Fuschia M. Sirois · Danielle S. Molnar
Editors

Perfectionism, Health, and Well-Being

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Editors
Fuschia M. Sirois
Department of Psychology
University of Sheffield
Sheffield
United Kingdom

Danielle S. Molnar
Research Institute on Addictions
University at Buffalo, The State University of New York
Buffalo, NY
United States of America

Department of Psychology
Brock University
St. Catharines
Canada

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To my angels Domenic and Madeline,
for always believing in me; and to
Alice Cooper—I couldn't have done this
without you!

— Danielle Sirianni Molnar

To my husband, Mike,
for his never-ending support; and to my
girls, Cyan and Teala for reminding me to
take joy in the imperfections of life.

— Fuschia M. Sirois

Preface

The drive to improve oneself, to strive for the ideal, to seek better performance, and even higher standards, are in many ways the characteristics of the human condition. Indeed, this striving for betterment has served our species well and driven many great accomplishments throughout history. In today's performance-focused society, an unrelenting pursuit of ideal standards that leave no room for error, or perfectionism, is often revered with little consideration of its consequences. Understanding these consequences is becoming an increasingly important concern, especially in light of evidence that personality can confer risk or resilience for health-related outcomes. Whether we view perfectionism as a situationally bound quality induced by social or intra-psychic pressures for peak performance and flawless outcomes, or as an enduring tendency to have frequent cognitions about the attainment of ideal and often unrealistic standards, research has begun to highlight the ways in perfectionism may impact health and well-being.

The public health implications of perfectionism are evidenced by the growing body of research demonstrating that perfectionism, (i.e., the setting and striving for unrealistically high standards, often accompanied by harsh self-criticism) can have important consequences not only for mental health, but also for physical health and well-being. Yet, to date there are no books or edited volumes that provide a focused account of the different ways and domains in which perfectionism contributes to health and well-being, for better or worse. Our purpose for this edited volume was to address this surprising gap by presenting the latest theoretical and empirical perspectives from leading researchers in the perfectionism field on this important topic.

A significant limitation plaguing the perfectionism and health field is that aside from a few noteworthy exceptions, research on perfectionism and health has been largely atheoretical. To this end, a central goal in organizing this book was to include contributions that provide an overview of not only the most recent advances on this topic, but also those that present new conceptual models that may help further our understanding of when, how, and why perfectionism may be implicated in health and well-being. Collectively, these contributions provide in depth analyses and discussions of the specific mechanisms and processes that may render certain perfectionists particularly vulnerable to poor health and well-being, but leave other perfectionists less vulnerable to these same consequences.

Perfectionism is a topic that has relevance for not only scholars and researchers, but also for those who work therapeutically with people experiencing issues related to perfectionism, or who work in a setting in which perfectionism may be particularly rampant due to performance pressures and expectations. For these reasons, we have included contributions that focus on how perfectionism may relate to well-being, with a particular emphasis on, health-related and social contexts. For example, this volume includes chapters explicating the role of perfectionism in the context of general and specific chronic illness, psychopathology, and eating disorders, and in the relationship, academic, and work-life arenas. To further highlight the translational value and application of the book, we have also encouraged contributors to include a discussion of prevention and treatment issues surrounding perfectionism, where possible, which may be useful for clinicians and service providers. In doing so, we hope that this volume will be an important resource not only for researchers, but also for those who wish to use it in applied and clinical settings.

The chapters offer important and exciting new insights into the role of perfectionism in health and well-being written by authors who are well-respected international scholars. Each of these chapters presents the most up-to-date and cutting edge research on perfectionism, health, and well-being, and importantly, also highlights how these latest findings impact longstanding debates in these fields such as how perfectionism is best conceptualized and whether or not perfectionism can be healthy. As research on perfectionism has grown exponentially in the past 2 decades, these debates have also grown in their complexity. Accordingly, the contributors have weighed in on these controversial issues from a variety of different critical perspectives to provide the reader with an engaging, comprehensive, and up-to-date understanding of the current field of perfectionism with respect to health and well-being.

This book is structured to first provide an introductory overview of the fundamental conceptualization issues that need to be navigated for understanding the nuances that characterize the research on perfectionism, health, and well-being. Following this, the book is organized into three main sections, each concentrating on important and related topic areas. The first section examines the role of perfectionism in physical health—an area that has been relatively understudied by perfectionism researchers. In the second section, perfectionism as it relates to well-being and psychopathology is explored. The final section of the book focuses on specific social contexts and how they may contour the associations of perfectionism with health and well-being. We then conclude the book with a final chapter that highlights potentially fruitful and important avenues of research on perfectionism, health, and well-being yet to be explored that will hopefully contribute to the momentum of this fast growing field of research.

Given its focus and coverage, we believe that this volume will be useful to a number of different groups. It should serve as a useful reference book for researchers and scholars and also as a textbook suitable for advanced undergraduate and graduate courses dealing with personality and health, and/or personality and well-being. This book may also be of particular interest to those who work in applied settings where perfectionism is more common or more problematic, and where there is a

pressing need to understand the processes linking perfectionism to health and well-being outcomes. As such, it may be a useful resource for those working in clinical, counselling, health, educational, and organizational areas, to name just a few. By presenting the latest theory and research on perfectionism, health, and well-being, we hope that this book makes a unique and useful new addition to the perfectionism literature that helps underscore the need to address the potential burden of perfectionism for health and well-being.

