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Efficacy of Existential Group Therapy and Self-Compassion Therapy in Reducing Negative Perfectionism and Self-criticism Among Individuals with Obsessive-Compulsive Personality Disorder

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Abstract

Background: Maladaptive (negative) perfectionism and self-criticism are core therapeutic targets in obsessive-compulsive personality disorder (OCPD).

Objectives: This study compared the efficacy of existential group therapy (EGT) and self-compassion therapy (SCT) in reducing negative perfectionism and self-criticism among individuals with OCPD.

Methods: This quasi-experimental study used a pretest-posttest control group design with a 3-month follow-up. Forty-five adults diagnosed with OCPD in Kerman, Iran, during 2024 - 2025 were selected through purposive sampling and randomly allocated to three groups (n = 15 each): EGT (10 sessions of 90 minutes), SCT (10 sessions of 90 minutes), or a nonintervention control group. Outcomes were assessed using the Negative Perfectionism subscale of the Positive and Negative Perfectionism Scale and the Levels of Self-Criticism Scale. Data were analyzed using repeated-measures analysis of variance (ANOVA) with Bonferroni post hoc tests in SPSS version 26.

Results: Both interventions significantly reduced negative perfectionism and self-criticism compared with the control group ($P < 0.01$ for all posttest comparisons). EGT was more effective than SCT in reducing negative perfectionism ($P = 0.002$). No significant difference was observed between EGT and SCT in reducing self-criticism, indicating comparable therapeutic efficacy.

Conclusions: Both modalities reduced core OCPD symptoms. EGT provided greater clinical benefit for negative perfectionism, whereas EGT and SCT showed comparable efficacy in alleviating self-criticism.

Keywords: Obsessive-Compulsive Personality Disorder, Psychotherapy, Perfectionism, Self-compassion

1. Background

Obsessive-compulsive personality disorder (OCPD) is a debilitating psychiatric condition characterized by a pervasive preoccupation with orderliness, extreme perfectionism, interpersonal rigidity, and a compelling need for mental and environmental control (1). Individuals with OCPD set unrealistic performance standards for themselves and others, contributing to a chronic fear of failure and severe executive dysfunction (2). These rigid cognitive and behavioral patterns impair occupational productivity, disrupt interpersonal relationships, and impose substantial socioeconomic burdens (3). Furthermore, the persistent inability to meet self-imposed standards increases vulnerability to comorbid affective disorders (4). Consequently, targeting the core transdiagnostic mechanisms underlying OCPD is a priority for clinical psychotherapy.

Perfectionism is a multidimensional personality trait involving the pursuit of flawlessness, excessively high performance standards, and hypercritical self-evaluation (5). In its maladaptive (negative) form, perfectionism involves rigid, all-or-nothing cognitive distortions in which success is defined exclusively by the attainment of unrealistic ideals (6). In individuals with OCPD, negative perfectionism contributes to psychological distress,

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persistent dissatisfaction, burnout, and emotional exhaustion (7). Because negative perfectionism undermines healthy coping strategies, modifying overly stringent standards is fundamental to disrupting the pathological cycle of overcontrol (8).

Closely linked to negative perfectionism, self-criticism is a punitive cognitive and emotional tendency to harshly evaluate one's perceived faults and mistakes (9). Individuals with high levels of self-criticism experience intense distress in response to everyday failures, accompanied by shame, guilt, and diminished self-worth (10). Rather than promoting adaptive emotion regulation, severe self-criticism perpetuates a cycle of self-blame and emotional avoidance (11). In OCPD, this persistent internal criticism acts as an emotional penalty for failing to achieve unrealistic standards, thereby maintaining psychological distress (12).

Existential group therapy (EGT) addresses psychological suffering by encouraging clients to confront the fundamental concerns of existence: death, freedom, isolation, and meaninglessness (13). Rather than relying solely on symptom-reduction techniques, EGT promotes self-awareness, personal growth, and authentic living by encouraging the acceptance of personal responsibility (14). Empirical studies indicate that existential interventions improve psychological well-being, life satisfaction, cognitive emotion regulation, and overall mental health across diverse clinical populations (15). Qualitative research has explored the relationship between perfectionism and existential vulnerability (16).

