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Relationship of Emotional Regulation and Perfectionism with Anxiety and Depression among Pakistani Adults:The Mediating Role of Social Support

by

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CERTIFICATE OF APPROVAL

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Abstract

The present study investigated the relationship between emotion dysregulation (expressive suppression), maladaptive perfectionism, and anxiety and depression among Pakistani adults, while exploring the mediating role of perceived social support. Grounded in Emotion Regulation Theory and the Multidimensional Theory of Perfectionism with perceived social support conceptualized as a protective psychosocial resource influencing emotional adjustment and psychological well-being, the research utilized a cross-sectional design with a sample of 390 university students, aged 18 years and above, from public and private universities in Rawalpindi and Islamabad. Data were collected using the Emotion Regulation Questionnaire (ERQ), the Frost Multidimensional Perfectionism Scale (FMPS), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Depression Anxiety Stress Scales-21 (DASS-21). The results revealed that maladaptive perfectionism had a significant moderate positive correlation with both depression ($r = .378$, $p < .01$) and anxiety ($r = .328$, $p < .01$). Although expressive suppression had a significant positive correlation with anxiety ($r = .129$, $p < .05$), its correlation with depression was determined to be non-significant. Mediation analyses indicated that perceived social support significantly partially mediated the relationship between expressive suppression and both anxiety (B = -0.05, CI [-0.09, -0.02]) and depression (B = -0.04, CI [-0.08, -0.02]). Nevertheless, the role of perceived social support in mediating the relationship between maladaptive perfectionism and anxiety and depression was not supported by data. Specifically, the indirect effect was found to be non-significant for both depression (B = -0.02, CI [-0.04, 0.00]) and anxiety (B = -0.01, CI [-0.03, 0.00]). Regarding group comparisons, independent sample t-tests revealed no significant gender differences in depression ($t = 0.35$, $p = .86$) or anxiety ($t = 0.00$, $p = .92$). Furthermore, one-way ANOVA indicated that neither perceived socioeconomic status (depression: $F = 0.65$, $p = .52$; anxiety: $F = 0.46$, $p = .62$) nor family structure (depression: $F = 1.03$, $p = .35$; anxiety: $F = 2.59$, $p = .76$) significantly influenced anxiety and depression. These findings highlight the critical role of cognitive-emotional vulnerabilities in shaping the mental health of Pakistani adults and suggest that while perceived

social support buffers the impact of emotion suppression, it may not mitigate the effects of perfectionistic tendencies.

Keywords: Emotional Regulation, Adults, Anxiety, Depression

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Abbreviations

A	Anxiety
D	Depression
DASS-21	Depression Anxiety Stress Scale-21
ERQ	Emotion Regulation Questionnaire
ES	Expressive Suppression
FMPS	Frost Multidimensional Perfectionism Scale
MP	Maladaptive Perfectionism
MSPSS	Multidimensional Scale of Precived Social Support

Chapter 1

Introduction

1.1 Background of the Study

Mental health concerns among adults have increased substantially across the globe, with anxiety and depression consistently identified as the most common psychological disorders affecting this population (World Health Organization, 2023).

Depression typically involves persistent feelings of sadness, reduced interest in previously enjoyable activities, low energy, and feelings of worthlessness, whereas anxiety is characterized by excessive worry, fear, and heightened physiological arousal (American Psychiatric Association, 2022). These conditions not only affect emotional well-being but also interfere with academic performance, interpersonal relationships, and overall social functioning (American Psychiatric Association, 2022; World Health Organization, 2023).

Depression is known to impact around 56% of the adult population globally, with anxiety disorders being equally prevalent, making them a significant contributor to the global burden of disease (World Health Organization, 2023). Anxiety and depression are significantly more common in Pakistan, with researchers estimating that anywhere between 27-34% of adults report symptoms of the two (Mirza and Jenkins, 2004). These rates are frequently higher among adults who are pursuing a university education because of academic demands, career indecision, and

social pressures (Khan et al., 2021; Nadeem et al., 2020). Although this prevalence is high, mental health services are not well accessed because of stigma, lack of awareness, and the insufficiency of psychological resources (Rizvi and Najam, 2014; Patel et al., 2007). This means that numerous people are still suffering psychologically without getting the right intervention or support.

Emotional regulation and perfectionism are among the psychological factors that have been widely identified as having a significant influence on anxiety and depression (Aldao et al., 2010; Flett and Hewitt, 2002). Emotional regulation can be defined as the mechanisms that people use to track, appraise, and adjust their emotional experiences in relation to both internal and external needs. Emotionally dysregulated individuals tend to use maladaptive means especially expressive suppression which refers to the inhibition of outward manifestation of emotions but the inner emotional experience remains (Gross and John, 2003). Although these strategies could be employed to preserve social appropriateness, their continued application is linked with dysfunctional emotional processing, increased internal distress, and susceptibility to anxiety and depressive symptoms (Aldao et al., 2010).

Perfectionism is a personality trait that is multidimensional and is defined by the predisposition to establish high personal standards and critical self-evaluation (Frost et al., 1990). Modern studies draw the distinction between adaptive and maladaptive facets of perfectionism, especially when the concept is operationalized in the Frost Multidimensional Perfectionism Scale (FMPS).

Maladaptive perfectionism is represented by Concern over Mistakes, Doubts about Actions, Parental Expectations, and Parental Criticism dimensions. These dimensions are indicative of a tendency towards over self-criticism, fear of failure, persistent dissatisfaction with performance, and the belief that worth depends on living up to unrealistic standards (Frost et al., 1990; Flett and Hewitt, 2002). People with high maladaptive perfectionism tend to see small errors as big failures and constantly doubt what they are doing, which also adds to the intensity of

emotional distress. In contrast to adaptive striving, maladaptive perfectionism is always linked to adverse psychological effects, such as anxiety, depression, and stress (Limburg et al., 2017; Smith et al., 2016).

Within this context, perceived social support plays a crucial protective role. Perceived social support refers to the emotional, informational, and practical assistance available from family members, friends, peers, and significant others which helps individuals cope with stress and maintain psychological well-being (Cohen and Wills, 1985).

Individuals who perceive strong social support tend to manage emotional challenges more effectively and are better equipped to cope with perfectionistic pressures. Conversely, those who experience limited or conditional support may face greater vulnerability to emotional challenges and anxiety and depression (Batool and Khalid, 2012).

Given these considerations, it is important to examine how maladaptive emotional regulation, particularly expressive suppression, and maladaptive perfectionism contribute to anxiety and depression, while also exploring the mediating role of perceived social support.

Investigating these relationships within the Pakistani cultural context can provide valuable insight into the psychological and social mechanisms underlying mental health difficulties among adults enrolled in universities. Such understanding may inform the development of culturally appropriate interventions aimed at strengthening emotional regulation skills, reducing maladaptive perfectionism, and enhancing supportive social environments for adults.

1.2 Gap Analysis

Although international research has extensively examined emotion regulation, perfectionism, and social support in relation to anxiety and depression, limited work

has explored the combined interaction of these variables within collectivist societies such as Pakistan (Batool and Khalid, 2012; Khan et al., 2021; Zafar et al., 2020).

Existing local studies have largely examined these constructs in isolation. For example, Zafar et al. (2020) reported that emotion dysregulation predicts internalizing symptoms among Pakistani populations but did not include perfectionism or social support.

Similarly, Ijaz and Khalid (2020) investigated perfectionism in relation to academic burnout without considering emotion regulation or social support. Also, the literature on social support has emphasized its role in alleviating the anxiety and depression but in most cases, its interaction with cognitive and emotional vulnerabilities have not been addressed (Batool and Khalid, 2012).

Other local studies have focused on narrower outcomes, such as self-concept or online stress, rather than broader mental health indicators like anxiety and depression (Shah and ul Ain, 2023). This restricts the capacity to comprehend the entire psychological processes that lie behind anxiety and depression.

Given the high prevalence of anxiety and depression among Pakistani university students (Khan et al., 2021; Abbas et al., 2022), a study that combines emotional, cognitive, and social variables in one framework is required.

Particularly, little empirical research exists regarding the role of maladaptive emotional regulation (expressive suppression) and maladaptive perfectionism in co-occurring and creating anxiety and depression, with the mediating role of perceived social support in these relationships in the Pakistani cultural context.This gap demonstrates the necessity of having an integrative and culturally sensitive model that explores the interactive impact of expressive suppression and maladaptive perfectionism on anxiety and depression, while having perceived social support as a mediating variable.

1.3 Problem Statement

Anxiety and depression are highly prevalent among Pakistani university students, with a significant proportion experiencing clinically relevant symptoms (Khan et al., 2021; Abbas et al., 2022). Despite this, help-seeking behaviors remain limited due to stigma, lack of awareness, and insufficient mental health resources. Emotion regulation difficulties (expressive suppression) and maladaptive perfectionism are known predictors of anxiety and depression, yet the role of perceived social support in shaping these relationships has received limited empirical attention in the Pakistani context.

The present study aims to examine the relationship between maladaptive emotion regulation (expressive suppression) and maladaptive perfectionism in relation to anxiety and depression, while investigating the mediating role of perceived social support among Pakistani adults. Findings from this study are expected to contribute to a better understanding of culturally relevant psychological processes and inform the development of targeted interventions to improve mental well-being among university students.

1.4 Rationale

Given the high prevalence of anxiety and depression among Pakistani adults, there is a critical need to examine the combined influence of emotional, cognitive, and social factors within a culturally relevant framework.The current investigation offers a more specific insight into psychological risk factors that lead to anxiety and depression by narrowing the scope to maladaptive emotional regulation (expressive suppression) and maladaptive perfectionism. Simultaneously, the inclusion of perceived social support as a mediating variable will enable a more in-depth analysis of the effects of interpersonal contexts on anxiety and depression.

Not only does this integrative approach fill an important gap in current research,

but also provides practical implications of developing culturally sensitive interventions to enhance emotional well-being, decrease maladaptive thinking patterns, and empower supportive social environments in university adults.

1.5 Theoretical Framework

The present study is based on the assumption that both cognitive-emotional vulnerabilities and interpersonal resources play an important role in shaping anxiety and depression among Pakistani adults. Emotional dysregulation, especially expressive suppression, was chosen as a major variable because it is a maladaptive emotion regulation strategy and is related to increased emotional distress, poor coping and heightened risk for anxiety and depression (Gross and Levenson, 1997; Gross and John, 2003). Those who repeatedly inhibit emotions tend to feel the same emotions internally that would lead to continued psychological discomfort and interpersonal problems (Gross, 2015).

Maladaptive perfectionism was also added as an important vulnerability factor, as being overly concerned with mistakes, fearful of criticism, feeling self-doubt and having unrealistic standards is consistently linked to anxiety, depression and chronic self-criticism (Frost et al., 1990). Aside from these vulnerabilities, perceived social support was added to the psychosocial resource that could affect emotional and cognitive coping. Emotional reassurance, validation, and coping assistance from supportive family, friends, and significant others can lower vulnerability to anxiety and depression (Zimet et al., 1988; Lakey and Orehek, 2011). Therefore, the present study integrates emotional, cognitive, and interpersonal factors to better understand anxiety and depression among Pakistani adults.

1.5.1 Emotion Regulation Theory

The Emotion Regulation Theory that has been put forth by James Gross offers a very thorough background to the entire study of how people deal and react to emotional experiences (Gross, 1998). The theory conceptualizes emotion regulation as a dynamic process by which people control the onset, intensity, duration

and expression of emotions. Instead of perceiving emotions as the uncontrollable or automatic responses, this framework focuses on the fact that people actively influence their emotional experiences by using a variety of regulatory responses (Gross, 1998, 2015).

The Process Model of emotion regulation by Gross represents emotion regulation strategies in broad terms as antecedent-focused and response-focused strategies. Antecedent-oriented strategies are initiated prior to the full activation of an emotional response and involve making changes in the way a situation is interpreted in order to change its emotional effect. A key example of such a category is cognitive reappraisal, whereby people redefine a situation that could be distressing in a more adaptive way. This plan has always been linked with favorable mental results, such as diminished emotional disturbance and enhanced well-being (Gross and John, 2003).

Response-focused strategies on the other hand are adopted when an emotion has already been elicited. Expressive suppression is a widely examined response-based approach, which entails blocking external manifestations of emotions, but does not change the inner experience. Suppression can have short-term social or interpersonal utility, but is typically linked to adverse psychological effects, such as heightened physiological arousal, emotional fatigue and diminished well-being (Gross and Levenson, 1997; Gross and John, 2003). The Emotion Regulation Theory also highlights that regular use of maladaptive coping mechanisms including suppression, avoidance and rumination also play a big role in development and persistence of anxiety and depression (Aldao et al., 2010). People who cannot manage their emotions successfully are more likely to be emotionally reactive and slow in stress recovery as well as have negative affect that can persist leading to greater susceptibility to anxiety and depression (Berking and Wupperman, 2012).

In the context of Pakistan, culture tends to enforce emotional restraint and discourage emotional expression. Consequently, people can develop greater tendencies towards suppression-based approaches, which, in the long run, could lead to

emotional dysregulation and anxiety and depression (Rizvi and Najam, 2014). Emotion Regulation Theory, therefore, offers a critical guide to understanding the impact of differences in regulatory strategies on anxiety and depression (Gross, 2015).

In addition to directly influencing psychological well-being, difficulties in emotion regulation, specifically expressive suppression, may also influence individuals' interpersonal functioning and perception of supportive relationships. Those who engage in expressive suppression may seem emotionally unavailable, less communicative, or withdrawn socially (Gross and John, 2003).

These interpersonal patterns can decrease the sense of emotional connectedness and diminish one's perception of available support from others, including family members, friends, and important others (Zimet et al., 1988). Conversely, individuals who perceive higher levels of emotional, informational, and instrumental support may experience greater emotional reassurance and coping resources despite emotional difficulties (Lakey and Orehek, 2011). Therefore, supportive interpersonal relationships can reduce negative psychological outcomes of maladaptive emotion regulation strategies and reduce anxiety and depression.

