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Perfectionism and Psychological Well-Being in Sport and Performance Psychology Professionals

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PERFECTIONISM AND PSYCHOLOGICAL WELL-BEING IN SPORT AND PERFORMANCE

PSYCHOLOGY PROFESSIONALS

by

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(Under the Direction of Megan Byrd)

ABSTRACT

Sport and performance psychology (SPP) professionals working in performance-enhancement training, counseling/clinical psychology, academia, and the military, face various work demands that can lead to chronic stress and impaired well-being (McCormack, 2019). Perfectionism is a multi-dimensional personality trait in which an individual sets excessively high personal standards of performance (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). While striving for high standards is not necessarily a negative trait, perfectionism is not considered a healthy pursuit of excellence, rather a "compulsive drive to achieve flawlessness" (Burns, 1980, p. 38). Given that SPP professionals' responsibilities are to help athletes and other performers maintain optimal mental health and performance, providers may be expected to meet unrealistic expectations in these arenas. For the perfectionistic SPP professional, coping with failing to meet such expectations, as well as organizational demands and stressors, may be particularly challenging. However, there has been no research to explore perfectionism in SPP professionals or how perfectionism influences well-being in this population. The purpose of this study was to analyze the impact of SPP professionals' perfectionism on their psychological well-being (PWB). The study sample consisted of 81 SPP professionals. Results indicated that discrepancy, defined as the perception of failing to meet one's high standards or expectations, had strong, significant, negative correlations to overall PWB [$r(81) = .731, p < 0.01$] and four components of PWB (i.e., autonomy, environmental mastery, positive relations with others, and self-acceptance). Furthermore, discrepancy accounted for almost half of the variance in environmental mastery and more than half of the variance in self-acceptance and overall PWB. Therefore, this study provides support that perfectionism is not only negatively correlated to PWB but can also predict specific components of one's PWB. Given the implications of perfectionism, it is critical to gain a better understanding of the potential impact of perfectionism in SPP professionals as it may guide future interventions to prevent mental health concerns and optimize well-being in this population.

INDEX WORDS: Perfectionism, Psychological well-being, Mental health, Sport psychology

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by

KAYTLYN JOHNSON

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CHAPTER 1

INTRODUCTION

Helping professionals are likely to experience high levels of stress associated with emotionally draining and demanding work, personality characteristics, and a person-centered orientation (Pines et al., 1981). Applied psychologists and other mental health professionals are especially prone to experience work-related health impairments, such as burnout (McCormack et al., 2018), compassion fatigue (Figley, 2002), and vicarious traumatization (Dunkley & Whelan, 2006). According to Kinman and Grant (2022), compassion fatigue, difficulties detaching from work, overinvolvement, and poor self-care habits may intensify the risks for impaired well-being. Furthermore, perfectionism is a multi-dimensional personality trait in which an individual sets excessively high personal standards of performance (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). Perfectionistic individuals are more negatively affected by stressors, and as a result, experience higher levels of anxiety and lower levels of well-being (D'Souza, 2011). Sport and performance psychology (SPP) professionals, holding roles in performance-enhancement training, counseling/clinical psychology, and/or academia, face various work demands (e.g., workload, time pressure) that can lead to chronic stress and impaired well-being. (McCormack, 2019). Given that SPP professionals' responsibilities are to help athletes and other performers maintain optimal mental health and performance, they may be expected to meet high expectations in these arenas. For example, professionals holding roles in multiple arenas (i.e., academia, performance-enhancement) may have to meet university standards for faculty positions while maintaining a caseload with performers. the perfectionistic professional, coping with meeting these expectations as well as organizational demands and stressors may be particularly challenging. However, there has been no research to explore perfectionism in SPP professionals or how perfectionism influences well-being in this population. As such, exploring perfectionism in SPP professionals will help gain a better understanding of the potential consequences of perfectionism on well-being and perhaps guide future preventative interventions to minimize mental health issues in this population.

Well-Being

Well-being is often referred to as a multi-dimensional concept that refers to optimal psychological functioning and experience. Conceptualizations of well-being are commonly rooted in two philosophies, hedonism and eudaimonism, which prescribe different developmental and social processes to achieving well-being (Ryan & Deci, 2001). Due to these differing views, the construct of well-being is complex and controversial (Lundqvist, 2011; Ryan & Deci, 2001). Coan (1977) and Christopher (1999) argue that factors such as culture, history, ethnicity, and other social structures influence individuals' judgements and understanding of well-being. As such, breaking down well-being into specific perspectives helps gain greater insight into these differences.

Dimensions of Well-Being

The hedonic view summarizes well-being as an experience of pleasure or happiness (Ryan & Deci, 2001). Those following this perspective believe that well-being is achieved through increasing happiness by striving for pleasure, moving towards meaningful goals, and increasing positive affect (Lundqvist, 2011). A major outcome variable of hedonism in the research is subjective well-being (SWB; Ryan & Deci, 2001), which incorporates one's emotional responses, domain satisfaction, and global judgments of life satisfaction. Specifically, SWB is based on a person's cognitive and affective evaluations of their life as a whole (Diener et al., 2009). SWB is largely dependent on the individual and how they interpret their life circumstances.

The eudaimonic perspective of well-being separates subjective happiness from well-being, such that not all desires, even those that an individual values most, would lead to well-being when accomplished (Ryan & Deci, 2001). Rather than seeking to achieve pleasure and happiness, eudaimonism is concerned with activities that people are engaged with to develop and reach their full potential (Lundqvist, 2011). Eudaimonia is based within self-realization theories, which refer to achieving *daimon*, or true self. Eudaimonic psychologists focus more on social and psychological well-being. Social well-being, influenced by factors such as age, education, and socioeconomic status, is useful in understanding

one's ability to function in their personal life and how they contribute to society. Social well-being represents an individual's social functioning and perceptions of social flourishing (Lundqvist, 2011).

Psychological Well-Being. Psychological well-being (PWB), on the other hand, is considered a multidimensional concept that encompasses different aspects of human actualization. Grounded in two conceptualizations of positive functioning, PWB encompasses both happiness and life satisfaction (Ryff & Keyes, 1995). Ryff and Keyes' (1995) proposed structure of PWB incorporates six aspects: autonomy, personal growth, self-acceptance, life purpose, mastery, positive relatedness. Autonomy refers to one's sense of freedom in governing their own lives. Personal Growth represents one's continued desire to develop and expand as a person, rather than remaining at a fixed state. Self-Acceptance, the most recurrent criterion of PWB, is defined as a characteristic of self-actualization, optimal functioning, and maturity. Holding positive attitudes towards oneself is considered a central characteristic of positive psychological functioning. Life purpose refers to the feeling that life is meaningful, and as such, one has goals, intentions, and a sense of direction that contribute to their greater purpose. Mastery suggests that individuals' ability to choose or create environments that are congruent with their skills is a crucial characteristic of mental health. Finally, Positive relatedness refers to the importance of engaging in warm, trusting interpersonal relationships and is repeatedly stressed in conceptualizations of PWB. When considered together, these six dimensions help define PWB theoretically and operationally (Ryan & Deci, 2001).

Well-Being in the Helping Professions

Individuals in the human service field are typically humanitarian, hoping they can be helpful in service to others (Cherniss, 1980). The professional's role is often defined by their clients' needs, and as a result, maintaining an effective work-life balance may be challenging. According to McCormack et al. (2018), psychologists and other mental health professionals are prone to several work-related health impairments. For example, Rabin and colleagues (1999) identified five stressors encountered by psychotherapists, including maintaining the therapeutic relationship, scheduling, professional doubt, overinvolvement in work, and personal depletion. Furthermore, these populations suffer from compassion

fatigue, difficulties detaching from work, overinvolvement, and poor self-care (Kinman & Grant, 2022). One key indicator of well-being in the helping professions is burnout. Burnout consists of emotional exhaustion, depersonalization, and feelings of diminished personal accomplishment (Maslach & Jackson, 1981). Job demands, personal characteristics, and availability of resources can contribute to the development of burnout among applied psychologists (McCormack et al., 2018). Within the field of psychology, burnout has been associated with depression (Gilroy et al., 2002; Pope & Tabachnick, 1994) and anxiety (Morse et al., 2012). Research has also shown that the relationship between burnout and employee turnover typically occurs relatively early in one's career, in which burnout may lead individuals to quit or leave the helping profession (Maslach, 1982). Therefore, monitoring the well-being of helping professionals is vital to maintaining healthy and competent individuals in the field.

Well-Being in Sport and Performance Psychology (SPP) Professionals. While there is limited research exploring SPP professionals' overall well-being, there is literature available on SPP professionals' work-based well-being (McCormack, 2019), professional quality of life in sport psychology professionals (Quartiroli et al., 2019a; 2019b), and sport psychologists' job experiences at the Olympic Games (Arnold & Sarkar, 2014; McCann, 2008). Work demands of SPP professionals are often dynamic, including multiple roles and responsibilities. Fletcher and colleagues (2011) note that work demands caused by unsociable hours, isolation, and seasonal demands of athletics can lead to chronic stress in this population. Teaching, research, consulting, workload, and hours were found to be the most common organizational demands of SPP professionals (Fletcher et al., 2011). Furthermore, those working directly with teams, issues including practice settings, dual relationships, and confidentiality can pose work-related stressors (Andersen et al., 2001).

The work environment for SPP professionals puts them at risk to experience high job demands and stress, resulting in feelings of burnout and workaholism (McCormack, 2019). Workaholism is characterized as an addiction to working that has a tangible negative impact on one's health, happiness, and relationships (Clark et al., 2016). For example, McCormack (2019) found that applied sport psychologists commonly engaged in "workaholic" tendencies (i.e., boundaryless working, working

while sick, inability to detach from work) regardless of the environment in which they worked (i.e., academia, applied, counseling/clinical) and invested themselves deeply into their jobs. The inability to detach from work is negatively associated with well-being through emotional exhaustion and need for recovery (Sonnentag et al., 2010). Additionally, burnout can lead to depression (Hakanen & Schaufeli, 2012), fatigue, physical discomfort, insomnia, overexcitement, negative feelings, and decreased productivity at work (Bernier, 1998). As such, analyzing well-being in SPP professionals is important to maintain a steady workforce of individuals prepared to handle the stressors associated with their work and minimize the impact of burnout and workaholism. However, limited research exists exploring the potential contributors of impaired well-being in SPP professionals. The current study will add to the literature by examining perfectionism as a potential factor influencing well-being.

Perfectionism

Perfectionism is considered a multi-dimensional personality trait in which an individual sets excessively high personal standards of performance (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). Although striving for high standards is not an undesirable trait, perfectionism is not considered a healthy pursuit of excellence or high standards, rather perfectionism is a "compulsive drive to achieve flawlessness" (Burns, 1980, p. 38). Hamachek (1978) originally differentiated perfectionism dimensions into neurotic and normal perfectionism. These dimensions have since been referred to as healthy versus unhealthy (Adler, 1956), adaptive versus maladaptive (Rice et al., 1998), and positive striving versus maladaptive evaluation concerns (Frost et al., 1990). Neurotic, or maladaptive perfectionism, is characterized by setting high standards and allowing little space for mistakes. Normal, or adaptive perfectionism, is characterized by setting high standards and feeling free to make mistakes (Hamachek, 1978).

Maladaptive perfectionists often feel that tasks are never fully completed or not completed well enough, and they demand a higher level of performance that is often impossible to meet (Hamachek, 1978). When standards are not met, maladaptive perfectionists dwell on their shortcomings, resulting in feelings of being inferior or under-rewarded (Burns, 1980). Perfectionistic concerns, typically associated

with maladaptive perfectionism, reflect one's self-deprecating appraising processes or psychological maladjustment (Stoeber & Otto, 2006). Perfectionistic concerns are also related to a lower sense of self-value, specifically lower self-esteem, and higher self-criticism (Hill et al., 2018). Given the different conceptualizations, the impact of perfectionism may vary depending on the individual. Frost and colleagues (1990) emphasize the psychological implications of perfectionism lie within the critical evaluative tendencies of oneself. As such, the concern to meet excessively high standards and the maladjustment issues associated with not meeting those standards has the potential to negatively impact individuals in many ways, including anxiety (Frost & DiBartolo, 2002), depression (Flett & Hewitt, 2006), and eating disorders (Bardone-Cone et al., 2007).

Dimensions of Perfectionism

Hewitt and Flett. Hewitt and Flett (1990) define perfectionism as a multi-dimensional concept comprising both personal and social factors. They focus on three primary dimensions in their conceptualization of perfectionism: self-oriented perfectionism, other-oriented perfectionism, and socially-prescribed perfectionism. Self-oriented perfectionism involves self-directed behaviors, such as "exacting standards for oneself and stringently evaluating and censuring one's own behavior" (Hewitt & Flett, 1990, p. 457). Other-oriented perfectionists have unrealistic expectations for significant others and rigidly evaluate others' performance (Hewitt & Flett, 1990). While self-oriented perfectionism is focused more heavily on intrapersonal feelings, other-oriented perfectionism is related to interpersonal frustration towards others. Socially-prescribed perfectionism entails one's "belief or perception that significant others have unrealistic standards of them, evaluate them stringently, and exert pressure on them to be perfect" (Hewitt & Flett, 1990, p. 457). The perceived need to attain standards and expectations is directed towards avoiding disapproval by others (Hewitt & Flett, 1990; Stoeber & Otto, 2006).

Frost, Marten, Lahart, and Rosenblate. Frost and colleagues (1990) conceptualization of perfectionism is made up of five dimensions, which capture the overly critical evaluative tendencies of perfectionists: personal standards, concern over mistakes, doubt about actions, parental expectations, parental criticism, and organization. Personal standards, the most prominent element of perfectionism

(Burns, 1980; Frost et al., 1990; Hamachek, 1978), represents the excessively high personal standards of performance and the critical evaluation tendencies associated with those standards. Concern over mistakes explains how maladaptive perfectionists approach goals by fear of failure rather than striving for achievement (Hamachek, 1978). Doubt about actions relates to the vague sense of skepticism related to the quality of one's performance, specifically the uncertainty regarding if a task is done *or* done well enough (Frost et al., 1990). Parental expectations and parental criticism both refer to the extent to which one places value on parental expectations and evaluations of them. For the perfectionist, "self-evaluations of performance are inextricably tied to assumptions about parental expectations and approval or disapproval" (Frost et al., 1990, p. 451). Finally, organization characterizes perfectionists' over-emphasis on precision, order, and organization (Frost et al., 1990).

   Slaney, Rice, Mobley, Trippi, and Ashby. Slaney and colleagues (2001) sought to highlight both the adaptive and maladaptive aspects of perfectionism in their conceptualization of perfectionism. In particular, they focused on defining the maladaptive dimension of perfectionism, which was not previously differentiated in earlier measures. According to Slaney and colleagues (2001), the concept of discrepancy "seems integral to perfectionism and phenomenologically operationalizes the excessive aspect of perfectionism" (p. 132). Discrepancy, defined as the perception of failing to meet one's high standards or expectations, helps analyze the difference between one's standards and one's performance in conceptualizing perfectionism and captures the negative dimension of the construct (Slaney et al., 2002). Furthermore, having high standards has been established as a common characteristic of perfectionism (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). Furthermore, orderliness, neatness, or organization are also integral to the definition of perfectionism, when combined with high standards (Slaney & Ashby, 1996). When analyzed together, the high standards and order scales have the highest structure coefficient to the adaptive factors (Slaney et al., 2002). Thus, Slaney and colleagues' (2001) description of perfectionism is one that supports both the adaptive (i.e., high standards and order) and maladaptive (i.e., discrepancy) aspects of perfectionism. Specifically, this definition accounts for the

ambivalence between high standards and perceived performance and the distress that this perceived difference evokes.

Perfectionism in the Helping Professions

As a personality trait, perfectionism may manifest in a more excessive investment in the work environment. According to Falco and colleagues (2014), setting high standards, holding high expectations for others, and perceptions of others' evaluations of oneself can be associated with an urge to work excessively and compulsively, which is commonly referred to as workaholism. Socially-prescribed perfectionism has shown to have a positive direct effect on both emotional exhaustion and professional inefficiency (Falco et al., 2014) as well as role stress, inefficiency, and exhaustion over time (Childs & Stoeber, 2012). Maladaptive coping mechanisms, such as suppression, denial, and disengagement, can inhibit one's ability to cope with perfectionistic concerns, leading to burnout in the workplace. Burnout may then lead to emotional exhaustion, depersonalization or cynicism, and low levels of personal accomplishment or efficacy (Hill & Curran, 2016). Flett and Hewitt (2020) also found that perfectionism may lead to a workaholic orientation that includes poor work-life balance and neglect of key social relationships. Furthermore, stressful life conditions, opportunities, and realities may not fit a perfectionist's need to achieve at an exceptionally high level and be recognized (Flett & Hewitt, 2020).

Furthermore, individuals in the helping professions may be more susceptible to stressors as a result of various factors, including performance of work that is emotionally draining and demanding, having certain personality characteristics (i.e., sympathetic, understanding, unselfish), and holding a person-centered orientation (Pines et al., 1981). Taking into consideration potential stressors and that perfectionists have a higher tendency to experience stress and engage in maladaptive coping strategies, perfectionistic professionals may be more susceptible to burnout and other work-related stressors (Kinman & Grant, 2022). Moreover, an increased pressure for professionals to perform at unrealistically high standards where outcomes may be outside of their control could also be problematic for perfectionistic professionals (Kinman & Grant, 2022). For example, D'Souza and colleagues (2011) examined the relationship between perfectionism, stress, and burnout in 87 clinical psychologists in

Australia. Results indicated that stress was a significant indicator of personal, work-related, and client-related burnout. Participants higher in perfectionism were also more likely to experience increased stress levels (D'Souza et al., 2011). Additionally, Moate and colleagues (2016) found that adaptive perfectionists experienced significantly less stress and burnout than maladaptive perfectionists (Moate et al., 2016). Specifically, maladaptive perfectionists reported higher levels of stress, personal burnout, work-related burnout, and student-related burnout. Maladaptive perfectionists' tendency to focus on the possibility of failure (Hamacheck, 1978) may cause feelings of depression (Noble et al., 2014).

Perfectionism in Sport and Performance Psychology (SPP) Professionals. Perfectionism in sport has been an area of great interest over the last two decades (Hill et al., 2018). Flett and Hewitt (2005) coined the "perils of perfectionism" in sport which are moderated by factors such as anxiety, goal orientation, fear of failure, performance success, self-presentation concerns, and coping strategies. While a considerable amount of literature exists examining perfectionism's influence on athletes, there is limited evidence on how it can impact service professionals in sport, including SPP professionals, coaches, and athletic trainers. The most relevant research available examines the relationship between perfectionism and burnout (Tashman et al., 2010; Vealey et al., 2020) and emotional regulation in coaches (Hill & Davis, 2014).

Tashman and colleagues (2010) examined the effects of perceived stress (PS) on the relationship between adaptive and maladaptive perfectionism and burnout in a sample of 177 collegiate coaches. Findings suggested that coaches who experienced more Concern over Mistakes, Need for Approval, Parental Pressure, and Rumination made more negative evaluations of stress, experienced higher levels of emotional exhaustion and depersonalization, and lower levels of personal accomplishment. Moreover, maladaptive perfectionism dimensions led to threatening appraisals of stress and directly impacted the development of burnout regardless of how individuals perceived the stress (Tashman et al., 2010). Vealey and colleagues (2020) found that perfectionism was related to both motivation and burnout in collegiate coaches. Socially-prescribed perfectionism, the most significant predictor variable in the study, demonstrated positive relationships with emotional exhaustion and burnout and negative relationships

with motivation and personal accomplishment. Vealey et al. (2020) suggested that socially-prescribed perfectionism can be maladaptive for coaches, especially when they are pressured by external sources (i.e., athletic departments, community members) to achieve unrealistic standards or achievements. Furthermore, coaches who focus on seeking approval from others and meeting unrealistic expectations may be setting themselves up for failure (Vealey et al., 2020). These studies demonstrate that maladaptive perfectionists do not believe they are able to meet demands, which may increase stress and the likelihood for burnout. As such, understanding the depth of how perfectionism impacts SPP professionals may help promote overall well-being and decrease the chances of burnout and workaholism.

Significance of the Study

To date, there has been no research to analyze perfectionism in SPP professionals. While there is some research available on work-based well-being in this population, no current literature is available on how perfectionism influences psychological well-being in this population. Given that SPP professionals encounter a wide range of demands within their jobs and experience several organizational demands and stressors (Fletcher et al., 2011), they may be more prone to burnout and workaholism. Furthermore, SPP professionals are trained to help athletes manage stress (Fletcher et al., 2011) and counter their maladaptive perfectionistic tendencies (Egan et al., 2014; Hewitt et al., 2016), yet have little guidance on how these constructs may affect their own professional performance and well-being.

Understanding how perfectionism, both adaptive and maladaptive, relates to psychological well-being, and to what extent, perfectionism influences well-being within SPP professionals is both pertinent and relevant. Therefore, the purpose of this study is to analyze the impact of SPP professionals' perfectionism on their psychological well-being. The research questions addressed in this study were as follows: (1) Is there a relationship between perfectionism and psychological well-being in SPP professionals, and (2) To what extent does perfectionism predict SPP professionals' psychological well-being? Given the potential impact perfectionism has on one's well-being, this research aims to build awareness around the prevalence of perfectionism in SPP professionals as well as provide future directions to further support and maintain the well-being of professionals in the field.

CHAPTER 2

METHODS

Design

This correlational and predictive study examined the relationship between perfectionism and psychological well-being (PWB) in sport and performance (SPP) psychology professionals. The research questions answered were (1) Is there a relationship between perfectionism and psychological well-being, and (2) To what extent does perfectionism predict SPP professionals' psychological well-being?

Based on previous literature, two hypotheses were generated: (1a) There would be a significant, negative relationship between the discrepancy subscale and the PWB subscales, (1b) There would be a significant, positive relationship between the high standards and order subscales and the PWB subscales, and (2) perfectionism, specifically high standards, order, and discrepancy, would predict SPP professionals' PWB, across all subscale scores and the total score.

Participants

The study's target population included working professionals in sport and performance psychology (SPP). Inclusion criteria for the study were as follows: (a) have worked with athletes or other performance populations as an applied SPP practitioner, (b) are Certified Mental Performance Consultants (CMPC®), licensed counselors or psychologists, or are under supervision/mentorship, and (c) are 18 years of age or older. Power analyses were run given the parameters of a medium effect size ($f^2 = 0.15$) and an alpha level of 0.05 to ensure a power of 0.80. Based on the total number of three predictor variables, a minimal sample size of 77 was determined appropriate for this study.

Demographics. A total of 97 SPP professionals participated in the study, however due to ineligibility or incomplete data, 81 participants were included in the final analysis. A summary of the descriptive data can be found in Table 1. Of the 81 participants, 42% (n = 34) were male, 54.3% were female (n = 44), and 3.7% were nonbinary (n = 3). The largest portion of the sample was 20-29 years old (48%), while 30.9% were 30-39 years old. The ethnic/racial breakdown of the sample was mainly White (84%; n = 68) with 9.9% identifying as African American or Black (n = 8). 3.7% Asian (n = 3), and 2.5% Hispanic or Latino (n = 2). Furthermore, 70.4% (n = 57) of the sample worked in the applied arena and 37% (n = 30) worked in Clinical/Counseling settings. Of the 81 participants, 43 had zero to five years of experience working with athletes or other performance populations. Four participants had more than 20 years of experience.

