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ScienceDirect

Procedia - Social and Behavioral Sciences 159 (2014) 78 – 81

Procedia
Social and Behavioral Sciences

WCPCG 2014

Perfectionism Dimensions in Children: Association with Anxiety and Depression

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Abstract

Although it is known that, childhood and adolescence are the most important periods the development of perfectionism (Flett & Hewitt, 2002). this is almost unknown research area in R. Macedonia. This research aimed to explore the relationship of perfectionism dimensions with anxiety and depression among children. We examined possible differences among four groups of children (children without evident symptoms; children with evident symptoms of anxiety; children with evident symptoms of depression; children with evident symptoms of anxiety and depression) with regard to the level of dimensions of perfectionism (Sensitivity to mistakes; Contingent Self-Esteem; Compulsiveness; Need for admiration). The sample consisted of 468 pupils, aged 11-14, from 5th to 8th grade of primary school, of which 279 were female, and 189 male. The following instruments were used: Adaptive/Maladaptive Perfectionism Scale (Rice & Preusser, 2002), SKAN (Puric, 1992; according to Zaic, 2005) and Children's Depression Inventory (CDI, Kovacs, 1981). The findings suggest the existence of an association of the dimension of the dimension of perfectionism with anxiety and depression. However, this study does not enable conclusions about the causal relationship between these constructs.

Peer-review under responsibility of the Academic World Education and Research Center.
Keywords: perfectionism, anxiety, depression, children

1. Introduction

The area of perfectionism is still insufficiently explored and different theorists offer different conceptualizations and definitions of this concept. Striving for flawlessness in all aspects of life is one of the simplest definitions of perfectionism (Flett & Hewitt, 2002). Previous research on perfectionism among school-aged children has

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Peer-review under responsibility of the Academic World Education and Research Center.
doi:10.1016/j.sbspro.2014.12.332

confirmed that perfectionism is a multidimensional construct (Flett, Hewitt, Boucher, Davidson & Monro, 2000; Rice, Kubal, & Preusser, 2004; Hawkins, Watt & Sinclair, 2006; Rice, Leever, Noggle & Lapsley, 2007). The manifestations of unhealthy perfectionism during childhood and adolescence have been studied for their relationship with anxiety and depression (Hewitt et al., 2002). Much of the literature on perfectionism has focused on late adolescents, young adults and adult clinical populations (Rice & Preusser, 2002). There are fewer studies on perfectionism in school-aged children. Although it is known that, childhood and adolescence are the most important periods for the development of perfectionism (Flett & Hewitt, 2002), this is almost unknown research area in R. Macedonia. This research aimed to explore the relationship of perfectionism dimensions with anxiety and depression among children. We examined possible differences among four groups of children (children without evident symptoms; children with evident symptoms of anxiety; children with evident symptoms of depression; children with evident symptoms of anxiety and depression) with regard to the level of dimensions of perfectionism (Sensitivity to mistakes; Contingent Self-Esteem; Compulsiveness; Need for admiration).

2. Design & method

After obtaining informative consent from the students' parents and adhering to ethical standards, research was conducted in two primary schools in Stip, R. Macedonia. The sample consisted of 468 pupils, aged 11-14, from 5th to 8th grade of primary school, of which 279 were female, and 189 male. The following instruments were used: Adaptive/Maladaptive Perfectionism Scale (Rice & Preusser, 2002), SKAN (Puric, 1992; according to Zaic, 2005) and Children's Depression Inventory (CDI, Kovacs, 1981). The dimensions of perfectionism are operationalized with adaptive/maladaptive scale for measuring perfectionism (Adaptive/Maladaptive Perfectionism Scale; Rice & Preusser, 2002). Anxiety in children is operationalized with the scale for measuring anxiety in children SKAN (Puric, 1992). Depression is operationalized with the scale for measuring depression in children Children's Depression Inventory (CDI, Kovacs,1981).

3. Results and Discussion

In order to answer the posed research problem, we first calculated the number and frequency of children in four groups indentified on results and cut-off points from test results of SKAN (anxiety) and CDI (depression). In accordance with clinical experience and previous research (Zaic, 2006; Belavic, 2006), the first group was identified as being "*without evident symptoms of anxiety and depression*", i.e. children achieved low scores (<11) of the scale for anxiety SKAN, and on the scale for depression CDI (<9). The second group ("*with evident symptoms of anxiety*") consisted of subjects who achieved high scores (> 11) of SKAN, and low scores (<9) of CDI. The third group ("*with evident symptoms of depression*") consisted of subjects who achieved high scores (> 9) of CDI, and a low score (<11) of SKAN. The last, fourth group ("*with evident symptoms of anxiety and depression*") was constituted of children who achieved high scores of SKAN (> 11) and high scores (> 9) of CDI.

Table 1 Number and frequency of children in four groups indentified on results and cut-off points from test results of SKAN (anxiety) and CDI (depression)

Children groups	N	Frequency
Children without evident symptoms of anxiety and depression	215	46%
Children with evident symptoms of anxiety	41	8.7%
Children with evident symptoms of depression	90	19.2%
Children with evident symptoms of anxiety and depression	122	26.1%

It can be seen from Table 1 that the highest is the percentage of respondents "*without evident symptoms of anxiety and depression*" (46%), followed by respondents "*with evident symptoms of anxiety and depression*" (26,1%), then those "*with evident symptoms of depression*" (19,2%), while the lowest percentage of respondents is "*with evident symptoms of anxiety*" (8.7%).