Contents

Chapter 1
Conceptualizations of Perfectionism, Health, and Well-Being: An Introductory Overview

Fuschia M. Sirois and Danielle S. Molnar

Perfectionism research has burgeoned over the past two decades. During this time, there have been a number of empirical and theoretical advances providing insight into the nature of perfectionism and its associated risks. Broadly, perfectionism can be described as setting and striving for excessively high and often unrealistic standards, accompanied by frequent thoughts focused on attainment of these standards and overly critical self-evaluation (Frost, Marten, Lahart, & Rosenblate, 1990). However, it is now recognized that the perfectionism construct is multidimensional, as shown simultaneously by the work of Frost and associates (1990) and by Hewitt and Flett (1990, 1991). This recognition has, nonetheless, complicated the field with respect to understanding the implications of different perfectionism dimensions for health and well-being. Yet, navigating the complexities of these issues has important theoretical and clinical repercussions. If we consider perfectionism as a relatively stable tendency, as many researchers do, then the potential benefits of understanding how, why, and when perfectionism may confer risk or resilience for health and well-being can be far-reaching. For example, personality is increasingly being recognized as an important epidemiological factor for understanding health-related trajectories and outcomes, including morbidity and mortality, in part through its associations with modifiable risk factors for the development of mental

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As of July 1, 2015, Fuschia Sirois is with the Department of Psychology, the University of Sheffield, Western Bank, Sheffield, UK.

F. M. Sirois (✉)
Department of Psychology,
University of Sheffield, 309 Western Bank, Sheffield, S10 2TP, UK
e-mail: f.sirois@sheffield.ac.uk

Centre for Research on Aging, Sherbrooke, QC, Canada

D. S. Molnar
Research Institute on Addictions, University at Buffalo,
The State University of New York, Buffalo, NY, USA

Department of Psychology, Brock University, St. Catharines, ON, Canada

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and physical health issues (Bogg & Roberts, 2013; Friedman, 2011; Hampson, Goldberg, Vogt, & Dubanoski, 2007).

This surge of interest in personality as risk or resilience for health in recent years has lent momentum to a burgeoning literature focused on the role of perfectionism in health. Two important themes have tended to capture the lion's share of researchers' attention in this rapidly growing literature. The first concerns perfectionism's role in psychological distress with an extensive body of work clearly implicating perfectionism in a vast array of adjustment problems including anxiety, depression, and eating disorders in both clinical and nonclinical samples (see Bardone-Cone et al., 2007; Flett & Hewitt, 2002; Frost & DiBartolo, 2002). Accordingly, it has been suggested that perfectionism be considered as a significant and unique form of personality dysfunction when revising diagnostic systems (see Ayearst, Flett, & Hewitt, 2012). From this perspective, perfectionism can confer risk for poor psychological well-being.

The other predominant theme in the perfectionism literature is whether perfectionism has adaptive or "healthy" components that may promote well-being. This theme has grown from the zeitgeist of positive psychology (Seligman & Csikszentmihalyi, 2000), in which some contemporary researchers have begun to question the traditional view of perfectionism as being entirely maladaptive and to demand a more inclusive model of perfectionism that considers the possibility that perfectionism can be both beneficial and detrimental to one's health, sense of well-being, and overall functioning. The logic here is that it may be plausible for individuals to display perfectionistic traits, but use them in ways that promote success rather than lead to dysfunction. Proponents and opponents of this notion have examined this issue at both the conceptual and empirical levels (see Bieling, Israeli, & Antony, 2004; Flett & Hewitt, 2006; Stoeber & Otto, 2006). However, as you will see throughout the chapters of this volume, it remains a topic ripe with controversy and complexity.

We suggest that there is a third theme that is of equal or even greater importance from a public health perspective, but it is a domain in the perfectionism field that has not thus far received the sustained attention it deserves—that is, the role of perfectionism in physical health. The notion that perfectionism might be linked to not only poor mental health, but also poor physical health outcomes is not new (see Wolff, 1937, 1948, and Flett, Hewitt, & Molnar, Chap. 2, this volume). Yet, perfectionism as it relates to physical health has only recently begun to be a primary focus for perfectionism researchers (e.g., this volume, Kempke, van Houdenhove, Claes, & Luyten, Chap. 5; Molnar, Sirois, & Methot-Jones, Chap. 4), perhaps because a focus on physical health in relation to perfectionism has been eclipsed by the preponderance of evidence indicating that certain forms of perfectionism pose a risk for mental health (see this volume Burgess & DiBartolo, Chap. 8; Dunkley, Solomon-Krakus, & Moroz, Chap. 7; Flett, Hewitt & Nepon, Chap. 6). From a biopsychosocial perspective, psychological states and social factors play an integral role in the development and exacerbation of physical health issues and are therefore essential factors to consider for understanding how perfectionism may confer risk or resilience for physical health outcomes. Accordingly, we propose that widening

the scope of perfectionism and mental health research to include a more specific and routine emphasis on physical health is a natural next step in the evolution of this important research literature and one that can have significant implications for understanding a range of health-related outcomes.

After introducing and summarizing the different ways that the perfectionism construct has been conceptualized and measured, we then present a brief introduction to how the terms "health and well-being" have been defined in the literature, highlighting areas that may be particularly relevant for understanding the potential linkages to perfectionism dimensions. We then conclude with an overview of the structure and organization of this book, which provides the latest perspectives and research on perfectionism, health, and well-being organized into three sections: Perfectionism and Health; Perfectionism, Psychopathology, and Well-Being; and Perfectionism, Health, and Well-Being in Context.

Conceptualization and Measurement of Perfectionism

It is important to recognize up front that there are striking differences among researchers with respect to how they define, conceptualize, and assess perfectionism. These discrepancies are important to acknowledge because the way in which perfectionism is conceptualized and measured has a considerable impact on the results that emerge from empirical research. Typically, research conducted on perfectionism and health does not incorporate multiple measures of perfectionism representing different theoretical "camps," and it should not be presumed that measures that seem substantially related to each other are indeed equivalent, especially in terms of their implications for health outcomes. Fry and Debats (2011), for example, examined the link between perfectionism and mortality risk in a sample of older adults with diabetes. Contrary to their hypotheses, they found that trait perfectionism was associated with greater longevity. However, when they focused on the role of perfectionistic dysfunctional attitudes in mortality risk in the same sample, they found that perfectionism was associated with greater mortality risk. These conflicting findings that have divergent and potentially critical implications attest to the importance of considering measurement issues when assessing links between perfectionism and health. Consequently, the first section of the book will introduce the reader to the different ways that the perfectionism construct has been conceptualized and measured.

