Rational coaching with perfectionistic leaders to overcome avoidance of leadership responsibilities

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As coaches and coaching psychologists you may find yourself working with executive leaders who have issues with decision making, procrastination, stress, and feeling overworked. They may be avoiding making those important decisions, putting off tasks until deadlines are looming, not delegating work to lighten their workload, or continuing with tasks that make them feel confident and successful but are no longer their remit. It is possible that these behaviours are caused by perfectionism. This paper describes perfectionism, discusses the links between perfectionism and performance interfering behaviours, and outlines how perfectionistic beliefs can be adapted in coaching to be less rigid in order to improve performance.

Keywords: Perfectionism; Leadership Style; Procrastination; Rational Emotive Behaviour Therapy; Rational Coaching.

What is Perfectionism?

These days we hear the word ‘perfectionist’ bandied about quite freely, often used to describe individuals who have a tendency to pay excessive attention to detail. These may be people we see in the workplace, for example, who get stressed about things not being perfect, strive for flawlessness, think they can ‘do it best’, and may criticise other’s attempts. Historically, however, perfectionism has been treated as a more serious construct; being considered cognitively dysfunctional (Beck, 1976), or indeed, as a psychopathological condition which often results in a pervasive neurotic style (Flett, Hewitt & Dyck, 1989; Terry-Short et al., 1995). Much of the early research into perfectionism was conducted in clinical settings looking at links between perfectionist beliefs and conditions such as eating disorders (Garner, Olmstead & Polivy, 1983), depression (Frost et al., 1990), and personality disorders (Hewitt & Flett, 1991b; Hewitt, Flett & Turnbull, 1992). Hamachek (1978) explained neurotic self-directed perfectionism as deriving from growing up in an environment of conditional positive regard, with exposure to such environments resulting in maladaptive behaviours, such as setting unrealistically high expectations for oneself, as well as an excessive fear of failure (Terry-Short et al., 1995). In turn, the fear of failing to meet expectations can lead to procrastination or avoidance of situations/tasks, which can cause stress and ‘beating oneself up’, potentially triggering anxiety and depression (Ellis, 1994), or more serious conditions such as those listed above.

More recent debates highlight perfectionism as a multilevel construct; one that is more complex in terms of dimensions (positive as well as negative perfectionism) and affected groups (healthy and unhealthy/functional and dysfunctional perfectionists) (Stoeber & Otto, 2006). This stance argues for the presence of a perfectionistic approach that is more akin to striving for excellence, i.e. wanting to get things done, rather than a demand for perfection, and the presence of perfectionistic traits in those not experiencing a pathological condition.

Positive vs. Negative Perfectionism

It was actually first suggested over 30 years ago (Hamachek, 1978) that perfectionism is not just a unidimensional pervasively negative
construct. Hamacheck argued for the concepts of ‘normal perfectionism’ (which produces functional outcomes), and ‘neurotic perfectionism’ (which produces dysfunctional outcomes). These views were initially overlooked and outweighed by the continuing focus of perfectionism as a purely negative, maladaptive construct. Over time, however, various multidimensional models were created by other researchers to allow them to observe and measure how particular facets of perfectionism relate to specific behaviours. Despite this more flexible view initial focus was still mainly on negative dimensions (Frost et al., 1990; Hewitt & Flett, 1991). In one model, for example, the suggested dimensions include concern over mistakes, doubts about actions, parental expectations, parental criticism, and personal standards; all related to trying to avoid mistakes and critically evaluating one’s own behaviour (Frost et al., 1990). Another multidimensional model was created by Hewitt and Flett (1991) which proposed three dimensions that encompassed; avoiding self-directed criticism (self-oriented), avoiding criticism from others (socially prescribed), and holding high expectations for others (other-oriented). A later study combined all the components of these two models and found evidence for two main factors/dimensions: one which accounted for concern over mistakes, doubts about actions, socially prescribed perfectionism, parental criticism, and parental expectations (labelled ‘maladaptive evaluation’); the second factor accounted for personal standards, a preference for organisation, self oriented perfectionism and other oriented perfectionism (labelled ‘positive striving’) (Frost et al., 1993). These two factors were then subject to analysis to observe how they correlated with well being. Maladaptive evaluation was found to be related to depression and negative affect, whilst positive striving was correlated with positive affect. This provided one of the first evidence based arguments for particular dimensions of perfectionism that can produce positive outcomes.

