nuances of the relationship with the world and with self. In the case described above, the therapist's PAME oriented by the need to avoid negative judgment from the patient, supervisor and group; for such judgment would mean witnessing the collapse of the self-image as impeccable nurtured by the assumed role in the family scenario. In a case such as this, PAME prevents access to other forms of subjectivity and relationality with the patient, such as with the supervisor and with the group (probably some or all of the extra-professional relationships as

well). For example, the therapist could not express her own sense of inadequacy and generally her vulnerability in her relationship with the group, and she could not attune to the patient's vulnerability.

The second mechanism through which PAME produces psychological suffering in the therapeutic relationship can be named *the problem of dichotomization of experience*. PAMEs stand as oppositely organized closed meaning structures (Kleinbub, Testolin, Palmieri *et al.*, 2021; Salvatore, S. *et al.*, 2024; Salvatore, G., 2024); that is, structures that regulate the interpretation of the meaning of experience and environmental inputs by moving linearly between the two opposite verses of a single vector. A useful metaphorical image for understanding this is the electric dipole. In physics, the electric dipole is a system consisting of two electric charges of equal intensity but opposite sign, generating a vector (the "electric dipole moment"), the direction of which coincides with the line joining the charges themselves, with direction (orientation) from negative to positive charge. The "+" sign – the positive charge of the PAME – coincides with its success, and with positive affect; the "-" sign – the negative charge – coincides with failure or the threat of failure, and with negative affect. For example, the therapist's PAME centered on the need to pander to the performative expectations of the environment is representable as a dipole of meaning that acts as a filter in the processes of interpreting experience; these processes will thus be strained between two polarities; the subject's affective experience may be directed exclusively toward the positive pole of the positive judgment obtained, a source of pleasure; or toward the negative pole of severe criticism, a source of displeasure. For PAME, reality is dichotomized. The moment-to-moment activated meanings can only coincide with one of two versions of a bivalent sense premise (e.g., from relationships and events the system can only draw that one is the one who humiliates or the one who is humiliated; or the one who judges or the one who is judged). PAME creates suffering because it is a way of experiencing self and the world that is rigidly dichotomous and that always allows only the same shades of meaning to be generated in external and internal events, as its structuring has saturated and continues to saturate mental space, preventing the development of the ability to grasp the (often) multiple shades of meaning of an event. PAME is also static in the sense that it cannot be turned off when needed, when the context demands it. A person with

a PAME characterized by the need for special appreciation experiences a romantic *liaison*, a game of table football with friends, a work deadline, always as a test of self-esteem. PAME cannot be deactivated – almost completely – in the first two cases, to make room, respectively, for the exploration of affinities with the other and the pleasure of play, because these "tracks" of experience are not viable; one could say they are not usable for lack of testing. PAME is activated in the first two scenarios with the same intensity as in the third.

The supervisory relationship as a preferred tool of intervention on therapist's perfectionism. In the case analyzed in this paper we observe how the therapist is guided by her perfectionist PAME as much in her relationship with her patient as in the supervisory relationship. We also observed how the supervisor foregrounds in his intervention the implicit information emerging from the supervisory relationship; this information is complex in nature, which for we can reductively classify as of two types: reactive-countertransferential (the supervisor feels rejected by the therapist's perfectionist PAME, which inhibits intersubjective connection by shifting the register of the relationship to a performance dimension); and identificatory-intersubjective (the supervisor evokes images in which a perfectionist, error-fearing part of him or her guided him or her in an interpersonal learning context). In this scenario, the supervisor foregrounds work on the supervisory relationship, and uses the elements of internal resonance as an essential trace for his or her own line of intervention. This direction is based on the assumption that if the therapist's perfectionist PAME colonizes that relationship, any attempt by the supervisor to provide help on the technical level or reading of the therapeutic relationship will be filtered through this same PAME. In other words, in the presence of a PAME that hypersimplifies and dichotomizes the meaning of the supervisor's interventions (and of the group's interventions) only in the terms of |positive judgment| / |negative judgment| about the quality of performance, the therapist's ability to make use of the support of supervision is greatly reduced. The supervision event will only be able to be affectively experienced in the terms of qualifying the performative value of performance. We argue that the supervisor, by focusing on the relationship, can promote the therapist's insight into his or her own perfectionist PAME; which allows for its intersubjective