Therefore, in the context of the current study, perceived social support is viewed as a significant psychosocial resource that can help account for the link between emotion dysregulation (expressive suppression) and anxiety and depression. People who feel more supported by their social networks may be more resilient to emotional stresses, while those who feel less supported may be more susceptible to anxiety and depression.

1.5.2 Multidimensional Theory of Perfectionism

In the current study, perfectionism is based on the Multidimensional Theory of Perfectionism put forward by Frost et al. (1990) that frames perfectionism as a multidimensional construct with both adaptive and maladaptive aspects (Frost

et al., 1990). The Frost Multidimensional Perfectionism Scale (FMPS) is a theoretical model which is a tool of the current study.

This theory argues that perfectionism is not a unitary phenomenon but rather made of different dimensions that have varied psychological implications (Frost et al., 1990). The model distinguishes adaptive (Personal Standards and Organization), and maladaptive (Concern over Mistakes, Doubts about Actions, Parental Expectations, and Parental Criticism) factors (Frost et al., 1990).

Adaptive perfectionism is a disposition to set high, though realistic goals, to be organized and to strive to succeed in a way that is not characterized by undue self-criticism (Frost et al., 1990). People with adaptive perfectionism can strive to be excellent without being bound to psychological rigidity and inflexibility (Frost et al., 1990).

Contrary to this, maladaptive perfectionism is marked by strict perfection, fear of failure and excessive worry about judgment (Frost et al., 1990). The fear of Mistakes represents the propensity to see errors as individual failures, whereas Doubts about Actions shows a constant doubt about performance. Parental Expectations and Parental Criticism are the perceived external demands and critical judgment of significant others (Frost et al., 1990). All these dimensions form a fear-driven, self-doubting, and conditional-self-worth pattern of perfectionism (Frost et al., 1990).

In this theoretical context, maladaptive perfectionism is perceived as a dysfunctional cognitive-emotional style where people judge themselves negatively and believe that their worth depends on their conforming to unrealistic standards (Frost et al., 1990). This type of perfectionism causes chronic dissatisfaction, increased sensitivity to failure, and constant inner pressure (Frost et al., 1990).

Maladaptive perfectionism is especially relevant in the framework of the current study as it is one of the vulnerability factors that are connected with higher levels

of anxiety and depression. The dimensions measured using the Frost Multidimensional Perfectionism Scale (FMPS) are directly related to this theoretical conceptualization, and one can examine the relationship between maladaptive perfectionistic tendencies and anxiety and depression in Pakistani adults (Frost et al., 1990).

In addition, maladaptive perfectionism can also have a negative impact on interpersonal relationships and on people's perceptions of social support. Fear of criticism, social evaluation, and failure can lead to emotional withdrawal, interpersonal sensitivity, and difficulty in openly expressing emotional needs (Frost et al., 1990). People with high maladaptive perfectionism are thus likely to experience less supportive relationships even when they are objectively supported (Zimet et al., 1988).

Their fear of judgment and tendency toward self-criticism may interfere with the development of emotionally secure and supportive interpersonal connections (Flett and Hewitt, 2002).. On the other hand, individuals who perceive strong emotional and interpersonal support from family, friends, and significant others may experience greater reassurance, emotional validation, and coping assistance when dealing with perfectionistic concerns(Lakey and Orehek, 2011). Supportive relationships can decrease feelings of failure, inadequacy, and psychological distress related to maladaptive perfectionism (Cohen and Wills, 1985; Lakey and Orehek, 2011). In this way, perceived social support may function as an important psychosocial mechanism that influences the relationship between maladaptive perfectionism and anxiety and depression.

Social and familial norms are frequently deeply embedded in achievement attitudes and self-evaluation in Pakistani culture. People feel pressured to perform in the school, the job, and society in order to be accepted by family and society. These sociocultural expectations can perpetuate unhealthy perfectionistic patterns and make a person more vulnerable to anxiety and depression, especially when they feel they have low social support or feel they are being negatively evaluated (Batool and Khalid, 2012).

Therefore, the Multidimensional Theory of Perfectionism provides an important framework for understanding how maladaptive perfectionistic tendencies contribute to anxiety and depression, while also highlighting the potential role of perceived social support in influencing emotional adjustment among Pakistani adults (Frost et al., 1990; Lakey and Orehek, 2011).

1.6 Conceptual Model of the Study

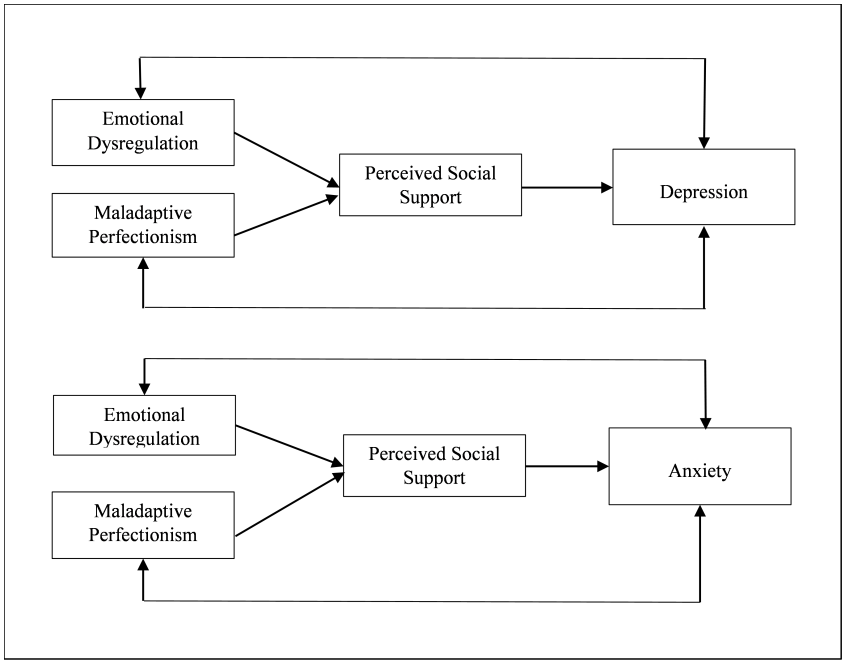

FIGURE 1.1: Conceptual Model of the Study

1.7 Research Objectives

The following are the objectives of this study:

i. To examine the relationship between emotional dysregulation (expressive suppression), maladaptive perfectionism and anxiety and depression among Pakistani adults, with perceived social support as a mediator.

ii. To explore the associations between demographic variables (gender, socioeconomic status, and family structure) and anxiety and depression.

1.8 Research Hypotheses

H1: Emotional dysregulation (expressive suppression) will be positively associated with anxiety and depression among Pakistani adults.

H2: Maladaptive perfectionism will be positively associated with anxiety and de¬pression among Pakistani adults.

H3: Perceived social support will mediate the relationships between emotional dysregulation (expressive suppression), maladaptive per¬fectionism and anxiety and depression among Pakistani adults.

H4: Female adults will report higher levels of anxiety and depression as compared to males.

H5: Adults who perceive themselves as belonging to lower socioeconomic backgrounds will report higher levels of anx¬iety and depression as compared to adults who perceive themselves as belonging to middle or upper socioeconomic statuses.

H6: Adults from single parent family systems will report higher levels of anxiety and depression as compared to adults belonging to nuclear and joint family systems.

Chapter 2

Literature Review

2.1 Depression and Anxiety

Depression and anxiety are among the most prevalent psychological disorders worldwide and frequently co-occur, sharing overlapping symptoms, risk factors, and developmental pathways. Both conditions involve persistent emotional distress and cognitive disruptions that significantly interfere with daily functioning, interpersonal relationships, academic performance, and overall quality of life (American Psychiatric Association, 2022). In the present study, depression and anxiety are conceptualized as outcome variables reflecting psychological distress among Pakistani adults in relation to dysfunctional emotion regulation strategies (expressive suppression), maladaptive perfectionism, and perceived social support.

Depression is defined as a mood disorder characterized by prolonged sadness, diminished interest in previously enjoyable activities, fatigue, feelings of worthlessness or excessive guilt, changes in appetite or sleep patterns, and, in severe cases, thoughts of self-harm or suicide (American Psychiatric Association, 2022). Anxiety is characterized by excessive and persistent worry, fear, and physiological arousal that disrupt normal functioning. Common symptoms include restlessness, muscle tension, increased heart rate, difficulty concentrating, and avoidance of perceived threats (American Psychiatric Association, 2022). While moderate anxiety can be adaptive and facilitate performance, chronic or disproportionate anxiety

leads to significant psychological distress and impairment. Among university students, anxiety is often linked to academic pressure, fear of failure, and concerns related to evaluation and social comparison, particularly in performance-oriented cultural contexts such as Pakistan (Khan et al., 2021).

Although depression and anxiety are classified as distinct disorders, they share common underlying mechanisms, including emotional dysregulation, maladaptive perfectionism, and inadequate perceived social support (Aldao et al., 2010; Flett and Hewitt, 2002; Cohen and Wills, 1985). Both conditions are associated with maladaptive emotional and cognitive processes such as rumination, suppression, avoidance, and excessive self-criticism (Egan et al., 2011). Individuals who struggle to regulate emotions effectively or who impose rigid perfectionistic standards on themselves are more vulnerable to experiencing anxiety and depression (Berking and Wupperman, 2012; Limburg et al., 2017). When such vulnerabilities are accompanied by limited perceived social support, the individual's capacity to cope with stress is further compromised, increasing the likelihood of depressive and anxious symptoms (Lakey and Orehek, 2011; Cohen and Wills, 1985).

In Pakistan, research conducted in South Punjab reported high prevalence rates of depression and anxiety among university students and young adults, with approximately 48.5% for depression and 41.1% for anxiety (Ijaz and Khalid, 2020). Several sociocultural factors contribute to this pattern, including academic competition, financial instability, unemployment concerns, and strong familial expectations. Cultural emphasis on achievement and social status often discourages open discussion of mental health concerns, leading many young individuals to suppress emotional distress and avoid seeking professional help (Rizvi and Najam, 2014).

Stigma surrounding mental illness remains a significant barrier in Pakistan, where psychological distress is frequently attributed to personal weakness or lack of faith (Rizvi and Najam, 2014; Mirza and Jenkins, 2004). Such beliefs discourage help-seeking behaviors and may contribute to the chronicity and severity of symptoms(Rizvi and Najam, 2014; Mirza and Jenkins, 2004). Gender-related dynamics

further complicate mental health outcomes. Research suggests that women experience higher rates of anxiety and depression due to gender-based discrimination, restricted autonomy, and sociocultural pressures (World Health Organization, 2023) . Conversely, men may experience anxiety and depression due to social norms that discourage emotional expression, often resulting in maladaptive coping strategies such as aggression or substance use (Addis and Mahalik, 2003).

From a theoretical perspective, depression and anxiety emerge from the interaction of intrapersonal and interpersonal processes (Aldao et al., 2010; Cohen and Wills, 1985). Intrapersonal factors, such as emotion regulation strategies, influence how individuals respond to stress and negative experiences, whereas interpersonal factors, such as perceived social support, affect how individuals seek reassurance, validation, and assistance (Gross, 1998; Cohen and Wills, 1985). Perfectionistic tendencies, particularly socially prescribed perfectionism, intensify both anxiety and depression by fostering unrealistic standards and fear of negative evaluation (Flett and Hewitt, 2002; Limburg et al., 2017).. When these tendencies coexist with poor emotion regulation and weak perceived social support, adults are more likely to internalize stress, leading to sustained anxiety and depression (Berking and Wupperman, 2012; Lakey and Orehek, 2011).

In the present study, depression and anxiety are conceptualized as outcomes reflecting the cumulative influence of emotional, cognitive, and social processes. Difficulties in emotion regulation heighten emotional reactivity, maladaptive perfectionism reinforces self-critical thinking, and insufficient perceived social support limits coping resources. Together, these factors create a psychological environment that increases vulnerability to depression and anxiety among Pakistani adults (Aldao et al., 2010; Cohen and Wills, 1985).

2.2 Emotion Regulation

Emotion regulation is defined as the mechanisms by which individuals can shape the nature of the emotions that they have, when and how they feel (Gross, 1998).

In psychological literature, emotion regulation strategies can be generally classified as either adaptive (functional) or maladaptive (dysfunctional) based on their effectiveness in alleviating emotional distress and enhancing psychological well-being. The relevance of maladaptive emotion regulation strategies, specifically in the development and persistence of anxiety and depression among university students is of particular interest.

The maladaptive strategies of emotion regulation are those that do not effectively lower negative emotional states and are usually linked with higher emotional intensity, long-lasting distress, and psychological dysfunction (Gross, 1998; Gross and John, 2003). Such strategies, according to the process model of Gross, tend to happen either once the emotion has been triggered or in a manner that disrupts adaptive emotional processing (Gross, 2015).

A meta-analytic review carried out by Aldao et al. (2010) offers robust empirical data that maladaptive emotion regulation strategies are always and significantly linked to psychopathology especially depression and anxiety. The analysis determined rumination, expressive suppression, avoidance, and catastrophizing as some of the most important maladaptive responses that demonstrate strong positive associations with emotional disorders in both clinical and non-clinical groups.
Notably, the authors concluded that maladaptive strategies are more predictive of psychopathology than is the case with adaptive strategies, which are more predictive of well-being, and have a central role in mental health outcomes.

Expressive suppression is another maladaptive strategy that has been extensively investigated and is described as inhibition of emotional expression following a previously activated emotional response (Gross and John, 2003). Whereas suppression might lower the external expression of emotion, it has no effect on internal emotional experience and can be accompanied by great mental effort.

Studies have always indicated that suppression is related to greater depressive symptoms, lower life satisfaction, impaired interpersonal functioning, and increased

anxiety and depression (Gross and John, 2003; Smith et al., 2016). A meta-analytic review revealed that suppression correlates with depression and anxiety, especially in that it avoids emotional processing and extends internal suffering (Aldao et al., 2010). Moreover, suppression has been observed to decrease social connectedness since people who suppress emotions are usually seen as less genuine in their interactions with people (Gross and John, 2003).