In line with the thinking around positive perfectionism, Silverman (1993, pp.58–59) refers to perfectionism as a basic drive to achieve excellence: ‘without perfectionism, there would be no Olympic champions, no great artistic endeavours, no scientific breakthroughs, no exquisite craftsmanship, no moral leaders.’ Consider this though; can we say that those Olympic champions, great artists, and ground breaking scientists, whilst producing truly honourable positive outcomes, weren’t also suffering with depression, stress and anxiety brought on by their perfectionistic strivings?

Healthy vs. Unhealthy Perfectionists
This section looks at what Stoeber and Otto (2006) termed healthy and unhealthy perfectionists, describing different categories of perfectionists. This doesn’t involve simply compartmentalising perfectionists into clinical and non-clinical populations. As discussed above, perfectionism in clinical populations has been linked to serious outcomes such as depression (Frost et al., 1990), eating disorders (Garner, Olmstead & Polivy, 1983), and even suicide (Hewitt et al., 1997; Hamilton & Schweitzer, 2000). Interestingly, serious outcomes such as suicide ideation, for example, were found not only in a clinical sample of perfectionists, consisting of adolescent psychiatric patients (Hewitt et al., 1997), but also in a sample that would typically be classed as non-clinical, consisting of university students (Hamilton & Schweitzer, 2000). So, what is meant by healthy perfectionists and unhealthy perfectionists?

According to Stoeber and Otto (2006), healthy perfectionists are those who, for example, work diligently towards a positive result but don’t give oneself a hard time along the way or in the event of not achieving success. They are described as having high levels of perfectionistic strivings but low levels of perfectionistic concerns. Healthy perfectionists have shown to have lower ego defenses (Dickinson & Ashby, 2005), less procrastination (Ashby &
Kottman, 1996), less obsessive compulsive symptoms (Ashby & Bruner, 2005), higher self-esteem and less depression (Rice & Slaney, 2002) than unhealthy perfectionists.

Unhealthy perfectionists on the other hand, are those who have high levels of perfectionistic strivings and high levels of perfectionistic concerns. Studies of perfectionists that fit this criteria have shown evidence for attitudinal inflexibility (Ferrari & Mautz, 1997), higher levels of stress (Flett, Parnes & Hewitt, 2001), a tendency for persistent worry and fear of failure (Flett et al., 1991), slow decision making (Rheaume, et al., 2000), low interpersonal sensitivity (Dixon et al., 2004), and engaging in ‘self-handicapping’ behaviours (Sherry, Flett & Hewitt, 2001). The term self-handicapping is used where individuals create obstacles to their own success, giving them an excuse/alibi that will explain what prevented them achieving a successful outcome (Jones & Berglas, 1978).

The term unhealthy perfectionist could intimate that the ‘sufferer’ is experiencing health issues, and although health can be affected as a consequence of perfectionism, for example, stress, it may not necessarily be the case. It may be more that the individual’s concerns and doubts result in procrastination and prevent them from being productive, but don’t necessarily result in stress and anxiety. Other terms which may be used to distinguish between types of perfectionists include functional versus dysfunctional (Rheaume et al., 2000) and conscientious versus self-evaluative (Hill et al., 2004).

