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The existential model of perfectionism and depressive symptoms: Tests of incremental validity, gender differences, and moderated mediation

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ABSTRACT

Socially prescribed perfectionism (i.e., perceiving others are demanding perfection of oneself) is a putative vulnerability factor for depressive symptoms. However, there is still much to learn about when and why socially prescribed perfectionists get depressed. Drawing on the existential model of perfectionism and depressive symptoms (EMPDS), we proposed difficulty in accepting the past (i.e., viewing life experiences as coherent, acceptable, satisfying, and meaningful) clarifies when and why socially prescribed perfectionism is linked to depressive symptoms. In the present study of 269 undergraduates (141 men and 128 women), we tested if accepting the past predicts depressive symptoms beyond competing explanations (e.g., self-esteem). And we extended existing research by testing a novel moderated mediation model wherein the strength of the mediated effect of socially prescribed perfectionism on depressive symptoms through accepting the past is stronger at higher levels of socially prescribed perfectionism than at lower levels of socially prescribed perfectionism. We also tested if our results generalized across women and men. Hypotheses were largely supported. Consistent with the EMPDS, our results suggested people high in socially prescribed perfectionism get depressed because they struggle to consolidate their life experiences into a personally meaningful story.

1. Introduction

Evidence suggests a robust link between perfectionism and depressive symptoms. Although several intervening variables (e.g., moderators and mediators) are proposed to explain the relationship between perfectionism and depressive symptoms, there is still much to learn about the link between perfectionism and depressive symptoms.

1.1. Socially prescribed perfectionism and depressive symptoms

There are several well-established dimensions of perfectionism (e.g., Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991). According to one model, self-oriented perfectionism involves demanding perfection of oneself, other-oriented perfectionism involves demanding perfection of others, and socially prescribed perfectionism involves perceiving others are demanding perfection of oneself (Hewitt & Flett, 1991). Among these dimensions, socially prescribed perfectionism is consistently linked to depressive symptoms (Sherry, Hewitt, Flett, & Harvey, 2003). People high in socially prescribed perfectionism show many of the key characteristics of those prone to depressive symptoms, including harsh self-scrutiny, evaluative fears, unrealistic expectations, and perceived criticism.

Drawing on the existential model of perfectionism and depressive symptoms (EMPDS; Graham et al., 2010), we propose that difficulty in accepting the past (i.e., viewing life experiences as coherent, acceptable, satisfying, and meaningful) explains when and why socially prescribed perfectionism is linked to depressive symptoms (Graham et al., 2010). Existential theorists (Frankl, 1984) suggest an inability to see one's life experiences as purposeful and satisfactory is conducive to depressive symptoms. Cognitive behavioral theorists also suggest the inability to accept thoughts, emotions, and experiences fosters depressive symptoms (Hayes, 2004). In sum, difficulty accepting the past is likely to contribute to depressive symptoms.

People high in socially prescribed perfectionism may have difficulty accepting the past for several reasons (Graham et al., 2010). Such people often try to meet the expectations of others, rather

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than following their own authentic desires, which is likely to undermine personal meaning and satisfaction (Hewitt & Flett, 1991). In attempting to achieve perfection, people high in socially prescribed perfectionism may avoid activities wherein perfection is unobtainable, thereby experiencing a narrow set of life events focused on achievement and excluding social relationships and personal growth. Perfection is also difficult to attain and the constant pursuit of perfection may result in frequent disappointment. People high in socially prescribed perfectionism are also prone to harsh self-criticism and evaluative fears wherein setbacks are seen as unacceptable and threatening to the self. Past events are viewed through this self-critical lens and perceived failures are seen as intolerable. Theory and research suggest difficulty accepting the past may explain why people high in socially prescribed perfectionism are vulnerable to depressive symptoms (Graham et al., 2010).

1.2. Advancing research on perfectionism and depressive symptoms

We propose socially prescribed perfectionism is robustly related to accepting the past. If this is the case, socially prescribed perfectionism should predict unique variance in accepting the past beyond competing variables (e.g., self-esteem). We also tested whether accepting the past predicted depressive symptoms over and above self-esteem. Self-esteem (i.e., one's subjective evaluation of one's worth) is correlated with socially prescribed perfectionism, acceptance, and depressive symptoms (Flett, Besser, Davis, & Hewitt, 2003; Preusser, Rice, & Ashby, 1994). Self-esteem is therefore a stringent covariate in the present study.

