Understanding and Treating Perfectionism in Frum Adolescents

Benzion Sorotzkin, Psy.D.
www.DrSorotzkin.com

(July 2005)

This article will examine issues unique to the treatment of *frum* adolescents, with a focus on a problem prevalent in this population, namely perfectionism, which often leads to anxiety, depression and other emotional disorders (Blatt, 1995). Perfectionism is also associated with obsessive-compulsive individuals who seek perfection with regard to self-control and self-restraint, and with narcissistic individuals who need to see themselves as perfect (Miller, 1996). Chronic back pain and other somatic conditions have also been attributed to the stress associated with perfectionistic tendencies (Sarno, 1998).

Perfection vs. Excellence

A perfectionist can be defined as someone who is driven by fear of failure to strive compulsively toward goals beyond reach and reason. This can be contrasted with someone who is motivated by the desire for success to strive for excellence (Hamachek, 1978). One of the characteristics that distinguish the pathological form of perfectionism from the nonpathological striving for excellence is how the person reacts to a less-than-perfect performance. Perfectionists not only derive no satisfaction from a less-than-perfect performance, they even experience a sense of humiliating defeat (Sorotzkin, 1985). In contrast, people who strive for excellence take pride in their effort, and derive a sense of pleasure from their superior performance even if it is less than perfect, because they accept both personal and environmental limitations (Pacht, 1984).

Parental Influence

Disapproving and Critical Parents

Parents of perfectionists tend to be nonapproving or inconsistently approving. Their love is conditional on their child's performance. In general they tend to be overly critical and demanding.[1] In contrast, striving for high standards and excellence is associated with parents who are positive, supportive, and encouraging and who set high standards for themselves (Blatt, 1995; Hamachek, 1978), and not just for their children.

Unrelenting overcriticalness can result in a child with deep-seated feelings of inferiority that he or she feels can only be ameliorated by feelings of grandiosity and perfection (Rothstein, 1991). The narcissistic injuries resulting from the inevitable, less-than-perfect performances and failures of grandiosity further feed the flames of inferiority feelings.

Shame

Pervasive feelings of shame often underlie the need for perfection (Sorotzkin, 1985). Miller (1996), in her insightful book on shame, invokes Broucek's (1991) concept of "objectifying" children, where a child is treated by the parent as an object rather than a subject. Broucek (1991) sees shame as "a response to having one's status as a subject ignored, disregarded, denied, or negated" (p. 8). He gives an example of a small child who "approaches his mother excitedly wanting to tell her about something he has just experienced. Mother looks at him and says with a frown, 'Your shirttail is hanging out'" (p. 47). Miller (1996) suggests that an "objectifying" upbringing could result in an obsessive-compulsive person where "the self is viewed as a collection of functions that are adequately or improperly executed and is viewed without regard for inner life as something to be recognized and valued" (p. 47).

Parents who are not attuned to their children's emotional needs (and certainly if they criticize those needs) will induce a feeling that having emotional needs is, in itself, shameful (Orange, Atwood, & Stolorow, 1997). This often happens in two phases. In the first, the parent hurts the child's feelings in some way. Then when the child reacts with negative emotions, he or she is criticized for the reaction (Stolorow, 1997). This can result in children who focus on their performance at the expense of their feelings (a major feature of perfectionism) and/or create a need for perfect control over feelings. It should be noted that it is the parents' general, overall attitude toward their children's emotional life, coined the "parental metaemotion" by Gottman, Katz, and Hooven (1996) that is the focus of our concern rather than specific parenting styles.

Parents of perfectionists are more likely to stress extrinsic motivations for behavior and the fear of the disapproval of others. They see themselves through the eyes of others rather than measure themselves by the yardstick of their own values and standards. Miller (1996) describes a child from such a family as:

> *"[One who] continually judges himself and others with a critical, outsider's eye, as if he is a thing, not a center of experiences. He seldom suspends such activity and seldom feels alive in the world. Every moment of sensation, analysis, or emotion is heavily overlaid with judgments about performance and appearances." (p. 122)*

This causes the individual's sense of self to be heavily dependent on the reaction of others (over which the person has little control), rather than on the person's own internal standards and values. As a result, there is a deep sense of emotional vulnerability that can induce a need for perfection as a means of avoiding this danger.

