

Chapter 2

Perfectionism in Health and Illness from a Person-Focused, Historical Perspective

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This chapter examines the role of perfectionism in health problems from a historical perspective. Our chapter qualifies what is known about the link between perfectionism and illness because most scholars and readers who are familiar with the perfectionism field would likely point to the last two decades of the previous century as the time period when the role of perfectionism in health and illness first became a significant topic. Indeed, this is the time period when several relevant papers and studies emerged. Initial investigations during this period tended to be based on the use of the various unidimensional perfectionism measures such as the Burns Perfectionism Scale, and the perfectionism subscales of the Eating Disorder Inventory and the Workaholism Inventory (e.g., Brewerton & George, 1993; Forman, Tosi, & Rudy, 1987; Kanai, Wakabayashi, & Fling, 1996). The eventual appearance of multidimensional perfectionism measures by Frost, Marten, Lahart, and Rosenblate (1990) and Hewitt and Flett (1990, 1991) made it possible to examine perfectionism using a more complex approach involving multiple trait dimensions.

Collective understanding of people with perfectionistic personalities has been substantially advanced over the past decade as a result of overall developments in the field. While the emphasis is now on multidimensional perfectionism and recent advances, the conceptual contributions and clinical observations of luminaries such as Alfred Adler, Karen Horney, and Hilde Bruch can never be discounted.

Adler suggested that all people have a need to be perfect and this stems from feelings of inferiority. These feelings are compensated for by striving for superior-

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ity and perfection. Adler left room for individual differences by noting variability in this tendency. Specifically, Adler (1938/1998) described certain people who strive for a godlike perfection as "... perpetually comparing themselves with the unattainable ideal of perfection, are always possessed and spurred on by a sense of inferiority" (p. 35–36). This sense of striving for perfection as a way of trying to lessen feelings of inferiority can be viewed as a constant source of pressure that causes physiological dysregulation. This was illustrated in a case account in the very first issue of *Psychosomatic Medicine*. Alexander (1939) described a hypertensive, submissive man with an inferiority complex and a chronic need to be perfect and outperform others in order to establish his worth.

Adler's views linking perfectionism with the inferiority complex resulted in perhaps the first empirical attempts to assess perfectionism. Heidbreder (1927) included item content that tapped self-reported perfectionism when creating a self-report measure of the inferiority complex. Perfectionists with an inferiority complex were identified in this study, but Heidbreder (1927) found via statistical analyses that the component tapping perfectionism did not effectively distinguish people with or without the inferiority complex because many people lacking a sense of inferiority complex also seemed perfectionistic. It is interesting to note that Heidbreder (1927) suggested long ago that, after further inspection, the results were limited by how perfectionism was assessed; that is, the measure had elements of conscientiousness rather than perfectionism *per se*.

Karen Horney focused on perfectionism and its roots in the basic anxiety and basic hostility that children experience as a result of frustrating and disquieting early experiences with parents. The child who feels hostility that cannot be expressed for fear of punishment is characterized by a strong neurotic conflict. Horney (1945/1972), in her classic book *Our Inner Conflicts*, suggested that one way of addressing a neurotic conflict is to create an idealized image of the perfect self that the individual perceives can be attained at some point. She also posited ten neurotic needs that were prime motivators, and one of these ten needs was the neurotic need for perfection and unassailability (Horney, 1950). These neurotic tendencies reflect a simultaneous desire to move toward people, but also move away from and against these people. This observation suggests that the neurotic need for perfection is underscored by a complex array of motives.

The views and observations of Hilde Bruch are especially relevant given that she focused on perfectionism within the context of a potentially life-threatening disorder—anorexia nervosa—that combines complex physical and psychological processes and functioning. Bruch is known for her seminal books on anorexia nervosa (Bruch, 1973, 1978, 1988), but her insights about perfectionism first emerged in her analysis of how children and their families responded after the child was diagnosed with diabetes. She noted that this response is rooted in the family's tendency to have "... a repressive, perfectionistic attitude toward the child" (Bruch & Hewlett, 1947, p. 205). Her subsequent work on the nature and etiology of anorexia (e.g., Bruch, 1962) described how girls suffering from anorexia were driven to achieve perfect grades in school and this was traced back to the unresolved psychological needs of the girls' mothers and fathers. These views about the perfectionistic demands of parents were later reflected by specific test items on the

Eating Disorder Inventory perfectionism subscale reflecting parental expectations and parental criticism (see Garner, Olmstead, & Polivy, 1983). Bruch's views about the role of perfectionism were elaborated upon in a series of books that documented Bruch's remarkable clinical insights after having spent years treating young people with anorexia nervosa (see Bruch, 1973, 1978, 1988). Her work foreshadowed the contemporary emphasis on socially prescribed perfectionism (i.e., the pressure to be perfect imposed on the self by other people) because she discussed the pressures to conform that faced adolescent girls and the problems that ensue when they cannot live up to these very high expectations. The most detailed analysis can be found in the book *Conversations With Anorexics* that Bruch worked on just prior to her death, and it was published posthumously (see Bruch, 1988). It is here that Bruch outlines her views that perfectionism is largely a façade that covers up a highly inadequate self. She observed:

"Deep down, every anorexic is convinced that basically she is inadequate, low, mediocre, inferior, and despised by others. She lives in an imaginary world with an assumed reality where she feels that people around her—her family, her friends, and the world at large—look down on her with disapproving eyes, ready to pounce on her with criticism. The image of human behavior and interaction that an anorexic constructs in her apparently well-functioning home is one of surprising cynicism, pessimism, and bitterness. All her efforts, her striving for perfection and excessive thinness, are directed toward hiding the fatal flaw of her fundamental inadequacy" (Bruch, 1988, p. 6).