Women are nearly twice as likely to experience depressive symptoms as men (Patten et al., 2006). What is less well known is whether proposed models for understanding depressive symptoms, including the EMPDS, generalize to women and to men. Knowledge of whether explanatory models of depressive symptoms generalize to women and to men is important in order to provide appropriate and gender-sensitive clinical services. In contrast to past studies that focus primarily on women or include only a small percentage of men (e.g., Graham et al., 2010), the present study has roughly equal number of women and men, allowing for more appropriate tests of gender differences.

Studies on perfectionism and depressive symptoms have examined several intervening variables to assist in explaining the relationship between perfectionism and depressive symptoms. Moderational models explain when (i.e., the conditions under which) perfectionism is related to depressive symptoms (e.g., when interpersonal stress is present; Enns & Cox, 2005; Sherry et al., 2003); mediational models explain why (i.e., the mechanisms through which) perfectionism is related to depressive symptoms (e.g., through difficulty accepting the past; Graham et al., 2010). Past research usually offers little compelling rationale as to why an intervening variable should be a mediator or a moderator. Very few studies of perfectionism examine both moderators and mediators in the same model.

In contrast, the present study tests a moderated meditation model (Preacher, Rucker, & Hayes, 2007). Moderated mediation occurs when the magnitude of an indirect effect (i.e., why one variable influences another) depends on the level of a moderator (i.e., when a variable influences another). In the present study we examined the indirect effect of socially prescribed perfectionism on depressive symptoms through difficulty accepting the past (i.e., mediation). We also examined whether the level of socially prescribed perfectionism (i.e., moderation) influenced the strength of the indirect effect (i.e., moderated mediation). Socially prescribed perfectionism was selected as the moderator given long standing evidence that depressive symptoms are higher at higher levels of socially prescribed perfectionism (Sherry et al., 2003).

1.3. Hypotheses

Building upon past research (Graham et al., 2010), we hypothesized socially prescribed perfectionism would contribute incrementally to our understanding of accepting the past beyond self-esteem. As in past research (e.g., Flett et al., 2003), we also hypothesized accepting the past would contribute incrementally to the prediction of depressive symptoms beyond self-esteem. We also tested whether the relationships between socially prescribed perfectionism, accepting the past, and depressive symptoms differ across men and women. Given the scarcity of research on this area, this question was considered exploratory.

Drawing on research supporting the EMPDS (Graham et al., 2010), we hypothesized a moderated mediation model wherein the strength of the mediation effect (i.e., the relationship between socially prescribed perfectionism and depressive symptoms would be mediated through difficulty accepting the past) would depend on the level of socially prescribed perfectionism (Fig. 1). Specifically, we hypothesized the mediation effect would be stronger at higher levels of socially prescribed perfectionism than at lower levels of socially prescribed perfectionism, consistent with past research showing depressive symptoms are higher at higher levels of socially prescribed perfectionism (Sherry et al., 2003).

2. Method

2.1. Participants

A sample of 269 undergraduates (141 men and 128 women) completed measures. Participants were recruited from first- or second-year psychology courses at the University of British Columbia. Men averaged 19.26 years of age (SD = 2.43) and 1.64 years of university education (SD = 0.90). Women averaged 19.55 years of age (SD = 3.18) and 1.52 years of university education (SD = 0.72). Additional demographics are in Table 1. Our sample is comparable to other samples of undergraduates recruited at the University of British Columbia (Sherry et al., 2003).

2.2. Measures

2.2.1. Multidimensional Perfectionism Scale (HFMPS)

The HFMPS (Hewitt & Flett, 1991) is a 45-item scale divided into three 15-item subscales: self-oriented perfectionism (e.g., "One of my goals is to be perfect in everything I do"), other-oriented perfectionism (e.g., "If I ask someone to do something, I expect it to be done flawlessly"), and socially prescribed perfectionism (e.g., "People expect nothing less than perfection from me"). Participants respond using a 7-point scale from 1 (*strongly disagree*) to 7 (*strongly agree*). HFMPS subscale scores range from 15 to 105. Evidence supports the alpha reliability, test–retest reliability, factorial validity, predictive validity, incremental validity, and discriminant validity of the HFMPS (e.g., Hewitt & Flett, 2004). In this study, alpha reliabilities for self-oriented, other-oriented, and socially prescribed perfectionism were acceptable (.89, .75, and .82, respectively for men; .88, .76, and .79, respectively for women).