The emphasis of form over substance exhibited by parents of perfectionists was recently illustrated by a patient whose relationship with his mother had deteriorated to the point where they had not spoken to each other in weeks. As a result, he did not send her a birthday card. His parents were outraged. When he tried to explain that it did not make sense to send such a card when the relationship was so negative, they could not understand his reasoning. His father kept saying, "But you know how important this is to your mother!" The message the patient got was that his parents were more concerned with the superficial appearances of the relationship than with its true nature.

Seeing Pathology Where There Is None

The perfectionistic need to have total control over feelings and behaviors often reflects viewing them out of context, thereby experiencing them as much more negative and pathological than they really are. This can also reflect early parental influences, for example, where unempatheic parents relate to their developing child's normal assertive competition as if it was a sign of "alarming hostility" (Kohut 1997, p. 235).

This insight has recently been confirmed by a study that found that mothers of aggressive boys were more likely to judge normal reactions of children as "noncompliance," and even more significantly, attribute defiant **intent** for this "non-compliance" (Strassberg, 1997).

Parental Expectations for Perfection

At times, the parental expectation for perfection is directly expressed, either by constant criticism of imperfect performance or by overt verbalizations by the parents that less than perfect is unacceptable. These children quickly learn that only by being perfect can they hope to escape the unbearable feeling of being a disappointment to their parents. There is no such thing as "that was good enough." In contrast, there are other situations when there is no overt rejection, but rather a sense of emotional neglect, perhaps as a result of the parents being wrapped up in their own emotional needs. Children from such homes will often strive for perfection in the hope that they will thus merit the interest and approval of their parents. The need for perfection, in such cases, is often experienced as internally imposed.

A less-common variation was recently illustrated by a perfectionistic, *frum* youngster who recalled that his

father was constantly praising him throughout his childhood, but for some reason it always made him uncomfortable. It was only after exploring these events and feelings in therapy that he understood that his father needed the patient's accomplishments to "feed" his own undernourished sense of self (i.e., the praise reflected the need of the parent rather than the need of the child). The patient's perfectionism was a result of his dread of being responsible for his father's psychic devastation if his son was less than perfect.

Some parents attribute their children's perfectionism to the highly competitive schools they attend. Yet, clearly, not all the students who attend these schools suffer from perfectionism. It seems more likely that highly competitive schools exacerbate perfectionistic tendencies in students from the types of homes described above.

Perfectionism and Adolescence

Research indicates (see Blatt, 1995) that perfectionism is more prevalent among adolescents because of their tendency toward idealism, and a tendency toward dichotomous thinking-black or white, saint or sinner-and that perfectionism is frequently a factor in adolescent suicide attempts. The association between perfectionism and suicide seems to be especially strong in regard to gifted adolescents. There seems to be several reasons for this. Gifted children are in fact superior to their peers in intelligence and often superior in academic achievement and other areas. This makes them more vulnerable to perfectionistic and grandiose fantasies, especially since they are often encouraged in their perfectionism by their parents and teachers. Their superior intelligence also makes it easier for them to cover up their emotional distress, since they do better academically than most of the other students even when they are unable to function at top form. The adults in their lives are often too impressed by their intelligence to pay attention to their emotional life.

The evaporation of the grandiose fantasy is likely to happen during adolescence for a number of reasons. This is often the time when youngsters begin to realize (often subconsciously) that they are living someone else's dream rather than their own life. This makes the effort to maintain their progress and accomplishments, already made difficult by the need for perfection, an unbearable burden rather than a natural process (see Omer, 1997 for an interesting case illustration). This is also the time when youngsters begin to make more of their own decisions. Perfectionistic adolescents have great difficulty with this task. There is the realistic fear that it will not be a perfect decision, since few decisions are. Likewise, many decisions are based, to a significant degree, on feelings, and perfectionistic youngsters are not sufficiently in touch with their feelings and thus are lacking an essential tool for the task of decision making.

The Impact of *Frumkeit*

Frum youngsters are encouraged to be idealistic and the idealized role models whom they are taught to emulate are often presented as having always been perfect in all aspects of their lives, while the struggles and failures that they had to endure before reaching their eventual exalted level of *ruchnius* are not acknowledged.[1] It is not surprising therefore, that, in the author's experience, perfectionism seems to be more prevalent among this segment of the population.

Since *Yiddishkeit* emphasizes performance and behavior over belief and attitude, it could be seen as providing legitimization - for those emotionally predisposed to neurotic religiosity (Spero, 1985b) - to overvalue superficial performance at the expense of emotionality, affection, and relationships. The impact of the traditional *shidduchim* process can further overemphasize the importance of superficial and external qualities for those with such an emotional predisposition. This emphasis on superficial behavior can be distorted to the point of feeling sinful for having normal emotions.

