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PERFECTIONISM AND PRESENTEEISM AMONG MANAGERS OF A SERVICE ORGANIZATION: THE MEDIATING ROLE OF WORKAHOLISM

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This article examines the negative consequences of perfectionism in the workplace, in terms of both workaholism and presenteeism. Specifically, we propose a theoretical model in which self-oriented perfectionism is both directly and indirectly associated with presenteeism, through workaholism. The study was conducted on a sample of 413 workers with leadership and responsibility roles within an Italian service organization. The results showed a positive association between self-oriented perfectionism and workaholism, which, in turn, was positively associated with presenteeism. Self-oriented perfectionism, however, was not associated with presenteeism, after controlling for the effect of workaholism. Workaholism, therefore, completely mediated the relationship between self-oriented perfectionism and presenteeism. Moreover, the mediating effect of workaholism was supported only for male participants. Altogether, these results help to expand the literature on the role of perfectionism in the workplace. Practical implications are discussed for managers and human resource professionals.

Key words: Perfectionism; Presenteeism; Workaholism; Managers; Mediating effect.

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Perfectionism is defined as an individual disposition to consider unacceptable anything that is not perfect (Stoeber, Otto, & Dalbert, 2009). Perfectionism is characterized by the tendency to set oneself very high (if not unrealistic) standards of performance, and by an excessive effort to meet these standards. Additionally, perfectionism determines an overgeneralization of failure and a rigid and severe self-evaluation of an "all or nothing" approach, in which only success or failure are considered (Hamachek, 1978; Hewitt & Flett, 1991). Individuals with high perfectionism, moreover, worry about the evaluations of others and feel a strong urge to attain the standards imposed by others (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991).

According to the theoretical model proposed by Hewitt and Flett (1991), perfectionism is a multidimensional construct, which comprises three distinct dimensions, based on both intra- and interpersonal aspects: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. Self-oriented perfectionism is characterized by setting extremely high standards for oneself, and involves beliefs that it is important to be perfect and to strive for perfection. Conversely, other-oriented perfectionism concerns beliefs and expectations of exceedingly high standards for significant others. Finally, socially prescribed perfectionism involves beliefs that significant others hold unrealistic standards for oneself, and that the individual will be accepted by others only by reaching these standards.

The present study aims to investigate the relationship between perfectionism and some negative outcomes for the individual in the workplace, namely workaholism and presenteeism (Chang, 2000; Childs & Stoeber, 2010, 2012; Falco, Piccirelli, Girardi, Di Sipio, & De Carlo, 2014; Hansen & Andersen, 2008; Kung & Chan, 2014; Löve, Grimby-Ekman, Eklöf, Hagberg, & Dellve, 2010). In particular, we hypothesize that self-oriented perfectionism is both directly and indirectly associated with presenteeism, through workaholism (i.e., workaholism mediates the relationship between self-oriented perfectionism and presenteeism).

Perfectionism in the Workplace

As mentioned in the introduction, in this study we focus attention on perfectionism in the work context. To date, in fact, some studies have showed a positive association between perfectionism and negative outcomes for the individual and the organization, such as, for example, work stress and workaholism, defined as the tendency to work excessively hard in a compulsive way (Chang, 2000; Childs & Stoeber, 2010, 2012; Falco et al., 2014; Kung & Chan, 2014; Schaufeli, Taris, & Bakker, 2008). At the same time, other studies have examined the consequences of workaholism. These studies showed that workaholics, given the strong inner urge to work hard, tend to have higher levels of presenteeism (Falco, Bortolato, Kravina, & De Carlo, 2011; Schaufeli, Bakker, van der Heijden, & Prins, 2009), defined as the act of going to work in spite of feeling sick (Aronsson, Gustafsson, & Dallner, 2000; Johns, 2010).