In collectivistic societies, like Pakistan, suppression can be socially supported by the culture that promotes emotional restraint, especially within the family and academic settings. Nonetheless, studies have indicated that the persistent repression is a cause of internal discomfort regardless of its acceptability in the society (Gross and John, 2003).

Adulthood especially in the university setting is the stage where there is heightened academic pressure, identity, and social judgment. Evidence indicates that academic stressors are associated with the use of maladaptive emotion regulation strategies by university students, particularly rumination and suppression (Aldao et al., 2010).

Research indicates as well that maladaptive emotion regulation is closely associated with anxiety and depressive symptomatology in college groups, indicating that these mechanisms are highly determinant in mental health outcomes in students (Aldao et al., 2010).

2.3 Perfectionisim

Perfectionism is a multidimensional personality trait, which is described by the propensity to make overly high standards of performance and overly critical self-assessment and the worry of how other people will assess us (Frost et al., 1990; Flett and Hewitt, 2002). Although in the early conceptualizations, perfectionism was seen as a unidimensional and essentially maladaptive characteristic, recent studies have noted that perfectionism has multidimensionality, with adaptive and

maladaptive dimensions (Smith et al., 2016).

This difference is especially crucial when considering the psychological outcomes since not every perfectionism is coupled with distress. Adaptive factors can stimulate success and motivation, and maladaptive ones are closely related to anxiety, depression, and emotional control problems. The Frost Multidimensional Perfectionism Scale (FMPS) was created by Frost et al. (1990) to conceptualize perfectionism in six dimensions: Concern over Mistakes, Doubts about Actions, Personal Standards, Parental Expectations, Parental Criticism and Organization. These dimensions have psychological implications that differ and are further divided into adaptive and maladaptive elements.

Concern over mistakes is the propensity to perceive mistakes as individual failures and signs of incompetence. People with high status on this dimension feel a lot of distress after any incidents of minor mistakes and indulge themselves with very strong self-criticism. This dimension has been found central in the maladaptive perfectionism where Frost et al. (1990) found that it is closely related with anxiety, depression, and fear of negative evaluation.

This association is supported with empirical research. Fear of error has been identified to forecast depressive symptoms, test anxiety, and maladaptive coping skills among university students (Dunkley et al., 2003). People with high levels on this dimension tend to ruminate and blame themselves, which also contributes to the increase of emotional distress.

Doubts about Actions is defined as a continuous uncertainty about the quality of performance, despite the completion of tasks. People who are high in this dimension often wonder whether they have done a good job and this results in repetitive checking and mental instability. This dimension has been associated with anxiety-related disorders, especially the obsessive-compulsive tendencies and the generalized anxiety (Frost et al., 1990). Studies reveal that the uncertainty about actions is linked to the amplified indecisiveness, diminished confidence, and

amplified psychological distress (Antony et al., 1998).

Parental expectations can be described as the feeling that the parents have unreasonable expectations towards the performance. Parental expectations tend to be a crucial factor in influencing academic motivation and self-worth in collectivistic societies, including Pakistan (Shah and Amjad, 2017).

Although moderate expectations are inspiring, high perceived expectations may be associated with external pressure, perceived fears of failure, and conditional self-esteem. It has been found that the parental expectations are positively related to stress, anxiety, and perfectionistic tendencies that are maladaptive in students (Frost et al., 1990; Enns et al., 2002).

Parental criticism is an expression of being overly criticized and not approved by parents. This dimension is part of internalizing self-critical attitudes and fear of negative evaluation. Studies have continually shown a close connection between parental criticism and depressive symptoms, low self-esteem, and emotional vulnerability (Frost et al., 1990). When people are exposed to high levels of parental criticism, they have a higher probability of developing maladaptive perfectionism that is typified by chronic dissatisfaction and self-doubt (Enns et al., 2002).

Academic pressure, competition, and evaluative conditions are some of the reasons why perfectionism can be mostly common among university students. Studies have shown that students with high maladaptive perfectionism tend to experience academic stress, fear of failure, procrastination, and symptoms of anxiety and depression (Flett and Hewitt, 2002).

Maladaptive perfectionism can be compounded in situations like in Pakistan where academic success is directly associated with familial demands and subsequent socioeconomic mobility. High expectations tend to be internalized and students become vulnerable to emotional distress by self-critical assessment (Ali and Aslam, 2016).

2.4 Perceived Social Support

Perceived Social support is the belief or fact that one is loved, appreciated, and is regarded as belonging to a supportive social system (Cohen and Wills, 1985). It is a highly important psychosocial asset that plays a significant role in psychological well-being and adaptation, especially in university students who have to cope with academic pressures, identity formation, and social adaptation. Family, peers, and significant others are expected sources of perceived social support in the university population, and they are crucial in determining emotional and psychological outcomes (Taylor, 2011).

Within the Pakistani culture, perceived social support is deeply rooted in collectivistic values, where people are tightly bound to the family systems and depend on them extensively to provide emotional, financial, and even social assistance (Khan et al., 2021). Pakistan has family structures that are mostly interdependent which may be a potent protective factor against stress. It is also worth mentioning, though, that the same family systems can turn out to be a form of pressure when the expectations about academic performance and social success are too high (Shah and Amjad, 2017). This is a two-fold role that complicates perceived social support in this cultural setting.

Perceived social support is usually categorized as a multidimensional concept that contains various forms of assistance. Emotional support is about showing care, empathy and reassurance to others, which make them feel that they are understood and appreciated (Cohen and Wills, 1985). Instrumental support means concrete assistance, i.e., financial aid or practical help in accomplishing tasks (Taylor, 2011). Informational support encompasses counseling, guidance and problem solving ideas that assist individuals to manage difficulties (House, 1981). Finally, there is the appraisal support, which is positive feedback and affirmation that help people analyze their situations more competently (Cohen and Wills, 1985).

The literature is rich with evidence that perceived social support is a crucial factor in psychological well-being, affecting emotional regulation, coping strategies, and

stress responses. People with stronger perceived networks tend to perceive stressful situations as manageable instead of overwhelming, thus also lowering emotional distress (Cohen and Wills, 1985; Taylor, 2011). This is especially important in a university setting where students get academic assessments and deadlines very often, and are also often subjected to comparison with peers.

Perceived social support also increases coping skills by offering emotional and instrumental support, which can help to diminish negative emotion regulation responses like rumination, avoidance, and expressive suppression (Aldao et al., 2010; Taylor, 2011).

Thus, perceived social support has been linked to more adaptive emotional functioning and psychological resilience. Supportive interpersonal relationships also play a role in emotional stabilization by validating, empathizing with, and supporting a sense of belonging, thus helping to process negative experiences more effectively and speed up emotional recovery (Cohen and Wills, 1985).

Empirical evidence consistently indicates that perceived social support is negatively correlated with depression, anxiety and stress among university students (Taylor, 2011). Students who perceive higher levels of support are able to report higher psychological adjustment, higher resilience and less emotional distress. The same has been reported in the Pakistani context.

For example, Rizvi and Najam (2014) identified a significant negative correlation between perceived social support and academic stress and anxiety and depression among university students. Likewise, Antony et al. (1998) found that family and peer support both significantly predicted better mental health outcomes and mitigated the negative psychological effects of academic stress and unclear futures.

Overall, the literature suggests that perceived social support serves as an important interpersonal and psychosocial resource that is associated with reduced levels of anxiety and depression and improved emotional well-being among university

students, including those in Pakistan.

2.5 Gender Differences in Vulnerability to Depression and Anxiety

Studies have consistently indicated that women are more anxious and depressed than men. Extensive epidemiological research has shown that the prevalence of anxiety disorders in women is much higher (on average 1.7 times as high as in men) and that they are also more likely to develop comorbid depression (Mirza and Jenkins, 2004). There is also meta-analytic evidence that females are approximately twice as prone to encounter major depressive disorder in comparison to males throughout the lifespan (Smith et al., 2016).

Furthermore, recent population-based studies have consistently found higher prevalence of anxiety and depression in women than men (Khan et al., 2021), indicating that this gender difference is stable across time and cultures. This chronicity suggests that the differences in emotional vulnerability observed are not just temporal or cultural, but have a long-lasting effect on emotional vulnerability throughout life.

2.6 Socioeconomic Status and Risk of Anxiety and Depression

Socioeconomic status has consistently been identified as an important factor influencing psychological well-being and vulnerability to mental health problems. Those from lower socioeconomic status are more likely to be exposed to chronic stressors of low income, lack of resources, unemployment, educational problems, and fewer opportunities for social mobility, which can lead to higher rates of anxiety and depression (Lorant et al., 2003). Several studies have consistently shown that socioeconomic disadvantage is related to higher levels of anxiety and depression and poor mental health outcomes in various populations (Reiss, 2013).

The results of the meta-analyses also suggest that people in lower SES groups are around 1.5 to 2 times more likely to develop depression than people in higher SES groups (Lorant et al., 2003). Financial strain and perceived social inequality may increase feelings of helplessness, insecurity, and reduced self-worth, thereby contributing to emotional distress and vulnerability to anxiety and depression (Lorant et al., 2003).

In addition to objective socioeconomic indicators such as income and occupation, individuals' subjective or perceived socioeconomic status has also been found to significantly influence psychological well-being (Addis and Mahalik, 2003). Perceived socioeconomic status is an individual's self-assessment of their social and economic position compared to other people. People who think they are in a lower socioeconomic class might feel more stressed, experience more social comparisons, and feel more disadvantaged, all of which can have a negative impact on their mental health (Addis and Mahalik, 2003). As such, objective and perceived socioeconomic disadvantage can increase vulnerability to anxiety and depression.

Socioeconomic inequities, inflation, financial insecurity, and a lack of mental health resources in Pakistan can also exacerbate emotional distress among lower socioeconomic groups (Lakey and Orehek, 2011; Patel et al., 2007; World Health Organization, 2023). Consequently, socioeconomic status remains an important psychosocial factor associated with anxiety and depression among Pakistani adults (Mirza and Jenkins, 2004).

2.7 Family Structure and Vulnerability to Anxiety and Depression

Family structure plays an important role in shaping individuals' emotional adjustment, coping resources, and psychological well-being. Past studies have consistently indicated a higher rate of anxiety and depression in single-parent families than in nuclear and joint families (Ali and Aslam, 2016).

This heightened vulnerability is typically blamed on the heightened financial burdens, lower emotional and instrumental support, increased caregiving duties, and higher levels of family-stress experienced by single-parent families (Khan et al., 2021). Emotional insecurity, role strain, and less parental support may lead to poorer psychological adjustment and to vulnerability to anxiety and depression can also negatively impact the emotional climate of the family, leading to loneliness, insecurity, and anxiety. (Amato, 2005).

Conversely, joint family systems have a greater capacity to offer social and emotional support via extended family members, shared responsibilities, and higher interpersonal connections (Shah and Amjad, 2017; Conger et al., 2010). Likewise, when the quality of family relationships and emotional climate in the family is taken into account, nuclear family systems may provide more autonomy, more clear communication patterns, and more meaningful parent-child interactions (Shah and Amjad, 2017). These supportive family environments may reduce emotional distress and enhance coping abilities during stressful life experiences.

Furthermore, supportive interpersonal relationships within families are considered important protective factors against psychological distress (Cohen and Wills, 1985; Taylor, 2011). Within family systems emotional reassurance, practical support and a sense of belonging can assist people to manage stress and emotional issues better. In other words, insufficient family support or higher family stress can make one more susceptible to anxiety and depression (Cohen and Wills, 1985).

Family systems are important in the Pakistani cultural context, as they can provide emotional and financial support as well as social guidance to individuals who may be heavily dependent on them (Shah and Amjad, 2017). Therefore, differences in family structure may substantially influence emotional well-being and susceptibility to anxiety and depression among Pakistani adults.

Chapter 3

Research Methodology

3.1 Research Design

The present study employed a cross-sectional research design to examine the re¬lationships among emotion dysregulation (expressive suppression), maladaptive perfectionism, perceived social support, and anxiety and depression among Pakistani adults. A cross-sectional approach was considered appropriate as it allows for the assessment of multiple psychological variables within a defined population at a single point in time and is commonly used in psychological research to identify associations among constructs.

3.2 Ethical Considerations

Ethical approval for the current study was obtained from the Ethics Review Committee of the Faculty of Management and Social Sciences, Capital University of Science and Technology. All participants were provided with a clear explanation of the study's purpose, procedures, and voluntary nature prior to participation. Written informed consent was obtained from all participants who were 18 years of age and older.

Confidentiality and anonymity were strictly maintained throughout the research process. Participants' identities were protected through the use of codes, and no

identifying information was included in any reports or publications. Data were stored securely and used solely for research purposes. Participants were informed of their right to decline answering any question and to withdraw from the study at any stage prior to data analysis without penalty or consequences.

3.3 Locale of the Study

The study was conducted in Rawalpindi and Islamabad, Pakistan, and included participants from both public and private sector universities located within these cities. These two urban centers were selected due to their diverse student populations, representing a wide range of socioeconomic, cultural, and educational backgrounds.

Participants were recruited from undergraduate and postgraduate programs. Inclusion of both public and private universities was intended to ensure representativeness and to capture variability in academic environments and social contexts. Data collection was carried out within university premises after obtaining formal permission from the respective administrations and in accordance with approved ethical guidelines.

3.4 Sampling Technique and Sample Size

To determine an appropriate sample size, the subject-to-item ratio method was used, which recommends a minimum of five participants per item included in the study instruments (Comrey and Lee, 1992). The total number of items across the four scales used in the study was 78, including the Emotion Regulation Questionnaire (10 items), Frost Multidimensional Perfectionism Scale (35 items), Multidimensional Scale of Perceived Social Support (12 items), and Depression Anxiety Stress Scales-21 (21 items).

