The effect of group psychotherapies on perfectionism: A systematic review

Dilara Turgut[1], Seda Tokgünaydın Arıtürk[2], İlkyaz Kaya Yıldırım[1]
[1]Res. Asis. [2]Assis. Prof., Department of Psychology, İzmir Katip Celebi University, İzmir, Turkey
https://orcid.org/0000-0002-7945-7585-https://orcid.org/0000-0002-8559-4148-https://orcid.org/0000-0002-3894-7377

SUMMARY

Perfectionism is known to be both a risk factor and explanatory mechanism for many psychological disorders and also a barrier to treatment. Perfectionism is considered as a transdiagnostic concept in terms of these characteristics and has led to the development of many interventions to treat different psychopathologies by targeting perfectionism. In the literature, it is seen that in addition to individual intervention approaches that are known to be effective on perfectionism, interventions in group format have also been developed. The aim of this study was to systematically examine the effectiveness of group psychotherapies addressing perfectionism. Method: For this purpose, Pubmed MEDLINE, Web of Science, Scopus, Science Direct, Wiley and ULAKBIM Medical and Social Sciences databases were searched for English and Turkish articles between 2004 and 2024. Eleven eligible studies were included in the systematic review. Results: Results showed that different group psychotherapy approaches (Cognitive Behavioral Therapy, Dynamic Relational Therapy, Mindfulness-Based Cognitive Therapy) were effective in reducing perfectionism in non-clinical samples. However, it was concluded that the treatment protocol should be carefully considered for groups with diagnoses such as obsessive-compulsive disorder and eating disorders. Conclusion: Group psychotherapies can be effective depending on the therapy approach adopted. However, addressing only perfectionism in clinical samples provides a limited approach.

Key Words: Peer support, mental health, social support, mental health services

INTRODUCTION

The field of clinical psychology and psychiatry has historically adopted a diagnosis-focused approach through classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), which have provided researchers and clinicians with a common language (1). However, limitations such as high comorbidity rates, heterogeneity of symptoms within diagnostic groups, and individual differences have raised questions regarding the validity and practicality of this approach (2). In response to such criticisms, transdiagnostic approaches—examining the shared mechanisms underlying various psychopathologies—have emerged as a central focus in clinical research (3). The transdiagnostic approach aims to move beyond traditional diagnostic categories by focusing on the common cognitive, emotional, and behavioral processes underlying different psychological disorders.

In this context, perfectionism has been identified as a common risk factor and maintaining mechanism across a range of psychological conditions, including depression, anxiety, eating disorders, and obsessive–compulsive disorder, thereby demonstrating a transdiagnostic feature (4,5). Perfectionism is characterized by the establishment of unrealistically high and often unattainable standards for oneself and the environment, coupled with intense self-criticism and a sense of inadequacy when these standards are not met (6,7). Adderholdt and Goldberg associated perfectionism with a persistent need for approval, fear of failure, procrastination, and a lack of effective coping strategies (8). Burns defined perfectionism as compelling oneself to achieve unattainable goals and evaluating self-worth primarily in terms of produc-

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tivity and achievement (9). Accordingly, perfectionistic thinking patterns often involve dichotomous ("all-or-nothing") thinking, overgeneralization, and "should" or "must" statements. Such individuals may adopt defensive behaviors in interpersonal relationships due to fears of judgment or criticism, while also displaying perfectionistic expectations toward others. Over time, this pattern can alienate those around them, reinforcing the perfectionist's fear of rejection. Moreover, perfectionists often feel lonely, unlovable, and worthless, leading to difficulties in personal relationships and a tendency toward social withdrawal (9).

Components of Perfectionism and Perfectionism as a Transdiagnostic Mechanism

Initially conceptualized as a symptom specific to depression, obsessive–compulsive disorder, and eating disorders (10,11), perfectionism is now understood as a multidimensional construct. In line with this conceptual shift, two independent research groups have developed distinct Multidimensional Perfectionism Scales (MPS) to capture the multifaceted nature of perfectionism (6,7).

First, Frost et al. operationalized perfectionism through 35 items encompassing six dimensions (6): Personal Standards (PS; setting high personal goals), Concern over Mistakes (CM; reacting negatively to mistakes and perceiving them as failures), Doubts about Actions (DA; doubting one's performance), Parental Expectations (PE; perceiving parents as setting high standards), Parental Criticism (PC; perceiving parental criticism for mistakes), and Organisation (O; emphasis on order and neatness). Among these, concern over mistakes and doubts about actions have been particularly emphasized as key factors with adverse implications for psychological well-being (12).

Second, Hewitt and Flett proposed a 45-item, three-dimensional model incorporating both intrapersonal and interpersonal facets of perfectionism (7). This model distinguishes: (1) self-oriented perfectionism, reflecting the drive to meet internally imposed high standards; (2) other-oriented perfectionism, denoting the imposition of high expectations on others; and (3) socially prescribed perfectionism, capturing the perception that others demand perfection from the individual. Factor analyses of these widely used scales typically yield a two-factor structure, comprising maladaptive evaluative concerns (CM, DA, PC, PE, and self-oriented perfectionism) and positive striving (PS, O, and other-oriented perfectionism) (12,13). Although there is some evidence linking positive striving to adaptive outcomes (14), numerous studies have identified robust associations between positive striving and various forms of psychopathology (4).

These scales, commonly employed in the study of perfectionism across a range of psychopathologies, contribute to four main lines of evidence supporting its transdiagnostic nature. First, perfectionism has been established as a risk factor for diverse disorders, including depression, anxiety, eating disorders, and body dysmorphic disorder (15). Second, elevated perfectionism is linked to the co-occurrence of multiple psychopathologies. Research has associated perfectionism with depression, suicidal ideation, anxiety disorders, interpersonal difficulties, and obsessive–compulsive disorder, and it has been proposed as a mechanism that may account for comorbidity across disorders (12). Third, perfectionism is implicated as a maintaining mechanism in various psychopathologies. Social isolation, diminished self-worth, and pervasive feelings of guilt are among the adverse consequences associated with perfectionism (4). These findings underscore the need to conceptualize perfectionism as a pervasive maintaining factor in psychopathology and as a critical target in treatment interventions (15). Fourth, interventions targeting perfectionism have been shown to yield symptom reductions across different psychopathologies (5). Furthermore, perfectionism has been identified as a barrier to treatment success in depressive disorders, anxiety disorders, and eating disorders (12).

In this regard, perfectionism emerges as a significant variable not only in the onset and maintenance of psychopathology but also in its treatment process. Evidence indicates that perfectionism can negatively influence therapy outcomes, reduce help-seeking behaviors, and undermine the therapeutic alliance (16). Taken together, these consid-

erations highlight the necessity of approaching perfectionism from a transdiagnostic perspective and developing psychological interventions that directly target perfectionism, independent of specific psychopathological diagnoses.

Approaches to the Treatment of Perfectionism

Given the pivotal role of clinical perfectionism in the development and treatment of psychopathology, a range of interventions have been designed to target perfectionism as a primary focus of treatment (17). Among these, Cognitive–Behavioral Therapy for Perfectionism (CBT-P) has been the most extensively researched and widely implemented intervention in clinical practice (18). In recent years, numerous studies have examined the efficacy of CBT delivered in individual, group, and internet-based formats (4).