Table 1

Participant Demographics (N=81)

Characteristics	Frequency	Percent
Age		
20-29	39	48.1
30-39	25	30.9
40-49	12	14.8
50-59	2	2.5
69+	2	2.5
N/A	1	1.2
Gender		
Male	34	42.0
Female	44	54.3
Nonbinary	3	3.7
Race/Ethnicity		
Asian	3	3.7
Black or African American	8	9.9
Hispanic or Latino	2	2.5
White	68	84.0
Other	2	2.5
Highest Earned Degree		
Bachelor's	16	19.75
Master's	38	46.91

Doctorate	27	33.33
Licensure/Certification(s)		
CMPC	22	27.2
In Progress	2	2.47
Licensed Psychologist	10	12.35
Licensed Professional Counselor	4	4.94
Provisional LPC	2	2.47
Licensed Mental Health Counselor	4	4.94
Other	16	19.8
None	17	30.0
Years Experience*		
0-5 years	43	53.0
6-10 years	20	24.7
11-15 years	11	13.6
15-20 years	3	3.70
20+ years	4	4.94
Area of Work/Specialty^		
Academia	22	27.2
Applied	57	70.4
Clinical/Counseling	30	37.0
Military	8	9.9
Other	6	7.4

*Denotes licensed/certified experience or experience under supervision/mentorship
^34 participants selected more than one area of work/specialty

Measures

Participants completed three self-report surveys measuring demographic characteristics, perfectionism, and psychological well-being. The demographic questionnaire contained questions about age, gender identity, race, ethnicity, number of years work experience, education level and/or education in progress, licensure or certifications, and area of work/specialty (i.e., academia, applied, clinical/counseling, military, other).

Almost Perfect Scale-Revised (APS-R)

The Almost Perfect Scale-Revised (APS-R) was used to measure negative and positive aspects of perfectionism (Slaney et al., 2001). Twenty-three items were measured on a 7-point Likert-type scale (1 = strongly disagree to 7 = strongly agree) over three subscales, including high standards, order, and discrepancy. Example questions for each subscale include high standards (e.g., "*I have standards for my*

performance at work or at school"), order (e.g., "*I think things should be put away in their place*"), and

discrepancy (e.g., "*My best just never seems to be good enough for me*"). Each subscale is scored

separately and summed based on responses. Max scores are 49 for high standards, 28 for order, and 84 for

discrepancy.

The structure coefficients of each item and subscale of the APS-R ranged from .42 to .88. Slaney

and colleagues determined Cronbach's alphas for the APS-R, which indicated adequate internal

consistency for each of the subscales (.85 for high standards, .86 for order, and .92 for discrepancy).

Mobley and colleagues (2005) reported alpha coefficients of .75 for high standards, .91 for order, and .88

for discrepancy in a sample of 251 African American university students. Furthermore, Ulu et al. (2012)

found alpha coefficients for .78 for high standards, .85 for discrepancy, and .86 for order in a large sample

of undergraduate students from Turkey. The APS-R has also been utilized in samples of African

American (Mobley et al., 2005) and Chinese college students (Wang et al., 2007), and some clinical

populations (Argus & Thompson, 2008), demonstrating that the APS-R is reliable across diverse

populations.

Rice and colleagues (2007) also found that the High Standards subscale of the APS-R was

correlated with self-oriented perfectionism (.68) and personal standards (.65) in a sample of 207

undergraduate students. These results indicate that the APS-R, while similar to other measures of

perfectionism, outlines a clear distinction between the adaptive and maladaptive aspects of perfectionism.

Thus, the APS-R and the incorporation of its discrepancy subscale offer a unique perspective of

perfectionism not included in other measures.

Scale of Psychological Well-Being (SPWB)

The SPWB (Ryff, 1989) includes 42 items rated on a 7-point Likert-type scale (*1 = strongly

agree* to *7 = strongly disagree*) with six subscales. Example items for each subscale include, autonomy

(e.g., *"I am not afraid to voice my opinions, even when they are in opposition to the opinions of most

people"*); environmental mastery (e.g., *"In general, I feel I am in charge of the situation in which I live"*);

personal growth (e.g., *"I am not interested in activities that will expand my horizons"*); positive relations with others (e.g., *"Most people see me as loving and affectionate"*); purpose in life (e.g., *"I live life one day at a time and don't really think about the future"*); and self-acceptance (e.g., *"When I look at the story of my life, I am pleased with how things have turned out*). There are some statements within the scale that are worded in the opposite direction of what the scale is measuring and are reverse scored (e.g., "*I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people*"). To calculate the subscale scores, respondents' answers to each subscale item are summed. Max scores are 49 and minimum scores are 1 for each subscale. Total scores for each subscale are summed equaling the final score on the SPWB. Higher scores indicate higher levels of psychological well-being.

Ryff (1989) determined internal consistency coefficients for each dimension: self-acceptance = .93, positive relations with others = .91, autonomy = .86, environmental mastery = .90, purpose in life = .90, and personal growth = .87. The test-retest reliability coefficients over a 6-week period on a subsample of respondents (*n* = 117) were self-acceptance = .85, positive relations with others = .83, autonomy = .88, environmental mastery = .81, purpose in life = .82, and personal growth = .81. Test-rested reliability was assessed in a subsample of 117 participants over six weeks, with coefficients ranging from .81 to .85. Cenkseven (2004) found the test-retest reliability coefficients over eight weeks to range from .74 to .84 in a sample of Turkish students. To assess the validity of the SPWB, correlations with existing measures were conducted. The correlations included the Affect Balance Scale [.25 (personal growth) to .62 (environmental mastery)], Life Satisfaction Index [.28 (autonomy) to .73 (self-acceptance)], Rosenberg Self-Esteem Scale [.29 (personal growth) to .62 (self-acceptance)], and the Zung Depression Scale [-.60 (environmental mastery) to -.33 (positive relationships with others)] Ryff, 1989).

Procedure

After receiving Institutional Review Board approval, participants were recruited to complete an online survey via Qualtrics (Qualtrics, Provo, UT). Participants were recruited through convenience sampling by distribution of the survey link and purpose of the study in the following ways: (1) posting on the Sport Psy Listserv, (2) contacting SPP professionals listed as members on the Association for Applied

Sport Psychology (AASP) website, (3) contacting SPP professionals listed on the United States Olympic

and Paralympic Committee (USOPC)'s Mental Health Registry and, (4) posting on the researcher's

personal social media platforms (i.e., Twitter). Participants completed a series of three self-report

questionnaires to gather data regarding demographics, perfectionism, psychological well-being in a one-

time collection period.

Participants were sent a link via Qualtrics. Qualtrics uses Transport Layer Security (TLS)

encryption (also known as HTTPS) for all transmitted data (Qualtrics, Provo, UT). Thus, access to survey

results was restricted to researchers to maintain confidentiality. The survey began with an informed

consent followed by the demographic questionnaire. Following the demographics questionnaire,

participants were given the APS-R and SPWB, which were counterbalanced to ensure validity. The

researcher piloted the survey to ensure there were no issues with formatting, question structure, or other

characteristics as well as to gauge an estimated time to complete the survey. Participants were informed

that participation was strictly voluntary, and they could discontinue their participation at any time. Data

were collected and analyzed using descriptive and inferential statistics.

Analysis

Descriptive statistics were calculated using measures of central tendency and variability,

including means, standard deviations, frequencies, and total scores computed for each subscale. The latest

version of IBM SPSS was used for data analysis (IBM Corp., 2022). All data were cleaned and organized

by eliminating any incomplete responses or outliers, as well as checking for normality, skewness, and

scale reliability. Participants missing more than one data point on the APS-R or the SPWB were

excluded, and all outliers were included in the final analysis. Cronbach's alpha coefficient was calculated

to determine internal consistency and scale reliability. Acceptable values of Cronbach's alpha range from

0.70 to 0.95 (Tavakol & Dennick, 2011); thus, scales resulting in 0.70 or lower were discarded.

Cronbach's alpha for the APS-R subscales resulted in .894 for high standards, .851 for order, and .956 for

discrepancy. For SPWB, Cronbach's alpha were .891 for autonomy, .744 for environmental mastery, .401

for personal growth, .716 for positive relations with others, .562 for purpose in life, and .785 for self-

acceptance. One item was removed from the self-acceptance subscale to improve the reliability to .804.

Personal growth and purpose for life did not meet reliability criteria and were therefore excluded from the

final analysis. The total score for the SPWB was calculated utilizing the four remaining subscales,

autonomy, environmental mastery, positive relations with others, and self-acceptance. Cronbach's alpha

for the total SPWB was .880.

To test the first hypothesis, a Pearson correlation between perfectionism and psychological well-

being (PWB) was calculated. The variables included in the analyses were the perfectionism scores, as

measured by the APS-R subscales (i.e., discrepancy, high standards, order), as well as the total PWB

score, as measured by the sum of each subscale. Furthermore, correlations were also conducted between

the subscales of the APS-R, *high standards, discrepancy,* and *order*, and each of the subscales of the

SPWB, *autonomy, environmental mastery, positive relations with others*, and *self-acceptance*.

Five hierarchical multiple regression analyses were conducted to answer the second research

question. Specifically, the analyses examined to what extent the perfectionism subscale scores predict

participants' overall PWB score, along with each of the four subscale scores of the SPWB. Each of the

analyses utilized one of the five PWB scores as the dependent variables and the discrepancy of the APS-R

as the predictor variable. When variance on a criterion variable is being explained by predictor variables

that are correlated with one another, a hierarchical regression is appropriate (Pedhazur, 1997). A

hierarchical regression allows the researcher to determine the order in which predictor variables are

analyzed based on previous research and theory (Lewis, 2007). Based on previous literature,

perfectionism has been linked to psychological implications (Frost et al., 1990) as well as other negative

health outcomes (Flett et al., 2016). Research also shows that even dimensions of perfectionism deemed

to be positive, such as perfectionistic strivings, can also lead to compulsive over-working, limited social

interactions (Graham et al., 2010) as well as stress, body image distortions, and suicide (Cockell et al.,

2002). Therefore, each subscale of the APS-R, including *high standards, order*, and *discrepancy*, may

correlate to PWB differently. Given the results of the correlations from the first hypothesis, discrepancy

was the sole predictor variable analyzed. Running this statistical analysis allowed for researchers to determine how strongly discrepancy predicted overall PWB and four components.

To detect multicollinearity or similarities between predictor variables, a variance inflation factor (VIF) was analyzed as well as a tolerance score. The researcher also examined any correlations among predictor variables. Vincent and Weir (2012) suggest that factors VIF of 10 or higher should be dropped due to multicollinearity. Values below 0.1 indicate a problem, while those below 0.2 suggest a potential problem (Menard, 1995). Through running the analysis for the three subscales of the APS-R, the researcher could identify which dimension of perfectionism predicted PWB. Additionally, the regression model allowed for each of the subscales of the SPWB to be analyzed. To make inferences about which variables, specifically *high standards, discrepancy*, and *order*, best predicted PWB, R^2 changes were analyzed to account for the variance after each variable was entered into the model.

CHAPTER 3

RESULTS

Descriptive Data

Measures of central tendency and variability were calculated for each instrument and its

subscales. A summary of the descriptive statistics can be found in Table 2. For the SPWB, average score

for positive relations with others was 42.05 (SD = 5.74) and 46.96 for overall PWB (SD = 19.82). The

average score for autonomy was 34.21 (SD = 7.76), 36.54 for environmental mastery (SD = 6.78), and

36.14 for self-acceptance (SD = 6.01). For the APS-R, the average for order was 21.17 (SD = 5.03).

Participants averaged 41.95 for high standards (SD = 7.29) and 38.00 for discrepancy (SD = 17.47).

Table 2

Descriptive Statistics

Variable	Mean	SD	Skewness (error)	Kurtosis (error)
Perfectionism				
Discrepancy	38.00	17.47	2.56 (.267)	-1.07 (.529)
Order	21.17	5.03	-2.79 (.267)	.715 (.529)
High Standards	41.95	7.29	-8.45 (.267)	12.48 (.529)
Psychological Well-Being				
Autonomy	34.21	7.76	-2.38 (.267)	0.10 (.529)
Environmental Mastery	36.54	6.78	-2.15 (.267)	0.15 (.529)
Positive Relations with Others	42.05	5.74	-4.20 (.267)	2.01 (.529)
Self-Acceptance	36.14	6.01	-3.45 (.267)	0.48 (.529)
Total PWB	46.96	19.82	-2.56 (.267)	-0.08 (.529)

Inferential Data

To test the first research question, Pearson correlation tests were run to determine relationships

between perfectionism (i.e., discrepancy, high standards, order) and PWB (i.e., autonomy, environmental

mastery, positive relations with others, self-acceptance, and overall PWB). A summary of all correlations

can be found in Table 3. Discrepancy had negative, significant correlations to autonomy ($r(81)$ = -.483, p

< .01), environmental mastery ($r(81)$ = -.671, p < .01), positive relations with others ($r(81)$ = -.322, p <

.01), self-acceptance ($r(81) = -.723$, $p < .01$), and overall score on the SPWB ($r(81) = -.731$, $p < .01$).

Analyses revealed no significant correlations between order and high standards with the SPWB subscales.

Order showed no correlations between autonomy ($r(81) = -.016$, $p = .890$), environmental mastery ($r(81)$

$= .165$, $p = .141$), positive relations with others ($r(81) = .032$, $p = .776$), self-acceptance ($r(81) = .217$, $p =$

$.052$), or overall SPWB ($r(81) = .126$, $p = .264$). Additionally, high standards was not correlated with

autonomy ($r(81) = -.068$, $p = .546$), environmental mastery ($r(81) = -.032$, $p = .780$), positive relations

with others ($r(81) = .038$, $p = .738$), self-acceptance ($r(81) = .067$, $p = .552$), and overall SPWB ($r(81) = -$

$.006$, $p = .957$).

Table 3

Correlations among dimensions of perfectionism and psychological well-being

Variable	D	O	HS	A	EM	PR	SA	TPWB
Perfectionism								
Discrepancy (D)	-	-	-	-	-	-	-	-
Order (O)	-.180	-	-	-	-	-	-	-
High Standards (HS)	-.073	.644*	-	-	-	-	-	-
Psychological Well-Being								
Autonomy (A)	-.483*	-.061	-.068	-	-	-	-	-
Environmental Mastery (EM)	-.671*	.165	-.032	.474*	-	-	-	-
Positive Relations with Others (PR)	-.322*	.032	.038	.145	.463*	-	-	-
Self-Acceptance (SA)	-.723*	.217	.067	.327*	.664*	.489*	-	-
Total PWB (TPWB)	-.731*	.126	-.006	.695*	.864*	.653*	.801*	-

*Indicates correlation is significant at the 0.01 level

To test research question two, hierarchical multiple regression analyses were conducted to predict

to what extent discrepancy predicted PWB across all subscale scores and the total PWB score. Analyses

were run with discrepancy as the only variable because it was the only subscale significantly related to

PWB. Discrepancy accounted for 23.3% of the variance in autonomy ($F(1,80) = 23.991$, $p < 0.001$, $r^2 =$

$.233$), 45% of the variance in environmental mastery ($F(1,80) = 65.542$, $p < 0.001$, $r^2 = .450$), 10.4% of

the variance in positive relations with others ($F(1,80) = 9.151$, $p < 0.003$, $r^2 = .104$), 52.2% of the variance

in self-acceptance ($F(1,80) = 86.381$, $p < 0.001$, $r^2 = .522$), and 53.5% of the variance in overall PWB

($F(1,80) = 90.778$, $p < 0.001$, $r^2 = .535$).

CHAPTER 4

DISCUSSION

The purpose of this study was to examine the relationship between perfectionism and psychological well-being (PWB) in sport and performance psychology (SPP) professionals and specifically to what extent perfectionism predicted PWB. Results demonstrated significant negative relationships between discrepancy and PWB and partial relationships between autonomy and order and PWB. Moreover, discrepancy was shown to significantly predict PWB and each of its sub-dimensions. The data from this study show that perfectionism can have a significant, negative impact on SPP professionals' overall PWB and specific dimensions of well-being.

In partial support for the first hypothesis, discrepancy showed a significant, negative relationship to the four measured PWB subscales (i.e., autonomy, environmental mastery, positive relations with others, and self-acceptance) and overall PWB. Specifically, strong correlations between discrepancy and self-acceptance, environmental mastery, and overall PWB suggest that maladaptive perfectionism has a considerable influence on these domains of one's well-being. Perfectionism is considered multi-dimensional and contains both interpersonal and intrapersonal aspects, including how one perceives the social environment as well as attitudes and behaviors towards oneself (Hewitt & Flett, 1990). Moreover, Stoeber and Madigan (2016) note that maladaptive perfectionists hold irrational concerns about making mistakes, fear receiving negative evaluations, and often react poorly to perceived imperfection. As such, the results of this study may further explain why maladaptive perfectionistic tendencies are detrimental to each domain of one's PWB. While individuals may perceive their perfectionistic tendencies to be only directed towards one specific domain, the results of this study demonstrate that these cognitions likely affect multiple aspects of their lives in negative ways. Flett and Hewitt (2020) capture the complex, challenging nature of perfectionism by noting that individuals may know they are not perfect, yet "…cannot abandon a personality orientation that continuously reminds them of their imperfect selves and the myriad ways they fall short of perfect health and mental health" (p. 11). Thus, if individuals do not

have adaptive mechanisms or skills to respond to failure or setbacks, their PWB may continue to be impacted by maladaptive perfectionistic tendencies.

Additionally, in support of the second hypothesis, results indicated that discrepancy was a significant predictor of overall PWB and the four measured subscales of PWB. Discrepancy had the strongest negative correlation to overall PWB and accounted for more than half of its variance, suggesting that individuals' well-being is impacted by the maladaptive perceptions of perfectionism. According to Sirois and Molnar (2016), the maladaptive aspects of perfectionism, specifically high levels of negative affect, worry, anxiety, and distress, may be indicators of poor well-being. As discrepancy operationalizes the excessive aspects of perfectionism (Slaney et al., 2001), the results may highlight the challenges associated with critical evaluative tendencies related to perfectionism. In other words, if one's perceptions and standards are misaligned with one's actual performance, their well-being is not only likely to be negatively impacted, but they may also experience high levels of anxiety (Frost & DiBartolo, 2002) and depression (Flett & Hewitt, 2006). Moreover, individuals lacking effective coping mechanisms may be more prone to the maladaptive tendencies of perfectionism, such as cognitive perseveration or rumination. As such, the results of this study emphasize the importance of mitigating the concerns brought on by such perfectionistic tendencies.

Furthermore, strong correlations between self-acceptance and discrepancy suggest that maladaptive perfectionistic tendencies negatively influence how one views themselves. According to Ryff (1989), self-acceptance demonstrates a positive attitude towards oneself and is central to positive psychological functioning. The psychological implications associated with perfectionism often lie in critical evaluation tendencies of oneself (Frost et al., 1990). With discrepancy measuring the excessive aspects of perfectionism (Slaney et al., 2001), perfectionistic SPP professionals may be overly critical of themselves, which then impacts their self-acceptance. These data further support the literature, which links perfectionism to a lower sense of self-value, specifically lower self-esteem, and higher self-criticism (Hill et al., 2018). In addition, evaluative concerns related to perfectionism are also intertwined with a wide variety of anxiety symptomatology, including social anxiety, general state and trait anxiety, and

obsessive-compulsive disorder (OCD; Burgess & DiBartolo, 2016). Additionally, perfectionism has also been linked to burnout within sport contexts, including both athletes (Chen et al., 2008; Madigan et al., 2015) and coaches (Tashman et al., 2010; Vealey et al., 2020). Therefore, supporting SPP professionals in managing overly critical self-evaluations may help them achieve greater psychological functioning through self-acceptance.

Results from this study also demonstrated significant, yet moderate relationships between discrepancy and autonomy. The maladaptive aspects of perfectionism tend to result from one's difficulty adjusting and recovering after failure. Perfectionistic individuals demand of themselves a higher level of performance than is possible to meet (Hamachek, 1978). Ryff (1989) noted that the fully functioning person is autonomous, having an "internal locus of evaluation, whereby one does not look to others for approval, but evaluates oneself by personal standards" (p. 1071). Regarding PWB, this internal focus gives individuals a sense of freedom in governing their own lives. The results of the current study potentially reflect the difficulty of both achieving excessively high standards and internal and external pressures to be perfect. Hewitt and Flett's (1990) conceptualization of perfectionism, which includes self-oriented and socially-prescribed perfectionism, helps further describe this relationship. Self-oriented perfectionism involves self-directed behaviors, such as exacting standards for oneself stringently evaluating one's behavior. Socially-prescribed perfectionism involves the perceived need to attain standards and expectations and efforts are directed towards avoiding disapproval by others (Hewitt & Flett, 1990; Stoeber & Otto, 2006). This further demonstrates that perfectionistic tendencies, whether perceived internally or from others, negatively impact individuals' ability to be independent and self-determining. Thus, helping perfectionistic SPP professionals become aware of these expectations and establish more cognitive flexibility may be an effective strategy to overcome these maladaptive elements.

Furthermore, environmental mastery reflects an individuals' active participation in environments congruent with their skillset (Ryff, 1989). The results of this study revealed strong, significant, negative correlations between discrepancy and environmental mastery, which may underscore the importance of one's environment to overall PWB. These results support the research linking maladaptive perfectionism

to higher levels of stress, personal burnout, work-related burnout, and student-related burnout (Moate et al., 2016). Perfectionistic tendencies, such as setting high standards for oneself, holding high expectations for others, and perceptions of others' evaluations of oneself, has been associated with an urge to work excessively and compulsively (Falco et al., 2014). In other words, SPP professionals may struggle to cope with maladaptive perfectionistic tendencies in their work environment due to expectations for oneself or attempting to meet others' expectations, which can result in a more excessive investment in work. Additionally, SPP professionals also must balance numerous organizational demands and stressors, including teaching, research, consultancy, workload, and hours (Fletcher et al., 2011). Thus, SPP professionals must not only attempt to meet expectations at work, but also work within stressful environments. The findings from this study suggest that SPP have perfectionistic cognitions in the work environment, which further emphasizes the importance of understanding how these tendencies impact one's professional performance.

Positive relations with others refer to the importance of warm, supportive relationships to one's overall well-being (Ryff, 1989). The interpersonal aspects of perfectionism, however, may present difficulties to the social components of well-being, as it is associated with both social problems and psychopathology (Sherry et al., 2016). The findings from this study further confirm that maladaptive perfectionistic tendencies can impact one's relationships and interactions with others. Hewitt and colleagues (2001) note that perfectionism is associated with tendencies to be in control and feel overly responsible in relationships, which may drive individuals to be more socially anxious or withdraw completely. Additionally, individuals with more maladaptive coping strategies may also be more likely to socially isolate (Dunkley et al., 2001). Thus, the results from the current study may further explain the moderate relationship between positive relations with others and maladaptive perfectionism, and as such, may highlight the importance of social support in SPP professionals' lives. Furthermore, the data provide strong evidence for the implications of maladaptive perfectionism in SPP professionals, specifically as it relates to how individuals view themselves, engage in work responsibilities, and interact with others.