Bruch's sage observations were acknowledged by Hewitt, Flett, and Ediger (1995) in our conceptualization of perfectionistic self-presentation and its role in eating disorders.

Unfortunately, scientific advances in research on perfectionism were hindered for several decades by the lack of available measures tapping perfectionism. The Irrational Beliefs Test (IBT) by Jones (1968) has a 10-item perfectionism subscale that taps the belief in perfect solutions to world problems. It fails to tap the core drive for achievement that is central to an understanding of perfectionism; this aspect of perfectionism is better captured by another IBT subscale tapping high self-expectations. Earlier we mentioned the Burns Perfectionism Scale (BPS), which was the first widely known measure constructed solely and specifically to assess perfectionism (see Burns, 1980). The BPS is a 10-item unidimensional measure that consists of attitude statements reflecting the importance of perfectionism and the catastrophes that await the person who is imperfect (e.g., If I don't set the highest standards for myself, I am likely to end up a second-rate person). Scale content is a reflection of the work that David Burns conducted with Aaron Beck on perfectionism within the context of the cognitive model of depression.

This measure was followed by the emergence of the six-item unidimensional perfectionism subscale of the Eating Disorder Inventory (EDI; Garner et al., 1983). It is more than symbolic that this subscale is one component of a measure designed to assess a form of psychopathology with clear health consequences. While perfectionism is often regarded as synonymous with eating disorders, people with an eating disorder vary in their levels of perfectionism. Clearly, perfectionism can have important consequences in the context of eating disorders, as illustrated by one of the initial studies with the EDI showing that more perfectionistic adolescents with

anorexia were less likely to complete treatment and, as such, they have greater risk (see Steiner, Mazer, & Litt, 1990).

The “Hidden Literature” on Perfectionism in Health and Illness

We stated at the outset of this chapter that most analyses of the link between perfectionism and health would likely focus on the 1980s and 1990s. However, when a detailed historical analysis is conducted as we did for the purposes of the current chapter, it becomes apparent that the notion that perfectionism contributes to illness is not new; in fact, there is a substantial “hidden literature” comprised of case accounts and some intriguing empirical studies that are highly informative and that stretch back several decades. We refer to this work as “hidden” because to our knowledge, much of this work has never been cited or documented by contemporary authors despite the exponential increase in research and theory on perfectionism over the past 25 years.

In light of these observations, this chapter contains a description of this early research and theory on perfectionism and health in keeping with our primary goal of heightening awareness of these earlier contributions. Early papers on perfectionism and health represent a vital source of hypotheses that deserve to be considered and tested by contemporary researchers. Indeed, this work points to several key themes.

As will be illustrated in the material presented below, the clear picture that emerges from this earlier literature is that perfectionists have “a pressure personality” that involves continuous exposure to stress from external and internal demands. There are also clear indications of the tendency for perfectionists to make themselves vulnerable to health problems as a result of striving to the point of exhaustion. We found it particularly useful to consider perfectionism from a person-focused perspective that emphasizes the factors and processes that can contribute to health and illness in the individual person.

Our historical overview of previous theory and research is provided below. While our search yielded some empirical investigations of perfectionism and health, there was also an abundance of descriptive case accounts. While such cases have limited value from a strict scientific perspective, we nevertheless found these descriptive accounts to be highly informative in at least two key respects. First, these reports point to key factors that need to be considered by researchers who are seeking to identify the specific mechanisms and processes that link perfectionism with illness. For instance, stress is one process that has been emphasized continuously by early authors. We have sometimes been frustrated by contemporary research that is designed to test whether perfectionism is adaptive versus maladaptive because it is often the case that no attempt was made to examine the role of stress, despite clear statements about how perfectionism can be regarded as a vulnerability factor that is activated when the perfectionist encounters ego-involving and personally threatening stressors (see Hewitt & Flett, 1991, 1993, 2002).

Second, as alluded to earlier, the descriptive case accounts from the previous century serve as a reminder of the need to remain cognizant of the link between perfectionism and health problems from a person-centered perspective; most perfectionism research thus far has used a variable-centered perspective. At the level of the individual person, and in keeping with a clinical and counseling focus, it is essential to consider the pattern of perfectionism across various perfectionism dimensions and how it relates to other personality features and the situational contexts that have an impact on the individual person. A clear example of the potential complexities involved for the individual perfectionist is a remarkable psychoanalytic account of a highly perfectionistic woman with a severe case of colitis (see Karush & Daniels, 1953). This case clearly illustrates the interpersonal aspects of perfectionism and how interpersonal stressors and strains can fuel health problems long before perfectionism took on an interpersonal focus. Most notably, the woman described by these authors had tried to compensate for her unmet interpersonal needs by working hard to maintain the façade that her marriage with her husband was perfect (i.e., perfectionistic self-presentation), but life became far from perfect when her husband had an affair with her friend; the betrayed woman, in turn, became sexually involved with her friend's husband. In this case example, perfectionism represented a way of coping with circumstances that were far from ideal. Karush and Daniels (1953) also described how this woman experienced much hostility because her husband fell far short of her wish to have an ideal, perfect partner. Perfectionism was a theme throughout this case analysis, including the component focused on the therapy process. For instance, at one point, the client tried to project her older brother's demanding perfection onto the therapist, and she also noted that she had come to see the therapist as expecting her to be perfect (i.e., socially prescribed perfectionism).