A Unitary or a Multifarious Construct?

A careful reading of the literature on perfectionism reveals that most of the discussion concerning the conceptualization and measurement of perfectionism can be boiled down to three central issues. The first issue concerns whether perfection-

ism should be considered as a unidimensional or as a multidimensional construct. Originally, there was a general consensus regarding the essence of perfectionism, as early theorists from different theoretical orientations, such as Sigmund Freud (1926/1959), Karen Horney (1950), Aaron Beck (1976), Albert Ellis (1962), and W. H. Missildine (1963), were quite explicit in treating perfectionism as a unitary construct that was pathological in nature. Indeed, they characterized perfectionists as individuals who set and strive compulsively toward excessively high standards, not because of a drive toward excellence, but because of a punishing fear of failure resulting from poor self-esteem. Horney's (1950) seminal writings speak directly to this point as she stated,

> He holds before his soul his image of perfection and unconsciously tells himself: Forget about the disgraceful creature you actually are; this is how you should be; and to be this idealized self is all that matters. You should be able to endure everything, to understand everything, to like everybody, to always be productive. (p. 65)

These classic theorists further observed that perfectionists scrutinize themselves and others harshly and approach life with a cognitive style characterized by rigidity and all or none thinking. This was best illustrated by Ellis (2002) when he stated in a rather terse manner that "perfectionists are more rigid and persistent in their irrational beliefs than what I call the 'nice neurotics'" (p. 228) and further emphasized by Asher Pacht (1984) when during his awards address to the American Psychological Association he spoke of perfectionists as having the "God/scum complex," in which perfectionists think that they must either be perfect or be a total failure. Finally, the early writings on perfectionism stressed that perfectionists lack the ability to experience joy and satisfaction even when they do reach their standards. This point was made glaringly clear when Weisinger and Lobsenz (1981) wrote, "The need to be perfect places a person in a self-destructive double bind. If one fails to meet the unrealistic expectation, one has failed; but if one does meet it, one feels no glow of achievement for one has only done what was expected" (p. 237).

Hamachek (1978) was the first to diverge from this unidimensional conceptualization of perfectionism and to suggest that perfectionism is multidimensional and that the different dimensions have distinct functional effects, allowing for both positive and negative outcomes. Specifically, he postulated that there are two distinct types of perfectionism: normal and neurotic. He delineated "normal perfectionists" as "those who derive a very real sense of pleasure from the labors of a painstaking effort and who feel free to be less precise as the situation permits" (p. 27). Conversely, he described neurotic perfectionists as "the sort of people whose efforts—even their best ones—never seem quite good enough, at least in their own eyes. It always seems to these persons that they could—and should—do better … they are unable to feel satisfaction because in their own eyes they never seem to do things good enough to warrant the feeling" (p. 27).

Early investigations tended to employ various unidimensional perfectionism measures such as the Burns Perfectionism Scale or the perfectionism subscales of the Eating Disorder Inventory (e.g., Burns, 1980; Garner, Olmstead, & Polivy, 1983). However, with the exception of a few researchers who favor a unitary con-

struct that focuses on the clinical aspects of perfectionism (e.g., Shafran, Cooper, & Fairburn, 2002), most contemporary researchers have followed from the work of Hamachek (1978) and adopted a multidimensional conceptualization of perfectionism in light of convincing evidence demonstrating the construct validity of multidimensional measures of perfectionism and strong support for the contention that different dimensions of perfectionism often have distinct functional consequences (Hewitt & Flett, 1991; Stoeber & Otto, 2006). However, accepting that perfectionism is a multifarious construct has only fueled the debate concerning the nature of perfectionism, as there is currently a general lack of agreement concerning what dimensions best define the core facets of perfectionism.

What are the Central Components of Perfectionism?

This leads us to the next layer of complexity in the conceptualization of perfectionism: What are the central components of perfectionism? Perfectionism is best understood at different levels, depending on one's theoretical orientation and research question. A typical approach is to treat perfectionism as a fairly stable personality trait. However, other potentially relevant aspects of perfectionism come to light when understood from other theoretical perspectives. For instance, the frequency with which individuals experience automatic perfectionistic thoughts concerning the need to be perfect (e.g., Perfectionistic Cognitions Inventory (PCI); Flett, Hewitt, Blankstein, & Gray, 1998; The Multidimensional Perfectionism Cognitions Inventory-English; Kobori, 2006; Stoeber, Kobori, & Tanno, 2010) are a source of interest when studying perfectionism through the lens of cognitive psychology, whereas the tendency to engage in perfectionistic self-presentation, such as perfectionistic self-promotion and defensive self-concealment (e.g., Perfectionistic Self-Presentation Scale (PSPS); Hewitt et al., 2003), is emphasized when examining perfectionism from the perspective of social psychology.