As indicated above, parents of perfectionists tend to stress extrinsic motivations for behavior. In their comprehensive review of the literature on religion and psychotherapy, Worthington and his associates, (1996) distinguish between "intrinsically religious people" who view religion as an end in itself, and "extrinsically religious people" who view religion as a means to achieve other ends (e.g., social status,

security, acceptance). Research shows that intrinsically religious people are more open to change and derive positive mental health benefits from religion, unlike extrinsically religious people who are more likely to experience negative mental health consequences from religion. Worthington and his associates (1996) also cite a study by Bergin that compared religious students who develop emotional disorders with those who do not. The healthy students were likely to have benevolent parents, non-conflicted childhoods, a smooth religious developmental history, and real, non-dramatic religious sentiments. In contrast, the more troubled students had conflict-laden childhoods and discontinuous religious commitment. Many experienced depression, anxiety, and rigid perfectionism. Not surprisingly then, the author's experience indicates that the parents of *frum* perfectionists tend to fall under the category of "extrinsically religious people."

Frum perfectionistic adolescents will often intensify their religious devotion as a reaction to emotional distress. As noted by Spero (1985b), however, "when religious belief is adopted to disguise or even resolve deeper psychological disorders, the disguise is generally transparent or the resolution only apparent and mediocre" (p. 8).

The religiously required capacity for guilt that reflects a realization that one has violated an internalized standard, and where the object of negative evaluation is the person's behavior, is often expressed as shame that reflects their negative evaluation of the self (Lewis, 1971; Tangney, 1995).[2] Such people often try to "overcome" their "defect" via perfectionism (i.e., total control over their thoughts, feelings, and behaviors).

Saint or Sinner (or Saint *and* Sinner)

The need for grandiosity and perfection prompts many perfectionists to split off or disavow those parts of themselves that they perceive as being bad or evil. These "evil" elements may, in fact, be normal feelings and reactions (e.g., jealousy) but which they have been influenced to feel are reflective of inherent, inner badness. This disavowal refers to the dissociative process Kohut (1971) terms a "vertical split," where different sectors of self-experience are defensively segregated from each other as a means of avoiding intolerable conflict. The split is termed vertical because the dissociation is achieved via disavowal, where different, unintegrated perspectives alternate with each other, rather than by repression (a horizontal split), where a relatively permanent perspective excludes certain aspects of awareness from becoming conscious (Goldberg, 1999; Orange et al., 1997).

This dissociation actually helps perfectionists come closer to achieving their goal of grandiosity (temporarily, of course), since the positive aspects of their personality can operate without the hindrance of the negative aspects. The flip side of this is that when the infantile and regressive forces do inevitably assert themselves, they do so without the moderating influence of the sequestered positive forces in their personality, resulting in more serious and extreme forms of acting out.

Since the personality is not adequately integrated, emotional growth is stunted and the infantile, shameful self can never grow up. On the other hand, since the disavowal can never be totally effective, the "good" part continues to strive for perfection and grandiosity as proof that the "bad" part is "not really me."

Similarly, Broucek (1991) describes a "dissociative type" of narcissist, where the "idealized self exists in a split-off dissociative form and is often detectable in the form of a subtle air of superiority and entitlement that exists side by side with a more consciously articulated self-devaluation" (p. 60). This is why perfectionists can describe themselves, in the very same sentence, as both better than everyone else and worse than everyone else (a saint **and** a sinner).

There is another factor that prevents the positive elements of the perfectionist's personality from moderating his or her infantile impulses. Since parents of perfectionists often react with harsh criticism to the most minor of infractions, the child is unable to distinguish between different levels of "badness." This encourages the attitude that "if I cannot be perfect I might just as well do the worst thing." I have found that those patients with obsessive-compulsive or narcissistic personality disorders, who feel compelled to be perfectly *frum*, are

the ones who are also likely to commit what they consider the most grievous sins whenever they are no longer able to sustain their self-defined exalted status (e.g., if they cannot stop themselves from violating a "minor" sin). In their minds, there are no gradations in levels of "badness."

