

# Turkish Adaptation of the Clinical Perfectionism Questionnaire: A Psychometric Evaluation in Clinical and Non-Clinical Samples



Yağmur Sever FİDAN<sup>1</sup>, Arda KIZILSERT<sup>1</sup>, Nazmiye İlayda DIŞPINAR USTA<sup>1</sup>,  
Nisa PARLAYICI KOÇAK<sup>1</sup>, Sümeyye Yasemin ÇALLI<sup>2</sup>, Cansu ÖZÇERİ<sup>3</sup>,  
Selin USLU ALİHANOĞLU<sup>3</sup>, Enes OKAN<sup>3</sup>, Mihriban ALBAYRAK<sup>4</sup>, Ömer AYDEMİR<sup>5</sup>

## ABSTRACT

**Objective:** The aim of this study was to evaluate the validity and reliability of the Turkish version of the Clinical Perfectionism Questionnaire (CPQ-TR) in clinical and non-clinical samples.

**Method:** This cross-sectional study included 63 clinical participants (Obsessive–Compulsive Disorder and Major Depressive Disorder) and 148 non-clinical participants. The scale adaptation was conducted using a translation–back translation procedure. Confirmatory factor analysis and internal consistency analyses were performed. Convergent and concurrent validity were examined through correlations with the Frost Multidimensional Perfectionism Scale (FMPS), Depression Anxiety Stress Scales–21 (DASS–21), and the Yale–Brown Obsessive Compulsive Scale (Y-BOCS).

**Results:** The internal consistency of the original 12-item CPQ-TR was found to be at a borderline level (Cronbach's  $\alpha=0.677$ ); following the removal of Items 2 and 8, the Cronbach's alpha coefficient of the resulting 10-item form increased to 0.76. Confirmatory factor analysis indicated limited support for a unidimensional factor structure. The CPQ-TR showed strong correlations with the FMPS ( $r=0.593$ ) and moderate correlations with the Y-BOCS and DASS-21 ( $r=0.30-0.35$ ). Participants with Obsessive–Compulsive Disorder had significantly higher CPQ scores compared to those with Major Depressive Disorder ( $p=0.018$ ) and healthy controls ( $p < 0.001$ ).

**Conclusion:** The findings indicate that the 12-item CPQ-TR demonstrates borderline internal consistency but remains a valid instrument for assessing clinical perfectionism. The 10-item version appears to be a more psychometrically robust option for use in both research and clinical settings.

**Keywords:** Clinical perfectionism, Clinical Perfectionism Questionnaire, confirmatory factor analysis, clinical and non-clinical samples, psychometrics, Turkish adaptation, validity and reliability

## INTRODUCTION

Perfectionism is a multidimensional personality trait characterized by individuals setting excessively high, often unrealistic standards for themselves and experiencing intense self-criticism, guilt, and feelings of worthlessness when these standards are not met (Shafran et al., 2002; Stoeber & Otto, 2006). Clinical perfectionism, in contrast, is defined by an individual's tendency to base self-worth predominantly on achievement and to exhibit rigid cognitive and behavioral responses when confronted with perceived failure (Fairburn et al., 2003). These responses may include repetitive checking behaviors, reassurance seeking from others, social comparison, and all-or-nothing thinking patterns.

A growing body of evidence indicates that perfectionism functions as a transdiagnostic process contributing to the development and maintenance of various psychiatric disorders (Egan et al., 2011). In particular, perfectionism-related concerns in depression and obsessive–compulsive disorder (OCD) have been associated with increased symptom severity and resistance to treatment (Egan et al., 2011; Limburg et al., 2017). Features such as fear of making mistakes, the need to meet excessively high standards, and cognitive inflexibility may play a central role in sustaining symptoms in both depressive disorders and OCD (İnözü et al., 2022).

