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Application and Effectiveness of Cognitive-Behavioural Therapy for Perfectionism.

A Review of Research on the Reduction of Perfectionism and Symptoms of Co-Occurring Disorders

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Abstract

Objective: The aim of this paper is to present the nature of perfectionism as a personality trait, its impact on mental health, and effective therapeutic methods within the framework of cognitive-behavioural therapy (CBT).

Theses: Perfectionism includes both an adaptive striving for high standards and maladaptive aspects related to fear of mistakes and social pressure. In its maladaptive form, perfectionism constitutes a risk factor for the development and maintenance of numerous mental disorders, such as depression, anxiety disorders, eating disorders, and obsessive–compulsive disorder. Cognitive and behavioural mechanisms of perfectionism—such as dichotomous thinking, self-criticism, rumination, and avoidance—contribute to the persistence of these problems. Cognitive-behavioural therapy, delivered in various forms (individual, group, and online), is an effective method for reducing both perfectionistic concerns and the symptoms of co-occurring mental disorders.

Conclusions: Research shows that perfectionism can have not only positive but also negative effects on patients, and its maladaptive form is associated with a serious threat to mental health. Cognitive-behavioural therapy is currently one of the most well-documented and effective methods for addressing perfectionism. Properly selected and supported interventions promote long-term reduction of maladaptive aspects of perfectionism and improvement in the psychological well-being of patients—both adults and individuals from younger age groups.

Keywords: perfectionism, cognitive-behavioral therapy, mental disorders, transdiagnostic approach

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Perfectionism is a multidimensional trait that encompasses both adaptive strivings for high standards and self-improvement, as well as maladaptive concerns about making mistakes, harsh self-criticism, and fear of social evaluation, all of which may lead to significant mental health problems and difficulties in everyday functioning (Flett & Hewitt, 2002; Stoeber & Otto, 2008).

Even early works on perfectionism indicated that perfectionistic beliefs and tendencies were associated with emotional suffering (Adler, 1956; Ellis, 1958). Perfectionism has been identified as an important factor contributing to the onset, intensification, and maintenance of anxiety, depression, and eating disorders (Egan et al., 2011), and it may also negatively affect treatment outcomes (e.g., Blatt et al., 1995). Clinical perfectionism is understood as a transdiagnostic process, meaning that the core cognitive-behavioural mechanisms maintaining this trait are present in, and hinder recovery from, a range of mental disorders such as depression, anxiety disorders, and eating disorders. The transdiagnostic approach makes it possible to apply universal therapeutic interventions that focus on the key mechanisms underlying psychopathology (Harvey et al., 2004; Newby et al., 2015).

The aim of this literature review is to present scientific evidence concerning the effectiveness of cognitive-behavioural interventions targeted at the treatment of perfectionism and co-occurring disorders.

Hamachek (1978) was probably the first researcher to propose a two-dimensional division of perfectionism into normal perfectionism and neurotic perfectionism. "Normal" perfectionists derive satisfaction from their striving and demonstrate greater flexibility, whereas neurotic perfectionists are excessively self-critical and never regard their efforts as good enough (Hamachek, 1978).

In the 1990s, two key multidimensional models of perfectionism were developed independently. Frost and colleagues (1990) defined perfectionism as a trait characterized by setting very high standards for oneself, a preference for order and organization, and a tendency toward excessive self-criticism, including intolerance of mistakes and doubts about the quality of one's actions. Their *Multidimensional Perfectionism Scale* (FMPS) includes six dimensions: high personal standards, concern over mistakes, doubts about actions, high parental expectations, parental criticism, and the need for organization and order (Frost et al., 1990).

In turn, Hewitt and Flett (1991b) distinguished three dimensions of perfectionism: self-oriented perfectionism (high, strict standards and evaluation of one's own behaviour), other-oriented perfectionism (imposing unrealistic standards on others and criticizing them), and socially prescribed perfectionism (the belief that others hold high expectations and are critical of the individual).