Thus, maladaptive perfectionistic tendencies may negatively influence individuals' ability to engage in meaningful, supportive relationships, placing additional strain on their overall PWB.

Results were inconsistent for hypothesis 1b, which predicted a significant, positive relationship between the high standards and order subscales of the APS-R and the PWB subscales. Findings demonstrated no significant, positive relationships between order and high standards and the PWB subscales and overall PWB. Given that perfectionism is a multidimensional concept, there is some debate on whether perfectionism is solely maladaptive or unhealthy. Stoeber and Otto (2006) differentiated the adaptive and maladaptive facets of perfectionism as perfectionistic strivings and perfectionistic concerns. The adaptive characteristics, referred to as perfectionistic strivings, align with qualities such as diligence, industry, and perseverance (Flett & Hewitt, 2016). However, perfectionistic strivings can also be related to higher levels of obsessive-compulsiveness and rigidity as well as neuroticism and depression (Stoeber & Otto, 2006). Thus, while perfectionism can potentially result in healthy behaviors, and greater overall well-being, it may be largely dependent on the individual. This may explain a lack of strong correlations between the adaptive dimensions of perfectionism, high standards and order, to each of the domains of PWB in SPP professionals. It is also possible that perfectionism is mostly detrimental to SPP professionals' PWB, so the adaptive components are not as influential in achieving greater well-being. As such, Flett and associates (2016) recommend a person-centered approach to grasp how personality and situational factors impact perfectionists individually. Personalizing management strategies may prove to be the most beneficial strategy in supporting SPP professionals PWB, especially given the multidimensional nature of both concepts.

Limitations and Future Directions

While this study is the first to examine the relationship between perfectionism and psychological well-being (PWB) in SPP professionals, it is not without limitations. The sample was largely homogenous; thus, a more diverse sample could provide a greater perspective of perfectionism, particularly as it relates to ethnicity, gender identity, and racial identity DiBartolo and Rendón (2012) found that collectivism and parental characteristics may account for observed differences in perfectionism

across ethnicities. As such, researchers recommend embracing intersectionality to better understand the complexity of perfectionism across individuals and cultures (DiBartolo & Rendón, 2012). Furthermore, Flett and Hewitt (2020) identified perfectionism as a global issue that impacts individuals not only in the United States and Canada, but also England, China, Israel, Italy, and Portugal. The study sample was comprised of mostly White-identified participants (84%), which limits the ability to identify potential differences in perfectionistic cognitions as suggested, as well as the external validity of the study's finding. Lastly, while the inclusion criteria allowed researchers to obtain participants with proper training in sport and performance psychology (i.e., CMPC®, licensure, supervision), this may have excluded people outside of the United States or Canada. Adjusting inclusion criteria to incorporate those with training outside of the U.S. could offer a more robust description of perfectionism in SPP professionals. This adjustment may also offer a solution to capturing a more diverse, global perspective of perfectionism in this specific population. Lastly, while the inclusion criteria aimed to capture individuals who were Certified Mental Performance Consultants (CMPC®), licensed counselor or psychologists, or were under supervision/mentorship, the demographic questionnaire did not capture those who were currently in training towards certification or licensure. Furthermore, participants self-reported their area of work/specialty, making it difficult to accurately differentiate how individuals defined their experience (i.e., applied v. clinical/counseling experience).

To expand on these findings, future studies could recruit a more inclusive sample of SPP professionals, including professionals from countries outside the U.S., diverse ethnic and racial backgrounds, and varying years of experience. Factors related to multicultural considerations and experiences, including individuals from collectivist cultures, should also be considered and examined. Furthermore, taking a qualitative approach to analyzing perfectionism in SPP professionals may allow for participants to describe and elaborate on their perspectives of how perfectionism influences their well-being and account for the complexity of perfectionism. Given the subjective nature of well-being and individual differences of perfectionism, this approach may help paint a more complete picture of individuals' experiences with perfectionism. By building on the literature available to perfectionism and

well-being in SPP professionals, specific interventions aimed at mitigating the maladaptive tendencies associated with perfectionism and supporting well-being can be developed.

Conclusion

Perfectionism, specifically in its maladaptive form, can be detrimental to SPP professionals' psychological well-being. Results from this study suggest that maladaptive perfectionism is a significant negative predictor of overall PWB and four dimensions of PWB (i.e., autonomy, environmental mastery, positive relations with others, and self-acceptance). Maladaptive perfectionism negatively influences how individuals see themselves, interact with others, and approach responsibilities in their surrounding environment. Furthermore, the more maladaptive perfectionistic tendencies tend to be, the more difficult it is to overcome shortcomings and challenges, further inhibiting optimal psychological functioning. In lieu of research on perfectionism in athletes, SPP professionals may also attempt to develop more cognitive flexibility and adjust their expectations to meet demands and current levels of personal functioning (Hewitt & Flett, 2005). Helping individuals learn to live with failures and mistakes in healthy, productive ways may promote greater well-being. Overall, perfectionism has the potential to negatively impact one's psychological well-being in a multitude of domains, making it pertinent to consider the ways in which SPP professionals are impacted by these tendencies and how to develop effective coping strategies to handle such challenges.

REFERENCES

Adams, T., Bezner, J., Garner, L., & Woodruff, S. (1998). Construct validation of the perceived wellness

   survey. *American Journal of Health Studies, 14*(4), 212-226.

Adler, A. (1956). *Individual psychology of Alfred Adler*. New York: Basic Books, Inc.

Alado, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across

   psychopathology: A meta-analytic review. *Clinical Psychology Review, 30*. 217-237.

Alvarez, W. C. (1947). The migrainous personality and constitution: The essential features of the disease:

   A study of 500 cases. *The American Journal of the Medical Sciences, 213*. 1-8.

Andersen, M. B., Van Raalte, J. L., & Brewer, B. W. (2000). When sport psychology consultants and

   graduate students are impaired: Ethical and legal issues in training and supervision. *Journal of

   Applied Sport Psychology, 12*(2), 134-150. http://doi.org/10.1080/10413200008404219

Andersen, M. B., Van Raalte, J. L., & Brewer, B. W. (2001). Sport psychology service delivery: Staying

   ethical while keeping loose. *Professional Psychology: Research and Practice, 32*(1), 12–18.

   https://doi.org/10.1037/0735-7028.32.1.12

Anderson, M. R, (1977). A study of the relationship between life satisfaction and self-concept, locus of

   control, satisfaction with primary relationships, and work satisfaction (Doctoral dissertation,

   Michigan State University, 1977). *Dissertation Abstracts International, 38*, 2638 9A. (University

   Microfilms No. 77-25, 214).

Andrews, F. M., & McKennell, A. C. (1980). Measures of self-reported well-being. *Social Indicators

   Research, 8*, 127-156

Andrews, F. M., & Withey, S. B. (1976). *Social indicators of well-being: America's perception of life

   quality*. New York: Plenum Press.

Arnold, R., & Sarkar, M. (2014). Preparing athletes and teams for the Olympic Games: Experiences and

   lessons learned from the world's best sport psychologists. *International Journal of Sport and

   Exercise Psychology, 13*(1), 4–20. http://doi.org10.1080/1612197x.2014.9328

Bardone-Cone, A. M., Wonderlich, S. A., Frost, R. O., Bulik, C. M., Mitchell, J. E., Uppala, S., et al (2007). Perfectionism and eating disorders. Current status and future directions. *Clinical Psychology Review, 27*, 384–405. http://doi.org/10.1016/j.cpr.2006.12.005

Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55*. 1247-1263. Doi: 10.1037/0003-066X.55.11.1247

Bech, P. (2012). *Clinical Psychometrics*. Wiley Blackwell, Oxford. http://dx.doi.org/10.1002/9781118511800

Bernier, D. (1998). A study of coping: Successful recovery from severe burnout and other reactions to severe work-related stress. *Work & Stress, 12*(1), 50-65. doi:10.1080/02678379808256848

Bortner, R. W., & Hultsch, D. F. (1970). A multivariate analysis of correlates of life satisfaction in adulthood. *Journal of Gerontology, 25*, 41-47.

Brailovskaia, J., Lin, M., Scholten, S., Zhu, M., Fu, Y., Shao, M., Hu, S., Li, X., Guo, W., Cai, D., Lu, S., & Margraf, J. (2022). A qualitative cross-cultural comparison of well-being constructs: The meaning of happiness, life satisfaction, and social support for German and Chinese students. *Journal of Happiness Studies, 23*(4), 1379–1402. https://doi.org/10.1007/s10902-021-00454-6

Braun, P. M. W. (1977). Psychological well-being and location in the social structure (Doctoral dissertation, University of Southern California, 1976). *Dissertation Abstracts International*, *38, 2351 A*.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong. *Psychological Bulletin, 117,* 497-529. http://doi.org/10.1037/0033-2909.117.3.497

Besser, A., Flett, G., & Hewitt, P. L. (2004). Perfectionism, cognition, and affect in response to performance failure vs. success. *Journal of Rational-Emotive & Cognitive Behaviour Therapy, 22*(4), 297–324.

Blankstein, K. R., & Flett, G. L. (1993). Development of the General Hassles Scale for Students. Unpublished manuscript.

Blankstein, K. R., Flett, G. L., Hewitt, P. L., & Eng, A. (1993). Dimensions of perfectionism and irrational fears: An examination with the Fear Survey Schedule. *Personality and Individual Differences, 15*, 323-328.

Blatt, S. J. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. *American Psychologist, 50,* 1003-1020. doi:10.1037/0003-066X.50.12.1003

Blatt, S. J., D'Afflitti, J. P., & Quinlan, D. M. (1976). Experiences of depression in normal young adults. *Journal of Abnormal Psychology, 85*, 383-389.

Bradburn, N. M. (1969). *The structure of psychological well-being*. Chicago: Aldine.

Brailovskaia, J., Lin, M., Scholten, S., Zhu, M., Fu, Y., Shao, M., Hu, S., Li, X., Guo, W., Cai, D., Lu, S., & Margraf, J. (2022). A qualitative cross-cultural comparison of well-being constructs: The meaning of happiness, life satisfaction, and social support for German and Chinese students. *Journal of Happiness Studies, 23*(4), 1379–1402. https://doi.org/10.1007/s10902-021-00454-6

Brosschot, J. F., Gerin, W., & Thayer, J. F. (2006). The perseverative cognition hypothesis: A review of worry, prolonged stress-related physiological activation, and health. *Journal of Psychosomatic Research, 60.* 113-124.

Buhler, C. (1935). The curve of life as studied in biographies. *Journal of Applied Psychology, 19*, 405-409.

Burgess, A. M. & DiBartolo, P. M. (2016). Anxiety and perfectionism: Relationships, mechanisms, and conditions. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.* (pp. 177-204). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Burns, D. D. (1980). Feeling good: The new mood therapy. New York: New American Library.

Campbell, A. (1976). Subjective measures of well-being. *American Psychologist, 31*, 117-124.

Campbell, A. (1981). *The sense of well-being in America: Recent patterns and trends*. New York: McGraw-Hill.

Campbell, A., Converse, P. E., & Rodgers, W. L. (1976). *The quality of American life*. New York: Russell Sage Foundation.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization. *Smith College Studies in Social Work, 75*(2), 81–101. http://doi.org/10.1300/j497v75n02_06

Cantril, H. (1965). *The pattern of human concerns*. New Brunswick, NJ: Rutgers University Press.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*, 267-283.

Chen, L. H., Kee, Y. H., Chen, M. Y., & Tsai, Y. M. (2008). Relation of perfectionism with athletes' burnout: further examination. *Perceptual and motor skills*, *106*(3), 811–820. https://doi.org/10.2466/pms.106.3.811-820

Cherniss, C. (1980). *Staff burnout: Job stress in the human services*. London: Sage Publications.

Childs, J. H., & Stoeber, J. (2012). Do you want me to be perfect? Two longitudinal studies on socially prescribed perfectionism, stress and burnout in the workplace. *Work & Stress, 26*(4), 347–364. http://doi.org/10.1080/02678373.2012.7375

Christopher, J. C. (1999). Situating psychological well-being: Exploring the cultural roots of its theory and research. *Journal of Counseling & Development, 77*(2), 141–152. https://doi.org/10.1002/j.1556-6676.1999.tb02434.x

Clark, M. A., Michel, J. S., Zhdanova, L., Pui, S. Y., & Baltes, B. B. (2016). All work and no play? A meta-analytic examination of the correlates and outcomes of workaholism. *Journal of Management, 42*(7), 1836-1873. https://doi.org/10.1177/0149206314522301

Clemente, E, & Sauer, W. J. (1976). Life satisfaction in the United States. *Social Forces, 54*, 621-631.

Cockell, S. J., Hewitt, P. L., Seal, B., Sherry, S. B., Goldner, E. M., Flett, G. L., et al. (2002). Trait and self-presentational dimensions of perfectionism among women with anorexia nervosa. *Cognitive Therapy and Research, 26*, 745-758.

Coan, R. W. (1977). *Hero, artist, sage, or saint?* New York: Columbia University.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*, 385–396. http://doi.org/10.2307/2136404

Cohn, R. M. (1979). Age and the satisfactions from work. *Journal of Gerontology, 34*, 264-272.

Cox, B. J., Enns, M. W., & Clara, I. P. (2002). The multidimensional structure of perfectionism in clinically distressed and college student samples. *Psychological Assessment, 14*(3), 365-373. https://doi.org/10.1037//10403590.14.3.365

Cutrona, C. E., & Russell, D. (1987). The provisions of social relationships and adaptation to stress. In W. H. Jones & D. Perlman (Eds.), *Advances in personal relationships* (Vol. 1, pp. 37-68). Greenwich, CT: JAI Press.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: an introductory report. *Psychological Medicine, 13*, 595-605.

DiBartolo, P. M., & Rendón, M. J. (2012). A critical examination of the construct of perfectionism and its relationship to mental health in Asian and African Americans using a cross-cultural framework. *Clinical Psychology Review*, *32*(3), 139–152. https://doi.org/10.1016/j.cpr.2011.09.007

Diener, E. (1984). Subjective well-being. *Psychological Bulletin, 95*(3), 542–575.

Diener, E. (2009). Subjective well-being. In E. Diener (Ed.), *Social Indicators of Research Series. The science of well-being* (vol. 37, pp. 11-58). New York: Springer Science+Business Media B.V.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment, 49*(1), 71–75. https://doi.org/10.1207/s15327752jpa4901_13

Diener, E., & Lucas, R. (1999). Personality and subjective well-being. In D. Kahneman, E. Diener, & N. Schwarz (Eds.), *Well-being: The foundations of hedonic psychology*. New York: Russell-Sage.

Diener, E., Lucas, R.E., & Oishi, S. (2005). Subjective well-being. In C.R. Snyder & S.J. Lopez (Eds.), *Handbook of Positive Psychology* (pp. 63-73). New York: Oxford University Press, Inc.

Diener, E., Oishi, S., & Lucas, R. E. (2009). Subjective well-being: The science of happiness and life satisfaction. In S. J. Lopez & C. R. Snyder (Eds.), *The Oxford Handbook of Positive Psychology* (pp. 186–194). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195187243.013.0017

Disabato, D. J., Goodman, F. R., Kashdan, T. B., Short, J. L., & Jarden, A. (2016). Different types of well-being? A cross-cultural examination of hedonic and eudaimonic well-being. *Psychological Assessment, 28*(5), 471–482. https://doi.org/10.1037/pas0000209

Drumgoole, W. P. (1981). Self-concept and life satisfaction as perceived by young, middle-aged, and senior adults (Doctoral dissertation, East Texas State University, 1980). *Dissertation Abstracts International, 41*, 2939A. (University Microfilms No. 80-27,666)

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change, 28*(1), 17–28. https://doi.org/10.1375/bech.28.1.17

Duncan, C. H., Stevenson, I. P., & Ripley, H. S. (1950). Life situations, emotions, and paroxysmal auricular arrhythmias. *Psychosomatic Medicine, 12,* 23-37.

Dunkley, J., and Whelan, T. A. (2006). Vicarious traumatisation: current status and future directions. *British Journal of Guidance Counseling, 34*, 107–116. https://doi.org/10.1080/03069880500483166

Dunkley, D. M., Blankstein, K. R., Halsall, K., Williams, M., Winkworth, G. (2000). The relationship between perfectionism and distress: Hassles, coping, and perceived social support as mediators and moderators. *Journal of Counseling Psychology, 47*. 437-453.

Dunkley; D. M., Zuroff, D. C., & Blankstein, K. R. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal of Personality and Social Psychology, 84*, 234-252. https://doi.org/10.1037/0022-3514.84.1.234

Dunkley, D. M., Solomon-Krakus, S., & Moroz, M. (2016). Personal standards and self-critical perfectionism and distress: Stress, coping, and perceived social support as mediators and moderators. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.* (pp. 157-176). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Edelwich, J., & Brodsky, A. (1980). *Burn-out: Stages of disillusionment in the helping professions*. New York: Human Sciences Press.

Edwards, D., Hannigan, B., Fothergill, A., & Burnard, P. (2002). Stress management for mental health professionals: A review of effective techniques. *Stress and Health, 18*(5), 203–215. https://doi.org/10.1002/smi.947

Egan, S. J., Wade, T. D., Shafran, R., & Antony, M. M. (2014). *Cognitive-behavioral treatment of perfectionism*. Guilford Publications.

Erikson, E. (1959). Identity and the life cycle. *Psychological Issues, 1*, 18-164.

Falco, A. (2014). "The best or nothing": The mediating role of workaholism in the relationship between perfectionism and burnout. *TPM - Testing, Psychometrics, Methodology in Applied Psychology, 2*, 213–232. https://doi.org/10.4473/TPM21.2.7

Farber, B. A., & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology, 13*(2), 293–301. https://doi.org/10.1037/0735-7028.13.2.293

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*, 1433–1441. doi: 10.1002/jclp.10090

Fletcher, D., & Hanton, S. (2003). Sources of organizational stress in elite sports performers. *The Sport Psychologist, 17*(2), 175–195. Retrieved from http://journals.humankinetics.com/tsp-pdf-articles?DocumentScreen=Detail&ccs=6424&cl=13538

Fletcher, D., Rumbold, J. L., Tester, R., & Coombes, M. S. (2011). Sport psychologists' experiences of organizational stressors. *The Sport Psychologist, 25*(3), 363–381. https://doi.org/10.1123/tsp.25.3.363

Flett, G. L., Hewitt, P. L., Shapiro, B., & Rayman, J. (2001). Perfectionism, beliefs, and adjustment in dating relationships. *Current Psychology*, *20*(4), 289–311. https://doi.org/10.1007/s12144-001-1013-4

Flett, G. L., & Hewitt, P. L. (2005). The perils of perfectionism in sports and exercise. *Current Directions in Psychological Science, 14*(1), 14–18. https://doi.org/10.1111/j.0963-7214.2005.00326.x

Flett, G. L., & Hewitt, P. L. (2006). Positive versus negative aspects of perfectionism in psychopathology: A comment on Slade and Owen's dual process model. *Behavior Modification, 30*, 11–24. https://doi.org/10.1177/0145445506288026

Flett, G. L., & Hewitt, P. L. (2014). The "perils of perfectionism in sports" revisited: Toward a broader understanding of the pressure to be perfect and its impact on athletes and dancers. *International Journal of Sport Psychology, 45*(4), 395-407.

Flett, G. L., & Hewitt, P. L. (2016). Reflections on perfectionism and the pressure to be perfect in athletes, dancers, and exercisers: A focus on perfectionistic reactivity in key situations and life contexts. In A.P. Hill (Ed.), *The psychology of perfectionism in sport, dance and exercise.* (pp. 296-320). London, UK: Routledge.

Flett, G. L., & Hewitt, P. L. (2020). Reflections on Three Decades of Research on Multidimensional Perfectionism: An Introduction to the Special Issue on Further Advances in the Assessment of Perfectionism. *Journal of Psychoeducational Assessment, 38*(1), 3–14. https://doi.org/10.1177/0734282919881928

Flett, G. L., Hewitt, E L., & Dyck, D. (1989). Self-oriented perfectionism, neuroticism, and anxiety. *Personality and Individual Differences, 10*, 731-735.

Flett, G., Hewitt, P., & Molnar, D. (2016). Perfectionism in health and illness from a person-focused historical perspective. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.* (pp. 25-44). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Flett, G., Nepon, T., & Hewitt, P. (2016). Perfectionism, worry, and rumination in health and mental health: A review and a conceptual framework for a cognitive theory of perfectionism. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.* (pp. 121-156). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Friedman, M., & Rosenman, R. H. (1974). *Type A behavior and your heart*. New York: Wildwood House.

Frost, R. O., & DiBartolo, P. (2002). Perfectionism, anxiety and obsessive compulsive disorder. In G. Flett & P. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment*. Washington, DC: American Psychological Association Press.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research*, *14*(5), 449–468. https://doi.org/10.1007/BF01172967

Frost, R. O., Heimberg, R. G., Holt, C. S., Mattia, J. I., & Neubauer, A. L. (1993). A comparison of two measures of perfectionism. *Personality and Individual Differences, 14*(1), 119–126. https://doi.org/10.1016/0191-8869(93)90181-2

Garner, D. M., Olmstead, M. P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2*, 15-34.

Gilroy, P. J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33*(4), 402–407. https://doi.org/10.1037/0735-7028.33.4.402

Glenn, N. D. (1975). The contribution of marriage to the psychological well-being of males and females. *Journal of Marriage and the Family, 37*, 594-600.

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health, 6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Gotwals, J. K., Stoeber, J., Dunn, J. G. H., & Stoll, O. (2012). Are perfectionistic strivings in sport adaptive? A systematic review of confirmatory, contradictory, and mixed evidence. *Canadian Psychology, 53*(4), 263-279. https://doi.org/10.1037/a0030288

Graham, A. R., Sherry, S. B., Stewart, S. H., Sherry, D. L., McGrath, D., Fossum, K., & Allen, S. L., (2010). The existential model of perfectionism and depressive symptoms: A short-term, four-wave longitudinal study. *Journal of Counseling Psychology, 57,* 423-438. https://doi.org/10.1037/a0020667

Greenglass, E. R., Burke, R. J., & Fiksenbaum, L. (2001). Workload and burnout in nurses. *Journal of Community & Applied Social Psychology, 1*(3), 211–215. https://doi.org/10.1002/casp.614

Grzegoreketal, J. L., Slaney, R. B., Franze, S., & Rice, K. G. (2004). Self-Criticism, Dependency, Self-Esteem, and Grade Point Average Satisfaction Among Clusters of Perfectionists and Nonperfectionists. *Journal of Counseling Psychology, 51*(2), 192–200. https://doi.org/10.1037/0022-0167.51.2.192

Habke, A. M. & Flynn, C. A. (2002). Interpersonal aspects of trait perfectionism. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 151-180). Washington, DC: American Psychological Association. https://doi.org/10.1037/10458-006

Hakanen, J. J., & Schaufeli, W. B. (2012). Do burnout and work engagement predict depressive symptoms and life satisfaction? A three-wave seven-year prospective study. *Journal of Affective Disorders, 141*(2-3), 415-424. http://dx.doi.org/10.1016/j.jad.2012.02.043

Hall, H. K. (2019). Perfectionism in competitive sport. In T. S. Horn & A. L. Smith (Eds.), *Advances in sport and exercise psychology*. (pp. 95-114). Champaign, IL: Human Kinetics.