Psychotherapy with Perfectionists

Deflated Grandiosity

Perfectionistic adolescents typically come to therapy after a breakdown in the vertical split, usually after a blow to their feelings of grandiosity or even just a lack of mirroring[3] (Garland & Zigler, 1993). Some patients report that the strain of maintaining perfection becomes so burdensome that they feel compelled to act out in a most negative manner as a means of jettisoning the burden. Their agenda for therapy is to turn back the clock to the time when they were able to maintain the illusion of perfection. Initially, they have little interest in emotional growth or integration of affect since they had long ago been compelled to abandon natural emotional responsiveness in favor of desirable behaviors. They are really striving to **look** perfect more than to **be** perfect since they "know" how bad they really are. But, consistent with their early life experience, how they look to others is what really counts.

The need for therapy is experienced as a disgraceful narcissistic injury and the antithesis of the perfection and grandiosity they so desperately need to see in themselves. Miller (1996) relates this type of feeling to the following imaginary childhood experience:

> *A child . . . asks his mother, "Mom, will you go to the park with me?" and the mother's response is, "What's the matter with you? You can't go by yourself?" In other words, the wish for human companionship inherent in the request is not recognized and valued . . . but is reinterpreted as a deficiency with regard to autonomy. (pp. 79-80)*

I agree with Miller (1996) who is "uncomfortable with the notion that an essential therapeutic function is the mirroring of infantile grandiosity and perfection" (p. 129). Orange and her associates (1997) are also critical of the notion of mirroring defensive grandiosity. They recommend neither mirroring nor puncturing the grandiosity. Rather they suggest waiting for "opportunities to make contact with the painful affect walled off on the other side of the vertical split" (p. 82).

While the therapist clearly has to be empathic in regard to the patient's need for perfection and infantile grandiosity,[4] the goal of therapy is to find satisfaction and meaning in the process of growth and in the everyday activities of the self. This is more difficult than it sounds since it is very painful for someone with a poor self-image to give up the dream of glory inherent in perfection for the, as yet never experienced, joy of gradual emotional growth. A crucial ingredient of successful therapy is recognizing and taking pride in every small step of progress. The difficulty this entails for the perfectionist was expressed by one youngster: "You don't understand, how can I be proud of a step toward solving my problem when I'm not yet ready to admit that I **have** a problem?!"

Perfectionistic, *frum* youngsters will often claim that they enjoy their learning and *davening*. They are, therefore, mystified as to why they experience so many emotional roadblocks in these very same activities. Closer analysis, however, reveals that what they are enjoying is only the escape from feeling the shame they would have felt if they did not perform their religious duties, rather than intrinsic enjoyment from the activity itself.

The attitudes of teachers and parents can sometimes hinder the progress of therapy. Often, at the same time the therapist is encouraging the patient to feel pride in his or her small steps, the teacher or parent is making it clear that he or she is not at all impressed since the patient is so far from where he or she "should be."

Performance Without the "Burden" of Emotions

The resistance to giving up grandiose goals is exacerbated by the fact that perfectionism can have a positive impact on performance (Flett, Hewitt, Blankstein, & Mosher, 1991); albeit at a high cost to emotional health (that in turn, eventually impacts negatively on performance). As *frum* perfectionistic patients become emotionally healthier, they may seem, at least superficially, to be less religiously observant. The patients themselves are usually very troubled by this and their families may likewise react negatively to the therapy and therapist as a result. It is difficult for many people to see that, qualitatively, their religious observance is becoming more meaningful.

Another problem is the feeling of loss when perfectionists realize that many of the accomplishments they have been so proud of were the result of unhealthy needs. As they become more knowledgeable about psychological issues, they may also become perfectionistic in the process of therapy, by trying to become the perfect emotional specimen (i.e., by not having any anxieties, conflicts, or fears).

The Need for External Validation

Another goal of therapy is to develop the ability to measure oneself with internalized standards and values (religious, moral, and so on), rather than through the eyes of others. There are many difficulties to overcome in achieving this goal. The perfectionist needs the adoration of others to fill the "black hole" left by the lack of early mirroring. Unlike the mirroring during normal early childhood development which encourages positive feelings regarding the self at a time when it is still a "blank slate," the later adoration needs to counteract an intensely experienced negative self-image. It is for this reason that being proud of one's own normal achievements is not enough for the perfectionist, especially since the person knows (what he considers) the "truth" about himself or herself. With others, in contrast, there is the hope of impressing them with a grandiose, perfect performance. The problem here, of course, is that the fix is short-lived, as the person thinks, "if they only knew the truth about me they would not be so impressed."

In his comprehensive review of the literature, Blatt (1995) reports that "brief treatment, both pharmacologic [and] psychologic, appears to be relatively ineffective with self-critical, perfectionistic individuals ..." (p. 1014).