Frost and colleagues (1993) conducted a factor analysis of elements from both of these models (FMPS and HMPS) and identified two higher-order factors. The first dimension consists of perfectionistic strivings, combining high personal standards, organization, and self-oriented perfectionism, and is associated with adaptive, positive affect and the absence of depressive symptoms. The second factor includes perfectionistic concerns—concern over mistakes, doubts about the quality of one's actions, parental expectations and criticism, as well as

socially prescribed perfectionism—which are associated with negative affect and symptoms of depression. Thus, a distinction was made between adaptive and maladaptive perfectionism (Stoeber, 2018; Szczucka, 2010).

Shafran, Cooper, and Fairburn (2003) proposed an alternative clinical model of perfectionism, defining it as a dysfunctional construct referring to the maladaptive form of perfectionism, in which self-esteem is excessively dependent on achieving very high, self-imposed standards despite negative consequences. This model highlights maintaining mechanisms such as fear of failure, cognitive distortions, avoidance, and procrastination (Shafran et al., 2010). Research confirms the association between perfectionism and feelings of guilt and shame following failure, as well as the tendency for individuals with high levels of perfectionism to continually raise the bar after achieving their goals (Egan et al., 2007; Kobori et al., 2009; Stoeber et al., 2018).

The foundation of this pattern is dichotomous thinking, that is, the tendency to perceive reality in extreme categories such as "all or nothing" or "perfect or a disaster" (Shafran et al., 2017). This type of thinking leads individuals to set unrealistically high and rigid standards, the underachievement which is interpreted as failure and evidence of one's low self-worth, resulting in intense self-criticism and chronic dissatisfaction (Flett & Hewitt, 2002; Stoeber & Otto, 2008).

Rumination and worry also play an important role—repetitive negative thought processes that increase emotional tension and hinder adaptive change (Egan et al., 2011; Watkins, 2008). Rumination involves persistent reflection on one's own imperfections and mistakes, while worry focuses attention on potential threats or the consequences of making mistakes. These psychological processes, acting as mediators of clinical perfectionism, reinforce self-criticism and intensify symptoms of anxiety and depression (Shafran et al., 2017).

At the behavioural level, perfectionists typically engage in excessive checking of their actions and avoid situations that may involve failure or criticism (Harvey et al., 2004). Paradoxically, such avoidance deepens the sense of personal incompetence and hinders the development of new, more adaptive experiences (Newby et al., 2015).

Perfectionism constitutes a transdiagnostic process associated with many forms of psychopathology, such as depression, anxiety disorders, obsessive–compulsive disorder (OCD), eating disorders, and social phobia (Antony et al., 1998; Bieling et al., 2004; Egan et al., 2011; Frost et al., 1997; Lundh & Öst, 2001; Sassaroli et al., 2008). This means that perfectionism is not specific to a single disorder but represents a universal risk factor and a mechanism maintaining symptoms across different diagnoses (Egan et al., 2011).

Many research findings are consistent with this model. Individuals with high levels of perfectionism tend to "raise the bar" after achieving their initial goals (Kobori et al., 2009), and dichotomous thinking predicts significant variability in perfectionism (Egan et al., 2007). There is also evidence confirming that both self-oriented and socially prescribed perfectionism are associated with higher levels of guilt and shame following failure in task performance, which supports the predictions of the model (Stoeber et al., 2008).

In their transdiagnostic theory in the context of eating disorders, Fairburn, Cooper, and Shafran (2003) argue that clinical perfectionism is one of the four core mechanisms maintaining the pathology of eating disorders. This suggests that removing perfectionism as a maintaining mechanism could facilitate the treatment of eating disorders.

Associations Between Perfectionism and Other Mental Disorders

Cross-sectional studies consistently indicate that individuals with high levels of clinical perfectionism show an increased prevalence of depressive and anxiety symptoms, as well as traits typical of eating disorders and obsessive–compulsive disorder (Hewitt & Flett, 1991a; Limburg et al., 2017). Perfectionism is strongly correlated with negative mood and represents a risk factor for persistent depressive symptoms, which contributes to increased rumination and worry among perfectionistic individuals (Limburg et al., 2017).