In addition to CBT, the conceptualization of perfectionism as a personality trait has prompted limited but promising evidence supporting its treatment through long-term psychodynamic approaches (19,20). Furthermore, there is growing interest in mindfulness-based interventions and various self-help strategies aimed at reducing perfectionism. Delivered in both individual and group formats, these approaches, although supported by a modest evidence base, offer valuable insights into the treatment of perfectionism (17,21).

Cognitive–Behavioral Therapy

Cognitive–Behavioral Therapy (CBT) is the most widely applied approach in the treatment of perfectionism. In recent years, alongside the growing interest in transdiagnostic therapies, an advanced form of CBT—Enhanced Cognitive–Behavioral Therapy (CBT-E)—has gained prominence. Unlike conventional CBT, CBT-E does not solely target specific symptoms; rather, it aims to address underlying cognitive patterns and schemas, thereby treating a broad range of psychological disorders. Although initially developed for the treatment of eating disorders, CBT-E's primary goal is to target the mechanisms that maintain psychopathology. Accordingly, it incorporates additional interventions designed to influence psychological processes such as perfectionism, self-criticism, and self-compassion (22).

In general, CBT seeks to modify dysfunctional beliefs related to excessively high personal standards. Through techniques such as self-monitoring and psychoeducation, individuals are encouraged to identify and challenge their irrational perfectionistic beliefs. Behavioral experiments help evaluate the extent to which these beliefs align with reality, while cognitive restructuring addresses cognitive distortions such as selective abstraction (17). Research indicates that group therapy interventions employing CBT techniques yield effective outcomes in reducing perfectionism (22,23,24).

Dynamic Relational Therapy

Dynamic approaches have emerged as a potentially valuable avenue for the treatment of perfectionism (20). Among these, Dynamic Relational Therapy (DRT) conceptualizes perfectionism not merely as a trait, but as a personality style shaped by early relational experiences, which affects functioning both intrapersonally and interpersonally. The primary aim of DRT is to help individuals identify and transform relational cycles that adversely impact their self-perception and relationships with others. This process is facilitated through techniques such as "here-and-now" interventions, relational repair, and interpretation (19).

Hewitt and colleagues have demonstrated the beneficial effects of group-based DRT on perfectionism and its associated difficulties in multiple studies (16,19,20). They emphasize that group therapy fosters a sense of safety, consistency, and acceptance, while encouraging interpersonal risk-taking. Addressing perfectionism within a group context can also lead to lasting changes in self- and other-perceptions (25). In a seminal study, Hewitt et al. found that a 10-session group DRT program produced significant reductions in perfectionism levels, with these effects maintained at a four-month follow-up (19). Moreover, DRT was associated with improvements not only in perfectionism but also in depression, anxiety, and interpersonal problems (16). Focusing on "relational dynamics" as interfering behaviors within therapy has further

been reported to enhance therapeutic alliance, thereby improving treatment adherence and continuity (20).

Mindfulness-Based Therapies

In recent years, the effectiveness of mindfulness-based therapies in addressing perfectionism has been increasingly investigated, yielding encouraging results (18). These interventions aim to enhance individuals' awareness of their thoughts and emotions, cultivate an open and accepting stance toward these experiences, and foster a compassionate self-attitude. Compared to traditional CBT, mindfulness-based approaches encourage individuals to relate to their thoughts with psychological distance, viewing them as mental events rather than absolute truths (21).

One such approach, Mindfulness-Based Cognitive Therapy (MBCT), is designed for group delivery and is classified among third-wave interventions. MBCT emphasizes reducing self-criticism and increasing mindfulness. Given that perfectionism is negatively associated with both self-compassion and mindfulness (26), MBCT offers promising potential for its treatment. For example, James and Rimes reported that group-based MBCT reduced daily perfectionistic thoughts and increased levels of self-compassion (21).

The Present Study

There is empirical evidence supporting the effectiveness of various psychotherapeutic approaches in the treatment of perfectionism. Group psychotherapy, with its focus on interpersonal interactions and shared experiences, may represent a particularly valuable intervention format for addressing perfectionism.

Group-based interventions bring together individuals struggling with similar difficulties, fostering mutual support. This process can reduce feelings of shame and isolation, thereby reinforcing a sense of normalization and belonging (27). The group setting offers perfectionistic individuals an opportunity to observe, reflect upon, and challenge their own thoughts and behaviors, while also promoting the development of empathy, understanding, and reciprocal support among members (28). Through feedback mechanisms within the group, participants can gain greater awareness of the interpersonal impact of their perfectionistic tendencies and take steps toward modifying these patterns (27). Additionally, group psychotherapy has been highlighted as a time- and cost-effective intervention, as it enables simultaneous access to multiple clients (29). In resource-limited clinical contexts, group-based interventions provide an important alternative for reaching a broad client population.

Despite these advantages, to the best of current knowledge, no study has systematically examined the effects of group psychotherapy on perfectionism. In this context, the present systematic review aims to synthesize existing research on group-based psychotherapies targeting the reduction of perfectionism, evaluate outcomes across different group-delivered therapeutic approaches, and determine the effectiveness of these interventions in reducing perfectionistic attitudes and behaviors.

METHOD

To examine the effectiveness of group psychotherapy programs in the treatment of perfectionism, a systematic search was conducted in the PubMed, MEDLINE, Web of Science, Wiley Online Library, Science Direct, and Scopus databases for English-language articles published between 2004 and October 2024, as well as in the ULAKBIM database for Turkish-language publications. The keywords used for the English search were: group therapy OR group intervention OR group treatment AND perfect (to capture perfectionism, perfectionist, perfectionistic). For the Turkish search, the keywords were: grup AND mükemmeliyetçi (with truncation).

The inclusion criteria were as follows: (a) publication between 2004 and 2024; (b) empirical studies assessing treatment effectiveness; (c) randomized controlled trial (RCT) or quasi-experimental design; (d) inclusion of a group psychotherapy method; and (e) examination of the effect of group psychotherapy on perfectionism. Exclusion criteria

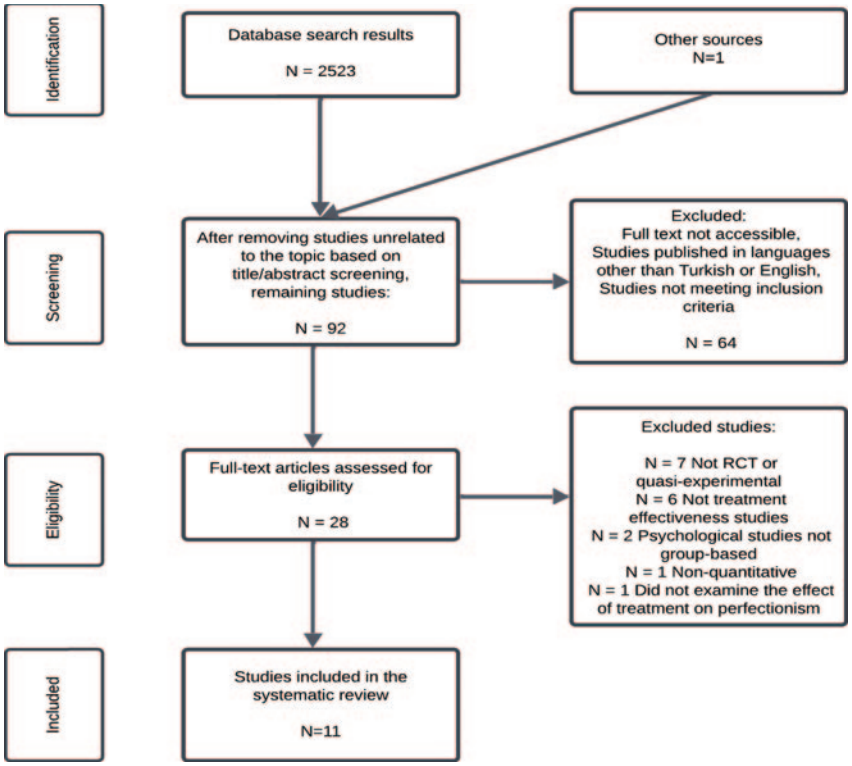

Figure 1. Flowchart of studies included in the systematic review

were: studies employing designs other than RCT or quasi-experimental; interventions delivered in an individual psychotherapy format; studies not assessing the impact of the intervention on perfectionism; publications written in languages other than Turkish or English; and studies not meeting the definition of a treatment effectiveness study.

