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Perfectionism

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Overview

Perfectionism has been associated with higher levels of psychological maladjustment and disorder in adolescence and lower levels of subjective well-being and psychological adjustment. Perfectionism, however, is a multidimensional disposition, and not all dimensions of perfectionism are necessarily unhealthy and maladaptive. This entry presents an overview about perfectionism in adolescence and the main dimensions of perfectionism: perfectionistic strivings and perfectionistic concerns. It shows how the two dimensions are related to subjective well-being, psychological adjustment and maladjustment, and disorder. Moreover, it informs on how perfectionism can be measured and what factors influence the development of perfectionism in children and adolescents. Moreover, it will discuss what is still unknown about perfectionism and why the notion that perfectionism can be healthy or adaptive is controversially debated.

Entry Essay

Dimensions of Perfectionism

Perfectionism is a personality disposition characterized by striving for flawlessness and setting excessively high standards for performance accompanied by tendencies for overly critical evaluations (Flett & Hewitt, 2002; Frost, Marten, Lahart, & Rosenblate, 1990). It is a disposition that pervades all areas of life, particularly work and school, and may also affect one's personal appearance and social relationships (Stoeber & Stoeber, 2009).

Traditionally, perfectionism has been regarded as a sign of psychological maladjustment and disorder (e.g., Burns, 1980; Pacht, 1984) as people seeking treatment for anxiety and depression often showed elevated levels of perfectionism. In addition, early psychological conceptions regarded perfectionism as a one-dimensional personality disposition (e.g., Burns, 1980). In the 1990s, however, a more differentiated view emerged conceptualizing perfectionism

as multidimensional and multifaceted (Frost et al., 1990; Hewitt & Flett, 1991; see Enns & Cox, 2002, for a review). Moreover, it emerged that two main dimensions of perfectionism should be differentiated (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993; Stoeber & Otto, 2006): perfectionistic strivings and perfectionistic concerns. The dimension of *perfectionistic strivings* captures those facets of perfectionism that relate to perfectionistic personal standards and a self-oriented striving for perfection. This dimension was found to be associated with positive characteristics, processes, and outcomes such as conscientiousness, adaptive coping, and positive affect and also higher levels of subjective well-being and psychological adjustment. In comparison, the dimension of *perfectionistic concerns* captures those facets of perfectionism that relate to concern over mistakes, doubts about actions, concern over others' evaluation of one's performance, and feelings of discrepancy between one's expectations and performance. This dimension was found to be associated with negative characteristics, processes, and outcomes such as neuroticism, maladaptive coping, and negative affect and also higher levels of indicators of psychological maladjustment and disorder (see Stoeber & Otto, 2006, for a comprehensive review). Moreover, with the two main dimensions of perfectionism, people can be classified into three groups of perfectionists: healthy perfectionists, unhealthy perfectionists, and nonperfectionists (see Figure 1). Healthy perfectionists (also referred to as adaptive perfectionists) show high levels of perfectionistic strivings, but low levels of perfectionistic concerns. Unhealthy perfectionists (also referred to as maladaptive perfectionists) show high levels of perfectionistic strivings and high levels of perfectionistic concerns. Finally, nonperfectionists show low levels of perfectionistic strivings (see also Rice & Ashby, 2007). The differentiation between perfectionistic strivings and perfectionistic concerns as well as the differentiation between the three groups of perfectionists (particularly healthy and unhealthy

perfectionists) has proven key to understanding the findings from research on perfectionism in general and research on perfectionism in adolescence in particular.