Although the present study was conceptually focused on expressive suppression

as an indicator of emotional dysregulation (from the Emotion Regulation Questionnaire), maladaptive perfectionism dimensions from the Frost Multidimensional Perfectionism Scale, and anxiety and depression subscales of the DASS-21, the full versions of all scales were administered. This was required since the instruments used in the study were standardized instruments that were validated to be complete instruments and the use of only selected sub-scale or individual item may result in loss of validity, reliability, and psychometric integrity. Furthermore, the scoring processes of the standardized tools are conceived to be interpreted in the context of the whole scale administration, and partial administration might impact comparability with published norms and earlier reports. Thus, although the analytical interest was narrow, an administration of the full scale was maintained to guarantee methodology and follow standard psychometric procedures.

Based on the 5:1 ratio, the required sample size was calculated as 390 participants ($78 \times 5 = 390$). The final sample consisted of 390 university students aged 18 years and above, enrolled in public and private universities in Rawalpindi and Islamabad. Of these, 166 were male and 224 were female participants. Convenience sampling was used due to accessibility and feasibility within the academic setting.

3.4.1 Inclusion Criteria

Participants were included in the study if they met the following criteria:

i. Aged 18 years or older.

ii. Currently enrolled in a public or private university in Rawalpindi or Islamabad.

iii. Able to understand and respond to the study questionnaires.

3.4.2 Exclusion Criteria

Participants were excluded from the study if they met the following criteria:

i. Were below 18 years of age or not enrolled in a university program.

ii. Provided incomplete or inconsistent responses on the study measures.

3.5 Instruments

3.5.1 Demographic Sheet

A self-developed demographic form was used to collect basic participant information, including age, for descriptive purposes, whereas gender (male, female), educational level (bachelor's or master's), employment status (not employed, part-time employed, full-time employed, self-employed or internee), perceived socioeconomic status (lower, middle, or upper class), and family structure (nuclear, joint, or single-parent) were included to examine their associations with anxiety and depression.

3.5.2 Emotion Regulation Questionnaire

The Emotion Regulation Questionnaire (ERQ), developed by Gross and John (2003), is a 10-item self-report measure assessing two emotion regulation strategies: cognitive reappraisal (6 items) and expressive suppression (4 items). Responses are recorded on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree).

There are no reverse-coded items on the ERQ (Gross and John, 2003). Expressive suppression score is calculated by taking the mean of items 2, 4, 6, and 9, whereas cognitive reappraisal score is calculated by taking the mean of items 1, 3, 5, 7, 8, and 10.

The ERQ has demonstrated strong psychometric properties, including satisfactory internal consistency (with Cronbach's alpha values typically between .79 and .85 for reappraisal and .73 to .76 for suppression) and test–retest reliability (around .69 for reappraisal and .73 for suppression).

Factor analytic studies support its two-factor structure, and its validity has been established across diverse cultural contexts (Gross and John, 2003; Balzarotti et al., 2010).

3.5.3 Frost Multidimensional Perfectionism Scale

The Frost Multidimensional Perfectionism Scale, developed by Frost et al. (1990), is a 35-item self-report instrument designed to measure multiple dimensions of perfectionism. Each item is typically scored on 1-5 Likert Scale. The scale includes six subscales: Concern over Mistakes, Personal Standards, Parental Expectations, Parental Criticism, Doubts about Actions, and Organization. In the decades following its development, researchers have consistently categorized these dimensions into adaptive (Personal Standards and Organization) and maladaptive perfectionism, comprising of all other dimensions (Smith et al., 2016).

The total score of FMPS can be constituted by summing all items except those in the Organization subscale. This is because Organization subscale correlates poorly with the other dimensions and is often considered more "adaptive" trait (Frost et al., 1990). To calculate the maladaptive perfectionism score, using the Frost Multidimensional Perfectionism Scale, aggregate of the four subscales (Concerns over Mistakes, Doubts about Actions, Parental Expectations, and Parental Criticism) should be taken (Frost et al., 1990).

The FMPS demonstrates strong internal consistency (with Cronbach's alpha coefficients typically ranging from .70 to .90) and acceptable test–retest reliability. Previous research supports its factorial validity and its utility in distinguishing adaptive and maladaptive forms of perfectionism, particularly in relation to anxi¬ety and depression (Frost et al., 1990).

3.5.4 Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS), developed by Zimet et al. (1988), is a 12-item self-report measure assessing perceived social support from three sources: family, friends, and significant others. Each subscale contains four items rated on a 7-point Likert scale from 1 (very strongly disagree) to 7 (very strongly agree). Subscale and total scores are calculated by averaging item responses, with higher scores indicating greater perceived support.

The MSPSS has demonstrated excellent internal consistency (with Cronbach's alpha values typically reported above .85 for the total scale and ranging from .81 to .91 across the three subscales), and test–retest reliability (with coefficients ranging from .72 to .85 over periods of two to three months) and cross-cultural validity across diverse populations.

3.5.5 Depression Stress Anxiety Scales-21

The Depression Anxiety Stress Scales-21 (DASS-21), developed by Lovibond and Lovibond and Lovibond (1995), is a 21-item self-report instrument designed to assess symptoms of depression, anxiety, and stress. Each subscale consists of seven items rated on a 4-point Likert scale ranging from 0 (did not apply to me at all) to 3 (applied to me very much or most of the time). The sum of each subscale must be multiplied by 2 because the clinical severity labels were originally developed from 42-item version. Doubling the DASS-21 score allows to use those established norms (Lovibond Lovibond, 1995).

The DASS-21 has demonstrated strong internal consis¬tency (with Cronbach's alpha values typically above .90 for each subscale), con¬struct validity, and reliability and is widely used in both clinical and research settings.

Chapter 4

Results

The present study was conducted to examine the relationships among emotion dysregulation (expressive suppression), maladaptive perfectionism, perceived social support, and anxiety and depression among Pakistani adults. This chapter presents the findings obtained through descriptive and inferential statistical analyses aligned with the study objectives and hypotheses.

4.1 Data Analysis

Data analysis was conducted using the Statistical Package for Social Sciences (SPSS), Version 21. Prior to analysis, the data were screened and cleaned. No missing values were identified. Descriptive statistics, including frequencies, percentages, means, standard deviations, skewness, and kurtosis, were computed to summarize participant characteristics and study variables.

Preliminary analyses were conducted to check the assumption of normality for all primary variables (FMPS, ERQ, MSPSS, and DASS-21). Although Kolmogorov-Smirnov tests reached statistical significance ($p < .05$) for several variables, suggesting a departure from normality. This is a typical outcome for large samples ($N = 390$) where formal tests are overly sensitive to the minor deviations (Field, 2018).Visual inspection of histograms revealed distributions that were approximately symmetrical and bell-shaped. Furthermore, the mean, median, and mode

for each variable were found to be nearly identical, indicating a strong central tendency. Given the large sample size and the robustness of the Central Limit Theorem, parametric statistical tests were employed.

Reliability analyses were performed using Cronbach's alpha to assess internal consistency of all scales and sub-scales. Pearson Product-Moment correlation coefficients were computed to examine associations among emotion dysregulation (expressive suppression), maladaptive perfectionism, depression, and anxiety. Group differences across demographic variables were assessed using the Independent Sample t-test for two-group comparisons and the One-way ANOVA test for comparisons involving more than two groups. To examine the mediating role of perceived social support, mediation analyses were conducted using the PROCESS macro for SPSS (Version 4.2) developed by Hayes, employing Model 4 with bootstrapping procedures.

4.2 Descriptive Characteristics of the Sample

The demographic profile of the participants was defined by the young adult population, with all 390 respondents being aged 18-30. The most significant age range was the 22-25 year group that represented 50.3% of the total sample (n=196). The next age group was 26-30 year olds which represented 37.4% of the sample size (n = 146). The 18-21 year group had the smallest percentage, at 12.3% (n=48) of the sample. The final sample consisted of 390 participants, including 166 males (42.6%) and 224 females (57.4%). Regarding educational level, 212 participants (54.4%) were enrolled in bachelor's degree programs, while 178 participants (45.6%) were pur¬suing master's degrees. In terms of employment status, 127 participants (32.6%) were full-time students, 90 (23.1%) were part-time employed while studying, 113 (29.0%) were full-time employed, 37 (9.5%) were self-employed, and 23 (5.9%) were engaged in intern¬ships or trainee positions. The majority of participants belonged to the middle socioeconomic class (81.3%), followed by the upper class (11.8%) and lower class (6.9%). With respect to family structure, 186 participants (47.7%) reported living in nu¬clear families, 152 (39.0%) in joint family systems, and 52 (13.3%) in single-parent families.

TABLE 4.1: Demographic Characteristics of the Sample

Demographic Variable	**Categories**	*f*	%
Age	18–21 years	48	12.3
	22–25 years	196	50.3
	26–30 years	146	37.4
Gender	Male	166	42.6
	Female	224	57.4
Educational Level	Bachelor's	212	54.4
	Master's	178	45.6
Employment Status	Not employed	127	32.6
	Part-time employed	90	23.1
	Full-time employed	113	29.0
	Self-employed	37	9.5
	Internship or trainee position	23	5.9
Perceived Socioeconomic Status	Lower Class	27	6.9
	Middle Class	317	81.3
	Upper Class	46	11.8
Family Structure	Nuclear	186	47.7
	Joint	152	39.0
	Single Parent	52	13.3

Note. *f* = frequency of the sample; % = percentage of the sample.

4.3 Reliability of Scale

The internal consistency of the scales and subscales used in the current study was assessed using Cronbach's alpha (a) coefficients. According to the established psychometric standards, alpha values above .70 are considered to be acceptable, whereas alpha values above .80 and .90 are interpreted as good and excellent respectively. The reliability statistics for the total sample (N = 390) are summarized in the table below. The normality of the data for the total sample (N = 390) was assessed through a multi-method approach, considering measures of

TABLE 4.2: Mean, median, mode, standard deviation, skewness, kurtosis, normality test and its p value for Emotional Regulation Questionnaire subscale, the Frost Multidimensional Scale of Perfectionism subscales, Multidimensional Scale of Perceived Social Support, and subscales of Depression Anxiety Stress Scales-21 (N=390).

Scale and Subscales	**N**	**M**	**SD**	α	**Range**	**Skew**	**Kurt**
Expressive Suppression	4	16.50	6.03	0.83	0.43	0.15	-0.81
Concern over Mistakes	9	26.61	5.62	0.71	0.58	0.29	0.53
Parental Expectations	5	15.68	3.81	0.65	0.38	0.12	-0.39
Parental Criticism	4	11.54	2.92	0.53	0.15	0.10	-0.04
Doubts about Actions	4	11.79	3.02	0.59	0.26	0.12	-0.30
MSPSS	12	50.00	14.35	0.91	0.58	0.10	-0.39
Depression	7	9.07	4.42	0.76	0.12	0.00	-0.14
Anxiety	7	8.80	4.23	0.70	0.21	0.04	-0.22

Note. N = number of items; M = mean; SD = standard deviation; α = Cronbach's alpha; MSPSS = Multidimensional Scale of Perceived Social Support; Skewness = distribution asymmetry; Kurtosis = distribution peakedness.

central tendency, distributional shape, and formal normality tests. This finding is often due to the high sensitivity of the Kolmogorov-Smirnov (K-S) tests to larger sample sizes than to a significant violation of assumptions of normality. Further review of the descriptive statistics showed that the mean, median, and mode of each variable were very close, which indicated symmetrical distributions of all constructs. In addition, skewness and kurtosis values of all the scales were well within the acceptable range of -1 to +1, with the largest skewness reported at 0.29 in Concern over Mistakes, and the highest kurtosis at -0.81 in expressive suppression.

While formal tests of normality may be significant, this is expected in a large sample (N = 390) due to increased statistical power. Following Field (2018), the assumption of normality was justified through the Central Limit Theorem, the minimal discrepancy between measures of central tendency, and a visual inspection of histograms which confirmed a distribution that is approximately normal and suitable for parametric analysis.

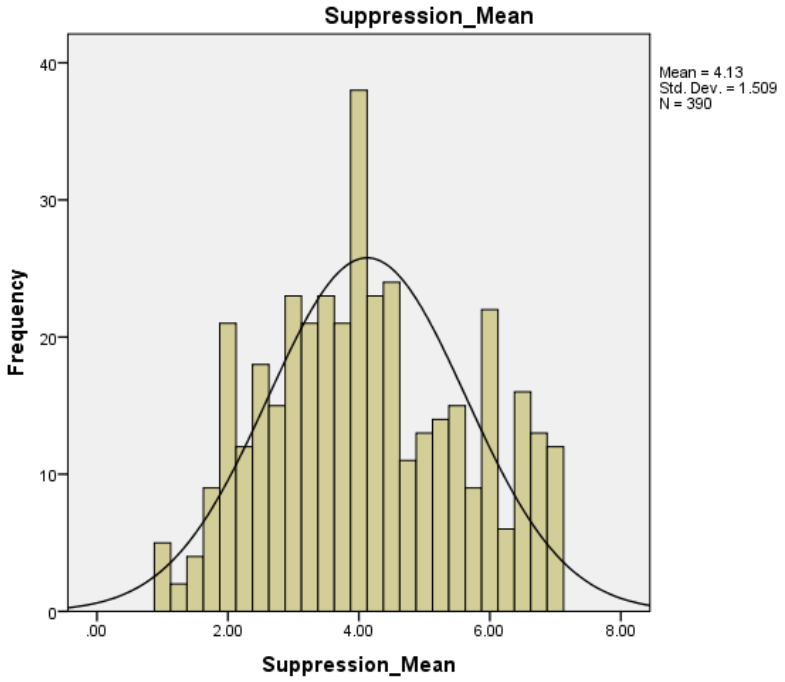

FIGURE 4.1: Distribution of Scores across Expressive Suppression Dimension of Emotion Regulation Questionnaire (ERQ) (N=390).

