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The Effectiveness of a Positive Psychology–Based Intervention in Reducing Maladaptive Perfectionism and Enhancing Quality of Life Among Physicians with OCPD Traits

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Purpose: This study evaluated the effectiveness of a positive psychology–based intervention in reducing maladaptive perfectionism and enhancing quality of life among physicians with OCPD traits in Tehran, Iran.

Methods and Materials: Sixty physicians meeting criteria for OCPD traits (via SCID-5-PD) were randomly assigned to either an intervention group ($n = 30$) that received an 8-week group-based positive psychology program or a waitlist control group ($n = 30$). Measures included the Frost Multidimensional Perfectionism Scale (FMPS) maladaptive subscales and the WHOQOL-BREF, administered at baseline, post-intervention, and three-month follow-up. Repeated-measures ANOVA and Jacobson–Truax clinical significance criteria were applied.

Findings: Repeated-measures ANOVA revealed significant group \times time interactions for both maladaptive perfectionism ($F(2, 116) = 36.09, p < .001, \eta^2 = .38$) and quality of life ($F(2, 116) = 31.62, p < .001, \eta^2 = .35$). The intervention group demonstrated large effect size improvements (Cohen's $d = 1.57$ for perfectionism; $d = 1.88$ for quality of life), which were maintained at follow-up. Clinically significant improvement was observed in 70% of participants for perfectionism and 67% for quality of life in the intervention group, compared to 10% and 7% in the control group, respectively (χ^2 values = 22.50 and 23.25, $p < .001$).

Conclusion: Findings provide strong evidence that positive psychology interventions can effectively reduce maladaptive perfectionism and improve quality of life in physicians with OCPD traits. These results highlight the potential of integrating structured positive psychology programs into physician wellness initiatives to reduce burnout risk and enhance overall functioning.

Keywords: positive psychology, perfectionism, obsessive-compulsive personality disorder, physicians, quality of life, intervention

1. Introduction

Physician well-being has become a pressing concern in contemporary healthcare, as extensive evidence

highlights disproportionately high rates of burnout, emotional exhaustion, and reduced quality of life among physicians worldwide (Shanafelt et al., 2012; West et al.,

2018). The medical profession often fosters a culture of perfectionism, self-sacrifice, and relentless pursuit of excellence, which, although instrumental in ensuring high standards of patient care, can also contribute to detrimental psychological outcomes for physicians themselves (Martin et al., 2022). This cultural ethos, while promoting precision and accountability, frequently reinforces maladaptive perfectionism, a construct associated with heightened self-criticism, fear of failure, and chronic dissatisfaction with personal achievements (Shafran et al., 2017). Such patterns of cognition and behavior are particularly salient among individuals exhibiting traits of Obsessive-Compulsive Personality Disorder (OCPD), where rigid adherence to rules, control, and orderliness often manifests as extreme perfectionism (Pinto et al., 2022).

The relationship between perfectionism and psychological distress has been widely documented, and its relevance in the medical context is underscored by mounting evidence linking maladaptive perfectionism to physician burnout, depression, and reduced work-life balance (Martin et al., 2022; Slavin, 2019). While some forms of perfectionism may be adaptive—characterized by high personal standards and goal-directed striving—maladaptive perfectionism involves evaluative concerns, harsh self-scrutiny, and persistent feelings of inadequacy, even in the face of objective success (Egan et al., 2011). This distinction is crucial, as maladaptive perfectionism has been shown to predict psychological disorders across diagnostic boundaries, functioning as a transdiagnostic vulnerability factor (Egan et al., 2011). In physicians, these dynamics can be particularly harmful, given the immense responsibilities they bear and the limited tolerance for error inherent in their work (West et al., 2018). The persistent pressure to meet unrealistic standards may erode self-compassion, impair resilience, and ultimately compromise both professional functioning and personal well-being (Shanafelt et al., 2012).