Rooted in evolutionary models of emotion regulation, self-compassion therapy (SCT) targets the neurobiological imbalance between an overactive threat system and an underactive soothing system (17). By cultivating self-kindness, mindfulness, and recognition of common humanity, SCT guides individuals in replacing a punitive inner critic with a supportive, compassionate internal voice (18). Ferrari et al. (19) found that self-compassion moderates the association between perfectionism and depression in adolescents and adults. Paranjothy and Wade (20) reported associations among disordered eating, self-criticism, and self-compassion. By establishing an emotionally supportive relationship with oneself, SCT addresses the fear of failure that contributes to OCPD pathology (11).

Although EGT and SCT offer frameworks for modifying rigid cognitive and emotional patterns, the literature has predominantly evaluated these modalities independently. To date, no empirical study has directly compared their relative efficacy in addressing negative perfectionism and self-criticism among patients with OCPD. Given the substantial personal and social costs of OCPD, establishing targeted, evidence-based interventions is clinically important.

2. Objectives

This study aimed to compare the effectiveness of EGT and SCT in reducing negative perfectionism and self-criticism in individuals with OCPD.

3. Methods

3.1. Study Design

This quasi-experimental study used a pretest-posttest control group design with a 3-month follow-up assessment.

3.2. Participants

The target population comprised adults diagnosed with OCPD who were receiving treatment at psychological centers in Kerman, Iran, during 2024 - 2025. A sample of 45 patients who met the diagnostic criteria for OCPD, based on the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), was selected through purposive sampling. Diagnosis required at least four core criteria. Participants were randomly allocated to three equal groups (n = 15 per group): EGT, SCT, and a nonintervention control group. Inclusion criteria were a verified OCPD diagnosis, age between 18 and 50 years, and written informed consent. Exclusion criteria were missing more than one intervention session, concurrent participation in other psychotherapeutic programs, or comorbid psychotic spectrum disorders. Ethical approval was obtained from the Ethics Committee of Islamic Azad University, Kerman Branch (approval code: IR.IAU.KERMAN.REC.1404.094).

3.3. Instruments

3.3.1. Positive and Negative Perfectionism Scale

Developed by Terry-Short et al. (21), the Positive and Negative Perfectionism Scale is a 40-item self-report instrument that assesses adaptive (positive perfectionism, 20 items) and maladaptive (negative perfectionism, 20 items) traits. Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Each subscale yields scores ranging from 20 to 100, with higher scores indicating stronger perfectionistic tendencies. Only the Negative Perfectionism subscale was used as the primary outcome measure in this study because of its central role in OCPD psychopathology. Original validation studies reported high internal consistency ($\alpha = 0.89$ for the negative subscale). The

construct validity of the Farsi version has been confirmed in Iranian undergraduate students (22). In the current sample, Cronbach's alpha for the Negative Perfectionism subscale was 0.87.

3.3.2. Levels of Self-Criticism Scale

Developed by Thompson and Zuroff (23), the Levels of Self-Criticism Scale assesses self-critical cognitive styles using 22 items rated on a 7-point Likert scale from 0 (strongly disagree) to 6 (strongly agree). The scale assesses two dimensions: comparative self-criticism and internalized self-criticism. Total scores range from 0 to 132, with higher scores indicating greater self-criticism. Thompson and Zuroff (23) reported high internal consistency ($\alpha = 0.87$). In Iranian populations, reliability coefficients ranged from 0.55 to 0.87 (24). In the current study, the total Cronbach's alpha was 0.86.

3.4. Interventions

Participants in the experimental groups received 10 weekly 90-minute sessions of either EGT or SCT, conducted by licensed psychotherapists. The control group received no therapeutic intervention during the study period. Both intervention protocols are detailed in Table 1.

3.5. Data Analysis

Statistical analyses were conducted using SPSS version 26. Baseline characteristics were summarized using means and standard deviations. Repeated-measures analysis of variance (ANOVA) was used to evaluate treatment effects across the pretest, posttest, and 3-month follow-up assessments. Before hypothesis testing, statistical assumptions were assessed using the Shapiro-Wilk test for normality, Levene's test for homogeneity of variance, Box's M test for equality of covariance matrices, and Mauchly's test for sphericity. Bonferroni post hoc tests were then performed ($\alpha = 0.05$).