Perfectionism in Leaders
Coming back to the title of this article, how does perfectionism relate to leaders and their leadership style? As discussed, perfectionism can result in concerns such as fear of failure, worrying about making mistakes, angst about what others think, etc., and these concerns can lead to stress, procrastination, avoidance, slow decision making, inflexibility, issues with interpersonal sensitivity, etc. Linking this to leadership, it is interesting to consider the leadership derailment literature, which outlines studies that have explored the behaviours that cause leaders to derail. Findings are pretty consistent across 40 years of research into derailment factors. The most common causes of derailment are poor decision making, resisting change, and poor interpersonal skills (Hawkes, 2005). Sound familiar? These map onto the types of behaviours described in the perfectionism research literature as discussed above. The suggestion, therefore, is that these maladaptive leadership behaviours may be caused by maladaptive perfectionism.

So, what can be done to overcome rigid maladaptive perfectionism and prevent procrastination, improve performance, reduce stress, and essentially improve leadership style? As well as potentially preventing more serious conditions such as depression.

Treating Perfectionism
Cognitive behavioural approaches have shown to be successful in reducing perfectionism and improving related behaviours, such as procrastination. Kearns, Forbes and Gardiner (2007) used cognitive behavioural methods in coaching with 28 doctoral students to treat perfectionism and self-handicapping behaviours. The students each attended a series of cognitive behavioural coaching workshops. Measures were taken at three time intervals; before the intervention, post-intervention, and one-month follow-up. Both perfectionism levels and self-handicapping behaviours had improved at the one-month follow-up.

In the leadership derailment literature several of the behaviours listed as predictors of derailment map also onto those discussed in the literature relating to one of the cognitive behavioural approaches; Rational Emotive Behaviour Therapy (REBT). These include avoidance, procrastination, and poor interpersonal sensitivity. The theory behind the REB approach states that unhelpful behaviours are caused by rigid unhelpful (irrational) beliefs and demands,
and that our evaluations/beliefs about an event determine our behavioural and emotional reactions (Ellis, 1994). The REB approach is designed to assist clients in recognising how their beliefs influence their behaviour, and how they can trigger emotions and physiological reactions. For example, fear of failure can result in avoidance, which can bring on anxiety and stress, which can cause sleeplessness.

The four categories of beliefs addressed by the REB approach are: Demands (e.g. I must get the best result), Awfulising (e.g. this is totally horrific), Low Frustration Tolerance (e.g. I can’t stand it!), and Depreciation/Downing (e.g. I’m a complete failure, I’m useless) (Palmer, 1997, 2009). Using REB methods includes examining and disputing beliefs and replacing them with more rational/helpful beliefs. This involves creating alternatives which are non-demanding (I would prefer to be the best but I don’t have to be), de-awfulising (It’s bad but it’s not the end of the world), high frustration tolerance (I don’t like it but in reality I can stand it), and self accepting (if I don’t get this right it doesn’t mean I’m useless).

The principles and techniques of the REB approach can be used in coaching. In doing so the approach is referred to as Rational Emotive Behaviour Coaching (REBC), or rational coaching for short (Palmer, 2009). Working with coachees in rational coaching can include the use of the ABCDE model from the REB approach to assist in identifying, disputing and replacing unhelpful beliefs in order to develop helpful, goal focused beliefs.

The coaching process involves taking the coachee through each stage of the model: identifying the issue at hand; exploring their internal dialogue; helping them to see the links between what they are telling themselves and how they feel and behave as a consequence; exploring how the inner dialogue can be adjusted to be more positive/realistic/flexible, and discussing how the improved internal dialogue could link with more positive performance enhancing behaviours. An example is given below in Table 1. Examples of the ABCDE model often include the precise terminology related to each stage. Whilst the model is designed to assist individuals in understanding the links between their beliefs, behaviours, emotions, and physiology, the examples also include cognitions offered by the coachee to demonstrate in a more conversational way what might actually be stated by the coachee in this situation.