2.2.2. Rosenberg Self-Esteem Scale (RSES)

The RSES (Rosenberg, 1965) is a 10-item scale designed to measure global self-esteem (e.g. "I feel I do not have much to be proud of"). Scores range from 0 to 30. Participants respond using a 4-point scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*). RSES scores range from 0 to 30. Research supports the alpha reliability, test–retest reliability, predictive validity, incremental validity, and discriminant validity of the RSES among university

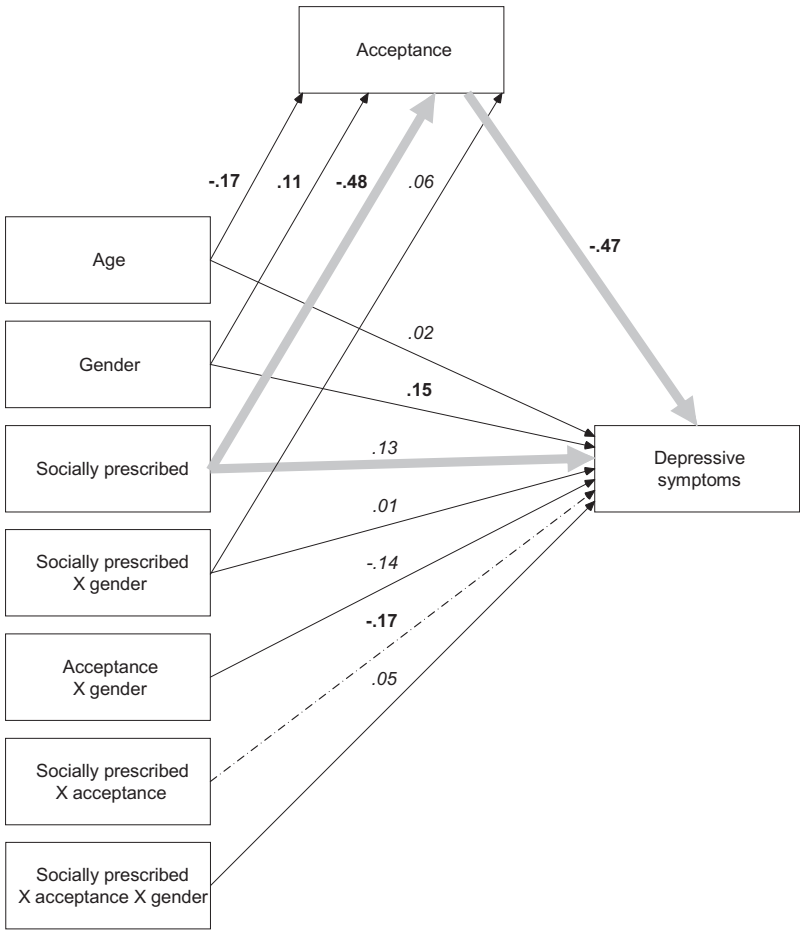

Fig. 1. Moderated mediation model. Rectangles represent manifest variables. Unbroken thin black arrows represent paths; the unbroken thick gray arrows represent the hypothesized mediated effect; the broken thin black arrow represents the hypothesized moderated effect. In the interest of clarity, correlations among exogenous variables and error terms are not shown. Standardized path coefficients appearing in bold are significant ($p < .05$); standardized path coefficients appearing in italics are nonsignificant ($p > .05$). Socially prescribed = socially prescribed perfectionism; Acceptance = accepting the past.

Table 1
Demographics.

