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Why does socially prescribed perfectionism place people at risk for depression? A five-month, two-wave longitudinal study of the Perfectionism Social Disconnection Model

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ABSTRACT

The Perfectionism Social Disconnection Model (PSDM) is a promising integrative model explaining relations between socially prescribed perfectionism (i.e., perceiving others require perfection) and depressive symptoms. Yet, the nature of the social disconnection proposed by the PSDM requires explication. Likewise, longitudinal tests of the PSDM are scarce. We addressed these important limitations by extending, testing, and supporting the PSDM in 127 undergraduates using a five-month, two-wave longitudinal design. Our model posited socially prescribed perfectionism generates depressive symptoms via two putative triggers: interpersonal discrepancies (i.e., viewing oneself as falling short of others' expectations) and social hopelessness (i.e., negative expectations concerning future interpersonal relationships). Congruent with the PSDM, bias-corrected bootstrapped tests of mediation revealed socially prescribed perfectionism conferred vulnerability for depressive symptoms five months later via interpersonal discrepancies and social hopelessness. Furthermore, results supported the specificity of our model beyond self-oriented perfectionism and other-oriented perfectionism. Findings lend credence and coherence to theoretical accounts suggesting socially prescribed perfectionism has a generative role in the development of psychosocial environments conducive to depressive symptoms. Moreover, our study offers investigators a conceptual framework for understanding the specific interpersonal mechanisms involved in the socially prescribed perfectionism-depressive symptom link.

1. Introduction

Depression is a widespread mental health problem involving a loss of positive affect that manifests in a range of symptoms including lack of motivation, feelings of worthlessness, lack of self-care, anxiety, suicide ideation, and poor concentration (APA, 2013). Nearly 30.6% of undergraduates suffer from depressive symptoms. And depressive symptoms impair students' interpersonal, academic, and psychological functioning (Ibrahim, Kelly, Adams, & Glazebrook, 2013; Steptoe, Tsuda, Tanaka, & Wardle, 2007). Depressive symptoms in young adulthood can also lead to an accumulation of negative life events that carry over into adulthood and leave lasting psychological scars (Ibrahim et al., 2013). Moreover, the incidence of depressive symptoms among undergraduates is threefold higher than the general population (Gonzalez et al., 2010). Accordingly, the pressures of young adulthood and the demands of university life appear to leave students particularly susceptible to depressive symptoms. As such, investigators are increasingly interested in testing explanatory models of depression to inform development of more effective, targeted prevention and intervention strategies for undergraduates. Our study extended and tested one such explanatory model—the Perfectionism Social Disconnection Model (Hewitt, Flett, Sherry, & Caelian, 2006).

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1.1. Perfectionism and depression

As with depression (Miller & Chung, 2009), the incidence of perfectionism among North American and UK undergraduates has increased over the last three decades (Curran & Hill, in press). But, what is perfectionism? Several conceptualizations of perfectionism exist (e.g., Dunkley, Zuroff, & Blankstein, 2003; Frost, Marten, Lahart, & Rosenblate, 1990), and one widely used model is proposed by Hewitt and Flett (1991). Hewitt and Flett (1991) maintain perfectionism is best understood as a multidimensional personality trait with three dimensions: self-oriented perfectionism (i.e., demanding perfection of the self), other-oriented perfectionism (i.e., demanding perfection from other people), and socially prescribed perfectionism (i.e., perceiving other people demand perfection of oneself).

Self-oriented perfectionism confers vulnerability for depression in the presence of ego-involving stressors, such as achievement failure (e.g., poor performance on an exam; Békés et al., 2015; Enns & Cox, 2005). Similarly, socially prescribed perfectionism confers vulnerability for depression in the presence of interpersonal stressors, such as social disconnection (i.e., feeling rejected by and disliked by others; Hewitt et al., 2006; Sherry, Mackinnon, & Gautreau, 2016; Sherry, Mackinnon, Macneil, & Fitzpatrick, 2013). Nonetheless, relative to self-oriented perfectionism, socially prescribed perfectionism is a more robust predictor of depression (Smith et al., 2016). Likewise, though people high on other-oriented perfectionism distress those close to them (Hewitt, Flett, & Mikail, 1995; Sherry et al., 2016; Smith, Speth, Sherry et al., 2017), other-oriented perfectionism is an inconsistent predictor of depression (Chen, Hewitt, & Flett, 2017). Accordingly, evidence suggests socially prescribed perfectionism is the perfectionism dimension most relevant to depressive symptoms. As such, we focused on interpersonal mediators of the socially prescribed perfectionism-depressive symptom link.