Therefore, as pointed out in the previous section, the objective of this study is to test a theoretical model in which perfectionism is both directly and indirectly associated with presenteeism, through workaholism. As mentioned earlier, workaholism represents a behavior of addiction to work. In a recent meta-analysis, Clark, Michel, Zhdanova, Pui, and Baltes (2014) define the core characteristics of the workaholic worker. The workaholic, by virtue of a kind of internal drive and compulsion to work, thinks continuously about working, even when out of the work environment, and works in an excessive way beyond what can reasonably be expected, without considering the negative consequences for the self and the family members.

One of the most recognized theoretical models in the literature on workaholism (also used in the present study) is the one proposed by Schaufeli et al. (2008), which identified two central dimensions of workaholism: working excessively (WE) and working compulsively (WC). Workaholism is characterized by the simultaneous presence of high levels in these two dimensions. The result is a high work involvement of the workaholic workers on a compulsive basis. While WE drives people to work considerably, WC leads to an obsessive commitment to work, requiring a strong mental and emotional effort.

Therefore, a positive association between perfectionism and workaholism can be expected. In fact, the tendency of perfectionists to achieve their (high) personal performance standards may result in a more incisive and excessive investment in their work. This can also be aimed at being accepted and approved by their working group (i.e., by colleagues and superiors). Bovornusvakool, Vodanovich, Ariyabuddhiphongs, and Ngamake (2012) identify perfectionism as a key factor in the development of workaholism. According to these authors, workaholism may represent, in some cases, a socially acceptable possibility to express workers' perfectionistic tendencies. In fact, especially in the contemporary business world, workers who aspire to perfection and who invest all their energy and attention in the work tasks are often repaid with rewards and praise.

Although limited, the studies in the literature have showed the presence of a positive relationship between perfectionism and workaholism (Burke, Davis, & Flett, 2008; Clark, Lelchook, & Taylor, 2010; Falco et al., 2014; Stoeber, Davis, & Townley, 2013; Taris, van Beek, & Schaufeli, 2010). Indeed, positive associations between perfectionism and workaholism (Burke et al., 2008) and, in particular, between self-oriented perfectionism (SOP) and workaholism (Falco et al., 2014; Stoeber et al., 2013) were highlighted. In the study by Burke et al. (2008), all the three dimensions of perfectionism (self-oriented, other-oriented, and socially prescribed) were positively associated with work addiction (i.e., high work involvement, feeling high drive, low joy in work), according to the theoretical model proposed by Spence and Robbins (1992). Among these, the association was stronger for SOP and work addiction. Moreover, in the study by Falco et al. (2014), self-oriented perfectionism was more strongly associated with workaholism than the other two dimensions of perfectionism (i.e., other-oriented and socially prescribed perfectionism). Therefore, since Hewitt and Flett (2004) describe self-oriented perfectionists as potential workaholics, and given that self-oriented perfectionism is positively associated with workaholism (Burke et al., 2008; Falco et al., 2014; Flett & Hewitt, 2006; Stoeber et al., 2013), we assume a positive association between self-oriented perfectionism and workaholism.

Hypothesis 1: self-oriented perfectionism is positively associated with workaholism.

As mentioned above, presenteeism is the act of going to work despite feeling sick (Aronsson et al., 2000; Johns, 2010). Presenteeism arises therefore on the opposite side of absenteeism, which refers to not being present at work during working hours. Following the financial crisis and the global economic depression, which led to a series of organizational restructuring and reorganizations in an attempt to "do more with fewer resources," the phenomenon of presenteeism has assumed an increasing salience and relevance in recent years.

Although presenteeism could be considered a competitive advantage to those organizations facing major challenges and labor shortages, research has amply demonstrated that being present at work while not in optimal health may be a cost in terms of productivity, performance and quality of services, even more than absenteeism (Burton, Chen, Conti, Schultz, & Edington, 2006; Hemp, 2004; Robertson & Cooper, 2011). Moreover, the costs associated with lost productivity due to presenteeism must be added to subsequent costs related to future absenteeism, arising from having neglected episodes of malaise, and the increase in forms of unease and discomfort for the person (Aronsson et al., 2000; Bergström, Bodin, Hagberg, Aronsson, & Josephson, 2009; Falco et al., 2011; Falco, Girardi, Parmiani, et al., 2013).