In the initial search phase, no restrictions were placed on title or abstract fields, and the full record was accessed for all hits. The initial search yielded a total of 2,524 studies. After removing duplicates and screening titles and abstracts for relevance, 92 articles remained. Of these, 64 were excluded because the full text was unavailable, the language was other than Turkish or English, or the study did not meet inclusion criteria. The full texts of the remaining 28 articles were assessed for eligibility. Following the exclusion of studies that (a) were not treatment effectiveness studies, (b) were not quantitative in nature, (c) did not employ RCT or quasi-experimental designs, (d) did not evaluate the effect of treatment on perfectionism, or (e) did not involve a group-based psychotherapy format, a total of 11 published articles met the final inclusion criteria.

The included studies were conducted between 2008 and 2023, and were carried out in Australia (3 studies; 22,30,31), Canada (3 studies; 19,23,32), the United Kingdom (1 study; 21), Greece (1 study; 33), China (1 study; 34), and Iran (2 studies; 28,35). Numerical details regarding the search, screening, and inclusion process are presented in the PRISMA Flow Diagram (see Figure 1).

Title, abstract, and full-text screenings were independently performed by two reviewers. In cases of disagreement, a third reviewer was consulted to reach a final decision. Data extraction from included studies was also performed independently, using a structured data extraction form. Extracted variables included sample characteristics, number and duration of sessions, measurement instruments, type of treatment, follow-up period, and outcome variables.

In evaluating the studies, attention was given not only to the reported findings but also to sample-related details (e.g., inclusion and exclusion criteria), methodological aspects (e.g., treatment approaches, randomization procedures, measurement tools), and group psychotherapy–specific ele-

Table 1. Methodological Characteristics of the Included Studies

Study	Design	Sample	Inclusion Criteria	Exclusion Criteria	Treatment and Control Groups	Random Assignment	Dropout Rate	Assessments	Outcomes	
									Post-test	Follow-up
Handley et al. (2015)	RCT	42 participants (34 female, 9 male)	Scoring above 24.7 on the Concern over Mistakes (CM) subscale of the FMPS; if on medication, maintaining a stable dose for at least one month.	Acute severe disorders (self-harm, suicide, psychosis, substance use disorder), BMI < 17.5, participation in other psychotherapy treatments.	CBT Treatment Group (n = 21) Waitlist Control Group (n = 21)	Yes	None	Pre-test, post-test, 3-month and 6-month follow-up; FMPS, CPQ, DAS-SC, Interference Scale, Distress Scale, BDI-II, EDE-Q, Anxiety subscale of the DASS-21, FNE-B, PSWQ, ASI-3, Q-LES-Q-18, RSES, RNTS.	Significant improvements in perfectionism, depressive symptoms, eating disorder symptoms, social anxiety, anxiety sensitivity, rumination, self-esteem, and quality of life; changes in perfectionism significantly predicted changes in other variables (depression, eating disorder symptoms, social anxiety, rumination, self-esteem, quality of life); CBT > Control.	Improvements maintained at 3- and 6-month follow-up.
Hewitt et al. (2023)	RCT	80 participants (58 female, 21 male, 1 nonbinary)	Scoring at least one standard deviation above the mean on any perfectionism dimension.	Acute severe disorders (psychosis, suicidal ideation); unwillingness to disclose personal information during the interview; no history of close relationships.	DRT Treatment Group (n = 41) SPT Comparison Group (n = 39)	Yes	10	Pre-test, mid-test, post-test, 6-month follow-up; MPS, PSPS, PCI, BSI, SWLS, WSAS	Both DRT and SPT groups showed improvements in all perfectionism components, as well as in life satisfaction, work functioning, and social adjustment. Greater improvements in self-oriented perfectionism, perfectionistic self-presentation, nondisclosure of imperfection, and nondisplay of imperfection were observed in the DRT group compared to the SPT group..	Improvements were maintained at the 6-month follow-up.
James & Rimes (2017)	RCT	60 university students (49 female, 11 male)	Age ≥ 18; score ≥ 22 on the Concern over Mistakes subscale of the FMPS; perfectionism considered significantly impairing; significant impairment in key life domains; if taking antidepressant medication, on a stable dose for at least 3 months.	Current serious suicidal ideation; currently receiving any psychological treatment targeting perfectionism; diagnosis of substance dependence or anorexia nervosa according to DSM-IV.	MBCT Treatment Group (n = 28) CBT Self-Help Comparison Group (n = 32)	Yes	5	Pre-test, post-test, 10-week follow-up; MINI, SCID-I, FMPS, CPQ, WASAS, DASS, FFMQ, BESS, SCS, TEQ, RRQ.	Significant changes in perfectionism, emotions, repetitive thoughts, mindfulness, self-compassion, and reductions in unhelpful beliefs about experiential avoidance; MBCT > Self-Help Group.	Improvements maintained at the 10-week follow-up.
Zikopoulou et al. (2021)	RCT	81 young adults (M_{age} = 21.95)	Score at least one standard deviation above the mean on any FMPS subscale.	Not specified.	CBT Treatment Group (n = 40) Inactive control group (n = 41).	Yes	48	Pre-test, post-test; FMPS, DASS-21, STAI, MOPS.	CBT group showed greater improvements than the control group in perfectionism scores, Concern over Mistakes subscale, and reductions in depression, anxiety, and stress scores.	No follow-up assessment conducted.
Zuo & Zhang (2023)	RCT	64 university students (36 female, 28 male)	Being an undergraduate or graduate student; willingness to participate in group therapy; FMPS score ≥ 84; SDS score between 53 and 72 standard points or SAS score between 50 and 70 standard points; commitment to attend group therapy until completion.	Severe mental disorders (psychosis, suicidal tendency, etc.); participation in other psychological treatments; any change in psychotropic medication within 3 months prior to therapy initiation.	CBT□Positive Psychology Treatment Group (n = 32) Waitlist Control Group (n = 32).	Yes	8	Pre-test, post-test, 8-week follow-up; FMPS, SDS, SAS	CBT□PP group showed greater improvements than the control group in the Concern over Mistakes and Doubts about Actions subscales, as well as reductions in depression and anxiety scores.	Improvements were maintained at the 8-week follow-up, though the effect sizes were reduced.
Wade et al. (2017)	RCT	40 adult women with eating disorders	Age over 18; BMI > 17.5 and BMI < 30.	Severe mental disorders (suicidal tendency, psychotic disorders).	CBT-E Treatment Group (n = 19) Waitlist Control Group (n = 21).)	Yes	12	Pre-test, post-test, 3-month follow-up; EDE, BMI, EDE-Q, RSES, CPQ, TOMS, IIP-32, MINI.	No significant change in perfectionism scores between pre- and post-test; however, CBT-E group showed greater improvements than the control group in eating disorder symptoms, self-esteem, perceived difficulties, and emotion tolerance scores.	Perfectionism scores showed significant changes between post-test and follow-up; other improvements were maintained at the 3-month follow-up.
Babaei et al. (2022)	Quasi-experimental design	25 university students (14 women, 11 men)	Age 20□35; at least associate-level education; not currently receiving any other therapy; scoring at least 0.5 SD above the mean on a perfectionism measure.	Severe mental disorders (e.g., substance use, psychosis, borderline personality disorder); missing more than three sessions	Brief DRT Treatment Group (n = 12) Waitlist Control Group (n = 13)	Yes	5	Pre-test, post-test, 1-month follow-up, 4-month follow-up; SCID-5-RV, SCID-5-PD, TMPS, PSPS, PCI, BDI-II, BAI, IIP-32	Brief DRT group showed greater improvements than the control group in perfectionism, anxiety, depression, and interpersonal problems.	Improvements were maintained at both the 1-month and 4-month follow-ups.
Hamedani et al. (2023)	Quasi-experimental design	30 female university students	Scoring above the cut-off point on the Hill□s Perfectionism Questionnaire, Self-Criticism Scale, and Self-Compassion Scale; agreeing to attend all sessions and comply with group rules.	Presence of severe psychiatric disorders; use of psychiatric medication; participation in other psychotherapy or counseling sessions.	CBT-E Treatment Group (n = 15) Control Group (n = 15).	Yes	None reported	Pre-test, post-test; Hill□s Perfectionism Questionnaire, Self-Criticism Scale, Self-Compassion Scale.	The CBT-E group showed greater improvements than the control group in perfectionism, self-criticism, and self-compassion.	No follow-up assessment conducted.
Hewitt et al. (2015)	Quasi-experimental design	71 participants (47 females, 24 males)	Scoring at least half a standard deviation above the mean on at least one perfectionism dimension.	Presence of severe psychiatric disorders (e.g., suicidal tendency, psychosis); unwillingness to provide personal information during the interview.	DRT Treatment Group (n = 53) Waitlist Control Group (n = 18).	Yes	10	Pre-test, post-test, 4-month follow-up; MPS, PSPS, PCI, BDI, BAI, IAS, IIP.	The DRT group showed greater improvements than the control group in perfectionism, anxiety, depression, and interpersonal problems.	Improvements were maintained at the 4-month follow-up.
Kutlesa & Arthur (2008)	Quasi-experimental design	90 university students (75 females, 15 males)	Not specified	Not specified	CBT and Interpersonal Therapy Treatment Group (n = 30) Career Comparison Group (n = 30) Psychology Comparison Group (n = 30).	Yes	46	Pre-test, post-test; BDI-II, BAI, MPS	The CBT and Interpersonal Therapy group showed greater improvements in perfectionism, depression, and anxiety compared to the control groups.	No follow-up assessment conducted.
Sadri et al. (2017)	Quasi-experimental design	11 participants diagnosed with OCD (M_{age} = 40.00)	Age 18 or older, primary OCD diagnosis, score of 22 or higher on the FMPS Concern over Mistakes subscale.	Acute severe disorders (suicidal tendencies, psychosis), participation in other psychological treatments, changes in psychiatric medication dosage (if used, dose had to remain stable).	CBT Treatment Group (n = 4) Waitlist Control Group (n = 7).	Yes	8	Pre-test, post-test, 3-month follow-up; YBOCS, FMPS, CPQ.	CBT was associated with improvements in perfectionism and OCD severity, though statistical significance was not achieved.	At follow-up, two of the three participants showed continued improvement, while one participant reported worsening symptoms..