Several instruments have been developed to assess perfectionism, including the Frost Multidimensional

**How to cite:** Atif için: Fidan YS, Kızılsert A, Dişpınar Usta Nİ et al. (2026) Turkish Adaptation of the Clinical Perfectionism Questionnaire: A Psychometric Evaluation in Clinical and Non-Clinical Samples. *Türk Psikiyatri Derg* 37:59–66. <https://doi.org/10.5080/u27873>

**Received:** 16.12.2025, **Accepted:** 16.01.2026, **Publication Date:** 28.03.2026

<sup>1</sup>Psychiatrist, <sup>2</sup>Assist Prof., <sup>4</sup>MD, Erenköy Mental Health and Neurological Diseases Training and Research Hospital, Istanbul; <sup>3</sup>MD, <sup>5</sup>Prof., Manisa Celal Bayar University Faculty of Medicine, Department of Psychiatry, Manisa, Türkiye

Yağmur Sever Fidan, e-mail: dr.yagmurfidan@gmail.com

Perfectionism Scale (FMPS) and the Hewitt and Flett Multidimensional Perfectionism Scale (MPS). Although these measures are valuable for multidimensional assessment, some of their subscales (e.g., Organization in the FMPS and Other-Oriented Perfectionism in the MPS) do not directly capture the clinically most salient components of perfectionism. Consequently, they may not always be sufficiently sensitive to detect therapy-related change in clinical practice (Frost et al., 1990; Hewitt and Flett, 1990).

To address this limitation, Fairburn, Cooper, and Shafran (2003) developed the Clinical Perfectionism Questionnaire (CPQ), a brief self-report measure designed to assess the extent to which an individual's self-worth is contingent on achievement. The CPQ consists of 12 items that evaluate perfectionism-related thoughts and behaviors experienced over the past month. The scale provides a concise, rapid, and change-sensitive assessment tool for monitoring treatment processes in clinical interventions targeting perfectionism, including cognitive-behavioral, schema-focused, acceptance and commitment, and psychodynamic approaches.

The CPQ has been adapted into several languages, including German, Swedish, and Persian, and the majority of validation studies have supported its two-factor structure, demonstrating strong discriminant validity in clinical samples diagnosed with Major Depressive Disorder (MDD) and OCD (Chang and Sanna, 2012; Parks et al., 2021). However, fit indices in two-factor solutions have generally remained moderate with notable cross-loadings, suggesting that the factor structure may not be stable across cultures (Parks et al., 2021). In addition, the scale has been shown to be reliable and valid in non-clinical samples, indicating that the CPQ is also a functional tool for assessing perfectionistic tendencies in the general population. Accordingly, the CPQ may be used not only for clinical assessment but also as a preventive screening instrument to identify individuals who may be at risk for perfectionism-related psychopathology.

Despite its widespread international use, a validated Turkish version of the CPQ (CPQ-TR) is not yet available. The absence of such an instrument limits both the clinical assessment of perfectionism and research in this field in Türkiye. Systematic evaluation of perfectionism in individuals with MDD and OCD may provide important information for diagnostic processes and treatment monitoring, while assessments conducted in non-clinical samples may allow for earlier identification of individuals at risk.

Accordingly, the present study aimed to adapt the Clinical Perfectionism Questionnaire into Turkish and to examine its psychometric properties in both clinical (OCD and MDD) and non-clinical samples. In line with the study hypotheses, it was anticipated that the Turkish version of the scale (CPQ-TR) would demonstrate high internal consistency and

replicate the factor structure reported in previous research. It was further hypothesized that participants in the clinical groups (OCD and MDD) would have significantly higher CPQ-TR scores than non-clinical participants, thereby supporting the discriminant validity of the scale. Finally, CPQ-TR scores were expected to be positively associated with levels of depression, anxiety, and stress, providing evidence for the convergent and concurrent validity of the instrument.

## METHODS

### Study Design and Procedure

This study was conducted as a cross-sectional investigation aimed at adapting the Clinical Perfectionism Questionnaire into Turkish and evaluating its psychometric properties. Ethical approval for the study was obtained from the Erenköy Mental Health Clinical Research Ethics Committee (Date: June 26, 2025; Approval No: 60). Data collection was carried out between July 1 and November 1, 2025.

The clinical sample consisted of individuals who had been diagnosed with MDD or OCD by a psychiatrist according to DSM-5 diagnostic criteria. Participants were consecutively recruited from two different outpatient psychiatry clinics. Initially, 35 patients with MDD and 35 patients with OCD were included in the study. After excluding participants with incomplete data, the final clinical sample comprised 63 individuals, including 32 patients with MDD and 31 patients with OCD.