Research on Perfectionism in Adolescence

If we define adolescence as the life time from 10 to 21 years (Steinberg, 2008), but exclude studies with undergraduate students (because undergraduate student samples also contain older students) and studies with gifted adolescents, adolescent inpatients, adolescents seeking treatment, and adolescent athletes (because they represent special populations), most research findings on perfectionism in adolescence come from studies conducted with school students attending grades 6 to 12. Mirroring the findings from studies with undergraduate and adult samples, the findings from studies with adolescent school students show that perfectionism in adolescence is often associated with indicators of psychological maladjustment and disorder. However, across studies, the findings consistently demonstrate that perfectionistic concerns—not perfectionistic strivings—is the dimension of perfectionism that is predominantly associated with such indicators. For example, perfectionistic concerns in adolescents are associated with higher levels of fear of failure, stress, depression, anxiety, and somatic complaints (Einstein, Lovibond, & Gaston, 2000; Gilman, Ashby, Sverko, Florell, & Varjas, 2005; Hewitt et al., 2002; Nounopoulos, Ashby, & Gilman, 2006; Stoeber & Rambow, 2007). In addition, perfectionistic concerns are associated with low levels of academic confidence and satisfaction with life (satisfaction with self, school, family). In contrast, the perfectionistic strivings dimension of perfectionism has been found to be associated with indicators of subjective well-being and psychological adjustment. For example, perfectionistic strivings in adolescents are associated with higher levels of hope for success, motivation for attending school, motivation for exam preparation, mastery and work orientation (showing a preference for challenging tasks),

academic confidence, peer acceptance, number of hours spent studying per week, and academic achievement (as indicated by higher grade point average) as well as with higher self-esteem and satisfaction with life (Accordino, Accordino, & Slaney, 2001; Einstein et al., 2000; Gilman et al., 2005; Nounopoulos et al., 2006; Stoeber & Rambow, 2007).

Moreover, adolescents classified as healthy perfectionists generally show higher levels of subjective well-being and psychological adjustment (e.g., satisfaction with life, grade point average) than adolescents classified as unhealthy perfectionists. In some studies, adolescents classified as healthy perfectionists even showed significantly higher levels of subjective well-being and psychological adjustment (e.g., satisfaction with life) than adolescents classified as nonperfectionists (Öngen, 2009; Wang, Yuen, & Slaney, 2009). In contrast, adolescents classified as unhealthy perfectionists have been found to show higher levels of indicators of psychological maladjustment and disorder (e.g., depression) than adolescents classified as healthy perfectionists and nonperfectionists (e.g., Gilman et al., 2005; Wang et al., 2009).

Measuring Perfectionism in Adolescence

In the past 20 years, the measurement of perfectionism has made great progress evolving from one-dimensional measures of perfectionism (e.g., Burns, 1980) to multidimensional measures of perfectionism capturing all important aspects of perfectionism (see Enns & Cox, 2002, for a review). To measure multidimensional perfectionism in adolescence, three self-report questionnaires are predominantly used: (a) the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991) and its version specifically adapted for children and adolescents, the Child-Adolescent Perfectionism Scale (Flett, Hewitt, Boucher, Davidson, & Munro, 2000); (b) the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990); and (c) the Almost Perfect Scale-Revised (APS-R; Slaney, Rice, Mobley, Trippi, & Ashby, 2001). The MPS and

CAPS contain scales that measure self-oriented perfectionism and socially prescribed perfectionism. Self-oriented perfectionism captures self-oriented striving for perfection, whereas socially prescribed perfectionism captures beliefs that others have high standards for oneself and that acceptance by others is conditional on fulfilling these standards. The FMPS contains scales that measure personal standards and concern over mistakes; and the APS-R contains scales that measure high standards and discrepancy. Both personal standards and high standards capture setting extremely high standards for one's performance, whereas concern over mistakes captures concerns about making mistakes and not living up to these high standards, and discrepancy captures feelings of discrepancy between one's expectations and performance. Despite their differences, all three measures can be used to capture the two main dimensions of perfectionism: Perfectionistic strivings can be captured with MPS/CAPS self-oriented perfectionism, FMPS personal standards, and APS-R high standards; and perfectionistic concerns can be captured with MPS/CAPS socially prescribed perfectionism, FMPS concern over mistakes, and APS-R discrepancy (Stoeber & Otto, 2006). Moreover, by using median splits or empirically determined cut-off scores, the scales can be used to classify individuals into the three groups of healthy perfectionists, unhealthy perfectionists, and nonperfectionists (see Rice & Ashby, 2007; Stoeber & Otto, 2006).