Rigid perfectionist beliefs are often imbibed and/or developed during childhood (Palmer, 1997). Therefore, it may take some coachees a prolonged period of time to start believing the more flexible and less demanding alternative beliefs developed during coaching. The coachee may not have realised they held these rigid beliefs, and may be reluctant to consider an approach that encourages them to change their beliefs (Hewitt & Flett, 1996). However, it is useful to know that such beliefs can be flexed and replaced with more helpful performance enhancing beliefs (PETs), with the potential to improve leadership style, as shown in research. Grieger and Fralick (2007) discuss how the REB approach can make a significant contribution to leadership effectiveness. They discuss the use of the ABCDE model to help leaders ‘rid themselves of emotional contamination’. Anderson (2002) used the REB approach with executives to address rigid core beliefs related to low self-worth and low frustration tolerance. In a case study of seven executives’ beliefs he worked with coaches to adapt their beliefs and improve their leadership skills, resulting in less anger, better interpersonal skills, improved communication and less avoidance of conflict.

In summary, perfectionism, whilst historically considered a pathologically maladaptive construct which caused clinical conditions such as eating disorders and depression, has also shown to be linked with both negative and positive behaviours in non-clinical populations. Negative behaviours include
### Table 1: An example of the ABCDE model.

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<th>Stage of the Model</th>
<th>Example: Coachee's response</th>
<th>Observation</th>
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| **A: Activating event**  
What is the issue, or cause for concern? | Making an important decision about the future of a department. | |
| **B: Belief**  
What is the coachee telling them self?  
Explore with them the belief(s) that may be influencing their approach to making this decision. | 'I must get this right, if I don't I will feel like a total failure.'  
'If I do get it wrong everyone will think I am a useless leader who shouldn’t be in this position.' | The coachee demands that they ‘must’ get it right. The coachee’s beliefs indicate that in their mind, an error equals failure. In addition, the coachee thinks that others will negatively judge them if they make an error and will see them as ‘useless leader.’ |
| **C: Consequences**  
What are the resulting behaviours, emotions, and physiological reactions? | 'I’m putting it off which I know isn’t helping, but I’ve also been busy on another project that is very important and I’m really needed there. I am anxious though as the deadline for the decision is looming, and I’m starting to get quite stressed. I’ve noticed that I’m not sleeping well too.' | Behavioural: procrastination (e.g. I’m putting off’); avoidance and making excuses. Emotional: stress and anxiety. Physiological: not sleeping. |
| **D: Disputing**  
How can the coachee dispute the beliefs holding them back?  
What could they tell themselves that will be more helpful and goal focused? | 'I really do want to make the right decision but procrastinating doesn’t help. The best I can do is to make sure I have all the information required to inform my decision on and ensure that I have listened and taken into consideration the opinions of those that are involved. If I get it wrong it is evidence I’m just fallible and not a total failure. My colleagues can choose whether or not to respect my decision.' | The new belief is less demanding and more flexible. It allows for error without extreme self judgment and anxiety about others’ beliefs. |
| **E: Effective new approach and Evaluating**  
How are the new beliefs holding up?  
How have things changed? | 'I kept in mind what we discussed and finally got on with facing the decision. I stopped avoiding the situation and took the time to gather the information I needed. I did feel anxious at first but I reminded myself that my decision can only be as good as the information I have. I feel more comfortable now that I realise I’m fallible and not a total failure, regardless of outcome, so I am less stressed. It will take practice but I can see the benefits of being more flexible.' | The coachee practised using the new belief, though it was not without some anxiety. The coachee is less stressed as a result. The coachee can see firsthand how the process works but they recognise that it will take practice. |
procrastination and avoidance. Even in non-clinical populations these can cause health issues, such as anxiety and stress. In executive leaders these behaviours can result in leadership derailment. Working with negative perfectionist beliefs to make them more flexible and adaptive can result in better health and more performance enhancing behaviours. This can be achieved through using the ABCDE model in rational coaching by raising awareness of current beliefs, highlighting the effect of the beliefs on the behaviours and emotions, disputing the unhelpful beliefs and replacing them with more adaptive beliefs, putting these into practice, and evaluating the outcomes. In short, rational coaching could potentially be a key method or approach in preventing leadership derailment.

References

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