modulation. PAME is recognized by therapist, supervisor, and group in its adaptive value; and a differentiation is fostered in the therapist between the internalized relational scenario that characterized ontogeny and the current experiential field: supervisor and group do not constitute a reissue of the therapist's mother, who in order to regulate her own relationship with reality and with the therapist privileges the totalizing dichotomous dimension |positive judgment| / |native judgment|, later internalized by the therapist herself. Supervisor and group will constitute for the therapist an intersubjective environment regulated by different affective dimensions, centered on the acceptance of vulnerability and cooperation that makes error a shared opportunity for understanding deeper levels of meaning.

In the remainder of this section, we will very briefly describe the theoretical framework on which the line of intervention just described is based, which emphasizes the relevance of the supervisory relationship.

In early reflections on the supervisory relationship, it was considered in terms of countertransferential dynamics. In this context, Ekstein and Wallerstein (1958) observed parallels between the active processes between clinician and patient, on the one hand, and those between supervisor and clinician, on the other. They noted how supervisors tended to perceive and react in ways that reflected the same emotions, predispositions and attitudes, which supervising therapists manifested toward the patient they were talking about during supervision. The authors called this phenomenon *parallel process*, according to which a therapist's countertransference toward a patient unconsciously recalls a similar experience in the supervisor, triggered by the therapist. The study of the supervisory relationship has deepened to include, in addition to the elements of the supervisor's countertransference, two other elements: the learning-supervisory alliance and the real relationship. The former, initially studied by Fleming and Benedek (1964, 1966) is a cooperative working relationship composed – similar to the context of the therapeutic alliance (Bordin, 1983) – of human bond, shared awareness of the shared goal of supervisee development, and the shared tasks that stimulate pursuit of goal attainment (Beinart, 2014; Fleming & Benedek, 1964). The concept of real relationship has also been shaped from reflections on the "real" aspects of the therapeutic relationship (Gelso, 2011, 2014; Wampold, 2010,

2015) and describes the more personal and authentic aspects of the relationship between supervisee and supervisor-which may manifest, for example, in mutual politeness, shared interests and preferences, and phases of "frivolous" dialogue-which are considered as distinct from countertransferential distortions and the cooperative-performative dimension of the alliance. Watkins' (2015) supervision pyramid model places these aspects in a broader conceptual-operational framework. It is inspired by Fife and collegues'(2014) conceptualization of the therapeutic pyramid. According to these authors, the effectiveness of therapeutic intervention is decided by a foundational common factor, the base of the pyramid: the therapist's way of being; on this factor rests the intermediate element of the pyramid, which is the therapist-client alliance, on which in turn rests the effective use of skills and techniques. Similarly, at the top of the supervision pyramid is the clinical outcome of supervision, that is, the general and symptomatic improvement of the patient; this is on the basis that supervision is a triadic supervisor-supervisee-patient experience. This element rests on the *supervisor's continuous learning*, determined by the unfolding of the specific technical aspects of the supervisor's intervention. But the more distal elements of the pyramid can unfold in a positive sense only if they rest on the quality of the *supervisory relationship* (which includes bonding, real relationship and countertransferential processes); which in turn rests on the base: the *supervisor person and personhood*; that is, the supervisor's way of being and presence. The first aspect refers to an openness-oriented, nonjudgmental and respectful attitude. The second describes a total involvement and ability to attune to the supervising therapist. In this perspective that places the personal qualities of the supervisor at the center, Mc Williams (2021) also emphasizes the relevance to the effectiveness of supervision of personal qualities of the supervisor such as honesty, openness in the relationship, and empathic understanding. The author resorts to interventions consistent with the supervisor person and personhood relevance of the supervision pyramid; for example, calming down; normalization of the possibility of making mistakes; self-revelation about one's mistakes and critical aspects of one's learning journey, as well as experiences and reflections that have fostered progress over time in the same problematic issues that engage the supervisee; frequently asking for feedback on how the supervision is progressing from the supervisee's