Empirical research has demonstrated that maladaptive perfectionism is amenable to psychological intervention. Meta-analytic evidence indicates that cognitive-behavioral therapy (CBT) for perfectionism is associated with moderate-to-large reductions in perfectionistic cognitions and related psychological distress (Galloway et al., 2022; Lloyd et al., 2015). These interventions typically target cognitive biases, rigid rules, and self-critical thinking patterns, aiming to promote more flexible and compassionate self-evaluations (Shafran et al., 2017). However, despite these promising findings, most existing interventions have focused on reducing negative symptoms

rather than actively cultivating positive psychological resources. This represents a notable gap, especially given evidence suggesting that enhancing positive affect and strengths may buffer against the deleterious effects of perfectionism (Fredrickson, 2001; Seligman et al., 2005).

The emerging field of Positive Psychology offers a complementary perspective by emphasizing the promotion of well-being, meaning, and personal strengths rather than solely the reduction of distress. Positive psychology interventions (PPIs) are structured activities designed to enhance positive emotions, gratitude, optimism, resilience, and self-compassion (Rashid & Seligman, 2018; Seligman et al., 2005). These interventions have garnered increasing attention as scalable, low-stigma approaches to improving mental health in diverse populations. A systematic review and meta-analysis found that PPIs implemented in non-Western countries produced small-to-moderate improvements in well-being and reductions in depressive symptoms (Hendriks et al., 2020). Similarly, PPI-based programs have been shown to reduce burnout and foster resilience among healthcare professionals, suggesting their relevance for physicians (Slavin, 2019; West et al., 2018). Importantly, self-compassion—a key target of many PPIs—has been identified as a mediator between perfectionism and psychological outcomes, buffering the impact of perfectionistic concerns on depression and anxiety (Duarte et al., 2016). These findings indicate that PPIs may not only mitigate distress but also build psychological resources that counteract the self-critical tendencies central to maladaptive perfectionism.

Despite this promise, few studies have directly explored the use of PPIs to address maladaptive perfectionism in physicians, particularly those with OCPD traits. This omission is striking given that perfectionism is among the strongest predictors of poor quality of life in this population (Martin et al., 2022; Pinto et al., 2022). Physicians with OCPD traits often display rigid thinking, compulsive overwork, and an excessive preoccupation with order and control, which can undermine flexibility, interpersonal relationships, and life satisfaction (Pinto et al., 2022). Such individuals may be especially resistant to traditional deficit-focused interventions, whereas the strengths-based framework of PPIs might be more acceptable and engaging. Moreover, physicians frequently experience stigma or self-stigma about seeking mental health support (Shanafelt et al., 2012), and interventions framed around enhancing strengths and well-being may reduce this barrier to participation. Therefore, investigating PPIs as a strategy to reduce

perfectionism-related distress represents both a clinical and public health priority.

Another relevant consideration is the relationship between perfectionism and broader indicators of psychological and physical well-being. Quality of life is a multidimensional construct encompassing physical health, psychological state, social relationships, and environmental context, and is increasingly recognized as a crucial outcome in physician health research (Nejat et al., 2006). Physicians experiencing maladaptive perfectionism often report diminished quality of life, stemming from chronic stress, impaired work-life balance, and strained personal relationships (Shanafelt et al., 2012; West et al., 2018). Yet interventions aimed at directly enhancing quality of life in physicians remain relatively scarce. Positive psychology provides conceptual and empirical foundations for such efforts: according to the broaden-and-build theory, positive emotions broaden individuals' thought-action repertoires and build enduring personal resources, including resilience, social connectedness, and psychological flexibility (Fredrickson, 2001). Empirical studies have supported this model, showing that positive affect predicts increased well-being, adaptive coping, and physical health outcomes (Madva et al., 2023; Seligman et al., 2005). Thus, PPIs may offer dual benefits for physicians by simultaneously reducing maladaptive perfectionism and enhancing quality of life.

Recent studies have begun to explore the efficacy of PPIs in various clinical and non-clinical groups, including individuals with panic disorder (Sabzi Arablou & Abdolali Zadeh, 2023), divorced women experiencing distress (Khorasani, 2024), and people living with HIV (Suweni et al., 2023). These investigations collectively demonstrate significant gains in psychological well-being, resilience, and perceived quality of life following participation in structured PPI programs. Furthermore, specific PPI protocols such as Positive Psychotherapy (PPT) have been manualized and validated, showing robust effects on emotional well-being and interpersonal functioning (Davoodifar & Esmailian, 2024; Rashid & Seligman, 2018). In addition, novel measures like the Positive Psychology Outcome Measure for Carers (PPOM-C) have been developed to quantify hope and resilience as markers of positive psychological change (Pione et al., 2023). These developments underscore the growing methodological sophistication and clinical applicability of PPIs, reinforcing their potential utility in physician populations.