4. Results

The final sample comprised 45 adults diagnosed with OCPD, distributed equally across the three groups (n = 15 per group). The overall mean age was 32.11 years (range: 22 - 48 years). Mean ages were 31.80 ± 5.12 years in the EGT group, 32.40 ± 4.86 years in the SCT group, and 32.13 ± 5.34 years in the control group. One-way ANOVA showed no statistically significant age differences among the three groups ($F = 0.05$, $P = 0.951$). The sample included 24 women (53.33%) and 21 men (46.67%). A chi-square test showed no significant difference in gender distribution among the groups ($\chi^2 = 0.18$, $P = 0.914$). No significant differences in demographic variables were observed at baseline, indicating that the groups were comparable.

Descriptive statistics for negative perfectionism and self-criticism at pretest, posttest, and the 3-month follow-up are presented in Table 2. Baseline mean scores for both outcomes were similar across the three groups, with no statistically significant between-group differences. Both intervention groups showed reductions in negative perfectionism and self-criticism at posttest compared with pretest. These reductions were maintained at the 3-month follow-up. In contrast, scores in the control group remained stable across the three assessments, indicating no spontaneous symptom remission over time.

All parametric assumptions were assessed before inferential analysis. The Shapiro-Wilk test indicated normal distributions of dependent-variable scores across all groups and assessment points ($P > 0.05$). Levene's test supported homogeneity of variance for negative perfectionism ($F = 0.87$, $P = 0.426$) and self-criticism ($F = 0.30$, $P = 0.742$). Mauchly's test indicated that the sphericity assumption was met for the main effect of time for negative perfectionism ($W = 0.92$, $\chi^2 = 3.41$, $P = 0.182$) and self-criticism ($W = 0.89$, $\chi^2 = 4.82$, $P = 0.090$). Box's M test also supported equality of covariance matrices (Box's M = 41.67, $F = 1.10$, $P = 0.310$).

A 3 × 3 repeated-measures ANOVA was conducted with group (EGT, SCT, or control) as the between-subjects factor and time (pretest, posttest, or follow-up) as the within-subjects factor. As shown in Table 3, the main effects of time and group were significant for both negative perfectionism and self-criticism ($P = 0.001$ for all effects). The time × group interactions were also significant for negative perfectionism ($F = 18.32$, $P = 0.001$, $\eta p^2 = 0.47$) and self-criticism ($F = 12.45$, $P = 0.001$, $\eta p^2 = 0.37$). These interactions indicate that changes in both outcomes over time differed according to the intervention received.

Bonferroni-adjusted pairwise comparisons were used to assess between-group differences (Table 4) and within-group changes over time (Table 5). Both the EGT and SCT groups showed significantly lower negative perfectionism scores at posttest than the control group ($P = 0.001$ and $P = 0.003$, respectively). EGT was significantly more effective than SCT in reducing negative perfectionism, with a mean difference of −14.20 and a standard error (SE) of 3.71 ($P = 0.002$). For self-criticism, both EGT and SCT were more effective than the control group at posttest ($P = 0.009$ and $P = 0.001$, respectively), but the difference between the two interventions was not statistically significant (MD = 6.43, $SE = 3.67$, $P = 0.270$), indicating comparable clinical efficacy. Within-group analyses confirmed significant reductions from pretest to posttest for both active treatments ($P =$

Table 1. Structured Overview of Existential Group Therapy and Self-Compassion Therapy Protocols

Session	EGT Protocol	SCT Protocol
1	Orientation, establishing group norms, confidentiality, and introducing core study variables.	Introduction, setting group expectations, outlining program structure, introducing soothing breathing exercises.
2	Discussion of Viktor Frankl's experiences; framing existential concepts of freedom and personal responsibility.	Identifying self-critical versus self-compassionate mindsets; exploring causes and emotional consequences of self-criticism.
3	Analyzing personal reflections on Man's Search for Meaning; exploring individual life purpose.	Practicing self-forgiveness; fostering acceptance of personal mistakes to facilitate change.
4	Uncovering hidden personal capacities and self-awareness through structured group exercises.	Cultivating emotional acceptance; developing distress tolerance for difficult life circumstances.
5	Challenging irrational beliefs and over-reliance on external expectations; fostering authentic self-worth.	Developing self-appreciation and emotional self-worth; gratitude exercises.
6	Expanding agency: recognizing that while conditions are given, individuals remain free to choose their response.	Introducing compassionate mental imagery (safe space, compassionate mentor visualization).
7	Role-playing exercises to clarify personal responsibility in interpersonal problems and life construction.	Differentiating self-compassionate thoughts from inner critical dialogues; behavioral practice.
8	Confronting death anxiety as a catalyst for authentic, vital, and meaningful living.	Chair-work technique: facilitating dialogue between the self-critic, criticized self, and compassionate self.
9	Identifying individual pathways to meaning during personal crises and existential anxieties.	Self-compassionate letter writing practice; visualizing compassionate self-talk.
10	Synthesis of therapeutic gains, integration of existential principles, posttest administration, and closure.	Reviewing and consolidating compassionate skills, strategy integration, posttest administration, and closure.

