Perfectionism and Disordered Eating:

An Exploratory Analysis of Recent Literature

by

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ABSTRACT

This review outlines current research on the interrelationship of perfectionism and disordered eating. Research demonstrates that perfectionism may be a risk factor and a maintenance factor for disordered eating. Additionally, current literature supports three of the four subtypes of perfectionism explored in this review to have a significant relationship with disordered eating. Specific treatment for those with both disordered eating and perfectionism is lacking. More research needs to be conducted on the dynamics of perfectionism and disordered eating so mental health professionals may have heightened awareness of the occurrence of this interrelationship, as well as a more comprehensive understanding of how to implement supportive and appropriate treatment interventions.

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CHAPTER I: INTRODUCTION

The concept of perfectionism has been well researched and is considered to be both a maladaptive and an adaptive trait in current literature (Franco-Paredes, Mancilla-Diaz, Vasquez-Arevalo, Lopez-Aguilar, & Alvarez-Rayon, 2005). Yet, historically, perfectionism was viewed solely as psychopathology; a sign of neuroticism (Stoeber & Otto, 2006). Eating disorders have gained a spotlight in research over the past few decades as there has been a strong link to psychological distress such as depression, anxiety, and personality disorders (Shafran & Mansell, 2001). Additionally, from both a phenomenological perspective as well as a theoretical perspective, there has been an enduring link between eating disorders and perfectionism (Shafran & Mansell, 2001). Despite the prevalence of these two concepts in empirical research, there is a lack of comprehensive understanding and treatment interventions. For example, in a large-scale national study published in 2007 by the National Institute of Mental Health (NIMH), it was discovered that of those that had disordered eating, less than 45% sought treatment for the eating disorder, but instead presented with other concerns. Due to the shame associated with disordered eating, mental health professionals need to be more proactive in assessment (Vince & Walker, 2008). Although many clinical intakes inquire about a change in eating, the NIMH national study demonstrates this is not sufficient. Clients may not initially be willing to disclose struggles with eating. Furthermore, perfectionism is not likely to be presented as a problem, as many with perfectionism perceive it as part of their identity. According to an APA Press Release in 2006, there is a lack of empirically validated treatment options available to support this population. This data highlights the need for heightened awareness of the link between perfectionism and disordered eating.

Fortunately, a treatment guide for mental health professionals was published by Fairburn (2008) that has been found to be an empirically validated intervention for disordered eating and perfectionism. Fairburn (2008) developed an approach to viewing eating disorders from a non-diagnostic standpoint in which all the diagnostic categories are collapsed into one group. The approach holds that there is a similar underlying core psychopathology paired with a maintaining factor that promotes the continuation of the eating symptomology. Furthermore, this approach lays the foundation for this literature review as according to Fairburn, one of the maintaining factors of disordered eating is perfectionism. Hence, the relationship between perfectionism and disordered eating then becomes the main focus of treatment. Greenspon (2008) elaborates by stating that "for perfectionists, hard work and aiming for success are not at issue. The problem of perfectionism is not a problem of overcommitment, or over organization, or obsessive attention to details, or lack of ability to delegate; the problem of perfectionism is in what all of these personal qualities reflect: the struggle for acceptance as a person," (p. 267). When that acceptance encompasses one's body shape, weight, and overall appearance, perfectionism and disordered eating emerge. Thus, it is necessary to understand the specific factors in this association, such as the subtypes of perfectionism. Armed with this knowledge, a counselor may then better support a client presenting with both disordered eating and perfectionism.

Statement of the Problem

Perfectionism and disordered eating have been linked in research for decades. Perfectionism has been associated with the propensity to be a risk factor, a maintenance factor, and a relapse factor in regard to disordered eating. Despite such information in current literature, awareness of this topic is lacking in the field (Shafran & Mansell, 2001). Lack of awareness is evidenced by the need for literature discussing interventions and techniques for treatment of

these two constructs together. It would be advantageous for mental health professionals working with clients presenting with disordered eating to be knowledgeable about perfectionism, including the subtypes, thus contributing to the development of empirical treatment options to better support clients.

Purpose & Significance of the Literature Review

The purpose of this literature review was to examine the dynamics and interrelationship between perfectionism and disordered eating. Moreover, the following comprehensive overview was conducted so that mental health professionals may gain heightened awareness of the subtypes of perfectionism, as well as heightened awareness of how all eating disorders may manifest from the same underlying core pathology. Thus, mental health professionals may be better able to support clients regardless of the presenting type of disordered eating and perfectionism. Hence, the first aim of this article is to provide such a review with the hope that it will advance knowledge of the link between perfectionism and disordered eating.

The second aim is to consolidate knowledge from research on subtypes of perfectionism which is crucial to treatment of disordered eating. The third aim is to discuss treatment implications and to promote more rigorous research in the field so that mental health professionals are more equipped to support clients presenting with both disordered eating and perfectionism.

Definition of Terms

Perfectionism Subtypes. As this paper explores how perfectionism and disordered eating may thread together, the term, *perfectionism*, must be defined. As aforementioned, there exists a multitude of variations of the term. For the purposes of this paper, subtypes of perfectionism are defined below.

Nonperfectionists. "Individuals with low levels of perfectionistic strivings," (Stoeber & Otto, 2006, p. 296).

Self-Oriented Perfectionism (SOP). Self-oriented perfectionism is "an intrapersonal dimension characterized by a strong motivation to be perfect, setting and striving for unrealistic self-standards, focusing on flaws, and generalization of self-standards... self-oriented perfectionism may also involve a well-articulated ideal self-schema" (Hewitt & Flett, 1991, p. 98). SOP is the subtype most often referred to by clinicians and researchers when speaking of a patient with perfectionism (Hill, McIntire & Bacharach, 1997).