Hamachek, D. E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology: A Journal of Human Behavior, 15*(1), 27–33.

Harper, H., & Minghella, E. (1997). Pressures and rewards of working in community mental health teams. *Mental Health Care, 1*, 18–21.

Harwood, C., & Knight, C. (2009). Understanding parental stressors: An investigation of British tennis players. *Journal of Sports Sciences, 27*(4), 339–351.

Martin, M., Harris, M., & Martin, D. (2013). The relationship between psychological well-being and perceived wellness in graduate-level counseling students. *Higher Learning Research Communications, 3*(2). https://doi.org/10.18870/hlrc.v3i2.91

Headey, B., & Wearing, A. (1989). Personality, life events, and subjective well-being: Toward a dynamic equilibrium model. *Journal of Personality and Social Psychology, 57*, 731-739.

Hewitt, P. L., & Flett, G. L. (1990). Perfectionism and depression: A multidimensional analysis. *Journal of Social Behavior and Personality, 5*, 423-438.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology*, *60*(3), 456–470. https://doi.org/10.1037/0022-3514.60.3.456

Hewitt, P. L., & Flett, G. L. (1993). Dimensions of perfectionism, daily stress, and depression: A test of the specific vulnerability hypothesis. *Journal of Abnormal Psychology, 102*, 58-65.

Hewitt, P. L., Flett, G. L. & Mikail, S. F. (2016). *Perfectionism: A relational approach to 8 conceptualisation, assessment, and treatment*. Guilford Publications.

Hewitt, P. L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., McMurtry, B., Ediger, E., Fairlie, P., & Stein, M. B. (2003). The interpersonal expression of perfection: Perfectionistic self-presentation and psychological distress. *Journal of Personality and Social Psychology, 84*(6), 1303–1325. https://doi.org/10.1037/0022-3514.84.6.1303

Hewitt, P. L., Flett, G. L., Sherry, S. B., & Caelian, C. (2006). Trait perfectionism dimensions and suicidal behavior. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 215–235). American Psychological Association. https://doi.org/10.1037/11377-010

Hewitt, P. L., Mittelstaedt, W., & Flett, G. L. (1990). Self-oriented perfectionism and generalized performance importance in depression. *Individual Psychology, 46*, 67-73.

Hill, A. P., & Curran, T. (2016). Multidimensional Perfectionism and Burnout: A Meta-Analysis. *Personality and Social Psychology Review, 20*(3), 269–288. https://doi.org/10.1177/1088868315596286

Hill, A. P., & Davis, P. A. (2014). Perfectionism and emotion regulation in coaches: A test of the 2×2 model of dispositional perfectionism. *Motivation and Emotion, 38*(5), 715–726. https://doi.org/10.1007/s11031-014-9404-7

Hill, A. P., Mallinson-Howard, S. H., & Jowett, G. E. (2018). Multidimensional perfectionism in sport: A meta-analytical review. *Sport, Exercise, and Performance Psychology, 7*(3), 235–270. https://doi.org/10.1037/spy0000125

Hill, R.W., Huelsman, T.J., Furr, R.M., Kibler, J., Vicente, B.B., & Kennedy, C. (2004). A new measure of perfectionism: The perfectionism inventory. *Journal of Personality Assessment, 82*, 80-91.

https://doi.org/10.1037/0022-3514.84.6.1303Hoge, D. R., & McCarthy, J. D. (1983). Issues of validity and reliability in the use of real-ideal discrepancy scores to measure self-regard. *Journal of Personality and Social Psychology, 44*, 1048-1055.

Hollander, M. H. (1965). Perfectionism. *Comprehensive Psychiatry, 6*, 94-103.

Johnson, W., & Krueger, R. F. (2005). Higher perceived life control decreases genetic variance in physical health: Evidence from a national twin study. *Journal of Personality & Social Psychology, 88*, 165-173. https://doi.org/10.1037/0022-3514.88.1.165

Jones, R. G. (1968). A factored measure of Ellis' irrational belief systems with personality and maladjustment correlated. Wichita, KS: Test Systems.

Joseph, S., Linley, P. A., Harwood, J., Lewis, C. A., & McCollam, P. (2004). Rapid assessment of well-being: The Short Depression-Happiness Scale (SDHS). *Psychology and psychotherapy, 77*(Pt 4), 463–478. https://doi.org/10.1348/1476083042555406

Kahneman, D., Diener, E., & Schwarz, N. (1999). Well-being: The foundations of hedonic psychology. New York: Russell Sage Found.

Kammann, R., & Flett, R. (1983). Affectometer 2: A scale to measure current level of general happiness. *Australian Journal of Psychology, 35*(2), 259–265. https://doi.org/10.1080/00049538308255070

Kashdan, T. B., Biswas-Diener, R., & King, L. A. (2008). Reconsidering happiness: The costs of distinguishing between hedonics and Eudaimonia. *The Journal of Positive Psychology, 3*, 219 – 233. http://dx.doi.org/10.1080/17439760802303044

Kempke, S., Van Houdenhove, B., Claes, S., & Luyten, P. (2016). The role of perfectionism in chronic
fatigue syndrome. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.*
(pp. 101-120). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Keyes, C. L. M. (1998). Social well-being. *Social Psychology Quarterly, 61*(2), 121.
https://doi.org/10.2307/2787065

Kinman, G. and Grant, L. (2020). Emotional demands, compassion and mental health in social workers.
Occupational Medicine, 70(2), 89–94.

Kinman, G., & Grant, L. (2022). Being 'good enough': Perfectionism and well-being in social workers.
The British Journal of Social Work, 00, 1-18. https://doi.org/10.1093/bjsw/bcac010

Klass, E. T. (1987). Situational approach to assessment of guilt: development and validation of a self-
report measure. *Journal of Psychopathology and Behavioral Assessment, 9*, 35-48.

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout
Inventory: A new tool for the assessment of burnout. *Work & Stress, 19*, 192–207.
https://doi.org/10.1080/02678370500297720

Lawton, M. P. (1975). The Philadelphia Geriatric Center Morale Scale: A revision. *Journal of
Gerontology, 30*, 85-89.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Levenson, H. (1974).Activism and powerful others: Distinctions within the concept of internal-external
control. *Journal of Personality Assessment, 38*, 377-383.

Lonsdale, C., Hodge, K., & Rose, E.A. (2008). The Behavioral Regulation in Sport Questionnaire
(BRSQ): Instrument development and initial validity evidence. *Journal of Sport & Exercise
Psychology, 30*, 323355. PubMed ID: 18648109 https://doi.org/10.1123/jsep.30.3.323

Lundqvist, C. (2011). Well-being in competitive sports—The feel-good factor? A review of conceptual
considerations of well-being. *International Review of Sport and Exercise Psychology, 4(*2), 109–
127. https://doi.org/10.1080/1750984X.2011.584067

Lyubomirsky, S., Layous, L., Chancellor, J., & Nelson, K. S. (2015). The scholarly contributions and

    intellectual legacy of Susan Nolen-Hoeksema. *Annual Review of Clinical Psychology, 11*. 4.1-

    4.22.

Madigan, D. J., Stoeber, J., & Passfield, L. (2015). *Perfectionism and burnout in junior athletes: A three-*

    month longitudinal study. Journal of Sport and Exercise Psychology, 37(3), 305–

    315. https://doi.org/10.1123/jsep.2014-0266

Mahoney, V. P., Bockus, H. L., Ingram, M., Hundley, J. W., & Yaskin, J. C. (1949). Studies in ulcerative

    colitis. I. A study of the personality in relation to ulcerative colitis. *Gastroenterology, 13*, 547-

    563.

Marcussen, B., & Wolff, H. G. (1949). A formulation of the dynamics of the migraine attack.

    Psychosomatic Medicine, 4, 5-61.

Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.

Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational*

    Behavior, 2, 99-113.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1997). Maslach Burnout Inventory: Third edition. In C. P.

    Zalaquett & R. J. Wood (Eds.), *Evaluating stress: A book of resources* (pp. 191–218). Scarecrow

    Education.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*(1),

    397–422. https://doi.org/10.1146/annurev.psych.52.1

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). New York: Van Nostrand.

Menard, S. (1995). *Applied logistic regression analysis.* Sage University Paper Series on Quantitative

    Applications in the Social Sciences, 07-106. Thousand Oaks, CA: Sage.

McCann, S. (2008). At the Olympics, everything is a performance issue. *International Journal of Sport*

    and Exercise Psychology, 6(3), 267-276. https://doi.org/10.1080/1612197X.2008.9671871

McCormack, H. (2019). Practicing what we preach: an investigation of the work-based well-being of

    applied sport psychologists. [Doctoral dissertation, University of Limerick].

    http://hdl.handle.net/10344/8479

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The

    prevalence and cause(s) of burnout among applied psychologists: A systematic review. *Frontiers*

    in Psychology, 9, 1897. https://doi.org/10.3389/fpsyg.2018.01897

Medley, M. L. (1980). Life satisfaction across four stages of adult life. *International Journal of Aging and*

    Human Development, 11, 193-209.

Moate, R. M., Gnilka, P. B., West, E. M., & Bruns, K. L. (2016). Stress and burnout among counselor

    educators: Differences between adaptive perfectionists, maladaptive Perfectionists, and

    nonperfectionists. *Journal of Counseling & Development, 94*(2), 161–171.

    https://doi.org/10.1002/jcad.12073

Moore, Z.E. (2003). Ethical dilemmas in sport psychology: Discussion and recommendations for practice.

    Professional Psychology, Research and Practice, 34(6), 601–610.

Molnar, D., Sirois, F., & Methot-Jones, T. (2016). Trying to be perfect in an imperfect world: Examining

    the role of perfectionism in the context of chronic illness. In F. M. Sirois & D. S. Molnar (Eds.),

    Perfectionism, health, and well-being. (pp. 69-100). Springer International Publishing.

    https://doi.org/10.1007/978-3-319-18582-8_1

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental

    health services: A review of the problem and its remediation. *Administration and Policy in*

    Mental Health and Mental Health Services Research, 39(5), 341–352.

    https://doi.org/10.1007/s10488-011-0352-1

Mittleman, B., & Wolff, H. G. (1942). Emotions and gastroduodenal function: Experimental studies on

    patients with gastritis, duodenitis, and peptic ulcer. *Psychosomatic Medicine, 4,* 5-61.

Nielsen, A. D., Hewitt, P. L., Han, H., Habke, A. M., Cockell, S. J., Stager, G., & Flett, G. L. (1997,

    June). *Perfectionistic self-presentation and attitudes toward professional help-seeking*. Poster

presented at the annual meeting of the Canadian Psychological Association, Toronto, Ontario, Canada.

Noble, C. L., Ashby, J. S., & Gnilka, P. B. (2014). Multidimensional perfectionism, coping, and depression: Differential prediction of depression symptoms by perfectionism type. *Journal of College Counseling, 17*, 80–94. https://doi.org/10.1002/j.2161-1882.2014.00049.x

Neugarten, B. L. (1973). Personality change in late life: A developmental perspective. In C. Eisdorfer & M. P. Lawton (Eds.), *The psychology of adult development and aging* (pp.311-335). Washington, DC: American Psychological Association.

Neugarten, B. L., Havighurst, R., & Tobin, S. (1961). The measurement of life satisfaction. *Journal of Gerontology, 16*, 134-143.

Pavot, W., & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment, 5*, 164-172.

Pedhazur, E. J. (1997). *Multiple regression in behavioral research* (3rd ed.). Orlando, FL: Harcourt Brace.

Pines, A., & Kafry, D. (1978). Occupational tedium in the social services. *Social Work, 23*(6), 499–507. http://www.jstor.org/stable/23715339

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25*(3), 247–258. https://doi.org/10.1037/0735-7028.25.3.247

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., & Thornicroft, G. (1997). Perceived sources of work stress and satisfaction among hospital and community mental health staff, and their relation to mental health, burnout and job satisfaction. *Journal of Psychosomatic Research, 43*, 51–59.

Quartiroli, A., Etzel, E. F., Knight, S. M., & Zakrajsek, R. A. (2019a). The multifaceted meaning of sport psychology professional quality of life. *Journal of Clinical Sport Psychology, 13*(4), 645–667. https://doi.org/10.1123/jcsp.2017-0048

Quartiroli, A., Etzel, E. F., Knight, S. M., & Zakrajsek, R. A. (2019b). Self-care as key to others' care: The perspectives of globally situated experienced senior-level sport psychology practitioners. *Journal of Applied Sport Psychology, 31*(2), 147–167. https://doi.org/10.1080/10413200.2018.1460420

Rabin, S., Feldman, D., & Kaplan, Z. E. (1999). Stress and intervention strategies in mental health professionals. *British Journal of Medical Psychology, 72*(2), 159–169. https://doi.org/10.1348/000711299159916

Raedeke, T.D., Granzyk, T.L., & Warren, A. (2000). Why coaches experience burnout: A commitment perspective. *Journal of Sport & Exercise Psychology, 22*, 85–105. doi:10.1123/jsep.22.1.85

Ratliff, N. (1988). Stress and burnout in the helping professions. *Social Casework, 69*(3), 147–154. https://doi.org/10.1177/104438948806900303

Ravalier, J. M. (2019). Psycho-social working conditions and stress in UK social workers. *British Journal of Social Work, 4*9(2), 371–90.

Reid, D. W., & Ziegler, M. (1977). A survey of the reinforcements and activities elderly citizens feel are important for their general happiness. *Essence, 2*, 5-24.

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., & Thornicroft, G. (1999). Explanations for stress and satisfaction in mental health professionals: A qualitative study. Social Psychiatry and Psychiatric Epidemiology, 34, 301–308.

Rice, K.G., Ashby, J.S., & Slaney, R.B. (1998). Self-esteem as a mediator between perfectionism and depression: A structural equation analysis. *Journal of Counseling Psychology, 45*. 304-314.

Rice, K. G., Richardson, C. M. E., & Tueller, S. (2014). The Short Form of the Revised Almost Perfect Scale. *Journal of Personality Assessment, 96*(3), 368–379. https://doi.org/10.1080/00223891.2013.838172

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Rudolph, S. G., Flett, G. L., & Hewitt, P. L. (2007). Perfectionism and deficits in cognitive emotion regulation. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 25*(4), 343-357.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on gedonic and eudaimonic well-being. *Annual Review of Psychology, 52*(1), 141–166. https://doi.org/10.1146/annurev.psych.52.1.141

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081. https://doi.org/10.1037/0022-3514.57.6.1069

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*(4), 719–727. https://doi.org/10.1037/0022-3514.69.4.719

Ryff, C. D., & Singer, B. H. (2006). Best news yet on the six-factor model of well-being. *Social Science Research, 35*(4), 1103–1119. https://doi.org/10.1016/j.ssresearch.2006.01.002

Ryff, C. D., Lee, Y. H., Essex, M. J., & Schmutte, P. S. (1994). My children and me: Midlife evaluations of grown children and self. *Psychology and Aging, 9*, 195-20.

Schaufeli, W. B., & Baker, A. B. (2003). Utrecht work engagement scale: Preliminary manual. Occupational Health Psychology Unit, Utrecht University, Utrecht, 26.

Schaufeli, W. B., Leiter, M. P., Maslach, C., & Jackson, S. E. (1996). Maslach Burnout Inventory-General Survey (MBI-GS). In C. Maslach, S. E. Jackson, & M. P. Leiter (Eds.), MBI Manual (3rd ed., pp. 1926). Palo Alto, CA: Consulting Psychologists Press.

Schaufeli, W. B., Taris, T. W., & Bakker, A. B. (2008). It takes two to tango: Workaholism is working excessively and working compulsively. In R. J. Burke & C. L. Cooper (Eds.), The long work hours culture: Causes, consequences and choices (pp. 203-225). Bingley, UK: Emerald.

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the Life Orientation Test. *Journal of Personality and Social Psychology, 67*(6), 1063.

Sherry, S.B., Mackinnon, S. P., & Gautreau, C. M. (2016). Perfectionists do not play nicely withj others: Expanding the social disconnection model. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-being.* (pp. 225-243). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Sirois, F. M., & Molnar, D. S. (2014). Perfectionism and Maladaptive Coping Styles in Patients with Chronic Fatigue Syndrome, Irritable Bowel Syndrome and Fibromyalgia/Arthritis and in Healthy Controls. *Psychotherapy and Psychosomatics, 83*(6), 384–385. https://doi.org/10.1159/000365174

Sirois, F. M., & Molnar, D. S. (2016). Conceptualizations of perfectionism, health, and well-being: An introductory overview. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-Being.* (pp. 1–21). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Sirois, F. (2016). Perfectionism and health behaviors: A self-regulation resource perspective. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, health, and well-Being.* (pp. 45-68). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Sirois, F. M. & Molnar, D. S. (2016). Perfectionism, health, and well-being. Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_1

Slaney, R. B., & Ashby, J. S. (1996). Perfectionists: Study of a criterion group. *Journal of Counseling & Development, 74*, 393–398

Slaney, R. B., & Johnson, D. G. (1992). *The Almost Perfect Scale*. Unpublished manuscript, The Pennsylvania State University, University Park.

Slaney, R. B., Rice, K. G., & Ashby, J. S. (2002). A programmatic approach to measuring perfectionism: The Almost Perfect Scales. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment.* (pp. 63–88). American Psychological Association. https://doi.org/10.1037/10458-003

Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The Revised Almost Perfect Scale. *Measurement and Evaluation in Counseling and Development, 34*(3), 130–145. https://doi.org/10.1080/07481756.2002.12069030

Sonnentag, S., Kuttler, I., & Fritz, C. (2010). Job stressors, emotional exhaustion, and need for recovery: A multi-source study on the benefits of psychological detachment. *Journal of Vocational Behavior, 76*(3), 355-365. https://doi.org/10.1016/j.jvb.2009.06.005

Spence, J. T., & Robbins, A. S. (1992). Workaholism: Definition, measurement, and preliminary results. *Journal of Personality Assessment, 58*(1), 160-178. https://doi.org/10.1207/s15327752jpa5801_15

Stewart-Brown S (2002) Measuring the parts most measures do not reach: a necessity for evaluation in mental health promotion. *Journal of Mental Health Promotion, 1*(2), 4-9.

Stoeber, J. (2011). The dual nature of perfectionism in sports: Relationships with emotion, motivation, and performance. *International Review of Sport and Exercise Psychology, 4*(2), 128-145. https://doi.org/10.1080/1750984X.2011.604789

Stoeber, J. (2014). How other-oriented perfectionism differs from self-oriented and socially prescribed perfectionism. *Journal of Psychopathology and Behavioral Assessment, 3*6(2), 329–338. https://doi.org/10.1007/s10862-013-9397-7

Stoeber, J., Davis, C. R., & Townley, J. (2013). Perfectionism and workaholism in employees: The role of work motivation. *Personality and Individual Differences, 55*(7), 733–738. https://doi.org/10.1016/j.paid.2013.06.001

Stoeber, J., & Madigan, D.J. (2016). Measuring perfectionism in sport, dance and exercise: Review, critique and recommendations. In A.P. Hill (Ed.), *The psychology of perfectionism in sport, dance and exercise*. (pp. 31-56). London, UK: Routledge.

Stoeber, J., & Otto, K. (2006). Positive conceptions of perfectionism: Approaches, evidence, challenges. *Personality and Social Psychology Review, 10*(4), 295–319. https://doi.org/10.1207/s15327957pspr1004_2

Tashman, L. S., Tenenbaum, G., & Eklund, R. (2010). The effect of perceived stress on the relationship between perfectionism and burnout in coaches. *Anxiety, Stress & Coping, 23*(2), 195–212. https://doi.org/10.1080/10615800802629922

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53–55. https://doi.org/10.5116/ijme.4dfb.8dfd

Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *The American Psychologist, 55*. 99-109. https://doi.org/10.I037//0003-066X.55.1.99

Tellegen, A. (1985). Structures of mood and personality and their relevance to assessing anxiety, with an emphasis on self-report. In A. H. Tuma & J. D. Maser (Eds.), *Anxiety and the anxiety disorders* (pp. 681-706). Hillsdale, NJ: Erlbaum.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes, 5*(1), 63. https://doi.org/10.1186/1477-7525-5-63

Thelwell, R.C., Weston, N.J.V., Greenlees, I.A., & Hutchings, N.V. (2008). Stressors in elite sport: A coach perspective. *Journal of Sports Sciences, 26*(9), 905–918.

Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: A systematic review of the literature. *Psychotherapy and Psychosomatics, 84*(3), 167–176. https://doi.org/10.1159/000376585

Vallerand, R. J., Blanchard, C., Mageau, G. A., Koestner, R., Ratelle, C., Léonard, M., … Marsolais, J. (2003). Les passions de l'âme: On obsessive and harmonious passion. *Journal of Personality and Social Psychology, 85*(4), 756–767. https://doi.org/10.1037/0022-3514.85.4.756

Van Droogenbroeck, F., Spruyt, B., & Vanroelen, C. (2014). Burnout among senior teachers: Investigating the role of workload and interpersonal relationships at work. *Teaching and Teacher Education, 43*, 99–109. https://doi.org/10.1016/j.tate.2014.07.005

Vealey, R. S., Martin, E., Coppola, A., Ward, R. M., & Chamberlin, J. (2020). The slippery slope: Can motivation and perfectionism lead to burnout in coaches? *International Sport Coaching Journal, 7*(1), 1–10. https://doi.org/10.1123/iscj.2018-0043

Warwick Medical School. (2020, November 4). *Warwick Medical School*. About WEMWBS. Retrieved September 11, 2022, from https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/

Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of Personality and Social Psychology, 64*(4), 678-691.

Watson, D., & Clark, L. A. (1991). The Mood and Anxiety Symptom Questionnaire. Unpublished manuscript, University of Iowa, Iowa City.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070.

Wei, M., Heppner, P. P., Russell, D. W., & Young, S. K. (2006). Maladaptive perfectionism and ineffective coping as mediators between attachment and future depression: A prospective analysis. *Journal of Counseling Psychology, 53*, 67–79. https://doi:.org/10.1037/0022-0167.53.1.67

White, B. V., Cobb, S., Jones, C. M. (1939). *Mucous colitis: A psychological medical study of 60 cases. Psychosomatic Medicine Monograph, 1*. Washington, DC: National Research Council.

Zung, W. K. (1965). A self-rating depression scale. *Archives of General Psychiatry, 12*, 63-70.

