

Available online at www.sciencedirect.comPERSONALITY AND
INDIVIDUAL DIFFERENCES

Personality and Individual Differences xxx (2007) xxx–xxx

www.elsevier.com/locate/paid

Perfectionism, silencing the self, and depression [☆]

Gordon L. Flett ^{a,*}, Avi Besser ^b, Paul L. Hewitt ^c, Richard A. Davis ^a

^a *Department of Psychology, York University, Toronto, Ontario, Canada M3J 1P3*

^b *Sapir Academic College, Israel*

^c *University of British Columbia*

Received 5 May 2006; received in revised form 19 February 2007; accepted 22 March 2007

Abstract

The current study examined the associations among dimensions of perfectionism, silencing the self, and depression. A sample of 202 participants completed the Multidimensional Perfectionism Scale, the Silencing The Self Scale, and a depression measure. The results indicated that both self-oriented and socially prescribed perfectionism were associated with dimensions of silencing the self with a stronger link between socially prescribed perfectionism and silencing the self. Both socially prescribed perfectionism and dimensions of silencing the self were associated significantly with depression. Statistical tests of moderator effects indicated that socially prescribed perfectionism and silencing the self interacted to predict elevated levels of depression. In addition, mediational analyses indicated that self-silencing was a partial mediator of the link between socially prescribed perfectionism and depression. The practical and theoretical implications of these findings are discussed.

© 2007 Published by Elsevier Ltd.

Keywords: Perfectionism; Self-silencing; Coping; Depression

[☆] This research was supported by a research grant from the Social Sciences and Humanities Research Council of Canada. Gordon Flett was also supported by the Canada Research Chairs Program.

* Corresponding author.

E-mail address: gflett@yorku.ca (G.L. Flett).

1. Introduction

A focus on the attainment of high standards is a continuing theme in research on personality and depression. Extensive research has explored the role of individual differences in perfectionism (Cox & Enns, 2003; Flett, Besser, Davis, & Hewitt, 2003; Hewitt & Flett, 1991). This research indicates that certain perfectionism dimensions may be associated not only with concurrent depressive symptoms, but also with the chronicity of depressive symptoms (Cox & Enns, 2003; Hewitt, Flett, Ediger, Norton, & Flynn, 1999). Research with the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1991) has focused on three dimensions – self-oriented perfectionism (i.e., exceeding high personal standards), other-oriented perfectionism (i.e., demanding perfection from others), and socially prescribed perfectionism (i.e., a pressure to be perfect imposed on the self). Socially prescribed perfectionism has shown a consistent association with depression (see Flett & Hewitt, 2002).

Another highly relevant perspective for understanding depression involves individual differences in self-silencing. Jack (1991) proposed the construct of self-silencing to account for the preponderance of depression among females. However, subsequent research has shown that self-silencing is relevant for both females and males (Thompson, 1995). People high in self-silencing are self-sacrificing individuals who keep their distress to themselves in an attempt to maintain or improve interpersonal relationships. Their distress often takes the form of unexpressed anger (see Jack, 1999b, 2001). People high in self-silencing conceal their true feelings out of desires to maintain relationships and obtain the approval of significant others.

A link between perfectionism and self-silencing follows from Jack's (1999a) observation that the standards used for self-evaluation are central to an understanding of self-silencing behaviour. Jack suggested that a sense of inferiority and self-reproach stems from the idealistic standards that the self-silencer uses to judge the self. The standards themselves have a social aspect because they reflect social dictates and a sense of being obliged to act in a socially approved of manner and to achieve prescribed goals. Unfortunately, for the self-silencing individual, this focus on ideals and being perfect as the accepted standard should make them susceptible to dysphoria when they perceive a substantial gap between the actual self and the goal of being perfect.

Jack (1999a) provided a series of compelling case examples of distressed people who clearly exhibited perfectionistic characteristics and self-silencing. These people appear to suffer from the “tyranny of the shoulds” described by Horney (1950) and by Ellis (2002) as part of their descriptions of perfectionism. For instance, Jack (1999a) documented the case of Carol, a physician who described the perfectionistic pressures inherent in the “Supermom syndrome”. Carol responded to these pressures by silencing the self and trying to appear perfect to others.