***Frum* Therapist vs. Non-*frum* Therapist**

Frum patients often use their *frumkeit* as a resistance in therapy (e.g., "*Halacha* requires that I strive for perfection"). In order to deal with this resistance, therapists of the same religious background as the patient would have an obvious advantage. They would find it easier to distinguish between neurotic versus healthy religiosity (Spero, 1985b), and are more willing than secular therapists to question and explore beliefs that are clearly "erroneous" (Worthington et al., 1996). They are also less likely to imply that the patient's beliefs have only psychological meaning, an implication that is obviously insulting to *frum* patients (Spero, 1985a). While *frum* people will sometimes specifically request a non-*frum* therapist because they fear being judged and condemned by a *frum* therapist for what they perceive as sinful behavior, the nonjudgmental and empathic attitude of the non-*frum* therapist will lack the full therapeutic impact since the patient will think to himself; "Of course the therapist accepts me, he does not even understand what's wrong with this behavior."

Perfectionistic patients, who tend to have internalized a superficial perspective, will often attribute their emotional difficulties to the restrictions imposed by their religious beliefs since many of their daily conflicts involve these restrictions. This allows them to deny the impact or even the existence of family conflict or other underlying dynamics (just as parents sometimes attribute the rebelliousness of their children to "bad friends" and/or a "naturally overactive *yetzer hara*" as a means of denying family problems). A religiously similar therapist who is aware of many emotionally healthy people who live with the same religious restrictions is more likely to detect the underlying dynamic issues.

But there are also distinct dangers in a religious patient being treated by a religiously similar therapist. While highly religious patients usually prefer religiously similar therapists (Wikler, 1989; Worthington et al., 1996),

this preference can mask a patient's defense against full engagement in the psychotherapy process (Spero, 1990). Transference and countertransference issues may also become exacerbated (Peteet, 1994) as the therapist hears his own religious beliefs being presented in a distorted manner or being attacked as the cause of the patient's emotional difficulties. There is also a risk that a therapist will so closely identify with a patient's beliefs and experiences that they are not recognized as containing psychologically significant material (see Atwood & Stolorow, 1984).

It is interesting to note that according to the research literature, even when religious patients request religiously similar therapists, they do not want the therapy to focus on religion (Worthington et al., 1996). Still, the issue of religion and religious conflict will inevitably come up with religious patients especially if they are in treatment with a religiously similar therapist.

Peteet (1994) discusses four levels at which the therapist can approach religious issues, ranging from acknowledging the religious issues but focusing exclusively on their psychological dimensions, to addressing the religious problems directly within the treatment through the use of a shared religious dimension. In choosing the approach to take, Peteet emphasizes the importance of determining the need represented by the patient's presentation of a religious problem in therapy.

Discussing religious doctrine with a patient carries the danger of assuming the role of pastoral counselor but it also holds the opportunity to explore psychological factors contributing to idiosyncratic religious beliefs and experiences.

Case Illustration

Psychotherapy with "Shmuel,"[5] a 19-year-old Yeshiva student, underscored some of the unique issues involved in treating perfectionists in general, and *frum* perfectionistic in particular.

Shmuel was living a double life. On the one hand, he excelled in all areas of school life. He possessed a superior intelligence and was a star student in both learning and in his secular studies (when he was in high school). His *rebbeim* told him many times that they saw him as a future *godol*. In spite of the intensity of his learning, he was also a popular student and a successful athlete.

And yet, there was a darker side to his life. After hours of intense learning, he would suddenly feel compelled to go to disreputable places and act out in a variety of very inappropriate ways. He would then feel consumed by shame and humiliation, feelings that he would try to banish by intensifying his learning and *davening* even further. He felt like he was two people rolled into one. The fact that his public persona was at such odds with his self-image created unbearable tension and inner turmoil.

Shmuel experienced his achievements as meaningful only as a way of maintaining his external facade. While his successes did feed his grandiose, perfectionistic fantasies, they had no impact on his core self-concept.

The tension between the grandiose fantasies and the underlying self-devaluation was felt from the very first session. Shmuel kept oscillating between convincing me how superior he was in his learning and *frumkeit* (with the focus mostly on how highly he was held in other people's esteem) and emphasizing to what levels of depravity his behavior has sunk to.

As is common with perfectionists, who are not likely to view emotions as an important factor in influencing their behavior, he saw his problem as reflecting an incidental aberration in an otherwise perfect being (i.e., a naturally high level of testosterone) rather than reflecting emotional distress. His initial agenda for therapy was to get help in "controlling" his *taivah* impulses.