The link between perfectionism and stress-related health symptoms has been described by several other authors. For instance, Rodger (1948) described Mrs. H., who was characterized as "... a young bride with an over-conscientious, perfectionist, meticulous personality" (p. 155) who continued to manage her parents' business after being married. She suffered symptoms following periods of emotional tension and stress.

Perhaps the clearest illustration of the need for a complex, person-centered focus that allows for complex blends of various perfectionism dimensions was provided by Lundh, Saboonchi, and Wangby (2008) who examined how patterns of perfectionism, as assessed by the Frost Multidimensional Perfectionism Scale (FMPS), are related to various forms of clinical disorder. They conducted a cluster analysis that yielded a ten-cluster solution with several combinations deemed to reflect clinically significant perfectionism. Three patterns involving extreme perfectionism across most of the FMPS subscales were overrepresented among the patients with social phobia but underrepresented among the nonclinical participants. Lundh et al. (2008) cautioned that it is inappropriate to characterize high scores on the personal standards factor as adaptive because when the focus is on the individual person, some patterns involving high perfectionism often reflect combinations that also include high concern over mistakes and high doubts about actions. These data have clear

implications for variable-centered research that isolates perfectionism dimensions (e.g., personal strivings versus evaluative concerns perfectionism), and there is little attempt to think about the extreme perfectionist who is highly vulnerable due to elevations on both dimensions.

Themes Emerging from the Historical Work on Perfectionism and Health

Our historical overview is provided below. When this material is being considered, we found it helpful to remain cognizant of three key themes. First, it became evident early on that perfectionism is primarily maladaptive and there is little suggestion in these initial accounts that it is adaptive; by and large, perfectionism was implicated in various forms of illness by authors in ways that are not in keeping with the notion that perfectionism yields benefits to the individual. One way to frame this issue is that the costs of perfectionism, especially health costs, seem to far outweigh the benefits.

Our second theme is that the mind and body connection is clearly relevant in seeking to understand those people who are driven by a need to be perfect. This is particularly well illustrated by complex case studies of the various individuals who have also suffered from comorbid psychological and medical problems. These complexities continue to be evident in contemporary case accounts of perfectionists. For instance, a recently published case study of a young woman who died by suicide noted that she had diagnosed depression and psychotic features, but also a long-standing history of significant health issues, including migraine headaches, fibromyalgia, and Wolff–Parkinson–White syndrome (see Hassan, Flett, Ganguli, & Hewitt, 2014).

Finally, as mentioned earlier, a third theme that is highly salient is the notion of “the stressed perfectionist” who does not respond well to stress and pressure, but who nevertheless takes on too much responsibility and responds to challenge and threat by striving even harder and even longer to be perfect. A clear sense emerges of depleted and exhausted perfectionists who lack the resources and resilience to withstand further stresses and challenges to their well-being. Surprisingly, in this regard, one of the most cogent and insightful analyses of the role of stress in perfectionism was provided by the infamous Ewen Cameron, the psychiatrist who was later to be disgraced for his unethical treatment of his research participants in Montreal. Regarding perfectionism, Cameron (1944) described the “tensional breakdowns” of a cohort of workers who responded poorly to wartime pressures and job stress because they had to work under time pressures that did not allow for them to be as exacting, deliberate, and precise as they would like to be, yet they were not permitted to make mistakes. Cameron (1944) observed that “... there is a range of personalities running from those who are exceedingly meticulous and perfectionistic in their work and in their social relations, through those who are considered reliable and conscientious members of society ...” (p. 117). Cameron

(1944) described the perfectionists as people who are painstaking, meticulous, and seldom satisfied and who are "... a little lacking in self-confidence unless they feel quite strongly that they are doing the right thing" (p. 117). He then suggested that there is a subset of particularly stress prone perfectionists "... who tend to be rather anxious-minded; who worry unduly about things that most of us take in stride; who may not be quite as careful to do the right thing as those whom I have just described, but who, when they fail to do so, worry quite excessively about it" (p. 117). Some insights from Cameron have yet to be tested empirically, but they fit with our notion that some perfectionists are overly anxious ruminators who are at risk for stress-related illnesses and associated difficulties.

The three themes outlined above are reflected throughout the remainder of this chapter. The summary overview we provide below is organized into various sections according to distinguishable health problems. Specifically, we describe the role of perfectionism in the following: (1) ulcers and other gastrointestinal illnesses; (2) migraine headaches; and (3) cardiovascular illnesses. We also provide a section that summarizes the early empirical research linking perfectionism with illness.