Socially Prescribed Perfectionism (SPP). Socially prescribed perfectionism is of the interpersonal dimension (Sherry, 2008) and entails "perceiving that others have unrealistically high standards for the individual, that they stringently evaluate the individual, and that they exert pressure on them to be perfect," (Shafran & Mansell, 2001).

Adaptive Perfectionism (AP). This type of perfectionism has been referred to as positive perfectionism, functional perfectionism, normal perfectionism, active perfectionism, conscientious perfectionism, and adaptive perfectionism in current research and literature (Stoeber Otto, 2006). For the purpose of this paper, all will be grouped together under the title of *adaptive perfectionism*. "Adaptive perfectionism has been described as the positive aspects of perfectionism, such as striving for high standards," (Bardone-Cone, Weishuhn, & Boyd, 2009).

Maladaptive Perfectionism (MP). This type of perfectionism has been referred to as negative perfectionism, neurotic perfectionism, dysfunctional perfectionism, passive

perfectionism, unhealthy perfectionism, and maladaptive perfectionism in current research and literature (Stoeber & Otto, 2006). For the purpose of this paper, all types will be grouped together under the title of *maladaptive perfectionism*. "...maladaptive perfectionism has been described as the negative aspects of perfectionism, including being motivated by fear of failure," (Bardone-Cone et al., 2009).

Disordered Eating (DE). Rather than use the term *eating disorders*, this review will use DE to be inclusive of all eating symptomology, including the following eating disorder diagnoses from the American Psychiatric Association's (2000) Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR):

Anorexia Nervosa (AN). "Anorexia Nervosa is characterized by a refusal to maintain a minimally normal body weight," (APA, 2000, p. 583). See DSM-IV-TR for expanded definition.

Bulimia Nervosa (BN). "Bulimia Nervosa is characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise," (APA, 2000, p. 583).

Eating Disorder Not Otherwise Specified (EDNOS). "An Eating Disorder Not Otherwise Specified category is also provided for coding disorders that do not meet criteria for a specific eating disorder," (APA, 2000, p. 583). Included in this category is Binge Eating Disorder (BED). See DSM-IV-TR for expanded definition.

Assumptions and Limitations

It is assumed that current and pertinent research on types and roles of perfectionism have been conducted. Additionally, it is assumed that the interrelationship of perfectionism and

disordered eating has also been a topic of empirical research. A possible limitation of this review is a deficient amount of information in the above areas to complete a comprehensive literature review. Therefore, it is assumed that the mental health professional reading this review will remain current with advances in the field. Additionally, it is also assumed that the information stated here does not hold true for every client a mental health professional or other provider may work with.

CHAPTER II: LITERATURE REVIEW

This review will begin with a comprehensive overview of the construct of perfectionism, followed by a review of the transdiagnostic approach to treatment of eating disorders (Fairburn, 2008). The next section will explore the research on perfectionism evident before, during and after disordered eating; perfectionism as a risk factor for disordered eating; and perfectionism as a maintenance factor for disordered eating. This chapter will then highlight research examining the link between each subtype of perfectionism and disordered eating. Finally, the chapter will conclude with a discussion of troublesome factors that may arise during treatment and subsequent interventions.

Overview of Perfectionism

Whether researchers have focused on perfectionism alone, or researched the interrelationship with another construct, the number of research studies, theoretical approaches, and books published on the topic is increasing (see Greenspon, 2008, for a review). This is based on the conjectured link of perfectionism with psychological distress, one's level of functioning, and that perfectionism may be a significant vulnerability factor in the development of psychopathologies (Ghaly, 2008; Greenspon, 2008; Shafran & Mansell, 2001; Hewitt, Flett & Ediger, 1995; Soenens, Nevelsteen, & Vandereycken, 2007; Glover, Brown, Fairburn, & Shafran, 2007; Stoeber & Otto, 2006; Castro-Fornieles et al., 2007; Pinto de Azevedo et al.,, 2009). Greenspon (2008) defines this term as follows, "Perfectionism is understood as a desire for perfection, a fear of imperfection, the equating of error to personal defectiveness, and the emotional conviction that perfection is the route to personal acceptability," (p. 263).

Two schools of thought, or theories, have been used to define perfectionism for the past few decades: *Unidimensional* theory of perfectionism and *Multidimensional* theory of

perfectionism (Franco-Paredes et al., 2005). Perfectionism from the unidimensional viewpoint is defined as "the setting of excessively high standards for performance accompanied by overly critical self-evaluations," (Franco-Paredes et al., 2005, p. 62). Conversely, perfectionism from the multidimensional viewpoint includes high demand for perfect standards imposed either by oneself, by society, or, the individual imposes the high standards for perfection upon others (Ghaly, 2008). The difference between these two theories on perfectionism is that the unidimensional theory only accounts for one type of perfectionism: that which is placed upon oneself by oneself (also referred to as SOP). The multidimensional theory accounts for three types of perfectionism: expectations for perfectionism in others' capabilities (also referred to as other-oriented perfectionism), intrapersonal demands for perfectionism (also referred to as SOP), and perceived or actual demands for perfectionism of self by others (also referred to as SPP), (Franco-Paredes et al., 2005).

A large majority of current research on the topic of perfectionism tends to define perfectionism as a multidimensional construct rather than a unidimensional construct (Soenens et al., 2007; Pinto de Azevedo et al., 2009). This is because the limitation of defining perfectionism from the unidimensional school of thought is that there is not discernment between those that have high strivings and those that are perfectionistic. Some people are highly conscientious and competent, which may be adaptive rather than pathological and could thereby aid one in being successful. Thus, defining perfectionism from the unidimensional view is severely narrow in its focus (Owens & Slade, 2008).

