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A randomised controlled trial of group cognitive behavioural therapy for perfectionism

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ABSTRACT

Perfectionism is associated with symptoms of anxiety disorders, eating disorders and mood disorders. Treatments targeting perfectionism may reduce the symptoms of these disorders (Egan, Wade, & Shafran, 2011). This study is the first randomised controlled trial to investigate the efficacy of group cognitive behavioural therapy (CBT) for perfectionism. Forty-two participants with elevated perfectionism and a range of anxiety, eating and mood disorders were randomised to group CBT for perfectionism or a waitlist control. The treatment group reported significantly greater pre-post reductions in perfectionism, symptoms of depression, eating disorders, social anxiety, anxiety sensitivity and rumination, as well as significantly greater pre-post increases in self-esteem and quality of life compared to the waitlist control group. The impact of treatment on most of these outcomes was mediated by pre-post change in perfectionism (Concern over Mistakes). Treatment gains were reliable and clinically significant, and were maintained at 6-month follow-up. Findings support group CBT for perfectionism being an efficacious treatment for perfectionism and related psychopathology, as well as increasing self-esteem and quality of life.

Perfectionism involves setting demanding standards and having a significant concern over mistakes (Frost, Marten, Lahart, & Rosenblate, 1990). This definition has primarily arisen from the results of factor analytic studies of multidimensional perfectionism measures (Frost et al., 1990; Hewitt & Flett, 1991) as opposed to being based on theoretical descriptions of the construct (Shafran, Cooper, & Fairburn, 2002). Perfectionism has been identified as an important factor in the onset, severity and maintenance of anxiety, mood and eating disorders (Egan, Wade, & Shafran, 2011). It can account for the co-morbidity of disorders (Bieling, Summerfeldt, Israeli, & Antony, 2004) and can negatively impact treatment (e.g., Blatt, Quinlan, Pilkonis, & Shea, 1995). Consequently, perfectionism has been argued to be a transdiagnostic process (Egan et al., 2011). This implies that treatments targeting perfectionism may not only reduce perfectionism but also the symptoms of related disorders (Egan et al., 2011).

Several studies have examined the efficacy of cognitive behavioural therapy (CBT) for perfectionism (CBT-P) and the results so far are promising. A recent meta-analysis examined the outcomes of eight studies of CBT-P and found large pooled effect sizes for pre-post treatment reductions in perfectionism and medium pooled effect sizes for pre-post treatment reductions in depression and anxiety (Lloyd, Schmidt, Khondoker, & Tchanturia, 2014). Only two of the studies included in the meta-analysis were RCTs examining the efficacy of CBT-P in clinical samples. Riley, Lee, Cooper, Fairburn, and Shafran (2007) found in a sample of participants, of whom 70% met diagnoses of anxiety and depression, that CBT-P resulted in significant reductions in Clinical Perfectionism Questionnaire (CPQ; Fairburn, Cooper, & Shafran, 2003) scores relative to a waitlist control condition. Post-treatment reductions in perfectionism, anxiety and depression were maintained at 4-month follow-up. Clinically significant change in perfectionism occurred in 75% of participants and the number of anxiety and depression diagnoses halved at post-treatment. Steele and Wade (2008) examined the efficacy of guided self-help CBT-P relative to standard CBT for Bulimia Nervosa (BN; Cooper, 1993, in Steele & Wade, 2008) and mindfulness (Segal, Williams, & Teasdale, 2002) in individuals with BN and Eating Disorder Not Otherwise Specified (EDNOS). Participants in all conditions demonstrated significant decreases in perfectionism, depression and eating disorder symptoms and significant increases in self-esteem between pre- and post-treatment. CBT-P tended to produce larger effect sizes for co-morbid anxiety

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and depression compared to the other conditions. These trends have clinical relevance as they are consistent with perfectionism having a transdiagnostic role (Egan et al., 2011); however, the findings are limited by the absence of a pure control condition (Steele & Wade, 2008).

Only two studies have explored the effectiveness of group CBT-P in individuals with elevated perfectionism and psychological disorders and neither study was an RCT (Egan & Stout, 2007; Steele et al., 2013). In Egan and Stout's (2007) single case series design, downward trends were observed in perfectionism, depression and anxiety, with one of the three participants demonstrating clinically significant decreases in anxiety and depression. Steele et al.'s (2013) case series design investigated the effectiveness of psycho-education and group CBT-P in 21 individuals with elevated perfectionism as well as anxiety disorders or current or past depression. Psycho-education did not produce any significant reductions. Following group CBT-P there were statistically significant decreases in perfectionism, stress, anxiety and depression that were maintained at 3-month follow-up, and clinically significant change in perfectionism was observed in 32% of participants; however, there was no separate waitlist control group. Group therapy has some advantages over individual therapy such as time efficiency, decreased cost (Himle, Van Etten, & Fischer, 2003) and therapeutic benefits (Bieling, McCabe, & Antony, 2013); hence it would be useful to determine the efficacy of group CBT-P in an RCT. Furthermore, it is important to determine if pre-post changes in perfectionism are responsible for pre-post changes in symptoms as there has been no analysis of mediators of change in the perfectionism treatment literature to date.