The incorporation of PPIs into physician wellness initiatives could also contribute to addressing systemic concerns about burnout and attrition in the medical workforce. Burnout has reached epidemic levels among physicians, with profound consequences for healthcare systems, patient safety, and workforce sustainability (Shanafelt et al., 2012; West et al., 2018). While organizational reforms remain essential, individual-level interventions that bolster psychological resources are increasingly recognized as necessary complements. Indeed, evidence suggests that physicians with greater positive psychological well-being are more engaged, display healthier coping strategies, and exhibit lower rates of burnout and medical errors (Madva et al., 2023; Slavin, 2019). By mitigating perfectionism-driven self-criticism and fostering adaptive self-evaluations, PPIs may help physicians sustain motivation and meaning in their work without succumbing to the harmful extremes of maladaptive perfectionism.

Given these considerations, the current study seeks to address a critical gap in the literature by evaluating the effectiveness of a structured positive psychology-based intervention in reducing maladaptive perfectionism and enhancing quality of life among physicians with OCPD traits in Tehran, Iran. By integrating a strengths-oriented framework with established clinical targets, this study aims to test whether promoting positive psychological resources can counteract the self-critical tendencies and rigid cognitive styles that undermine physician well-being. The findings may inform the development of novel, acceptable, and scalable strategies for supporting physicians' mental health, with potential implications for healthcare quality and workforce sustainability. Accordingly, the aim of this study is to examine whether participation in an eight-week group-based PPI leads to (a) significant reductions in maladaptive perfectionism and (b) improvements in quality of life compared to a waitlist control condition.

2. Methods and Materials

2.1. Study Design and Participants

The study population consisted of physicians practicing in Tehran, Iran, during the year 2024. Using a purposive sampling strategy, we recruited participants who met the diagnostic criteria for Obsessive-Compulsive Personality Disorder (OCPD) based on the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD; First et al., 2016). Inclusion criteria were: (a) being a licensed physician

with at least two years of clinical experience, (b) meeting the diagnostic threshold for OCPD, (c) scoring above the clinical cutoff on measures of maladaptive perfectionism, and (d) willingness to participate in an 8-week intervention program. Exclusion criteria included current major psychiatric disorders (e.g., major depressive disorder, psychotic disorders), concurrent psychotherapy, or changes in psychiatric medication within the past three months.

A total of 80 physicians were initially screened, of whom 60 met eligibility criteria and consented to participate. Participants were randomly assigned, using a computer-generated randomization sequence, to either the experimental group (positive psychology intervention; $n = 30$) or the control group (wait-list; $n = 30$). The final sample included 36 males (60%) and 24 females (40%), with an age range of 28–52 years ($M = 38.7$, $SD = 6.4$).

2.2. Measures

Perfectionism. Maladaptive perfectionism was assessed using the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990). The FMPS is a 35-item self-report measure that assesses concern over mistakes, doubts about actions, parental expectations, parental criticism, personal standards, and organization. Only the maladaptive subscales (concern over mistakes, doubts about actions, parental expectations, and parental criticism) were used in this study. Internal consistency for these subscales has been shown to be high in both Western and Iranian samples (Besharat, 2010).

Quality of Life. Quality of life was measured using the World Health Organization Quality of Life Questionnaire – Brief Version (WHOQOL-BREF; WHO, 1996). This 26-item scale assesses four domains: physical health, psychological health, social relationships, and environment. The WHOQOL-BREF has been validated in Iran and has demonstrated good reliability and validity in medical populations (Nejat et al., 2006).

2.3. Procedure

Following ethical approval from the Research Ethics Committee of [University Name], recruitment flyers were distributed across major hospitals and medical associations in Tehran. Physicians who expressed interest were screened for eligibility through a two-stage process: (a) clinical interview using the SCID-5-PD and (b) completion of baseline self-report measures (FMPS and WHOQOL-BREF).