The meta-analysis conducted by Limburg and colleagues (2017) provides a comprehensive review of research on two main dimensions of perfectionism—perfectionistic strivings and perfectionistic concerns—in relation to a broad spectrum of mental disorders. The analysis of 284 studies comprising more than 2,000 effects showed that both dimensions of perfectionism are significantly associated with symptoms and diagnoses of disorders such as depression, anxiety disorders, obsessive–compulsive disorder, and eating disorders, as well as with self-injurious behaviours and suicidal ideation. These extensive correlations confirm the role of perfectionism as a transdiagnostic factor – a common mechanism underlying many forms of psychopathology.

The component of perfectionistic concerns, including self-criticism and fear of failure, shows a particularly strong association with psychopathology, whereas strivings for high standards demonstrate weaker and more varied relationships with symptoms of mental disorders. In the case of eating disorders, both dimensions – strivings and concerns – are strongly correlated with symptom severity, highlighting the complexity of these disorders and the role of perfectionism in their etiology and maintenance. The authors also emphasize the positive relationship between the two dimensions, suggesting that dividing perfectionism strictly into adaptive and maladaptive forms may be an oversimplification (Limburg et al., 2017).

Retrospective studies also confirm that high levels of perfectionism in childhood predispose individuals to the development of these disorders (Bills et al., 2023; Southgate et al., 2008; Vacca et al., 2021). Studies involving adolescents and children by Vacca et al. (2021) and Bills et al. (2023) demonstrated that perfectionism—particularly its anxiety-related dimension – correlates with the severity of eating disorder symptoms, providing a basis for targeted interdisciplinary interventions during this developmental period.

In anxiety disorders, perfectionism primarily manifests through fear of making mistakes and fear of negative social evaluation, which hinders proper social functioning and increases the risk of social isolation (Hewitt & Flett,

1991b). Moreover, clinical perfectionism plays a key role in the etiology and maintenance of eating disorders, as high self-imposed demands and chronic fear of social evaluation contribute to the persistence of unhealthy eating patterns and hinder therapeutic progress (Bardone-Cone et al., 2007).

Perfectionism also co-occurs with other mental disorders, such as obsessive–compulsive disorder (OCD) and sleep problems. Perfectionistic individuals often display obsessive symptoms related to the need for control and perfection, while chronic worry may contribute to heightened emotional tension and sleep difficulties (Akram et al., 2015; Limburg et al., 2017).

A meta-analysis of 45 studies including 11,747 participants confirmed that most dimensions of perfectionism, except for other-oriented perfectionism and the organization trait, are positively associated with suicidal ideation (Smith et al., 2018). Socially prescribed perfectionism plays a particularly important role, as it not only predicts the presence of suicidal thoughts but also their increasing severity over time.

It should be emphasized that the literature often distinguishes two main types of perfectionism: adaptive perfectionism, associated with positive, motivating striving for achievement and personal development, and maladaptive (clinical) perfectionism, characterized by excessive self-criticism, anxiety, and avoidance of mistakes. Many authors argue that it is maladaptive perfectionism that serves as a key factor maintaining and intensifying symptoms of mental disorders (Frost et al., 1990; Stoeber & Otto, 2008).

Effectiveness of Cognitive-Behavioural Therapy (CBT) for Perfectionism

Cognitive-behavioural therapy targeting perfectionism has demonstrated effectiveness in numerous clinical studies. Most research evaluating CBT in relation to perfectionism is based on the cognitive-behavioural model of clinical perfectionism (e.g., Egan et al., 2014; Handley et al., 2015; Shu et al., 2019). This type of treatment focuses on a range of cognitive and behavioural factors that maintain perfectionism, such as repeated checking of outcomes, cognitive errors, self-criticism, procrastination, and avoidance. The therapy aims to reduce the role of these mechanisms through various techniques, including behavioural experiments that allow patients to experience alternative ways of acting, cognitive restructuring, and psychoeducation.