Our analysis of the various perfectionism dimensions indicates that self-silencing is most relevant to socially prescribed perfectionism, given that socially prescribed perfectionists are focused on obtaining approval and avoiding the disapproval of others (Hewitt & Flett, 1991, 2004). Although some individuals reject this pressure to be perfect, developmental analyses emphasize that most people with high socially prescribed perfectionism seek to please others, including parental figures, by trying to live up to expectations (Flett, Hewitt, Oliver, & Macdonald, 2002). Also, socially prescribed perfectionism is similar to self-silencing it too is associated with passive, indirect responses to problems and conflicts (Hewitt & Flett, 2002). Unfortunately,

empirical research on perfectionism and self-silencing is quite limited at present. A link between socially prescribed perfectionism and self-silencing can be inferred from the results of a study of dating students (see Flett et al., 2003). This study showed that socially prescribed perfectionism was associated with low scores on a measure of “voice”. Voicing one’s concerns is one way of responding to dissatisfaction in interpersonal relationships.

To our knowledge, the only study conducted thus far on perfectionism and self-silencing was by Geller, Cockell, Hewitt, Goldner, and Flett (2000). They administered the MPS and the Silencing The Self Scale (STSS) to 21 anorexic patients, 21 women with other psychiatric disorders, and 21 normal control participants. Geller et al. (2000) examined the correlations for the total sample by collapsing across the groups. These analyses showed that both self-oriented and socially prescribed perfectionism were associated robustly with all STSS measures (r 's ranging from .55 to .77). However, there is a need to re-examine the magnitude of the associations between silencing the self and trait perfectionism in another sample because the extreme scores among the group of anorexic patients likely inflated the magnitude of these correlations. Also, questions always exist about the representativeness of samples comprised of individuals who seek treatment. Accordingly, perfectionism and self-silencing were re-examined in the current investigation.

We also evaluated whether the association between perfectionism and depression is moderated or mediated by self-silencing. In particular, we tested whether socially prescribed perfectionism interacts with elevated self-silencing to produce elevated depression. We also evaluated the related possibility that self-silencing mediates the link between socially prescribed perfectionism and depression. Just as socially prescribed perfectionism is linked consistently with depression, self-silencing is also associated with depression (see Ali, Oatley, & Toner, 2002; Thompson, 1995; Thompson, Whiffen, & Aube, 2001). At the conceptual level, the “silencing the self” construct has several components and features that are relevant to socially prescribed perfectionism and that ought to combine with socially prescribed perfectionism to produce elevated depression. In general, self-silencing is believed to contribute to a “loss of self” that is linked with depression (see Drew, Heesacker, Frost, & Oelke, 2004) and this loss of self should be particularly deleterious for socially prescribed perfectionists who feel hopeless to achieve the standards imposed on them. Also, certain aspects of the silencing the self-construct should be particularly damaging for socially prescribed perfectionists. Most notably, individuals with a high socially prescribed perfectionism who also tend to judge themselves by external standards should be at risk because the impact of their inability to meet expectations is magnified.

The notion that self-silencing is a mediator of the link between socially prescribed perfectionism and depression is in keeping with coping models which suggest that a maladaptive response to stress mediates or moderates the link between perfectionism and depression (see Hewitt & Flett, 2002). In the present instance, the tendency for socially prescribed perfectionists to be high in self-silencing would constitute an ineffective way of responding to interpersonal conflict and stress and this tendency to silence the self could, in turn, contribute to depression. A mediational model is also suggested to the extent that self-silencing does indeed involve a loss of sense of self and a negative self-view; other research has indicated that diminished self-esteem and a lack of unconditional self-acceptance mediate the link between perfectionism and depression (Flett et al., 2003; Rice, Ashby, & Slaney, 1998). Thus, the possible mediating role of self-silencing was also assessed.

2. Method

2.1. Participants and procedure

The sample consisted of 202 participants (102 women, 100 men) with a mean age of 21.59 years ($SD = 3.83$). The participants were volunteers recruited from a third-year undergraduate class. Overall, 99 participants (45 men, 54 women) were currently in romantic relationships and 103 participants (57 men, 46 women) did not have current romantic relationships. Given that self-silencing is particularly relevant for those in a relationship, we took this information into account when examining the associations between perfectionism and self-silencing.