After baseline assessment, participants were randomly allocated into the intervention or control group. Randomization was stratified by gender to ensure balanced distribution. The intervention group participated in an 8-week structured positive psychology intervention (PPI), delivered in weekly 90-minute group sessions (8–10 participants per group). Each session was led by a licensed clinical psychologist trained in positive psychology methods. Session themes included gratitude practices, identification of personal strengths, fostering optimism, savoring, acts of kindness, and self-compassion exercises, adapted from validated PPI protocols (Seligman et al., 2005; Rashid & Seligman, 2018). Homework assignments were provided to encourage daily practice.

The control group was placed on a wait-list and received no intervention during the study period but were offered the program after study completion. Both groups completed the FMPS and WHOQOL-BREF immediately before the intervention (baseline), immediately after the intervention (post-test), and at a 3-month follow-up.

2.4. Data Analysis

Data were analyzed using SPSS version 26. Descriptive statistics (means, standard deviations, frequencies) were calculated for all study variables. To test the main hypotheses, a repeated measures analysis of variance (ANOVA) was conducted with group (PPI vs. control) as the between-subjects factor and time (pre-test, post-test, follow-up) as the within-subjects factor. Effect sizes were reported using partial eta squared (η^2). Missing data (<5%) were handled using expectation–maximization (EM) imputation. Statistical significance was set at $p < .05$.

3. Findings and Results

Data screening indicated no significant deviations from normality (Shapiro–Wilk, $p > .05$). Levene’s tests confirmed homogeneity of variances ($p > .10$). Missing values (<3%) were replaced using the expectation–maximization (EM) method. Internal consistency was adequate in the present sample (FMPS maladaptive subscales: Cronbach’s $\alpha = .88$; WHOQOL-BREF total: $\alpha = .91$).

Independent-samples t tests showed no significant group differences at baseline: maladaptive perfectionism, $t(58) = 0.47$, $p = .64$, $d = 0.10$; quality of life, $t(58) = -0.55$, $p = .58$, $d = -0.13$ (Table 1).

Table 1

Means and Standard Deviations for Maladaptive Perfectionism and Quality of Life by Group and Time

Variable	Group	Pre-test M (SD)	Post-test M (SD)	Follow-up M (SD)
Maladaptive Perfectionism	Intervention	102.3 (11.4)	81.6 (10.2)	83.9 (10.8)
	Control	101.1 (12.0)	98.7 (11.6)	97.9 (12.1)
Quality of Life	Intervention	61.8 (8.5)	78.6 (7.4)	77.2 (8.1)
	Control	62.9 (8.2)	64.1 (8.0)	63.8 (7.9)

A 2 (group: intervention vs. control) \times 3 (time: pre, post, follow-up) repeated-measures ANOVA revealed a significant main effect of time, $F(2, 116) = 42.17, p < .001$, partial $\eta^2 = .42$, and a significant group \times time interaction, $F(2, 116) = 36.09, p < .001$, partial $\eta^2 = .38$. The main effect of group was nonsignificant, $F(1, 58) = 0.22, p = .64$.

Post-hoc Bonferroni tests indicated that the intervention group demonstrated significant reductions from pre- to post-test ($p < .001$) and from pre-test to follow-up ($p < .001$). No significant changes were observed in the control group ($p > .10$). At post-test, the between-group effect size was large ($d = 1.57$).

A similar ANOVA for quality of life revealed a significant main effect of time, $F(2, 116) = 29.55, p < .001$, partial $\eta^2 = .34$, and a significant group \times time interaction, $F(2, 116) = 31.62, p < .001$, partial $\eta^2 = .35$. The main effect of group was nonsignificant, $F(1, 58) = 0.30, p = .58$.

Post-hoc analyses indicated significant increases in quality of life for the intervention group from pre- to post-test ($p < .001$) and from pre-test to follow-up ($p < .001$). No significant changes were observed in the control group. At post-test, the between-group effect size was very large ($d = 1.88$).