APPENDICES

Literature Review

Well-Being

      Well-Being Defined. Well-being is best considered as a multi-dimensional concept that refers to optimal psychological functioning and experience (Ryan & Deci, 2001). The study of well-being grew in the 1960's when psychology research shifted to a focus on prevention of mental health issues (Diener, 1984). Given there is not one agreed upon definition of well-being, the construct is both multifaceted and complex (Lundqvist, 2011) and to some degree, controversial (Ryan & Deci, 2001). Christopher (1999) argued that all understandings of well-being are moral visions based on individuals' judgments rooted in their own culture and values. Additionally, Coan (1977) outlines that culture, history, ethnicity, class, and other social structures may result in differing or conflicting views of well-being. Nonetheless, research has expanded in recent decades in an attempt to fill the multi-cultural gap in well-being literature (Brailovskaia, 2022; Gopalkrishnan, 2018; Ryan & Deci, 2001).

      Conceptualizations of well-being commonly revolve around two distinct philosophies, hedonism and eudaimonism. Both views are founded on human nature and what encompasses a good society (Ryan & Deci, 2001). However, these philosophies also prescribe different developmental and social processes to achieving well-being (Ryan & Deci, 2001). The two perspectives complement one another in the research, which provides a well-rounded conceptualization of the personal, contextual, and cultural factors that relate to promoting wellness (Ryan & Deci, 2001). Thus, each philosophical distinction of well-being will be discussed to help further explain the construct.

The Hedonic Perspective

      The hedonic perspective summarizes well-being as an experience of pleasure or happiness. Aristippus, a Greek philosopher, taught that happiness is the totality of one's hedonic experiences (Ryan & Deci, 2001). According to Ryan and Deci (2001), "the predominant view among hedonic psychologists is that well-being consists of subjective happiness and concerns the experience of pleasure versus

displeasure broadly construed to include all judgements about the good/bad elements of life" (p. 4). In other words, happiness is generally associated with hedonic happiness, and is considered a subjective experience (Waterman, 1993). Kahneman and colleagues (1999) define well-being as experiencing pleasure versus pain, or what makes life experiences pleasant and unpleasant. Hedonic psychologists believe that well-being is achieved through increasing happiness by striving for pleasure, moving towards meaningful goals, and increasing positive affect (Lundqvist, 2011). Hedonic enjoyment can be achieved when positive affect is felt in accordance with the satisfaction of physical, intellectual, or social needs (Waterman, 1993). Consequently, the hedonic perspective utilizes the label of subjective well-being (SWB), which has been a major outcome variable in the research of well-being (Ryan & Deci, 2001). Therefore, in order to understand the hedonic perspective, SWB must be discussed.

Subjective Well-Being. SWB is considered a general area of interest rather than a specific construct (Diener et al., 1999). This phenomena includes individuals' emotional responses, domain satisfaction, and global judgments of life satisfaction. SWB is defined as "a person's cognitive and affective evaluations of his or her life as a whole" (Diener et al., 2009, p. 1). Early literature on SWB analyzed how and why people experience their lives in positive ways (Diener, 1984). The concept of SWB has evolved to encompass the positive as well negative and judgmental aspects of well-being (Lundqvist, 2011). Thus, studies of SWB are mostly concerned with how the balance between positive and negative affect serve as important indicators of overall well-being (Diener, 2009; Diener et al., 2005). Furthermore, research has shown SWB as a relatively stable concept. Headey and Wearing (1989) believe that individuals eventually adapt to life changes and return to "set points." Given this knowledge, SWB is a broad concept including both high levels of positive emotions and moods, low levels of negative emotions and moods, and overall high life satisfaction (Diener et al., 2009). As such, life circumstances may play an influential role in well-being, which highlights the specific standards on which individuals evaluate their own well-being.

In theory, SWB is made up of two components: life satisfaction and happiness over one's lifetime (Lundqvist, 2011). However, as Diener (1984) highlights, terms like happiness have been used frequently

in society and have varying meanings. The standards on which an individual evaluates their overall well-being may differ from normative standards (Lundqvist, 2011). As a result of these standards, judgment theories such as the social comparison theory, help researchers understand the extent to which individuals determine their overall happiness and well-being. In the social comparison theory, one uses other people as a standard for judging their own circumstances (Diener, 1984). Thus, those who experience difficult life circumstances with lower levels of normative standards, can maintain SWB depending on their perceptions and judgments of the situation (Lundqvist, 2011). Likewise, others might experience life circumstances comparable to normative standards and experience a lack of well-being (Diener, 2009). Therefore, SWB is largely dependent on the individual and how they interpret their life circumstances.

Research shows that SWB is determined by a large number of factors rather than being dependent on a few influential variables (Diener, 1984). Factors can include subjective satisfaction (Campbell, 1981), income (Braun, 1977; Campbell et al., 1976), age (Bortner & Hultsch, 1970; Cantril, 1965; Clemente & Sauer, 1976; Medley, 1980), employment (Campbell, 1976; Cohn, 1979), and family (Andrews & Withey, 1976; Glenn, 1975). Furthermore, personality characteristics such as self-esteem (Anderson, 1977; Drumgoole, 1981; Reid & Ziegler, 1980), extraversion, and neuroticism (Diener & Lucas, 1999) have also shown to play a role in one's overall well-being. Due to the complexity of the concept, analyzing SWB at an individual level is difficult. Individuals' differing levels of SWB is largely dependent on how they interpret their lives and experiences. Diener and colleagues (2009) emphasized that researchers understand the "complex interplay of culture, personality, cognitions, goals and resources, and the objective environment" when considering what causes SWB (p. 295). However, SWB consists of three components: life satisfaction, the presence of positive mood, and the absence of negative mood, together identified as happiness (Ryan & Deci, 2001). Thus, while SWB may be highly individualized, researchers attempt to capture differences through maximizing happiness and pleasure.

The Eudaimonic Perspective

The eudaimonic perspective of well-being separates subjective happiness from well-being, such that not all desires, even those that an individual values most, would lead to well-being when

accomplished. According to this perspective, not all outcomes would promote wellness, and therefore, subjective happiness cannot be compared to well-being (Ryan & Deci, 2001). According to Waterman (1993), eudaimonia is achieved when individuals live their lives in congruence with their deeply held beliefs. Rather than achieving pleasure and positive affect, the eudaimonic view is concerned with activities people are engaged with to develop and reach their full potential (Lundqvist, 2011). Eudaimonism, an ethical theory of self-realization, often refers to the *daimon*, or true self (Waterman, 1993). The *daimon* is "an ideal in the sense of being an excellence, a perfection toward which one strives, and hence, it can give meaning and direction to one's life" (Waterman, 1993, p. 678). Personal expressiveness and self-realization are linked to eudaimonia, in which what is considered desirable or valued in life is within us or through personal excellence (Waterman, 1993). From this perspective, eudaimonic psychologists challenge SWB and focus more on psychological and social well-being (Lundqvist, 2011). As such, understanding each dimension helps conceptualize the eudaimonic perspective of well-being.

Social Well-Being. According to Keyes (1998), the social aspects of well-being must be accounted for in evaluating one's overall well-being. Social well-being is "the appraisal of one's circumstances and functioning in society" (Keyes, 1998, p. 122). The construct represents an individual's social function and perceptions of social flourishing (Lundqvist, 2011) and is made up of five dimensions. Keyes (1998) suggests these dimensions develop from social challenges faced by individuals and outline overall social wellness. The first dimension, social integration, refers to the quality of one's relationship to society and others. The second, social acceptance, is displayed through trusting others and believing other people are capable of being kind and diligent. Social contribution is the evaluation of one's social value, which includes the belief that one has something to contribute to society. The fourth dimension is social actualization, which focuses on the potential of society, and that society controls its destiny. The final dimension, social coherence, is the perception that the social world is interesting, logical and predictable. Those who have greater social wellness do not believe they live in a perfect world, rather believe in the desire to make meaning in their lives. Socially healthier individuals also regard society as

pleasant, perceive themselves as social resources, lead lives in congruence with their values, and care for their communities. Social well-being remains a single component of one's overall well-being, and thus may be influenced by various factors, such as age, education, and socioeconomic status (Keyes, 1998). However, social well-being remains useful in understanding individuals' ability to function in their personal lives as well as their contribution to society.

Psychological Well-Being. Psychological well-being (PWB) is rooted in two primary conceptualizations of positive functioning (Ryff & Keyes, 1995). The first, based on Bradburn's (1969) initial work, defined happiness as the balance between positive and negative affect. The second emphasized life satisfaction as the key indicator of well-being and happiness (Andrews & McKennell, 1980). Given the extensive literature within positive psychological functioning, defining well-being has included the perspectives of self-actualization (Maslow, 1968), the conceptualization of the fully functioning person (Rogers, 1961), psychosocial stages of development (Erikson, 1959), basic life tendencies (Buhler, 1935), and personality changes across the lifespan (Neugarten, 1973). Thus, Ryff & Keyes (1995) proposed PWB as a multidimensional concept that encompasses six aspects of human actualization: autonomy, personal growth, self-acceptance, life purpose, mastery, and positive relatedness.

According to Ryff (1989), the fully functioning person is "described as having an internal locus of evaluation, whereby one does not look to others for approval, but evaluates oneself by personal standards" (p. 1071). In regards to PWB, this internal focus gives individuals a sense of freedom in governing their own lives, otherwise known as autonomy. Second, self-acceptance is considered the most recurrent criterion of well-being. Ryff (1989) concludes that holding a positive attitude towards oneself is central to positive psychological functioning. The third aspect, life purpose, refers to feeling that life is meaningful. According to Ryff (1989), "mental health is defined to include beliefs that give one the feeling that there is purpose in and meaning to life" (p. 1071). One who functions positively has goals, intentions, and a sense of direction that all contribute to their greater purpose. Mastery, the fourth aspect of PWB, suggests that active participation in and mastery of one's environment are crucial to psychological functioning. Individuals' ability to choose or create environments that are congruent with

their skills is a characteristic of mental health. Furthermore, positive relatedness refers to the importance of engaging in warm, trusting interpersonal relationships. Those who are described as having strong feelings of empathy and as being capable of greater love and deeper friendship are considered to be self-actualizers (Ryff, 1989). Finally, personal growth relates to one's desire to meet all other characteristics and continued motivation to develop and expand as a person. In this regard, individuals emphasize continual growth and confronting new challenges over one's lifetime. When considered together, each construct helps define PWB both theoretically and operationally (Ryan & Deci, 2001). Ryan and Keyes (1995) confirmed that well-being is multidimensional and encompasses all six aspects.

One key retortion against PWB from SWB theorists is that SWB research allows individuals to elaborate on their experiences, while PWB experts define well-being for individuals (Diener et al., 1998). However, both have led to valuable insights concerning the causes, consequences, and understanding of well-being and elicits a greater understanding of the concept of well-being, particularly in regards to overall human experience (Ryan & Deci, 2001). Furthermore, Disabato and colleagues (2016) found that hedonia (SWB) and eudaimonia (PWB) showed little evidence of discriminant validity, but were strongly correlated ($r = .96$) in a large community-based, international sample. The sample consisted of 7,617 late adolescent and adult participants ($M = 33.5$ and $SD = 14.2$). The researchers suggest that this high magnitude correlation may mean that the two constructs reflect the same over-arching well-being construct (Disabato et al., 2016). Specifically, while there is clear philosophical debate of the differences between the two constructs there is no clear scientific distinction or empirical support to confirm them (Disabato et al., 2016; Kashdan et al., 2008). Thus, researchers may opt to look into specific variables that influence well-being and determine what level is most appropriate.

Well-Being Measures

Given the dynamic processes of well-being, current instruments in the field were developed around these conceptualizations as the starting point (Tennant et al., 2007). Furthermore, each measures different components of well-being, including positive and negative affect (Watson et al., 1988), cognitive facets of well-being (Diener et al., 1985), psychological well-being (Ryff & Keyes, 1995),

general well-being and mental health (Topp et al., 2015), and well-being as a continuum between depression and happiness (Joseph et al., 2004). There are also scales developed specifically for population samples, in which results can help practitioners measure and evaluate the effectiveness of their programs (Tennant et al., 2007). Thus, instruments that measure the factors that influence well-being at an individualized level are necessary.

The Positive and Negative Affect Schedule (PANAS). The balance between positive and negative affect are one focus of SWB research (Diener, 2009; Diener et al., 2005). Prior to its development, a reliable and valid measure consisting of both Positive and Negative Affect did not exist. Thus, Watson and colleagues (1988) sought to develop a The Positive and Negative Affect Schedule (PANAS) to fill the void. According to Watson and colleagues (1988), PA reflects the extent to which an individual feels enthusiastic, active, and alert. High PA typically can be characterized as high energy, full engagement, and focus, whereas low PA can be characterized by sadness and fatigue. Conversely, NA is described as subjective distress and unpleasurable engagement. High NA can be observed through anger, contempt, disgust, and fear, but low NA is seen through calmness. Tellegen (1985) suggests that low PA and high NA are major contributors to depression and anxiety.

The PANAS scale started with a broad sample of 60 mood descriptors to identify basic PA and NA factors. From that sample, three terms from 20 content categories were selected. Categories were identified through a principal-components analysis of content sortings of a large sample of descriptors (Watson et al., 1988). Factor analysis yielded a final 10 descriptors for the PA scale: *attentive, interested, alert, excited, enthusiastic, inspired, proud, determined, strong*, and *active*. The final NA scale also yielded 10 descriptors: *distressed, upset, hostile, irritable, scared, afraid, ashamed, guilty, nervous,* and *jittery*. Participants are asked to answer the extent to which they experience each mood state during a specified time frame. Mood states are rated on a 5-point scale labeled *slightly or not at all, a little, moderately, quite a bit,* and *very much*. Additionally, subjects rate how they felt (a) right now (moment), (b) today, (c) during the past few days, (d) during the past week, and (e) during the past few weeks, (f) during the past year, and (g) in general, that is, on the average.

Watson and colleagues (1988) tested basic psychometric data in undergraduate students and a group of 53 adults. For each time frame, researchers collected data on large samples totaling 660 (moment), 657 (today), 1,002 (past few days), 586 (past few weeks), 649 (year), and 663 (general). A subset of 101 students completed ratings on all seven time frames to provide retest data. Alpha reliabilities for the PANAS scale ranged from .86 to .90 for PA and from .84 to .87 for NA. The correlation between the NA and PA scales range from -1.2 to -.23, showing that the two scales share 1-5% of their variance. Test-retest reliability was conducted with 101 undergraduate students on two different time points during the semester. No significant differences in the stability values were found between the two time points.

The PANAS scales were also administered to a nonstudent and clinical samples to test the generalizability across multiple populations. A sample of 164 adult employees yielded similar results to those of the undergraduate sample. The alpha reliabilities were .86 and .87 for the PA and NA scales, and the correlation between the two was -.09. Furthermore, data was collected on a sample of 61 psychiatric inpatients. The alpha reliabilities were .85 for PA and .91 for NA, while the correlation between the two was moderate ($r = $ -.27). Results show that each 10-item scale is internally consistent and demonstrate stability over a 2-month time frame.

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). Tennant and colleagues (2007) developed the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) to capture a broad view of well-being, including the affective and emotional aspects, cognitive evaluations, and psychological functioning (Tennant et al., 2007). Its development enabled the monitoring of mental well-being in population groups and evaluation of community projects and policies aimed to enhance overall well-being (Warwick Medical School, 2020). The WEMWBS builds on previous well-being scales to be used in population-level surveys, including the PANAS scale, the Satisfaction with Life Scale (SWLS), Scale of Psychological Well-Being (SPWB), Short Depression-Happiness Scale (SDHS), and the WHO Well-Being Index (WHO-5). Due to the recent push in positive psychology theories and interventions, the

WEMWBS contains positively worded items that capture aspects of positive mental health (Tennant et al., 2007).

The WEMWBS is based on the Affectometer 2 (Kammann & Flett, 1983), which was developed in New Zealand in the 1980s to measure well-being and promote mental health in the UK (Stewart-Brown, 2002). The Affectometer 2 has 20 statements and 20 adjectives both negatively and positively worded. Fifty-six participants from community groups associated with mental health were recruited to participate in focus groups. They were asked to complete the Affectometer 2 and discuss their concept of positive mental health and its relationship to items in the scale (Tennant et al., 2007). Content analysis was used to identify themes the groups found consistently confusing as well as those that related to mental well-being that should be included. From there, a panel of experts in psychiatry, psychology, public health, and social science convened to consider the results of the focus groups. The panel agreed on key concepts related to mental well-being, including positive affect and psychological functioning (autonomy, competence, self-acceptance, personal growth), and interpersonal relationships.

The final scale consisted of 14 items comprising both hedonic and eudaimonic aspects of mental health, including positive affect, satisfying interpersonal relationships, and positive functioning (Tennant et al., 2007). Participants complete the scale based on their experiences over the past two weeks on a 5-point Likert scale (*none of the time, rarely, some of the time, often,* and *all of the time*). The total score is calculated by tallying the total scores for each item, which means a higher WEMWBS score indicates a higher level of well-being. Example items from the scale include *"I've been feeling optimistic about the future"* and *"I've been feeling close to other people"*.

Reliability and validity tests for the WEMWBS were conducted using convenience samples of undergraduate and postgraduate students at Warwick and Edinburgh universities. A total of 348 (98%) fully completed the WEMWBS for an overall response rate of 53%. In the second week of testing, 124 out of 255 (47%) completed the scale. The second set of data utilized in the study combined data from two Scottish health education population surveys, the Scottish Health Education Population Survey (HEPS) and the 2006 Well? What do you think? Survey. Out of a total of 2075, 323 (16%) failed to

respond to any WEMWBS items or only answered partially, leaving 1749 participants for the respondent population sample. Cronbach's alpha was 0.89 for the student sample and 0.91 for the population sample.

Spearman's rank correlation tests were run between scores on the WEMWBS and eight other scales covering physical and mental health and well-being utilizing the student sample. Overall health showed a low to moderate significant correlation (r = 0.43, $p < 0.01$). Additionally, scales measuring components of well-being showed significant correlations with the WEMWBS (PANAS r = 0.71, $p < 0.01$; SPWB r = 0.74, $p < 0.01$; SDHS r = 0.73, $p < 0.01$; WHO-5 r = 0.77, $p < 0.01$). Test-retest reliability in the student sample was 0.83 ($p < 0.01$), indicating high reliability for the WEMWBS. According to Tennant and colleagues (2007), the WEMWBS did not show a ceiling effect in either of the population, which shows that it may help document improvement in well-being for population samples. Furthermore, it can be used to distinguish between groups in a way that is consistent with other population surveys.

WHO-5 Well-Being Index (WHO-5). The WHO-5 Well-Being Index (WHO-5) is one of the most widely used scales measuring subjective well-being (Topp et al., 2015). The WHO-5 is a short and generic measure that was developed without any diagnostic specificity (6). The scale only contains positively phrased items, including: (1) I have felt cheerful and in good spirits, (2) I have felt calm and relaxed, (3) I have felt active and vigorous, (4) I woke up feeling fresh and rested, and (5) My daily life has been filled with things that interest me. Participants are asked to rate themselves on how well each statement applies to them on a scale of 0 (none of the time) to 5 (all of the time) using the time frame of the past two weeks. Example items for the WHO-5 include *"I have felt cheerful and in good spirits"* and *"I woke up feeling fresh and rested"*.

In a systematic review of literature on the WHO-5, Topp and colleagues (2015) focused on establishing the clinometric validity, the responsiveness/sensitivity in controlled clinical trials, the potential of the WHO-5 as a screening tool for depression, and the applicability across study fields of the WHO-5. Furthermore, the WHO-5 has been used as an outcome measure in controlled clinical trials in patients with major depression (Topp et al., 2015). Specifically, the scale can be used to discover the

differences between desired clinical effects and unwanted side effects in clinical trials (Bech, 2012).

Lastly, it has proven to be a reliable generic measure of well-being across study fields. According to Topp

and colleagues (2015), the WHO-5 is a useful tool that can be used to assess well-being over time or

compare well-being between groups of people. The ideal goal of utilizing the WHO-5 should be to reach

the general population mean score (Topp et al., 2015). Thus, individual scores can be added to a

meaningful total score.

The Satisfaction with Life Scale (SWLS). The Satisfaction with Life Scale (SWLS) was

designed to assess a person's global judgment of life satisfaction, which is theorized to depend on an

individual's comparison of life circumstances to one's own standards (Pavot & Diener, 1993). This

judgment is internally-imposed, which means that subjective well-being centers on one's own judgments

and not based on criterion set by the researcher (Diener, 1984). As stated previously, individuals may

place different values on what is considered to be desirable, including one's health, income, and

occupation. Thus, Diener and colleagues (1985) sought to develop a multi-item scale that measures life

satisfaction as a cognitive-judgmental process.

In the initial development of the SWLS, 48 self-report items were generated. From these items,

three domains were identified: positive affect, negative affect, and satisfaction. Both affect items were

removed as well as satisfaction items that had factor loadings less than .60, resulting in a final five-item

scale. Each item on the SWLS is scored from 1 to 7 (*1 = strongly disagree* to *7 = strongly agree*). The

total score can range from 5 (low satisfaction) to 35 (high satisfaction). Example items of the SWLS

include *"In most ways my life is close to ideal"* and *"The conditions of my life are excellent"*.

Psychometric properties of the scale were tested on 176 undergraduate students. In the first round,

all students were given the SWLS in a group setting. Two months later, 76 of these students were re-

administered the scale. The overall mean score on the SWLS was 23.5. The test-retest correlation

coefficient was .82 with a coefficient alpha of .87. Scores on the SWLS also revealed a low correlation (*r*

= 0.02) with the Marlowe-Crowne scale of social desirability (Diener et al., 1985). These results indicate

the SWLS is not prone to social desirability. Therefore, the SWLS has shown strong internal reliability

and moderate temporal validity (Pavot & Diener, 1993). According to Magnus and colleagues, however, the test-retest reliability of the SWLS decreases from 0.84 to 0.54 over longer periods, suggesting that significant change may occur throughout one's lifetime.

While the SWLS provides a measure of subjective well-being based on an individual's experiences, more evidence is needed to determine its effectiveness in cross-cultural populations. Furthermore, additional evidence could provide insight into the use of the scale in clinical settings (Diener et al., 1993). A number of happiness, affect, and life satisfaction measures are widely used today, yet a major concern of researchers in the field is the validity of self-report measures, particularly for SWB (Diener et al., 2009). Moreover, global judgments of life satisfaction also do not correspond directly to the average mood level or level of satisfaction experienced across different moments. As noted by Christopher (1999), well-being is based on individuals' judgments rooted in their own culture and values. Therefore, individuals use this information when analyzing their own life satisfaction or well-being. More sophisticated methodologies are needed to capture how these variables influence SWB (Diener, 1984; Diener et al., 2009). Specifically, valid and reliable non-self-report measures biological and cognitive measures of well-being would be useful to increase the understanding of what existing measures are evaluating (Diener et al., 2009).

The Scale of Psychological Well-Being (SPWB). The Scale of Psychological Well-Being (SPWB) was developed to capture important aspects of positive psychological functioning that were previously missing from literature (Ryff, 1989). Specifically, Ryff (1989) argued that other instruments of life satisfaction and psychological functioning neglected theory to define the structure of well-being. Integrating mental health, clinical, and lifespan developmental theories of well-being constitute common themes. When these perspectives are converged together, they make up the core dimensions of psychological well-being (Ryff, 1989). As discussed above, these dimensions include self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Ryff (1989) operationalized these dimensions resulting in key aspects that are both theoretically and

empirically-distinct from existing perspectives. The purpose of Ryff's (1989) study was to develop structured, self-report measures that serve as indicators of these constructs.