Initial Historical Links Between Perfectionism and Health Problems

Perfectionism in Ulcers and Other Gastrointestinal Illnesses

Initial links between perfectionism and health problems began to emerge in the 1930s when perfectionism was conceptualized as a monolithic construct focused on personal perfection. One of the earliest case studies was provided by Fremont-Smith (1932) who described a 39-year-old single man suffering from an ulcer. He was described as a perfectionist who had unrealistic relationship ideals and a tendency to take his responsibilities and mistakes far too seriously. His perfectionism reflected being raised by a domineering aunt and he learned to react to disappointment by developing exaggerated ambition and fear of failure. There was also a stated history of phobias and feelings of panic and guilt. As an adult, ulcer symptoms emerged when his work schedule became too heavy during the winter months. This man had a tendency to suffer symptoms when he felt that he was being pressured by more work than he could possibly accomplish in the period allowed; ulcer symptoms could be triggered simply by thinking about not getting all of his work done. This case study is one of the first illustrations of the potential relevance of perfectionism to workplace health. It also shows how long-standing stressors (i.e., a domineering aunt) can combine with current stressors and strains to elicit symptoms such as pain in perfectionistic people. Fremont-Smith (1932) emphasized that this type of case shows a clear link between states of mind and ulcer-related pain.

Mittelman and Wolff (1942) also pointed to a link between perfectionism and ulcers by identifying perfectionism as a maladaptive response exhibited by their

adult patients suffering from ulcers in response to feelings of low self-esteem. The family histories of these individuals often involved family discord and conflict and this elicited a common response according to reports of the patients' childhoods. Specifically, Mittelman and Wolff (1942) noted that "in several instances, children threatened with fear of abandonment and rejection because of expressed conflict between parents attempted to gain approval through perfect performance, usually linked with repression or resentment. The development of such compensatory measures began in early childhood" (p. 6). To our knowledge, this emphasis on striving not just for perfection but also for approval is one of the earliest accounts of the self-worth contingencies that are arguably central to an understanding of perfectionism.

Mittelman and Wolff (1942) also provided an exceedingly detailed case account that includes analyses of physiological reactions with objective data of an ulcer patient who dealt with feelings of abandonment, resentment, and submissiveness by trying to live up to high ideals and expectations by having flawless performance. This patient then condemned himself for inevitably failing to be perfect. This is one of the earliest documented cases of the self-critical perfectionism described by Blatt (1995). A clear conclusion that can be drawn from this case study is that the path to recovery must involve developing a sense of self-compassion and self-acceptance. Negative self-views can play a vital role in exacerbating the link between perfectionism and illness.

Further support for the role of perfectionism in ulcer came from an analysis of the first 50 cases of men with ulcer who were treated in a hospital in London, Ontario (see Ross, Geddes, Hauch, & Scratch, 1950). Detailed personality information was not gathered, but it was concluded that emotional tension was present in 35 of the 50 cases. Most of the patients were described as hard-driving perfectionists who found it difficult to leave work behind when it was time to go home for the day. Several were assembly-line foremen. It was noted that they showed less spontaneity in their responses than other patients. A similar description was provided by Bingham (1960) in his description of his 50 patients with an ulcer and how they were distinguished from 50 ulcer patients who were also suffering from alcoholism. Bingham (1960) noted that the perfectionism was often an overcompensation response that emerged during times of stress and challenge.

Parenthetically, it should be noted that in keeping with the case study noted above, perfectionism has also been implicated in non-ulcerative colitis. We will focus on two of the most detailed analyses. First, Mahoney, Bockus, Ingram, Hundley, and Yaskin (1949) provided a detailed description of 20 patients with non-ulcerative colitis based on psychiatric interviews and personality tests. The psychiatric interviews identified that 12 patients were characterized by perfectionism and aggression. Other associated features included nervous tension and anxiety, hostility, and immaturity. Comparative conclusions were limited, unfortunately, by the lack of a comparison group.

Second, White, Cobb, and Jones (1939) described the personality features of 60 patients with colitis as part of their detailed monograph. Their summary description sounds very much like depictions of neurotic perfectionists who need social

approval. They described overconscientious, meticulous individuals with restricted emotional expression despite being filled with anxiety, guilt, and resentment. These people were highly focused on being mistreated by others, even when, according to the investigators, it involved forms of mistreatment that less sensitive people would probably not notice. They also linked this style with a rigid and obsessive form of rumination that involved a cognitive preoccupation with their problems. They observed that “This constant preoccupation is presumably responsible for the prolongation of tension and hence for the prolonged action of the parasympathetic system upon the colon” (p. 95). The role of rumination and other forms of cognitive perseveration in perfectionism are discussed at length by Flett et al., 2016 in Chap. 6.

Perfectionism in Migraine Headache

The 1930s decade also is the period when there was a great emphasis on the role of perfectionism in migraine headache. This really began with a detailed description of “the migrainous patient” by Touraine and Draper (1934). Their article in the *Journal of Nervous and Mental Disease* appeared in two separate parts of approximately 23 pages each. The second segment has brief descriptions of each one of 50 patients. These accounts focused on having an insecure attachment to one’s mother, with the mother being someone who is difficult to please and who is capable of being quite critical. Touraine and Draper (1934) observed that people afflicted with migraine headaches often were people who seemed healthy, useful and of high intelligence. These people were described as reserved individuals who did not easily make social contacts. Perfectionism was first highlighted in the work context. Specifically, it was noted that:

“In his (sic) occupation he is a detailed perfectionist, and the urge to check and re-check his work is a characteristic common to his sort. This is particularly the result of an extremely sensitive response to criticism, for it is his nature to seek the cause within himself. Unnecessary burdens and responsibilities are assumed...whether or not they are found in the reality or phantasy worlds. He is anxious, anticipates catastrophe, and is discouraged. He does not lose himself in the art of living. His emotions are deep, but the expression of them appears to be frustrated, and there is a tendency to revert to self-pity.” (Touraine & Draper, 1934, p. 2).