The original form of CBT for perfectionism (CBT-P) consisted of approximately 10 individual sessions delivered over an eight-week period (Riley et al., 2007). The therapeutic process included four stages: identifying perfectionism-related mechanisms that maintain the problem, conducting behavioural experiments to test beliefs, psychoeducation with a particular focus on cognitive restructuring, and broadening self-evaluation by developing alternative standards and ways of functioning (Egan, Wade, Shafran, & Antony, 2023).

Early studies based on case reports and small clinical samples demonstrated that CBT focused on perfectionism (CBT-P) led to visible improvements in reducing unrealistic standards, rumination, and worry (Shafran et al., 2002).

Clinical studies on small groups showed clinically significant reductions in perfectionism as well as symptoms of depression and anxiety. For example, a study by Glover et al. (2007) involving nine individuals with anxiety and depressive disorders showed significant improvement after 10 sessions of individual CBT-P. Similar results were obtained in a study involving four individuals with depression (Egan & Hine, 2008). Riley and colleagues (2007) conducted an evaluation involving 20 individuals with anxiety or depressive disorders, demonstrating both statistically significant symptom reduction and clinically meaningful reductions in perfectionism in 75% of patients.

Randomized controlled trials (RCTs) provide strong evidence for the effectiveness of CBT-P. Research by Egan and colleagues (2014) showed that therapy reduces key dimensions of perfectionism, including concern over mistakes and rigid self-imposed standards, and also decreases rumination and worry, which translates into improved emotional functioning in patients.

Behavioural exercises and cognitive restructuring constitute key therapeutic techniques. Comparisons between face-to-face therapy and self-help approaches have shown that direct therapeutic contact produces better outcomes, particularly in terms of self-esteem and concerns about mistakes (Egan et al., 2014; Galloway et al., 2021; Pleva & Wade, 2007).

RCTs confirm the effectiveness of CBT-P in treating symptoms of anxiety, depression, and eating disorders in both adults and children and adolescents (O'Brien et al., 2022). Furthermore, studies comparing CBT-P with other transdiagnostic approaches suggest that focusing on perfectionism and emotion regulation produces similar therapeutic outcomes, although CBT-P appears to be more effective in reducing perfectionism itself (Mahmoodi et al., 2021).

Meta-analyses provide the strongest confirmation of the effectiveness of CBT-P. Lloyd and colleagues (2015) found large treatment effects in reducing clinical perfectionism and concerns about mistakes, as well as moderate effects in reducing symptoms of anxiety, depression, and eating disorders. Suh and colleagues (2019) confirmed moderate effectiveness of CBT-P in reducing these dimensions as well as symptoms of depression and anxiety.

Robinson and Wade (2021) and Galloway and colleagues (2021) indicated that CBT-P effectively reduces symptoms of eating disorders, anxiety, and depression, both in face-to-face therapy and in internet-based self-help formats. A meta-analysis by Cuijpers and colleagues (2013) found that 59–68% of adult patients with depression experienced clinically significant improvement following CBT, while fewer than 5% showed deterioration, which further supports the effectiveness of cognitive-behavioural therapy targeting perfectionism.

However, according to the meta-analysis by Smith and colleagues (2022), the effects of CBT on enduring traits of perfectionism, cognitive schemas, and life satisfaction remain uncertain (Flett et al., 2022; Hewitt & Flett, 1991). After the completion of therapy, the difference between treated and control groups often diminishes, raising questions about the durability of therapeutic effects and the advantage of therapy over natural improvement. Moreover, only about half of patients reported improvement in concerns about mistakes, and more than 70% did not experience a clear improvement in clinical perfectionism, which indicates the

need to develop more effective therapeutic methods. Narcissistic personality traits and social loneliness (Hewitt et al., 2018; McCown & Carlson, 2004; Zuroff et al., 2000) influence therapy outcomes and increase the risk of premature dropout. The authors of the meta-analysis suggest that enduring aspects of perfectionism may require relationship- and support-based therapies, such as Dynamic Relational Therapy (DRT) or Psychodynamic Supportive Therapy (PST)**,** which in studies by Hewitt et al. (2025) demonstrated high effectiveness in achieving lasting improvements. Further research comparing the effectiveness of CBT, DRT, and PST in the treatment of clinical perfectionism is therefore necessary.