Owens & Slade (2008) write about the current struggle to define perfectionism in the field through either school of thought. They advise researchers and mental health professionals "against simplistic conceptualizations" of perfectionism, such as the unidimensional perspective

(p. 928). Furthermore, the literature overwhelmingly supports this view the multidimensional construct of perfectionism (Hewitt et al., 1995; Vohs, Joiner, Bardone, Abramson & Heatherton, 1999; Soenens et al., 2007; Ghaly, 2008; Pole, 2008).

Overview of the Transdiagnostic Approach to Disordered Eating

Fairburn (2008) developed the transdiagnostic approach to disordered eating. A unique position the transdiagnostic approach is the view that all eating disorders share similar underlying mechanisms and it is unnecessary and even counterproductive to delineate them into labels such as Anorexia Nervosa, Bulimia Nervosa, Eating Disorders Not Otherwise Specified, Binge Eating Disorder, Night Eating Syndrome, and the newly discovered Purging Disorder (Fairburn, 2008). The premise is that patients with eating problems will migrate between certain diagnoses, not recover from one and then a new one developed. Fairburn (2008) explains this is in a very straightforward example:

> If a patient with eating disorder NOS, who had a history of anorexia nervosa and bulimia nervosa, were told that she had suffered from three different psychiatric disorders, two of which she had recovered from, she would react with surprise and skepticism. From her perspective she has had a single evolving eating disorder – and, surely, this is indeed the case. (p. 17)

Additionally, this approach holds that there are factors called maintaining processes which interact with the core eating pathology, thereby allowing for the maintenance of the disordered eating (Fairburn, 2008). The four maintaining processes are clinical perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties. A client may present with one or more maintaining factors. Thus, the counselor must explore the maintaining factor in addition to the

eating symptomology focus on one would only hinder treatment and potential for recovery (Fairburn, 2008).

Perfectionism and Disordered Eating

The interrelationship between perfectionism and disordered eating is not a novel topic, as the links between these two issues have been studied for decades (Sherry, 2008; Gustafsson, Edlund, Kjellin & Norring, 2008; Pole, 2008). As stated by Vohs et al. (1999), "perfectionism long has been associated with eating disorders... Indeed, the very nature of eating disorders – relentlessly striving toward an impossible standard of thinness – is perfectionistic," (p. 695). Additionally, Gustafsson et al., (2008) remark that disordered eating and subsequent focus on one's body is "often an expression of perfectionism," (p. 464). As a result, countless studies at high schools, college campuses, and longitudinal studies spanning adolescent development and adulthood continue to be conducted in an effort to study the significant interrelationship that exists between perfectionism and disordered eating (Pinto de Azevedo et al., 2009). The present published literature states that perfectionism has been identified as having potential to be present before disordered eating, while the individual is suffering from disordered eating, as well as after the individual has recovered (Stice, 2002; Pinto de Azevedo et al., 2009; Peck & Lightsey, Jr., 2008; Ghaly, 2008; Franco-Paredes et al., 2005; Bardone-Cone et al., 2009; Gustafsson et al., 2008; Sherry, 2008; Nilsson et al, 2008; Vince & Walker, 2008; and Landa & Bybee, 2007). For example, Holston & Cashwell (2000) found support for perfectionistic traits present in participants prior to disordered eating symptomology. Researchers stated "the strongest predictor of eating disorder behaviors was perfectionism," (as cited in Franco-Paredes et al, 2005, p. 67).

In one of the earlier studies on the relationship between eating disorders and perfection, Santonastaso, Fricderici & Riguard (as cited in Peck & Lightsey, Jr., 2008) administered pre- and

post-tests to women with eating disorders, as well as to control groups. Those with perfectionism and eating disorders at pre-test were more likely than others (control) one year later at post-test to still meet DSM-IV diagnostic criteria for disordered eating. Although this research study is nearly two decades old, it still provides long-standing empirical evidence that perfectionism may be a maintenance factor for disordered eating across several populations.

In another study, Landa & Bybee (2007) conducted research on perfectionism and disordered eating with both undergraduate members as well as alumnae from a national sorority. Results of the assessment measures illustrated that all participants with high scores on the Eating Disorder Inventory also had high scores on the Multidimensional Perfectionism Scale, suggesting that while one is suffering from disordered eating, perfectionism may present. Furthermore, Nilsson et al. (2008) conducted a longitudinal study of perfectionism with participants suffering from anorexia nervosa – restricting type (AN-RT). The sample was made up of those with adolescence-onset. The study began between 1980 and 1985 and concluded between 1996 and 2001. The sample was made up of patients who had previously been admitted to a child and adolescent clinic, but at the start of the study, were in recovery from AN-RT. Researchers conducted the first follow-up with the participants eight years later. The second follow-up was conducted eight years after the first, a total of approximately sixteen years since the initial study at the beginning of the participants' recovery phase. Focusing primarily on the Perfectionism subscale of the EDI, Nilsson et al. found that the level of perfectionism was maintained while disordered eating symptoms decreased.