Several associated attributes in this description ring true in terms of more recent accounts of perfectionists; key themes include being sensitive to criticism, being overly responsible, and an unwillingness or inability to express negative emotions.

Harold Wolff (1937) was also highly instrumental in highlighting the role of perfectionism in illness beginning with his observations that also pointed to the role of perfectionism in migraine headache. Wolff was a pioneer in the early study of head pain and was former president of the American Neurological Association. It was primarily his observations that led to perfectionism receiving very early consideration as one of the leading psychological causes of migraine headache (see Wolff, 1937, Wolff, 1948). Marcussen and Wolff (1949) concluded that people with these personality attributes are “not necessarily ‘neurotic’ in the usual sense”

(p. 251). Rather, they are tense, driven people who are rigid, ambitious, and perfectionistic. As a result, they tend to strive relentlessly and ignore bodily needs for rest and relaxation to the extent that they put themselves at risk. Marcussen and Wolff (1949) then outlined four case studies of migraine sufferers who had considerable stress and tension in their lives. Central themes emerging from these case studies portrayed these individuals as interpersonally sensitive and highly reactive to failure and feedback highlighting their lack of accomplishment.

A descriptive analysis of 500 people with “the migrainous personality” provided by a Mayo Clinic physician named Walter Alvarez (1947) also emphasized the role of perfectionism. Alvarez (1947) focused on women because women comprised the vast majority of his patients. He concluded that “The outstanding characteristics of the migrainous woman are her hypersensitiveness, her quickness of thought and movement and her tendency to get tense, to worry, to tire easily, to tire suddenly and to sleep poorly. Usually, she is a perfectionist who works fast and accurately and likes to push other persons along to work fast with her” (p. 3). Alvarez (1947) also noted that these women are also quite prone to marital problems because these women are prone to dissatisfaction because even a good husband does not approximate her ideal of the perfect husband.

The relevance of perfectionism as part of migraine personality involving perfectionism was also highlighted by Donahue (1949) as part of his comprehensive analysis of the link between migraine and ocular functioning. Donahue (1949) concluded his analysis with detailed case excerpts of five people who suffered from migraines that impacted their visual capacities. Three of the five people showed clear indications of perfectionism, while a fourth person was described as having a striving and ambitious temperament but her interest in graduate studies was discouraged by her husband. The most perfectionistic person was a 44-year-old male office worker referred to as “Case 2.” He was described as someone who was an “... extremely hard-working, driving, perfectionistic and ambitious type of man who was interested in and able to keep a number of different activities in operation at the same time. In order to accomplish this, he was required to make quick decisions and to be constantly alert and attentive; if he encountered any delay, or if for some reason he was unable to maintain his high standard of efficiency, he became extremely tense and resentful. It was during these periods that his migraine attacks took place.” Observation of Case 2 over a 6-month period showed that he would permit no compromises in terms of needing to be excellent and efficient at all times, but he was also prone to periods of great tension, irritability, and dejection. What is clear from this case analysis is that as was suggested initially by Hewitt and Flett (1991, 1993), it is essential to consider stressors and factors in the situational context that trigger the vulnerabilities of extreme perfectionists.

Perfectionism was also seen as highly relevant in cluster headaches (see Friedman, 1958). Some support for the existence of “the migraine personality” (i.e., meticulousness, preoccupation with achievement, and relentless striving for perfection) was found by Burns (1965) who determined that 57 of the 92 migraine patients in his rural practice were perfectionistic and had “the migraine personality”

versus 20 of the 92 patients in the control group. Unfortunately, the methods and criteria used to establish the presence of this personality style were not outlined.

Some particularly useful insights about perfectionism and migraine headache were provided by Graham (1953), who conducted a descriptive study of 46 adults (36 women, 10 men) who had suffered for years from “normal” migraine headaches. Graham (1953) indicated that “the large majority” were perfectionists. In general, the patients were described succinctly as people, “who, by virtue of their personality, tend to seek stress but who, by virtue of their physiology, are ill-equipped to meet it. The advent of stress of various sorts tends to precipitate their attacks” (p. 73). Graham (1953) went on to note that his sample consisted largely of “thin, tense, intelligent housewives or white collar workers, who are perfectionists in their outlook and are chronically fatigued” (p. 62). They also have “conscientious drive,” little rest, and irregular or disturbed sleep. Graham’s (1953) work is particularly representative in that it emphasizes the association that perfectionism has with stress as well as the propensity for perfectionists to over-strive to the point of mental and physical exhaustion. An appended commentary on Graham’s (1953) paper further highlighted the anger of perfectionists and “... chronic resentment resulting from inability to satisfy perfectionistic demands and compulsively assumed responsibilities” (p. 74).