Despite numerous analyses and the growing number of CBT-P interventions, there is still a clear lack of research on the effectiveness of this therapy among children and adolescents. The therapy has been tested in preventive and clinical studies involving children and adolescents aged 10–19, demonstrating effectiveness in preventing symptoms of anxiety, depression, and eating disorders in both face-to-face and online formats (Nehmy & Wade, 2015; Shu et al., 2019; Vekas & Wade, 2017; Wilksch et al., 2008). School-based interventions and short programs for younger adolescents (mean age 11–13) have produced positive effects in reducing perfectionism, improving well-being, and decreasing emotional problems (Fairweather-Schmidt & Wade, 2015; Osenk et al., 2023). Preliminary studies also suggest that CBT-P may be effective for very young children, including those of preschool age, indicating potential for both preventive and therapeutic applications during development (Fairweather-Schmidt & Wade, 2015). However, it is important to note the limitations of the available studies—most were cross-sectional and based on self-reports, which makes it difficult to draw conclusions about directionality and causality (Bills et al., 2023). Further longitudinal research involving diverse populations is necessary to deepen understanding of the mechanisms and dynamics linking perfectionism with eating disorders during youth development (Livet et al., 2023).

Furthermore, there is a lack of studies comparing perfectionism-focused therapy with other transdiagnostic approaches or with treatments specific to particular mental disorders. Mahmoodi and colleagues (2021) compared two transdiagnostic protocols (perfectionism-focused CBT (CBT-P) and the Unified Protocol for transdiagnostic treatment (UP) with a control group. The study involved 75 participants with depressive and anxiety disorders and high levels of perfectionism. Both treatment groups achieved better outcomes than the control group, and the effects were maintained for six months. The results showed no significant difference between CBT-P and UP in reducing symptoms of anxiety, depression, or worry; however, CBT-P was more effective in reducing perfectionism, while UP had a greater impact on emotion regulation. The study suggests that both focusing on perfectionism and focusing on emotion regulation may lead to similar reductions in symptoms of depression and anxiety. The results also indicate that perfectionism does not constitute a major obstacle to treatment using the UP, which may suggest a broader scope of application for this protocol. Nevertheless, further research comparing these protocols is needed.

It is important to note that perfectionism itself may hinder the effectiveness of psychotherapy. Individuals with higher levels of perfectionism prior to treatment

tend to show poorer therapeutic outcomes, including weaker therapeutic alliance and limited social support, which negatively affects their ability to cope with stress after treatment has ended (Blatt et al., 1995; Shahar et al., 2004; Zuroff et al., 2000). For this reason, therapeutic work aimed at reducing perfectionism is a particularly important component in improving treatment effectiveness.

In addition to CBT, there are several other therapeutic approaches to perfectionism, including Dynamic Relational Therapy (a psychodynamic approach), habituation techniques for making mistakes, Mindful Compassion for Perfectionism (which combines compassion-focused therapy with relational therapy), Mindfulness-based Cognitive Therapy, and Acceptance and Commitment Therapy (Cheli et al., 2020, 2022; Hewitt et al., 2015, 2020, in press; James & Rimes, 2018; Ong et al., 2019; Redden et al., 2022; Visvalingam et al., 2023; Woodfin et al., 2021). Despite their diversity and grounding in different theoretical models, no strongly established alternative with clearly confirmed clinical effectiveness has yet emerged, which creates an impulse for further research into the effectiveness and mechanisms of these methods.

It should also be noted that despite promising research findings, there are several limitations to cognitive-behavioural therapy for perfectionism. One of the main limitations of CBT-P is the lack of comprehensive epidemiological data. Moreover, there are difficulties in distinguishing perfectionism from adaptive high achievement. Questions have also arisen as to whether it is appropriate to distinguish between adaptive and maladaptive perfectionism, or whether only one of these forms may occur (Limburg et al., 2017). Another problem is the scarcity of studies using active control groups (e.g., groups participating in alternative forms of therapy), which significantly limits the ability to assess the specificity of interventions (Shafran et al., 2023). Additionally, inconsistencies in the measures used to assess perfectionism complicate the development of a coherent theory and the interpretation of research results (Mahmoodi et al., 2021; Rozental et al., 2017). The CBT-P model must also take into account increasing social pressure and external factors influencing perfectionism, especially among adolescents (Curran & Hill, 2019).