Definitions of the six dimensions of well-being were generated by three-item writers who were instructed to write self-descriptive items that fit within the theoretical definitions (Ryff, 1989). Writers utilized 80 partially written items generated from the bipolar scale definitions. Items were subject to preliminary evaluations based on ambiguity or redundancy of items, lack of fit, lack of distinctiveness, inability to provide variable responses, and whether all aspects of the scale definitions were covered by the items. This procedure resulted in 32 items per scale (16 positive and 16 negative). Item-to-scale correlations were computed for each item with all of the scales, and items that were more highly correlated with a scale other than their own or showed low correlations with the total scale were deleted. The scale was reduced to 20 items, divided equally between high scoring versus low-scoring definitions.

The final scale includes 42 items rated on a 7-point Likert scale (*1 = strongly agree* to *7 = strongly disagree*) with six subscales. Example items for each subscale include, autonomy (e.g., *"I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people"*); environmental mastery (e.g., *"In general, I feel I am in charge of the situation in which I live"*); personal growth (e.g., *"I am not interested in activities that will expand my horizons"*); positive relations with others (e.g., *"Most people see me as loving and affectionate"*); purpose in life (e.g., *"I live life one day at a time and don't really think about the future"*); and self-acceptance (e.g., *"When I look at the story of my life, I am pleased with how things have turned out*).

Internal consistency coefficients for each dimension included the following: self-acceptance = .93, positive relations with others = .91, autonomy = .86, environmental mastery = .90, purpose in life = .90, and personal growth = .87. The test-retest reliability coefficients over a 6-week period on a subsample of respondents (*n* = 117) were self-acceptance = .85, positive relations with others = .83, autonomy = .88, environmental mastery = .81, purpose in life = .82, and personal growth = .81. Furthermore, correlations with prior measures of positive functioning were all positive and significant, with coefficients ranging from .25 to .73. Correlations with prior measures of negative functioning were

all negative and significant, with coefficients ranging from -.30 to -.60. These results demonstrate that these measurements have promising preliminary psychometric properties. However, higher correlations between dimensions suggests that the scale may be measuring the same underlying construct (Ryff, 1989). This was seen in self-acceptance and environmental mastery ($r = .76$) and with self-acceptance and purpose in life ($r = .72$). Ryff and Singer (2006) argued against this criticism, noting that not all scales were highly correlated with one another. For example, purpose in life showed generally low correlations with life satisfaction, affect balance, and self-esteem. Furthermore, age trajectories also varied, in which self-acceptance showed no age differences, while environmental mastery showed significant increments from young adulthood through old age (Ryff & Singer, 2006).

Ryff (1989) tested the psychometric properties of the scale in a group of individuals from civic and community organizations. Three hundred and twenty-one men and women were divided among young ($n = 133$, mean age = 19.53), middle-aged ($n = 108$, mean age = 49.85), and older adults ($n = 80$, mean age = 74.96). Among the three groups, the education levels were high, with almost 60% of the middle age group and 47% of the older adult group completing four years of college. Participants were asked to rate themselves on the six new dimensions of psychological well-being along with previously used instruments, including the Affect Balance Scale (Bradburn, 1969), The Life Satisfaction Index A (LSI-A; Neugarten et al., 1961), Self-Esteem Scale (Rosenberg, 1965), The Revised Philadelphia Geriatric Center Morale Scale (Lawton, 1975), Locus of Control subscales (Levenson, 1974), and the Self-Rating Depression Scale (SDS; Zung, 1965). Respondents rated themselves on each item on a 6-point scale ranging from *strongly agree* to *strongly disagree*.

Results confirmed a significant overall effect of age ($F(12, 620) = 5.98$, p < .001). This was accounted for by the dimensions of autonomy, environmental mastery, purpose in life, and personal growth ($p < .01$). There were no age differences for the positive relations with others and self-acceptance dimensions. A significant overall effect of sex was also found ($F(6,310) = 8.65$, $p < .001$). This was accounted for by the positive relations with others, in which women scored higher than men. Personal growth also approached significance, with women scoring higher than men in this dimension as well ($F(1,$

315) = 3.61, $p < 0.058$). These results demonstrate that no age differences in self-esteem and incremental levels of happiness across age groups (Ryff, 1989). While more empirical evidence is needed, the results also suggest that women favor the interpersonal dimension of psychological well-being over men.

14-Item SPWB. Ryff and colleagues (1994) developed a shortened version of the SPWB consisting of 14 items divided between positively and negatively phrased items. Ryff et al. (1994) utilized this scale in a sample of 215 midlife parents. Mothers (*M* = 53.1, *SD* = 7.2) and fathers (*M* = 54.3, *SD* = 6.2) were in their early 50s. Items for the scale were selected on their basis of fit and extent to which they covered the guiding definition. As all parent scales had multifactorial structures, items were selected from subfactors within each longer scale. Correlations to the original 20-item scale outlined above ranged from .97 to .98. Alpha coefficients ranged from .82 to .90. Test-retest reliability over a 6-week period ranged from .81 to .88. Participants completed the survey on a 6-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

Dierendonck (2003) examined the factorial effect of and content validity of the SPWB scales, specifically the 3-item, 9-item, and 14-item versions in a sample of 233 first year undergraduate students (*N* = 233, Mean age = 22 years, *SD*, = 6) using the SPWB 14-item version and a sample of professionals from various occupational backgrounds (*N* = 420, Mean age = 36 years, *SD* = 8) using the 9-item version. Results demonstrated that the 14-item scale had good reliabilities, with Cronbach's alpha running from 0.77 to 0.90 (Self-Acceptance = .90, Positive Relations = 0.80, Autonomy = .83, Environmental Mastery = 0.77, Purpose in Life = 0.84, and Personal Growth = 0.82). While the factorial validity was only found to be acceptable with the 3-item scale, each of the shorter scales' correlations with the 14-item scale were at least 0.91. van Dierendonck and colleagues (2008) calculated the goodness of fit with the use of the chi-square goodness-of-fit index and the standardized root-mean-square residual (SRMR), and results demonstrated a relatively good fit (SRMR = .06).

Harris (2010) utilized the 14-item version of the SPWB to analyze the relationship between PWB and perceived wellness in masters-level counseling students. A total of 99 graduate counseling students participated in the study (14 male and 85 female); two participants failed to fully complete the surveys

and were removed from the total sample. A majority of the participants were 21-59 years old (82.9%) and 7% were 41-59 years old. Results showed that perceived wellness was significantly, positively, and strongly related to Positive Relations with Others ($r = .662$, $p < .001$), Environmental Mastery ($r = .756$, $p < .001$), Personal Growth ($r = .458$, $p < .001$), Purpose in Life ($r = .696$, $p < .001$), and Self-Acceptance ($r = .674$, $p < .001$). Autonomy ($r = .252$, $p < .01$) was significant at the 0.01 level. The R^2 equaled .605 (adjusted $R = .601$), which indicated that PWB was a strong predictor of perceived wellness.

While the SPWB has been used in a variety of studies, including cross-cultural research in Spanish, Chinese, and Swedish populations (van Dierendonck et al., 2008), there remains some dispute that the high internal factor correlations indicate there is substantial overlap among the dimensions (Springer & Hauser, 2006). This may mean that each of the subscales are measuring the same concepts and challenge the multidimensional nature of the SPWB. However, as mentioned previously, Ryff and Keyes (1995) concluded that these dimensions may differ across an individual's lifespan. Additionally, Ryff and Singer (2006) responded to Springer and Hauser's (2008) rebuttal, noting the analyses that prove the multidimensional nature of the Ryff's PWB scales. Furthermore, the SPWB has been administered in major studies, including the National Survey of Families and Households II (NSFH II), the National Survey of Midlife in the United States (MIDUS), the Wisconsin Longitudinal Study (WLS), and the Canadian Study of Health and Aging (CSHA), and the original scale (Ryff, 1989) has been cited in over 400 research papers (Springer & Hauser, 2008).

Well-Being in the Helping Professions

Individuals who are drawn to the human service field are typically sensitive to others and are humanitarian, hoping that they can be helpful (Cherniss, 1980). Often, the professional's role is defined by the clients' needs. Psychotherapists' perceived difficulties in work include the need to maintain attentiveness, be responsible, show detached concern, and deal with the slow pace of therapeutic progress (Farber & Heifetz, 1982). Rabin and colleagues (1999) identified five general stressors encountered by psychotherapists as maintaining the therapeutic relationship, scheduling, professional doubt, work over involvement, and personal depletion. According to McCormack et al. (2018), psychologists and other

mental health professionals are prone to several work-related health impairments, including compassion fatigue (Figley, 2002) and both secondary (Canfield, 2005) and vicarious traumatization (Dunkley & Whelan, 2006). These environmental, occupational and psychosocial hazards associated with working in a helping profession may influence overall well-being. For example, unmanageable caseloads (Wooten et al., 2011), interpersonal conflict, and emotional labor (Kinman & Grant, 2020; Ravalier, 2019) are among the primary risk factors for social workers. Compassion fatigue, difficulties detaching from work, overinvolvement, and poor self-care may also intensify the risks for impaired well-being (Kinman & Grant, 2022). Edwards and colleagues (2002) conducted a systematic review identifying a variety of stressors experienced by mental health workers. These stressors included increased workload (Prosser et al., 1997), lack of resources and management problems (Harper & Minghella, 1997), and managing crises alone (Reid et al., 1999).

Job demands, personal characteristics, and availability of resources can contribute to the development of burnout among applied psychologists (McCormack et al., 2018). Within the field of psychology, burnout has been associated with depression (Gilroy et al., 2002; Pope & Tabachnick, 1994) and anxiety (Morse et al., 2012). Maslach and Jackson (1981) define burnout as a syndrome comprising three dimensions: mental fatigue or emotional exhaustion, negative feelings or perceptions about colleagues, and a decrease in feelings of personal accomplishment. In applied psychologists and allied mental health professionals, emotional exhaustion is the most commonly reported dimension of burnout (McCormack et al., 2018). High workload was another factor that contributed to burnout in this population. Maslach et al. (2001) reported that workload contributes to emotional exhaustion by placing excessive demands on an individual. Previous research has confirmed this in nurses (Greenglass et al., 2001) and teachers (Van Droogenbroeck et al., 2014). With this knowledge, monitoring the well-being of helping professionals is vital to maintaining healthy and competent individuals in these fields.

Harris and colleagues (2013) analyzed the relationship between psychological well-being in counseling graduate students. A total of 97 graduate students participated in the study (ages 21-59 years), with the majority of participants being between the ages 21 and 30 years (82.9%). Fourteen participants

identified themselves as male, and 85 participants identified as female (two participants excluded from final sample for incomplete data). Participants completed two survey instruments and a demographic questionnaire. The first survey instrument was the SPWB, which provides scores for six subscales of PWB (*positive relations with others, autonomy, environmental master, personal growth, purpose in life, and self-acceptance*) and a total score. The second instrument was the Perceived Wellness Survey (PWS; Adams et al., 1998), a 36-item self-report scale used to measure perceived wellness across six life dimensions, including: emotional, intellectual, physical, psychological, social, and spiritual wellness. Demographic information collected included ethnicity, gender, age, and previous experiences with and benefit of personal counseling.

Two multiple regression analyses were conducted to examine the relationship between the overall scores on perceived wellness and psychological well-being as well as the relationship between perceived wellness and each of the six predictor variables of PWB. Results from the regression analyses revealed that perceived wellness was significantly correlated to positive relations with others ($r = .662$, $p < 0.001$), environmental mastery ($r = .756$, $p < 0.001$), personal growth ($r = .458$, $p < 0.001$), purpose in life ($r = .696$, $p < 0.001$), and self acceptance ($r = .674$, $p < 0.001$). Autonomy ($r = .252$, $p < 0.01$) was significant at the .01 level. The R^2 equaled .605 (adjusted $R = .601$), which confirmed that psychological well-being was a strong predictor of perceived wellness. To assess the impact of the six dimensions of PWB on perceived wellness, a second multiple regression analysis was conducted. The R^2 equaled .688 (adjusted $R2 = .667$), which indicated that the six dimensions of PWB accounted for 66% of the variance in perceived wellness and were strong predictors of perceived wellness. Overall, Harris et al. (2013) found that perceived wellness is strongly predicted by overall PWB and three subscales: positive relations with others (ß = .239, p = .003), environmental mastery (ß = .342, p = .006), and purpose in life. This study provides a unique perspective of the overall health and well-being of counselors in training (Harris et al., 2013), and thus highlights the need for competent and effective mental health professionals.

Sport and Performance Psychology (SPP) Professionals

Limited research exists examining SPP professionals' work-based well-being (McCormack, 2019). The most relevant literature in this domain examines professional quality of life in sport psychology professionals (Quartiroli et al., 2019a; 2019b) and sport psychologists' job experiences at the Olympic Games (Arnold & Sarkar, 2014; McCann, 2008). SPP professionals tend to come from two distinct backgrounds, psychology and sport science, so service descriptions typically include "mental skills training" or "clinical work" (McCann, 2008). The field developed from educational and coaching models, in which professionals were primarily viewed as educators who taught mental skills (i.e., relaxation, imagery, goal-setting) to athletes (Andersen et al., 2001). The field of sport psychology has evolved to include performance-enhancement training, counseling/clinical psychology, and teaching/academia components. Thus, the work demands of SPP professionals are dynamic, often inclusive of multiple roles and responsibilities.

Fletcher and colleagues (2011) note that work demands caused by unsociable hours, isolation, and seasonal demands of athletics can lead to chronic stress in this population. SPP professionals that hold roles within academia may experience a combination of administrative duties, research, and teaching responsibilities. Furthermore, those working directly with teams, issues including practice settings, dual relationships, and confidentiality can pose potential work-related stressors (Andersen et al., 2001). For example, work settings may be in locker rooms, hotels, or on the playing field, compared to a traditional office setting. These work settings may be particularly stress provoking due to the unsociable hours, isolation, and seasonal demands of the sport they work with (Fletcher et al., 2011). Further understanding the work demands of SPP professionals helps to address and target such stressors.

Fletcher and colleagues (2011) found that teaching, research, consultancy, and workload and hours were among the most common organizational demands of SPP professionals. Moore (2003) also emphasized that SPP professionals are required to balance presentation issues, evaluation in the workplace, and ethical obligations. Providing services to multiple clients, including coaches, athletes, and other support staff may cause the workplace to be especially challenging (Moore, 2003). Interestingly, Fletcher and colleagues (2011) mentioned, "while applied sport psychologists are typically trained to

design and deliver stress management interventions this is a different skill to effectively implementing such techniques in one's own life" (p. 377). The work environment for SPP professionals puts them at risk to experience high job demands and stress, resulting in feelings of burnout and workaholism (McCormack, 2019). Given the services SPP professionals provide to athletes to enhance their well-being, it is vital that their own well-being be maintained and valued as well.

McCormack's (2019) dissertation assessed the work-based well-being of applied sport psychologists from both academic and applied backgrounds. The research questions included: (a) *What is the general state of work-based well-being among applied sport psychologists?* (b) *What is the prevalence and cause(s) of burnout among applied psychologists?* (c) *What impact does working at the Olympic and/or Paralympic Games have on the work-based well-being of applied sport psychologists?* Interviews were conducted to examine practitioners' experiences and their use of social support. The study also included a longitudinal investigation of the potential effects of the Olympic and/or the Paralympic Games on practitioners' well-being using a survey. The survey included the following measures: The Maslach Burnout Inventory (MBI; Maslach et al., 1997), The Utrecht Work Engagement Scale (UWES; Schaufeli & Bakker, 2003), The Life Orientation Test, Revised (LOT-R; Scheier et al., 1994), the PANAS Scale (Watson et al., 1988), and the Passion Scale (Vallerand et al., 2003). McCormack (2019) highlighted that the use of both quantitative and qualitative methodologies allowed for a greater perspective on the experiences of sport psychologists. One potential limitation, however, was that a majority of participants worked in a clinical or counseling setting, which may offer different experiences than those who work in academia or applied settings.

Fifty-one participants provided informed consent to participate via an online survey from a target sample of 80. Thirty practitioners (18 males and 12 females) agreed to participate in follow-up interviews. Inclusion criteria included (a) practitioners currently accredited or certified as a sport psychologist by a relevant sport psychology organization (i.e. Association of Applied Sport Psychology [AASP]) and (b) working within the high performance environment (have attended an international competition such as the Olympics or Paralympics, World Cup, European Cup, Pan-American or the Commonwealth Games in the

role of sport psychologist or have worked with athletes who have competed at this level). Of the participants, thirteen were accredited in North America, eight in the United Kingdom, five in Australia, and four in Ireland, and all engaged in applied work. Four reported 100% of their time was dedicated to applied work, while others identified other work as teaching, research, and/or administration.

McCormack (2019) found that all participants had experienced burnout during their careers. For those psychologists, the intensity of burnout was offset by social support. Social support led to fewer perceived experiences of burnout and enabled professionals to recover from stressful work environments. Prolonged exposure to increased job demands, such as those experienced at the Olympic/Paralympic Games, may put professionals at greater risk of experiencing burnout. Participants reported taking a minimum of a month to feel fully recovered from their experiences at the Games. Knowing how burnout impacts applied sport psychologists' well-being is important because it can lead to depression (Hakanen & Schaufeli, 2012), fatigue, physical discomfort, insomnia, overexcitement, negative feelings, and decreased productivity at work (Bernier, 1998). Furthermore, participants commonly engaged in workaholic tendencies regardless of the environment in which they worked (i.e., academia, applied, counseling/clinical) and invested themselves deeply into their jobs. According to Sonnentag et al. (2010), the inability to detach from work is negatively associated with well-being through emotional exhaustion and need for recovery. Because applied sport psychologists may be required to be "on" at all times, they may have more difficulty achieving work-life balance (McCormack, 2019).

Many SPP professionals are former athletes who may work with an athlete whose sport is one the professional played. As such, overidentification with a client may stem from past dreams of the professional and may unconsciously begin to view themselves as the athlete (Andersen et al., 2000). Prior athletic experiences may also increase the risk for experiencing mental health issues. Specifically, professionals' use of maladaptive coping strategies during their athletic careers could potentially be detrimental to their well-being later in life if those issues were not addressed (McCormack, 2019). The sport environment has proven to be stress-inducing for athletes (Fletcher & Hanton, 2003), coaches (Thelwell et al., 2008), and parents (Harwood & Knight, 2009). Given the workload and responsibilities

of the sport and performance psychology professionals, the well-being of this population must also be examined.

Perfectionism

Perfectionism Defined. Perfectionism is considered a multi-dimensional personality trait in which an individual sets excessively high personal standards of performance (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). While striving for high standards is not necessarily a negative trait in itself, perfectionism is not considered a healthy pursuit of excellence or high standards, rather a "compulsive drive to achieve flawlessness" (Burns, 1980, p. 38). Researchers have conceptualized perfectionism into productive and counterproductive forms, which will be further defined and discussed.

Hamachek (1978) separates perfectionism into two independent dimensions, normal and neurotic perfectionism, which highlights the distinction between positive and negative perceptions of the trait. The first dimension, normal perfectionism, is characterized by setting high standards and feeling free to make mistakes. Neurotic perfectionism, however, is characterized by setting high standards and allowing little space for mistakes (Hamachek, 1978). Neurotic perfectionists hold irrational concerns about making mistakes, fear receiving negative evaluations, and often react poorly to imperfection (Stoeber & Madigan, 2016). Researchers have also used terms such as healthy versus unhealthy (Adler, 1956), adaptive versus maladaptive (Rice et al., 1998), and positive striving versus maladaptive evaluation concerns (Frost et al., 1990) to describe what Hamachek (1978) identified as normal or neurotic perfectionism. For the purpose of coherence, this paper will refer to the two dimensions of perfectionism as adaptive and maladaptive.

Utilizing Hamachek's (1978) conceptualization, Stoeber and Otto (2006) further categorized the adaptive and maladaptive facets of perfectionism. The adaptive characteristics, referred to as perfectionistic strivings (Stoeber & Otto, 2006), align with adaptive qualities such as diligence, industry, and perseverance (Flett & Hewitt, 2016). Furthermore, perfectionistic strivings have been related to greater subjective well-being in regards to positive affect and satisfaction with life (Stoeber & Otto, 2006). While adaptive perfectionism has some positive characteristics, it has been associated with both

better and worse health and well-being (Sirois & Molnar, 2016). Additionally, Besser and colleagues (2004) found that perfectionistic strivings are a risk for greater psychological maladjustment following failure. The compulsive drive to achieve excellence and cognitive inflexibility causes perfectionists to struggle with coping with challenges.

Maladaptive perfectionists have a tendency to feel that tasks are never completed or completed well enough. These individuals demand of themselves a higher level of performance than is possible to meet (Hamachek, 1978). When standards are not met, they tend to dwell on these shortcomings, often feeling inferior and under rewarded (Burns, 1980). The negative facets associated with this type of perfectionism are known as perfectionistic concerns (Stoeber & Otto, 2006). Perfectionistic concerns reflect one's self-deprecating appraisal processes, which are considered a form of psychological maladjustment (Hall, 2019). Maladjustment problems associated with perfectionism include anxiety (Frost & DiBartolo, 2002), depression (Flett & Hewitt, 2006), and eating disorders (Bardone-Cone et al., 2007). Hill and colleagues (2018) also found perfectionistic concerns to be related to a lower sense of self-value, specifically lower self-esteem and higher self-criticism.

The psychological implications associated with perfectionism lie in critical evaluation tendencies of oneself, rather than setting excessively high standards (Frost et al., 1990). Slaney and colleagues (2002) confirmed that high personal standards alone are not related to the problematic areas of perfectionism, rather one's responses to their perceptions about failing to meet those standards. As described previously, perfectionism is made up of both positive and negative characteristics (Slaney et al., 2002). Additionally, perfectionism includes both interpersonal and intrapersonal aspects that are critical to understanding adjustment difficulties (Hewitt & Flett, 1990). The interpersonal components of perfectionism refer to the ways in which one's social functioning or perceptions of the social environment are impacted. For example, perfectionist's behaviors and attitudes towards others may be more hostile or submissive (Habke & Flynn, 2002). Intrapersonal components represent attitudes and behaviors towards oneself, such as motivation or goal orientations (Hewitt & Flett, 1990). These constructs help establish

perfectionism as a multi-dimensional concept that lies on a continuum, which requires further elaboration.

Dimensions of Perfectionism

Hewitt and Flett. Research encompasses several constructs of perfectionism, with varying evaluative tendencies. Hewitt and Flett (1990) define perfectionism as a multi-dimensional concept comprising both personal and social factors. They focus on three primary dimensions in their conceptualization of perfectionism. The first dimension, self-oriented perfectionism, involves self-directed behaviors, such as "exacting standards for oneself and stringently evaluating and censuring one's own behavior" (Hewitt & Flett, 1990, p. 457). Self-oriented perfectionism has been associated with anxiety (Flett et al., 1989), subclinical depression (Hewitt & Flett, 1990, Hewitt et al., 1993) and low self-regard (Hoge & McCarthy, 1983). The self-oriented perfectionist's main motivation is to achieve perfection in one's endeavors and avoid failure (Hewitt & Flett, 1990).