More recently, perfectionism was featured in a descriptive analysis of 20 patients with migraine headaches and allergies to food (see Wilson, Kirker, Warnes, & O’Malley, 1980). This study involved a psychiatric interview, and it was deemed that 17 of the 20 patients had an obsessional personality, while all 20 were characterized by perfectionism. While intriguing, it should be noted that a detailed description of how perfectionism was conceptualized and assessed was not provided other than to note that the patients “... had traits of perfectionism, meticulousness, orderliness and high standards of behavior” (p. 618). However, a measure of “hysteroid-obsessional” style was used and “... it was noted that the whole group rated high on conscientiousness, stability, fear of change, tension, and a desire to live up to high standards and ideals” (Wilson et al., 1980, p. 618).

Perfectionism in Hypertension and Cardiovascular Illnesses

Contemporary research on how perfectionists cope with cardiac illness is now emerging (Dunkley et al., 2012; Shanmugasagaram et al., 2014), and this research has its roots in work conducted over 60 years ago on hypertension and cardiovascular illness. Alexander’s (1939) case account of a man with hypertension was noted earlier. Simon’s (1948) article on the role of the psychiatrist in cardiovascular illness supported previous observations by Binger, Ackerman, Cohn, Schroeder, and Steele (1945) who implicated perfectionism in hypertension. Simon observed that these people are described as individuals who “... worry over their jobs, everything must be just right, and in this way they display their compulsive drive to perfectionism which may be so intense as to interfere in the achievement of their goal... They dis-

like and resent criticism. However, they do not overtly express their anger, but tend to repress their feelings. Outwardly they act as though they want to please people and gain their approval, and inwardly they may be 'mad as hell'. As a result they are in a psychological turmoil because of the conflict between their need for approval and their need to express the anger they repress" (Simon, 1948, p. 187-188). Simon (1948) discussed at length the turmoil that characterizes perfectionistic people because their abiding need for approval does not mesh well with their unexpressed anger and resentment that sometimes cannot be controlled and creates interpersonal problems for the vulnerable perfectionist.

Other investigations focused on apparent links between perfectionism and cardiac difficulties and contributing conditions such as hypertension. Duncan, Stevenson, and Ripley (1950) provided another insightful account of the perfectionism-illness link following their thorough analysis of 14 patients with cardiac arrhythmias. All 14 patients showed signs of driven, compulsive tendencies, and they were all found to be perfectionistic in the standards they set both for themselves and for others. Emotional factors were seen as quite important in general in these cardiac patients. Overall, 11 of the 14 patients had long-standing problems with anxiety and observed difficulties with expressing hostility and resentment.

Finally, several authors considered perfectionism as part of the great initial interest in the Type A coronary-prone style. The initial descriptions of the Type A personality by Friedman and Rosenhan mentioned several characteristics that are often found among perfectionists, but the role of perfectionistic standards was not emphasized explicitly by these groundbreaking researchers (see Friedman & Rosenhan, 1974; Friedman & Ulmer, 1984). However, other clinical accounts made frequent references to perfectionism. For instance, a qualitative analysis of 12 people suffering from chest pains and migraines led to the observation that "all patients exhibited the aggressive, obsessive and perfectionistic make-up of Type A personality" (Leon-Sotomayor, 1974).

Perhaps the most insightful observations here were provided by Henry Russek (1959), a physician based in New York, who compared risk factors for 100 young patients under 40 years of age with coronary heart disease and 100 patients with other diseases. In general, Russek (1959) highlighted the role of emotional stress and strain in coronary heart disease, but key for our purposes is that Russek concluded that the Type A personality pattern "... presents a caricature rather than a portrait of the average coronary patient under the age of 40 in our series" (p. 505). Why? Russek (1959) noted that these people had seemingly high levels of self-control, reserve, and an outward complacency, but they were actually driven perfectionists who were victims of overwork and taking on too many responsibilities while feeling guilty and being unable to relax during those times when they were on vacation. Russek (1959) deserved particular credit for noting that these overmeticulous perfectionists were "stress-blind" (p. 505) with any attempt at self-care; instead, they "... minimized their symptoms, and neglected prudent rules of health." (p. 505). It is our experience that perfectionists are exceptionally low in self-care, especially those who are workaholics with heavy role demands (e.g., physicians, lawyers), and this lack of focus on self-protective behaviors likely con-

tributes substantially to their susceptibility to illness. Contemporary research has yet to document the diminished self-care of those perfectionists who seemingly live in a world of stress.

Given the overlapping features of perfectionism and the Type A style, we find it surprising that with but few exceptions (e.g., Flett, Hewitt, Blankstein, & Dynin, 1994; Flett, Panico, & Hewitt, 2011), contemporary research has also failed to extensively evaluate the degree to which perfectionism and the Type A style are interrelated yet distinguishable. A very plausible hypothesis that merits future research from a person-centered perspective is that it is the highly perfectionistic Type A people who are particularly at risk for health problems, especially if their sense of being stressed and driven is accompanied by chronic feelings of resentment and hostility.

