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Perfectionistic strivings and concerns are differentially associated with self-rated health beyond negative affect

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ABSTRACT

A growing literature on how perfectionism relates to self-reported physical health has rarely considered the role of negative affect or contextual factors. We addressed this by examining how Perfectionistic Concerns (PC) and Perfectionistic Strivings (PS) were associated with self-rated health across thirteen samples (total $N = 4991$) before and after controlling for negative affect, and meta-analyzed the effects. PC was associated with poor self-rated health, whereas PS was associated with good self-rated health. The associations were attenuated after adjusting for negative affect, but remained on average significant. The effects for PC were moderated by sample type, perfectionism measure, and sex. Findings suggest that the associations of perfectionism with subjective health are not solely due to biases associated with negative affect.

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1. Introduction

Commonly conceptualized as consisting of two super-ordinate dimensions (Stoeber & Otto, 2006), perfectionism is a personality trait that has received much attention from health researchers in recent years. This growing body of research has brought to the forefront an ongoing debate regarding when and how perfectionism may or may not be healthy. Characterized by extreme self-scrutiny, excessive concerns with mistakes and the perception that others demand perfection, Perfectionistic Concerns (PC) is generally considered to reflect the unhealthier aspects of perfectionism in part because of its associations with higher levels of negative affect (Molnar, Reker, Culp, Sadava, & DeCourville, 2006). In contrast, Perfectionistic Strivings (PS) is comprised of setting and compulsively striving to reach excessively high standards, and has mixed associations with negative affect (Flett, Blankstein, & Hewitt, 2009; Molnar et al., 2006), and health outcomes (Fry & Debats, 2009; Molnar, Sadava, Flett, & Colautti, 2012).

Both PC and PS have been examined in relation to a range of outcomes related to physical health including stress (e.g., Dunkley, Mandel, & Ma, 2014; Molnar et al., 2012), health behaviours (e.g., Sirois, 2016; Williams & Cropley, 2014), and physical symptoms (e.g., Flett, Panico, & Hewitt, 2011; Molnar et al.,

2006). Yet research directed at understanding the reasons for these linkages, or the lack thereof, is scant (Molnar, Sirois, Flett, Janssen, & Hewitt, 2018), and has often not considered the role of factors well-known to bias the reporting of physical health outcomes, such as negative affect (Watson & Pennebaker, 1989). Moreover, researchers have largely ignored associations with self-rated health, an important and robust predictor of a wide-range of consequential physical health outcomes (Jylhä, 2009) with reliable associations to broader personality traits (Löckenhoff, Sutin, Ferrucci, & Costa, 2008; Löckenhoff, Terracciano, Ferrucci, & Costa, 2012).

The aim of the current research is to address this gap in the literature by examining how PC and PS are associated with self-rated health across multiple and diverse samples, and by testing the contribution of negative affect in these linkages.

1.1. Personality and self-rated health

Described as “a summary statement about the way in which numerous aspects of health, both subjective and objective, are combined within the perceptual framework of the individual respondent” (Tissue, 1972, p. 92), self-rated health is a widely used and robust predictor of important health outcomes that theory indicates is necessarily influenced by personality. For example, self-rated health reliably predicts objective health outcomes in the form of health behaviours, cortisol responses to stress, morbid-

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ity, and mortality (Jylhä, 2009; Kristenson, Olsson, & Kucinskiene, 2005; Mora, Orsak, DiBonaventura, & Leventhal, 2013; Tamayo-Fonseca et al., 2013). Current theory posits that, unlike other measures of health, self-rated health arises from an active cognitive process of self-assessment and reflection that is necessarily evaluated within the context of the individual's socio-cultural and individual differences (Jylhä, 2009). According to this Cognitive Process Model of self-rated health (Jylhä, 2009), the evaluation of health status is a multi-stage process that first involves a consideration of the relevant cultural and personal-historical information that can determine one's health including any existing medical diagnoses and functional status, symptoms experienced, genetic risk factors, and biological sex. This initial conceptualization of health is then evaluated and summarized within the context of individual differences in positive and negative dispositions, depression, health experiences, and expectations. Factors such as current age, previous health status, and perceptions of one's health relative to others also contribute to the experiences and expectations that inform the evaluation of current health status. The information from these processes is then considered in terms of the way in which the rating of health is presented, to arrive at an overall self-rating of health (Jylhä, 2009).

From the perspective of the Cognitive Process Model, personality plays a central role in shaping the appraisals that result in the subjective rating of health. For example, individuals with personality traits that are characterized by a high degree of negative affect and/or that are linked to depression may perceive and evaluate the factors relevant for health, such as physical symptoms, as being worse in comparison to someone scoring low on such traits. This proposition is consistent with both the classic (Watson & Pennebaker, 1989), and updated symptom perception hypotheses (Howren & Suls, 2011), which posit that negative affect can inflate reports of physical symptoms because of a greater attention to internal somatic symptoms and changes, regardless of whether these changes reflect symptoms of actual illness. This perceptual bias can also inflate retrospective recall of past physical symptoms (Howren & Suls, 2011), and the subsequent evaluation of past health status, and how it factors into judgements of current health. Finally, high levels of negative affect can influence the relative assessment of one's health in relation to others, and result in lower subjective ratings of health (Löckenhoff et al., 2012). Consequently, it is prudent to control for negative affect when understanding how personality traits may relate to self-reports of physical health.