The second dimension of Hewitt and Flett's (1990) multidimensional construct is other-oriented perfectionism. Other-oriented perfectionists have unrealistic expectations for significant others and stringently evaluate others' performance (Hewitt & Flett, 1990). While self-oriented perfectionism is focused more heavily on intrapersonal feelings, other-oriented perfectionism is related to interpersonal frustration towards others. Research has demonstrated other-oriented perfectionism as the most relevant domain of interpersonal functioning (Sirois & Molnar, 2016; Stoeber, 2014). Other-oriented perfectionism often leads to blaming, difficulties trusting, and feelings of hostility towards others (Hewitt & Flett, 1990). While other-oriented perfectionism can be associated with positive characteristics such as leadership abilities, it can also lead to interpersonal struggles (Hewitt & Flett, 1990). For example, Stoeber (2014) found participants who scored high in other-oriented perfectionism were less interested in helping and supporting others. The study revealed that other-oriented perfectionism showed negative relationships with nurturance, intimacy, and social development.

The last dimension of the Hewitt and Flett (1990) model, socially-prescribed perfectionism, entails one's "belief or perception that significant others have unrealistic standards of them, evaluate them

stringently, and exert pressure on them to be perfect" (Hewitt & Flett, 1990, p. 457). The perceived need

to attain standards and expectations is directed towards avoiding disapproval by others (Hewitt & Flett,

1990; Stoeber & Otto, 2006). Socially prescribed perfectionism results in a variety of negative

consequences because standards set by others are perceived as excessive and uncontrollable (Hewitt &

Flett, 1990). Furthermore, this type of perfectionism is correlated with a fear of negative social

evaluation, a need for approval from others, and an external locus of control (Hewitt & Flett, 1990).

Frost, Marten, Lahart, & Rosenblate. Frost and colleagues (1990) developed a second

multidimensional construct of perfectionism that is commonly used. Their conceptualization is made up

of five dimensions, which capture the overly critical evaluative tendencies of perfectionists. The first of

these dimensions is Personal Standards (PS), the most prominent element of perfectionism (Hamachek,

1978; Burns, 1980; Frost et al., 1990). PS represents the excessively high personal standards of

performance and the critical evaluation tendencies associated with those standards. The first evaluative

tendency is Concern Over Mistakes (COM), which explains how maladaptive perfectionists approach

goals by fear of failure rather than for achievement (Hamachek, 1978). Sagar and Stoeber (2009) found

that COM shows a positive relationship with fear of experiencing shame and embarrassment with

negative affect after failure in sport competitions. In the perfectionist's eyes, "performance must be

perfect or it is worthless" (Frost et al., 1990, p. 451).

A second evaluative tendency is Doubt about Actions (DA). DA relates to the vague sense of

doubt related to the quality of one's performance (Frost et al., 1990). Frost and colleagues (1990)

emphasize that feelings of doubt do not have to do with the recognition or evaluation of mistakes, rather

the uncertainty regarding if a task is done *or* done well enough. Reed (1985) compares this dimension of

perfectionism with obsessive-compulsiveness, which reflects one's reluctance to complete a task if not

done perfectly.

Furthermore, perfectionists place considerable value on parental expectations and evaluations of

them (Frost et al., 1990). In childhood, perfectionists likely grew up in environments where love and

approval were conditional and any mistakes put them at risk for rejection or loss of love (Frost et al.,

1990). Hamachek (1978) described this element of perfectionism as conditional positive approval, which causes individuals to over-value performance and under-value the self. According to Frost and colleagues (1990), for the perfectionist, "self-evaluations of performance are inextricably tied to assumptions about parental expectations and approval or disapproval" (p. 451). Thus, Parental Expectations (PE) and Parental Criticism (PC) represent two additional components of perfectionism.

The fifth and final dimension, Organization, characterizes perfectionists' over-emphasis on precision, order, and organization (Frost et al., 1990). While this component is not necessarily related to setting excessively high standards or evaluation of those standards, it represents how perfectionists function in their daily lives. Hollender (1965) describes the perfectionist to be under considerable pressure and desires exact order, noting, "There is a place for everything and everything must be in its place" (p. 96). This type of energy expenditure makes the perfectionist appear to be productive, however, is rooted in the desire to perform perfectly and please others (Hollender, 1965).

Slaney, Rice, Mobley, Trippi, and Ashby. Slaney and colleagues (2001) sought to highlight the maladaptive dimension of perfectionism, which was not included in previous conceptualizations. The concept of discrepancy "seems integral to perfectionism and phenomenologically operationalizes the excessive aspect of perfectionism" (Slaney et al., 2001, p. 132). As such, incorporating discrepancy into the conceptualization of perfectionism helps analyze the difference between one's standards and perceptions and one's actual performance. Furthermore, having high standards has been established as a common characteristic of perfectionism (Burns, 1980; Frost et al., 1990; Hamachek, 1978; Hewitt & Flett, 1990). Lastly, orderliness, neatness, or organization are also integral to the definition of perfectionism, when combined with high standards (Slaney & Ashby, 1996). Thus, their conceptualization incorporates high standards, order, and discrepancy as sub-dimensions. This description is one that supports both the negative and positive aspects of perfectionism, while emphasizing the critical evaluative tendencies associated with it. Specifically, this conceptualization highlights discrepancy as a factor that "operationalizes the excessive aspect of perfectionism contained in the dictionary definitions"

(Slaney et al., 2001, p. 132). Thus, this definition accounts for the ambivalence between high standards and perceived performance.

As reviewed, perfectionism is characterized by the setting of excessively high standards for oneself and the overly critical evaluation of those standards. Research confirms perfectionism as a multi-dimensional construct encompassing both interpersonal and intrapersonal difficulties (Hewitt et al., 2003). Curran & Hill (2016) found that multidimensional perfectionism in college students has increased overtime, indicating that young individuals perceive others to be more demanding of them, expect more of others, and hold themselves to excessively high standards. Thus, as college students graduate and enter into the workforce, it may be that perfectionism exists in professional work environments as well.

Perfectionism Measures

Prior to the development of perfectionism as a multidimensional concept, only portions of perfectionism were measured. The Dysfunctional Attitudes Scale (Burns, 1980), the Irrational Beliefs Test (IBT; Jones, 1968), and the Eating Disorders Inventory (EDI; Garner et al., 1983) were used to measure broader constructs of perfectionism, each with a different emphasis. None of these scales captured the multidimensionality of perfectionism, however, which led to the development of three primary measures of perfectionism.

Hewitt and Flett (1991) developed the Multidimensional Perfectionism Scale (Hewitt-MPS) to assess unrealistic expectations for oneself (self-oriented perfectionism), unrealistic expectations for others (other-oriented perfectionism), and perceptions of others' expectations of oneself to be perfect (socially prescribed perfectionism). The MPS is a 45-item measure of the three dimensions of perfectionism on a 7-point Likert scale (1 = *strongly agree* to 7 = *strongly disagree*). The Hewitt-MPS measures high personal standards (e.g., "*One of my goals is to be perfect in everything I do*") as well as social expectations for others (e.g., "*I have high expectations for the people who are important to me*") and pressure from external sources (e.g., "*My family expects me to be perfect*").

The Hewitt-MPS and its three subscales demonstrated adequate levels of reliability and validity across clinical populations. Test-retest data for 49 clinical outpatients showed that MPS dimensions

represent stability for each trait, with correlations being .69, .66, and .60 for self-oriented, other-oriented, and socially prescribed perfectionism ($p < .05$). For a small student sample, test-retest coefficients were .88 for self-oriented perfectionism, .85 for other-oriented perfectionism, and .75 for socially prescribed perfectionism (Hewitt & Flett, 1991a). Bonferroni corrections revealed significant relationships between self-oriented perfectionism and high self-standards ($r = .62$), self-criticism ($r = .47$), overgeneralization ($r = .55$), and perseveration ($r = .50$) ($p < 0.001$). Additionally, self-oriented perfectionism was related significantly to the Frost-Multidimensional Perfectionism Scale (F-MPS) measures of concern over mistakes ($r = .52$), personal standards ($r = .64$), and parental expectations ($r = .47$) ($p < 0.001$). Furthermore, in a clinical sample of 387 patients (194 male and 193 female), Hewitt and Flett (1991b) found gender differences in other-oriented perfectionism with men scoring higher than women (F(1, 385) = 13.68, $p < .001$). However, in this same sample, women scored higher on socially-prescribed perfectionism (F(1, 385) = 8.67, $p < .01$). These scores highlight the importance of gender differences in perfectionism. Overall, the MPS proves to be a reliable measure of perfectionism in both clinical and nonclinical populations.

Frost and colleagues (1990) developed another Multidimensional Perfectionism Scale-Frost (Frost-MPS) to measure six dimensions of perfectionism. The Frost-MPS was developed to capture individuals' high standards of performance as well as overly critical evaluations of behaviors associated with those standards. The evaluative tendencies include Personal Standards (PS), Concern Over Mistakes (COM), Doubt about Actions (DA), Parental Expectations (PE), Parental Concerns (PC), and Organization (O). The Frost-MPS is composed of 35 questions on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Example questions from the Frost-MPS include "*If I fail at work or school, I am a failure as a person*" and "*Only outstanding performance is good enough*".

Reliability analysis showed that the Frost-MPS had a Cronbach alpha of 0.91 demonstrating the reliability coefficients for each subscale revealed consistent internal factor structure (CM = .91, PS = .81, PE = .82, PC = .77, D = .79, O = .94). Concern Over Mistakes is the most highly correlated component of

the Frost-MPS and previous measures of perfectionism (Burns, 1980; Garner et al., 1983). Organization was the least highly correlated. Thus, results indicate that COM is a central component of perfectionism.

Frost and colleagues (1990) also tested whether perfectionism related to a broad range of symptoms of psychopathology. A total of 72 undergraduate female students were given the 35-item MPS-F, Brief Symptom Inventors (BSI; Derogatis & Melisaratos, 1983), the Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976), and the Situational Guilt Scale (Klass, 1987). Results demonstrated that those high in perfectionism experience high frequency and wider symptoms of psychopathology than those low in perfectionism.

There is substantial overlap between Frost et al.'s (1990) and Hewitt and Flett's (1991) perfectionism scales (Frost et al., 1993). Frost et al. (1993) conducted correlation and factor analyses to test the magnitude of differences between measures of perfectionism and depression/dysphoria. Results showed that the Total Perfectionism score of the Frost-MPS reflected consistency with both Self-Oriented and Socially-Prescribed perfectionism measures of the Hewitt-MPS. Furthermore, Personal Standards (PS) was most closely related to Hewitt and Flett's Self-Oriented Perfectionism scale, which demonstrates an emphasis on self-standards and expectations (Frost et al., 1993). The Socially-Prescribed Perfectionism scale reflects several dimensions of the Frost-MPS, including parental expectations, parental criticism, and concern over mistakes. Results from the factor analysis shows that Personal Standards, Organization, Self-Oriented Perfectionism, and Other-Oriented Perfectionism reflect more positive aspects of perfectionism. Those scoring high in this factor may be adaptive achievers, or healthy perfectionists. concern over mistakes, parental criticism, parental expectations, doubts about actions, and socially-prescribed perfectionism reflect the negative aspects of perfectionism. The central factor being evaluative concerns, the scales reflect personal concerns over failure and concerns about others' criticism.

Moreover, Slaney and colleagues (2001) developed the Almost Perfect Scale-Revised (APS-R) to highlight both the negative and positive aspects of perfectionism. However, one key difference in the APS-R from the other measures is the focus on defining the maladaptive dimension of perfectionism. As mentioned previously, one of the key determinants of maladaptive perfectionism is an overly critical

evaluation of oneself following failure. According to Slaney and colleagues (2001), the concept of discrepancy "seems integral to perfectionism and phenomenologically operationalizes the excessive aspect of perfectionism" (p. 132). Building on the original Almost Perfect Scale (APS; Slaney & Ashby, 1996) and research conducted by Frost and colleagues (1990) and Hewitt and Flett (1991), researchers determined dimensions that best represented the negative aspects of perfectionism (Slaney et al., 2001). Given that perceived discrepancy, or difference between one's standards and one's performance, is the central component of the APS-R, researchers wanted to ensure it was captured in the development of the scale.

The initial version of the APS-R included 39 total items, with six measuring order, 13 measuring high standards, and 20 measuring discrepancy. Factor analysis was conducted to validate and cross-validate the final measure. The final APS-R was reduced to 23 items, seven measuring standards, 4 measuring order, and 12 measuring discrepancy. Items are measured on a 7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*). Example questions from the APS-R include "*My best just never seems to be good enough for me*" and "*I think things should be put away in their place*".

The structure coefficients of each item of the APS-R, High Standards, Order, and Discrepancy, ranged from .42 to .88. Cronbach's alphas indicated internal consistency for each of the subscales (.85 for High Standards, .86 for Order, and .92 for Discrepancy). Rice and colleagues (2007) found that the High Standards subscale of the APS-R was correlated with self-oriented perfectionism (.68) and personal standards (.65) in a sample of 207 undergraduate students.

To assess validity Slaney and colleagues (2001) examined correlations between subscales of the APS-R and those of the Hewitt-MPS and Frost-MPS in two samples. One sample composed of 173 participants (74 male, 89 female, and 10 chose not to report) ranging in ages 17-43 years (*M* = 19.23 years). The second sample totaled 174 participants (50 male, 121 female, and 3 chose not to report) with ages 17-51 years (*M* = 20.42). Researchers found significant correlations between the High Standards subscale of the APS-R and the Hewitt-MPS Self-Oriented subscale in each sample (.64 and .55) (Slaney et al., 2001). High Standards was significantly correlated with personal standards subscale of the Frost-

MPS (.64). Furthermore, the APS-R Discrepancy subscale significantly correlated with the self-oriented (.31 and .23) and socially-prescribed (.43 and .45) subscales of the Hewitt-MPS. The Discrepancy subscale was significantly correlated with concern over mistakes (.55) and doubts about actions (.62) of the Frost-MPS (Slaney et al., 2001).

Rice and colleagues (2014) created a shorter item set from the APS-R to measure two major dimensions of the scale: High Standards and Discrepancy. The Short Almost Perfect Scale (SAPS), similar to the APS-R, consists of eight items on a 7-point Likert scale 1 = *strongly disagree* to 7 = *strongly agree*). An example question for the High Standards subscale is "*I have high expectations for myself*", while an example question for Discrepancy is "*Doing my best never seems to be enough*".

Authors aimed to produce a shortened version of the APS-R through testing invariance between men and women, evaluating association between scores derived from the measure, identifying criterion indicators, and applying a factor modeling approach to examine both perfectionists and non-perfectionists (Rice et al., 2014). In Study I, participants included 749 undergraduate students (500 female, 239 male, and 10 missing gender data), ages 18-26 years (M = 19.63). Four Standards items and four Discrepancy items made up the SAPS and provided substantial fit for the data ($\chi 2(19, N = 749) = 68.52, p < .0001$). Study II was conducted to replicate reliability and examine validity of the SAPS found in the previous study. Three hundred and forty undergraduate students (264 female, 67 male, and 9 missing gender data) participated in the study. Reliability scores were comparable to Study 1 (p = .85 and .87 for standards and discrepancy). Results from Study II confirmed that discrepancy is a central component of maladaptive perfectionism (Rice et al., 2014). Furthermore, Standards and Discrepancy were significantly associated with academic performance, depression, and emotional regulation strategies. One potential limitation of the SAPS is its lack of generalizability to more gender-balanced populations, as well as those outside of university settings. Furthermore, because the population samples in the above studies were largely White (60.1% in Study I and 54.7% in Study II), cross-cultural examinations may help conceptualize perfectionism in diverse samples.

Perfectionism and Well-Being

According to Sirois & Molnar (2016), "...the potential benefits of understanding how, why, and when perfectionism may confer risk or resilience for health and well-being can be far-reaching" (p. 1). Flett and colleagues (2016) reviewed research on perfectionism and health and concluded three key themes. First, in regards to health outcomes, the costs of perfectionism seem to far outweigh the benefits. Second, the mind and body connection is particularly relevant in seeking to better understand the motivation behind perfectionistic tendencies. Lastly, highly stressed perfectionists do not respond well to pressure, but have a tendency to take on too much and respond to adversity by striving even more to be perfect (Flett et al., 2016). Thus, it is important to remain cognizant of the value in person-centered research to grasp how personality and situational factors impact perfectionists individually (Flett et al., 2016). Furthermore, according to Lazarus and Folkman (1984), coping behaviors, which help regulate an individual's physiological stress response, play an important role in maintaining health. As perfectionism is connected to maladaptive coping and health behaviors (Dunkley et al., 2016), perfectionists may experience symptoms of poor psychological, physical, and social well-being.

Psychological. Perfectionists are thought to "instigate daily stress for themselves" as a result of self-critical evaluations and focus on negative outcomes (Dunkley et al., 2016, p. 160). Self-critical perfectionists, for example, tend to engage in avoidant coping strategies, making it more difficult to address stress and stress-related situations in their lives (Dunkley et al., 2000). Without directly addressing stressors, perfectionists make themselves more susceptible to additional stressors (Dunkley et al., 2003). As such, one major contributing factor to perfectionism's impact on psychological well-being is its relationships to stress.

Molnar and colleagues (2016) refer to stress and coping as dynamically and reciprocally linked concepts. In the Stress and Coping Cyclical Amplification Model of Perfectionism in Illness (SCCAMPI), Molnar and associates (2016) highlight the concept that perfectionists experience poorer adjustment to chronic illness due to their elevated stress response and tendency to engage in maladaptive coping behaviors. According to Molnar et al. (2016), "...a cyclic amplification of stress through the interplay of

stress and coping can put the perfectionist at even further risk for the harmful effects of stress" (p. 82). The authors note that ineffective coping may amplify stress and activate the desire to engage in more maladaptive coping efforts.

Furthermore, perfectionists are more apt to ruminate, worry, and overthink stressful life situations (Flett et al., 2016). Flett and colleagues (2016) analyzed how worry and rumination, comparable forms of cognitive perseveration, can impair well-being and exacerbate emotional distress. Cognitive perseveration is defined as "the repeated or chronic activation of the cognitive representation of one or more psychological stressors" (Brosschot et al., 2006, p. 113). In other words, cognitive perseveration can be defined as various forms of overthinking. Flett and colleagues (2016) note that perfectionism "is associated with multiple forms of cognitive perseveration, including some types of cognitive operations, processes, and products that are quite unique to perfectionism" (p. 122). Cognitive perseveration may present itself as ruminating about the need to be perfect or specific mistakes, setting extreme personal standards, and comparing oneself to others (Flett et al., 2016). Thus, cognitive perseveration is an important element of perfectionism, particularly in regard to the effect it may have on an individual.

Chronic cognitive perseveration stems from the constant desire to be perfect, which can lead to impaired cognitive functioning (Flett et al., 2016). For example, those who possess higher levels of self-critical perfectionism tend to engage in harsh self-evaluations and magnify the negative components of their lives (Dunkley et al., 2016; Dunkley et al., 2003). Furthermore, the stress brought about by chronic overthinking or ruminating can cause perfectionists to be more vulnerable to psychological distress (Aldao et al., 2010; Lyubomirsky et al., 2015) than non-perfectionists. Moreover, evaluative concerns related to perfectionism are also intertwined with a wide variety of anxiety symptomatology, including social anxiety, general state or trait anxiety, and obsessive-compulsive disorder (OCD) (Burgess & DiBartolo, 2016). Avoidance can cause anxiety to remain constant or intensify in stressful situations (Barlow, 2000), which means that avoidant-coping in response to perfectionistic concerns may also further exacerbate anxiety symptoms (Burgess & DiBartolo, 2016).

Given the relationship between perfectionism and multiple forms of cognitive distress, individuals' overall mood states and perceptions of self may also be impacted. The maladaptive aspects of perfectionism, specifically high levels of negative affect, worry, anxiety, and distress, could be indicators of poor well-being (Sirois & Molnar, 2016). Studies have confirmed that mood disturbances associated with perfectionism can predispose individuals to have lower levels of self-esteem and higher levels of depression than non-perfectionists (Grzegoreketal et al., 2004; Rice & Slaney, 2002).

Rice and Slaney (2002) conducted a pair of studies to analyze the differences in perfectionist groups on adjustment, affect, anxiety, and self-esteem. In the first study, they identified groups of perfectionists (adaptive and maladaptive) and non-perfectionists amongst 258 undergraduate students (50 male, 205 female, and three missing data for gender). Participants were given the Almost Perfect Scale-Revised (APS-R; Slaney et al., 1996), Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965), Positive and Negative Affect Schedule (PANAS; Watson et al., 1998), Anxiety (Slaney & Johnson, 1992), and GPA. Adaptive perfectionists reported significantly higher scores on positive self-esteem and affect, while maladaptive perfectionists reported significantly more problematic adjustment. Furthermore, the authors conducted a second study to extend potential implications regarding perfectionism and student adjustment. Three hundred and seventy-five undergraduate students (290 female and 85 male) participated in the second study. Adaptive perfectionists reported significantly higher average scores on self-esteem and positive adjustment than the other groups. Conversely, maladaptive perfectionists reported higher negative affect scores than adaptive perfectionists. Therefore, differentiating between maladaptive and adaptive forms of perfectionism may be especially important in enhancing one's well-being.

Grzegoreketal and colleagues (2004) replicated the aforementioned studies and compared three clusters of perfectionists (adaptive, maladaptive, and non-perfectionists) on self-esteem, depression, GPA, and GPA satisfaction. Participants were 273 undergraduate students (72 male and 201 female). Ages of participants ranged from 17 to 54 years ($M = 19.87$). Participants were given the APS-R (Slaney et al.,

1996), Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976), Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965), and asked about GPA and GPA satisfaction.

Results indicated that maladaptive perfectionists had higher scores on the self-critical subscale of the DEQ than adaptive perfectionists. Furthermore, adaptive perfectionists had significantly higher scores on the RSE than both maladaptive and non-perfectionists. Maladaptive perfectionists were also less satisfied with their GPA than adaptive perfectionists. Similar to the results of Slaney and colleagues (2002), this study confirms that maladaptive perfectionists tend to set extremely high standards for themselves and are overly critical of themselves when failing to meet those standards (Frost et al., 1990; Hill et al., 2018). These studies also echo the concept that maladaptive perfectionists have difficulty adjusting following failure than adaptive perfectionists (Besser et al., 2004). It is clear from each of these studies that maladaptive perfectionists respond poorly to failure, as indicated by lower GPA satisfaction, lower scores on self-esteem, and higher negative affect. The cyclical nature of maladaptive perfectionism and its impact is concerning. Given that maladaptive perfectionists engage in more self-critical evaluations, have lower levels of self-esteem, and are more prone to stress, it may be difficult to find an end to the means of the cycle, thus negatively impacting their well-being.