Early Empirical Research on Perfectionism and Health

We will conclude our chapter with a broader overview of some of the earliest empirical research on individual differences in perfectionism in the context of health. As noted earlier, a major difficulty that impeded early research on perfectionism was its focus on description rather than empirical assessment (e.g., Graham, 1953). And, of course, when perfectionism was actually measured, the results were constrained by significant limitations due to their less than optimal assessments of perfectionism. For instance, Moos and Solomon (1965) conducted their own investigation on perfectionism and arthritis to extend clinical accounts (e.g., Robinson, 1957). Their results were based on the identification of a subset of Minnesota Multiphasic Personality Inventory (MMPI) items that tapped perfectionism and compulsivity. A group of women with arthritis, when compared to their non-arthritic sisters, had significantly higher levels of perfectionism, compliance, nervousness, depression, and sensitivity to anger. Yet, related analyses established that perfectionism was among the factors associated with slower disease progress among those with arthritis (Moos & Solomon, 1964). This research, however, should be interpreted with substantial caution given that the degree to which the MMPI items provide an accurate assessment of perfectionism remains to be determined.

Heightened stress reactivity was implicated in perhaps the first detailed empirical investigation of perfectionism and chronic disease. This study by Prichard, Schwab, and Tillmann (1951) examined different personality styles associated with Parkinson's disease. To our knowledge, this study has never been cited by perfectionism researchers until now. Prichard et al. used a variety of pieces of information to group patients into one of four categories: (1) Group A had people with normal, placid personalities; (2) Group B had patients with dependent, submissive, and somewhat neurotic personalities; (3) Group C had patients described as having perfectionistic personalities; and (4) Group D had patients with more extreme forms of psychopathology and dysfunction. A total of 100 patients were classified into one of these four groups based jointly on the impressions that were reached when

the patients came for appointments, but also based on informant feedback from the family doctor as well as from friends and families. In addition, each patient was asked to assign him or herself to one of the four groups. Prichard et al. (1951) reported close agreement between informant and self-classifications, and this yielded 48 patients in Group A, 33 patients in Group B, and 19 perfectionistic patients in Group C. Only two patients had Group D attributes, so they were not considered further. Those with the perfectionistic style were described as "... obsessive and perfectionistic and they all demand from life, their family, and their physician far more than is obtainable" (p. 106). Group comparisons established that these three groups differed significantly in two key respects. First, analyses of responses to drug treatment showed that much lower success rates were found with the Group C perfectionists relative to the other two groups. In all likelihood, this is the first empirical demonstration of perfectionism impeding treatment success. In addition, whereas Group A and Group B participants showed little evidence of being "stress affected," 58% of the perfectionistic patients were deemed to be stress affected in terms of overt stressors, both minor and major, reported to the investigators. This impressive study by Prichard et al. (1951) clearly deserves to be cited because it shows with multiple forms of assessment that perfectionism can be linked with disease and stress, as well as with response to treatment. This paper was published over 60 years ago. It stands as an illustration of the usefulness of going back to examine the historical literature. This research is also remarkable because it incorporated informant feedback; going beyond self-reports seldom occurs in today's perfectionism research!

Another study evaluated patients with rheumatoid arthritis from clinics affiliated with McGill University (see Cormier & Whittkower, 1957). It was based on 18 patients who were interviewed by a psychologist and a psychiatrist on at least three occasions. One sibling of each patient who did not have rheumatoid arthritis was also interviewed for comparison purposes. Detailed family histories were gathered and personality judgments from a psychoanalytic perspective were made by the interviewers. Participants also completed projective personality tests. Accounts of family histories typically identified one or both parents as excessively demanding, suggesting a role for high parental expectations and parental criticism. One of the clearest differences was a tendency for the patients, relative to their siblings, to "... be punctual, tidy, and perfectionistic... Obsessional doubts and brooding are common manifestations of their inability to face a situation demanding immediate action" (p. 536), suggesting that the perfectionists with arthritis had difficulties in responding to challenging situations.

Earlier data were provided by Gressel, Shobe, Saslow, Dubois, and Schroeder (1949). They rated personality factors in three groups of participants: 50 people with essential hypertension, 50 people with normal blood pressure who had some form of psychiatric illness, and 50 people with chronic medical problems in which "psychologic factors are considered to have low etiologic relevance" (p. 267). Ratings tapped perfectionism as part of obsessive-compulsive style. Other personality ratings included impulsiveness, subnormal assertiveness (i.e., not showing overt assertiveness), anxiety, hysteria, and depressive behavior. Degree of hypertension

was indeed associated significantly with obsessive-compulsive personality features ($r=.44$) and with subnormal assertiveness ($r=.38$), and it was not associated significantly with hysteria, anxiety, depression, and impulsiveness. These findings were generally in keeping with later research on obsessional perfectionism. Analyses of the personality component obsessiveness subscale of the Crown-Crisp Experiential Index showed that the patients with myocardial infarction, relative to those who had not experienced an infarction, had higher mean scores on perfectionism, conscientiousness, and cleanliness (Crisp, Queenan, & D'Souza, 1984).