	Men		Women	
	n	%	*n*	%
Year in university				
1st year	80	56.7	76	59.4
2nd year	42	29.8	41	32.0
3rd year	10	7.1	8	6.3
4th year	8	5.7	3	2.3
5th year	1	0.7	0	0.0
Ethnicity				
Asian	56	39.7	51	39.8
Caucasian	55	39.0	50	39.1
East Indian	9	6.4	7	5.5
Other (e.g., mixed ethnicity)	12	8.5	16	12.5
Did not specify	9	6.4	4	3.1

students (e.g., Greenberger, Chen, Dmitrieva, & Farruggia, 2003). In this study, alpha reliabilities for the RSES were acceptable (.88 for men, .88 for women).

2.2.3. Accepting the Past Scale (ACPAST)

The ACPAST (Santor & Zuroff, 1994) is a 16-item scale assessing mental representations of past events as coherent, acceptable, satisfying, and meaningful. Sample ACPAST items include: "All in all, I am comfortable with the choices I have made in the past;" "I look back on things I have done with a sense of satisfaction;" and, "I have not led a very meaningful life (reverse scored)." Participants respond using a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). ACPAST scores range from 16 to 80. Higher scores indicate greater acceptance of the past. There is evidence supporting the alpha reliability, test–retest reliability, factorial validity, predictive validity, and incremental validity of the ACPAST (e.g., Graham et al., 2010). In this study, alpha reliabilities for the ACPAST were acceptable (.88 for men, .90 for women).

2.2.4. Beck Depression Inventory (BDI)

The BDI (Beck, Steer, & Garbin, 1988) is a 21-item inventory constructed to quantify depressive symptoms over a 2-week period. Participants respond using a 4-point scale from 0 (*no symptoms of depression*) to 3 (*severe symptoms of depression*). BDI scores range from 0 to 63. Research has demonstrated the alpha reliability, test–retest reliability, convergent validity, incremental validity, and discriminant validity of the BDI (Richter, Werner, Heerlein, Kraus, & Sauer, 1998). In this study, alpha reliabilities for the BDI were acceptable (.89 for men, .89 for women).

2.3. Procedure

Participants were recruited between September and April during the fall/winter term from the undergraduate participant pool of the Department of Psychology at the University of British

Columbia. Participants responded to a bulletin board advertisement requesting their participation in a study on personality. Overall, 71% of participants who enrolled in the study returned a completed questionnaire. In exchange for participating in this study, each participant received a 1% bonus added to his or her final course grade. Participation was voluntary and anonymous.

2.4. Data analytic plan

Descriptive statistics and bivariate correlations provided information on the variables of the EMPDS and their interrelationships. Hierarchical multiple regression was used to test unique contributions of predictors to outcomes. We tested if observed findings generalized across men and women using interaction terms.

Moderated mediation analyses were conducted consistent with recommendations by Preacher et al. (2007). We used bootstrap analyses, the SPSS Macro created by Preacher et al. (2007) and Mplus 6.0 (Muthén & Muthén, 2010). Specifically, we tested if the indirect effect was significant at different levels of the moderator. Gender was also included in these analyses to test for possible gender differences.

3. Results

3.1. Descriptive statistics and bivariate correlations

Means for all scales (see Table 2) were within one standard deviation of previous research involving university samples (Graham et al., 2010; Hewitt & Flett, 1991; Sherry et al., 2003), suggesting our means are comparable to earlier research.

Age and gender were the only demographics that significantly correlated with study variables and were used as covariates. For women and men (see Table 2), socially prescribed perfectionism was significantly and negatively correlated with accepting the past and with self-esteem, and socially prescribed perfectionism was significantly and positively correlated with depressive symptoms. Accepting the past was significantly and negatively related to depressive symptoms and significantly and positively related to self-esteem. These results suggest self-esteem is a suitable covariate for tests of incremental validity. Depressive symptoms were significantly and negatively correlated with accepting the past and with self-esteem. Consistent with past research (Sherry et al., 2003), for both women and men, self-oriented perfectionism and other-oriented perfectionism were not significantly correlated with self-esteem, accepting the past, or depressive symptoms. All perfectionism dimensions were significantly and positively correlated. This pattern of intercorrelation suggests merit in testing our multivariate hypotheses.

Table 3
Hierarchical regression analyses with interaction predicting accepting the past.