Also, some researchers have stressed the importance of the distinction between "general perfectionism," which assesses broad tendencies toward having unrealistically high standards and harsh self-scrutiny, and "domain-specific" perfectionism, which assesses perfectionism in particular areas of life. An example is "romantic perfectionism," which assesses perfectionistic beliefs and standards specifically about romantic relationships (Matte & Lafontaine, 2012). Indeed, research has supported that "romantic perfectionism" has incremental predictive utility beyond general perfectionism with regard to relationship adjustment (Matte & Lafontaine, 2012; Shea, Slaney, & Rice, 2006). The addition of these measures has surely enriched our understanding of perfectionism by allowing a more nuanced approach to its study. For instance, findings from several studies now provide compelling evidence to support the notion that experiencing automatic perfectionistic thoughts uniquely predicts several important and diverse outcomes such as athletic burnout (Hill & Appleton, 2011), depression (Flett et al., 2012), and eating disturbance (Downey, Reinking, Gibson, Cloud, & Chang, 2014) after accounting for trait measures of

perfectionism. However, they also complicate the field such that contemporary researchers are now faced with choosing between a seemingly endless assortment of possibly relevant perfectionism measures with divergent findings often resulting from different conceptualizations and measures of perfectionism being employed.

Perfectionism as a Trait

This issue is perhaps best illustrated when examining perfectionism at the trait level. Several measures that assess perfectionism at the trait level are currently available for use (Enns & Cox, 2002). However, it is clear that there are three primary models of trait perfectionism that dominate the field. Frost et al. (1990) developed the Multidimensional Perfectionism Scale (MPS-F) to assess their conceptualization of perfectionism which posits that perfectionism consists of six key dimensions tapping high standards, organization, concern over mistakes, doubts about actions, parental criticism, and high parental expectations. Although the MPS-F has been shown to have good psychometric properties and continues to be widely used in both clinical and nonclinical samples (Frost & DiBartolo, 2002), it has also drawn criticism on both empirical and conceptual grounds. For instance, the stability of Frost et al.'s (1990) factor structure has come into question with some arguing in favor of a three-factor structure (Purdon, Antony, & Swinson, 1999) and others demonstrating evidence to support a four-factor structure (Stöber, 1998).

On conceptual grounds, the MPS-F has received two primary criticisms. First, some have questioned the validity of the MPS-F on the basis that some of the subscales tap measures of psychopathology that are seen as correlates or outcomes of perfectionism rather than perfectionism per se. For instance, Shafran and Mansell (2001) claimed that the doubt about actions subscale of the MPS-F assesses checking symptoms of obsessive-compulsive disorder (OCD), rather than perfectionism itself, a criticism that may have validity, as this subscale consists primarily of items taken from the Maudsley Obsessive Compulsive Inventory (MOCI; Hodgson & Rachman, 1977) which measures OCD symptoms. Second, the MPS-F has been challenged on the basis that the parental expectations and parental criticism subscales confound etiological factors with the core components of perfectionism. For instance, Rheaume et al. (2000) pointed out that "the inclusion of developmental aspects of perfectionism makes it difficult to interpret results and understand perfectionism itself" (p. 120). This criticism has merit, given that parental factors have been given the greatest emphasis regarding the etiology of perfectionism.

Based on their review of the literature and clinical observations, Hewitt and Flett (1991) concluded that perfectionism includes intrapersonal as well as interpersonal aspects and asserted that perfectionism should be conceptualized as three dimensions centered on interpersonal source and direction: self-oriented perfectionism (i.e., the setting of excessively high personal standards, accompanied by strict guidelines and evaluations of personal behavior); other-oriented perfectionism (i.e., the tendency to hold exceedingly high standards for other people); and socially pre-

scribed perfectionism (i.e., the need to attain standards perceived to be imposed by significant others) (Flett & Hewitt, 2002). They further developed their own Multidimensional Perfectionism Scale (MPS-HF; Hewitt & Flett, 1991) to assess each of these components, and the reliability and validity of the MPS-HF have been shown to be quite impressive (Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991). Hence, whereas Frost et al.'s (1990) model treats perfectionism primarily as a self-focused construct, Hewitt and Flett's (1991) conceptual framework places equal emphasis on both the personal and social aspects of perfectionism.

A large body of literature supports that self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism are differentially related to myriad important outcomes such as psychopathology, relationship functioning, and health (Hewitt & Flett, 1991; Hewitt, Flett, & Mikail, 1995; Molnar, Reker, Culp, Sadava, & DeCourville, 2006). However, the MPS-HF is not without its critics. Shafran et al. (2002), for example, argue that consistent with historical definitions, only self-oriented perfectionism assesses the construct of perfectionism and that the other two dimensions (i.e., other-oriented perfectionism and socially prescribed perfectionism) are only tangential to the construct. They then go on to blame the widespread acceptance and use of the Frost et al.'s (1990) and the Hewitt and Flett's (1991) Multidimensional Perfectionism Scales as bolstering the view that perfectionism is multidimensional rather than remain a clinically based construct. However, Hewitt, Flett, Besser, Sherry, and McGee (2003) maintain that perfectionism is multidimensional by drawing attention to evidence indicating that each of the MPS-HF dimensions is differentially related to numerous outcomes, such as psychopathology, and by highlighting that both socially prescribed and other-oriented perfectionism disrupt the therapeutic alliance, thus showing that the interpersonal dimensions of perfectionism also have important clinical implications.

Finally, Slaney and colleagues (see Slaney, Rice, & Ashby, 2002; Slaney, Rice, Mobley, Trippi, & Ashby, 2001) developed the Almost Perfect Scale-Revised (APS-R) in an effort to assess both positive and negative features of perfectionism, especially with regard to their implications for therapy. According to their model, perfectionism consists of three dimensions: high standards, order, and discrepancy. Standards assess individuals' self-performance expectations and incorporate some elements of personal standards, as measured by the MPS-F, and some features of self-oriented perfectionism, as measured by the MPS-HF, whereas the unique dimension of discrepancy measures the degree of self-critical evaluation in an individual's perceived capability to achieve expected standards (e.g., doing my best never seems to be enough). Order assesses preferences for order and organization, but it appears to be less pivotal in gauging the central aspects of perfectionism (Stoeber & Otto, 2006). Research has supported the psychometric properties of the APS-R, demonstrating adequate reliability and that the standards and the order factors are positively and moderately associated, whereas the association between the standards and discrepancy scales is generally inconsequential (Ashby & Rice, 2002; Slaney et al., 2001). This last finding is worth noting as it indicates that the APS-R is likely measuring two very well-defined forms of perfectionism.