Type of Group Therapy: DRT: Dynamic Relational Therapy, MBCT: Mindfulness-Based Cognitive Therapy, SPT: Supportive Psychodynamic Therapy

Scales: SCID-5-RV: Structured clinical interview for DSM -5 disorders, SCID -5-PD: Structured clinical interview for DSM -5 personality disorders, TMPS: Tahram Multidimensional Perfectionism Scale, PSPS: Perfectionistic self-presentation scale, PCI: Perfectionism co gnitions inventory, BDI -II: Beck depression inventory -II, BAI: Beck anxiety inventory (BAI), IIP -32: Inventory of interpersonal problems, FMPS: Frost Multidimensional Perfectionism Scale, CPQ: Clinical Perfectionism Questionnaire, DASSC: Dysfunctional Attitudes Scale-Self Criticism, EDE-Q: Eating Disorder Examination Questionnaire, FNEB: Fear of Negative Evaluation Scale-brief version, PSWQ: Penn State Worry Questionnaire, ASI-3: Anxiety Sensitivity Index-3, Q-LES-Q-18: Quality of Life, Enjoyment and Satisfaction Questionnaire-18, RSES: Rosenberg Self-Esteem Scale, RNTS: Repetitive Negative Thinking Scale, MPS: Multidimensional Perfectionism Scale, BSI: Brief Symptom Inventory, SWL S: The Satisfaction With Life Scale, WSAS: Work and Social Adjustment Scal e, IAS: Interaction Anxiousness Scale, DASS-21: Depression Anxiety Stress Scale-21, STAI: Spielberger State-Trait Anxiety Inventory, MOPS: Measure of Parental Style, SDS: Self-Rating Depression Scale, SAS: Self-Rating Anxiety Scale, FFMQ: Five Facets Mindfulness Questionnaire, WOQ: Written Open Questions, SSI: Semi-structured Interview, YBOCS: Yale-Brown Obsessive Compulsive Scale, DAS: Dysfunctional Attitude Scale, MINI: The Mini -International Neuropsychiatric Interview, EDE: Eating disorder examination, BMI: Body Mass Index, , TOMS: Tolerance of mood states scale, BES: Beliefs about Emotions Scale, TEQ: The Experiences Questionnaire, SCS: Self-Compassion Scale,RRQ: The Rumination Responses Questionnaire