Variables	ΔR^2	ΔF	β
Step 1	.04	5.48**	
Age			−.16**
Gender			.13*
Step 2	.49	279.57***	
Self-esteem			.71***
Step 3	.02	3.58*	
Self-oriented			.01
Other-oriented			−.03
Socially prescribed			−.14**
Step 4	.01	0.24	
Self-oriented × gender			.06
Other-oriented × gender			−.11
Socially prescribed × gender			.06

Note. For gender, men = 1 and women = 2. Self-oriented = self-oriented perfectionism; Other-oriented = other-oriented perfectionism; Socially prescribed = socially prescribed perfectionism.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

3.2. Hierarchical multiple regression analyses

Hierarchical multiple regression analyses were conducted to determine the unique contribution of self-esteem, perfectionism dimensions, and the interaction of gender and perfectionism dimensions in predicting accepting the past (see Table 3). To protect against multicollinearity, we centered predictor variables for all hierarchical multiple regression analyses (Cohen, Cohen, West, & Aiken, 2003). Age and gender (step 1) and self-esteem (step 2) were significant predictors of accepting the past. In step 3, socially prescribed perfectionism predicted unique variance. The interaction vectors (step 4) were nonsignificant and did not explain additional variance in accepting the past, suggesting the link between perfectionism and accepting the past did not change depending on gender.

Hierarchical multiple regression analyses were also conducted to test the unique contribution of self-esteem, accepting the past, and the interaction of gender and accepting the past in predicting depressive symptoms (see Table 4). Age and gender (step 1) were not significant predictors of depressive symptoms, whereas self-esteem (step 2) was a significant predictor of depressive symptoms. In step 3 accepting the past predicted unique variance. The interaction vectors (step 4) were nonsignificant and did not explain additional variance in depressive symptoms. This suggests the relationship between accepting the past and depressive symptoms did not change based upon gender.

Table 2
Means, standard deviations, and bivariate correlations.

Variables	1	2	3	4	5	6	*M*	*SD*
1. Self-oriented perfectionism	–	.47***	.17*	.10	.04	−.09	64.91	14.96
2. Other-oriented perfectionism	.45***	–	.26**	.15	.07	−.08	55.42	10.52
3. Socially prescribed perfectionism	.36***	.25**	–	−.50***	−.52***	.37***	53.12	12.12
4. Self-esteem	.05	.13	−.39***	–	.74***	−.71***	20.18	5.67
5. Accepting the past	−.02	−.01	−.35***	.71***	–	−.51***	53.34	10.70
6. Depressive symptoms	.01	−.06	.36***	−.76***	−.73***	–	10.26	8.17
M	65.69	54.53	52.25	20.51	55.99	11.19	–	
SD	13.82	10.51	11.44	5.48	11.72	8.45		–

Note. Statistics for men are above the diagonal; statistics for women are below the diagonal.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

Table 4
Hierarchical regression analyses with interaction predicting depressive symptoms.

Variables	ΔR^2	ΔF	β
Step 1	.01	1.82	
Age			.10
Gender			.05
Step 2	.52	299.28***	
Self-esteem			−.73***
Step 3	.02	10.63***	
Accepting the past			−.20***
Step 4	.01	1.93	
Accepting the past × gender			−.12

Note. For gender, men = 1 and women = 2.
*** $p < .001$.

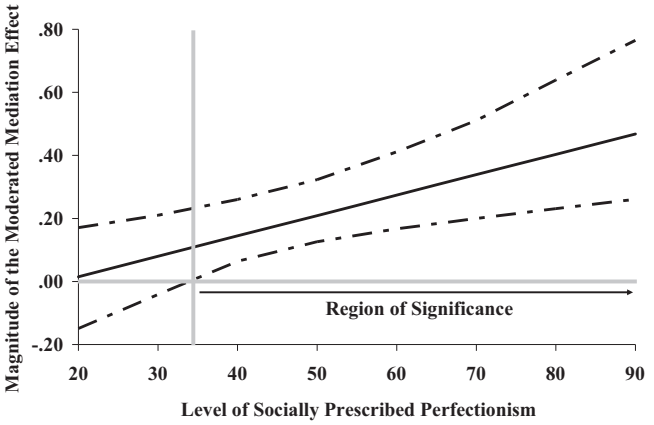

Fig. 2. Graphical representation of the standardized moderated mediation effect. The unbroken horizontal gray line represents a standardized moderated mediation effect of zero; the unbroken vertical gray line represents the boundary of the region of significance; the unbroken diagonal black line represents the standardized moderated mediation effect; the broken diagonal curved black lines represent upper and lower 95% confidence intervals for the standardized moderated mediation effect. Adapted from Preacher et al. (2007, p. 214).