Adler, MacRitchie, and Engel (1971) conducted a retrospective study of "32 men with 35 strokes." No comparison group was included. A common pattern that emerged was a personality style described as "pressured" that involved satisfying elevated self-set goals, a sense of personal responsibility, and chronic problems controlling anger. This description has many elements in common with the Type A coronary-prone style. Most noteworthy were the conditions deemed to precede the onset of the stroke itself. The authors concluded that "The typical setting in which the stroke occurred was one in which the patient was reacting with a feeling of anger, hopelessness and sometimes shame when he (sic) felt he was not performing up to his standards, no longer was in control of his or her environment, or no longer was meeting the needs of others" (p. 1). This emphasis on the loss of key attributes and skills and diminished performance points to the potential role of temporal self-comparisons and a sense of a loss of self that leaves the vulnerable person with the sense of an emerging discrepancy between standards that are central to one's sense of self and identity and a self that may no longer be up to the challenge. The "pressured pattern" has five attributes: (1) pressure to keep busy; (2) a self-image focused on being an active and hard worker; (3) high standards and sense of responsibility; (4) urgency, time pressure, need to fulfill goals; and (5) sense of determination and strong will. High standards and responsibility were found in 84% of the men who had strokes. Overall, 14 of the men (43%) had all five attributes. Adler and associates (1971) described how they took steps to reduce interview bias as part of their observation that they unearthed many features of the Type A style despite not setting out to do so. Another feature that pointed to perfectionism was the tendency to have fleeting feelings of satisfaction experienced when goals were met. Work activity did not provide much pleasure; instead, it seemed to be a defensive form of distraction. Indeed, one participant noted that "being busy keeps me from thinking" (p. 22).

Another study contrasted 10 men with completed cerebral infarctions (strokes), 16 men with transient cerebral ischemic attacks (TIA), and 14 control participants who were hospitalized with various problems such as hernias or lumbar problems (see Gianturco, Breslin, Heyman, Gentry, Jenkins, & Kaplan, 1974). Group comparisons of the presence of "the pressured personality pattern" based on interview data found a marginally significant group difference ($p<.10$), with the pattern found in 7 (70%) of the men in the stroke group, 5 of the 16 (31%) men in the TIA comparison group, and 5 of the 14 (36%) men in the control group. The high standards component indicative of perfectionism was found in 9 of the 10 men who had strokes, but was also found in at least 75% of the men in the other two groups.

Most noteworthy for our purposes was the authors' observation that the men who had combined cerebral and coronary vascular disease were clearly perfectionistic. These men were described as having "... an intense striving toward self-imposed goals, a keen sense of responsibility and a determination to discharge responsibilities 'even if it kills me'. The need to maintain an image of a hard, active worker was frequently cited by these men as a motivation for their life styles" (p. 459). It was also noted that these men sought out work situations that afforded a sense of control.

The relevance of perfectionism in the "pressured pattern" was illustrated by the list of seven life stressors that preceded the illness. Several of these stressors are precisely the kinds of stressors deemed highly relevant in diathesis–stress accounts of perfectionism (see Hewitt & Flett, 2002). They were (1) personal inadequacies, (2) environmental demands, (3) loss of control over objects, (4) specific personal failure, (5) object loss, (6) loss of status of being useful and needed, and (7) failure to meet standards.

Subsequently, Adler was part of a team that examined personality features related to a high need for control among women who had a stroke (Goetz, Adler, Weber, & Siegrist, 1992). This study contrasted 19 women who had a stroke, 19 women with non-arteriovascular disease, and 19 healthy women. Participants completed a six-factor scale created for this study that included a "perfectionism/need for making plans" subscale. Participants were also evaluated with the Bortner Type A measure that was completed by themselves and a family member. Group comparisons of the six scale factors found that the women with a history of stroke were significantly higher than women in the other two groups on three subscales including the "perfectionism/need for making plans" subscale, and this difference was evident in terms of both self-ratings and informant ratings.

Summary

We have seen in this chapter that evidence of the association between perfectionism and illness goes back several decades and that there is an extensive "hidden literature" that includes some well-designed, controlled studies that were conducted despite the widespread ability of suitable perfectionism measures. In some respects, this chapter illustrates a growing problem in psychology, that is, the need to somehow come to grips with the previously published literature and use available past information to full advantage by building on it. In this particular instance, foreknowledge of the existing literature on the role of perfectionism in illness would likely have resulted in the early development of an extended diathesis–stress model of perfectionism and illness. We located several clear and detailed descriptions of the stress experienced by perfectionists and how this stress combined with dispositional characteristics to create or exacerbate health problems. Specific stressors were highlighted as well as the constant pressure to be perfect experienced by hyperconscientious, driven perfectionists.

It was also evident from the early literature on perfectionism and illness that there was little sense that perfectionism should be regarded as adaptive or beneficial. Moreover, perfectionists do not typically engage in protective health behaviors and self-care. A picture emerged of people who are excessively striving in ways that reflect their sense of responsibility and obligation, and their efforts get taken too far in ways that exact significant health costs. That is, people are holding themselves up to exceptionally high standards and paying a physiological price for it as if self-oriented perfectionism should be regarded as self-imposed or self-inflicted perfectionism.

Hopefully, the perfectionism and health field will advance in the future by focusing to a greater degree on specific illnesses rather than on health problems in general. The current chapter shows that this would simply be a return to earlier days when perfectionism was implicated in specific illnesses and health problems such as migraine headache and rheumatoid arthritis. We are not yet at the point of being able to ascertain whether certain perfectionism dimensions are more or less relevant in specific illnesses, and we also need much more evidence of the potential causal role of perfectionism in illness. In the meantime, we will remain hopeful and optimistic that future developments will be informative and will meaningfully extend previous work and detailed accounts of the link between perfectionism and illness.

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