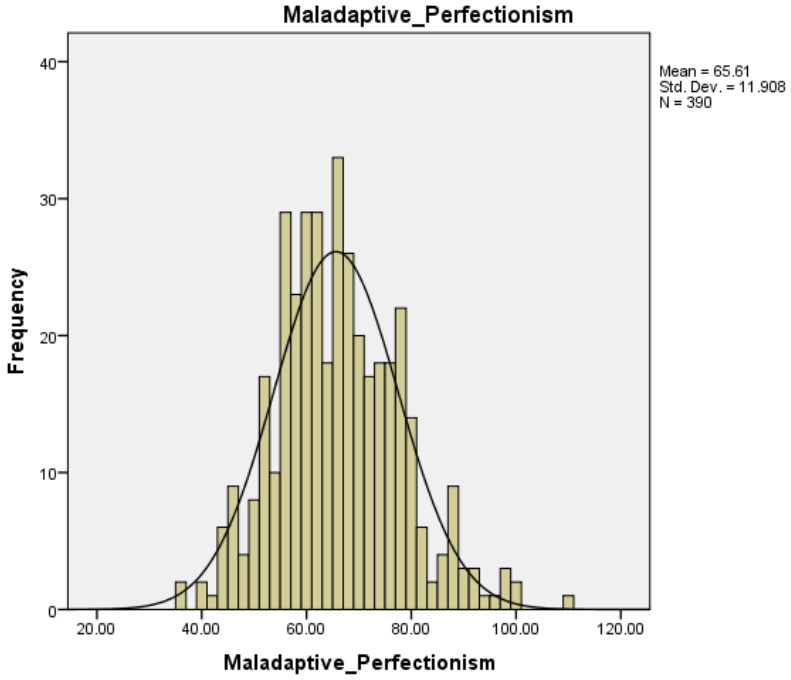

FIGURE 4.2: Distribution of Scores across Concern over Mistakes, Parental Expectations, Parental Criticism, and Doubts about Actions (Maladaptive Perfectionism) Dimensions of the Frost Multidimensional Perfectionism Scale (FMPS) (N=390).

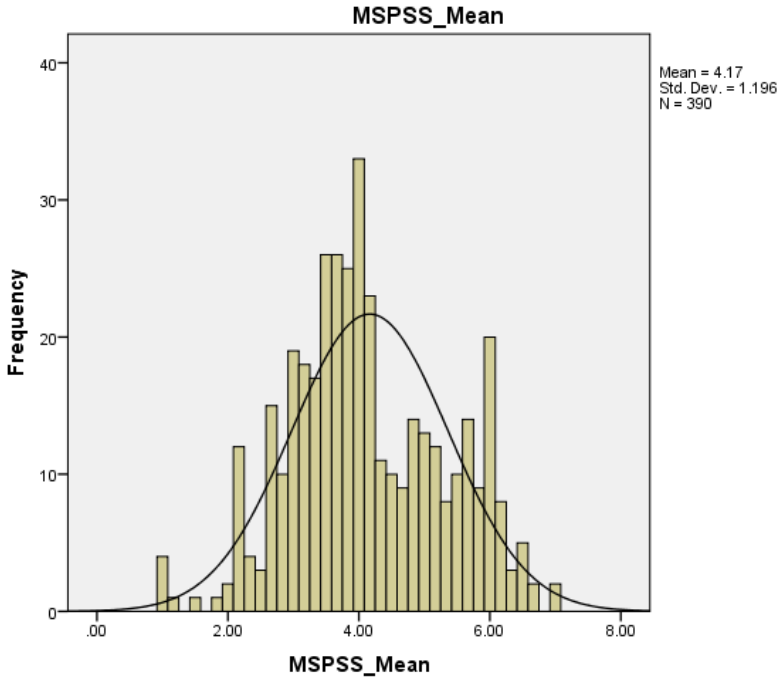

FIGURE 4.3: Distribution of Scores across the Multidimensional Scale of Perceived Social Support (MSPSS) (N=390).

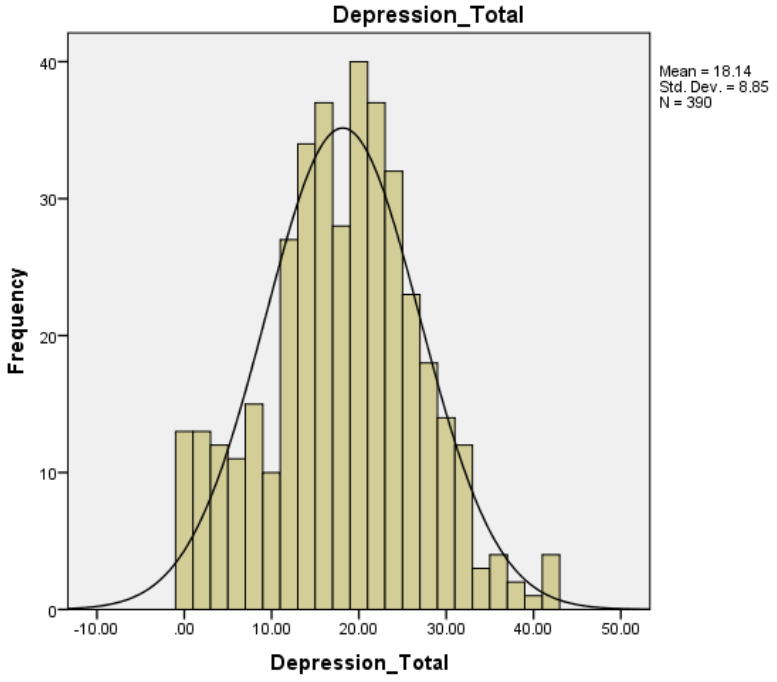

FIGURE 4.4: Distribution of Scores across the Depression Dimensions of Depression Anxiety Stress Scales-21 (DASS-21) (N=390).

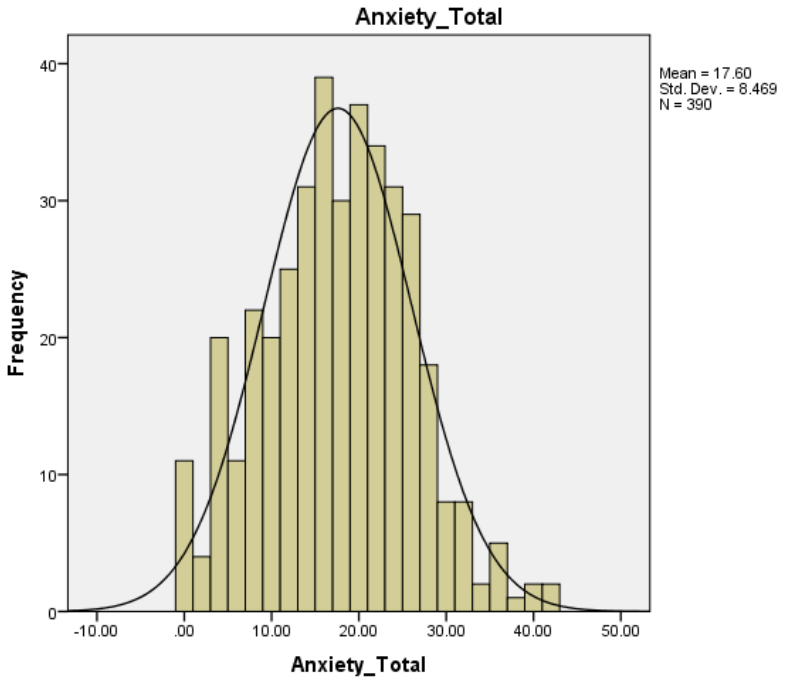

FIGURE 4.5: Distribution of Scores across the Anxiety Dimensions of Depression Anxiety Stress Scales-21 (DASS-21) (N=390).

4.4 Association of Emotion Dysregulation i.e. Expressive Suppression with Depression and Anxiety

Hypothesis 1 proposed emotional dysregulation (expressive suppression) will be positively associated with anxiety and depres¬sion among Pakistani adults.

TABLE 4.3: Association of emotional dysregulation measured through Emotional Regulation Questionnaire with depression and anxiety measured through Depression Anxiety Stress Scales-21 (N=390).

Variables	**1**	**2**	**3**
1. Emotional Dysregulation (Expressive Suppression)	–	.094	.129*
2. Depression	–	–	.690**
3. Anxiety	–	–	–

Note. $^{*}p < .05$, $^{**}p < .01$.

The results indicate a non-significant, very weak relationship between expressive suppression and depression (r = .094, p ¿ .05). Nonetheless, there was a significant, although weak, positive correlation between expressive suppression and anxiety(r =.129, p ¡.05), indicating that the higher the tendency to suppress emotional expression, the higher the levels of anxiety tend to be within the sample.

4.5 Association of Maladaptive Perfectionism with Depression and Anxiety

Hypothesis 2 suggested that maladaptive perfectionism will be positively associated with anxiety and de¬pression among Pakistani adults.

TABLE 4.4: Association of Maladaptive Perfectionism (Concern over Mistakes, Doubts about Actions, Parental Criticism, Parental Expectations) measured through the Frost Multidimensional Scale of Perfectionism (FMPS) with depression and anxiety measured through Depression Anxiety Stress Scales-21 (DASS-21) (N=390).

Variables	**1**	**2**	**3**
1. Maladaptive Perfectionism	–	.378**	.328**
2. Depression	–	–	.690**
3. Anxiety	–	–	–

Note. $^{**}p < .01$, $^{*}p < .05$.

Maladaptive perfectionism showed a significant moderate positive correlation with depression (r =.378, p ¡ .01) and a significant moderate positive correlation with anxiety (r =.328, p ¡ .01). These findings suggest that individuals who report higher levels of maladaptive perfectionistic tendencies, such as concern over mistakes and doubts about actions, are likely to experience higher levels of both depression and anxiety. Stable and highly significant positive correlation was observed between depression and anxiety in both tables of the analysis (r = +.690, p ¡.01). This implies that the two constructs are strongly interrelated since high levels of depressive symptoms are strongly correlated with high levels of anxiety symptoms in the present sample.

4.6 Mediating Role of Perceived Social Support in the Relationship between Emotional Dysregulation i.e. Expressive Suppression, Maladaptive Perfectionism and Anxiety and Depression

Hypothesis 3 proposed that perceived social support will mediate the relationships between emotional dysregulation (expressive suppression), maladaptive perfectionism and anxiety and depression among Pakistani adults.

In the first mediation model, perceived social support significantly mediated the relationship between expressive suppression and depression. The findings revealed that expressive suppression significantly predicted perceived social support (a path, B = 0.78, p ¡ .001), while perceived social support significantly predicted lower levels of depression (b path, B = -0.06, p ¡ .001). Furthermore, the direct effect of expressive suppression on depression remained significant even after including the mediator (c path, B = 0.11, p ¡ .001). The indirect effect was also significant (B = -0.04, CI [-0.08, -0.02]), as the confidence interval did not include zero. These findings indicate a significant partial mediation, suggesting that perceived social support partially explains the association between expressive suppression and depression, although additional mechanisms may also contribute to this relationship.

In the second mediation model, perceived social support significantly mediated the relationship between expressive suppression and anxiety. Expressive suppression significantly predicted increased perceived social support (a path, B = 0.78, p ¡ .001), whereas perceived social support significantly predicted lower anxiety levels (b path, B = -0.06, p ¡ .001). The direct effect of expressive suppression on anxiety remained statistically significant after controlling for the mediator (c path, B = 0.14, p ¡ .001). Moreover, the indirect effect was significant (B = -0.05,

CI [-0.09, -0.02]), indicating that the confidence interval excluded zero. Therefore, the mediation was partial in nature, demonstrating that perceived social support serves as one of the mechanisms through which expressive suppression influences anxiety, while other direct pathways may also exist.

The third mediation analysis examined whether perceived social support mediated the relationship between maladaptive perfectionism and depression. Results showed that maladaptive perfectionism significantly predicted perceived social support, although the effect size was very small (a path, B = 0.01, p = .02). Perceived social support significantly predicted lower depression levels (b path, B = -1.83, p $<$ .001), and maladaptive perfectionism also had a significant direct positive effect on depression (c path, B = 0.30, p ¡ .001). However, the indirect effect was not statistically significant (B = -0.02, CI [-0.04, 0.00]) because the confidence interval included zero. These findings suggest that perceived social support does not significantly mediate the relationship between maladaptive perfectionism and depression, indicating that maladaptive perfectionism influences depression primarily through direct pathways rather than indirectly through social support.

In the fourth mediation model, perceived social support was tested as a mediator between maladaptive perfectionism and anxiety. The findings demonstrated that maladaptive perfectionism had a small but significant positive effect on perceived social support (a path, B = 0.01, p = .02), while perceived social support significantly predicted lower anxiety levels (b path, B = -1.43, p = .001).

Additionally, maladaptive perfectionism maintained a significant direct positive effect on anxiety even after including the mediator (c path, B = 0.25, p ¡ .001). Although the indirect effect was negative, it was not statistically significant (B = -0.01, CI [-0.03, 0.00]) because the confidence interval included zero. Therefore, the results indicate no significant mediation effect, suggesting that perceived social support does not explain the relationship between maladaptive perfectionism and anxiety, and that maladaptive perfectionism affects anxiety predominantly through direct influences.

Table 4.5: Mediating Role of Perceived Social Support in Relationship between Expressive Suppression and Depression (N=390).

Effect	**Variable**	**Predictor**	**B**	**SE**	**t**	***p***	**F**	**df1**	**df2**		**LL**	**UL**
a path (ES → PSS)	PSS	ES	0.78	0.11	6.90	< .001	47.61	1	388	0.33	0.56	1.01
b path (PSS → D)	D	PSS	-0.06	0.01	-4.25	< .001	-	-	-	-0.23	-0.08	-0.03
c path (ES → D)	D	ES	0.11	0.03	3.53	< .001	12.51	2	387	0.18	0.05	0.18
Total effect (c)	D	ES	0.06	-	-	-	-	-	-	-	-	-
Indirect effect (a×b)	D	PS	-0.04	0.01	-	-	-	-	-	-0.07	-0.08	-0.02

Note. Note: ES=Expressive suppression, PSS=Perceived social support, D=Depression, B=unstandardized regression coefficient; SE=standard error; p=significance value; df1=numerator degrees of freedom; df2=denominator degrees of freedom; =standardized regression coefficient; LL=lower limit of 95% confidence interval; UL=upper limit of 95% confidence interval; a path=effect of independent variable on mediator; b path=effect of mediator on dependent variable; c' path=direct effect of independent variable on dependent variable controlling for mediator; c path=total effect of independent variable on dependent variable.