2.2. Measures and procedure

Participants were asked to take part in a study on personality and adjustment in university students. Once written consent was provided, participants completed the following measures:

The Multidimensional Perfectionism Scale. The MPS is a 45-item measure of self-oriented, other-oriented, and socially prescribed perfectionism (Hewitt & Flett, 1991, 2004). Extensive evidence attesting to the psychometric properties of the subscales is summarized in the test manual (Hewitt & Flett, 2004). Internal consistency in the present study was $\alpha = .83$, $.78$ and $.85$ for self-oriented, other oriented, and socially prescribed perfectionism, respectively.

The Silencing The Self Scale. The Silencing The Self Scale (Jack & Dill, 1992) is a 31-item inventory. It has four factors that are described as silencing the self (e.g., I don't speak my feelings in an intimate relationship when I know they will cause disagreement), externalized self-perception (e.g., I tend to judge myself by how I think other people see me), care as self-sacrifice (e.g., Caring means putting the other person's needs in front of my own), and divided self (e.g., Often I look happy enough on the outside, but inwardly I feel anxious and rebellious). Internal consistency in the present study was $\alpha = .78$, $.85$, $.79$, and $.81$ for silencing the self, externalized self-perception, care as self-sacrifice, and divided self, respectively.

The Center For Epidemiological Studies Depression (CES-D). The CES-D Scale is a 20-item inventory with items that measure the affective and somatic symptoms of depression. It is a well-known measure that has acceptable levels of internal consistency (see Radloff, 1977). Internal consistency in this study was $\alpha = .88$.

3. Results

The means and standard deviations for the various measures are shown in Table 1 for men and women. A MANOVA indicated that the only significant gender difference in mean scores was a higher score for men on the STSS externalized self-perception subscale ($F[1, 200] = 7.87, p < .006$). There were no significant differences for people in relationships versus not in relationships, nor were there significant gender by relationship interactions.

Table 1
Means and standard deviations for the measures by gender

Variables	Men <i>n</i> = 100		Women <i>n</i> = 102	
	<i>M</i>	SD	<i>M</i>	SD
<i>MPS subscales</i>				
1. Self-oriented perfectionism	70.26	15.30	71.77	13.94
2. Other-oriented perfectionism	57.94	10.07	59.47	9.57
3. Socially prescribed perfectionism	53.71	11.95	53.93	11.20
<i>STSS measures</i>				
4. Silencing the self	17.46	4.14	17.63	4.26
5. Externalized self-perception	28.56	3.79	26.93	4.46
6. Care as self-sacrifice	25.58	5.83	24.16	5.62
7. Divided self	19.50	4.09	19.15	4.85
8. Overall silencing the self	87.86	16.01	91.11	14.62
9. <i>Depression</i>	15.41	10.48	15.40	11.04

3.1. Correlational analyses

Correlations among the measures are shown in Table 2 for the total sample. A significant association was found between self-oriented perfectionism and the silencing the self-subscale ($r = .24$, $p < .001$). No other significant correlations involving self-oriented perfectionism were obtained after performing a Bonferroni correction. Significant associations were also found between socially prescribed perfectionism and total STSS score, $r = .32$, $p < .0001$ and between socially prescribed perfectionism and each STSS subscale.

CES-D scores were correlated significantly with socially prescribed perfectionism, $r = .42$, $p < .0001$, overall silencing the self, $r = .55$, $p < .0001$, and each STSS subscale.

Additional correlations were also computed to explore the associations among the variables for women and men and for participants with or without a current relationship. The pattern of find-

Table 2
Correlations among perfectionism, silencing the self, and depressive symptoms for the total sample

Variables	1	2	3	4	5	6	7	8
<i>MPS subscales</i>								
1. Self-oriented perfectionism	–							
2. Other-oriented perfectionism	.44***	–						
3. Socially prescribed perfectionism	.35***	.30***	–					
<i>STSS subscales</i>								
4. Silencing the self	.24***	.12	.42***	–				
5. Externalized self-perception	.13	–.10	.19***	.50***	–			
6. Care as self-sacrifice	.04	–.06	.20***	.59***	.53***	–		
7. Divided self	.08	–.08	.27***	.65***	.39***	.72***	–	
8. Overall silencing the self	.14	–.04	.32***	.82***	.72***	.89***	.84	–
9. <i>Depression</i>	.16	.05	.42***	.54***	.35***	.44***	.47***	.55***

Note: Based on $N = 202$, *** $p < .01$, two-tailed. A full Bonferroni correction was applied to insure that the chance of making a Type I error was less than .05.

ings was comparable for women and men and for participants with or without a current relationship.