The non-clinical sample was composed of healthy volunteers with no history of psychiatric diagnosis. Participants were recruited from the researchers' social networks using convenience and snowball sampling methods. Of the 160 individuals initially contacted, 148 completed the assessment battery in full and were included in the analyses.

Overall, the study sample consisted of a total of 211 participants, including 63 clinical and 148 non-clinical individuals. Written informed consent was obtained from all participants prior to participation. Participants completed the sociodemographic information form, the FMPS, the Depression Anxiety Stress Scale-21 (DASS-21), the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), and the CPQ-TR, respectively.

### Scale Adaptation Process

The Turkish adaptation of the Clinical Perfectionism Questionnaire was conducted after obtaining written permission from the original developers of the scale and followed the translation-back-translation procedures recommended by Beaton et al. (2000) and Sousa and Rojjanasirat (2011). First, the scale was translated from

English into Turkish by two independent translators. These two translations were then reviewed and synthesized into a single consensus version based on expert evaluation. Subsequently, two translators whose native language was English and who were blinded to the original version of the scale performed the back-translation. The back-translated version was compared with the original scale to ensure conceptual and linguistic equivalence.

A three-stage expert committee consisting of faculty member in the Department of Psychiatry and eight psychiatrists evaluated the cultural adaptation of the scale, the semantic clarity of the items, and content validity. Based on expert feedback, necessary revisions were made, followed by a pilot administration with approximately 30 participants. Minor linguistic adjustments were then completed, and the final Turkish version of the scale was established.

### Statistical Analyses

All statistical analyses were conducted using R (version 4.3 or higher), Jamovi, and IBM Statistical Package for Social Sciences (SPSS) version 26. Descriptive statistics included means, standard deviations, skewness, kurtosis, minimum, and maximum values. The normality of distributions was evaluated using the Shapiro–Wilk test, as well as visual inspection of Q–Q plots and histograms.

Internal consistency was assessed using Cronbach's alpha coefficient, with values of  $\alpha \geq 0.70$  considered acceptable. Item–total correlations were calculated, and values above 0.20 were deemed adequate.

To evaluate construct validity, confirmatory factor analysis (CFA) was performed. Model fit was assessed using the chi-square to degrees of freedom ratio ( $\chi^2/df$ ), the Comparative Fit Index (CFI), the Tucker–Lewis Index (TLI), and the Root Mean Square Error of Approximation (RMSEA). Comparative fit index and TLI values greater than 0.90 and RMSEA values below 0.08 were considered indicative of poor-to-acceptable model fit.

Convergent validity was examined through correlations between CPQ-TR scores and the FMPS. Concurrent validity was evaluated based on the relationships between CPQ-TR scores and scores on the Y-BOCS and the DASS-21.

Depending on the distributional properties of the variables, Pearson correlation coefficients were used in correlation analyses. It was expected that the CPQ-TR, which directly assesses clinical perfectionism, would show stronger positive correlations with the FMPS, the most conceptually related construct, and moderate positive correlations with the Y-BOCS and the DASS-21. This pattern was considered evidence for the convergent and concurrent validity of the scale.

Known-groups validity was examined by comparing CPQ-TR scores across OCD, MDD, and healthy control groups using one-way analysis of variance (ANOVA) with appropriate post hoc tests. Independent samples t-tests were used for pairwise group comparisons. In addition, group differences according to age, sex, marital status, education level, employment status, and place of residence were analyzed.

In all analyses, the level of statistical significance was set at  $p < 0.05$ .

### Data Collection Instruments

**Frost Multidimensional Perfectionism Scale (FMPS):** The Frost Multidimensional Perfectionism Scale (FMPS), one of the most widely used instruments for the assessment of perfectionism, consists of six subscales: Concern over Mistakes, Personal Standards, Parental Expectations, Parental Criticism, Doubts about Actions, and Organization (Frost et al., 1990). The Turkish adaptation of the scale was conducted by Kağan (2011) in a sample of university students, with an internal consistency coefficient of 0.91 reported for the total scale. Confirmatory factor analyses supported the construct validity of the FMPS, and the Organization subscale was shown to reflect adaptive rather than maladaptive perfectionism. Although its multidimensional structure is advantageous for research purposes, the limited sensitivity of the FMPS to therapy-related change has highlighted the need for shorter, more intervention-focused assessment tools.