However, as seen with the previous two trait measures of perfectionism, there are also criticisms of the APS-R as well. First, it can be argued that some of the dimensions assessed in the APS-R do not seem to conceptually map onto other measures of perfectionism (e.g., the MPS-F and the MPS-HF) very well, thus making comparison of studies difficult. Some researchers have also called the construct validity of the APS-R into question. Flett and Hewitt (2002), for instance, have argued that discrepancy is not a fundamental element of perfectionism, but is a related and independent construct. Specifically, they contend that there are important temporal differences between trait perfectionism and self-evaluation, such that perfectionism is relatively stable, whereas self-evaluation varies based on one's experiences and feedback (Flett & Hewitt, 2002). In support of their argument, they drew attention to research on perfectionism and self-efficacy, which demonstrates that the two constructs are separable.

Perfectionistic Strivings and Perfectionistic Concerns

Although each of these models and accompanying measures of trait perfectionism continue to be widely used in the field, contemporary research has indicated that two underlying higher order dimensions of trait perfectionism can be extrapolated from the most widely used perfectionism measures (e.g., the MPS-HF, Hewitt & Flett, 1991; the MPS-F, Frost et al., 1990; and the APS-R, Slaney et al., 2001). Although they have been cast with different labels, most researchers tend to refer to these underlying factors as perfectionistic strivings (PS) and perfectionistic concerns (PC). *PS* refers to the propensity to set excessively high personal standards that are often unrealistic in nature and to demand nothing less than perfection from the self. Indicators of PS include the personal standards subscale of the MPS-F along with the self-oriented perfectionism subscale from the MPS-HF and the standards subscale from the APS-R. *PC* includes extraordinarily critical appraisals of one's own behavior, chronic harsh self-scrutiny, excessive preoccupations with others' evaluations, expectations, and criticism, and an inability to gain satisfaction even when one is successful in an endeavor. Subscales tapping this dimension include concern over mistakes, parental expectations, parental criticism, and doubt about actions from the MPS-F, socially prescribed perfectionism from the MPS-HF, and discrepancy from the APS-R.

Not only do factor analytic studies support these two high-order factors of perfectionism using a variety of samples and measures of perfectionism (Bieling et al., 2004; Slade & Owens, 1998; Terry-Short, Owens, Slade, & Dewey, 1995), but researchers have also documented that these factors are differentially related to health and well-being. PC is consistently related to poorer health (Molnar, Sadava, Flett, & Colautti, 2012), greater psychopathology (see Shafran & Mansell, 2001), and poorer well-being (Chang, 2000, Chang, Watkins, & Banks, 2004; Dunkley et al., 2003). PS, on the other hand, is associated with both better and worse health and well-being. On the one hand, PS is associated with higher levels of positive affect

(Bieling, Israeli, Smith, & Antony, 2003), greater life satisfaction (Bergman, Nyland, & Burns, 2007; Chang et al., 2004), and better physical health (Molnar et al., 2006). Yet, on the other hand, it is also a risk factor for eating disorders (Bardone-Cone et al., 2007) and poorer physical health (Fry & Debats, 2011; Molnar et al., 2012) and is related to experiencing greater psychopathology after a performance failure (Besser, Flett, & Hewitt, 2004).

Finally, consistent with Hewitt and Flett's (1991) model of perfectionism, some researchers are beginning to argue in favor of a three-factor model, suggesting that other-oriented perfectionism (OOP) should be included along with PS and PC. OOP measures the extent to which individuals rigidly demand perfection from others in an exacting and entitled way and are being highly critical of others. Indeed, research has demonstrated that OOP is most relevant in the domain of interpersonal functioning as it has been related to maladaptive relational outcomes, such as higher levels of negative affect, higher levels of marital conflict, and lower levels of sexual satisfaction (Blatt, 1974; Habke, Hewitt, & Flett, 1999). Further, it has been established that OOP is uniquely related to other markers of poor relationship functioning, such as the dark triad traits of narcissism, Machiavellianism, and psychopathy (Sherry, Gralnick, Hewitt, Sherry, & Flett, in press; Stoeber, 2014). However, our understanding of OOP is rather limited since this dimension of perfectionism has received far less attention in the research literature in comparison with PS and PC.

Health and Well-Being: An Introductory Primer

The terms "health and well-being" are common conceptual companions in the contemporary vernacular that refer to related but distinct concepts. A frequent underlying assumption in pairing these concepts is that in experiencing good health, one may also expect to experience well-being. However, this also implies the converse; that without good health, well-being may be elusive. The assumed directionality of these statements aside, theory and research indicates that health and well-being are inextricably linked.

Unpacking the Dynamics of Health

One of the most widely recognized and used conceptualizations of health is from the World Health Organization (WHO) which in 1948 defined health as "a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity."

Current conceptualizations of health have emerged largely from this positive and inclusive view of health which acknowledges the importance of assessing health not just in physical terms, but also with respect to psychological and social well-being. Extending this view, public health promotion perspectives conceptualize health as

"the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish, Green, Ratner, Chomik, & Larsen, 1996, p. 6). This definition moves from a primarily descriptive view of health to one that highlights the key roles of factors such as coping and health behaviors for maximizing, promoting, and maintaining health. Characteristic coping responses can up- or down-regulate the physiological stress response, through differences in how potential stressors are appraised and perceptions of the availability of coping resources (Lazarus & Folkman, 1984). The magnitude and length of activation of the stress response (and the hypothalamic–pituitary–cortical–adrenal (HPCA) system in particular) in turn, can have important implications for the regulation of the immune system and inflammatory processes which are known precursors of a variety of acute and chronic illnesses (Cohen et al., 2012; Juster, McEwen, & Lupien, 2010; McEwen, 2007). Similarly, maximizing health-promoting behaviors and minimizing health risk behaviors are key for maintaining health and reducing risk of disease (Bogg & Roberts, 2013; Hampson et al., 2007).