3.3. Moderated mediation analyses

Moderated mediation examines if the strength of the mediation effect depends on the level of a moderator variable (Preacher et al., 2007). Consistent with Preacher et al. (2007; MODMED macro v1.1, Model 3), we used bootstrapping (5000 resamples) to generate bias-corrected 95% confidence intervals (CIs) for the magnitude of the indirect effects at different values (i.e., point estimates) of the moderator. A statistically significant indirect effect is present when the 95% bias corrected CIs of the indirect effect exclude zero. Fig. 1 provides a visual representation of the moderated meditation model at the mean level of the moderator. As hypothesized, the relationship between socially prescribed perfectionism and depressive symptoms was significantly mediated by accepting the past wherein socially prescribed perfectionism was negatively related to accepting the past, which was, in turn, negatively related to depressive symptoms. Age was negatively and significantly correlated with accepting the past and gender was positively and significantly correlated to accepting the past (i.e., women had higher levels of accepting the past than men). Consistent with a large literature, gender was also positively and significantly correlated to depressive symptoms, indicating women had higher levels of depressive symptoms than men (Patten et al., 2006). The interaction terms including gender were not significant indicating the relationships are consistent for women and for men. The significant interaction between socially prescribed perfectionism and accepting the past in predicting depressive symptoms captures the moderated effect within this mediational model. This moderated mediation effect is displayed in Table 5 where results showed the conditional indirect effects were significant at higher levels of socially prescribed perfectionism but not at lower levels of socially prescribed perfectionism.

A graphical representation of the regions of significance at various levels of the moderator is in Fig. 2. This figure shows the strength of the mediated effect of socially prescribed perfectionism on depressive symptoms through accepting the past is stronger at higher levels of socially prescribed perfectionism than at lower levels of socially prescribed perfectionism.

4. Discussion

Our study found accepting the past is an important link between socially prescribed perfectionism and depressive symptoms. Results indicated socially prescribed perfectionism predicts accepting the past beyond self-esteem, and accepting the past predicts depressive symptoms beyond self-esteem. We also extended existing research by testing a novel moderated mediation model wherein the strength of the mediated effect of socially prescribed perfectionism on depressive symptoms through accepting the past was conditional on the level of socially prescribed perfectionism. That is, consistent with the EMPDS, and our study hypotheses, socially prescribed perfectionism not only generated difficulty

Table 5
Bootstrap analyses indicating that the strength of the mediated effect of socially prescribed perfectionism on depressive symptoms through accepting the past is conditional on the level of socially prescribed perfectionism.

Level of socially prescribed perfectionism	Unstandardized moderated mediation effect (B)	Standardized moderated mediation effect (β)	Bootstrap estimates	
			SE for the standardized moderated mediation effect	Lower and upper 95% CIs for the standardized moderated mediation effect
20	.01	.02	.08	−.15, .17
30	.06	.08	.06	−.04, .21
40	.10	.15	.05	.06, .26*
50	.15	.21	.05	.13, .32*
60	.19	.27	.06	.17, .41*
70	.24	.34	.08	.20, .51*
80	.28	.40	.10	.23, .64*
90	.33	.47	.13	.26, .77*

Note. Bootstrap analyses are based on 5000 bootstrap samples (with each sample involving $n = 269$). B = unstandardized beta; β = standardized beta; *SE* = bias-corrected standard error; CI = confidence intervals.
* CIs excluding zero are significant at $p < .05$.

accepting the past, but also exacerbated the impact of difficulty accepting the past on depressive symptoms. Finally, our results showed relationships among variables in our model generalized across women and men.