As reviewed, there is some promising preliminary evidence for the efficacy of CBT-P, with the majority of studies having investigated the intervention when delivered in an individual format. Only two uncontrolled studies have investigated CBT-P delivered via a group therapy approach and the results are promising (Egan & Stout, 2007; Steele et al., 2013). Currently, no RCTs of group CBT-P have been conducted. Therefore, the aim of the current study is to compare group CBT-P with a waitlist control group. It is predicted that participants who receive group CBT-P will show statistically and clinically significant reductions in perfectionism from pre-to post-test, whereas the control group will show only negligible pre-post changes. As perfectionism is proposed to be a transdiagnostic process (Egan et al., 2011), it is also predicted that participants receiving group CBT-P will show statistically and clinically significant pre-post reductions in symptoms of eating disorders, depression and anxiety, as well as statistically significant and reliable pre-post increases in self-esteem and quality of life, whereas the control group will show only negligible pre-post changes. It is also hypothesised that pre-post changes in perfectionism will account for pre-post changes in symptoms. Finally, it is predicted that all changes will be maintained at 6-month follow-up.

Method

Participants

Participants self-referred in response to advertisements distributed to universities, GPs, psychologists, psychiatrists and workplaces throughout Perth, Australia. Participants were required to have elevated perfectionism, defined by a score greater than 24.7 on the Concern over Mistakes (CM) subscale of the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990). This is the average CM score derived from previous research examining perfectionism in anxiety disorder samples included in Egan et al.'s (2011) review. Exclusion criteria included self-harm, moderate or severe suicidality, a body mass index below 17.5, psychosis, and substance abuse or substance dependence, as determined by the Mini International Neuropsychiatric Interview (MINI, Sheehan et al., 1998). Participants were required to abstain from external psychological treatment between baseline and follow-up. Those on medication were to be on a stable dose for one month before the study and throughout the trial. Using G*Power (Version 3.1; Faul, Erdfelder, Lang, & Buchner, 2007), it was estimated that approximately 40 participants (20 per group) would be required for the Generalised Linear Mixed Model (GLMM; Holden, Kelley, & Agarwal, 2008) procedure to have an 80 percent chance of detecting moderate to large interaction effects at a per-test alpha level of 0.05. Forty-three participants (79% females; 21% males) were eligible.

Design and procedure

After baseline assessment, participants were randomly allocated to treatment or control conditions. Randomisation was conducted using randomised number lists generated by Saghaei's (2004) Random Allocation Software Version 1.0. The treatment group commenced therapy while the control group received no therapy. After eight weeks all participants were re-assessed. Participants from the control group received group CBT-P followed by their post-treatment assessment (the treated control group). Treatment and treated control groups were assessed at 3-months and 6-months post-treatment. This RCT complied with CONSORT guidelines (Moher et al., 2010) and was registered as a clinical trial with the Australian and New Zealand Clinical Trials Registry (2007). Ethics approval was received from the Curtin University Human Research Ethics Committee.

Treatment

Treatment consisted of eight 2-hour group therapy sessions over eight weeks. Treatment was adapted from Shafran, Egan, and Wade (2010). This protocol was evaluated in the pilot trial of group CBT-P in a different sample (Steele et al., 2013). Sessions included understanding perfectionism, motivation to change, challenging perfectionist beliefs through behavioural experiments and thought diaries, decreasing procrastination and self-criticism, and balancing self-esteem (Shafran et al., 2010).

Therapists

Treatment was administered by a Clinical Psychologist Registrar (Handley) who conducted four groups, as well as two Master of Clinical Psychology students who each co-facilitated two groups. Students were trained by a Clinical Psychologist (Egan) who is a co-author of the CBT-P treatment. Egan also provided weekly supervision to ensure treatment adherence.

Treatment adherence and collaborative structure

Two independent Clinical Psychologists rated five randomly selected videotapes of group therapy. Consistent with an RCT of group CBT for obsessive-compulsive disorder (Anderson & Rees, 2007), adherence to session objectives was rated on 7-point Likert-type scales. Inter-rater reliability of the adherence measure was high (r = .89), and mean adherence to protocol was high (M = 6.71/7; SD = 0.98). Therapist behaviour (e.g., warmth) was rated using nine items from the Collaborative Study Psychotherapy Rating Scale-6 (CSPRS-6; Evans, Piasecki, Kriss, & Hollon, 1984) and mean scores were high: warmth: 6.1/7 (SD = 0.87); supportive encouragement: 6.6/7 (SD = 0.52); empathy: 5.8/7 (SD = 0.92); rapport: 5.5/7 (SD = 1.08), conveyance of expertise: 5.6/7