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Perfectionism and health functioning in women with fibromyalgia

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ABSTRACT

Objective: The purpose of this study was to examine the associations between dimensions of perfectionism (self-oriented, other-oriented, and socially prescribed perfectionism) and health functioning in a sample of 489 women with fibromyalgia.
Methods: Hierarchical multiple regression was used to determine whether dimensions of perfectionism were differentially associated with health functioning among women with fibromyalgia after accounting for broader personality traits related to both perfectionism and health functioning.
Results: The results confirmed that both socially prescribed perfectionism and self-oriented perfectionism were associated with lower health functioning. Moreover, these associations were found after accounting for the effects of conscientiousness, extraversion, and neuroticism. The findings involving self-oriented perfectionism were particularly complex and suggested that moderate self-oriented perfectionism may be somewhat adaptive, but too much or too little self-oriented perfectionism is associated with substantial reductions in health functioning among women with fibromyalgia.
Conclusion: Collectively, these findings clarify that overall levels of perfectionism are not elevated among women with fibromyalgia, but those women who are exceptionally high in levels of self-oriented perfectionism or high in socially prescribed perfectionism are particularly likely to suffer lower health functioning. These results suggest that perfectionism should be specifically assessed and targeted for intervention among women with fibromyalgia and there should be a particular emphasis on the pressure to meet perceived or actual expectations imposed on the self.

Introduction

Fibromyalgia syndrome (FMS) is a chronic condition typified by widespread musculoskeletal pain that has been shown to have vast consequences for daily living [1–3]. Indeed, it has been reported that quality of life is lower among individuals suffering from FMS than among relatively healthy individuals and even individuals suffering from other chronic health conditions [4,5]. At present, there is no consensus regarding the specific underlying causes and pathogenesis of FMS, but it is clear that FMS involves a complex interplay of biological and psychosocial factors [2,6–8].

This paper focuses on perfectionism and health functioning in women with FMS in light of indications that perfectionism is a personality factor implicated in FMS. Case accounts have documented how perfectionism complicates the ability to cope with FMS [9,10] and the three main psychological causes reported spontaneously by patients with FMS are stress, perfectionism, and traumatic events [11]. Psychological causes or correlates of FMS also make frequent references to the role of perfectionism [12]. A study that examined clinical impressions of individuals with FMS found that about one-quarter (23%) of 105 physicians and physicians-in-training reported that they observed perfectionism as present in their patients with FMS either frequently or very frequently, and that perfectionism was more common among older patients [13]. Furthermore, Van Houdenhove and colleagues observed that the onset of FMS is frequently related to extreme forms of perfectionism and an overactive lifestyle [14,15]. Specifically, Van Houdenhove and colleagues have included perfectionism as part of a premorbid condition described as "high action proneness," which they operationally defined as an individual's propensity toward direct action and achievement. Moreover, this orientation toward living an overactive lifestyle has been implicated as a maintaining factor in the experience of FMS and chronic fatigue syndrome [15]. In light of these observations, Grisart and colleagues issued an explicit call for future studies on the role of perfectionism in FMS [16].

The current study used the multidimensional conceptualization of perfectionism advanced by Hewitt and Flett [17]. This model states that perfectionism includes interpersonal as well as intrapersonal aspects and posits that perfectionism consists of 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 prescribed perfectionism (i.e., the need to attain

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standards perceived to be imposed by significant others). The potential relevance of these dimensions in health problems was demonstrated by Fry and Debats in a longitudinal 7-year study of health outcomes in a large sample of middle-aged Canadians [18]. They found that self-oriented and socially prescribed perfectionism predicted early all-cause mortality after accounting for other personality factors implicated in health problems, such as conscientiousness and neuroticism.

While multidimensional perfectionism has not been explored specifically in individuals with FMS, recent research with patients with colitis or Crohn's disease suggests that perfectionism hinders the ability to cope with chronic illness in general. Flett and colleagues found that trait perfectionism was associated robustly with maladaptive coping and greater sickness impact ratings in terms of the psychosocial impact of colitis or Crohn's disease [19]. This finding held even after accounting for the impact of other personality factors such as optimism and conscientiousness.