In addition to research finding perfectionism to being a more enduring trait despite recovery from disordered eating, there is clear support that perfectionism may also function as a risk factor for disordered eating (Stice, 2002; Sherry, 2008; Bardone-Cone et al., 2009; and

Shafran & Mansell, 2001). Sherry, Hewitt, Besser, McGee & Flett (2003) stated that "researchers and practitioners have long recognized that perfectionism predisposes, precipitates, and prolongs eating disorders," (p. 69). A significant number of studies, conducted with both community and clinical populations resulted in evidence supporting perfectionism as a specific risk factor in the development of disordered eating (Shafran & Mansell, 2001). Stice (2002) reviewed dozens of studies beginning in the 1980's and concluding in the past eight years in an attempt to find maintenance and risk factors for disordered eating. The research reviewed included longitudinal studies with follow-ups over months and years, studies with males and females, and studies with children, adolescents, and adults alike. Overwhelmingly, there was empirical support that perfectionism is a risk factor and maintenance factor for eating pathology (Sherry, 2008; Stice, 2002; Glover et al., 2007; Bardone-Cone et al., 2009; and Shafran & Mansell, 2001). Vince & Walker (2008) conducted a review of 232 studies, totaling 87,878 participants, to consolidate a list of the factors associated with and maintaining disordered eating. Results from the massive literature review found a moderate association ($r = .30$) between females currently experiencing disordered eating symptomology and being perfectionistic. Thus, females with disordered eating were more likely than the controls in the studies to have perfectionism. Furthermore, these researchers concluded that more likely than not, perfection was a factor contributing to the development of the eating symptoms.

Paralleling research by Vince & Walker (2008), Bardone-Cone et al. (2009) reviewed current literature and found empirical evidence that perfectionism was implicated as a maintenance factor for females, but discovered that a majority of the samples were primarily Caucasian. Therefore, they sought to replicate this research on a sample self-identified African American women ($N = 97$). Researchers used the Multidimensional Perfectionism Scale (MPS-

H) and the Frost Multidimensional Scale (MPS-F) to measure perfectionism, Body Mass Index (BMI), and self-report measures of perceived weight status were collected. Results of Bardone-Cone et al.'s (2009) research supported "... perfectionism as a reasonable target of intervention for African American women, as well," in regards to treatment for disordered eating (p. 273).

Subtypes of Perfectionism & Disordered Eating in Current Research

This section is a compilation of current empirical research on each subtype of perfectionism (SOP, SPP, MP, and AP, as previously defined) in relation to propensity of disordered eating.

Self-Oriented Perfectionism & Disordered Eating (SOP). Self-oriented perfectionism ceaselessly requires oneself to achieve perfectionism (Sherry et al., 2003; Sherry, Hewitt, Flett & Lee-Baggley, 2007). This subtype of perfectionism is self-imposed; not a reaction to others' expectation of oneself. Additionally, SOP is intrapersonal; not directed at others (Pinto de Azevedo et al., 2009). SOP involves rigid constant self-evaluation and non-acceptance of imperfection. Therefore, one will be highly cognizant of self-perceived failures. The result may then be ceaseless engagement in self scrutiny and self blame. (Ogai, 2004; Castro-Fornieles et al., 2007; Ghaly, 2008; Nilsson, Sundbom & Hägglöf, 2008; Stoeber & Otto, 2006). Ogai (2004) states that SOP involves two facets: "pursuing perfection simply as a goal, and not accepting imperfection. The former is said to enhance mental health, while the latter deteriorates it," (p. 199).

One with SOP may lead life with the self-created rule such as "I must be absolutely perfect in every way," and self-punishment may ensue when the rule is broken (Shafran & Mansell, 2001). Subjecting oneself to self-punishment may be cyclical as the individual is never able to meet the standards they created because their negative evaluation of self is relentless

(Ogai, 2004). When one also has a self-created rule such as "I must be thin to be perfect, and if I am not I am a failure," disordered eating may arise. Yet, not all individuals with SOP suffer from disordered eating. Landa & Bybee (2007) conducted a study on self-image and SOP in 2007 with both young adult men and young adult women to explore the developmental process of these two constructs. Although a significant number of participants with SOP did meet diagnostic criteria for AN, BN, or EDNOS, some did not. It was found that the most prominent feature of those with SOP was a lack of forgiveness for themselves. When this feature was absent, eating symptomology was not as marked, if at all (Landa & Bybee, 2007).

Yet, evidence reviewed indicates that the presence of SOP is associated with eating symptomology more often than not (Shafran & Mansell, 2001; Nilsson et al., 2008; Castro-Fornieles et al., 2007; Sherry, 2008; Ghaly, 2008; Franco-Paredes et al., 2005). Shafran & Mansell (2001) conducted an extensive review of empirical and theoretical literature on perfectionism and psychopathology from the past decade to present. Types of perfectionism researched were self-oriented, other-oriented, and social-prescribed. Eating disorders were one of the seven psychopathologies investigated. Results provided evidence of a significant relationship between SOP and underweight AN, weight restored AN, and EDNOS.

Castro-Fornieles et al. (2007) sought to compare perfectionism in three sample groups: the general population ($N = 213$); in clients with depressive disorders ($N = 38$), anxiety disorders ($N = 32$), and adaptive disorders ($N = 16$); and in those with eating disorders, AN ($N = 75$) and BN ($N = 33$). All subtypes of perfectionism were assessed. After analysis, researchers found that "...both bulimic and anorexic patients scored higher on self-oriented perfectionism than the other two groups," (p. 562). Thus, this current empirical study concluded that SOP is significantly more prominent in those with eating disorders than in other populations.

Paralleling the 2007 study by Castro-Fornieles et al., Franco-Paredes et al. (2005) reviewed the validity and reliability of measures of assessment for eating disorders and perfectionism. Results from the critical review of literature found that those with eating disorder diagnosis consistent with the DSM-IV-TR also had significantly higher scores for SOP than those without an eating disorder. Results were based upon a review of all subscales of the MPS-F and the EDI-P.