TABLE 4.6: Mediating Role of Perceived Social Support in Relationship between Expressive Suppression and Anxiety (N=390).

Effect	**Variable**	**Predictor**	**B**	**SE**	**t**	***p***	**F**	**df1**	**df2**		**LL**	**UL**
a path (PSS → ES)	PSS	ES	0.78	0.11	6.90	< .001	47.61	1	388	0.33	0.56	1.01
b path (PSS → A)	A	PSS	-0.06	0.01	-4.40	< .001	-	-	-	-0.22	-0.09	-0.03
c path (ES → A)	A	ES	0.14	0.03	3.92	< .001	13.10	2	387	0.20	0.07	0.21
Total effect (c)	A	ES	0.19	-	-	-	-	-	-	-	-	-
Indirect effect (a×b)	A	PSS	-0.05	0.01	-	-	-	-	-	-0.07	-0.09	- 0.02

Note: ES=Expressive suppression, PSS=Perceived social support, A=Anxiety, B=unstandardized regression coefficient; SE=standard error; p=significance value; df1=numerator degrees of freedom; df2=denominator degrees of freedom; =standardized regression coefficient; LL=lower limit of 95% confidence interval; UL=upper limit of 95% confidence interval; a path=effect of independent variable on mediator; b path=effect of mediator on dependent variable; c' path=direct effect of independent variable on dependent variable controlling for mediator; c path=total effect of independent variable on dependent variable.

TABLE 4.7: Mediating Role of Perceived Social Support in Relationship between Maladaptive Perfectionism and Depression (N=390).

Effect	**Variable**	**Predictor**	**B**	**SE**	**t**	***p***	**F**	**df1**	**df2**		**LL**	**UL**
a path (MP → PSS)	PSS	MP	0.01	0.00	2.29	0.02	5.25	1	388	0.11	0.00	0.02
b path (PSS → D)	D	PSS	-1.83	0.33	-5.42	< .001	-	-	-	-0.24	-2.49	-1.17
c path (MP → D)	D	MP	0.30	0.03	8.89	< .001	49.4	2	387	0.40	0.23	0.36
Total effect (c)	D	MP	0.28	0.03	8.03	< .001	64.6	1	388	0.37	0.21	0.34
Indirect effect (a×b)	D	PSS	-0.02	0.01*	-	-	-	-	-	-0.02	-0.04	0.00

Note. MP=Maladaptive perfectionism, PSS=Perceived social support, D=Depression, B=unstandardized regression coefficient; SE=standard error; p=significance value; df1=numerator degrees of freedom; df2=denominator degrees of freedom; =standardized regression coefficient; LL=lower limit of 95% confidence interval; UL=upper limit of 95% confidence interval; a path=effect of independent variable on mediator; b path=effect of mediator on dependent variable; c' path=direct effect of independent variable on dependent variable controlling for mediator; c path=total effect of independent variable on dependent variable..

TABLE 4.8: Mediating Role of Perceived Social Support in Relationship between Maladaptive Perfectionism and Anxiety (N=390).

Effect	**Variable**	**Predictor**	**B**	**SE**	**t**	***p***	**F**	**df1**	**df2**		**LL**	**UL**
a path (MP → PSS)	PSS	MP	0.01	0.00	2.29	0.02	5.25	1	388	0.11	0.00	0.02
b path (PSS → A)	A	PSS	-1.43	0.33	-4.28	< .001	-	-	-	-0.20	-2.09	-0.77
c path (MP → D)	A	MP	0.25	0.03	7.44	< .001	33.64	2	387	0.35	0.18	0.31
Total effect (c)	A	MP	0.23	0.03	6.84	< .001	46.83	1	388	0.32	0.16	0.30
Indirect effect (a×b)	A	PSS	-0.01	0.01*	-	-	-	-	-	-0.02	-0.03	0.00

Note: MP=Maladaptive perfectionism, PSS=Perceived social support, A=Anxiety, B=unstandardized regression coefficient; SE=standard error; p=significance value; df1=numerator degrees of freedom; df2=denominator degrees of freedom; =standardized regression coefficient; LL=lower limit of 95% confidence interval; UL=upper limit of 95% confidence interval; a path=effect of independent variable on mediator; b path=effect of mediator on dependent variable; c' path=direct effect of independent variable on dependent variable controlling for mediator; c path=total effect of independent variable on dependent variable.

4.7 Gender Differences in Vulnerability to Depression and Anxiety

Hypothesis 4 postulates that female adults will report higher levels of anxiety and depression as compared to males. An independent sample t-test was conducted

TABLE 4.9: Gender Differences in Experiencing Depression and Anxiety Measured by DASS-21 (N=390).

	Male (N = 166)				**Female (N = 224)**			
Variable	M	SD	t	p	M	SD	LL	UL
Depression	18.32	8.67	0.35	0.86	18.00	8.99	-1.45	2.10
Anxiety	17.60	8.28	0.00	0.92	17.59	8.62	-1.70	1.71

Note. M = Mean; SD = Standard Deviation; t = t-value; p = significance value; LL = lower limit; UL = upper limit; CI = confidence interval.

to compare the scores between male (n = 166) and female (n = 224) participants. The results indicated no significant differences between genders for depression, t (388) = 0.35, p = .86, or anxiety, t (388) = 0.00, p = .92. For depression, males (M = 18.32, SD = 8.67) and females (M = 18.00, SD = 8.99) reported nearly identical levels of depression and anxiety. Similarly, anxiety scores for males (M = 17.60, SD = 8.28) and females (M = 17.59, SD = 8.62) showed negligible variation. The very small effect sizes (Cohen's d ranging from 0.00 to 0.03) further suggest that gender does not significantly impact these constructs within the current sample.

4.8 Socioeconomic Status and Risk of Anxiety and Depression

According to Hypothesis 5 adults who perceive themselves as belonging to lower socioeconomic backgrounds will report higher levels of anx¬iety and depression as compared to adults who perceive themselves as belonging to middle or upper socioeconomic statuses. A one-way ANOVA was conducted to determine if anxiety

Table 4.10: Socioeconomic Differences in Experiencing Depression and Anxiety Measured by DASS-21 (N=390).

Variable	**Source**	**SS**	**df**	**MS**	**F**	**p**
Depression	Between Groups	102.63	2	51.31	0.65	0.52
	Within Groups	30365.89	387	78.46	—	—
	Total	30468.52	389	—	—	—
Anxiety	Between Groups	66.73	2	33.36	0.46	0.62
	Within Groups	27830.86	387	71.91	—	—
	Total	27897.60	389	—	—	—

Note. SS = Sum of Squares; df = Degrees of Freedom; MS = Mean Square; F = F-ratio/statistic; p = significance value.

and depression varied across perceived socioeconomic classes (Lower, Middle, and Upper class). No significant differences were found between socioeconomic groups for depression, F (2, 387) = 0.65, p = .52, or anxiety, F (2, 387) = 0.46, p = .62. These findings imply that the participants' perceived socioeconomic standing was not a differentiating factor for their levels of depression or anxiety.

4.9 Family Structure and Vulnerability to Anxiety and Depression

Hypothesis 6 postulates that adults from single parent family systems will report higher levels of anxiety and depression as compared to adults belonging to nuclear and joint family systems.

Table 4.11: Family Structure Differences in Experiencing Depression and Anxiety Measured by DASS-21 (N=390).

Variable	**Source**	**SS**	**df**	**MS**	**F**	**p**
Depression	Between Groups	161.62	2	80.81	1.03	0.35
	Within Groups	30306.89	387	78.31	—	—
	Total	30468.52	389	—	—	—
Anxiety	Between Groups	369.14	2	184.57	2.59	0.76
	Within Groups	27528.45	387	71.13	—	—
	Total	27897.60	389	—	—	—

Note. SS = Sum of Squares; df = Degrees of Freedom; MS = Mean Square; F = F-ratio/statistic; p = significance value.

Similarly, the impact of family structure (Nuclear, Joint, or Single Parent) was analyzed. The findings indicated that there were no statistically significant differences in depression, F (2, 387) = 1.03, p =.35, or anxiety, F (2, 387) = 2.59, p =.76, across the various family types. This suggests that the domestic environment, in terms of household composition, did not lead to significant variations in the reported psychological distress of the sample.

Chapter 5

Discussion and Conclusion

The current study explored the associations between emotional dysregulation (expressive suppression), maladaptive perfectionism, perceived social support, and anxiety and depression in a sample of 390 Pakistani adults. The results indicated that emotional dysregulation (expressive suppression) was correlated with higher anxiety scores. While the initial correlation with depression was weak, mediation analysis confirmed that expressive suppression significantly predicts both depression and anxiety. This indicates that suppressing outward expression of emotions, which is a typical strategy among adults, is associated with psychological distress. Likewise, maladaptive perfectionism showed significant positive correlations with depression and anxiety. This indicates that individuals who experience high concern over mistakes and perceive intense parental expectations or criticism are more emotionally vulnerable to symptoms of anxiety and depression.

The study also examined the mediating role of perceived social support in the relationship between these psychological vulnerabilities and anxiety and depression. The findings revealed that perceived social support significantly mediated between expressive suppression and depression and anxiety. Since the direct effects remained significant, this indicates partial mediation, suggesting that perceived social support accounts for some, but not all, of this relationship. However, contrary to the initial hypotheses, perceived social support did not significantly mediate the relationship between maladaptive perfectionism and either depression or anxiety.

Rather, the contribution of perfectionistic tendencies to mental health seems to be direct, suggesting that perception of external social resources is not likely to be a significant buffer against perfectionism in this sample.

The study also examined gender, socioeconomic status and other family differences in depression and anxiety. The results revealed that there were no statistically significant sex differences in the mean scores of depression and anxiety reported by male and female participants. Furthermore, no statistically significant differences were found in depression or anxiety based on perceived socioeconomic status or family structure, such as living in nuclear or joint family systems. This indicates that psychological distress in this particular population was not differentiated by the domestic environment and socioeconomic status. These findings are explained in detail in the following sections, with their theoretical and practical implications.

5.1 Reliability of Study Instruments

As for the internal consistency of the instruments applied in the present research, the results showed satisfactory to excellent, meaning that the instruments used measured the intended constructs in the target population with high reliability. The Expressive Suppression subscale of the Emotion Regulation Questionnaire yielded good reliability (a = .836), which is consistent with previous research suggesting that the ERQ maintains strong psychometric properties across diverse cultural contexts. The high reliability indicates that the responses to these items assessing the outward expression of emotions were consistently understood and acted upon, further confirming the consistency of the emotion regulation data in this sample.

Similarly, the Multidimensional Scale of Perceived Social Support (MSPSS) demonstrated excellent internal consistency (a = .917), which aligns with international and regional validation studies confirming its robustness in measuring social resources. The subscales of Depression and Anxiety of Depression Anxiety Stress Scales-21 (DASS-21) met the required criterion with depression (a = .762) and

anxiety (a = .706), which shows that the Depression Anxiety Stress Scales-21 is suitable in the assessment of psychological distress in a non-clinical Pakistani sample.

Regarding the Frost Multidimensional Perfectionism Scale (FMPS), the Concern over Mistakes subscale showed acceptable reliability (a = .719). However, relatively lower coefficients were observed for Parental Expectations (a = .655), Doubts about Actions (a = .593), and Parental Criticism (a = .534). While these values fall below the traditional .70 cutoff, such findings are common in subscales with a small number of items, such as the four-item sets used here. In the Pakistani context, these differences could also be understood as the influence of collectivist values and social evaluations on the expression of perfectionistic tendencies. Overall, the satisfactory reliability of these instruments provides a solid foundation for the validity of the subsequent statistical analyses.

5.2 Discussion for Hypothesis 1

Results of the present study support the first hypothesis, as emotional dysregulation in the form of habituated use of expressive suppression was found to be a significant predictor of depression and anxiety among Pakistani adults. The bivariate correlations were initially found to be small, but the path analyses yielded significant positive effects of expressive suppression on depression (B = 0.11, p ¡ .001) and anxiety (B = 0.14, p ¡ .001). These findings indicate that suppression of outward expression of emotions is not a neutral process of self-control but an active process that heightens inner conflict and is cognitively demanding (Gross and John, 2003).

Theoretically, these findings correspond with the Process Model of Emotion Regulation (Gross, 1998). Expressive suppression is considered a "response-focused" strategy, which occurs late in the emotion-generating process, after the emotional response is fully formed. Unlike cognitive reappraisal, which focuses on the "input" by changing the way a person thinks about a situation, suppression focuses

only on the "output." This results in what is known as the "Suppression Paradox": the person might look calm and composed on the outside but on the inside they are reacting physiologically in a certain manner. Constantly monitoring and suppressing emotions has been found to be a very effortful process, and it places a constant "cognitive tax" on executive resources (Gross, 2015). This reduces mental capacity to engage in adaptive problem solving, which eventually becomes the emotional exhaustion that is experienced during depression and the hypervigilance that occurs during anxiety. Such findings carry greater weight when views in the Pakistani context. In many collectivistic societies, emotional restraint is socialized as a mark of maturity, moral discipline, and respect for social hierarchies (Mirza and Jenkins, 2004). In Pakistan, people can learn from a young age to maintain harmony at the expense of self-expression, resulting in a "burden of harmony." Therefore, suppression often acts as a "social survival tool" to prevent conflict or to protect the family from the "shame" of personal struggle. However, the current data highlights a tragic irony: the very strategy used to protect social relationships actually creates a profound internalized burden. That in this context, suppression becomes a form of "silence" to prevent the cognitive processing of negative affect. Emotions that are suppressed stay "active" in the mind, frequently contributing to rumination which is a known risk factor for depressive symptoms (Aldao et al., 2010).