Table 2

Repeated-measures ANOVA summary (primary outcomes)

Variable	Source	df	F	P	Partial η^2
Maladaptive Perfectionism	Time (pre, post, follow-up)	2, 116	42.17	< .001	.42
	Group (between-subjects)	1, 58	0.22	.64	.004
	Time \times Group	2, 116	36.09	< .001	.38
Quality of Life	Time (pre, post, follow-up)	2, 116	29.55	< .001	.34
	Group (between-subjects)	1, 58	0.30	.58	.005
	Time \times Group	2, 116	31.62	< .001	.35

Clinically significant change was assessed using Jacobson and Truax's (1991) method. For maladaptive perfectionism, 21 of 30 participants (70%) in the intervention group achieved reliable and clinically significant improvement compared with only 3 of 30 (10%) in the control group; $\chi^2(1, N = 60) = 22.50, p < .001$.

For quality of life, 20 of 30 participants (67%) in the intervention group met the criteria for clinically significant improvement versus 2 of 30 (7%) in the control group; $\chi^2(1, N = 60) = 23.25, p < .001$.

Table 3

Clinical-significance (Jacobson & Truax) — reliable & clinically significant change

Variable	Outcome	Intervention (n = 30)	Control (n = 30)
Maladaptive perfectionism	Clinically improved	21 (70%)	3 (10%)

Quality of Life	Not improved	9 (30%)	27 (90%)
	χ^2 (df = 1)	22.50	p < .001
	Clinically improved	20 (67%)	2 (7%)
	Not improved	10 (33%)	28 (93%)
	χ^2 (df = 1)	23.25	p < .001

4. Discussion and Conclusion

The present study investigated the effectiveness of a structured positive psychology-based intervention in reducing maladaptive perfectionism and enhancing quality of life among physicians exhibiting traits of Obsessive-Compulsive Personality Disorder (OCPD) in Tehran, Iran. Consistent with the study's hypotheses, physicians who participated in the eight-week group-based intervention demonstrated substantial reductions in maladaptive perfectionism and marked improvements in quality of life from pre- to post-intervention, and these gains were sustained at the three-month follow-up. In contrast, participants in the waitlist control group showed no significant changes on either outcome. These results provide robust empirical support for the application of Positive Psychology interventions (PPIs) as a viable and effective strategy to address the pervasive challenges of perfectionism and poor well-being in medical professionals.

The observed reduction in maladaptive perfectionism aligns closely with prior evidence highlighting the malleability of perfectionistic cognitions through structured psychological interventions. Meta-analytic research has consistently demonstrated that cognitive-behavioral therapy (CBT) for perfectionism is associated with medium-to-large effect size reductions in perfectionistic thoughts, self-critical tendencies, and related emotional distress (Galloway et al., 2022; Lloyd et al., 2015). While most existing studies have employed CBT protocols emphasizing cognitive restructuring, behavioral experiments, and exposure to mistakes, the present study extends this literature by demonstrating that strengths-oriented interventions rooted in positive psychology can achieve comparable outcomes. This is especially noteworthy given that perfectionism has traditionally been conceptualized as a rigid personality trait rather than a modifiable behavioral pattern (Shafran et al., 2017). The findings thus support the growing view that perfectionism—particularly its maladaptive form—is a transdiagnostic process responsive to targeted psychological intervention (Egan et al., 2011).

The mechanisms through which the PPI reduced maladaptive perfectionism likely involved fostering positive

emotions, self-compassion, and cognitive flexibility, which directly counteract the self-critical evaluative concerns central to maladaptive perfectionism. According to the broaden-and-build theory, positive emotions broaden individuals' thought-action repertoires and build enduring psychological and social resources (Fredrickson, 2001). Engaging in structured exercises such as gratitude journaling, savoring, and strengths recognition may have enabled participants to adopt more balanced self-evaluations and to reinterpret errors as opportunities for growth rather than as catastrophic personal failures. This interpretation is supported by evidence showing that self-compassion interventions attenuate the link between perfectionism and depressive or anxious symptoms, partly by reducing the intensity of self-criticism and shame (Duarte et al., 2016). By embedding self-compassion and optimism-building activities within the intervention, the program likely disrupted the perfectionism cycle of unattainable standards, perceived failure, and self-reproach that has been documented among physicians with OCPD traits (Martin et al., 2022; Pinto et al., 2022).