1.2. Advancing research on the socially prescribed perfectionism-depression link

To improve our understanding of *why* socially prescribed perfectionism confers vulnerability for depressive symptoms, we need methodological improvements. In fact, much of our understanding of the socially prescribed perfectionism-depression link derives from cross-sectional designs, which are incapable of testing the extent to which socially prescribed perfectionism predicts change in depressive symptoms (e.g., Wei, Mallinckrodt, Russell, & Abraham, 2004). Similarly, some longitudinal studies measure depression at one time point and fail to account for depression's self-propagating effect (e.g. Chang & Sanna, 2001). Likewise, mediation models examining relations between socially prescribed perfectionism and depression commonly include mediating variables that are likely multi-factorial (e.g., social self-esteem; Smith, Sherry, Mushquash et al., 2017). Moreover, some studies restrict their focus to socially prescribed perfectionism and depression (e.g., Dean, Range, & Goggin, 1996). However, not controlling for socially prescribed perfectionism's overlap with self-oriented and other-oriented perfectionism potentially obscures distinct relationships (see Stoeber & Gaudreau, 2017). Lastly, measurement occasions in longitudinal studies have made drawing conclusions challenging. For instance, some studies limit follow-up assessments to days or weeks (e.g., Smith, Sherry, Mushquash et al., 2017)—potentially too short a duration for a rigorous test of the socially prescribed perfectionism-depressive symptom link. Other studies allow several years to elapse between measurement occasions (e.g., Dunkley, Sanislow, Grilo, & McGlashan, 2006)—potentially too long a duration, given that major life events can lead to improvements or deteriorations in depressive symptoms.

Given the above limitations, Limburg, Watson, Hagger, and Egan (2016) issued a call for investigators to improve methodologically research on the perfectionism-psychopathology link. We answered Limburg et al.'s (2016) call by rigorously testing the Perfectionism Social Disconnection Model (PSDM; Hewitt et al., 2006) using a 5-month, 2-wave longitudinal design.

1.3. The Perfectionism Social Disconnection Model

Our extended PSDM posits socially prescribed perfectionism generates depressive symptoms via two putative triggers: interpersonal discrepancies and social hopelessness (Habke & Flynn, 2002; Hewitt, Flett, & Mikail, 2017). Specifically, people high on socially prescribed perfectionism see their world as a threatening place where others demand perfection (Sherry et al., 2016). Subsequently, socially prescribed perfectionism predisposes cognitions of falling short of other people's expectations (i.e., interpersonal discrepancies). These adverse social cognitions then precipitate negative expectations concerning one's ability to “fit in” and be comfortable with others (i.e., social hopelessness), which gives rise to depressive symptoms (Habke & Flynn, 2002; Hewitt et al., 2017; Sherry et al., 2016).

Supporting these assertions, Flett and Hewitt (1994) reported positive associations between socially prescribed perfectionism, social hopelessness, and depressive symptoms. Likewise, Rice, Leever, Christopher, and Porter (2006) reported intrapersonal discrepancies correlated positively with general hopelessness. Moreover, Besser, Flett, Guez, and Hewitt (2008) demonstrated that during an experimentally induced negative mood state, people with high socially prescribed perfectionism were prone to attend to, and remember, information characterized by interpersonal discrepancies. And Sherry, Mackinnon, Fossum et al. (2013) and Sherry, Mackinnon, Macneil, and Fitzpatrick (2013) found that interpersonal discrepancies mediated socially prescribed perfectionism's relationship with depressive symptoms. Hence, evidence implies important links between socially prescribed perfectionism, interpersonal discrepancies, social hopelessness, and depressive symptoms. Nonetheless, these findings have not yet been integrated into a theory-driven model.

1.4. Present study

We conducted a longitudinal test of our extended PSDM to advance understanding of the social mechanisms through which socially prescribed perfectionism confers vulnerability for depressive symptoms. Guided by theory (e.g., Habke & Flynn, 2002; Hewitt et al., 2017; Sherry et al., 2016) and evidence (e.g., Besser et al., 2008; Flett & Hewitt, 1994; Rice et al., 2006; Sherry, Mackinnon, Fossum, et al., 2013; Sherry, Mackinnon, Macneil, & Fitzpatrick, 2013), we anticipated socially prescribed perfectionism would have a significant indirect effect on follow-up depressive symptoms via interpersonal discrepancies and social hopelessness (see Fig. 1). We also expected the indirect effect of socially prescribed perfectionism on depressive symptoms would remain significant after controlling for self-oriented perfectionism, other-oriented perfectionism, and baseline depressive symptoms.

2. Method

2.1. Participants

We recruited 143 participants (79.0% female) from a large university in western Canada to test our model (see Fig. 1). Participants had a mean age of 19.9 years (SD = 2.7). Most participants (86.0%) were in their first year of university. Of the original sample, 127 participants (88.8%) completed Time 2 roughly five months after Time 1. Ethnicity data was not collected.

2.2. Measures

2.2.1. Perfectionism

Perfectionism was measured at Time 1 using Hewitt and Flett's