Table 2. Descriptive Statistics for Negative Perfectionism and Self-Criticism Across Assessment Phases [a]

Variable and group	Pretest	Posttest	Follow-up
Negative perfectionism			
Existential Group Therapy	78.40 ± 6.85	49.12 ± 5.94	50.05 ± 6.02
Self-Compassion Therapy	77.93 ± 7.10	63.32 ± 6.21	64.10 ± 6.35
Control Group	78.13 ± 6.92	77.84 ± 6.78	78.20 ± 6.81
Self-criticism			
EGT	79.80 ± 8.12	67.45 ± 7.15	68.10 ± 7.22
SCT	80.13 ± 8.45	61.02 ± 6.88	61.85 ± 7.01
Control Group	79.60 ± 8.28	79.64 ± 8.05	79.90 ± 8.12

[a] Values are expressed as mean ± SD. Abbreviations: EGT, existential group therapy; SCT, self-compassion therapy; SD, standard deviation.

0.001), with no significant changes between posttest and the 3-month follow-up ($P > 0.05$), indicating maintenance of treatment effects.

5. Discussion

This study evaluated the comparative efficacy of EGT and SCT in addressing two core clinical features of OCPD: negative perfectionism and self-criticism. Both modalities produced statistically significant, sustained reductions in both outcomes compared with the nonintervention control group, with treatment effects maintained over a 3-month follow-up. These findings align with the literature describing the transdiagnostic utility of existential and compassion-based frameworks for modifying rigid personality traits (15, 25). The differential effects provide insight into the mechanisms underlying cognitive and emotional change in OCPD.

A central finding was that EGT was more effective than SCT in reducing negative perfectionism. In OCPD, negative perfectionism operates as a psychological defense mechanism: a strategy intended to exert control over the environment and protect against existential anxiety, uncertainty, and fear of failure (9). EGT addresses this defense by confronting patients with the existential concerns of freedom, choice, isolation, and personal responsibility (13). By encouraging patients to acknowledge human fallibility and relinquish the illusion of complete control, EGT challenges rigid, all-or-nothing cognitive frameworks (6). Rather than striving for unattainable flawlessness, patients learn to embrace authentic living and accept personal responsibility within the limits of reality (16). Thus, EGT addresses the existential

Table 3. Repeated Measures ANOVA Results for Negative Perfectionism and Self-Criticism [a]

Variables and Sources	SS	df	MS	F	P	Partial η^2
Negative perfectionism						
Time	2461.30	2	1230.65	48.65	0.001	0.54
Group	1124.94	2	562.47	27.91	0.001	0.57
Time × Group	926.96	4	231.74	18.32	0.001	0.47
Self-criticism						
Time	3120.45	2	1560.23	32.18	0.001	0.43
Group	533.69	2	266.84	9.75	0.001	0.32
Time × Group	2415.30	4	603.83	12.45	0.001	0.37

[a] Abbreviations: ANOVA, analysis of variance; SS, sum of squares; df, degrees of freedom; MS, mean square; partial η^2, partial eta squared.

Table 4. Between-Group Bonferroni Post-Hoc Comparisons at Posttest [a]

Dependent Variable	(I) Group	(J) Group	Mean Difference (I - J)	Standard Error	P	95% Confidence Interval
Negative perfectionism	EGT	SCT	-14.20	3.71	0.002	[-23.67, -4.73]
	EGT	Control	-28.72	3.79	0.001	[-38.40, -19.04]
	SCT	Control	-14.53	3.89	0.003	[-24.46, -4.57]
Self-criticism	EGT	SCT	6.43	3.67	0.270	[-2.94, 15.80]
	EGT	Control	-12.19	3.75	0.009	[-21.77, -2.61]
	SCT	Control	-18.62	3.85	0.001	[-28.46, -8.78]

[a] Abbreviations: EGT, existential group therapy; SCT, self-compassion therapy.

roots of overcontrol rather than merely alleviating its associated distress, which may explain its greater effect on negative perfectionistic standards. Latifian et al. (26) reported reductions in perceived rejection and anxiety following existential group psychotherapy. Vos et al. (27) demonstrated that existential group interventions reduce negative perfectionism by helping clients relinquish unrealistic expectations in favor of self-acceptance and existential authenticity.