Some previous studies have highlighted several possible factors, both at the organizational and individual levels, which can contribute to presenteeism. Among these, at the organizational level, organizational culture, job insecurity, work-family/family-work conflict, workload, work re-

placement, and interdependence were highlighted as possible antecedents of presenteeism (Aronsson & Gustafsson, 2005; Falco, Girardi, Parmiani, et al., 2013; Johns, 2010, 2011; McGregor, Iverson, Caputi, Magee, & Ashbury, 2014). With regard to individual characteristics, these possible antecedents are work ethic, overcommitment, self-esteem based on performance, and health locus of control (Johns, 2011; Löve et al., 2010; in this regard, see also the reviews by Falco, Girardi, Parmiani, et al., 2013; Johns, 2010).

Among the individual characteristics, workaholism might play a central role (Falco et al., 2011; Schaufeli et al., 2009). As mentioned above, workaholics devote a considerable amount of time to work, and also think obsessively about their work, even in moments that should be devoted to leisure and family. By virtue of this strong drive to work, it is reasonable to expect a positive relationship between workaholism and presenteeism. In fact, the workaholic worker, addicted to work because of an inner obsessive drive, will tend to be present in the workplace even if health conditions are not optimal and/or there is an obvious sickness.

The studies in the literature, although still limited, have showed a positive relationship between workaholism and presenteeism. In the study by Schaufeli et al. (2009), conducted in a sample of medical residents, workaholics showed higher levels of presenteeism than non-workaholics. Falco et al. (2011) detected the presence of presenteeism and excessive work (one of the dimensions of workaholism) in managers and leaders, emphasizing a greater resistance to psychophysical disorders and a tendency to underestimate their disease states by part of those who hold positions of responsibility. Overall, in the light of previous studies, we expect that workaholics may go to work despite being sick, since they feel driven to work. Consequently, we assume a positive association between workaholism and presenteeism.

Hypothesis 2: workaholism is positively associated with presenteeism.

Therefore, considering what assumed earlier, we can expect that self-oriented perfectionism is positively and indirectly associated with presenteeism, through workaholism. In other words, it is expected that workaholism mediates the relationship between perfectionism and presenteeism. In fact, as mentioned earlier, setting high, if not unreasonable, performance standards, engaging in achieving success and results, and assessing one's personal value depending on the achievement of these standards could promote workaholism and, indirectly, presenteeism.

In addition, as far as the authors know there are no studies in the literature that examine the relationship between perfectionism and presenteeism, so it is not possible to exclude that other constructs (in addition to workaholism) may mediate this relationship. These possible mediators, for example, may be performance-based self-esteem (PbSe), social support, and coping strategies. In fact, it is possible that individuals with high perfectionism show higher levels of PbSe, are more likely to engage in problem-solving coping strategies (i.e., active coping), and perceive less social support. This, in turn, can affect presenteeism (Dunkley, Blankstein, Halsall, Williams, & Winkworth, 2000; Hansen & Andersen, 2008; Löve et al., 2010).

Consequently, it is assumed that workaholism partially mediates the relationship between perfectionism and presenteeism (i.e., the direct association between perfectionism and presenteeism is significant, after controlling for the effect of workaholism). This is compatible with the hypothesis that other constructs, in addition to workaholism, may mediate the relationship between perfectionism and presenteeism (Zhao, Lynch, & Chen, 2010).

Hypothesis 3: self-oriented perfectionism is positively associated with presenteeism.

Hypothesis 4: self-oriented perfectionism is positively and indirectly associated with presenteeism, through workaholism.