**Depression Anxiety Stress Scale–21 (DASS–21):** The scale was developed as a short form of the original 42-item instrument (Lovibond and Lovibond, 1995a, 1995b). It consists of 21 items divided into three subscales assessing depression, anxiety, and stress, and is rated on a four-point Likert scale ranging from 0 to 3. Subscale scores range from 0 to 21, with higher scores indicating greater symptom severity. The Turkish validity and reliability studies were conducted by Yilmaz et al. (2017) and further validated in both clinical and community samples by Sariçam (2018). The findings indicate that the DASS-21 is a psychometrically reliable self-report instrument and a functional tool for assessing mood-related symptoms.

**Yale–Brown Obsessive–Compulsive Scale (Y-BOCS):** The scale was developed to assess the severity of OCD symptoms and consists of a total of 10 items, including five items assessing obsessions and five items assessing compulsions (Goodman et al., 1989). Each item is rated on a scale of 0 to 4, yielding a total score ranging from 0 to 40. The scale is regarded as a structured clinical assessment tool that evaluates both the frequency of symptoms and the level of distress and functional impairment they cause. The Turkish adaptation was conducted by Tek et al. (1995), with a Cronbach's alpha coefficient of 0.81 reported, along with satisfactory test–retest reliability and construct validity.

**Clinical Perfectionism Questionnaire (CPQ):** The scale developed by Fairburn, Cooper, and Shafran (2003) is designed to assess clinical levels of perfectionistic tendencies. The Turkish adaptation of the scale was carried out within the scope of the present study. The CPQ consists of a total of 12 items, with Items 2 and 8 being reverse scored. Prior to statistical analyses, the reverse-scored items (Items 2 and 8) were appropriately recoded, and all reliability and factor analyses were conducted using these corrected scores. The assessment covers the previous 28 days, and items are rated on a Likert-type scale ranging from 1 to 4. Total scores range from 12 to 48, with higher scores indicating more pronounced clinical perfectionism. A systematic review by Egan et al. (2016) reported strong internal consistency for the CPQ, with Cronbach's alpha values of 0.83 in community samples and 0.82 in eating disorder samples, and concluded that the CPQ is a valid instrument widely used in both clinical and non-clinical populations.

## RESULTS

### Descriptive Statistics

A total of 211 participants were included in the study. The sociodemographic characteristics of the participants are presented in Table 1.

### Internal Consistency (Cronbach's $\alpha$ )

The internal consistency of the original 12-item CPQ-TR was found to be borderline internal consistency (Cronbach's

$\alpha=0.677$ ). Item analysis indicated that Item 2 ("Have you tended to focus on what you have achieved, rather than on what you have not achieved?") and Item 8 ("Have you done just enough to get by?") showed negative correlations with the total score. This finding suggests that these items may have limited conceptual alignment with the overall construct measured by the scale. Item-total correlations for the original version of the scale are presented in Table 2.

After removing these two items, the 10-item version of the scale demonstrated acceptable internal consistency (Cronbach's  $\alpha=0.756$ ). Item-total correlations and the Cronbach's alpha values obtained if each item were deleted are presented in Table 3. In the 10-item form, Item 12 showed a relatively low item-total correlation ( $r=0.221$ ); however, this value exceeded the minimum threshold commonly accepted in the literature ( $r \geq 0.20$ ). Removing this item resulted in only a minimal increase in Cronbach's alpha ( $\alpha=0.762$ ). In order to preserve the theoretical coverage of the scale, Item 12 was retained.

### Item Analysis and Structural Evaluation Process

Item-total correlations and internal consistency were first examined. After removing psychometrically weak items (Items 2 and 8), confirmatory factor analysis was conducted to evaluate the factor structure of the remaining items. Given that clinical perfectionism is theoretically conceptualized as a unidimensional construct, a single-factor model was tested.