3.2. Mediation analyses

The next set of statistical analyses tested whether overall Silencing The Self Scale and its subscales *mediate* the association between perfectionism and depression. Hierarchical Multiple Regression (HMR) models were performed to test the mediating role of STSS and its subscales in the association between perfectionism and depression. As for the MPS scales, only socially prescribed perfectionism met the initial criteria for mediation outlined by [Baron and Kenny \(1986\)](#) – that is, it was significantly associated with depression and with silencing the self. Mediation would be indicated by (a) a significant relationship between the independent variable and hypothesized mediator, (b) a significant relationship between the hypothesized mediator and dependent variable, and (c) a decrease in the direct relationship between the independent and dependent variables ([Baron & Kenny, 1986](#); [Kenny, Kashy, & Bolger, 1998](#)). If the direct relationship in (c) remained significant, partial mediation would be indicated, whereas if this direct relationship no longer remained significant, full mediation would be indicated. As a further test of mediation, [MacKinnon, Lockwood, Hoffman, West, and Sheets \(2002\)](#) z' test was computed to examine the significance of the indirect relationship between the independent and dependent variables via the hypothesized mediator.

Using HMR, five models were explored (with the STSS total score and subscales as mediating variables). Age and gender were controlled in each model. As can be seen in [Fig. 1](#), while controlling for age and gender the association between socially prescribed perfectionism and depression was significant ($\beta = .42, t = 6.5, p < .0001$). [Fig. 1](#) also indicates that while controlling for the assumed mediators the association between socially prescribed perfectionism and depression association was lower but remained significant ($\beta = .27, t = 4.52, p < .0001$ when STSS was entered as the mediator; $\beta = .23, t = 3.68, p < .0001$ when silencing the self-subscale was entered as the mediator; $\beta = .36, t = 5.78, p < .0001$ when externalized self-perception was entered as the mediator; $\beta = .34, t = 5.69, p < .0001$ when care as self-sacrifice was entered as the mediator and $\beta = .32, t = 5.17, p < .0001$ when divided self was entered as the mediator). The drops in the coefficients of the direct association between socially prescribed perfectionism and depression after controlling for the mediators (see values outside parentheses in [Fig. 1](#)) were significant according to the z' test ([MacKinnon et al., 2002](#)), $z' = 4.11, p < .0001$; $z' = 4.80, p < .0001$; $z' = 2.49, p < .01$; $z' = 2.67, p < .01$ and $z' = 3.37, p < .001$, for total STSS, silencing the self-subscale, externalized self-perception subscale, care as self-sacrifice subscale, and divided self-subscale, respectively. Thus significant partial mediation was obtained for STSS and its subscales in the association between socially prescribed perfectionism and depression. Socially prescribed perfectionism associates with depression both directly and indirectly through its associations with silencing the self-measures (see [Fig. 1](#)).

3.3. Moderator analyses

Next, possible interaction effects were evaluated. We computed Hierarchical Multiple Regressions (HMR) with interaction terms ([Cohen & Cohen, 1983](#)) to test whether the STSS measures