Finally, previous studies suggest that gender may influence the relationship between perfectionism, workaholism, and presenteeism. Firstly, there is some evidence that gender may be associated with both workaholism (in particular with respect to hours worked, including working overtime; Burke, 1999; Snir & Zohar, 2008) and presenteeism (Bierla, Huver, & Richard, 2013; Hansen & Andersen, 2008). Additionally, past research showed that women may report higher levels of irrational beliefs, which are defined as inflexible, illogical, and unreasonable cognitions (van Wijhe, Peeters, & Schaufeli, 2013; Woodward, Carless, & Findlay, 2001). Irrational beliefs are associated with perfectionism (especially with SOP; Flett, Hewitt, & Cheng, 2008) and they may also lead to the development of workaholism (Burke, 2000, 2001; van Wijhe et al., 2013). Moreover, according to some previous studies, SOP was associated with guilt in women but not in men (Klibert, Langhinrichsen-Rohling, & Saito, 2005). Guilt is a discrete negative emotion that plays a central role in workaholism, since workaholics may feel guilty when not working, and, therefore, driven to work even harder (Clark, Michel, Stevens, Howell, & Scruggs, 2014; Clark, Michel, Zhdanova, et al., 2014). Therefore, in order to investigate the role of gender in the relationship between perfectionism, workaholism, and presenteeism, the mediation analyses were also conducted separately for men and women.

METHOD

Participants

The study, conducted as part of a work-related stress risk assessment, involves 413 managers belonging to an Italian service organization. Participants were middle and top managers, who head the operating units of a company that encompasses from 10 to 15 employees. They were recruited from a population of approximately 1,000 managers employed by the organization. A weighted, stratified, random sample technique was adopted to select a representative sample of this population. Homogeneous strata were formed, based on the company's operating units. Participants were then randomly selected, in a way that the number of managers in each stratum was commensurate with the size of the stratum itself. The questionnaire was administered anonymously online. Participants were given a login identification code and a password, in order to access the online questionnaire. Additionally, they were assured that no personal information would be collected for the study. The final response rate was 100%. The characteristics of the sample are shown in Table 1.

Measures

In order to detect the dimensions under investigation, the following self-report measures were used.

Self-oriented perfectionism: three items with responses ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), taken from the Italian adaptation by Falco et al. (2014) of the Multidimensional Perfectionism Scale (HMPS; Hewitt & Flett, 1991). Example of item is "One of my goals is to be perfect in everything I do." Cronbach's alpha was .77.

TABLE 1
Characteristics of the sample

	N (%)
Gender	
Female	45 (10.9%)
Male	368 (89.1%)
Age	
29-39 years	30 (7.3%)
40-50 years	211 (51.1%)
51-61 years	170 (41.1%)
Over 61 years	2 (0.5%)
Education	
Secondary degree	249 (60.3%)
University degree	90 (21.8%)
Missing	74 (17.9%)
Years in the organization	
Less than 10	67 (16.2%)
10 to 20	129 (31.2%)
More than 20	217 (52.6%)
Years of work in the actual position	
Less than 3	218 (52.8%)
3 to 5	125 (30.3%)
More than 5	67 (16.2%)
Missing	3 (0.7%)

Workaholism: DUWAS scale, in the Italian adaptation by Kravina, Falco, Girardi, and De Carlo (2010). The 6-point response scale ranged from 1 (*strongly disagree*) to 6 (*strongly agree*). The scale consists of 10 items, designed to detect the two dimensions of working excessively and working compulsively. Examples of items for these two dimensions are as follows: "I persist in my work even when my colleagues have already gone" for working excessively, and "I feel that there's something inside me that drives me to work hard" for working compulsively. Since workaholism reflects the tendency to overwork compulsively (Schaufeli et al., 2008), we used a composite score of workaholism, which is the average of the two scales of working excessively and working compulsively (Clark, Michel, Stevens, et al., 2014; Falco et al., 2014). The alpha for the total scale was .77.

Presenteeism: measured with the single item "How many days approximately, over the last three months, did you go to work despite not feeling well?" (Aronsson et al., 2000; Johns, 2011). The response format provides a space in which the subject is asked to report the number of days in which he/she has gone to work despite not feeling well.