An exploration of his early years revealed a childhood growing up in a cold and loveless house. "I felt like I was a border renting a room, not like a child living with his parents." His mother was cold and distant, while

his father was very critical, controlling, and often physically abusive. Being of superior intelligence, he found some measure of solace and self-esteem from his superior academic performance. He always felt (subconsciously) that if he performed perfectly, maybe his mother would show more interest and his critical father would have nothing to criticize.

Eventually, the drive for perfection became so powerful, that an intense fear of failure (defined as anything less than perfect) developed. This fear intensified to the point of lying about his high school grades. If he got 90% on his test, he would tell everyone that he got 98%. As high school graduation time approached, he became panicky that everyone would wonder why he was not chosen to be valedictorian if he had the highest average.

The dynamics of his sexual acting out also reflected his perfectionistic attitude. When he found that he could not control his urges to masturbate (that in part, reflected his need to escape his state of chronic tension) he felt that he "might as well" visit a house of ill repute (the "saint or sinner" syndrome).

Shmuel's need to seem perfect also affected his athletic life. While he was superior in most sports, for some reason he had never learned to play tennis. And so he lived in terror that someone would discover this terrible "deficiency." Whenever his friends wanted to play tennis he would come up with various excuses in order to avoid playing without revealing this "deep dark secret."

As the gap between his public and private image widened, Shmuel became increasingly despondent and was close to suicide on a number of occasions. Yet, he remained careful not to show any signs of depression in school. When he could no longer cover up his feelings he would say that he was not feeling well and would go home for a few weeks where he would stay in bed in a severe depression. At one point he was too frightened to stay in his own room and so he slept with his parents in their bed (at the age of 17!) for a few days.

In spite of these obvious symptoms of depression, his parents never sought professional help for Shmuel, until he himself took the initiative.

In therapy, Shmuel was highly motivated and exhibited a capacity for psychological insights, and a therapeutic alliance was established fairly quickly.

Shmuel at first found it difficult to relate to his feelings as a serious area of concern, or to relate to affect from an internal perspective. At one point he explained that the way he knows that he is not happy, is "when I realize that my face is frowning" (i.e., how he looks to others).

As he became more attuned to his feelings he came to understand how early faulty mirroring created an emotional "black hole" that could only be filled with grandiose, perfectionistic accomplishments. He also came to the conclusion that his image of G-d as harsh, punitive, and rejecting was more a transference from his paternal image that an accurate reflection of Torah *hashkafa*.

He began to understand the connection between emotional distress and acting out, so that he got a deeper understanding of his own behavior. In the past, he viewed his acting out simply as a *yetzer hara* that had to be overcome with sheer force. Now it was "fight smarter (i.e., to recognize the events and feeling states that precipitate his acting out) - not harder."

At first, Shmuel felt a profound sense of loss realizing that many of his religious accomplishments were motivated by immature emotional needs, rather than by "pure" spiritual aspirations. Fortunately, he was able to accept that emotional growth was a worthwhile goal and so he could feel a sense of accomplishment in this arena.

Initially, Shmuel responded positively to my nonjudgmental attitude and unconditional positive regard,

especially as I was religiously similar to him. But at some point he began to feel that, at his age, and especially from the perspective of his Torah *chinuch*, positive self regard cannot truly be totally unconditional. I suggested that having standards and goals (religious or otherwise) could actually promote self-esteem, providing the major emphasis was internal (and not to impress others) and the goals were reasonable for his particular situation.

He came to accept the idea that emotional health was a prerequisite for healthy *avodas Hashem* and this further motivated him in his therapeutic endeavors. His initial inclination, not surprising for a perfectionist, was to demand of himself to instantly become a perfect emotional specimen. He would feel humiliated if his reaction revealed any remnants of unhealthy needs. But as therapy progressed, he became more accepting of his humanness and so he became more reasonable with his expectations.

As his depression lifted and he became less perfectionistic, the intensity of his *avodas Hashem*, at the behavioral level, receded. This troubled him, both because this had been a major source of positive feelings and because of his concern that he was shirking his religious duties. But here too, he began to see that while it was true that the external manifestations of his religiosity were receding, he was also acting out much less than ever before (i.e., the "split" was healing).