perspective, showing sensitivity about the possibility that it may be difficult at times for the supervisee to make problems explicit spontaneously. These exemplifications suggest not only how well-being, affective needs, and professional growth of the supervisee are placed at the center. They denote an essentially experiential conception of supervisee learning (Borders, 2014; Fernández-Alvarez, 2016). Consistent with these assumptions, we believe that net of the relevance nonetheless accorded to the didactic and technical dimensions of supervision, which are expressed for example in the promotion of the fostering of a model of intervention and advice on case management, the supervisee goes through an implicit learning process based on modeling: the supervisee makes his or her vulnerability explicit and models the supervisee with respect to the possibility of dialoguing with his or her own vulnerability nuclei and coming to terms with the dimension of error so that it is finally experienced not as failure but as part of the process of personal and existential growth. In the background of this approach there seems to be a tension toward reciprocity that modulates the hierarchical dimension of the supervisory relationship. Supervision not only provides technical skills but also helps supervisees become more aware of their own internal dynamics and how to apply them effectively in therapeutic practice.

The literature seems to agree in emphasizing the appropriateness of integrating the following aspects into the supervision process: a) emphasis on reciprocity in the supervision relationship, b) promotion of therapist insight, c) implementation of the therapist's technical skills.

Our perspective proposes a way that we believe is generalizable to integrate these aspects into supervision focused on the therapist's perfectionism. Schematically, we can describe our approach as divided into three phases: in the first the supervisor (and eventually the group) promotes the therapist's insight about how perfectionism is guiding the therapist in the supervision relationship.

At this stage, for example, the supervisor might notice (and tactfully point out to the therapist) that the therapist's expressive behavior, his or her way of presenting the case, and the supervisor's feelings are indicators of the "examination," "evaluation" atmosphere that has been created. This can determine a change in the quality of the supervisory relationship and allows the expression of a part of the therapist's self that is eager to share its insecurities and vulnerabilities. On

this basis, the supervisory process can investigate the impact of therapist's perfectionism on the therapeutic relationship. For example, the supervisor might explore in detail an episode of interaction between the part of self that the therapist now recognizes as perfectionist and the patient. In the new atmosphere of the supervision relationship the therapist is able to observe his own perfectionist part in action and to experience acceptance of the patient and to promote an emotionally warm and playful relational climate. The part of the therapist's that is able to intersubjectively attune with the supervisor and the group is able to experience the same attunement to the patient's internal painful experience. The third phase of the supervisory process focus the more technical aspect of the therapeutic intervention (e.g., how to repair a rupture in the therapeutic relationship, how to make a psico-educational or interpretative intervention) and case-management.

Conclusions and future considerations

In this paper, we started from the observation that clinical perfectionism seems a common phenomenon among psychotherapists and psychological practitioners; and that (the very few) studies about this topic suggest that it is negatively correlated with therapy effectiveness, and positively correlated with therapist emotional distress. We present a hypothesis about the mechanism underlaying these correlations. Starting with a parallel analysis of a clinical case and supervision over it, we show that perfectionism may be part of a PAME, which we define as a prevailing mode of relating to self and the world, necessitated by traumatic adaptation to the developmental relational environment, and resulting in an oversimplification of the implicit affective processes of attributing meaning to experience and dissociation of large portions of the self. On this basis, we show how – either in patients or in therapists – perfectionism pursues different goals depending on the PAME of which it is a part; how the therapist's perfectionist PAME functions as an automatic process that hinders intersubjective attunement with the patient; how a supervisory process focused on the shared exploration of the therapist's perfectionist PAME, of its developmental genesis, and of its impact on the supervisory relationship (conceived in a non-hierarchical but

affectively validating way) can modulate the therapist's perfectionism, foster attunement with the patient, functionally modify the line of intervention, and foster a positive outcome.