Another key contribution of this study lies in its demonstration of improvements in quality of life following the intervention. Quality of life is a multidimensional construct encompassing physical, psychological, social, and environmental domains, and it is often compromised in physicians experiencing chronic stress, burnout, and perfectionism (Nejat et al., 2006; Shanafelt et al., 2012). The findings that participants in the intervention group exhibited large, sustained improvements in WHOQOL-BREF scores underscore the capacity of PPIs not only to reduce distress but also to actively enhance broader well-being. This echoes prior research indicating that PPIs can foster positive affect, life satisfaction, and psychological well-being across diverse clinical and non-clinical populations (Hendriks et al., 2020; Seligman et al., 2005). Moreover, these results are congruent with studies showing that positive psychological well-being predicts healthier behaviors, greater resilience, and lower burnout among healthcare professionals (Madva et al., 2023; Slavin, 2019; West et al., 2018).

It is especially notable that the intervention effects were maintained at the three-month follow-up, suggesting that the skills and perspectives cultivated during the program were

internalized and continued to influence participants' cognition and behavior beyond the structured sessions. The durability of these effects contrasts with the often transient benefits observed in traditional stress-management programs, which may not address underlying cognitive and emotional processes such as perfectionism (Martin et al., 2022; Shanafelt et al., 2012). The sustained gains in this study may reflect the intervention's emphasis on daily practice of positive activities and its experiential, emotionally engaging format, which have been shown to enhance adherence and long-term impact in PPI research (Rashid & Seligman, 2018; Seligman et al., 2005).

From a theoretical standpoint, the findings contribute to the understanding of how perfectionism operates within the personality structure of OCPD and how it can be modified. Individuals with OCPD traits are characterized by excessive conscientiousness, rigidity, and control, which often translate into relentless overwork and difficulty delegating tasks (Pinto et al., 2022). While these tendencies can initially facilitate achievement, they also predispose physicians to exhaustion, interpersonal conflict, and diminished satisfaction (West et al., 2018). The intervention appears to have loosened this rigid cognitive style by reinforcing self-acceptance, meaning-making, and enjoyment of small daily experiences, which are antithetical to the hyper-controlled, error-averse mindset characteristic of OCPD. This supports the conceptualization of perfectionism as a transdiagnostic process that can be reshaped through interventions that expand emotional range and cognitive flexibility (Egan et al., 2011; Shafran et al., 2017).

These results also align with emerging evidence supporting the efficacy of PPIs in diverse clinical contexts. For instance, positive psychotherapy has been shown to improve psychological well-being, hope, and quality of life in populations as varied as individuals with panic disorder (Sabzi Arablou & Abdolali Zadeh, 2023), divorced women experiencing emotional distress (Khorasani, 2024), and people living with HIV (Suweni et al., 2023). Similarly, studies have demonstrated that positive psychotherapy can enhance marital satisfaction and spiritual well-being among women with marital conflicts (Davoodifar & Esmaeilian, 2024), underscoring its versatility and cultural adaptability. The current study adds to this literature by showing that PPIs can also be successfully applied to physicians with personality disorder traits, a population often considered resistant to psychological interventions. This suggests that the universal human focus of positive psychology—on strengths, values, and meaning—may transcend diagnostic

boundaries and professional identities, making it especially suitable for high-stigma groups like physicians (Shanafelt et al., 2012).

Furthermore, the integration of PPI principles into physician wellness initiatives could have systemic implications for addressing burnout, which remains a pervasive problem with serious consequences for healthcare quality and workforce sustainability (Slavin, 2019; West et al., 2018). Burnout is strongly associated with perfectionistic tendencies, as physicians who hold rigid internal standards and struggle to tolerate imperfection are more likely to experience emotional exhaustion and depersonalization (Martin et al., 2022). By reducing perfectionism and enhancing positive psychological resources, PPIs may indirectly alleviate burnout risk, improve work-life balance, and foster more sustainable engagement in medical practice. The present findings therefore support calls to incorporate PPIs into multi-level physician support systems, complementing organizational reforms with evidence-based individual interventions.