Table 2. Characteristics of Group Therapy

Study	Type of Group Therapy	Session Duration	Number of Sessions	Therapy Frequency	Number of Therapists	Number of Members	Group Therapy Tecniques
Babaei et al. (2022)	Short-Term Dynamic Relational Therapy (DRT)	90 minutes	16 weeks	Once a week	Two	15	The group therapy was divided into four stages: • "Attachment and verbal bonding" stage (Sessions 1 □2): In this stage, the therapist works to highlight commonalities among group members with different experiences and helps manage anxiety levels to ensure a safe environment. • "Pattern breaking" stage (Sessions 3 □7): The therapist supports group members in deepening their experiences and emotions, helping them express feelings and thoughts through increasingly challenging interventions. Resistance is at its highest level in this stage. • "Self-redefinition/authenticity filled with pain" stage (Sessions 8 □14): This stage focuses on questioning limiting patterns in communication and self-concept. Group members review their interaction patterns and attitudes toward themselves. • "Termination" stage (Sessions 15 □16): In this stage, significant experiences gained in the group therapy are integrated, and group members work on expressing feelings related to loss and unresolved issues. Additionally, each participant attended a one-session individual preparation meeting to facilitate the group process.
Hamedani et al. (2023)	Enhanced Cognitive Behavioral Therapy (CBT-E)	120 minutes	8 weeks	Once a week	One	15	Assessment of perfectionism, fostering and conceptualizing motivation for change, recognizing the difference between reality and fantasy, cognitive-behavioral formulation, behavioral experiments, psychological and self-help training, problem-solving training, challenging dichotomous thinking through behavioral experiments, addressing rigidity, overly high standards, broad attention, cognitive distortions, and cognitive biases, keeping daily thought records, addressing procrastination, problem-solving, time management, and scheduling pleasurable activities; emotional skills training, self-evaluation, reducing fear of making mistakes, fostering self-compassion over self-criticism, self-assessment, and relapse prevention.
Handley et al. (2015)	Cognitive Behavioral Therapy (CBT)	120 minutes	8 weeks	Once a week	Two	20	Psychoeducation on understanding perfectionism, motivation for change, behavioral experiments, thought records, reducing procrastination, reducing self-criticism, and balancing self-confidence.
Hewitt et al. (2023)	Dynamic Relational Therapy (DRT) Supportive Psychodynamic Therapy (SPT)	90 minutes	12 weeks	Once a week	Two	8-9	Dynamic-Relational Therapy (DRT): • Focuses on the patient□s relational dynamics with themselves and others • Interprets interactions among group members and group processes • Aims to explore and understand the patient□s relational needs with themselves and others Supportive Psychodynamic Therapy (SPT): • Aims to help patients adapt to life situations and challenges arising from perfectionism • Focuses on reinforcing support, empathic understanding, and appropriate problem-solving skills • Avoids interpreting interactions among group members While DRT focuses more on interpretative and relational processes, SPT adopts a more supportive approach.
Hewitt et al. (2015)	Dynamic Relational Therapy (DRT)	90 minutes	11 weeks	Once a week	Two	7-10	□Here-and-now□ approach, exploring relationships and experiences among group members, expressing emotions, providing interpersonal feedback, and interpreting transference reactions within the group.
James & Rimes (2017)	Mindfulness-Based Cognitive Therapy (MBCT)	120 minutes	8 weeks	Once a week	Two	?	Mindfulness meditation practices, inquiry, attentional focus, strategies for coping with negative thoughts and emotions, psychoeducation, and compassion meditation.
Kutlesa & Arthur (2008)	Cognitive Behavioral Therapy with an Interpersonal Approach	?	4 weeks	Twice a week	One	8	Principles of interpersonal theory focusing on the □here and now,□ knowledge and skills training, relaxation techniques, cognitive restructuring, role modeling, self-reinforcement techniques, and stress reduction techniques.
Sadri et al. (2017)	Cognitive Behavioral Therapy (CBT)	120 minutes	8 weeks	Once a week	?	?	?
Wade et al. (2017)	Enhanced Cognitive Behavioral Therapy (CBT-E)	120 minutes	20 weeks	Once a week	Two-Three	?	The group CBT-E treatment consists of four stages: During the first four sessions, the focus was on motivation, psychoeducation, regular eating, and emotion regulation. In the following two sessions (weeks 7 and 8), the aim was to conduct a detailed review of progress and identify factors hindering change. Sessions held between weeks 9 and 17 addressed over-evaluation of eating, shape, and weight, shape-checking and avoidance, cognitive distortions, and dietary rules. In this stage, additional sessions targeted maintaining factors such as personal perfectionism, low self-esteem, and interpersonal difficulties. The final two sessions focused on developing maintenance plans and preventing relapse.
Zikopoulou et al. (2021)	Cognitive Behavioral Therapy (CBT)	120 minutes	10 weeks	Once a week	?	?	Psychoeducation, behavioral experiments, cognitive strategies, modification of cognitive distortions, and cognitive-behavioral techniques.
Zuo & Zhang (2023)	Cognitive Behavioral Therapy (CBT)- Positive Psychotherapy	120 minutes	8 weeks	Once a week	One (Three assistant facilitators)	?	Identification of negative automatic thoughts, ABC theory, behavioral experiments, cognitive restructuring, practices for viewing mistakes and failures from a positive perspective, restructuring participants□ past mistakes and failures, learned optimism, hope-oriented thinking, and process orientation.

ments (e.g., session length, number and frequency of sessions, number of therapists, group size, and techniques employed).

RESULTS

Details of the included studies are summarized in Table 1 and Table 2.

Methodological Characteristics of the Studies

Of the 11 studies reviewed, six employed a randomized controlled trial design to examine treatment effects. The remaining five studies utilized a quasi-experimental design (19,23,28,30,35).

Sample

In six of the reviewed studies, the sample comprised university students and young adults (21,23,28,33,34,35). One study was conducted with a sample diagnosed with an eating disorder (31), and another with participants diagnosed with obsessive–compulsive disorder (OCD) (30). Across studies, females were generally overrepresented; only two studies reported a balanced gender distribution (34,35)

Inclusion and Exclusion Criteria

Inclusion criteria across the studies were primarily based on the assessment of perfectionism levels and the requirement to exceed specific cutoff scores. In all studies, individuals scoring high on

the Frost Multidimensional Perfectionism Scale (FMPS) or on subscales of other perfectionism measures were included in the sample. Additionally, some studies required participants to have at least an associate degree (35), to fall within specific age ranges (e.g., university students or aged 18 years and above) (21,31,34), and to be willing to participate in group therapy (28,34).

Exclusion criteria most commonly included acute severe psychiatric disorders (e.g., suicidal ideation, psychosis, substance use disorder) (n = 9), concurrent engagement in another psychological treatment (n = 5), and unstable psychiatric medication use (n = 5). Furthermore, participants with extremely low body mass index (BMI < 17.5) (22,31) or a diagnosis of anorexia nervosa (21) were excluded from treatment participation, as these conditions were considered potential barriers to engagement (21,22,31). Only two studies did not specify any exclusion criteria (23,33).

Treatment and Control/Comparison Groups

In the reviewed studies, treatment groups consisted of group therapy interventions based on various psychotherapeutic approaches. The most frequently used interventions were Cognitive–Behavioral Therapy (CBT) and its adaptations, such as Enhanced Cognitive–Behavioral Therapy (CBT-E) (n = 7). Three studies implemented Dynamic Relational Therapy (19,32,35), while one study employed Mindfulness-Based Cognitive Therapy (21). Control group conditions most commonly consisted of a waitlist (n = 8). In addition, three studies utilized comparison groups, which included active interventions such as a career support group (23), a CBT self-help group (21), and supportive psychodynamic therapy (32).

Except for one study (19), the number of participants in treatment and control groups was balanced. The size of the treatment groups ranged from 12 to 53 participants, with control groups showing a similar range. All studies employed random assignment to treatment and control groups.