Statistical Analysis

The hypothesized relationships were tested by estimating a structural equation model with observed variables (path analysis). For this purpose we used the software LISREL 8.8 (Jöreskog

& Sörbom, 2006). In order to evaluate the fit of the theoretical model to the data, the following fit indexes were taken into consideration, in addition to the χ^2: the root mean square error of approximation (RMSEA), the comparative fit index (CFI), and the standardized root mean square residual (SRMR). For SRMR and RMSEA, values close to or below .08 indicate a good fit to the data. For CFI, values close to or greater than .95 indicate a good fit to the data (Hu & Bentler, 1999). In addition, in order to investigate the role of gender in the relationship between perfectionism, workaholism, and presenteeism, the hypothesized relationships were tested separately for male and female workers. In this regard, given the reduced number of workers within the female gender (n = 45), four separate linear regression models were estimated using the software IBM SPSS Statistics 21. The significance of the indirect effect (i.e., mediation) was tested using the RMediation package (distribution of the product of the coefficients method; Tofighi & MacKinnon, 2011). The effect of mediation is supported if confidence intervals for the indirect effect do not contain zero.

RESULTS

In relation to presenteeism, workers quantified as about four the average number of days (in the last three months) in which they had gone to work despite not feeling well (M = 4.04, SD = 6.31). Only 17.4% of respondents stated that they had never gone to work when they were not feeling well. Workers also reported moderately high levels of both workaholism (M = 4.26, SD = 0.68) and perfectionism (M = 4.67, SD = 0.85). Means, standard deviations, and correlations between measures are presented in Table 2.

TABLE 2
Correlations between study variables

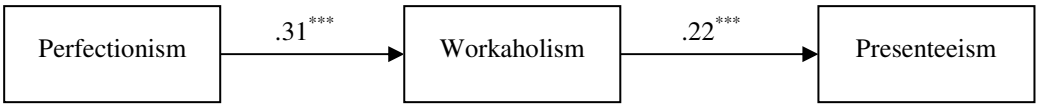
	M	*SD*	1	2	3
1. Presenteeism	4.04	6.31	–		
2. Workaholism	4.26	0.68	.22***	–	
3. Self-oriented perfectionism	4.67	0.85	.02	.31***	–

*** p < .001.

In order to test the mediating effect of workaholism in the relationship between perfectionism and presenteeism, a partial mediation model was initially estimated (Model 1), in which perfectionism is both directly and indirectly associated with presenteeism, through workaholism (i.e., workaholism partially mediates the relationship between perfectionism and presenteeism). In this model, perfectionism was positively associated with workaholism (γ = .31, p < .001), which, in turn, was positively associated with presenteeism, controlling for the effect of perfectionism (β = .23, p < .001). Therefore, Hypothesis 1 and Hypothesis 2 were supported. In addition, perfectionism was not directly associated with presenteeism, after controlling for the effect of workaholism. Hypothesis 3 was not supported.

In light of these results, an alternative model (Model 2) was therefore estimated, compatible with the complete mediation. In this model, the direct effect of perfectionism on presenteeism was fixed to zero, while other relationships were freely estimated, as in the previous model. The second model showed a good fit to the data, $\chi^2(1) = 1.07$, $p = .30$; RMSEA = .01; CFI = .99; SRMR = .02. In Model 2, perfectionism was positively associated with workaholism ($\gamma = .31$, $p < .001$), which, in turn, was positively associated with presenteeism ($\beta = .22$, $p < .001$).

Finally, since the confidence interval for the indirect effect did not contain zero, unstandardized indirect effect = .53; 95% CI [.27, .83], the indirect association between perfectionism and presenteeism through workaholism was significant. Hypothesis 4 was thus supported. Therefore, since the indirect association between perfectionism and presenteeism was significant, whereas the direct association was not, workaholism completely mediated the relationship between perfectionism and presenteeism. The complete mediation model (Model 2) is presented in Figure 1.