Bardone-Cone (2007) also used the MPS-F and the EDI-P to examine the relationship between SOP and disordered eating in young women ($N = 406$) over the course of multiple years. Results indicated that "self-oriented perfectionism was strongly linked to dietary restraint… after controlling for negative affect, only a self-oriented dimension of perfectionism predicted unique variance in bulimic symptoms," (Bardone-Cone, 2007, p. 1977). This study represents significant evidence of the interrelationship of SOP with disordered eating, as longitudinal studies are often more reliable and valid than single-time point studies, which may be more generalizable.

Both Sherry et al. (2003) and Nilsson et al. (2008) analyzed results from administration of the Eating Disorder Inventory to participants with disordered eating. Researchers in both studies specifically analyzed participants' results for SOP. Examples of questions measuring SOP from the assessment measure are as follows: "I hate to not be the best; I feel that I have to do things perfect – if not, I won't try; I set up very high goals for myself," (Sherry et al., 2004, as cited in Nilsson et al., 2008, p. 388). In the study conducted by Sherry et al. (2003), 110 women and 110 men from a university in the U.S. participated in the study. Results demonstrated that, "for both genders, EDI-SOP… [is] related independently to eating disorder symptoms," Sherry et al., 2003, p. 69).

Socially Prescribed Perfectionism & Disordered Eating (SPP). An interpersonal dimension of perfectionism, SPP reflects "individual concerns about being the target of unrealistic expectations... the perception that others are demanding imposed perfectionistic expectations on the self," (Flett, Hewitt, Shapiro & Rayman, 2001-02, p. 290). Individuals with this subtype of perfectionism would most likely be characterized by perceiving that others, such as significant others and family, maintain standards that are required to be achieved. The individual feels that if they do not succeed, they will not gain the approval or support of those closest to them, (Hill et al., 1997; Ghaly, 2008; O'Conner & O'Conner, 2003; Pintode et al., 2009; Sherry et al., 2007). Thus, the individual often will "...exhibit a greater fear of negative evaluation and avoid the disapproval of others," (Franco-Paredes et al., 2005). Ghaly (2008), remarks that socially-prescribed perfectionists "are more likely to internalize their true emotions in order to maintain an appearance of composure and social approval," (p. 4). As a result, the individual with SPP may operate under a facade more often than not, hiding his or her true self in an effort to present perfectly.

Sherry et al. (2007) found a relationship to SPP after conducting research on self presentation, body image, and cosmetic surgery. Respondents consisted of women that had undergone any type of cosmetic surgery and a control group of women that had not. Results indicated that SPP was not only a possible contraindication for cosmetic surgery, but that those that had undergone the surgery and had SPP, also reported a cognitive style, an interpersonal style, and chronic self-dissatisfaction which are all representative of disordered eating symptomology (Sherry et al., 2007). Similar to the study by Sherry et al. (2007), many studies have results stating that SPP is consistently implicated in appearance related concerns, body

shape and weight distress, and essentially, eating pathology (O'Conner & O'Conner, 2003; Sherry, 2008; Ghaly, 2008; Shafran e& Mansell, 2001; Pinto de Azevedo et al., 2009).

Franco-Paredes et al., (2005) reviewed the validity and reliability of measures of assessment for eating disorders and perfectionism. Results from the critical review of literature found that those with eating disorder diagnoses consistent with the DSM-IV-TR also had significantly higher scores for SPP than those without an eating disorder. In another study, Sherry et al. (2003) and Nilsson et al., (2008) analyzed results from the administration of the Eating Disorder Inventory to participants with disordered eating. Researchers in both studies specifically analyzed participants' results of questions measuring SPP. Examples of the questions are as follows: "Only the best achievements are enough in my family; My parents have expected the best achievements from me; As a child I made great efforts to not make my parents and teachers disappointed," (Sherry et al., 2004, as cited in Nilsson et al., 2008, p. 388). In the study conducted by Sherry et al. (2003), 110 women and 110 men from a university in the U.S. participated in the study and results demonstrated that, "for both genders, EDI-SPP... [is] related independently to eating disorder symptoms," Sherry et al., 2003, p. 69).

Maladaptive Perfectionism & Disordered Eating (MP). Maladaptive perfectionists may make personal demands to achieve goals to a higher degree than they are able. Thus, satisfaction is not felt by the individual due to failure to reach a certain caliber of success coupled with the prediction of failure. Projects may not be pleasurable, even if completed, and one may experience substantial distress about the project not being perfect (Franco-Paredes et al., 2005; Stoeber & Otto, 2006; Soenens et al., 2007). Rice & Mirzadeh (2000) remark that one may discern maladaptive perfectionists from other types of perfectionism by "their excessive concerns about making mistakes [and] strong self-doubts..." (p. 248).

Franco-Paredes et al., (2005) examined the multidimensional perspective of perfectionism and the relationship to eating disorders. Based upon prior study results in the literature, researchers sought to find the role of perfectionism in clients with an eating disorder. Hence, one area studied was the differences between people with eating disorders and those without, specifically regarding perfectionism. Franco-Paredes et al. (2005) found that when focusing on maladaptive perfectionism, those with eating disorders scored significantly higher than those without eating disorders.