This paper adopts a radically intersubjective perspective on the clinical encounter, under which patient and therapist – in equal measure – bring a relevant contribution to the events of the therapeutic relationship. Though our reflection is only a beginning, we suggest that this kind of supervisory process may be applicable to integrative, humanistic and psychodynamic psychotherapies. Beyond the fascination that this case-study may generate about the form of supervision proposed, several important limitations remain. For example, there are other complex issues involved in this form of supervision which would require more time to explore. Such as how supervision can help therapists respond to more extreme events such as breaks in therapy or patients' emotional dysregulation. Nevertheless, theorizing offers opportunities for empirical research. A possible research direction would involve studying the correlation between therapists' level of perfectionism (measured by validated rating scales) and therapists' responses (analyzed by independent judges) about how they cope with difficult moments in the therapeutic relationship (simulated in short video clips). A further development of this line would be to test – in a group of therapists from different theoretical backgrounds but sharing perfectionism – the existence of a correlation between evolution of quality of coping with moments of relationship rupture and quality of the supervisory relationships in a series of supervision sessions.

References

Alloy, L. B., Abramson, L. Y., Walshaw, P. D., Gerstein, R. K., Keyser, J. D., Whitehouse, W. G., Urosevic, S., Nusslock, R., Hogan, M. E., & Harmon-Jones, E. (2009). Behavioral approach system (BAS)–relevant cognitive styles and bipolar spectrum disorders: Concurrent and prospective associations. *Journal of Abnormal Psychology*, *118*(3), 459–471. DOI: 10.1037/a0016604

Aron, A., Paris, M., & Aron, E. N. (1995). Falling in love: Prospective studies of self-concept change. *Journal of Personality and Social Psychology, 69*(6), 1102-1112. DOI: 10.1037/0022-3514.69.6.1102

Atwood, G. E., & Stolorow, R. D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology*. Analytic Press.

Ayearst, L. E., Flett, G. L., & Hewitt, P. L. (2012). Where is multidimensional perfectionism in DSM-5? A question posed to the DSM-5 personality and personality disorders work group. *Personality Disorders Theory Research and Treatment*, *3*(4), 458–469. DOI: 10.1037/a0026354

Beinart, H. (2014). Building and sustaining the supervisory relationship. In C. E. Watkins, Jr. & D. L. Milne (Eds.), *The Wiley international handbook of clinical supervision* (pp. 257-281). Wiley Blackwell.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical investigation. *American Journal of Psychiatry*, *162*(5), 890-898. DOI: 10.1176/appi.ajp.162.5.890

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

Borders, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, *68*(2), 151-162.

Bordin, E. S. (1983). A working alliance based model of supervision. *The counseling psychologist*, *11*(1), 35-42.

Bromberg, P. M. (2011). *The shadow of the tsunami: And the growth of the relational mind*. Routledge.

Carotenuto, A. (1991). *Trattato di psicologia della personalità e delle differenze individuali*. Raffaello Cortina.

Coltart, N. (1996). The baby and the bathwater: Psychotherapy, care and control. *International Journal of Psychoanalysis, 77*(6), 1113-1126. DOI: 10.4324/9780429481161

Cornell, W. F. (2019). *Into TA: A comprehensive textbook on transactional analysis*. Routledge.