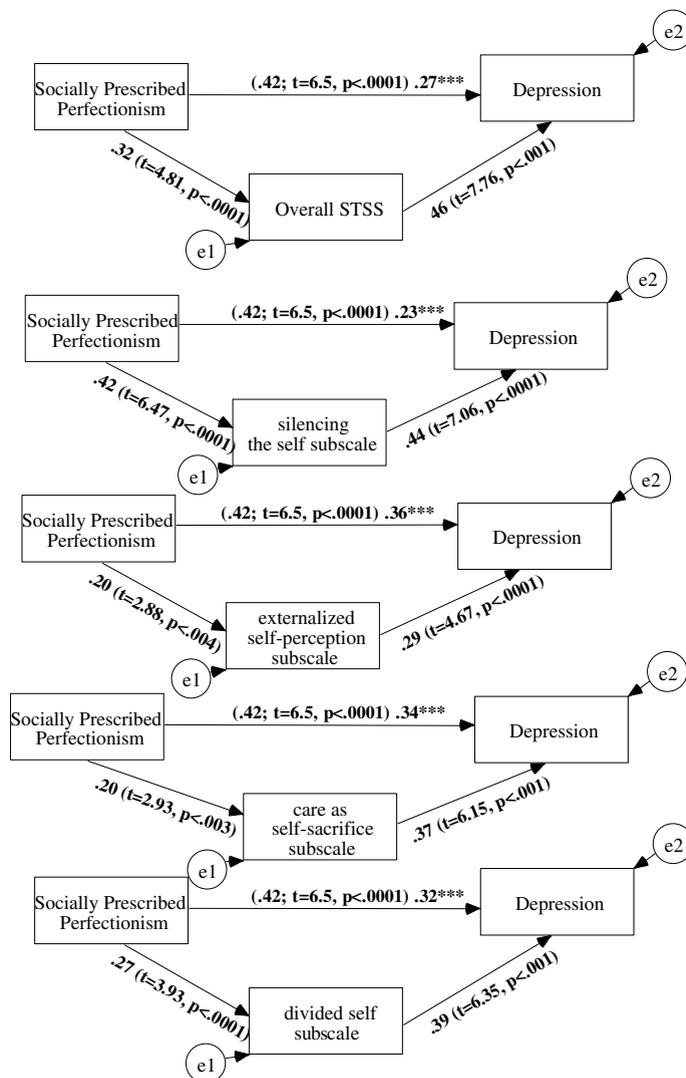


Fig. 1. Direct and indirect associations between socially prescribed perfectionism and depression and the mediating role of STSS and STSS subscales. *Note:* Bolded estimates are significant regression coefficient β s. Numbers in parentheses are β s before the overall Silencing The Self Scale or its subscales scores (assumed mediators) were entered into the model. Small circles represent residual variances, and unidirectional arrows depict hypothesized associations.

moderate the link between perfectionism and depression. The results are shown in Table 3. The first predictor block controlled for age and gender. This block predicted less than 1% of the variance in CES-D scores. The second predictor block of socially prescribed perfectionism predicted an additional 17% of the variance in CES-D scores (see Table 3). The subsequent entry of overall silencing the self or each of its subscales predicted 8–19% of unique variance in CES-D scores. Next, the block consisting of the two-way interaction involving socially prescribed perfectionism and overall silencing the self or each of its subscales was significant only for the socially prescribed

Table 3
Hierarchical Multiple Regression models of depressive symptoms

Predictors	<i>R</i>	<i>R</i> ²	ΔR^2	Overall <i>F</i>	<i>F</i> change	df	Beta
<i>Step 1</i>	.08	.007		.68	.68	2199	
Gender							–.00
Age							–.08
<i>Step 2</i>	.42	.18	+ .17	14.42***	41.62***	1198	
Socially prescribed perfectionism							.42***
<i>Step 3</i>	.61	.37	+ .19	28.74***	59.04***	1197	
Overall silencing the self							.46**
<i>Step 4</i>	.65	.41	+ .04	23.95***	4.02*	1196	
Socially prescribed perfectionism × Silencing the self							1.05*
<i>Alt. Step 3</i>	.59	.34	+ .16	25.65***	48.87***	1197	
Silencing the self-subscale							.44***
<i>Alt. Step 4</i>	.59	.35	+ .01	20.80***	1.27, ns	1196	
Socially prescribed perfectionism × Silencing the self-subscale							.52, ns
<i>Alt. Step 3</i>	.51	.26	+ .08	17.27***	21.38***	1197	
Externalized self-perception subscale							.30***
<i>Alt. Step 4</i>	.55	.30	+ .04	16.79***	11.28***	1196	
Socially prescribed perfectionism × Externalized self-perception subscale							1.93***
<i>Alt. Step 3</i>	.56	.31	+ .13	22.03***	37.01***	1197	
Care as self-sacrifice subscale							.37***
<i>Alt. Step 4</i>	.56	.32	+ .01	18.08***	1.88, ns	1196	
Socially prescribed perfectionism × Care as self-sacrifice subscale							.63, ns
<i>Alt. Step 3</i>	.56	.32	+ .14	22.79***	39.51***	1197	
Divided self-subscale							.39***
<i>Alt. Step 4</i>	.56	.32	+ .0	18.19***	.15, ns	1196	
Socially prescribed perfectionism × Divided self-subscale							.19, ns

Note: *N* = 202.

* *p* < .05.