Measurement Instruments and Assessment Frequency

Across the studies, a range of instruments was employed to assess multidimensional psychological variables such as perfectionism, depression, anxiety, eating disorder symptoms, self-esteem, and quality of life. Commonly used measures of perfectionism included the Frost Multidimensional Perfectionism Scale (FMPS), the Perfectionistic Self-Presentation Scale (PSPS), the Perfectionism Cognitions Inventory (PCI), the Clinical Perfectionism Questionnaire (CPQ), and the Multidimensional Perfectionism Scale (MPS). Additionally, measures targeting anxiety, depression, and stress—such as the Beck Depression Inventory-II (BDI-II), the Beck Anxiety Inventory (BAI), and the Depression Anxiety Stress Scales-21 (DASS-21)—were used for supplementary analyses.

In terms of assessment frequency, pre-test and post-test measurements were typically followed by follow-up assessments (e.g., at 3 months, 6 months, or 8 weeks) to evaluate the maintenance of therapeutic effects. Only three studies did not include any follow-up assessments (23,28,33).

Content and Implementation of Group Therapies in the Studies

Type of Group Therapy and Techniques Employed

The most frequently implemented therapy type across the studies was Cognitive–Behavioral Therapy (CBT) (n = 7). One of these studies integrated CBT with principles of Interpersonal Therapy (23), while another combined CBT with Positive Psychotherapy (34). In general, CBT-based interventions focused on psychoeducation, identification and restructuring of cognitive distortions, and behavioral experiments. However, the study by Sadri et al. did not provide any information regarding the specific techniques used (30).

Handley et al. conducted eight weekly sessions that incorporated psychoeducation on understanding perfectionism, thought records, strategies to

enhance self-confidence, reduction of self-criticism, and behavioral experiments (22). Similarly, Zikopoulou et al. implemented ten weekly sessions emphasizing cognitive restructuring and other cognitive–behavioral strategies (33). Enhanced Cognitive–Behavioral Therapy (CBT-E) was applied in two studies (28,31). The transdiagnostic treatment plans of CBT-E targeted reductions in cognitive distortions and self-criticism. In their eight-week program, Hamedani et al. supplemented the intervention with training in time management and problem-solving skills (28). Wade et al., in a 20-week, four-stage program, addressed regular eating patterns, cognitive distortions, and interpersonal problems, concluding with relapse prevention planning (31).

Zuo and Zhang integrated CBT with Positive Psychotherapy techniques in an eight-week group program (34). This intervention included positive psychology–oriented strategies such as restructuring negative automatic thoughts, adopting a more constructive perspective toward mistakes and failures, and fostering hope-oriented thinking. Kutlesa and Arthur combined CBT with Interpersonal Therapy in a four-week program with twice-weekly sessions, employing "here-and-now" techniques, relaxation strategies, cognitive restructuring, and self-reinforcement exercises (23).

Following CBT, the second most frequently used therapeutic approach was Dynamic Relational Therapy (n = 3), which aims to help individuals understand and modify the dynamics within their interpersonal relationships. Babaei et al. delivered a 16-week program organized into four stages—engagement, pattern interruption, self-redefinition, and termination—during which relational dynamics among group members were explored in depth, and participants' self-attitudes were reconstructed (35). Hewitt et al. (32) conducted a 12-week program incorporating interpretive work on group members' relational dynamics and exploration of transference processes within the group. In another study, Hewitt et al. (19) implemented an 11-week intervention featuring techniques such as emotional expression and interpretation of transference reactions within the group setting.

Mindfulness-Based Cognitive Therapy (MBCT) was applied in only one study (21). This intervention focused on enhancing mindfulness and self-compassion skills. In their eight-week program, James and Rimes incorporated mindfulness meditation, strategies for coping with negative thoughts, and compassion-focused meditation techniques (21).

Session Characteristics and Duration

Across the 11 reviewed studies, the duration of group therapy sessions ranged from 90 to 120 minutes, with the majority conducted as 120-minute sessions (n = 7). Three studies reported sessions lasting 90 minutes (19,32,35), while one study did not specify session length (23).

In terms of session frequency, a once-weekly schedule was the most commonly adopted format. The only exception was the study by Kutlesa and Arthur, in which sessions were held twice per week (23).

The total duration of therapy varied across studies, ranging from 4 to 20 weeks. Most interventions spanned 8 weeks (n = 5), though other formats included 10 weeks (23), 11 weeks (19), 12 weeks (32), and 16 weeks (35). The shortest intervention was implemented by Kutlesa and Arthur (23), consisting of a 4-week program with two sessions per week. The longest was conducted by Wade et al., who delivered a 20-week program with weekly sessions, each stage targeting specific therapeutic goals (31).

Some studies incorporated additional individual preparation sessions or individual therapy processes to complement the group intervention. For instance, Babaei et al. conducted two individual preparatory sessions prior to group therapy, aiming to enhance participants' readiness and adaptation to the group process (35). Similarly, Hamedani et al. also included individual preparatory components in their intervention (28).

Number of Members and Therapists

In the reviewed studies, group sizes generally ranged from 7 to 15 members. For example, in the

studies by Babaei et al. (35) and Hamedani et al. (28), each group consisted of 15 members, whereas in the study by Hewitt et al. (19), group sizes ranged from 7 to 10 members. In some studies, the number of members was not specified (21,23,30,31,34).

The number of therapists was most commonly two, although in some studies the group process was facilitated by a single therapist. For instance, in the studies by Hamedani et al. (28) and Kutlesa and Arthur (23), one therapist led the intervention. In contrast, Zuo and Zhang's (34) study involved one therapist supported by three assistant facilitators. In certain longer or more structured programs—such as the intervention by Wade et al.—two to three therapists were reported to have conducted the sessions (31).

Pre- and Post-Treatment Comparison Results

Overall, group therapies were found to be effective in reducing perfectionism. Cognitive–Behavioral Therapy (CBT) was the most frequently implemented approach, with most CBT-based studies reporting significant improvements. In the study by Handley et al. (22), significant changes were observed in perfectionism, depression, eating disorder symptoms, social anxiety, rumination, self-esteem, and quality of life in the CBT group compared to the control group. Furthermore, changes in perfectionism within the CBT group significantly accounted for improvements in depression, eating disorder symptoms, social anxiety, and self-esteem. These effects were maintained at 3- and 6-month follow-up assessments.

Similar findings were reported in the studies by Zikopoulou et al. (33), Kutlesa and Arthur (23), and Hamedani et al. (28), although no follow-up assessments were conducted in these studies. In addition to reductions in perfectionism, significant improvements were noted in depression and anxiety scores (23,33) and in self-criticism and self-compassion (28).

In their study integrating CBT with Positive Psychotherapy techniques, Zuo and Zhang reported improvements in the Concern over Mistakes and Doubts about Actions subscales of perfectionism. However, these effects partially diminished at follow-up. Significant improvements were also observed in depression and anxiety scores, with these changes maintained at the 2-month follow-up (34).

In the study by Wade et al., conducted with individuals diagnosed with eating disorders, no significant pre–post changes were found in clinical perfectionism scores in the CBT-E group; however, positive effects emerged during follow-up. Additionally, significant pre–post improvements were reported in eating disorder symptoms, self-esteem, interpersonal difficulties, and emotion tolerance, with these changes maintained at the 3-month follow-up (31).

The study by Sadri et al. (30) found that CBT led to improvements in perfectionism and obsessive–compulsive disorder (OCD) severity among individuals diagnosed with OCD; however, these improvements did not reach clinical significance. Moreover, due to a high dropout rate, follow-up data were collected from only three participants—two of whom maintained improvement in perfectionism, while one reported deterioration.