However, there are two caveats. First, self-oriented perfectionism as measured with the MPS and CAPS, which is an indicator of perfectionistic strivings, has been associated with disordered eating in adolescents, even when the influence of perfectionistic concerns is controlled for (McVey, Pepler, Davis, Flett, & Abdolell, 2002; Miller-Day & Marks, 2006). Moreover, the MPS and CAPS scale measuring self-oriented perfectionism not only contains items that capture perfectionistic strivings, but also items that capture beliefs that it is important

to be perfect (Campbell & Di Paula, 2002; Stoeber & Childs, in press) and items that capture self-criticism (McCreary, Joiner, Schmith, & Ialongo, 2004; O'Connor, Dixon, & Rasmussen, in press). Because only perfectionistic strivings are associated with subjective well-being and psychological adjustment (whereas importance of being perfect is not) and because self-criticism is associated psychological maladjustment and disorder, some studies have found that self-oriented perfectionism was associated with psychological maladjustment and disorder in adolescents (e.g., Einstein et al., 2000; Hewitt et al., 2002). To measure pure perfectionistic strivings, it is therefore advisable to use only those items of the MPS/CAPS that capture perfectionistic striving (Campbell & Di Paula, 2002). Second, the FMPS scale measuring perfectionist personal standards contains two items that capture contingent self-worth (i.e., making one's self-worth dependent on one's achievement or on others' approval). Consequently, it is advisable to remove these items from the scale to measure "pure personal standards" (DiBartolo, Frost, Chang, LaSota, & Grills, 2004).

Development of Perfectionism in Adolescence

Whereas the measurement of perfectionism has made great progress over the past 20 years and the different correlates and consequences of perfectionistic strivings and perfectionistic concerns are now well understood, the question of why some children and adolescents become perfectionists is still little understood. While there is general agreement that perfectionism has its roots in childhood development and that parents play a key role in the development of perfectionism (see Flett, Hewitt, Oliver, & Macdonald, 2002, for a review), research on the development of perfectionism is still in its infancy because of the dearth of longitudinal studies with children and adolescents. Most of our present knowledge is based on cross-sectional studies of university students and their parents and on studies with university

students' retrospective reports of perceived parenting. However, cross-sectional studies cannot show causal influences and developmental trajectories, and findings from retrospective studies may be biased (or even distorted) because how people remember their childhood and upbringing is influenced by people's present-day personality (Halverson, 1988). Still, the studies have produced converging evidence suggesting three main hypotheses as to how parents influence the development of perfectionism in their children and adolescents: (a) the parents' perfectionism hypothesis, (b) the parental pressure hypothesis, and (c) the parenting style hypothesis.

The *parents' perfectionism* hypothesis is based in social learning theory (Bandura, 1977). It proposes the idea that children and adolescents develop perfectionism because they "model" (i.e., observe and imitate) their parents' perfectionism. Supportive evidence for this hypothesis comes from studies that investigated correlations between university students' perfectionism and their parents' perfectionism (Chang, 2000; Frost, Lahart, & Rosenblate, 1991; Vieth & Trull, 1999). These studies found significant correlations between children's and parents' perfectionism suggesting that modeling of parents plays a significant role in the development of perfectionism. Moreover, one study (Vieth & Trull, 1999) found significant gender differences—female students' perfectionism correlated higher with their mother's perfectionism and male students' perfectionism correlated higher with their father's perfectionism—suggesting that same-sex modeling (mother-daughter, father-son) is more important than opposite-sex modeling (mother-son, father-daughter).

The *parental pressure* hypothesis is based in two different, but closely related, models of socialization: the social expectations model and the social reactions model (see Flett et al., 2002, for details). Parental pressure to be perfect is a combination of parental expectations that the child should be perfect (social expectations) and parental criticism if the child fails to fulfill

these expectations (social reactions). Traditionally, parental pressure has been associated with maladaptive perfectionism and with indicators of poor psychological adjustment (Frost et al., 1993; Stoeber & Otto, 2006). However, a number of studies have found that parental pressure can also be associated with adaptive perfectionism and good psychological adjustment (e.g., Stöber, 1998; Stoeber & Eismann, 2007). An explanation for these double associations may be that the two elements of parental pressure—parental expectations and parental criticism—have different effects: Parental expectations may mainly lead to perfectionistic strivings, whereas parental criticism may mainly lead to perfectionistic concerns (Rice, Lopez, & Vergara, 2005).