Consistent with this view and relevant for our focus on perfectionism, models linking personality to health include coping and health behaviors as routes through which personality may influence health and well-being outcomes (Smith, 2006). Not surprisingly, current research confirms that perfectionism is linked to both coping and health behaviors (see this volume, Dunkley et al., Chap. 7; Sirois, Chap. 3, this volume). Moreover, in the context of chronic illness which poses an ongoing challenge, perfectionism may confer particular risk for poor adjustment and disease management because of its links to poor coping and health behaviors (Sirois & Molnar, 2014; see also Kempke et al., Chap. 5; Molnar et al. Chap. 4, this volume).

No discussion of how we understand health would be complete without the mention of the biopsychosocial model of health and illness. Implicit within the name of this model is the notion that health and illness are based on multifactorial processes. Specifically, health is viewed as the intersection of biological, psychological, and social systems, and the interaction of micro- and macroprocesses across these systems. For example, microlevel processes, including cellular and immune system changes, are viewed as being nested within macrolevel processes, including availability of social support and levels of depressive affect, with changes in one level affecting the other and vice versa (Taylor & Sirois, 2014). Thus, the biopsychosocial model presents a dynamic and comprehensive framework for understanding the multiplicity of factors that can create risk or resilience for health.

With respect to perfectionism and physical health, the complexity of the biopsychosocial factors involved is only just beginning to be fully explored. For example, research is now providing compelling evidence that perfectionism may play a predisposing, precipitating, or perpetuating role in certain chronic health conditions (see Kempke et al., Chap. 5; Molnar et al., Chap. 4, this volume). Moreover, the mood disturbances associated with certain forms of perfectionism can create risk for the development of psychopathologies, such as eating disorders which are known to have a direct effect on physical health (see Wade, O'Shea, & Shafran, Chap. 9, this volume). The influence of perfectionism on stress and coping can also contribute to poor health outcomes in general (see Dunkley et al., Chap. 7, this

volume) and especially for those living with a chronic health condition (see Molnar et al., Chap. 4, this volume). Given the key role of social factors and social support for health in the biopsychosocial model, the social disconnection associated with perfectionism may also confer further risk for health (see Sherry, Mackinnon, & Gautreau, Chap. 10, this volume).

Well-Being: A Convergence of Competing Perspectives

Whether conceived of as a transitory state of positive feelings and satisfaction, or as a continuing process of growth and adaptation to changing life circumstances, well-being is an increasingly popular topic for researchers and clinicians alike (Sirois, 2011). In the past 5 years alone, the term "well-being" has more than 475,000 citations indexed within the scholarly research literature. Yet, despite this proliferation of interest, consensus regarding a single definition of well-being is lacking (Dodge, Daly, Huyton, & Sander, 2012). Instead, the term "well-being" is often viewed as being synonymous with related terms such as happiness, wellness, mental health, and quality of life. Indeed, the World Health Organization (2005, p. 2) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." This and similar views of well-being are in sharp contrast to early conceptualizations which focused on the absence of distress as the key defining quality of well-being (McDowell, 2010). In this respect, the evolution of our understanding of well-being has paralleled the trajectory for how we view health, moving towards definitions of inclusion rather than exclusion, but without one clear, universally agreed upon conceptualization.

This lack of agreement aside, a commonality among modern conceptualizations of well-being is that their roots come from one of two ancient Greek traditions. The first is aligned with the ancient Greek Epicurean conceptions of the nature of living the "Good Life" (Waterman, 1993, 2008) and emphasizes maximizing pleasure—"hedonia"—and minimizing pain. From this hedonic perspective, well-being is comprised of two broad components: an emotional component that includes high levels of positive emotions (e.g., happiness, contentment) and low levels of negative emotions (e.g., anxiety, depression) and an evaluative component that includes overall satisfaction with life and satisfaction with specific, important life domains such as family life, work, and personal life (Ryan & Deci, 2001). Given the subjective evaluation involved in both of these components, researchers often adopt the term "subjective well-being" to describe this particular hedonic view of well-being (Diener, 1984; Diener, Suh, Lucas, & Smith, 1999). In short, well-being in the hedonic tradition is feeling good and evaluating one's life as satisfying.

The alternative and rivalling view of well-being is rooted in the classical Greek teachings of Aristotle and his Nicomachean ethics (1985). The eudaimonic view proposes that well-being arises, not from the pursuit of pleasure, but from the

pursuit of goals that are aligned with the authentic self or *daimon*. To Aristotle, eudaimonia was not a subjective, but an objective state that arose from contemplating the best within oneself and personal excellence (Waterman, 2008). Modern scholars who subscribe to this particular view of well-being have extended this to acting upon personal contemplations of authenticity (Ryff, 1989; Ryff & Keyes, 1995), with well-being as an emergent property of engaging in growth-promoting pursuits that help develop one's potential (Sirois, 2011). Consistent with this view, Ryff and colleagues (1989; Ryff & Keyes, 1995) have proposed a model of *psychological well-being* comprised of multiple dynamic dimensions which reflect optimal psychological functioning. Three core dimensions—personal growth, purpose in life, and positive relations with others—are proposed to capture the essence of eudaimonic well-being and its dynamic, action-oriented focus on purposefully pursuing meaningful goals and cultivating rewarding relationships. Thus, well-being from the eudaimonic tradition is focused more on the process of flourishing rather than the outcome of simply feeling good (Sirois, 2011).