Dynamic Relational Therapy (DRT) interventions also produced significant improvements across various dimensions of perfectionism. In the study by Hewitt et al. (32), improvements were observed in both the DRT and supportive psychodynamic therapy (SPT) groups; however, greater changes were recorded in the DRT group in self-oriented perfectionism, perfectionistic self-presentation, and nondisclosure of imperfection. These effects were maintained over a 6-month follow-up period. In the study by Babaei et al., a short-term DRT intervention produced significant improvements in perfectionism and related psychological difficulties (e.g., depression and anxiety) compared to a control group, with these effects sustained over a 4-month follow-up (35). Similarly, positive effects of DRT on perfectionism were reported in the study by Hewitt et al. (19).

Finally, in a study conducted by James and Rimes with university students, Mindfulness-Based

Cognitive Therapy (MBCT) resulted in improvements in perfectionism, rumination, mindfulness, and self-compassion. These gains were maintained at the 10-week follow-up (21).

DISCUSSION

This systematic review examined the effects of group psychotherapies on reducing perfectionism, with findings varying according to the type of intervention, sample characteristics, and follow-up duration. Overall, group-based approaches such as Cognitive–Behavioral Therapy (CBT), Dynamic Relational Therapy (DRT), and Mindfulness-Based Cognitive Therapy (MBCT) demonstrated significant improvements, particularly in non-clinical populations. However, in clinical populations, the entrenched nature of perfectionism and the presence of comorbid psychopathologies resulted in more limited and complex patterns of effectiveness.

Several factors may underlie this limitation. First, in clinical populations, perfectionism often manifests as a deeply ingrained and chronic trait, making it more difficult to alter perfectionistic thought and behavior patterns through short-term interventions. Second, co-occurring psychiatric symptoms (e.g., severe anxiety, depression, personality disorders) can negatively impact engagement in therapy and the rate of change within the therapeutic process. Third, establishing and maintaining a therapeutic alliance may be more challenging in clinical samples. Fear of making mistakes, and concerns about criticism or evaluation, may lead perfectionistic individuals to participate less in group therapy and contribute to higher dropout rates. Consequently, research involving clinical samples requires more structured, longer-term, and individualized intervention programs.

In non-clinical samples, CBT has shown effectiveness by directly targeting perfectionistic cognitions and behaviors (22,33). Techniques such as cognitive restructuring, psychoeducation, and behavioral experiments have been found to enhance cognitive flexibility in perfectionists, thereby facilitating change. However, as observed in the study by Zuo and Zhang, these improvements partially diminished at follow-up (34), indicating the need to reinforce group interventions with long-term support mechanisms and relapse prevention strategies.

Findings from DRT interventions underscore the importance of addressing the interpersonal and self-representational dimensions of perfectionism. Hewitt et al. reported that DRT led to significant improvements in self-oriented perfectionism, perfectionistic self-presentation, and nondisclosure of imperfection, with these effects maintained over the follow-up period (32). This supports the conceptualization of perfectionism as not solely cognitive but also relational in nature. Similarly, Babaei et al. found that a short-term DRT program produced improvements in perfectionism as well as in depressive and anxiety symptoms (35). Taken together, these findings suggest that perfectionism is shaped within interpersonal dynamics and that DRT, by targeting these dynamics, can serve as an effective intervention. Hewitt et al. have emphasized the role of relational components in the emergence of perfectionism and the importance of addressing both causal and maintaining factors through group-based DRT (20).

Only one study examined the group format of MBCT, yielding significant results (21). This intervention effectively reduced ruminative thinking, increased self-compassion, and lowered stress levels associated with perfectionism. The findings suggest that MBCT offers a promising approach for reducing the negative thoughts and emotions associated with perfectionism. In MBCT, acceptance and self-compassion are taught as tools for coping with distressing thoughts, feelings, and experiences. As individuals enhance their awareness, they learn to respond with empathy, kindness, calmness, and patience. Discussing these processes within a group context may help reduce dysfunctional beliefs and self-judgment (36). Furthermore, MBCT has been shown to reduce rumination (37) and dysfunctional beliefs about emotions (36), while fostering a more decentered perspective toward thoughts (26). This approach directly addresses maladaptive beliefs, self-critical cognitions, low self-compassion, and limited mindfulness—core features often associated with perfectionism. Indeed, low self-compassion has been linked to maladaptive emotion regulation in response to failure (38). While perfection-

istic concerns can lead to severe self-criticism following perceived failure (13,14), MBCT promotes openness, acceptance, and a nonjudgmental stance toward setbacks and mistakes (26). This theoretical alignment between MBCT's structure and the core features of perfectionism may explain the significant results obtained in the study.

In summary, in non-clinical groups, the effect of group therapy on perfectionism was found to be significant regardless of the therapeutic approach. However, these favorable outcomes may be attributable to the greater flexibility and treatment responsiveness of perfectionism in non-clinical populations. Indeed, rigid cognitive patterns such as "concern over mistakes" and "personal standards" appear to be more resistant in clinical groups (39,40). Only two of the studies included in this systematic review involved clinical samples. The study by Sadri et al., involving individuals with OCD, did not achieve clinically significant results in reducing perfectionism (30). Similarly, Wade et al. reported no significant pre–post changes in perfectionism among individuals with eating disorders, with reductions observed only between post-treatment and follow-up assessments (31).

In clinical populations, particularly those with eating disorders and OCD, the effectiveness of group therapy has produced more variable results. For example, studies by Lloyd et al. (41) and Tchanturia et al. (40) reported significant reductions in perfectionism among individuals diagnosed with anorexia nervosa (AN), particularly in the subscales of "concern over mistakes" and "personal standards," with the group setting providing a safe environment for sharing experiences. Conversely, Levinson et al. found that while high personal standards decreased following intervention, concern over mistakes remained resistant to change (39). Given that concern over mistakes is the subscale most strongly associated with eating disorders (42), this finding suggests that treatment protocols should place greater emphasis on this domain. The positive responsiveness of high personal standards to group-based interventions may be related to the construct's sensitivity to social comparison; the group setting allows individuals to evaluate their standards in relation to others and to reconsider them accordingly. Similarly, concern over mistakes may also be addressed through interpersonal exchanges in the group context, where social feedback and shared experiences help individuals recognize and challenge cognitive biases. Therefore, targeting concern over mistakes—one of the core mechanisms in eating disorders—within the group's social context could contribute to the development of strategies that enhance intervention effectiveness.

Wade et al. further reported that a CBT intervention for individuals with eating disorders did not yield significant short-term improvements, but positive effects emerged during follow-up (31). This finding suggests that in eating disorders, changes in perfectionism may require more time and that long-term, staged interventions are necessary.

For individuals with OCD, the effectiveness of group therapy has been found to be more limited. In the study by Chik et al., group interventions did not yield significant effects on perfectionism, suggesting that in certain clinical conditions, perfectionism may represent a secondary feature (43). Similarly, Sadri et al. found that CBT produced only partial improvements in OCD patients, and these changes did not reach clinical significance (30). Such findings indicate that in clinical groups such as OCD, perfectionism tends to be more resistant and less responsive to intervention, highlighting the need for group-based treatments to be supplemented with individualized strategies (44).