The *parenting style* hypothesis, finally, is based in the theory and research on parenting styles by Baumrind (1971, 1991) and the findings that an authoritarian, harsh, and controlling parenting style is associated with higher levels of psychological maladjustment and disorder compared to a authoritative, warm, and supportive parenting style (see Darling & Steinberg, 1993, for a review). Accordingly, an authoritative, harsh, and controlling parenting style is seen as a factor in the development of unhealthy forms of perfectionism, particularly perfectionistic concerns. Preliminary empirical support for this proposition comes from findings that a harsh parenting style (characterized as critical parenting and low parental care) is associated with high levels of perfectionistic concerns (e.g., Enns, Cox, & Clara, 2002; see Flett et al., 2002 for a review). Moreover, parental psychological control has been shown to lead to increases in adolescents' perfectionistic concerns over time (Soenens et al., 2008). In contrast, parental responsiveness and positive parental communication (characterized as supportive, open communication orientations) have been associated with low levels of perfectionistic concerns (Miller-Day & Marks, 2006). What parental rearing styles may foster the development of perfectionistic strivings, however, is still unknown.

Furthermore, it is still unknown how environmental and social factors other than parents—for example, siblings, peers, teachers, and the school environment—influence the development of perfectionism in adolescents. In talented adolescent musicians, for example, perfectionistic strivings and perfectionistic concerns regarding one's music studies were as strongly related to perceived pressure to be perfect from music teachers as was perceived pressure to be perfect from parents (Stoeber & Eismann, 2007). Further to environmental and social factors, adolescents' personality plays a role in the development of perfectionism. Adolescents who were high in the personality trait of conscientiousness (i.e., the personality trait capturing individual differences in organization, persistence, and motivation in goal-directed behavior) showed increases in perfectionistic strivings over time (Stoeber, Otto, & Dalbert, 2009). Finally, perfectionism also seems to have a genetic component, indicating that individual differences in perfectionism are partly inherited (Tozzi et al., 2004).

Limitations

Besides the lack of longitudinal studies investigating the development of perfectionism in children and adolescents, there are further gaps in the research literature that future studies will have to address. In particular, there is a lack of studies investigating the longitudinal effects of perfectionism on adolescents' subjective well-being, psychological adjustment and maladjustment, and disorder. Because the majority of studies on perfectionism in adolescents has been conducted with samples from North America (USA, Canada) and Western Europe, we do not know if these findings generalize to other cultures. In particular, studies involving a direct cross-cultural comparison are missing. However, the few cross-cultural studies that have been conducted so far suggest that the relationships perfectionistic strivings and perfectionistic concerns show with indicators of psychological adjustment and maladjustment are similar across

cultures (e.g., German vs. Chinese adolescents: Essau, Leung, Conradt, Cheng, & Wong, 2008; North American vs. Croatian adolescents: Gilman et al., 2005).

Finally, it is important to note that some researchers are very critical of the notion that perfectionism may be healthy or adaptive (e.g., Greenspon, 2000). These researchers—most of whom come from a clinical background and work with clinical populations or with people seeking counseling or treatment—are predominantly focused on the negative characteristics, processes, and outcomes associated with perfectionism and consequently have serious doubts that perfectionism can be anything other than maladaptive (see Benson, 2003). Yet, it has long been recognized that there are forms of perfectionism that are not necessarily unhealthy and maladaptive and not necessarily associated with psychological maladjustment and disorder (e.g., Hamachek, 1978). Moreover, there is converging evidence that perfectionistic strivings are associated with positive characteristics, processes, and outcomes—particularly when the negative influence of perfectionistic concerns is controlled for or when healthy perfectionists are regarded who are high in perfectionistic strivings and low in perfectionistic concerns (Stoeber & Otto, 2006). Consequently, some clinical psychologists have begun realizing that there is nothing unhealthy or maladaptive about the striving for perfection *as such* (Lundh, 2004). What is unhealthy and maladaptive are dysfunctional cognitions (beliefs, perceptions, and attitudes) that are often associated with perfectionistic concerns such as persistent concern over mistakes and doubts about actions, harsh self-criticism, perceived pressure that others expect you to be perfect, and conditional acceptance, that is, making self-acceptance conditional upon achieving perfection and believing that others will only accept you if you are perfect (e.g., Lundh, 2004; Shafran, Cooper, & Fairnburn, 2002). Such cognitions can be highly distressing, and perfectionistic adolescents suffering from these cognitions may need special attention, help,

counseling, or treatment (for helpful interventions, see Antony & Swindon, 1998; Pleva & Wade, 2007). In perfectionistic adolescents who do not hold such dysfunctional beliefs, perceptions, and attitudes, however, perfectionistic strivings are nothing to be concerned about. In these adolescents, perfectionistic strivings may rather form part of a healthy pursuit of excellence.