Despite the distinctions in how well-being is conceptualized in each of these models, researchers have nonetheless acknowledged that considerable overlap does exist. For example, knowing that one is engaged in the pursuit of meaningful goals that reflect fulfilling one's potential may increase feelings of happiness and life satisfaction. Researchers have therefore suggested that from a practical standpoint, it makes sense to think of each type of well-being as running in tandem with each other (Biswas-Diener, Kashdan, & King, 2009; Kashdan, Biswas-Diener, & King, 2008), rather than being separate and distinct.

Elements from each of these conceptualizations have relevance for understanding how perfectionism dimensions may relate to different levels of well-being. From the lens of hedonic models of well-being, the high levels of negative affect such as worry, anxiety, and distress associated with PC perfectionism would be an indicator of poor well-being (see Burgess & DiBartolo, Chap. 8; Dunkley et al., Chap. 7; Flett et al., Chap. 6, this volume). In terms of the evaluative component of well-being, not being easily satisfied with one's performance is arguably one of the defining features of perfectionism, and especially PC perfectionism, which is linked to burnout and dissatisfaction with work (see Stoeber & Damian, Chap. 12, this volume) and lower academic satisfaction (see Rice, Richardson, & Ray, Chap. 11, this volume). However, there is some evidence that PS perfectionists also experience little satisfaction from their achievements (Hewitt & Flett, 1991; Mor, Day, Flett, & Hewitt, 1995) and may be more inclined to dissatisfaction with their performance after failure than PC perfectionists (Besser et al. 2004). Regarding general life satisfaction, several studies have now shown clear links between PC perfectionism and lower life satisfaction. (Ashby, Noble, & Gnilka, 2012; Chang, 2000; Williams & Cropley, 2014).

If we map perfectionism onto the eudaemonic landscape of well-being, the prospects are not as encouraging as what might be expected. Ostensibly, the setting and striving for high standards that is the hallmark of PS perfectionism should contribute to increased eudaemonic well-being, insomuch that this striving reflects pursuing one's purpose in life and/or promotes personal growth. However, when

this striving becomes excessive, unrelenting, and based on the standards of others rather than one's own, or on the standards that are inherently unrealistic rather than authentic, well-being may be at risk (see this volume, Rice et al., Chap. 11; Stoeber & Damian, Chap. 12). In addition, there is mounting evidence that many perfectionists are interpersonally distressed and find having positive relations with others a challenge (see Sherry et al., Chap. 10, this volume). Collectively, this constellation of findings suggests that perfectionism, and PC perfectionism in particular, creates risk for well-being.

Overview of the Book

Following this introductory chapter, the latest perspectives on perfectionism, health, and well-being will be presented in three main sections. Each chapter will not only present the most up-to-date and cutting-edge research on perfectionism, health, and well-being, but will also highlight how the latest findings impact long-standing debates in the field such as whether perfectionism has an adaptive component or not. The first section will cover both historical and emerging research perspectives on the linkages between perfectionism and physical health. The second section will examine the dynamic interrelations of affect and cognition that underlie how perfectionism relates to well-being and associated psychopathologies. The third section puts perfectionism, health, and well-being in context by discussing the latest findings on the implications of excessive striving for high standards in life domains that often demand excellence (work life and academics), or where having excessively high standards may be particularly problematic for both the perfectionist and those around the perfectionist (relationships).

Part I: Perfectionism and Health

Physical health is arguably a fundamental factor in the experience of well-being. Yet, until recently, understanding how perfectionism may be implicated in physical health has been an understudied area of the perfectionism literature. This initial set of chapters addresses this gap from historical, empirical, and theoretical perspectives.

Flett et al. (Chap. 2) take us on a historical journey of the theoretical, methodological, and ideological issues in the literature on perfectionism and health. Using case studies and early empirical research, their summary of the "hidden literature" highlights the value of a rich, but often overlooked source of information for both understanding and conceptualizing the linkages among perfectionism, physical health, and illness. They conclude that perfectionism is more of a liability than a benefit for physical health and call for a more person-centered rather than variable-

centered approach to understanding when and why perfectionism may pose health risks.

The contribution by Sirois (Chap. 3) focuses on positive health behaviors as an important route through which perfectionism may influence health. Sirois argues that taking a self-regulation approach is necessary for understanding how and why perfectionism dimensions may promote or prevent the practice of health-promoting behaviors and reviews the theory and research on perfectionism and self-regulation. Combining this limited literature with preliminary supportive evidence, Sirois proposes a new self-regulation resource model that highlights the reciprocal and dynamic roles of affective and temporal self-regulation resources and liabilities for conceptualizing how perfectionism relates to the practice of important health behaviors.

Next, Molnar et al. (Chap. 4) present a contemporary view of perfectionism in the context of chronic illness. Throughout this chapter, they propose that perfectionism should not only be considered when examining the etiological factors involved in illness, but also when examining adjustment to illness. After critically reviewing the literature relating perfectionism to chronic illness, they present their new Stress and Coping Cyclical Amplification Model of Perfectionism in Illness (SCCAMPI) that underscores the importance of the intrapsychic and interpersonal processes that link perfectionism to important health outcomes through the amplification of stress and maladaptive coping.

Moving from a broad to a more focused perspective of perfectionism and chronic illness, Kempke et al. (Chap. 5) review and discuss the involvement of perfectionism in the development and maintenance of chronic fatigue syndrome (CFS). Their research and review of this topic supports a working model of self-critical perfectionism and CFS that places chronic stress in a central role for understanding the deleterious effects of perfectionism in this context. They conclude that a greater emphasis on, and therapeutic attention to, the dysfunctional cognitive and affective patterns associated with self-critical perfectionism may be beneficial for treatment of CFS patients with high levels of self-critical perfectionism.