Caucasian women have historically been utilized as participants in studies involving eating disorders and perfectionism. Bardone-Cone et al., (2009) sought to change this pattern. As such, self-identified African American female undergraduates were assessed to explore any relationship between maladaptive and adaptive perfectionism and bulimic symptoms. Researchers stated "to our knowledge, this is the first study to examine multidimensional perfectionism in relation to bulimic symptoms in an African American female sample and the first study to examine predictors of change in bulimic symptoms in African American women," (Bardone-Cone et al., 2009, p. 267-268). Researchers studied the same group of women at two time points; the first time point involved 97 women, the second time point was five months following the first and involved 70 women due to drop-outs. Results provided evidence of a positive correlation between severity of bulimic symptoms and pervasiveness of maladaptive perfectionism. Additionally, researchers found that participants with maladaptive perfectionism at high levels combined with perceived self-weight status as overweight (regardless of actual weight), was related to high bulimic symptoms. Thus, "this study highlights the relevance of maladaptive perfectionism to bulimic symptoms in African American college women," (Bardone-Cone et al., 2009, p. 266).

Adaptive Perfectionism & Disordered Eating. Adaptive perfectionism may influence one to set and maintain realistic and attainable goals. Additionally, adaptive perfectionism offers motivation to accomplish those goals. Thus, the individual feels self-confident and is able to acknowledge the achievement and success made. Additionally, adaptive perfectionists may be highly conscientious (Landa & Bybee, 2007; Greenspon, 2008; Shafran & Mansell, 2001; Vohs et al., 1999). Adaptive perfectionism has been described as finding enjoyment in striving for high self-standards devoid of self-deprecating beliefs or actions when a standard is not met (Rice & Mirzadeh, 2000, p. 238). "Those that derive a real sense of pleasure from the labors of a painstaking effort and who feel free to be less than precise as the situation permits..." (Hamachek, 1978, p. 27 as cited in Bardone-Cone et al., 2009, p. 267). Adaptive perfectionists have also been illustrated as "individuals with high levels of perfectionistic strivings and low levels of perfectionistic concerns," (Stoeber & Otto, 2006, p. 296). Self-esteem and identity are therefore not threatened when a goal is not completed to the intended degree.

Many studies emphasize the importance of delineating adaptive perfectionism from maladaptive perfectionism, especially in regard to the relationship between perfectionism and eating disorders (Soenens et al., 2007; Ghaly, 2009; Gustafsson et al., 2008; Franco-Paredes et al., 2005; Rice & Mirzadeh, 2000; Bardone-Cone et al., 2009; Stoeber & Otto, 2006; Shafran & Mansell, 2001). In a review of the literature on perfectionism and psychopathology by Shafran & Mansell (2001), studies focusing on the relationship between eating disorders and adaptive and maladaptive perfectionism were critically reviewed. It was concluded that in samples comprised entirely of those with a diagnosed eating disorder, both adaptive and maladaptive perfectionism were present. However, maladaptive perfection levels were significantly higher than levels of adaptive perfectionism. The adaptive perfectionism levels were attributed to those that had

successfully restricted their food on a particular day, for example. The maladaptive perfectionism was much higher as the clients were found to be dissatisfied with their current eating symptomology (ex: I did not restrict enough even though I met my goal for the day) and subsequently self-deprecating.

Similarly, Gustafsson et al. (2008) conducted a study examining mediating factors of disturbed eating. Adolescent and young adult women ($N = 205$) between the ages of 14-21 were divided into one of three groups: disordered eating (DE), psychosocial problems (PS), and healthy eating attitudes/behavior and no reported psychosocial problems (SF). It was found that maladaptive perfectionism was specific to the DE group, whereas adaptive perfectionism was not. Conclusions by the researchers were that maladaptive perfectionism, as opposed to adaptive perfectionism, is more characteristic of those in the DE group and that it likely "contributes to the development and maintenance of eating disorders while [adaptive perfectionism] does not," (Gustafsson et al., 2008, p. 469).

Treatment of Perfectionism & Disordered Eating

This section will outline factors that may hinder the therapeutic process such as vulnerability to relapse and resistance to treatment. Additionally, treatment approaches for disordered eating and multidimensional perfectionism will be discussed, including assessment measures.

Factors that May Hinder Treatment. Current research provides evidence of troublesome factors mental health professionals must be aware of when working with clients presenting with perfectionism and disordered eating. For example, a dynamic between perfectionism and relapse from a recovery phase of disordered eating has been indentified (Stice, 2002; Soenens et al., 2007). Bizuel, Sadowsky & Riguad (2001) found that "high perfectionism pre-test scores have

predicted poor prognosis 5-10 years later in anorexic patients," (as cited in Peck & Lightsey, Jr., 2008, p. 185). Additionally, Stein et al. (2002) also maintains that the client may still be perfectionistic although the disordered eating symptomology has diminished. With perfectionism still prominent, there is higher probability for relapse into disordered eating attitudes, beliefs, behaviors, and cognitions (as cited in Sherry, 2008). Thus, perfectionism may operate as a vulnerability factor for relapse back into disordered eating.

In addition to relapse, perfectionism may operate as a resistance to treatment for disordered eating. Clinical and community studies have found that perfectionism may foster resistance to treatment for disordered eating (Sherry, 2008; Peake, Limbert & Whitehead, 2005; Franco-Paredes et al., 2005). Fletcher, Kupshik, Uprichard, Shah & Nash (2008) remark that "... there is increasing evidence of comorbidity of psychopathological mechanisms (e.g. perfectionism, ...) with eating disorders which, left untreated, may diminish any therapeutic effects," (p. 191). Peake et al., (2005) designed a study to explore perfectionism as it is linked to treatment resistance. Identifying personal factors related to adult clients dropping out of an eating disorders program between the years of 1994 and 2002 were sought. Case files of 576 clients were reviewed who had either completed treatment or had dropped out during treatment. All clients met DSM-IV-TR diagnostic criteria for eating disorders and were clients of either the day treatment program or sought outpatient individual therapy for disordered eating. The second highest factor to predict dropout was perfectionism (Peake et al., 2005).