** *p* < .01.

*** *p* < .001, two-tailed.

perfectionism interaction with the overall STSS and for socially prescribed perfectionism and its interaction with the externalized self-perception subscale; this accounted for a further 4% of the variance in CES-D scores. The specific nature of these interactions is displayed graphically in Figs. 2 and 3. Significant interactions were plotted according to Cohen and Cohen's (1983, p. 323 and p. 419) recommendations. As expected, high socially prescribed perfectionism combined with elevated scores on the externalized self-perception subscale score and with overall silencing the self to predict elevated depression.

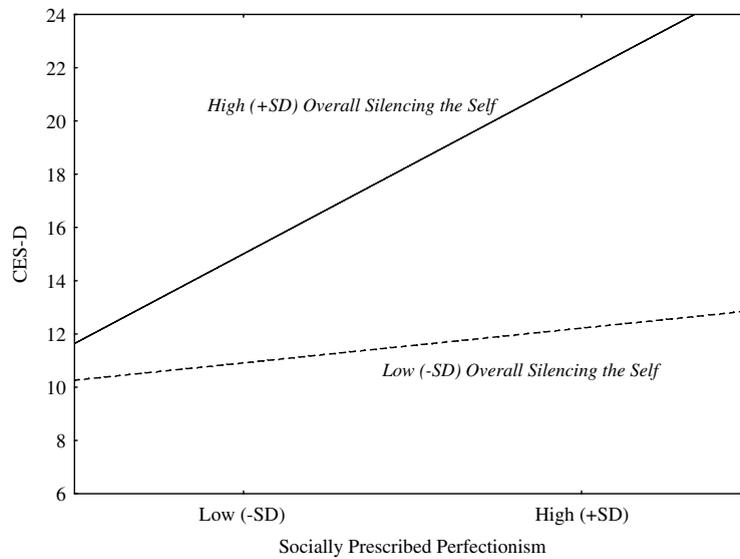


Fig. 2. The relations between high (+SD) and low (-SD) levels of socially prescribed perfectionism and depressive symptoms for high (+SD) and low (-SD) levels of overall silencing the self.

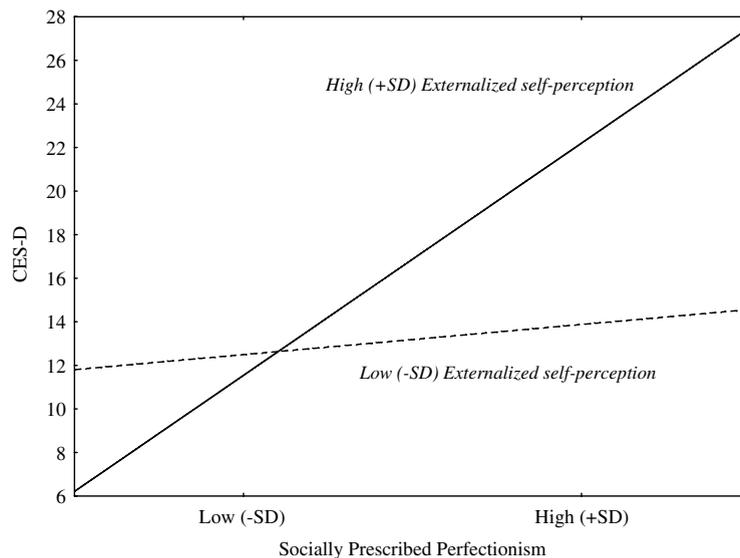


Fig. 3. The relations between high (+SD) and low (-SD) levels of socially prescribed perfectionism and depressive symptoms for high (+SD) and low (-SD) levels of externalized self-perception subscale.

Finally, we also explored the possibility that socially prescribed perfectionism or overall silencing the self or its subscales might interact with gender to predict elevated levels of depression. This final predictor block was not significant.

4. Discussion

The current study examined the association between the various dimensions that comprise the self-silencing and perfectionism constructs. Analyses revealed that there was a positive association between self-oriented perfectionism and the STSS self-silencing subscale, but much stronger associations were detected between socially prescribed perfectionism and self-silencing. In fact, socially prescribed perfectionism was associated significantly with all four STSS factors and the strongest link was with the self-silencing subscale.