Part II: Perfectionism, Psychopathology, and Well-Being

As noted earlier in this chapter, well-being and health are inextricably linked. But like health, well-being is often defined as being more than just the absence of distress or psychopathology. This more inclusive conceptualization aside, when distress and/or psychopathology is present, it is usually an indicator of poor well-being. The chapters in this section tackle the issue of how perfectionism may relate to both global and more specific indicators of poor well-being and provide unique perspectives on the latest research and theory to help guide both researchers and clinicians.

Flett et al. (Chap. 6) open this section with a review and discussion of the central roles of rumination and worry in poor health and well-being outcomes. Noting that tendencies to excessively worry and overthink are key features of both self-

oriented and socially prescribed perfectionists, they introduce a perfectionism cognition theory that explains how "perseverating perfectionists" may be vulnerable to both emotional distress and physical health problems. Their comprehensive review argues for the need to consider how issues concerning self and identity underlie a tendency toward perfectionistic rumination.

Dunkley et al. (Chap. 7) address the important issue of how perfectionism dimensions may differentially relate to stress and coping processes and associated well-being outcomes. Reviewing the literature with a focus on mediators and moderators of perfectionism and stress, they highlight the central roles of coping strategies and social support for understanding how and why self-critical and personal standards perfectionism may be related to different well-being outcomes. They further highlight several methodological limitations in the current perfectionism and stress research that should be addressed, including the predominance of self-report rather than physiological measures of stress and a lack of experimental and sophisticated event-sampling methodologies.

Burgess and DiBartolo (Chap. 8) continue and extend the theme of perfectionism and psychological distress by focusing more specifically on how the perfectionism–anxiety relationship is qualified by the multidimensional nature of perfectionism. In reviewing how perfectionism dimensions relate to a broad spectrum of anxiety symptomology, they note potential mediating and moderating roles for stress regulation, social factors, and cognitions. They conclude with recommendations for advancing the field that focus on theory-driven and methodological appropriate research to better elucidate the often complex nature of the perfectionism–anxiety relationship.

In their chapter, Wade et al. (Chap. 9) provide a comprehensive overview of the literature linking perfectionism to eating disorders. Their review of the prominent theories on this topic, along with the extant research suggesting a causal role for different perfectionism dimensions, highlights the complexities of mechanisms that may link perfectionism to both the development and maintenance of eating disorders. They argue for the importance of and need for interventions that target perfectionism not only in the treatment of, but also in the prevention of eating disorders.

Part III: Perfectionism, Health, and Well-Being in Context

The associations among perfectionism, health, and well-being do not manifest themselves in a social vacuum. It is therefore important that these linkages be studied within the context of the interpersonal worlds in which they occur. The chapters in this final section place perfectionism, health, and well-being in context by examining three key social arenas—interpersonal relationships, academic settings, and work life—where striving for perfection may have some expected as well as unexpected consequences.

Sherry et al. (Chap. 10) present their expanded social disconnection model (SDM) of perfectionism and psychopathology and argue that distinguishing between personality-dependent and personality-independent moderators is important

for gaining insights into the interpersonal ramifications of perfectionism. The expanded SDM provides an inclusive view of how different perfectionism dimensions create vulnerabilities for poor interpersonal relationships and elucidates the mechanisms that explain the link between perfectionism and psychopathology. Using two case studies of well-known public figures to illustrate the utility of the expanded SDM, they provide compelling evidence for their assertion that perfectionists do not play well with others.

Rice et al. (Chap. 11) navigate the important issue of how perfectionism may affect students across the academic setting continuum and present evidence supporting a multivalenced view of perfectionism in this context. They note that although perfectionism is fundamentally a performance-based construct, issues in the conceptualization and analysis of perfectionism can often make understanding the implications of perfectionism in academic settings difficult. Nonetheless, their review suggests that unhealthy forms of perfectionism put students at an overall disadvantage in terms of academic performance and well-being, due in part to the self-critical aspects of perfectionism.

Next, Stoeber and Damian (Chap. 12) provide an overview of how perfectionism relates to key well-being indicators in the context of working life. Their review of the limited research on how perfectionism dimensions relate to burnout, work engagement, and workaholism among employees reveals important distinctions between perfectionistic strivings and perfectionistic concerns. They propose two hypothetical models to explain these differential results and guide future research and note the importance of conducting more methodologically rigorous research to better understand the implications of perfectionism for well-being in the workplace.

In the concluding chapter of this volume, Molnar and Sirois (Chap. 13) highlight prominent themes that arise when studying the interface of perfectionism, health, and well-being. They then offer suggestions for future research to help guide the next generation of perfectionism researchers.

Conclusions

Empirical and theoretical advances into the nature of perfectionism and its associated outcomes have heightened awareness and understanding of the effects of setting and striving for excessively high, and often unrealistic, standards. Although striving for perfection may be viewed as desirable and even may be rewarded in certain contexts, the evidence to date is often equivocal regarding the nature of the linkages of perfectionism to health and well-being, and especially in light of more sophisticated and interrelated views of these concepts. Consistent with biopsychosocial and public health promotion views of health, understanding the implications of perfectionism for health and well-being requires integrating rather than separating research on these related outcomes as well as studying them in the contexts in which they occur. What becomes clear from these issues is that whether perfectionism is healthy or unhealthy may not be the best question to ask. Rather, asking when, why,

and how perfectionism can pose risk or resilience for health and well-being may provide richer and more accurate insights into these important issues. We believe that navigating the complexities of these often controversial issues and questions is a worthwhile endeavor as the answers can have significant public health implications. By taking different perspectives, the contributions in this book illustrate that there is strength in diversity when examining the mechanisms and processes that may render certain perfectionists particularly vulnerable to poor health and well-being. As editors, we hope that bringing these contributions fields together into one volume will provide a unique and useful resource for readers that will stimulate further research, theory, and debate.

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