*** $p < .001$.

FIGURE 1
Standardized solutions of the tested models.
Model 2: The complete mediation model.

Next, in order to investigate the role of gender in the relationship between perfectionism, workaholism, and presenteeism, four separate linear regression models were estimated. In the first model (Model M1), the effect of perfectionism on workaholism for male workers was estimated, while in the second model the effects of both workaholism and perfectionism on presenteeism were estimated simultaneously (Model M2), again for the male workers. The same models were finally estimated for female workers (Model F1 and Model F2, respectively). The results are reported in Table 3.

In relation to the male workers, the results were in line with those emerging from the overall sample. In fact, perfectionism was positively associated with workaholism ($\beta = .28$, $p < .001$), which, in turn, was positively associated with presenteeism ($\beta = .24$, $p < .001$), after controlling for the effect of perfectionism. Additionally, perfectionism was not associated with presenteeism, after controlling for the effect of workaholism. Since the confidence interval for the indirect effect did not contain zero, unstandardized indirect effect = .50; 95% CI [.24, .81], the indirect association between perfectionism and presenteeism through workaholism was significant. Therefore, for male workers, workaholism completely mediated the relationship between perfectionism and presenteeism.

However, interesting results emerged in relation to female workers. In fact, perfectionism was positively associated with workaholism ($\beta = .52$, $p < .001$), and this relationship seemed to be stronger for women than for men. In addition, neither workaholism nor perfectionism was associated with presenteeism in women.

TABLE 3
Linear regressions

	Males (N = 368)			Females (N = 45)		
	Model M1: Workaholism			Model F1: Workaholism		
	B	*SE*	β	*B*	*SE*	β
Perfectionism	.22	.04	.28***	.45	.11	.52***
	Model M2: Presenteeism			Model F2: Presenteeism		
	B	*SE*	β	*B*	*SE*	β
Perfectionism	–.39	.40	–.05	–.29	1.15	–.05
Workaholism	2.24	.51	.24***	.99	1.34	.13

*** $p < .001$.

DISCUSSION

The present study investigated the relationship between perfectionism, workaholism, and presenteeism in a large sample of workers with leadership roles and responsibilities. Specifically, the hypothesized model forecasted both a direct and indirect association between self-oriented perfectionism and presenteeism, through workaholism. As expected, self-oriented perfectionism showed a positive association with workaholism (H1 supported). Therefore, workers who set high standards of performance for themselves may devote more time to their work, and they may also think about their work in an almost obsessive way, even in moments of detachment and rest (i.e., self-oriented perfectionism may lead to workaholism). This result confirms the results of recent studies (Falco et al., 2014; Stoeber et al., 2013), and therefore the idea that workaholism is influenced by an inherent personal perfectionism.

In turn, workaholism was positively associated with presenteeism (H2 supported). By virtue of their perfectionistic tendencies, workaholics tend to work harder, to do their work alone, showing a difficulty in delegating the work to colleagues, to the point of feeling essential to the organization and going to work even when they are sick. This is in line with what has been showed by previous studies (Burke & Matthiesen, 2004; Falco et al., 2011; Schaufeli et al., 2009), according to which workaholism favors the tendency to go to work even when the conditions of health are not optimal and/or disease is evident.

Moreover, since there was no direct relationship between perfectionism and presenteeism (H3 not supported), workaholism completely mediated the relationship between perfectionism and presenteeism. Individuals with high self-oriented perfectionism, being pushed to work harder, to check and recheck their work, to think on an ongoing basis about their occupation and the things to be done, show a stronger tendency to underestimate their states of malaise and poor health and to go to work even when they feel sick, in order to reach their standards of performance and avoid failure (H4 confirmed). Overall, our study suggests that SOP is only indirectly associated with presenteeism, and that workaholism might play a central role in this process. Indeed, the individual's

drive to high performance standards fosters attitudes and behaviors of a workaholic type. That is, it is possible that workaholism for the perfectionist worker is currently configured as a socially acceptable behavior, even one that is encouraged in organizations. The importance of self-realization and of achieving their high work standards, increasing the obsessive inner drive to work, seems to make it impossible for them to disconnect from work even for reasons of illness and poor health.