EGT and SCT showed comparable efficacy for self-criticism, with no statistically significant difference between the two active treatments. Self-criticism in OCPD is a punitive cognitive and emotional response to perceived flaws or performance failures that can perpetuate shame and emotional avoidance (11). The comparable effects of these interventions may reflect their convergent influence on internal self-evaluation through different therapeutic pathways. SCT targets the threat-focused system by activating the soothing system through self-kindness, mindfulness, and recognition of common humanity (17). By replacing punitive internal criticism with a supportive, compassionate internal dialogue, SCT reduces self-blame and promotes emotional tolerance (28). Alternatively, EGT alleviates self-criticism by placing human error within a framework of existential responsibility and self-acceptance (29). Recognizing imperfection as an inherent aspect of the human condition may reduce existential guilt associated with failure and diminish self-condemnation (30). These findings align with studies by Wakelin et al. (11), Matos et al. (28), and Ghafari et al. (30), which indicate that compassion-based interventions reduce self-critical cognitive styles, and with findings from Bahremand et al. (31), which support the effects of existential interventions on self-directed hostility.

Clinically, these results suggest that treatment selection can be personalized, as both modalities were effective for OCPD. For patients with predominant cognitive rigidity, negative perfectionism, and excessive control-seeking behavior, EGT may offer a therapeutic advantage by modifying their underlying worldview. For individuals primarily experiencing shame, emotional distress, and self-directed hostility, both SCT and EGT may be viable options. Integrating existential reflection with compassion-focused emotion regulation techniques may improve outcomes in complex OCPD presentations.

5.1. Limitations

Table 5. Within-Group Bonferroni Post-Hoc Comparisons Across Assessment Intervals [a]

Variables	Groups	Comparison (Interval I vs J)	Mean Difference (I - J)	Standard Error	P
Negative perfectionism	EGT	Pretest vs. Posttest	29.28	2.14	0.001
		Pretest vs. Follow-up	28.35	2.20	0.001
		Posttest vs. Follow-up	−0.93	0.85	0.999
	SCT	Pretest vs. Posttest	14.61	2.10	0.001
		Pretest vs. Follow-up	13.83	2.15	0.001
		Posttest vs. Follow-up	−0.78	0.82	0.999
Self-criticism	EGT	Pretest vs. Posttest	12.35	1.95	0.001
		Pretest vs. Follow-up	11.70	1.98	0.001
		Posttest vs. Follow-up	−0.65	0.78	0.999
	SCT	Pretest vs. Posttest	19.11	1.92	0.001
		Pretest vs. Follow-up	18.28	1.96	0.001
		Posttest vs. Follow-up	−0.83	0.75	0.999

[a] Abbreviations: EGT, existential group therapy; SCT, self-compassion therapy.

Several methodological limitations should be considered. First, reliance on self-report questionnaires may have introduced social desirability bias. Second, extraneous variables, including cognitive functioning, academic status, and socioeconomic background, were not fully controlled and may have influenced treatment response. Finally, the relatively small sample from a single location (n = 45) limits generalizability. Future multicenter trials should incorporate semistructured clinical interviews and objective behavioral measures.

5.2. Conclusions

These findings tentatively suggest that EGT and SCT may be viable interventions for reducing negative perfectionism and self-criticism in individuals with OCPD. EGT appeared to have a greater effect on negative perfectionism, whereas both modalities showed comparable efficacy for self-criticism. These conclusions should be interpreted cautiously given the small sample and reliance on self-report measures. Larger randomized controlled trials are needed to corroborate these preliminary findings and refine personalized therapeutic guidance for OCPD.

Footnotes

AI Use Disclosure: The authors declare that no generative artificial intelligence (AI) tools were used in the creation of this article.

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Data Availability: The dataset used in the present study will be provided by the corresponding author upon reasonable request.

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