Research examining the links between personality and self-rated health has focused almost exclusively on the five factor model of personality. Collectively this research has noted that high Conscientiousness and Extraversion, along with low Neuroticism, are the three higher order personality factors with the most consistent associations with good self-rated health (Löckenhoff, Duberstein, Friedman, & Costa, 2011; Löckenhoff et al., 2008, 2012; Sirois, 2015). Although this research has not explicitly viewed these associations from the lens of the Cognitive Process Model, the findings are nonetheless in line with what might be expected given that all three traits have links to negative affect and health behaviours (Hampson, Goldberg, Vogt, & Dubanoski, 2007; Lemos-Giraldez & Fidalgo-Aliste, 1997; McCrae & Costa, 1991; Sirois & Hirsch, 2015).

1.2. Perfectionism, self-rated health, and negative affect

The Cognitive Process Model of self-rated health (Jylhä, 2009) provides a useful and comprehensive framework for understanding how perfectionism may be related to self-rated health. Current evidence suggests differential associations of PC and PS with negative affect, with weaker and more inconsistent associations for PS. For example, some studies have found that PC is associated

with higher levels, and PS associated with lower levels of negative affect, (e.g., Damian, Stoeber, Negru, & Băban, 2014; Gaudreau & Thompson, 2010; Molnar et al., 2006). In contrast, other studies have found that PC, but not PS, is related to state negative affect (e.g., Flett et al., 2009). Still other research has noted that both perfectionism dimensions are associated with negative affect when it is conceptualized as a state (Sirois, 2016), such as depression, anxiety, and anger (e.g., Hewitt & Flett, 2004; Stoeber, Schneider, Hussain, & Matthews, 2014), or as chronic negative emotionality (Shanmugasagaram et al., 2014). However, the associations with negative affect for PC are often stronger than those for PS (e.g., Hewitt & Flett, 2004; Sirois, 2016; Stoeber et al., 2014).

When viewed from the lens of the Cognitive Process Model (Jylhä, 2009), current evidence suggests that negative affect may contribute to the differential associations of PC and PS to self-rated health. Consequently, it is critical to account for the effects of negative affect when assessing how perfectionism is linked to self-rated health given that differential associations between perfectionism dimensions and self-rated health may be an artifact of negative affect. It is also important to consider that PC and PS are linked to self-rated health because of actual differences in physical health status. For example, using a physical illness self-report checklist previously shown to be unrelated to negative affect (Sirois, Melia-Gordon, & Pychyl, 2003), one study found that PC, but not PS, was consistently, yet weakly (average $r = 0.13$), linked to more self-reported acute health problems such as colds and headaches, across seven samples (total $n = 2150$) of community adults and students (Sirois, 2013). We therefore expect that the hypothesized associations between PC and poor self-rated health will remain after controlling for negative affect.

1.3. The present research

In this research we took a theory-driven approach to examine how perfectionism dimensions are related to self-rated health, using the Cognitive Process Model (Jylhä, 2009) of self-rated health as a guiding conceptual framework. Fig. 1 presents an operational model of the Cognitive Process Model that outlines the role of contextual factors in self-rated health, and highlights those examined in the current research. Building on this theory, and the evidence presented, we hypothesized that PC would be associated with poor self-rated health, whereas PS would be associated with good self-rated health. Because PC and PS share some overlap, it is recommended that this overlap be accounted for when examining their relations to adjustment outcomes to better understand the unique contribution of each higher order perfectionism dimension to the outcome of interest (Stoeber & Gaudreau, 2017; Stoeber & Otto, 2006). Accordingly, we also examined the associations of each perfectionism dimension in relation to self-rated health after partialling out the contribution of the other dimension, with the expectation that the associations would become stronger, as proposed by some researchers (Stoeber & Gaudreau, 2017; Stoeber & Otto, 2006). To better understand the unique associations of PC and PS to self-related health beyond the potential biasing effects of negative affect, we then partialled out the contribution of negative affect from both perfectionism and self-rated health. Given past research suggesting a consistent association between PC and poor health (Sirois & Molnar, 2016), even with measures of physical health that are unrelated to negative affect (Sirois, 2013), we expected that the association between PC and poor self-rated health would remain after statistically controlling for the contributions of both PS and negative affect.

We examined the above hypotheses across a set of thirteen unpublished data sets from our labs that included participants with a diverse range of health statuses, and then statistically meta-analyzed the associations to estimate the magnitude of these

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