This result seems to fit into a broader perspective, according to which the modern Western society is characterized by the increasing emphasis on individualism, the importance of self-realization and being successful, as if the value of an individual should be demonstrated and tested (Bauman, 2002; Beck & Beck-Gernsheim, 2002). This also seems to be reflected in the employment context, where the choices on the limits to give to work, in relation to the other activities of life and to health, seem to have shifted from the employer to the worker, who may have to work in a workaholic way (MacEachen, Polzer, & Clarke, 2008). Therefore, staying home sick could be very difficult for those people who base self-evaluation and self-esteem on the performance and the objectives achieved, encouraging presenteeism (Crocker & Park, 2004; Löve et al., 2010).

In addition, this study explored the role of gender in the relationship between the constructs investigated, providing interesting considerations from a qualitative point of view. While the completed mediation model was confirmed for male workers (as for the overall sample), different results emerged for women. Among female workers, self-oriented perfectionism was more strongly associated with workaholism, which, in turn, was not associated with presenteeism. Therefore, whereas self-oriented perfectionism seems to be more strongly associated with workaholism among women, workaholism itself does not drive women to go to work despite being sick.

This lack of relationship between workaholism and presenteeism in women can be explained in the light of the broader theory of social roles related to gender (Eagly, 1983). According to this theory, men, by virtue of the socially shared image of "stronger sex," tend more easily to adopt risky behaviors and beliefs, rather than protective and prevention behaviors, such as going to the doctor and taking care of themselves. Conversely, women are culturally seen as having a natural propensity to vulnerability, to disease, and to requiring medical help. This could, in conditions of poor health, reduce their presenteeism (Courtenay, 2000; Evans, Frank, Oliffe, & Gregory, 2011). This finding needs further investigation, from both a theoretical and an empirical standpoint, considering the influence of other variables including, for example, work-family conflict and family-work conflict.

This study has some limitations. First, the results are not generalizable to all the work sectors, since it was conducted on a large sample of tertiary workers with management roles and responsibilities. In these roles of management and leadership there is a prevalence of workaholism (Kravina et al., 2010; Taris, van Beek, & Schaufeli, 2012), which could be reinforced by the personal tendency to perfectionism. Furthermore, it is possible that perfectionism could have a less intense role, depending on the context of the work (e.g., public vs. private, health vs. financial services), as well as according to the assigned duties. Future research will verify the presence or absence of these relations in different samples of workers and the workplace.

Secondly, the cross-sectional design limits the possibilities of interpretation of the results. Only through longitudinal research or experimental designs it will be possible to check the direction of the relationship between perfectionism, workaholism, and presenteeism. Third, with regard to gender differences, the limited number of female workers within the sample must be acknowledged. This can result in a limited statistical power to detect the indirect relationship be-

tween perfectionism and presenteeism for female workers (Fritz & MacKinnon, 2007). Therefore, caution is warranted in drawing conclusions about the lack of an indirect relationship between perfectionism and presenteeism in women. Overall, these results are preliminary and further research is needed to replicate and extend these findings.

Finally, since the measures used in this study are self-report, the observed relationships between study variables could be inflated by common method bias and negative affectivity (Falco, Girardi, Marcuzzo, De Carlo, & Bartolucci, 2013). In the future, it would be useful to adopt also objective indicators of discomfort (such as medically certified sickness absences) or hetero-assessments of the health of workers certified by the occupational physician (Falco, Girardi, Kravina, et al., 2013; Falco, Girardi, Marcuzzo, et al., 2013; O'Connor & O'Connor, 2003). Also, it may be useful to use hetero-assessment of workaholism, performed by the spouse/partner or family (Falco et al., 2012).