4.1. Socially prescribed perfectionism, accepting the past, and depressive symptoms

As hypothesized, socially prescribed perfectionism predicted unique variance in accepting the past beyond a stringent covariate, self-esteem. However, caution is needed in interpreting this finding, as socially prescribed perfectionism predicted only a small amount of variance after self-esteem was taken into account. Accepting the past also predicted a small, but unique, amount of variance in depressive symptoms beyond self-esteem, a strong concurrent predictor of depressive symptoms (e.g., Preusser et al., 1994). Though the amount of incremental variance predicted by accepting the past is small, we see this result as meaningful since self-esteem is a strong predictor of depressive symptoms (e.g., Greenberger et al., 2003). Acceptance of oneself and one's experiences may be especially difficult for people high in socially prescribed perfectionism. People high in socially prescribed perfectionism appear to believe their self worth depends on attaining the unrealistic, perfectionistic standards set by others. This desire to attain perfection is likely to undermine any effort to accept imperfections with the self or one's experiences (Flett et al., 2003). This inability to accept one's experiences also appears to contribute uniquely to depressive symptoms.

There is a well-established gender difference in depressive symptoms with women far outnumbering men in experiencing depressive symptoms (Patten et al., 2006). However, much less is known about whether explanatory models of depressive symptoms such as the EMPDS generalize to women and to men. Our results suggest links among variables of the EMPDS hold for women and men alike. Such information is important to provide appropriate and effective assessment and treatment for both women and men experiencing depressive symptoms.

Consistent with the EMPDS and past research (Graham et al., 2010), the tendency of people high in socially prescribed perfectionism to have difficulty finding meaning and satisfaction in their life experiences makes them vulnerable to depressive symptoms. The harsh self-scrutiny, unrealistic expectations, and inability to tolerate perceived failures of people high in socially prescribed perfectionism appear to predispose difficulties in accepting the past. In trying to live their life to meet the expectations of others, people high in socially prescribed perfectionism may struggle to find meaningful, valued actions and to make sense of their lives. Furthermore, the depressing consequences of struggling to consolidate their life story in a coherent way appear to only intensify as socially prescribed perfectionism levels increase.

4.2. Clinical implications

Our study has important implications for helping professionals. Therapies such as acceptance and commitment therapy (ACT; Forman, Herbert, Moitra, Yeomans, & Geller, 2007) may assist perfectionists in addressing their difficulty in accepting the past. In ACT, clients learn to respond to cognitions and to emotions with a mindful, nonjudgmental, accepting stance and to move toward valued actions. Strategies from ACT may allow perfectionists to accept their perfectionistic and self-critical thoughts about their past while choosing purposeful and committed action in their lives in order to build a more vital and meaningful life (Hayes, 2004).

4.3. Limitations and future directions

Our sample involved undergraduates. It is unclear if our findings generalize to clinical or to community samples. As well, future research should examine whether our findings extend to older populations at key transition periods throughout their lives when introspection is more likely to occur (e.g., retirement; Erikson, Erickson, & Kivnick, 1986).

Our cross-sectional design fails to address questions regarding temporal confounding and directionality. Multiwave longitudinal designs are needed to address such questions.

Our self-report measures may also be inaccurate (e.g., due to limited insight of participants). Future studies should use multiple sources (e.g., informant reports). Research is also needed to clarify if difficulty accepting the past uniquely predicts depressive symptoms compared to other forms of distress (e.g., anxiety or shame).

4.4. Concluding remarks

The EMPDS suggests people high in socially prescribed perfectionism are vulnerable to depressive symptoms because they have difficulty accepting the past. Socially prescribed perfectionism provides unique information in predicting difficulty accepting the past beyond competing variables (i.e., self-esteem). Our integrated moderated mediation model explains both when and why socially prescribed perfectionism is linked to depressive symptoms through difficulty accepting the past. Our study confirms that socially prescribed perfectionism not only fosters difficulty accepting the past but also extends current research by demonstrating that socially prescribed perfectionism intensifies the depressing consequences of difficulty accepting the past. These results generalize across women and men.

As they go about their lives, women and men high in socially prescribed perfectionism struggle to consolidate their life experiences into a coherent, satisfying, and meaningful story. Lacking meaning and purpose for their actions and feeling regretful of the past, people high in socially prescribed perfectionism are especially vulnerable to depressive symptoms.

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