Cruciani, G., Liotti, M., & Lingiardi, V., (2024). Motivations to become psychotherapists: beyond the concept of the wounded healer. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *27*(2), 808. DOI: 10.4081/ripppo.2024.808

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*(1), 17–28. DOI: 10.1375/bech.28.1.17

Dimaggio, G., Lysaker, P. H., Calarco, T., Pedone, R., Marsigli, N., Riccardi, I., Sabatelli, B., Carcione, A., & Paviglianiti, A. (2015). Perfectionism and personality disorders as predictors of symptoms and interpersonal

problems. *American Journal of Psychotherapy*, *69*(3), 317–330. DOI: 10.1176/appi.psychotherapy.2015.69.3.317
Dimaggio, G., MacBeth, A., Popolo, R., Salvatore, G., Perrini, F., Raouna, A., Osam, C. S., Buonocore, L., Bandiera, A., & Montano, A. (2018). The problem of overcontrol: Perfectionism, emotional inhibition, and personality disorders. *Comprehensive Psychiatry*, *83*, 71–78. DOI: 10.1016/j.comppsych.2018.03.005
Dimaggio, G., Salvatore, G., MacBeth, A., Ottavi, P., Buonocore, L., & Popolo, R. (2016). Metacognitive Interpersonal Therapy for Personality Disorders: A Case Study series. *Journal of Contemporary Psychotherapy*, *47*(1), 11–21. DOI: 10.1007/s10879-016-9342-7
D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*(1), 17 28. DOI: 10.1375/bech.28.1.17
Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. *Clinical Psychology Review*, *31*(2), 203-212. DOI: 10.1016/j.cpr.2010.04.009
Ekstein, R., & Wallerstein, R. S. (1958). *The teaching and learning of psychotherapy.* Basic Books.
Epstein, L., & Feiner, A. H. (1988). Countertransference: The therapist's contribution to treatment. *Contemporary Psychoanalysis, 24*(4), 489-513. DOI: 10.1080/00107530.1988.10746272
Fernández-Alvarez, H. (2016). Reflections on supervision in psychotherapy. *Psychotherapy research*, *26*(1), 1-10.
Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. (2014). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy*, *40*(1), 20-33.
Fleming, J., & Benedek, T. (1964). Supervision. A method of teaching psychoanalysis: preliminary report. *The Psychoanalytic Quarterly*, *33*(1), 71-96.
Fleming, J., & Benedek, T.F. (1966). *Psychoanalytic supervision*. Grune & Stratton.
Flett, G. L., & Hewitt, P. L. (2002). Perfectionism and maladjustment: An overview of theoretical, definitional, and treatment issues. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 5–31). American Psychological Association eBooks.
Flett, G. L., Hewitt, P. L., & Heisel, M. J. (2014). The destructiveness of perfectionism revisited: Implications for the assessment of suicide risk and the prevention of suicide. *Review of General Psychology*, *18*(3), 156–172. DOI: 10.1037/gpr0000011
Flett, G. L., Nepon, T., Goldberg, J. O., Rose, A. L., Atkey, S. K., & Zaki-Azat, J. (2022). The Anti-Mattering Scale: development, psychometric

properties and associations with Well-Being and Distress measures in adolescents and emerging adults. *Journal of Psychoeducational Assessment*, *40*(1), 37–59. DOI: 10.1177/07342829211050544

Frost, R. O., & DiBartolo, P. M. (2002). Perfectionism, anxiety, and obsessive-compulsive disorder. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 341–371). American Psychological Association.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive therapy and research*, *14*, 449-468. DOI: 10.1007/bf01172967

Frost, R. O., & Di Bartolo, P. M. (2002). Perfectionism, anxiety, and obsessive-compulsive disorder. In G. L. Flett & P. L. Hewitt (Eds.). *Perfectionism: Theory, research and treatment* (pp. 341-272). American Psychological Association.

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 57*(8), 983-991. DOI: 10.1002/jclp.1065

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy research*, *24*(2), 117-131.

Gelso, C. J. (2011). *The real relationship in psychotherapy.* The hidden foundation of change. American Psychological Association.

Gelso, C. J., & Hayes, J. A. (2002). The management of countertransference. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 267-283). Oxford University Press.