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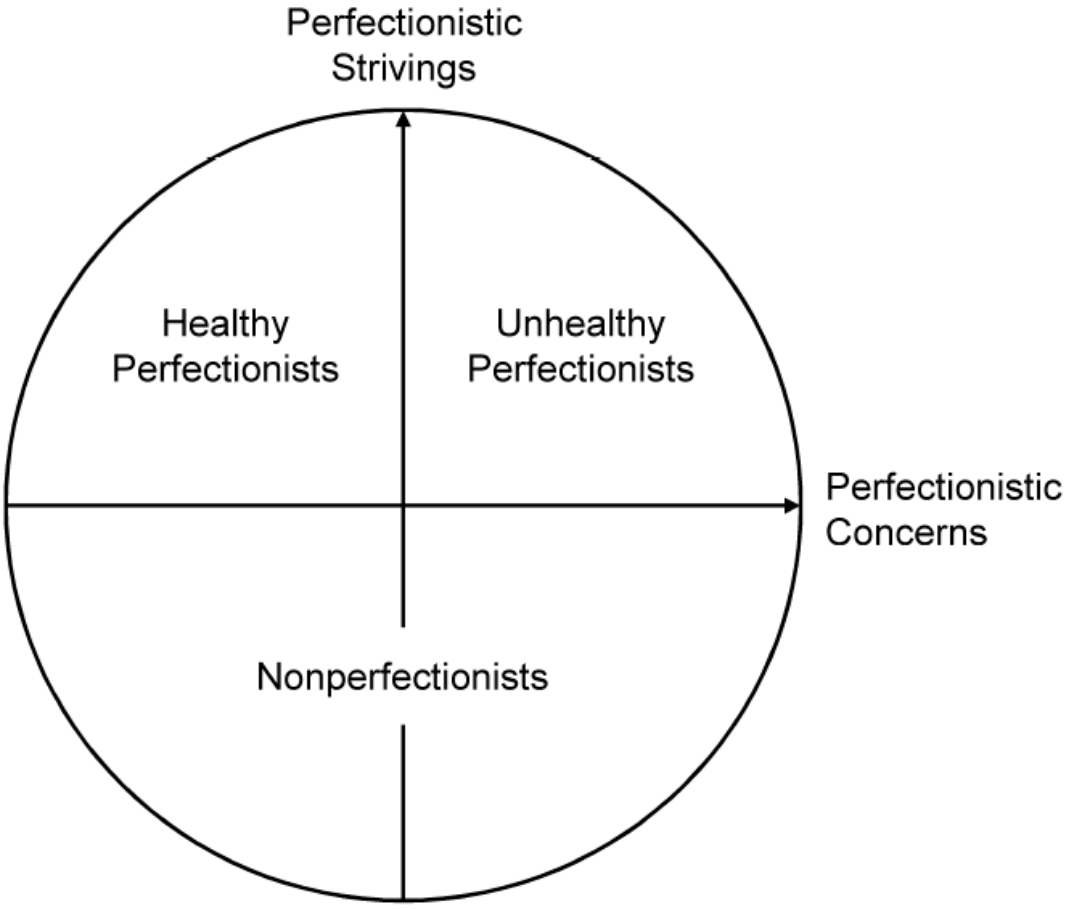

Figure 1. Across multidimensional models of perfectionism, two main dimensions of perfectionism can be distinguished (perfectionistic strivings, perfectionistic concerns) and can be used to differentiate between three groups of perfectionists (healthy perfectionists, unhealthy perfectionists, nonperfectionists). Adapted from "Positive conceptions of perfectionism: Approaches, evidence, challenges," by J. Stoeber and K. Otto, *Personality and Social Psychology Review, 10*, p. 296. Copyright 2006 by Lawrence Erlbaum Associates, Inc.