Furthermore, the detrimental impact of suppression extends into the interpersonal realm through the breakdown of social signals. Emotional expressions are evolved mechanisms that communicate our internal needs to others (Shafran et al., 2002). By masking these signals, individuals inadvertently sabotage their own social support systems. When an adult is able to successfully suppress their distressing emotions, they signal to their environment that they are coping well. This makes that family and peers, who are potentially a source of support, are unaware of the need for support (Butler et al., 2003). This perpetuates a cycle of isolation: The person feels lonely because they are not known to be that way, and their continued suppression keeps them isolated. The high comorbidity between depression and anxiety ($r = .690$, p ¡ $.01$) in this study likely reflects that suppression is a

common feature and trigger for transdiagnostic distress (Clark and Watson, 1991).

Overall, the findings indicate that use of expressive suppression is a maladaptive compromise for Pakistani adults. It can help maintain social status quo and accommodate cultural expectations of discipline in the immediate sense, but the price paid is a greater risk of emotional fragility in the future. The results highlight the critical need for mental health interventions that explicitly aim to destigmatize the experience of emotions and to teach adaptive regulation strategies, such as cognitive reappraisal, which enable emotions to be processed without the heavy cognitive and physiological burden of emotion suppression (Gross and John, 2003).

5.3 Discussion for Hypothesis 2

The results of the present study lend substantial empirical support to the second hypothesis, that maladaptive perfectionism is a strong and significant predictor of depression and anxiety. Correlation analyses revealed moderate positive relationships between maladaptive perfectionism and depression (r = .378, p ¡ .01) as well as anxiety (r = .328, p ¡ .01). Additionally, maladaptive perfectionism was found to have a significant direct effect on depression symptoms (B = 0.28, p ¡ .001) and anxiety level (B = 0.25, p ¡ .001) as revealed by regression models. The present findings indicate that the cognitive structure of maladaptive perfectionism which is the overreliance to evaluate oneself in terms of unattainable standards is a major source of psychological distress in the Pakistani context (Frost et al., 1990).

Theoretically, these results are consistent with the Cognitive-Behavioral Model of Perfectionism, which suggests that people with high maladaptive perfectionism are caught in a vicious circle of "all-or-nothing" thinking (Shafran et al., 2002)(. Two particular sub scales "Concern over Mistakes" and "Parental Expectations" were found to be very important in this study. Chronic evaluative threat occurs when people are seeing failures as their fault, instead of learning from them. This constant self-examination perpetuates a "perfectionism-procrastination-paralysis"

cycle that can result in the sense of hopelessness found in depression and a constant sense of worry found in anxiety (Smith et al., 2016).

The findings have significance in the Pakistani cultural context. Pakistani society is highly collectivist and hierarchical, where an individual's success is seen as an honour to the family (Ghairat). The results of the FMPS showed that the high scores for "Parental Expectations" and "Parental Criticism" underscore the fact that for numerous Pakistani adults, perfectionism is more than just a personal characteristic; it is a perceived social expectation (Hassan et al., 2015). For this, the fear of error is compounded with the fear of introducing "shame" from a social or family origin.

This cultural pressure results in the development of a type of "Socially Prescribed Perfectionism" which manifests as the belief that the person must match another person's standard of perfection to be accepted. Because these standards are often perceived as external and non-negotiable, the individual feels a lack of autonomy, which is a significant contributor to depressive affect. This persistence fear of bringing disappointment to one's family and community directly alleviates anxiety levels (Shafran et al., 2002). Finally, the strong correlation between maladaptive perfectionism with comorbid depression and anxiety ($r = .690$) also suggests that perfectionism serves as a transdiagnostic vulnerability factor. Perfectionism triggers a specific kind of "evaluative rumination" in which people ruminate about their failures over and over again. This inner voice keeps the person in a state of distress, regardless of their actual achievements.

To sum up, maladaptive perfectionism is a significant internal vulnerability that is directly linked with the deterioration of mental health among Pakistani adults. The findings highlight that this population experiences a psychological climate which is inherently conducive to anxiety and depression as a result of the internal drive for perfection, combined with perceived pressures from culture and family. Interventions should therefore aim to enhance self-compassion and to break the cycle of perfectionistic thinking, with a particular focus on separating one's sense

of self from one's performance(Nadeem et al., 2020).

5.4 Discussion for Hypothesis 3

The third hypothesis of this study proposed that perceived social support would serve as a significant mediator in the relationship between psychological vulnerabilities, specifically expressive suppression and maladaptive perfectionism, and mental health outcomes and depression and anxiety. The findings from the mediation analysis gave a complex and dichotomous picture of the interaction between external social resources and internal cognitive-emotional process. The hypothesis was confirmed for emotion regulation but not for maladaptive perfectionism, indicating that emotion regulation and maladaptive perfectionism are influenced differently by the social environment and psychological vulnerabilities.

In the case of emotion regulation, the results showed that perceived social support significantly mediated the relationship between expressive suppression and depression and anxiety. Interestingly, the analysis revealed a significant positive "a-path," showing that expressive suppression actually had a significant positive effect on perceived social support (B = 0.78, p ¡ .001). This finding suggests that within the Pakistani context, individuals who engage in higher levels of emotional suppression may be perceived as more "composed" or "socially adjusted" according to cultural norms, which in turn might facilitate higher reported levels of perceived support from family and friends.
The "b-path" then demonstrated that this perceived social support acted as a significant protective factor, negatively predicting depression (B = -0.19, p ¡ .001) and anxiety (B = -1.54, p ¡ .001). In this case, however, the suppression effect on distress was significant despite the inclusion of support, and hence this mediation is considered partial. This suggests that although perceived social support serves as an important link that can help buffer some of the pain of suppressing emotions, the psychological and physiological costs of emotional suppression, known as the "cognitive tax," are strong enough to exert their own negative effect on mental health (Gross and John, 2003). This partial mediation underscores the fact that

social resources can play a role in mitigating the negative effects of chronic emotional inhibition but is not enough.

In stark contrast, the results for maladaptive perfectionism suggested that the relationship between maladaptive perfectionism and depression and anxiety was not significantly mediated by perceived social support. Although there was a statistically significant but minimal effect of maladaptive perfectionism on perceived social support (B = 0.01, p = .02), the indirect effect through social support was non-significant for both depression (B = -0.02, CI [-0.04, 0.00]) and anxiety (B = -0.01, CI [-0.03, 0.00]). This indicates that the effect of maladaptive perfectionism on mental health is directly and that the perception of the social environment does not play a role in that effect.
This lack of mediation can be understood in terms of "Cognitive Encapsulation". Maladaptive perfectionism refers to a deeply internalized and rigid set of self-evaluative standards (Shah and Amjad, 2017). This trait is so dominant for some that the voice of the critic is so loud that no one, even family or friends who are excited for them, can calm the fear of failure or the shame of perceived imperfection. In addition, perfectionists may experience "perfectionistic self-presentation", which is defined as "the tendency to conceal one's problems while appearing flawless" ()(Hewitt et al., 2017). As a result, even if they think support is available, they might feel that they can't access it without "breaking character" or showing their vulnerabilities. This sets up a barrier in the mind that blocks the perceived social support from functioning normally and serving the buffering function which it normally does, and leaves the individual with no outside buffer (only internal, potentially self-destructive buffers) to soften the blow of their situation.

Combining this, the mediation analysis reinforces the Social Signaling theory of emotion. Expressive suppression, a strategy that deals with outward behavior, is still partially oriented to the social world: the individual suppresses to control social impressions, and the social world reacts to this controlled impression with support (Smith et al., 2016). However, maladaptive perfectionism is a more fundamental "identity-based" vulnerability. It alters the person's self-perception to

the point where the outside social world no longer affects the subjective perception of distress.

These results hold special significance in the Pakistani cultural context. They propose that in individuals who have difficulty regulating their emotions, perceived social support systems (family and community) are strong enough to provide some assistance, but not sufficient to break the rigid, internalized walls of maladaptive perfectionism. This underscores the importance of the existing support systems, as they are ineffective for perfectionistic adults and must be addressed by breaking down the internal cognitive distortions that create the dysfunction (Nadeem et al., 2020). Finally, the results highlight the importance of transdiagnostic treatments that attend to the specific ways in which various vulnerabilities mesh with, or dissociate from, the social landscape.

5.5 Discussion for Hypothesis 4

Discussion of Hypothesis 4 The results of the independent samples t-test indicated that there were no statistically significant differences between males and females regarding levels of depression (t = -0.56, p ¿ .05) and anxiety (t = 0.20, p ¿ .05). This discovery is especially significant when compared with the extensive literature from the West that often describes higher rates of internalizing disorders, such as depression and anxiety, among females (Nolen-Hoeksema, 2001). The absence of gender difference in this sample indicates that for the current educated adults or urban population of Pakistan, the stressors linked to school performance, job insecurity and social pressure may be identical. In a rapidly changing society, both adult men and women face intense pressure to succeed, which may be narrowing the traditional "gender gap" in psychological distress.

Theoretically, this suggests that the relationship between the core variables (expressive suppression and maladaptive perfectionism) is a universal mechanism. Men and women in this study seemed equally affected by the psychological "tax"

of emotional inhibition. This implies that the culture of Pakistan, which is associated with emotional regulation and performance, imposes a common pressure irrespective of gender.

These results suggest that mental health interventions in the Pakistani context do not necessarily need to be gender-segregated or gender-specific in their focus. Rather, a general strategy that focuses on challenging perfectionism and encouraging adaptive emotion regulation (cognitive reappraisal) may be more effective for both men and women.

5.6 Discussion for Hypothesis 5

Socioeconomic status showed no statistically significant differences across different income groups in depression or anxiety levels. While traditional psychological frameworks, such as the Social Causation Hypothesis, often link lower SES with higher psychological distress due to increased environmental stressors and limited resources (Lorant et al., 2003), this was not reflected in the current data.

The findings indicate that internal psychogenic factors of distress, namely rigid self-evaluation of perfectionism, serve as a "psychological equalizer'. The fear of making mistakes and meeting the perceived expectations of parents can be so strong that it is a distress regardless of one's social or financial position. For the Pakistani adults, the "status anxiety" associated with maintaining family honor and achieving upward mobility is a universal burden that is not alleviated by higher SES.

The respondents were predominantly from the university or highly educated adults, which may have meant that the effects of the family's financial circumstances were swamped by the culture of academic competition and professional ambition. That means in the educated population of Pakistan, the psychological context is more of "aspirational stress" than "resource scarcity."

The findings underscore that material wealth does not necessarily protect against the development of maladaptive cognitive patterns. Public health programs should

therefore aim to make mental health services available to the entire population, regardless of socioeconomic status, as the vulnerabilities described in this study are found throughout the population.

5.7 Discussion for Hypothesis 6

Contrary to the initial hypothesis, the results of this study revealed no statistically significant differences in the levels of depression and anxiety between individuals from single-parent households and those from two-parent households. Although a lack of parents is frequently cited in international literature as a risk factor for psychological distress linked to family economic and emotional resources (Conger et al., 2010), these results indicate that in the Pakistani context family structure is a less significant determinant of mental health than family function.

Perhaps one of the more interesting explanations of this non-significance is the extended family system in Pakistan. The social fabric of Pakistan is firmly embedded in the concept of kinship (Biradri) which is in contrast with the individualistic "nuclear" model that dominates the West. Grandparents, aunts or uncles, in the absence of a parent, can sometimes assume the role of the second parent, in terms of providing financial or emotional support. This "collective parenting" can reduce the problems of a single-parent home without the adults feeling the impact of the structural deficiency.

The results underscore the importance of the quality of the emotional setting over the number of parents in the home. It argues that a good functioning single-parent family that is warm and regulates well may be better protective than a conflicted two-parent family. In the Pakistani context, if the other parent can provide a supportive environment, the individual's susceptibility to depression and anxiety remains unchanged. This is consistent with mediation results, which indicated that perceived social support from any source is a key buffering mechanism against distress.

The results suggest maladaptive perfectionism and expressive suppression are

widespread cultural factors that extend beyond familial boundaries as the primary drivers of distress found in this study. The pressure to maintain family honor, excel academically, and behave emotionally is imposed on Pakistani adults irrespective of the family structure. This "socially prescribed" expectation is so ubiquitous that it produces a consistent amount of psychological stress that can conceal any small differences that might arise from the loss of a parent. The sample was predominantly composed of university students or well-educated people, it is possible that those who came from single-parent families had already achieved a degree of socioeconomic stability or support that enabled them to go to university. This "selection bias" could also result in the single-parent families in this sample being those who overcame the initial stresses of the situation, and thus experiencing degrees of distress similar to their two-parent counterparts.

Finally, these non-significant findings provide a departure from a "vulnerability" to a "resilience" frame. They argue that the Pakistani family, as it exists in all its forms, has certain strengths of its own that buffer its members from the possible trauma of family restructuring. This underlines the significance of supporting the social network around a family rather than only its structural composition for both clinicians and policymakers. It highlights that the mental processes within the person are the most important place for psychological action.