Low participation rates and high dropout rates (30) also emerge as important factors limiting the feasibility of group psychotherapies. For example, in the aforementioned study, a dropout rate of 42% was reported, with many participants withdrawing before initiating treatment. The researchers interpreted this as an indication that group therapy may be discouraging for some individuals. In this context, it has been emphasized that for individuals with OCD, individual therapy formats should be prioritized, and strategies should be developed to enhance participation rates (30).

The lower effectiveness of group-based interventions in clinical samples suggests that, in certain psychopathologies, other transdiagnostic proces-

ses—beyond perfectionism—may play a more central etiological role. Indeed, in OCD, cognitive biases such as thought–action fusion and inflated responsibility, which often accompany perfectionism, have been consistently identified in the literature as core and maintaining factors of the disorder (45). One possible explanation is that such disorder-specific cognitive processes may need to be addressed prior to directly targeting perfectionism.

Although perfectionism, by virtue of its close relationship to social comparison, is a suitable target for group-based work, focusing exclusively on perfectionism without addressing OCD-specific symptoms (e.g., thought–action fusion) may fail to yield clinically meaningful change. Therefore, before evaluating the effectiveness of group interventions in clinical samples, it is recommended to clearly define the primary cognitive mechanisms within the relevant psychopathology and to address perfectionism subsequently within the group context.

The effectiveness of group interventions also varies according to implementation dynamics and content. Steele et al. found that psychoeducational materials alone were ineffective, whereas group-based CBT produced significant reductions in perfectionism and negative affect (24). The fact that the intervention also reduced diagnoses of major depressive disorder and social phobia underscores the transdiagnostic role of perfectionism. In this regard, interventions should not be limited to cognitive change alone but should also incorporate compassion-focused and relational techniques.

Nevertheless, the limitations of group interventions should not be overlooked. In particular, the high dropout rates observed in clinical samples (30) pose challenges for treatment engagement. In Cheli's study, group interventions were found to be effective among individuals diagnosed with personality disorders; however, improvement occurred following individual therapy (44). This finding suggests that group therapy alone may be insufficient for individuals with personality pathology and should be supplemented with individual treatment.

While conducting group therapy with clinical samples, as in the studies mentioned above, is a considerable strength, none of these studies employed a control group condition. This raises the possibility that observed improvements may be attributable to confounding factors such as temporal effects, and should therefore be considered an important limitation (24,30,39,40,41,42,43).

Another possible reason for the limited effectiveness of group therapy in clinical populations is that perfectionism may crystallize into a more rigid, personality-level construct. As Hewitt et al. note, perfectionism develops within an interpersonal context, and defense mechanisms such as concealing flaws or striving to appear perfect in relationships may come into play (20). The effort to maintain a flawless image in a group setting may lead perfectionistic individuals to adopt defensive behaviors during therapy (20). At this point, as illustrated in the study by Babaei et al., the inclusion of individual preparatory sessions may serve as a strategy to enhance adaptation to group therapy (35).

Variations in implementation across the included studies may also be considered an important factor contributing to the heterogeneity of findings. For example, the number of group members, number of sessions, and number of therapists are critical variables shaping therapeutic effectiveness. In the study by Sadri et al., the small sample size (n = 11) may partly explain the absence of significant effects (30). Moreover, because information on the number of therapists, group size, and techniques employed was not reported, it is difficult to determine how these variables might have influenced outcomes.

Similarly, the study by Zikopoulou et al. reported the highest number of dropouts (n = 48) (33). As the number of therapists and group size were not specified, it is not possible to ascertain whether the high attrition rate was attributable to features of the intervention. On the other hand, despite the high dropout rate, the intervention appeared effective among those who completed the program, suggesting that individuals who stood to benefit from psychological treatment may have been more likely to remain engaged. Additionally, because no follow-up assessments were conducted, it is difficult to draw conclusions regarding the durability of

effects. Likewise, Kutlesa and Arthur's study also reported high dropout (n = 46) (23). This study employed an intensive format—four weeks with two sessions per week—which may have affected participant motivation and feasibility. Although both studies yielded significant reductions in perfectionism, the absence of follow-up data prevents evaluation of long-term effects.

In sum, the findings of this review indicate that group psychotherapies can be effective in reducing perfectionism, though effectiveness differs between clinical and non-clinical populations. Group-based interventions tend to produce quicker gains among non-clinical participants, whereas in clinical populations the more rigid and maintaining nature of perfectionism necessitates longer and more tailored interventions. Specifically targeting resistant subdimensions such as concern over mistakes, and augmenting interventions with compassion-focused and dynamic relational techniques, may enhance therapeutic impact.

This review has several limitations. First, methodological heterogeneity across studies (e.g., measurement tools, session length, number of sessions, number of therapists, and group size) complicated direct comparison of results. Differences in group size (e.g., ranging from 7 to 15 members) and treatment duration (4–20 weeks) may also have influenced outcomes. Second, there was considerable heterogeneity in instruments used to assess different dimensions of perfectionism. Such variability may undermine the consistency of findings and limit generalizability. Interventions targeting perfectionism have been measured with a variety of tools, including the Tehran Multidimensional Perfectionism Scale (TMPS), the Perfectionistic Self-Presentation Scale (PSPS), the Perfectionism Cognitions Inventory (PCI), and Hill's Perfectionism Questionnaire (HPQ), each capturing distinct facets of the construct. For instance, TMPS is oriented more toward internal processes based on cognitive schemas, whereas PSPS focuses on the outward, behavioral presentation of perfectionism. The MPS assesses perfectionism primarily from a cognitive perspective, emphasizing negative automatic thoughts, while HPQ—unlike many other instruments—aims to capture not only maladaptive but also functional dimensions of perfectionism. Accordingly, TMPS may be more suitable for evaluating dimensions related to internal motivation, personality traits, and individual schemas, whereas PSPS may be more functional for examining interpersonal processes such as social anxiety, shame, and social presentation. Because group-format interventions foreground the social expression of perfectionism, it is particularly important to select instruments that can capture behavioral responses in social contexts (e.g., PSPS) or perceptions related to external expectations (e.g., the Socially Prescribed Perfectionism subscale in TMPS). Third, especially among studies with clinical samples, the number of randomized controlled trials is insufficient, which limits the reliability of inferences regarding intervention effectiveness. In clinical samples, controlled comparisons would yield clearer and more valuable insights into how perfectionism manifests within target psychopathologies and how it should be addressed. Furthermore, many studies either lacked follow-up data or included only short-term follow-up, hindering evaluation of long-term effects. It is plausible that interventions targeting perfectionism may produce more pronounced effects over time; conversely, high effects at post-treatment may attenuate once contact with the group ends. This underscores the need for follow-up assessments to evaluate the durability and longer-term outcomes of treatment effects. Finally, imbalanced gender distributions (typically female-dominant) and small sample sizes in several studies may limit generalizability. Future research should adopt more homogeneous methodological approaches, recruit larger and more diverse samples, and develop protocols that evaluate long-term effects. In addition, individualized approaches may play an important role in overcoming limitations observed in clinical groups.

Moreover, the studies included in this review examined perfectionism in clinical and non-clinical samples without treating perfectionism itself as a formal diagnosis. In this regard, studies that evaluate the concept of "clinical perfectionism," develop group-based interventions that directly target clinical perfectionism, and test their effectiveness could substantially enrich the literature.

Correspondence address: Res. Asis., Dilara Turgut, Department of Psychology, İzmir Katip Celebi University, İzmir, Turkey
dilara.turgut@ikc.edu.tr

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