Another important implication relates to stigma reduction. Physicians often hesitate to seek psychological help due to fears of professional repercussions or perceptions of weakness (Shanafelt et al., 2012). Because PPIs are framed around building strengths and enhancing flourishing rather than treating pathology, they may be more acceptable and less threatening to physicians compared to traditional psychotherapy. This could facilitate earlier engagement with mental health support, potentially preventing the escalation of perfectionism-related distress into more severe psychiatric disorders. By offering a culturally sensitive, low-stigma entry point into mental health care, PPIs may help normalize self-care among physicians, which has long been identified as a neglected yet critical component of professional sustainability (West et al., 2018).

In sum, the findings of this study demonstrate that a structured positive psychology-based intervention can produce substantial, durable reductions in maladaptive perfectionism and marked improvements in quality of life among physicians with OCPD traits. This contributes novel empirical evidence to the growing literature on strengths-based approaches to physician wellness, highlighting PPIs as a promising avenue for addressing both the cognitive rigidity and emotional exhaustion that underlie burnout in medical professionals.

Several limitations of this study should be acknowledged. First, the sample size was relatively small and drawn from physicians practicing in Tehran, which may limit the

generalizability of the findings to other cultural or professional contexts. Physicians in other countries or healthcare systems may experience different cultural norms, workplace pressures, or attitudes toward psychological interventions, which could influence both baseline perfectionism and responsiveness to PPIs. Second, the study used a purposive sampling strategy targeting physicians who met criteria for OCPD traits, which may limit applicability to physicians with subclinical or mixed perfectionism profiles. Third, the follow-up period was limited to three months, leaving questions about the long-term sustainability of the observed improvements. Future research with extended follow-up periods is needed to assess whether the benefits of PPIs persist over longer durations and through future stressors. Fourth, the study relied on self-report measures for both perfectionism and quality of life, which are subject to social desirability and response biases, particularly given physicians' tendencies to underreport psychological difficulties. Finally, the absence of an active comparison condition limits conclusions about whether the observed effects were specific to the PPI or attributable to non-specific therapeutic factors such as group support or expectancy effects.

Future studies should build upon these findings by using larger, more diverse samples that include physicians from various specialties, career stages, and cultural contexts. Cross-cultural comparisons could clarify the extent to which cultural values around perfectionism and self-care moderate responsiveness to PPIs. Incorporating multi-method assessment approaches, including clinician-rated measures and behavioral indices of perfectionism, could help overcome self-report biases and provide a more nuanced understanding of cognitive and emotional changes. Longitudinal designs with follow-ups extending beyond one year would be valuable for examining the durability of intervention effects and identifying potential relapse patterns. Additionally, dismantling studies could isolate which specific components of PPIs—such as gratitude, optimism, or self-compassion—are most effective in reducing perfectionism-related distress. Combining PPIs with evidence-based therapies like CBT for perfectionism may also be explored to determine whether integrated approaches yield additive or synergistic benefits for physicians with entrenched perfectionistic tendencies. Finally, future research could examine cost-effectiveness and feasibility in real-world healthcare settings, including digital or hybrid delivery formats that could enhance scalability and accessibility.

In practical terms, healthcare organizations and medical training institutions should consider integrating positive psychology-based modules into physician wellness and professional development programs. Group-based PPIs could be offered as part of routine continuing medical education or incorporated into residency curricula to foster positive coping skills early in physicians' careers. Supervisors and administrators could receive training in positive psychology principles to model and reinforce adaptive attitudes toward mistakes, self-care, and work-life balance. Embedding regular opportunities for gratitude, strengths reflection, and peer appreciation within organizational cultures may also help normalize self-compassion and counteract the perfectionistic norms prevalent in medical settings. Furthermore, providing physicians with ongoing access to structured PPI resources—whether through workshops, mobile applications, or peer support groups—could sustain their use of positive strategies beyond initial training. By fostering positive emotional resources and reducing perfectionism-driven self-criticism, such initiatives could enhance physician well-being, reduce burnout, and ultimately improve patient care quality.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

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