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy*, *55*(4), 496–507. DOI: 10.1037/pst0000189

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: conceptualization, assessment, and association with psychopathology. *Journal of personality and social psychology*, *60*(3), 456. DOI: 10.1037/0022-3514.60.3.456

Hewitt, P. L., & Flett, G. L. (1993). Dimensions of perfectionism, daily stress, and depression: A test of the specific vulnerability hypothesis. *Journal of Abnormal Psychology*, *102*(1), 58–65. DOI: 10.1037/0021-843x.102.1.58

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

Hewitt, P. L., Flett, G. L., & Turnbull-Donovan, W. (1992). Perfectionism and suicide potential. *British Journal of Clinical Psychology*, *31*(2), 181–190. DOI: 10.1111/j.2044-8260.1992.tb00982.x

Hewitt, P. L., Flett, G. L., Sherry, S. B., & Caelian, C. (2006). Trait perfectionism dimensions and suicidal behavior. *Cognition and suicide: Theory, research, and therapy* (pp. 215–235). American Psychological Association eBooks.

Holden, C. L., & Jeanfreau, M. M. (2021). Are Perfectionistic Standards Associated with Burnout? Multidimensional Perfectionism and Compassion Experiences Among Professional MFTs. *Contemporary Family Therapy*, *45*(2), 207–217. DOI: 10.1007/s10591-021-09605-6

Horney, K. (1945). *Our inner conflicts*. Norton.

Horney, K. (1950). *Neurosis and human growth*. Norton.

Huprich, S. K., Porcerelli, J., Keaschuk, R., Binienda, J., & Engle, B. (2008). Depressive personality disorder, dysthymia, and their relationship to perfectionism. *Depression and Anxiety*, *25*(3), 207–217. DOI: 10.1002/da.20290

Kleinbub, J. R., Testolin, A., Palmieri, A., & Salvatore, S. (2021). The phase space of meaning model of psychopathology: A computer simulation modelling study. *PLoS ONE, 16*(4), Article e0249320. DOI: 10.1371/journal.pone.0249320

Landt, M. C. S., Claes, L., & Van Furth, E. F. (2016). Classifying eating disorders based on "healthy" and "unhealthy" perfectionism and impulsivity. *International Journal of Eating Disorders*, *49*(7), 673–680. DOI: 10.1002/eat.22557

Lowyck, B., Luyten, P., Vermote, R., Verhaest, Y., & Vansteelandt, K. (2016). Self-critical perfectionism, dependency, and symptomatic distress in patients with personality disorder during hospitalization-based psychodynamic treatment: A parallel process growth modeling approach. *Personality Disorders Theory Research and Treatment*, *8*(3), 268–274. DOI: 10.1037/per0000189

McWilliams, N. (2021). *Psychoanalytic supervision*. The Guilford Press.

McCown, W. G., & Carlson, G. (2004). Narcissism, perfectionism, and self-termination from treatment in outpatient cocaine users. *Journal of rational-emotive and cognitive-behavior therapy*, *22*, 325-336. DOI: 10.1023/b:jore.0000047314.90953.c9

O'Connor, R. C. (2007). The Relations between Perfectionism and Suicidality: A Systematic Review. *Suicide and Life-Threatening Behavior*, *37*(6), 698–714. DOI: 10.1521/suli.2007.37.6.698

Ogden, P. & Fisher, J. (2016). *Sensorimotor psychotherapy: interventions for trauma and attachment.* W.W Norton.

Orange, D. M., Atwood, G. E., & Stolorow, R. D. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice*. Analytic Press.

Pozza, A., Casale, S., & Dèttore, D. (2022). Therapists' emotional reactions

to patients with obsessive–compulsive disorder: the role of therapists' orientation and perfectionism. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *40*(4), 879-904. DOI: 10.1007/s10942-022-00443-5

Presley, V. L., Jones, C. A., & Newton, E. K. (2017). Are Perfectionist Therapists Perfect? The Relationship between Therapist Perfectionism and Client Outcomes in Cognitive Behavioural Therapy. *Behavioural and Cognitive Psychotherapy*, *45*(3), 225-237. DOI: 10.1017/s1352465817000054

Putnam, F. W. (1997). *Dissociation in children and adolescents*. Guilford Press.