Despite the limitations mentioned above, the results of this study serve to broaden the existing literature regarding the role of perfectionism in the employment context, highlighting the mechanisms through which it can affect workaholism and, in turn, presenteeism. Both in the work context and in the clinical setting, the dysfunctionality of perfectionism emerges in terms of promoting negative attitudes and behaviors for the well-being of the person, such as workaholism and, indirectly, presenteeism. Knowledge of these mechanisms will allow managers and human resource managers to implement appropriate interventions to reduce the potential risks arising from a high perfectionism.

These interventions, aimed at the prevention, identification, and management of dysfunctional perfectionism, can be divided into three levels: primary (i.e., reducing the risk of perfectionism among workers), secondary (i.e., identification and training of the workers at risk of perfectionism), and tertiary (i.e., minimizing the important negative consequences of perfectionism on health). At the primary level, the possible interventions aim to change the work environment. Since some organizational cultures can encourage workers in competitive and success-oriented behaviors and in fearing failure, the effort is to promote working environments and cultures that do not reward those attitudes and behaviors oriented to success at all costs. Therefore, both the supervisors and the executive management play a central role in spreading good working practices through behavior, communication, and interpersonal interactions (Dragoni, 2005).

In particular, it is important to promote organizational cultures that discourage the achievement of perfection at all costs, which instead interpret making mistakes as a learning opportunity and not a failure, and that encourage and reward effective management of working time. In this sense, it may be useful to provide positive feedback for efficient work, which is the result of productive time-management and does not merely reflect the amount of time devoted to work (Holland, 2008; van Wijhe, Schaufeli, & Peeters, 2010).

At a secondary level, the actions are intended to identify potential workers at risk of high perfectionism to whom adequate training programs can be extended. The administration of specific instruments, such as the adaptation of the HMPS to the Italian context provided by Falco et al. (2014), may allow the early identification of those workers at risk of perfectionism, who could benefit from specific training interventions. These training programs could be aimed at increasing some individual psychological resources that can help the worker to prevent the negative consequences of perfectionism. Considering their difficulty in recognizing and living positive emotions, we suggest techniques for emotional regulation that can promote the development of resil-

ience as the ability to cope and recover successfully from adversity (Klibert et al., 2014). Bryant and Veroff (2007) emphasize the importance of savoring techniques (such as meditation, the construction of an active memory, mindfulness, etc.). This can help the person to reduce worry about feeling unworthy, to learn to enjoy one's own successes, prolonging the positive emotions associated with them. Other possible interventions are aimed at improving the use of problem-focused coping strategies, as well as the ability to positively reframe negative events, failures, and personal bankruptcies, maintaining good satisfaction at the end of the day (Stoeber & Janssen, 2011).

At the third level, the actions will be targeted specifically to workers with a high level of perfectionism and will take the form of assistance and therapy. Specifically, in relation to perfectionism, possible interventions fall within the psychodynamic and cognitive-behavioral approach (Lombardo & Violani, 2011). The psychodynamic treatment is aimed at changing the structure of the personality which is the basis of the person's maladaptive perfectionism. In the cognitive-behavioral approach, interventions are designed to modify the cognitive processes of the dysfunctional perfectionist, such as the ruminative response style, the tendency to turn on automatic and repetitive thoughts, dichotomous thinking and irrational beliefs. By filling out diaries and thought records and conducting behavioral experiments, the therapist can help the patient to become aware of his/her perfectionist belief system, which is rigid and inflexible. In addition, the patient can learn to look at things from a different perspective, focusing on the framework as a whole, rather than on the small details, and learning to tolerate uncertainty (Shafran & Mansell, 2001). The goal of these treatments is not the elimination of the personal standards of success, but rather the change of some dysfunctional cognitive schemes, so as to allow individuals to reframe both their objectives and performance, in order to reduce malaise and distress (Macedo, Marques, & Pereira, 2014).

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