**Table 1.** Demographic characteristics of the participants (N=211)

Variable	Category	Healthy group (n=148)	OCD group (n=31)	MDD group (n=32)	p value
<b>Age (Mean <math>\pm</math> SD; Min-Max)</b>		41.25 $\pm$ 14.74 (18-65)	33.22 $\pm$ 11.78 (19-63)	37.28 $\pm$ 12.64 (19-64)	0.014 <sup>a</sup>
<b>Sex (n)-(% )</b>	Female	76 (51.4)	19 (61.3)	18 (56.3)	0.569 <sup>b</sup>
	Male	72 (48.6)	12 (38.7)	14 (43.8)	
<b>Marital status (n)-(% )</b>	Married	97 (65.5)	13 (41.9)	15 (46.9)	0.016 <sup>b</sup>
	Single	36 (24.3)	18 (58.1)	15 (46.9)	
	Divorced	11 (7.4)	0 <sup>#</sup> (0)	2 (6.3)	
	Widowed	4 (2.7)	0 <sup>#</sup> (0)	0 <sup>#</sup> (0)	
<b>Education level (n)-(% )</b>	Primary education	3 (2)	5 (16.1)	7 (21.9)	0.021 <sup>b</sup>
	High school	39 (26.4)	11 (35.5)	7 (21.9)	
	University	83 (56.1)	12 (38.7)	15 (46.9)	
	Postgraduate	23 (15.5)	3 (9.7)	3 (9.4)	
<b>Employment status (n)-(% )</b>	Employed	79 (53.4)	15 (48.4)	16 (50)	0.850 <sup>b</sup>
	Student	32 (21.6)	12 (38.7)	12 (37.5)	
	Unemployed	0 <sup>#</sup> (0)	1 (3.2)	2 (6.3)	
	Retired	37 (25)	3 (9.7)	2 (6.3)	
<b>Place of Residence (n)-(% )</b>	Urban	101 (68.2)	26 (83.9)	24 (75)	0.193 <sup>b</sup>
	Semi-urban	42 (28.4)	3 (9.7)	8 (25)	
	Rural	5 (3.4)	2 (6.5)	0 <sup>#</sup> (0)	

Mean: mean; SD: standard deviation; OCD: obsessive-compulsive disorder; MDD: major depressive disorder; <sup>#</sup>No participants were present in the relevant category; no missing data were present for any variable presented in this table (complete dataset). <sup>a</sup>: Kruskal-Wallis Test; <sup>b</sup>: Pearson Chi-Square Test. Post hoc analysis for age revealed a significant difference between the healthy control group and the OCD group. To enable the analysis of categorical variables, marital status was recoded as "married" and "other"; education level as "university and above" and "high school and below"; employment status as "employed" and "other"; and place of residence as "urban" and "other", and Pearson Chi-Square tests were applied accordingly.

**Table 2.** Item-total correlations for the original 12-item CPQ-TR

Item	Item-Total Correlation
CPQ 1	0.307
CPQ 2	-0.190
CPQ 3	0.457
CPQ 4	0.518
CPQ 5	0.546
CPQ 6	0.287
CPQ 7	0.533
CPQ 8	-0.004
CPQ 9	0.455
CPQ 10	0.376
CPQ 11	0.304
CPQ 12	0.194

CPQ: Clinical Perfectionism Questionnaire; CPQ-TR: Turkish version of the Clinical Perfectionism Questionnaire; items 2 and 8 showed negative correlations with the total scale score, suggesting that these items may be inconsistent with the overall construct of the scale.

**Table 3.** Item-total correlations and Cronbach's alpha values if item deleted for the 10-item CPQ-TR (items 2 and 8 removed)

Item	Item-total score correlation	Cronbach's $\alpha$ (if item deleted)
CPQ 1	0.326	0.748
CPQ 3	0.466	0.729
CPQ 4	0.560	0.714
CPQ 5	0.555	0.716
CPQ 6	0.286	0.755
CPQ 7	0.543	0.718
CPQ 9	0.496	0.725
CPQ 10	0.429	0.734
CPQ 11	0.291	0.752
CPQ 12	0.221	0.762

CPQ: Clinical Perfectionism Questionnaire; after the removal of Items 2 and 8, internal consistency was Cronbach's  $\alpha=0.756$ .