Putnam, F. W. (2016). *The way we are: How states of mind influence our identities, personality and potential for change*. IPBooks.

Reich, W. (1942). *The function of the orgasm*. Orgone Institute Press.

Reich, W. (1949). *Character analysis*. Orgone Institute Press.

Riddle, M. A., Maher, B. S., Wang, Y., Grados, M., Bienvenu, O. J., Goes, F. S., Cullen, B., Murphy, D. L., Rauch, S. L., Greenberg, B. D., Knowles, J. A., McCracken, J. T., Pinto, A., Piacentini, J., Pauls, D. L., Rasmussen, S. A., Shugart, Y. Y., Nestadt, G., & Samuels, J. (2016). Obsessive-Compulsive Personality Disorder: Evidence for Two Dimensions. *Depression and Anxiety*, 33(2), 128–135. DOI: 10.1002/da.22452

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, *51*(3), 381–387. DOI: 10.1037/a0036815

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. Jason Aronson.

Salvatore, G. (2024). Stanghellini, G., Rosfort, R., Rossi, R., & Salvatore, S. (2024). An intersubjective conception of complex trauma in the framework of the semiotic function of affectivity. *European Journal of Trauma & Dissociation, 8*, 1-13. DOI: 10.1016/j.ejtd.2024.100462

Salvatore, S., Palmieri, A., De Luca Picione, R., Bochicchio, V., Reho, M., Serio, M.R., Salvatore, G. (2024). The affective grounds of the mind. The Affective C(APER) model. *Physics of Life Reviews.* DOI: 10.1016/j.plrev.2024.07.008

Semerari, A. (2022). *Metacognizione e psicopatologia*. Raffaello Cortina.

Sherry, S. B., Hewitt, P. L., Flett, G. L., Lee-Baggley, D. L., & Hall, P. A. (2007). Trait perfectionism and perfectionistic self-presentation in personality pathology. *Personality and Individual Differences*, *42*(3), 477–490. DOI: 10.1016/j.paid.2006.07.026

Slof-Op't Landt, M. C., Claes, L., & van Furth, E. F. (2016). Classifying eating disorders based on "healthy" and "unhealthy" perfectionism and

impulsivity. *International Journal of Eating Disorders*, *49*(7), 673-680. DOI: 10.1002/eat.22557
Smith, M. M., Sherry, S. B., Ge, S. Y. J., Hewitt, P. L., Flett, G. L., & Baggley, D. L. (2022). Multidimensional perfectionism turns 30: A review of known knowns and known unknowns. *Canadian Psychology/Psychologie Canadienne*, *63*(1), 16–31. DOI: 10.1037/cap0000288
Stern, D. B. (1983). Unformulated experience. *Contemporary Psychoanalysis*, *19*(1), 71–99. DOI: 10.1080/00107530.1983.10746593
Stern, D. B. (2015). *Relational freedom*. Routledge eBooks.
Stolorow, R. D., & Atwood, G. E. (1992). *Contexts of being*. Analytic Press.
Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Analytic Press.
Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. Norton.
Wachtel, P. L. (2023). *Cyclical psychodynamics and the contextual self*. Guilford Press.
Wampold, B. E. (2019). *The basics of psychotherapy: An introduction to theory and practice*. American Psychological Association.
Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. 2nd ed., Erlbaum.
Watkins, Jr. C. E. (2015). Extrapolating Gelso's Tripartite Model of the Psychotherapy Relationship to the Psychotherapy Supervision Relationship: A Potential Common Factors Perspective. *Journal of Psychotherapy Integration, 25*, 143-157. DOI: 10.1037/a003888
Winnicott, D. W. (1960). Ego distortion in terms of true and false self. In D. W. Winnicott, *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 140-152). Hogarth Press.
Wittenberg, K. J., & Norcross, J. C. (2001). Practitioner perfectionism: Relationship to ambiguity tolerance and work satisfaction. *Journal of Clinical Psychology*, *57*(12), 1543–1550. DOI: 10.1002/jclp.1116