As expected, both socially prescribed perfectionism and self-silencing were associated significantly with depression. The other MPS dimensions were not correlated significantly with depression. Tests of mediator and moderator effects clarified the associations among socially prescribed perfectionism, self-silencing, and depression. First, the mediational analyses showed that all facets of the self-silencing construct were partial mediators of the link between socially prescribed perfectionism and depression. Thus, some of the dysphoria reported by socially prescribed perfectionists is due to the tendency for socially prescribed perfectionism to be associated with various aspects of self-silencing.

The analyses that tested for moderator effects were quite revealing. These analyses revealed that self-silencing in general interacts with socially prescribed perfectionism to produce elevated levels of depression, but further analyses revealed that it was the STSS externalized self-perception component that interacted with socially prescribed perfectionism. This is understandable in that the negative impact of socially prescribed expectations should be amplified among individuals who place importance (perhaps too much importance) on gaining the approval of others and meeting their expectations. That is, socially prescribed perfectionism has greater impact if the self is defined in terms of social evaluations.

Future investigations should explore the interpersonal consequences of being elevated in both socially prescribed perfectionism and silencing the self given that both constructs are deleterious and are associated with interpersonal adjustment problems (see Haring, Hewitt, & Flett, 2003; Uebelacker, Courtnage, & Whisman, 2003). Related research should focus on the possibility that certain perfectionists either do not express negative emotions or they display false positive emotions and this places them at risk for other problems. Here it is interesting to note that Horney (1950) stated several years ago that when it comes to emotional displays, neurotic perfectionists tend to display friendliness toward others because there is a palpable sense that they *should* be friendly to others out of a prescribed need to be obedient and devoted to others.

Future research should also explore the possibility that the self-silencing tendencies of certain socially prescribed perfectionists may result in engaging publicly in perfectionistic self-presentation. Indeed, the Geller et al. (2000) study provided evidence of a link between perfectionistic self-presentation and silencing the self. Perfectionistic self-presentation occurs when an individual attempts to manage impressions by trying to appear perfect in public or by minimizing the flaws and shortcomings that are noticeable in public (see Hewitt et al., 2003). Perfectionistic self-presenters are also unwilling to disclose imperfections and personal flaws when conversing with another person. It is likely that a tendency to silence the self is linked with the perfectionistic self-presentation construct. Both self-silencing and perfectionistic self-presentation reflect defensiveness and an unwillingness to reveal negative aspects that could potentially result in a loss of approval from significant others.

The current findings have clear implications for the treatment of depression and for the general counseling process. Perfectionists characterized by high levels of self-silencing would like benefit from interventions that will enable them to constructively address life problems and engage in effective forms of problem-solving, as opposed to passively internalizing their distress and not voicing their concerns. In addition, cognitive-behavioral interventions could target the tendency for socially prescribed perfectionists to rely on an externalized self-perception and could assess the extent to which pleasing others has been imbued with an irrational sense of importance.

The limitations of the current research must be noted. First, the current results have established that certain perfectionism dimensions are self-silencing are correlated, but no causal statements can be made on the basis of these correlations. Prospective research is required to shed light on the causal association, if any, between perfectionism and self-silencing, and the extent to which they combine to predict *vulnerability* to depression. In addition, future research is needed to explore whether the current findings are specific to depression or generalize to other forms of maladjustment such as the experience of symptoms of anxiety or eating disorders.

In summary, the results of the current study confirmed that socially prescribed and self-oriented perfectionism are associated with silencing the self. Additional results indicated that socially prescribed perfectionism and silencing the self are both associated with elevated symptoms of depression. Evidence of partial mediation was found; the Silencing the Self Scale and its subscales scores mediated the link between socially prescribed perfectionism and depression. Finally, tests of moderator effects showed that elevated depression was reported by socially prescribed perfectionists with an externalized self-perception or with overall high self-silencing. In general, these findings attest to the importance of studying multiple vulnerability factors within the same study and the continuing need to explore factors that influence the associations between perfectionism and distress.