Transdiagnostic Theory for Disordered Eating Treatment. A counselor today must be equipped with knowledge about treatment for disordered eating and perfectionism prior to beginning work with a client. As previously stated, rather than considering a different treatment for each DSM-IV-TR eating disorder diagnosis, Fairburn (2008) proposed the transdiagnostic

theory for eating disorders (see *Cognitive Behavior Therapy and Eating Disorders (CBT-E)* by Fairburn, 2008, for treatment outline). By utilizing this approach, the underlying core psychopathology similar in all eating disorder diagnoses, coupled with one or several common maintaining mechanisms (i.e. perfectionism, low self-esteem, mood intolerance, and interpersonal difficulties), are treated together. Thus, the transdiagnostic theory holds that as most eating disorders are built upon the same foundation (common underlying core psychopathology), treating the specific eating disorder will not fully treat the client as another eating disorder may emerge (Fletcher et al., 2008; Fairburn, Cooper & Shafran, 2003; Glover et al., 2007). However, treatment of the perfectionism requires discernment between the subtypes of perfectionism (Rice & Mirzadeh, 2000). Thus, the mental health professional will look at the common underlying core psychopathology that the client is demonstrating rather than a specific eating disorder, yet will identify the specific type of perfectionism the client is operating through (i.e. SOP, SPP, MP).

Multidimensional Perfectionism Assessment Measures. To assist in the discernment between the perfectionism subtypes and the maintaining mechanisms of the disordered eating, it is advantageous for the counselor to administer assessment measures. Such that the multidimensional school of thought is highly regarded as one of the most empirically validated methods to conceptualize perfectionism, many researchers have used assessment measures that uphold this perspective. One example is the Multidimensional Perfection Scale. It is commonly used in research on perfectionism by those following the multidimensional approach (Franco-Paredes et al., 2005; Stoeber & Otto, 2006; Landa & Bybee, 2007; Glover et al., 2007; Peck & Lightsey, Jr., 2008; Pintode de Azevedo et al., 2009; Bardone-Cone et al., 2009). The MPS is a self-report measure that assesses perfectionism from three different dimensions: self-oriented,

socially-oriented, and other-oriented perfectionism, thus capturing an expanded image of how perfection may play multiple roles one's life (Franco-Paredes et al., 2005).

Stoeber & Otto (2006) compiled a list of assessment measures that, similar to the MPS, assess perfectionism via the multidimensional approach: Almost Perfect Scale-Revised (APS-R), Frost Multidimensional Perfectionism Scale (MPS-F), Perfectionism Inventory (PI), and Perfectionism Questionnaire (PQ). Additionally, Franco-Paredes et al. (2005) emphasizes the significant amount of research on the topic of disordered eating and perfectionism utilizing both the Eating Disorder Inventory (EDI) and the Neurotic Perfectionism Questionnaire (NPQ). The EDI is an assessment measure used to collect information regarding one's cognitions and behaviors that are characteristic of eating disorders listed in the DSM-IV (Franco-Paredes et al., 2005). The EDI contains a subscale titled Perfectionism (EDI-P) that is often used in research on disordered eating and the pervasiveness of perfectionism. The NPQ was created to measure how perfectionistic attitudes, assumptions, and beliefs may relate to eating disorders (Franco-Paredes et al., 2005).

Therapeutic Techniques. Once the counselor has identified the unique presentation of disordered eating and perfectionism in the client, an exploration of client strengths may begin. With the goal of avoiding treatment emphasizing the dysfunction of perfectionism, therapeutic interventions could draw attention to adaptive perfectionism through empowering the client to achieve goals without self-deprecating thoughts, beliefs and behaviors (Gustafsson et al., 2008; Rice & Mirzadeh, 2000). Furthermore, as Stice (2002) states, therapy "...should focus on reducing malleable risk factors for eating pathology, such as thin-idealization, body dissatisfaction, and negative affect...they should also strive to increase protective factors, such as social support and self-esteem," (p. 844). Therapy can increase awareness through both

psychoeducation and client experience of the uselessness of SOP, SPP, or maladaptive perfectionism, rather than bluntly challenging the client. Interventions highlighting the sociocultural pressures to be perfect or to be thin are essential factors to process with the client (Gustafsson et al., 2008). Thus, the link between disordered eating symptomology and perfectionism are identified in the client's life.

Additionally, the counselor must also be cognizant of the client's need to perform homework and in-session activities without error (Greenspon, 2008). Just as perfectionism is applied to one's appearance, this over-evaluation of self, and need for heightened achievement threads into the counseling process (Fairburn, 2008). Thus, progress may be slow as the counselor makes this aware to the client. Fairburn (2008) provides an example, "Clinical perfectionism may also be expressed in patients' behavior in sessions with some patients slowing down treatment with innumerable questions about its finer details," (p. 200). Other examples may be meticulous body checking, weight checking, and over-evaluation of self-monitoring of eating symptomology (Fairburn, 2008). Therefore, when the counselor draws attention to the perfectionism, feelings of anxiety, anger, or even animosity toward the therapy process and/or counselor may emerge (Greenspon, 2008). Yet, asking the client to set aside judgment or to accept lower standards may hinder the therapeutic relationship (Fairburn, 2008; Greenspon, 2008). Though awareness is made of the perfectionism, but an exploration of how the client's cognitions and behavior may be adaptive or maladaptive is conducted in-session.

Another technique helpful to model to the client is the counselor's lack of perfection (Greenspon, 2008). For example, the counselor may make suggestions regarding themes emerging during the session, but find that the themes are not resonating with the client. The counselor can acknowledge this error, and then continue in the conceptualization of the client. In

addition to acknowledging imperfections of the counselor during sessions, it is imperative that the personal meaning of being perfect (or never faulting) to the client is discussed. Thus, the client may explore the messages and experiences that contributed to the perfectionism and disordered eating (Greenspon, 2008).