5.8 Limitations of the Study

Despite the theoretical and empirical significance of the current study, there are some limitations that should be taken into account when interpreting the results. i. First, the cross-sectional nature of the study design hinders the ability to make causal inferences among emotional dysregulation (expressive suppression), maladaptive perfectionism, perceived social support, and anxiety and depression. Although mediation analyses were performed, the temporal order of the variables cannot be ascertained. Therefore, the causal inferences derived from the mediation models should be viewed with caution, and longitudinal studies are required to validate the temporal order of these variables.

ii. Second, the research was based solely on self-report instruments, which are prone to response biases like social desirability, recall bias, and self-perception errors. Variables like emotional dysregulation (expressive suppression) and perceived social support are more susceptible to personal interpretation, which could have affected the responses of the participants. Moreover, the reliance on self-report instruments could have led to an overestimation of associations due to common method variance.

iii. Third, the research sample consisted of university students in Rawalpindi and Islamabad only, making the findings non-generalizable. The participants were largely young adults, urban, and middle-class individuals, and hence the findings may not be generalizable to non-student groups, rural areas, or people from more varied socioeconomic backgrounds in Pakistan.

iv. Fourth, the imbalanced distribution of socioeconomic status, with the vast majority of participants being middle-class (81.3%), may have reduced the statistical power to identify significant differences among the SES groups. This might account for the non-significant results obtained regarding socioeconomic status and anxiety and depression.

v. Fifth, although the Frost Multidimensional Perfectionism Scale generally had high reliability, certain dimensions, especially Parental Criticism and Doubts about Actions, tended to have slightly lower internal consistency. This indicates that these variables might not have been measured as accurately in this particular cultural setting, which could have impacted the degree of association obtained.

vi. Sixth, the current study mainly concentrated on depression and anxiety, leaving other important psychological variables like stress, emotional functioning, resilience, or coping styles unattended. Though stress was also assessed through the DASS-21, it was not considered in the primary analysis, which might have restricted the scope of mental health measurement.

5.9 Suggestions for Future Research

On the basis of the limitations and findings of the current study, the following are the recommended directions for future studies:

i. First, future studies should use longitudinal or prospective research designs to better investigate the causal links between emotional dysregulation (expressive suppression), maladaptive perfectionism, perceived social support, and anxiety and depression. Using longitudinal designs, researchers can investigate changes in anxiety and depression across time and determine whether perceived social support functions as a consistent mediator of these links across different stages of development.

ii. Second, future studies should use multi-method assessment strategies, such as clinical interviews, behavioral observations, and reports from other people, in addition to self-report questionnaires. This will help to minimize common method variance and will enable a more complete understanding of emotional and psychological processes.

iii. Third, future studies should aim to increase the generalizability of their findings by using a sample that includes non-student participants, people from rural areas, and people from different socioeconomic and educational backgrounds. Comparative studies across regions and cultures in Pakistan would also be very helpful.

iv. Fourth, future research should investigate other potential mediators and moderators, including coping styles, resilience, mindfulness, self-compassion, emotional intelligence, and personality. Investigating moderators such as gender, family structure, and cultural orientation (e.g., collectivism versus individualism) may also help to shed light on the conditions under which emotional dysregulation (expressive suppression) and maladaptive perfectionism affect mental health.

v. Fifth, qualitative or mixed-methods studies might be undertaken to provide a deeper understanding of the cultural meanings associated with the suppression of emotion, maladaptive perfectionism, and perceived social support. These types of studies may help to shed light on the culturally nuanced results, especially the role of perceived social support in relation to expressive suppression.

vi. Sixth, intervention-based research is suggested to assess the efficacy of emotion regulation skills training, cognitive-behavioral interventions for perfectionism, and social support enhancement interventions in reducing depression and anxiety symptoms among university students. Randomized controlled trials would be very

helpful in applying research outcomes to develop effective mental health interventions.

vii. Lastly, future research should consider measuring stress as a primary outcome variable and exploring its significance together with anxiety and depression, as stress could be an important precursor or co-occurring symptom of psychological distress among young adults.

5.10 Conclusion

In summing up, this study offers a thorough look into the psychological mechanisms that have been found to be linked to depression and anxiety in the adult population of Pakistan, including expressive suppression and maladaptive perfectionism. The results confirm that both constructs are important predictors of psychological distress, but that they do so through different pathways within the individual and in the social context. Expressive suppression, which is also lessened by the perception of social support, still has a direct negative impact on mental health, because it is a cognitively demanding emotion suppression strategy that carries a physiological and cognitive "tax. Maladaptive perfectionism, on the other hand, is a more internalized and maladaptive vulnerability that seems to be relatively impervious to external social buffers, which would imply a sense of "cognitive encapsulation" in which the internal critic outweighs the external support. This transdiagnostic nature of these vulnerabilities is further emphasized by the high comorbidity that was noted between depression and anxiety. Finally, this study shows that in the Pakistani cultural context, the pursuit of emotional restraint and perfection (socialized as virtues) is a major risk factor for chronic psychological distress.

5.11 Implications

i. The study brings the application of the Process Model of Emotion Regulation as well as the Cognitive-Behavioral Model of Perfectionism to a collectivistic

context, and it uncovers a "suppression paradox" by which cultural norms of emotional suppression actually promote internalized distress.

ii. Mental health professionals need to go beyond stress management to specific mechanisms; in this case, changing clients from expressing to reconceptualizing how they think about their emotions can lead to processing without a high cognitive load.

iii. Because social support was not found to buffer the effects of perfectionism, clinicians could use an identity-based approach, such as Compassion-Focused Therapy (CFT) or Acceptance and Commitment Therapy (ACT), to help people uncouple self-worth from their expectations of their parents or others in their social groups.

iv. Emotional literacy programs are necessary in educational institutions in Pakistan, which can help reduce the stigmatization of distress and encourage a rethinking of the cultural message of "moral strength" as one of emotional silence rather than emotional authenticity.

v. Interventions should aim to increase the quality and type of social support, as high parental expectations may make it harder for a young adult to raise their voice and communicate their distress.

vi. These findings support policy-level awareness campaigns to highlight the "burden of harmony" and advocate for mental health as a vital part of health to lower the long-term social costs of untreated anxiety and depression.

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Appendix A

Participant Information Sheet

Study: The Relationship of Emotional Regulation and Perfectionism with Anxiety and Depression: Mediating Role of Social Support

Researcher: Abeer Anjum

My name is Abeer Anjum and I am a Master's student in Psychology at Capital University of Science and Technology, Islamabad. You are invited to participate in a research study.
The following information is provided to help you decide whether you would like to take part in the study. Please read the information carefully. If you have any questions about the study, you may contact the researcher via email at **abeer.anjum@yahoo.com.**

What is the purpose of the study?

The purpose of this study is to explore the relationship between emotional regulation and perfectionism with anxiety and depression, while examining the mediating role of social support. The study aims to understand how individuals' ability to regulate their emotions and their perfectionistic tendencies influence their mental health, and how social support may buffer or mediate these effects. The findings may contribute to developing a deeper understanding of psychological well-being and inform future interventions to promote better mental health outcomes.

Why are you invited to participate in the study?

All young adults aged 18 years and above who are currently enrolled in public or private universities in Rawalpindi and Islamabad are invited to participate in this study.

What do you have to do to take part in the study?

If you decide to take part in this study, you will be asked to provide your consent before participation. You will then be required to complete a set of questionnaires, which will take approximately 15–20 minutes. These questionnaires will include items related to emotional regulation, perfectionism, anxiety, depression, and social support.

Who approved the study?

The study has been approved by the **Ethics Review Committee of the Faculty of Management and Social Sciences, Capital University of Science and Technology, Islamabad.**

What about confidentiality and anonymity?

Your responses will be kept strictly confidential and will not include your name or any identifying details. All the

information you provide will be used only for research purposes. Any reports or publications resulting from this study will not include any details that could identify you in any way.

What are the advantages or disadvantages of taking part in the study?

There are no personal or academic benefits or drawbacks to participating in this study. You may choose to withdraw from the study at any time until the point of data analysis, without providing any reason. Your decision to withdraw will not affect your academic standing or relationship with the university in any way. Some questions in the study may involve personal or sensitive topics. If at any point you feel uncomfortable or distressed, you may choose to stop participating. A list of professional organizations you can contact for emotional support will be provided at the end of the questionnaire.

What support is available?

If you feel the need to talk about your feelings or thoughts related to the topics covered in this study, you can reach out to the following helplines for professional support.

Youth help line:

1. **Well-Being Center, Capital University of Science and Technology (CUST)**

The Well-Being Center at CUST provides psychological counseling and emotional support to students in a confidential and supportive environment. Students can reach out for guidance regarding stress management, anxiety, academic pressure, or any personal concerns. The center aims to promote mental wellness and resilience within the university community. The WBC is easily accessible to all students within the university premises — appointments can be made through the Student Affairs Office, via email, or by directly visiting the center during working hours.

2. **Umang Helpline (0311-7786264)**

Umang is a national mental health helpline offering free and confidential psychological support to individuals across Pakistan. The service connects callers with qualified mental health professionals who provide counseling and guidance on issues such as depression, anxiety, stress, and emotional distress. The helpline is accessible through calls, WhatsApp, and social media platforms, making mental health care more reachable for all.

Participant Consent Form

I confirm that I have read and understood the information provided in the participant information sheet. I have been given the opportunity to ask questions regarding the study.

My participation in this research is completely voluntary, and I understand that I have the right to withdraw from the study at any time **until the point of data analysis**, without any impact on my academic standing or legal rights.

I understand that the information obtained from the questionnaires will remain anonymous and will be used solely for research purposes.

I agree to take part in this study.

Signature: _____

Date: _____

Demographic Information

Please provide the following information by ticking (✓) the appropriate option or filling in the blank where required:

Age: _____

Gender:

- ☐ Male
- ☐ Female

Educational Level:

- ☐ Bachelor's
- ☐ Master's

Employment Status

- ☐ Not employed (full-time student)
- ☐ Part-time employed (along with studies)
- ☐ Full-time employed
- ☐ Self-employed
- ☐ Internship or trainee position

Perceived Socio-Economic Status:

- ☐ Lower Class
- ☐ Middle Class
- ☐ Upper Class

Family Structure:

- ☐ Nuclear
- ☐ Joint
- ☐ Single-Parent

If you have selected **Joint Family Type**, please specify the family members you live with (e.g., grandparents, uncle, aunt, cousins, etc.): _____

Appendix B

Questionnaires
Emotion Regulation Questionnaire (ERQ)

Instructions and Items
We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

1	2	3	4	5	6	7
Strongly disagree	Disagree	Slightly disagree	Neutral	Slightly agree	Agree	Strongly agree

		1	2	3	4	5	6	7
		Strongly disagree	Disagree	Slightly disagree	Neutral	Slightly agree	Agree	Strongly agree
1	When I want to feel more positive emotion (such as joy or amusement), I change what I'm thinking about.							
2	I keep my emotions to myself.							
3	When I want to feel less negative emotion (such as sadness or anger), I change what I'm thinking about.							
4	When I am feeling positive emotions, I am careful not to express them.							
5	When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm.							
6	I control my emotions by not expressing them.							
7	When I want to feel more positive emotion, I change the way I'm thinking about the situation.							
8	I control my emotions by changing the way I think about the situation I'm in.							
9	When I am feeling negative emotions, I make sure not to express them.							
10	When I want to feel less negative emotion, I change the way I'm thinking about the situation.							

Frost Multidimensional Perfectionism Scale (FMPS)

Full name: _____ **Date answered:** _____

The following 35-item questionnaire aims to explore your level of perfectionism. There are 5 possible answers to the 35 items:

| **1** - Strongly disagree | **2** - Disagree | **3** - Neither agree or disagree |

| **4** - Agree | **5** - Strongly agree |

Please answer the following questions as honestly as possible to obtain accurate results.

Items	1 Strongly disagree	2 Disagree	3 Neither agree or disagree	4 Agree	5 Strongly agree
1. My parents set very high standards for me.	○	○	○	○	○
2. Organization is very important to me.	○	○	○	○	○
3. As a child, I was punished for doing things less than perfect.	○	○	○	○	○
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person.	○	○	○	○	○
5. My parents never tried to understand my mistakes.	○	○	○	○	○
6. It is important to me that I be thoroughly competent in everything I do.	○	○	○	○	○
7. I am a neat person.	○	○	○	○	○
8. I try to be an organized person.	○	○	○	○	○
9. If I fail at work/school, I am a failure as a person.	○	○	○	○	○
10. I should be upset if I make a mistake.	○	○	○	○	○
11. My parents wanted me to be the best at everything.	○	○	○	○	○
12. I set higher goals than most people.	○	○	○	○	○
13. If someone does a task at work/school better than I, then I feel like I failed the whole task.	○	○	○	○	○
14. If I fail partly, it is as bad as being a complete failure.	○	○	○	○	○

15. Only outstanding performance is good enough in my family.	○	○	○	○	○
16. I am very good at focusing my efforts on attaining a goal.	○	○	○	○	○
17. Even when I do something very carefully, I often feel that it is not quite right.	○	○	○	○	○
18. I hate being less than the best at things.	○	○	○	○	○
19. I have extremely high goals.	○	○	○	○	○
20. My parents have expected excellence from me.	○	○	○	○	○
21. People will probably think less of me if I make a mistake.	○	○	○	○	○
22. I never felt like I could meet my parents' expectations.	○	○	○	○	○
23. If I do not do as well as other people, it means I am an inferior human being.	○	○	○	○	○
24. Other people seem to accept lower standards from themselves than I do.	○	○	○	○	○
25. If I do not do well all the time, people will not respect me.	○	○	○	○	○
26. My parents have always had higher expectations for my future than I have.	○	○	○	○	○
27. I try to be a neat person.	○	○	○	○	○
28. I usually have doubts about the simple everyday things I do.	○	○	○	○	○
29. Neatness is very important to me.	○	○	○	○	○
30. I expect higher performance in my daily tasks than most people.	○	○	○	○	○
31. I am an organized person.	○	○	○	○	○
32. I tend to get behind in my work because I repeat things over and over.	○	○	○	○	○
33. It takes me a long time to do something "right."	○	○	○	○	○
34. The fewer mistakes I make, the more people will like me.	○	○	○	○	○
35. I never felt like I could meet my parents' standards.	○	○	○	○	○

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.
Circle the "1" if you Very Strongly Disagree
Circle the "2" if you Strongly Disagree
Circle the "3" if you Mildly Disagree
Circle the "4" if you are Neutral
Circle the "5" if you Mildly Agree
Circle the "6" if you Strongly Agree
Circle the "7" if you Very Strongly Agree

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

DASS 21

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree or a good part of time

3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3