References

- Ali, A., Oatley, K., & Toner, B. B. (2002). Life stress, self-silencing, and domains of meaning in unipolar depression: An investigation of an outpatient sample of women. *Journal of Social and Clinical Psychology, 21*, 669–685.
- Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173–1182.
- Cohen, J., & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences* (2nd. ed.). Hillsdale, NJ: Erlbaum.
- Cox, B. J., & Enns, M. W. (2003). Relative stability of dimensions of perfectionism in depression. *Canadian Journal of Behavioural Science, 35*, 124–132.
- Drew, S. S., Heesacker, M., Frost, H. M., & Oelke, L. E. (2004). The role of relationship loss and self-loss in women's and men's dysphoria. *Journal of Social and Personal Relationships, 21*, 381–397.
- Ellis, A. (2002). The role of irrational beliefs in perfectionism. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 217–229). Washington, DC: American Psychological Association.
- Flett, G. L., Besser, A., Davis, R. A., & Hewitt, P. L. (2003). Dimensions of perfectionism, unconditional self-acceptance, and depression. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 21*, 119–138.
- Flett, G. L., & Hewitt, P. L. (2002). *Perfectionism: Theory, research, and treatment*. Washington, DC: American Psychological Association.
- Flett, G. L., Hewitt, P. L., Oliver, J. M., & Macdonald, S. (2002). Perfectionism in children and their parents: A developmental analysis. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 89–132). Washington, DC: American Psychological Association.

- Geller, J., Cockell, S. J., Hewitt, P. L., Goldner, E. M., & Flett, G. L. (2000). Inhibited expression of negative emotions and interpersonal orientation in anorexia nervosa. *International Journal of Eating Disorders*, *28*, 8–19.
- Haring, M., Hewitt, P. L., & Flett, G. L. (2003). Perfectionism, coping, and quality of intimate relationships. *Journal of Marriage and the Family*, *65*, 143–158.
- Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology*, *60*, 456–470.
- Hewitt, P. L., & Flett, G. L. (2002). Perfectionism and stress in psychopathology. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 255–284). Washington, DC: American Psychological Association.
- Hewitt, P. L., & Flett, G. L. (2004). *Multidimensional perfectionism scale: Technical manual*. Toronto: Multi-Health Systems Inc..
- Hewitt, P. L., Flett, G. L., Ediger, E., Norton, G. R., & Flynn, C. A. (1999). Perfectionism in chronic and state symptoms of depression. *Canadian Journal of Behavioural Science*, *30*, 234–242.
- Hewitt, P. L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., et al. (2003). The interpersonal expression of perfection: Perfectionistic self-presentation and psychological distress. *Journal of Personality and Social Psychology*, *84*, 1303–1325.
- Horney, K. (1950). *Neurosis and human growth: The struggle toward self-realization*. London: W.W. Norton & Company.
- Jack, D. C. (1991). *Silencing the self*. Cambridge, MA: Harvard University.
- Jack, D. C. (1999a). Silencing the self: Inner dialogues and outer realities. In T. Joiner & J. C. Coyne (Eds.), *The interactional nature of depression* (pp. 221–246). Washington, DC: American Psychological Association.
- Jack, D. C. (1999b). Ways of listening to depressed women in qualitative research: Interview techniques and analyses. *Canadian Psychology*, *40*, 91–101.
- Jack, D. C. (2001). Understanding women's anger: A description of relational patterns. *Health Care For Women International*, *22*, 385–400.
- Jack, D. C., & Dill, D. (1992). The silencing the self scale: Schemas of intimacy associated with depression in women. *Psychology of Women Quarterly*, *16*, 97–106.
- Kenny, D. A., Kashy, D. A., & Bolger, N. (1998). Data analysis in social psychology. In D. Gilbert, S. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., pp. 233–265). New York: McGraw-Hill.
- MacKinnon, D. P., Lockwood, C. M., Hoffman, J. M., West, S. G., & Sheets, V. (2002). A comparison of methods to test mediation and other intervening variable effects. *Psychological Methods*, *7*, 83–104.
- Radloff, L. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*, 385–401.
- Rice, K. G., Ashby, J. S., & Slaney, R. B. (1998). Self-esteem as a mediator between perfectionism and depression: A structural equations analysis. *Journal of Counseling Psychology*, *45*, 304–314.
- Thompson, J. M. (1995). Silencing the self: Depressive symptomatology and close relationships. *Psychology of Women Quarterly*, *19*, 337–353.
- Thompson, J. M., Whiffen, V. E., & Aube, J. A. (2001). Does self-silencing link perceptions of care from parents and partners with depressive symptoms? *Journal of Social and Personal Relationships*, *18*, 503–516.
- Uebelacker, L. A., Courtngage, E. S., & Whisman, M. A. (2003). Correlates of depression and marital dissatisfaction: Perceptions of marital communication style. *Journal of Social and Personal Relationships*, *20*, 757–769.