Physical. The impact of perfectionism on overall well-being is not limited to only psychological variables. Indeed, physical health is a major component of one's overall well-being, yet the physical impact of perfectionism has been understudied in perfectionism literature (Sirois & Molnar, 2016). Recently, there has been some evidence connecting perfectionism to positive health behaviors (Sirois, 2016), adjustment to physical illness (Molnar et al., 2016), and development of chronic illnesses such as chronic fatigue syndrome (Kempke et al., 2016). However, most literature has shown the relationship between perfectionism and negative health outcomes. According to Flett et al. (2016), "people [perfectionists] are holding themselves up to exceptionally high standards and paying a physiological price for it…" (p. 41).

Distinguishable physical health problems associated with perfectionism may include ulcers (Mittlemann & Wolff, 1942) and gastrointestinal issues (Mahoney et al., 1949; White et al., 1939),

migraine headaches (Alvarez, 1947; Marcussen & Wolf, 1949), and cardiovascular illnesses (Duncan et al., 1950; Friedman & Rosenham, 1974). A commonality amongst physical difficulties faced by perfectionists, similar to the factors discussed above, is stress. How stress is perceived and handled can amplify various health problems for perfectionists (Flett et al., 2016). Furthermore, stress, when combined with dispositional characteristics, tends to create or exacerbate health issues (Flett et al., 2016). For example, individuals who report a lower sense of control over life outcomes are at greater risk of extended health problems (Johnson & Krueger, 2005; Taylor et al., 2000). Additionally, Flett et al. (1995) demonstrated that perfectionism is typically associated with increased desires for control. Thus, a sense of low personal control associated with perfectionism may entice greater stress and poorer overall health (Molnar et al., 2016).

Healthy eating, regular physical activity, and stress management are examples of health-promoting behaviors that encourage life-long health and self-regulation (Sirois, 2016). Rudolph and colleagues (2007) suggested that perfectionism may be a liability for self-regulation due to cognitive distortions and deficits in coping resources associated with perfectionism. Sirois (2016) developed the Self-Regulation Resource Model (SRRM) to explain the relationships between health-promoting behaviors and perfectionism dimensions. The model includes both perfectionistic concerns (PC) and perfectionistic strivings (PS). Negative emotions, positive emotions, and future time orientation are three factors believed to understand how perfectionism relates to health-promoting behaviors (Sirois, 2016). A community sample of 181 participants completed a survey including a range of health promoting behaviors, the Hewitt-MPS, a measure of state negative affect, and a measure of future orientation. Results indicated that PC perfectionism was associated with lower positive affect, higher negative affect, and fewer health-promoting behaviors (Sirois, 2016). The SRRM can help researchers understand if and how perfectionism dimensions influence health-promoting behaviors. If perfectionism dimensions, such as PC, deplete self-regulating, or coping resources, then individuals may not be able to manage ongoing stress, particularly stress associated with chronic illness (Sirois, 2016). These findings are particularly

relevant to individuals' overall well-being because perfectionism may pose health risks and further exacerbate physical illnesses and symptoms.

      Social. Positive relationships are vital to individuals' overall well-being (Baumeister & Leary, 1995). The interpersonal aspects of perfectionism, however, may present difficulties to the social components of well-being. Perfectionism is associated with both social problems and psychopathology (Sherry et al., 2016). Interpersonal distress, whether self-oriented or by others, may impact relationships indirectly through intrapersonal pathology (Habke & Flynn, 2002). Perfectionistic strivings are associated with stress, anorexia nervosa and other eating disorders, body image distortions, and suicide (Cockell et al., 2002). Furthermore, perfectionism can also affect relationships by limiting social contacts (Habke & Flynn, 2002). Blatt (1995) found that perfectionists are more likely to avoid relationships out of fear or failing to be perfect or being hurt. One mechanism to better understand the relationship between perfectionism and social disconnection is the Social Disconnection Model (SDM; Hewitt et al., 2006).

      The SDM describes how perfectionism creates psychopathology through negative social behaviors, cognitions, and outcomes (Sherry et al., 2016). The SDM incorporates four main relationships: socially-prescribed perfectionism, objective and subjective social disconnection, and interpersonal hostility and sensitivity (Hewitt et al., 2006). Recently, Sherry and colleagues (2016) proposed an expanded version of the SDM to include perfectionistic strivings, other-oriented perfectionism, personality-dependent mediators, personality-independent moderators, and multifinality.

      Authors suggested individuals high in perfectionistic strivings are driven to be perfect, which often leads to an imbalanced lifestyle (Sherry et al., 2016). Behaviors of someone high in perfectionistic strivings may include over-checking, avoiding mistakes, and compulsive over-working, which may limit opportunities for social interactions (Graham et al. 2010). Furthermore, other-oriented perfectionists may engage in behaviors that are strongly other-oriented and are more hostile and dominant (Habke & Flynn, 2002). Likewise, other-oriented perfectionists may act more hostile towards, are dominant around, or disappointed with others (Sherry et al., 2016).

In order to clarify the nature of interpersonal problems, the expanded SDM also includes personality-dependent mediators and personality-independent moderators. Personality-dependent mediators are things perfectionists do to themselves, whereas personality-independent moderators are things that happen to perfectionists (Sherry et al., 2016). These dimensions help better conceptualize how and why perfectionists experience problems (Sherry et al., 2016) and fall in line with Hewitt and colleagues (2016) suggestion to follow a person-centered approach to understanding perfectionists.

Given the understanding of the SDM, it becomes clear that perfectionists have a tendency to avoid or withdraw from social interactions. Socially-prescribed perfectionism is significantly associated with tendencies to be controlled and feel overly responsible in relationships. These tendencies may cause the perfectionist to be submissive and nonassertive in relationships, presenting in social anxiety and withdrawal (Flett et al., 2001). Moreover, socially-prescribed perfectionists report feeling scared of criticism, looking foolish, and authority figures (Blankenstein et al., 1993). Nielsen and colleagues (1997) also found that socially-prescribed perfectionism predicts low mental health stigma tolerance and less openness to sharing details about their lives. Other-oriented perfectionists may engage in behaviors reflective of demanding perfection from others, leading to a conflictive relationship style (Sherry et al., 2016; Hewitt & Flett, 1991). Thus, other-oriented perfectionists may struggle in interpersonal relationships because they place too much stress on significant others (Sherry et al., 2016). These studies support the notion that perfectionism can create difficulties in social interactions across perfectionism dimensions (Habke & Flynn, 2002).

Taking into account the stress-generating tendencies of perfectionists, individuals with low levels of perceived social support may be more prone to maladaptive coping mechanisms (Dunkley et al., 2016). In addition, perfectionism causes individuals to be more vulnerable to experiencing distress (Dunkley et al., 2000). Thus, it is likely that perfectionists withdraw and isolate themselves from significant others to focus more on themselves (Dunkley et al., 2000). While perfectionism remains relatively person-centered (Flett et al., 2016), it is important to note how perceived social support can either exacerbate or alleviate perfectionism symptoms.

Dunkley and colleagues (2000) found that the relationship between personal standards and self-criticism dimensions of perfectionism and distress for those who perceived more negative perceptions of social support than those who perceived more positive perceptions. Four hundred and forty-three undergraduate students (136 male and 307 female) with a mean age of 20.43 years were surveyed. Participants were given measures of evaluative concerns and personal standards perfectionism from the Hewitt-MPS and Frost-MPS, the COPE Inventory (COPE; Carver et al., 1989, the Social Provisions Scale (SPS; Cutrona & Russell, 1987), the General, Academic, and Social Hassles Scale for Students (GASHSS; Blankstein & Flett, 1993), and the Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991). Researchers developed a mediational model that structured hassles, coping, and perceived social support as key mechanisms between evaluative concerns perfectionism and distress.

Results showed that evaluative concerns perfectionism correlated with hassles, avoidant coping, and social support. Each of these mechanisms were associated with distress, when controlled for the influence on distress of other variables. Furthermore, researchers found that evaluative concerns perfectionism did not include other maladaptive components. These results suggest that perfectionists experience stressors with greater frequency and duration, which supports the idea that perfectionists tend to instigate stress in their lives (Dunkley et al., 2016; Hewitt & Flett, 1993). This study also highlights perfectionists' tendencies to engage in maladaptive coping styles, such as disengagement and denial, further amplifying their levels of stress. Lastly, perceived available support remains a key mediator in the relation between perfectionism and distress. Authors found a negative correlation between evaluative concerns and the perception that others are able to help (Dunkley et al., 2000). Dunkley and colleagues (2016) suggest that one route to decrease the perceptions of criticism from others and increase perceptions of social support is to develop a more compassionate perspective. In addition, focusing on decreasing daily stress may also help alleviate the evaluative concerns dimension of perfectionism (Dunkley et al., 2000).

Perfectionism in the Work Environment

It has been suggested that perfectionism can manifest in a more incisive and excessive investment in the work environment. Setting high standards for oneself, holding high expectations for others, and perceptions of others evaluations of oneself can be associated with an urge to work excessively and compulsively, otherwise considered workaholism (Falco et al., 2014). Falco and colleagues (2014) attempted to evaluate the psychometric properties of the Hewitt-MPS in Italian workers as well as how each dimension of the scale was associated with workaholism, emotional exhaustion, and professional inefficiency. The study involved 225 workers (141 female and 78 male), in positions such as senior managers, office managers, office workers, administrative officers, and blue-collar workers. Participant ages ranged from less than 30 years old (2.3%; five missing data), 31-50 years old (51.8%), and over 50 years old (45.9%). Participants were given the reduced form of the Hewitt-MPS (Hewitt & Flett, 1991; Cox et al., 2002) composed of 15 items on a 7-point Likert scale, the Dutch Workaholism Scale (DUWAS; Schaufeli et al., 2008), and the Maslach Burnout Inventory General Survey (MBI-GS; Schaufeli et al., 1996).

Results showed that self-oriented perfectionism (SOP; $\gamma = .25$, $p < .01$) and other-oriented perfectionism (OOP; $\gamma = .19$, $p < .01$) were positively correlated with workaholism. However, socially prescribed perfectionism (SOP) was not correlated to workaholism. This suggests that workaholism is mostly linked to individual rather than social aspects. Furthermore, SPP showed a positive direct effect on both emotional exhaustion and professional inefficiency. The authors concluded that "the fear of not living up to the standards of perfection expected by others increases the possibility of developing emotional exhaustion and a lower perception of professional efficiency" (Falco et al., 2014, p. 227). The results of this study echo the literature, which shows that perfectionism, specifically self-oriented perfectionism, is closely linked to maladaptive coping mechanisms in professionals, such as workaholism (Spence & Robbins, 1992; Stoeber et al., 2013).

Childs and Stober (2012) found that socially-prescribed perfectionism increases role stress, inefficiency, and exhaustion over time, indicating SPP may also contribute to stress and burnout in the workplace. Burnout may cause emotional exhaustion, depersonalization or cynicism, and low levels of

personal accomplishment or efficacy (Hill & Curran, 2016). Flett and Hewitt (2020) also found that perfectionism may lead to a workaholic orientation that includes poor work-life balance and neglect of key social relationships. Furthermore, stressful life conditions, opportunities, and realities may not fit a perfectionist's need to achieve at an exceptionally high level and be recognized (Flett & Hewitt, 2020). Thus, closely examining how perfectionism may impact professionals' well-being, may help prevent negative consequences such as workaholism and burnout.

Perfectionism in the Helping Professions

While stress and burnout are not limited only to the helping professions, the difficulties faced by these professionals in their work may increase their susceptibility to experiencing both (Ratliff, 1988). According to Edelwich and Brosdky (1980), one source of stress for helping professionals is the lack of criteria for measuring the degree of therapeutic success. Three additional stressors shared by service professionals are (1) performance of work that is emotionally draining and demanding, (2) personality characteristics, and (3) a person-centered orientation (Pines et al., 1981). Taking into consideration these potential stressors and that perfectionists have a higher tendency to experience stress and engage in maladaptive coping strategies, perfectionistic professionals may be more susceptible to burnout and other work-related stressors (Kinman & Grant, 2022). Individuals with higher levels of perfectionism are more negatively affected by stressors and experience higher levels of anxiety and lower levels of subjective well-being (D'Souza, 2011). The increased pressure for professionals to perform at unrealistically high standards where outcomes may be outside of their control could also be problematic for perfectionistic professionals (Kinman & Grant, 2022). Research thus far has shown that perfectionism is related to perceived stress and burnout in counselor educators (Moate et al., 2016), collegiate coaches (Tashman et al., 2010), clinical psychologists (D'Souza, 2011), and social workers (Kinman & Grant, 2022).

D'Souza and colleagues (2011) examined the relationship between perfectionism, stress, and burnout in 87 clinical psychologists in Australia. Eighty-six percent of the sample was female and 37% were aged 31-40. The results confirmed that stress is a significant indicator of personal, work-related, and client-related burnout. Furthermore, the study also revealed that psychologists who were higher in

perfectionism were more likely to experience increased stress levels (D'Souza et al., 2011). When controlling for age and gender, researchers found a significant relationship between perfectionism and stress (β = .444, p = .000), perfectionism and personal burnout, (β = .247, p = .019), and stress and personal burnout (β = .324, p = .001). The key takeaway from this study is that the influence of perfectionism on both work- and client-related burnout is largely due to the influence of perfectionism on stress (D'Souza, 2011).

Interestingly, differentiating between maladaptive and adaptive perfectionism may highlight differences in the role stress plays on professional burnout. Moate et al. (2016) investigated whether types of perfectionism were differentially associated with stress and various types of burnout in a national sample of counselor educators. One hundred seventy-eight counselor educators participated in the study (71.3% female, 28.1% male, and 0.6% declining to answer). Participants' age ranged from 27-68 years (M = 45.77). Participants completed a survey consisting of the APS-R (Slaney et al., 2001), the Perceived Stress Scale (PSS; Cohen et al., 1983), and the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005). Researchers conducted specific tests for each variable of the PSS, Personal Burnout, Work-Related Burnout, and Student-Related burnout scales.

Researchers created three latent classes consisting of non-perfectionists: maladaptive perfectionists, and adaptive perfectionists. Individuals in the non-perfectionists class (n = 40) were characterized as having low levels of standards (M = 35.95) and medium levels of discrepancy (M = 10.00). Individuals in the second class, or maladaptive perfectionists (n = 28), were characterized as having high levels of both discrepancy (M = 57.98) and standards (M = 45.25). Finally, the third class, or adaptive perfectionists (n = 110), were characterized by having high standards (M = 44.07) and low levels of discrepancy (M = 25.91). The adaptive perfectionist group made up almost two-third of the population sample (61.8%). Analyses were conducted to determine whether means of perceived stress and three types of burnout differentiated across the three latent classes.

Results from the study showed that adaptive perfectionists experienced significantly less stress and burnout than maladaptive perfectionists (Moate et al., 2016). Specifically, maladaptive perfectionists

reported higher levels of stress, personal burnout, work-related burnout, and student-related burnout. These results echo the findings of Noble et al. (2014), who found that adaptive perfectionists had lower levels of depression, while maladaptive perfectionists had the highest levels of depression. Noble and colleagues (2014) suggest that this can be attributed to maladaptive perfectionists' tendency to focus on the possibility of failure (Hamacheck, 1978). Furthermore, avoiding such hardships completely may cause feelings of depression to heighten (Wei et al., 2006), making individuals more susceptible to poor well-being.

It is important to note the differences between maladaptive and adaptive perfectionists because each group's stress appraisal and coping strategies differs (Moate et al., 2016; Noble et al., 2014). In targeted interventions, for example, it would likely be beneficial to highlight the positive coping mechanisms often used by adaptive perfectionists, while maladaptive perfectionists may need more guidance on implementing positive coping strategies into their lives (Noble et al., 2014). Service professionals who feel that they are failing to measure up to excessive internal and external standards may cause them to feel overwhelmed, leading to burnout (Moate et. al, 2016). Furthermore, Moate and colleagues (2016) state that prolonged stress may also result in an inhibited ability to maintain a sense of well-being (Moate et al., 2016). This notion again highlights the importance of recognizing perfectionistic professionals as those more susceptible to burnout and other work-related stressors (Kinman & Grant, 2022)

Helping Professionals in Sport

Research on what perfectionism looks like in sport, particularly its impact on athletes, has been of great interest over the last two decades (Hill et al., 2018). Flett and Hewitt (2005) coined the "perils of perfectionism" in sport which are moderated by factors such as anxiety, goal orientation, fear of failure, performance success, self-presentation concerns, and coping strategies. The exact consequences of perfectionism for athletes, however, still remain up to debate. For example, Flett and Hewitt (2014; 2016) consider perfectionism to be best considered as a vulnerability factor, while Stoeber's (2011) conceptualization of perfectionistic strivings (PS) represent more adaptive, and potentially helpful,

dimensions of perfectionism. In their recent meta-analysis of multidimensional perfectionism in sport, Hill and colleagues (2018) found that PS were characterized by a mix of achievement goals, motivation regulation, emotion/well-being, and better athletic performance. Researchers also found that perfectionistic concerns (PC) were characterized by maladaptive achievement goals, motivation regulation, emotion/well-being, and were unrelated to performance. As confirmed by Hill et al. (2018), Stoeber (2011), and Gotwals and colleagues's (2012) narrative reviews of the impact of PS and PC, perfectionism can be harmful to athletes. In these cases, support is necessary to help athletes manage the negative effects of perfectionism. While a considerable amount of literature exists examining perfectionism's influence on athletes, there is limited evidence on how it can impact service professionals in sport, including sport and performance psychology (SPP) professionals, coaches, and athletic trainers. The most relevant literature examines perfectionism's relationship to burnout (Tashman et al., 2010; Vealey et al., 2020) and emotional regulation (Hill & Davis, 2014) in collegiate coaches.

Tashman and colleagues (2010) examined the effects of perceived stress (PS) on the relationship between adaptive and maladaptive perfectionism and burnout. The population sample consisted of 177 collegiate coaches (114 male and 63 female) from various sports including men's and women's basketball, baseball, softball, swimming, tennis, track/cross country, diving, sailing, rowing, golf, volleyball, and bowling. Coaches were given the Maslach Burnout Inventory (MBI; Maslach et al., 1996), the Perfectionism Inventory (PI; Hill et al., 2004), and the Perceived Stress Scale (PSS; Cohen et al., 1983). The MBI measures Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). The PI measures Concern over Mistakes (CM), High Standards for Others (HSO), Need for Approval (NA), Organization (O), Parental Pressure (PP), Planfulness (P), Rumination (R), and Striving for Excellence (SE). Pearson Product Moment Correlation Coefficients (PPMCs) were used to estimate intercorrelations between test variables.

The findings revealed significant correlations between Emotional Exhaustion and Concern over Mistakes ($r = .45$), Need for Approval ($r = .50$), Parental Pressure ($r = .41$), and Rumination ($r = .55$). Significant correlations were also found between Depersonalization and CM ($r = .48$), NA ($r = .41$), PP (r

= .33), and R (r = .44). Thus, coaches who experienced more CM, NA, PP, and R made more negative evaluations of stress, experienced higher levels of EE and DP, and lower levels of PA (Tashman et al., 2010). The authors concluded that maladaptive perfectionism dimensions led to threatening appraisals of stress and directly impacted the development of burnout regardless of how individuals perceived the stress. Tashman et al. (2010) also found that the adaptive form of perfectionism was not a significant predictor of burnout, which can be explained by the difference between perfectionistic strivings and perfectionistic concerns (Stoeber & Otto, 2006). Furthermore, results demonstrated that maladaptive perfectionism potentially leads individuals to believe they do not have the necessary resources to meet demands, which increases levels of stress and likelihood for burnout (Rudolph et al., 2007). Adaptive perfectionism, however, may lead individuals to believe they possess appropriate coping resources and thus, does not cause a threatening perception of stress or burnout (Tashman et al., 2010). These findings are particularly important because it further demonstrates the complexity of perfectionism. Specifically, some professionals may view their perfectionistic tendencies as adaptive, in which they can appropriately cope with stressors. On the other hand, some may perceive these tendencies as maladaptive, wherein they cannot meet the demands which leads to stress and burnout.

The only additional study to look at perfectionism in coaches was conducted by Vealey and colleagues (2020). The purpose of their study was to analyze the relationship between perfectionism, motivation, burnout, and coaching satisfaction in high school and collegiate coaches. Participants included 311 coaches (151 male, 110 female, and 40 unspecified) whose ages ranged from 20-75 years (M = 44.25, SD = 10.86). Researchers distributed the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), the shortened version (Cox et al., 2002) of the Hewitt-MPS (Hewitt & Flett, 1991), seven subscales of the Behavioral Regulation in Sport Questionnaire (BRSQ; Lonsdale et al., 2008), and five questions about coaching satisfaction developed by Raedeke et al. (2000).

Results from the study showed that perfectionism was related to both motivation and burnout. Socially-prescribed perfectionism (SPP) was the most significant type of perfectionism. SPP demonstrated positive relationships with controlled forms of motivation and burnout, specifically with

emotional exhaustion ($\beta = 0.22$, $p < .001$) and depersonalization ($\beta = 0.22$, $p < .001$). SPP also

demonstrated negative relationships with the autonomous forms of motivation $\beta = -0.15$, $p = .01$) and

feelings of personal accomplishment ($\beta = -0.23$, $p < .001$). Socially prescribed perfectionists have a fear

of negative social evaluation and a need for approval from others (Hewitt & Flett, 1990). SPP can be

maladaptive for coaches, especially when they are pressured by external sources (i.e., athletic

departments, community members) to achieve unrealistic standards or achievements (Vealey et al., 2020).

Vealey and colleagues (2020) suggest that coaches who focus on seeking approval from others and

meeting unrealistic expectations may be setting themselves up for failure. Rather, helping perfectionistic

professionals become aware of their own thoughts and feelings about these expectations may be more

effective (Vealey et al., 2020).

Sport and Performance Psychology (SPP) Professionals

To date, there has been no research to analyze perfectionism in Sport and Performance

Psychology (SPP) professionals. Psychology-related professionals, whether working in academic or

clinical settings, encounter a wide range of demands associated with their jobs (Fletcher et al., 2011).

Fletcher and colleagues (2011) found that sport psychologists experience numerous organizational

demands and stressors, including teaching, research, consultancy, and workload and hours. Fletcher et al.

(2011) also highlighted that applied sport psychologists are typically trained to design stress management

interventions, yet do not receive specific recommendations for how to implement these strategies in their

own lives. Similarly, SPP professionals are trained to help athletes counter their maladaptive

perfectionistic tendencies (Egan et al., 2014; Hewitt et al., 2016), yet have no guidance on how this may

affect their own professional performance.

One key component of perfectionism is the degree to which individuals perceive stress (Dunkley

et al., 2000; 2003; 2016; Flett et al., 2016). As Lazarus and Folkman (1984) noted, adaptive coping

behaviors help regulate an individual's physiological stress response and play an important role in

maintaining health. Perfectionistic individuals tend to engage in avoidant coping strategies, however,

which make it more difficult to address stress and stress-related situations in their lives (Dunkley et al.,

2000). Thus, analyzing perfectionism in SPP professionals is an important avenue for research because individuals may be under-trained or sufficiently supported to address the stressors they face and may subsequently experience poor overall well-being. Given that there is existing literature exploring the significant impact of perfectionism on helping professionals, and SPP professionals are part of that population, it seems pertinent to future investigate this area in SPP.