It is important that research be conducted under strictly controlled conditions, involving broader use of attention-control methods, comparisons with other therapies such as DRT, and independent replications and long-term follow-up observations (Shafran et al., 2023). Reporting both improvement and deterioration indicators is also an important component in evaluating effectiveness. CBT for perfectionism also requires integration with healthcare and educational systems in order to increase the accessibility and quality of therapy.

Conclusion

Clinical perfectionism is a complex, multidimensional phenomenon which, in its maladaptive form, constitutes a significant risk factor and a mechanism maintaining numerous mental disorders, such as depression, anxiety disorders,

eating disorders, and obsessive–compulsive disorder (Bardone-Cone et al., 2007; Limburg et al., 2017). This phenomenon is not merely a personality trait associated with high achievement but also influences the development and maintenance of disorders through specific cognitive and emotional mechanisms.

Key pathogenic mechanisms include dichotomous, black-and-white thinking as well as processes of rumination and worry, which intensify anxiety and self-criticism while simultaneously hindering adaptive functioning and emotional regulation (Shafran et al., 2017; Watkins, 2008). Typical perfectionistic behaviours – such as excessive checking and avoidance of potentially risky situations – lead to the reinforcement of unhealthy patterns and a reduction in quality of life (Harvey et al., 2004).

Cognitive-behavioural therapy (CBT) forms the foundation for the treatment of maladaptive perfectionism. It effectively reduces key symptoms, including fear of mistakes, rumination, and excessive self-imposed demands, as confirmed by numerous randomized studies and meta-analyses (Egan et al., 2014; Egan, Wade, Watson et al., 2023; Smith et al., 2022). However, the effectiveness of therapy varies (Iliakis & Masland, 2021; Shafran et al., 2023), and the durability of treatment effects remains uncertain, indicating the need for further development and personalization of interventions.

Research suggests that cognitive-behavioural therapy for perfectionism is effective in various formats. Short CBT interventions reduce social anxiety (Ashbaugh et al., 2007; DiBartolo et al., 2001; Lundh & Öst, 2001), symptoms of depression (Egan & Hyde, 2008; Glover et al., 2007; Riley et al., 2007), symptoms of eating disorders (Egan et al., 2014; Steele et al., 2008), and symptoms of OCD (Egan & Wade, 2014; Handley et al., 2015). Meta-analyses confirm the high effectiveness of CBT both in reducing perfectionism and in alleviating symptoms associated with various mental disorders (Galloway et al., 2021; Lloyd et al., 2015; Robinson & Wade, 2021; Shu et al., 2019). Therapy delivered through direct therapeutic contact as well as self-help formats results in reductions in perfectionism and symptoms of depression, anxiety, and eating disorders (Egan et al., 2014; Egan, Wade, Shafran, & Antony, 2023).

However, perfectionism may also hinder the effectiveness of psychotherapy by negatively affecting the therapeutic alliance and access to social support. Higher levels of perfectionism prior to treatment are a significant predictor of poorer therapeutic outcomes and reduced ability to cope with stress after treatment completion (Blatt et al., 1995; Shahar et al., 2004; Zuroff et al., 2000). This relationship highlights the importance of addressing perfectionism in clinical practice.

There is still a lack of research on the effectiveness of CBT among children and adolescents, as well as studies comparing this therapy with other transdiagnostic methods or approaches specific to particular diagnoses.

In conclusion, cognitive-behavioural therapy is an effective method for treating maladaptive perfectionism and related mental disorders. Its broad application as a transdiagnostic intervention is well documented, although further research is needed on the durability of its effects, the personalization of interventions, and its application among younger populations. A comprehensive

diagnostic and therapeutic approach that takes into account individual mechanisms and patient-specific characteristics may significantly improve quality of life, reduce the severity of co-occurring disorders, and support psychosocial functioning.

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