The present research focuses on the associations that socially prescribed perfectionism and self-oriented perfectionism have with health functioning among women with FMS. Why should these dimensions be relevant to an understanding of FMS? Socially prescribed perfectionism can be regarded as a chronic form of psychosocial stress that can involve an inherent sense of helplessness or hopelessness [17]. It is associated with a range of coping and self-regulation deficits [20]. The coping difficulties and links that this dimension has with psychological distress should exact a toll on people with FMS. Similarly, self-oriented perfectionism should also be relevant in adaptation to FMS, despite conflicting results demonstrating that self-oriented perfectionism is associated with poorer health [18] and with better health [21]. However, a key premise of this study is that elevated self-oriented perfectionism is a vulnerability factor that adds substantially to the significant health challenges already facing individuals with FMS. Individuals with FMS who are also high in self-oriented perfectionism may regard themselves as failures due to an inability to work, or they may continue to try to strive relentlessly in a manner that adds to their pain and other health problems. The stress and distress of self-oriented perfectionists who must cope with FMS should be reflected in diminished health functioning, especially if the self-oriented perfectionists are highly focused on not living up to their perfectionistic ideals. Indeed, research has demonstrated that stress is a key factor that exacerbates the symptoms of FMS, with studies showing that individuals suffering from FMS consistently report that stress aggravates their symptoms [22,23]. Personal shortcomings should be particularly salient during periods when pain inherent in FMS interferes with goal-directed pursuit as documented by Affleck and colleagues [24].

These hypotheses were assessed by administering measures tapping personality and health functioning to a large sample of women with FMS. Trait measures of neuroticism, extraversion, and conscientiousness were included to assess the unique links involving perfectionism. We were particularly interested in contrasting the results for self-oriented perfectionism and conscientiousness, given evidence that conscientiousness is adaptive in terms of health functioning [25,26] and in coping with chronic illness [27]. Some researchers have emphasized the need to distinguish between conscientiousness and over-conscientiousness in the form of self-oriented perfectionism [28]. Perhaps extreme perfectionism is maladaptive, while moderate levels of self-oriented perfectionism are more akin to conscientiousness and are related to better health. This possibility points to the need to test curvilinear associations involving perfectionism and health functioning. There have been few tests of curvilinear effects in the perfectionism literature despite some clear indications that such tests should be conducted. Research on a related construct, self-criticism, has found curvilinear effects of self-criticism on depression among women with gestational diabetes [29], with high self-criticism having an exacerbated link with depression. Other recent data on disability and coping with musculoskeletal pain has found a curvilinear association with patients who continue to relentlessly pursue achievement goals also experiencing an exacerbated level of pain [30]. This non-monotonic curvilinear association could, at least in part, reflect having a personality dominated by a history of striving relentlessly to achieve impossibly high personal standards and finding it difficult to disengage from this deeply ingrained tendency. Linear and non-linear relationships between conscientiousness and health functioning were also explored given our interest in distinguishing perfectionism and conscientiousness.

In summary, the unique purpose of this study was to test the hypotheses that socially prescribed and self-oriented perfectionism are associated with diminished health functioning among women with FMS. We also examined the unique predictive ability of perfectionism when considered along with conscientiousness, extraversion, and neuroticism.

Method

Participants and procedure

A web-based sample of women who reported that they were diagnosed with FMS by a physician was recruited into the study through online support groups and websites that were created for the benefit of people with FMS. Women who agreed to participate ($N = 489$) completed a confidential web-based questionnaire through a URL link that was posted on the websites. Participation was anonymous and no individual incentives were given. Participants ranged in age from 20 to 79 years ($M = 48.78$, $SD = 10.41$) and 66% were American citizens. The majority of participants were married (58%), 24% had a Bachelor's degree, and 16% had completed college. Overall, 36% were on disability and 25% were employed full-time. The average household income of the participants was between $50,000 and $59,999 (range = under $5000 to over $100,000). The average time since diagnosis ranged from less than 1 year to more than 10 years, with 35% of participants reporting that they had been diagnosed with FMS for at least 10 years or longer. The survey did not assess respondent ethnicity or race.

Measures

Perfectionism

Perfectionism was assessed with the Multidimensional Perfectionism Scale [MPS-HF; 17]. The *self-oriented perfectionism* subscale measures the extent to which individuals place high standards on themselves (e.g., "One of my goals is to be perfect in everything I do"). The *other-oriented perfectionism* subscale measures the extent to which an individual places high standards of achievement on significant others (e.g., "I cannot stand to see people close to me make mistakes"). Finally, the *socially prescribed perfectionism* subscale measures the extent to which people feel that high standards are being imposed on them by significant others (e.g., "The people around me expect me to succeed in everything I do"). The MPS-HF and all of its subscales have demonstrated adequate reliability and validity in both clinical and non-clinical samples [31].

Health functioning

Multiple indicators were used to assess health functioning. The following measures were used:

SF-36 physical health. The four physical health subscales of the Short Form-36v1 Health Survey [32] were used as indicators of self-reported physical health. The physical functioning component consists of 10 items (e.g., "climbing several flights of stairs", "walking one block"). The role-physical component consists of four items. Respondents were asked whether they had any problems with work or regular activities (e.g., "accomplished less than you would like"). The bodily pain component consists of two items; one assessing severity of pain (rated from 1 — *none* to 6 — *severe*) and one assessing the interference of pain in daily functioning (rated from 1 — *not at all*