Disordered eating, coupled with perfectionism may be "so deeply entrenched and so difficult to overcome because it is a vital element of one's self experience, and of one's sense of reality," (Greenspon, 2008, p. 276). Furthermore, therapy asks the client to consider altering some of the core facets to their identity (Greenspon, 2008). A counselor working with someone struggling with both disordered eating and a type of perfectionism ultimately needs to focus on developing rapport and creating a trusting foundation for the therapeutic relationship to build off of. The client will likely be highly apprehensive of any judgment, criticism, or requests to lower standards. Thus, the counselor should "create the environment of acceptance in which perfectionism can eventually lose its grip," (Greenspon, 2008, p. 280).

Conclusion

Based upon the comprehensive literature review on current research, perfectionism has been found to have the propensity to contribute to the risk of developing disordered eating, maintenance of disordered eating, resistance to treatment, and vulnerability to relapse. It is evident that perfectionism has been present in clients before, during, and after disordered eating. Additionally, research has provided ample evidence supporting the association between disordered eating, regardless of the diagnostic category, with three subtypes of perfectionism: self-oriented perfectionism, socially prescribed perfectionism, and maladaptive perfectionism. Consistently, results from current research have shown that adaptive perfectionism is the least likely subtype to be associated with disordered eating. Lastly, treatment options for clients with

disordered eating and perfectionism must be carefully selected to provide optimal support for recovery.

CHAPTER III: DISCUSSION

Summary of Key Points

"It is probable that perfectionism begins as positive and rewarding but becomes excessive, negative, and destructive for a variety of reasons," (Shafran & Mansell, 2001). Therefore, it behooves mental health professionals to possess the capability to discern one dimension (subtype) of perfectionism from another, especially concerning disordered eating. As the previous sections describe, eating pathology may have unique presentations in regard to the perfectionism subtype (SOP, SPP, and MP) most prominent in the individual. Renowned researchers on the constructs of disordered eating and perfectionism, Hewitt et al. (1995) state:

> ...dimensions of perfectionism may be relevant to eating disorder symptoms in the sense that individuals may require themselves to meet ideal body or weight standards that derive from themselves or others... a strong need for perfectionistic self-presentation can influence eating behavior by not allowing the person to display imperfections, or admit to difficulties. (p. 318)

Accordingly, research has demonstrated the noteworthy importance of offering attention to the subtypes of perfectionism as results provide evidence supporting differing patterns across all dimensions (Landa et al., 2007). Sherry (2008) notes that not discriminating between the subtypes of perfectionism "... may distort or suppress unique information in predicting eating pathology," (p. 14). Although, one may discover clients in which disordered eating initially presents the same despite the subtype of perfectionism, the mental health professional with knowledge on this topic can have the ability to understand foundational processes and thus, offer enhanced treatment and support for clients.

Disordered eating and perfectionism have repeatedly been linked (Landa & Bybee, 2007). Levels of perfectionism have been extraordinarily prominent in studies with samples comprised of those with an eating disorder that Landa & Bybee (2007) remark, "...perfectionism is used as an operational indicator of eating problems and is included as a subscale in one of the most widely used measures of eating disorders (Eating Disorder Inventory) [EDI]..." (p. 85) Hence, as measurements have been created to assess both constructs and a progressive amount of studies are conducted on the topic, research supports the potential for perfectionism to be present before, during, and after an individual suffers from eating symptomology (Franco-Paredes et al., 2005). Further research was performed to elaborate on those conclusions. The goal was to discover more specifics about the role of perfectionism in disordered eating. The results of that research provided the counseling field with more information, as well as heightened awareness about perfectionism as a risk factor and a maintenance factor of disordered eating. In addition, that research also highlighted perfectionism as a resistance to treatment and as a vulnerability factor for relapse back into disordered eating (Stice, 2002; Soenens et al., 2007; Sherry, 2008; Peake et al., 2005; Glover et al., 2007; Bardone-Cone et al., 2009; Shafran & Mansell, 2001).

Thus, with the present information known about the interrelationship of perfectionism and disordered eating, some research has been conducted on treatment factors and interventions. Rather than focusing on negative factors, literature supports the technique of focusing on the adaptiveness of perfection (Greenspon, 2008). In addition, literature supports the technique of helping the client to identify his or her strengths and resiliencies. Furthermore, current literature also supports creating an environment of acceptance for the client in which perfectionistic tendencies about oneself may be shed. Greenspon (2008) describes this process as recovery from

disordered eating and perfectionism so the client may feel whole, feel entirely accepted, and have "the courage to be imperfect," (p. 280).

Future Implications for Research

Future research exploring the dynamics that exist between the concepts of perfectionism and disordered eating would be helpful for mental health professionals to gain more awareness of how this may present in counseling, the treatment implications, as well as treatment interventions. Additionally, examining the dynamics explored in the current review would be advantageous for medical professionals, schools professionals, and parents alike, especially in terms of awareness and prevention efforts. Current literature lacks in sampling populations of diverse ethnicities both in the United States and in other countries, socioeconomic status, sexual orientation, and gender. Many of the studies reviewed were comprised of single, heterosexual, Caucasian women, primarily in young adulthood, and from affluent backgrounds. Furthermore, studies reviewed were lacking in family involvement, especially in regard to support in treatment of the disordered eating and perfectionism. Research reviewed did include several longitudinal studies. It would be beneficial to continue conducting studies spanning across developmental levels.

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