Another area of concern was his relations with his parents. At first, he was very hesitant to label their behavior toward him as abusive. While this is a common reaction of abused children, and a major factor in the abused becoming abusers (Briggs & Hawkins, 1996), it can be especially difficult for *frum* children who worry that they are violating *kibud av ve'eim* if they acknowledge any negative attributes regarding their parents. This concern also caused Shmuel to resist the thought of becoming more assertive in dealing with his parents. At his own initiative, he discussed this issue with his Rov who was initially very restrictive in what he felt the patient could say to his parents. When I reviewed with the patient what he told the Rov, it became clear (as is often the case in these situations) that Shmuel had not been open as to how unreasonable his parents were toward him. With my encouragement, he gave his Rov a more honest and detailed description of his interactions with his parents. The Rov then became very supportive of his efforts to be more assertive toward his parents. Shmuel was pleasantly surprised to find that he was able to influence his parents to treat him more reasonably and their relationship improved significantly.

Shmuel became more involved in satisfying interpersonal relationships and took pride in asking friends to teach him to play tennis. He felt a sense of freedom and an unloading of a burden in not needing to project a perfectionistic image: "I can just be a plain, normal person." He started considering the possibility of not pursuing long-term, full-time learning because it was associated in his mind with grandiosity and pressure. That alone had a positive effect on his level of anxiety and acting out and this positively impacted on his learning.

Conclusion

In recent years, clinicians have reported an increased readiness among *frum* people to avail themselves of psychological services (e.g., Manevitz & Barnhill, 1993). I have personally experienced dramatic changes in my own practice (exclusively in the *frum* community) in recent years. Many of my adolescent and young adult patients have confided to troubled friends that they themselves were in psychotherapy as a means of convincing their friends to avail themselves of this service, something unheard of even 10 years ago.

This has given clinicians more opportunities to understand and study the issues unique to this population and the therapeutic approaches most effective in treating *frum* patients. Further research is needed to ascertain if perfectionism is, in fact, more prevalent in the *frum* community and the differences among the various *frum* subgroups in this regard.

In treating frum perfectionists, the challenge is seen as helping them recognize and resolve the psychological issues underlying the perfectionism they exhibit in their daily life, without causing them to feel compelled to

abandon the beliefs so central to their personal world. This can best be done by replacing the illusory grandiosity of perfection with the gratification from real, albeit modest, achievements.

References

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

Blatt, S. (1995). The destructiveness of perfection: Implications for the treatment of depression. *American Psychologist*. 50, 1003-1020.

Briggs, F. & Hawkins, R. M. F. (1996). A comparison of the childhood experiences of convicted male child molesters and men who were sexually abused in childhood and claimed to be non-offenders. *Child Abuse and Neglect*. 20, 221-233.

Broucek, F. (1991). *Shame and the self.* New York: Guilford

Flett, G. L., Hewitt, P L., Blankstein. K. R., & Mosher, S. W. (1991). Perfectionism, self-actualization, and personal adjustment. *Journal of Social Behavior and Personality*, 6, 147-160.

Garland. A. F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist*, 48, 169-182.

Goldberg, A. (1999). *Being of two minds: The vertical split in psychoanalysis and psychotherapy*. Hillsdale, NJ: Analytic Press.

Gottman, J. M. Katz, L. F., & Hooven, C. (1996). Parental metaemotion philosophy and the emotional life of families: Theoretical models and preliminary data. *Journal of Family Psychology*. 10, 243-268.

Hamacheck, D. E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology*, 15, 27-33.

Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.

Kohut, H. (1997). *The restoration of the self.* New York: International Universities Press.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Manevitz, A., & Barnhill, J. (1993). Treating a 38-year-old, Chassidic man with delusional depression. *The Journal of Psychotherapy Practice and Research*. 2, 258 - 267.

Miller, S. B. (1996). *Shame in context*. Hillsdale, NJ: Analytic Press.

Omer, H. (1997). Narrative empathy. *Psychotherapy*, 34, 19-27.

Orange, D., Atwood, G., & Stolorow, R. (1997). *Working intersubjectively: Contextualism in pychoanalytic practice.* Hillsdale. NJ: Analytic Press.

Pacht, A. R. (1984). Reflections on perfection. *American Psychologist*, 39, 386-390.

Peteet, J. R. (1994) Approaching spiritual problems in psychotherapy: A conceptual framework. *The Journal of Psychotherapy Practice and Research*, 3, 237-245.

Rothstein, A. (1991). On some relationships of fantasies of perfection to the calamities of childhood. *International Journal of Psychoanalysis*, 72, 313-323.

Sarno, J. (1998). *The mind-body prescription: Healing the body, healing the pain*. New York: Warner.

Sorotzkin, B. (1985). The quest for perfection: Avoiding guilt or avoiding shame? *Psychotherapy*, 22, 564-571.

Spero, M. H. (1985a). The reality and the image of G-d in psychotherapy. *American Journal of Psychotherapy*, 39, 75-85.

Spero, M. H. (1985b). Selected metaclinical problems in the psychotherapeutic treatment of the disordered, religious personality. In M. H. Spero (Ed.). *Psychotherapy of the religious patient* (pp. 5-15). Springfield, IL: Charles C. Thomas .

Spero, M. H. (1990). Parallel dimensions of experience in psychoanalytic psychotherapy of the religious patient. *Psychotherapy*, 27, 53-71.

Stolorow, R. (1997). Dynamic, dyadic, intersubjective systems: An evolving paradigm for psychoanalysis. *Psychoanalytic Psychology*. 14, 337-346.

Strassberg, Z. (1997). Levels of analysis in cognitive bases of maternal disciplinary dysfunction. *Journal of Abnormal Child Psychology*, 25, 209-215,

Tangney, J. P. (1995). Recent advances in the empirical study of shame and guilt. *American Behavioral Scientist*, 38, 1132-1145.

Wikler.M. (1989). The religion of the therapist: Its meaning to Orthodox-Jewish clients. *Hillside Journal of Clinical Psychiatry*, 11, 131-146.

Worthington, E. L. Jr., Kurusu, T. A., McCullough, M. E. & Sandage, S. G. (1996). Empirical research on religion and psychotherapeutic processes and outcome: A 10-year review and research prospectus. *Psychological Bulletin*. 119, 448-487.

***)**An edited version of this article ("Understanding and Treating Perfectionism in Religious Adolescents") was printed in *Psychotherapy*, Vol. 35 (1998), pp. 87-95 and reprinted in *Essential Readings on Jewish Identities, Lifestyles and Beliefs: Analyses of the Personal and Social Diversity of Jews by Modern Scholars.* Edited by Stanford M. Lyman. NY: Gordian Knot Books, 2003, pp. 191-207. A copy of the *Psychotherapy* version is available from the author.

1)Rabbi Yitzchok Kirzner *Zt"l*, in his tape "Coping with the Loss of Love"(Tape RL-12) states: The worst thing parents can do is to tie their children to their apron strings.... You create, in the mind of the child who is developing, [the idea] that the only way that the child will be accepted and loved is if he forsakes his pursuit of self for the happiness of the parent. This creates a horrendous distortion... of the child's normal emotional development. In fact, healthy [emotional] growth involves being able to give up our need for approval when the price for the approval is the giving up of the true self.

2)See Rav Yitzchok Hutner in the *Pachad Yitzchok*, *Igros VeK'sovim*, #128 (also translated in the *Jewish Observer,* Dec. 1981, p. 13).

3)While *chazal* seemingly speak approvingly of the capacity for shame (*busha*), they seem to be referring to what Broucek (1991) terms "anticipatory shame" or a sense of shame that inhibits us from doing or saying something that would cause this emotion. This is contrasted with shame as an affective reaction to something already present that leads to repression and concealment, and eventually to various emotional disorders. Broucek (1991) sees the healthy sense of shame as "vital to the individual and collective, emotional, moral, and spiritual welfare" (p. 5). Some contemporary English *seforim* translate *busha* as "modesty" rather than "shame." See also Rav Yeruchem Levovitz in *Sefer Daas Torah* (cited in *Yalkut Lekach Tov, Vayigash* 45:3) and Rav Henoch Lebowitz in *Sefer Chidushei HaLev, Sh'mini* (9:7).

4)Kohut (1971) emphasized children's need to have their emotional states "mirrored" or reflected by their parents. Children need their parents to admire them, to celebrate their progress and to applaud their accomplishments. He called this "the gleam in the parent's eye."

5)Most often perfectionistic patients will not spontaneously reveal their grandiose fantasies and the associated perfectionistic self-demands, both because they have never reflected on the connection between these fantasies and their symptoms ("prereflectively unconscious" [Atwood & Stolorow, 1984]), and because of the shame involved in revealing their grandiosity to others (Kohut, 1971). The grandiosity is usually uncovered in the process of trying to understand their symptoms. The severe anxiety of the social phobic, for example, is more understandable when it is realized that he experiences a less-than-perfect performance as a humiliating defeat.

6)The name and story has been altered to protect confidentiality.