Standardized factor loadings ranged from 0.207 to 0.790 (Table 4). While the majority of items loaded significantly onto the latent factor ( $p < 0.05$ ), Items 2 and 8 were excluded from the analysis due to their low factor loadings and weak contributions to scale reliability. Following the removal of these items, the remaining items demonstrated acceptable factor loadings.

Overall model fit indices indicated suboptimal but borderline acceptable fit to the data ( $\chi^2(35)=93.8$ ,  $p < 0.001$ ; CFI=0.853; TLI=0.811; RMSEA=0.089). These findings suggest that the CPQ represents a unidimensional structure at a borderline acceptable level within the Turkish sample.

### Correlation Analyses

To evaluate convergent and concurrent validity, Pearson correlation analyses were conducted between CPQ scores and other psychological measures. A strong and positive association was found between the CPQ total score and the FMPS, supporting the convergent validity of the scale.

Concurrent validity analyses showed that CPQ scores were positively correlated with scores on Y-BOCS and DASS-21. These findings indicate that higher levels of clinical perfectionism are associated with greater emotional distress and increased severity of obsessive-compulsive symptoms (Table 5).

### Group Differences

Group comparisons were conducted to examine whether CPQ scores differed according to demographic and

**Table 4.** Standardized factor loadings and model fit indices of the revised 10-item CPQ-TR

Item	Standardized factor loading ( $\lambda$ )	SE	Z	P
CPQ1	0.249	0.0649	3.83	<0.001
CPQ3	0.511	0.0733	6.97	<0.001
CPQ4	0.790	0.0679	11.63	<0.001
CPQ5	0.763	0.0634	12.04	<0.001
CPQ6	0.259	0.0756	3.42	<0.001
CPQ7	0.594	0.0651	9.12	<0.001
CPQ9	0.568	0.0651	8.73	<0.001
CPQ10	0.387	0.0721	5.37	<0.001
CPQ11	0.207	0.0656	3.16	0.002
CPQ12	0.210	0.0676	3.10	0.002
Model fit index	Value			Interpretation
$\chi^2$ (df=35)	93.8 ( $p < 0.001$ )			Expected to be significant in large samples
CFI	0.853			Poor-to-moderate model fit
TLI	0.811			Poor-to-moderate model fit
RMSEA (90% CI)	0.089 (0.067–0.111)			Poor-to-moderate model fit
$\chi^2/df$	2.68			Moderate model fit

CFI: comparative fit index; TLI: Tucker-Lewis index; RMSEA: root mean square error of approximation; SE: standard error; Z: critical ratio (estimate/SE).

clinical variables. No significant difference in CPQ scores was found with respect to sex ( $t(209)=1.68, p=0.094$ ). Similarly, no significant differences were observed according to education level ( $F(3,48.8)=0.484, p=0.690$ ), marital status ( $F(3,207)=1.04, p=0.375$ ), or place of residence ( $F(2,208)=0.87, p=0.421$ ).

A significant negative correlation was found between age and total CPQ scores ( $r=-0.211, p=0.002$ ). In addition, participants who were not employed had significantly higher CPQ scores compared to those who were employed ( $t(209)=2.12, p=0.035$ ).

Analyses based on psychiatric diagnosis revealed a significant main effect across groups ( $F(2,208)=6.41, p=0.002$ ). Post hoc Tukey tests indicated that CPQ scores in the OCD group were significantly higher than those in the MDD group ( $p=0.018$ ) and healthy controls ( $p<0.001$ ). Clinical perfectionism questionnaire scores in the MDD group were also significantly higher than those of the healthy control group ( $p=0.041$ ).

### Summary of Psychometric Properties

Overall, the CPQ-TR demonstrated acceptable psychometric properties in both clinical and non-clinical samples. Following the removal of Items 2 and 8, which were found to be psychometrically inadequate, the internal consistency of the remaining items increased, item-total correlations were strong, and each item was shown to contribute significantly to the total score. Confirmatory factor analysis supported a unidimensional structure with moderate but poor-to-moderate model fit. Correlation analyses further confirmed convergent and concurrent validity through significant associations with the FMPS, the Y-BOCS and the DASS-21.

No differences in CPQ scores were observed according to sex, education level, marital status, or place of residence. However, younger participants and unemployed individuals exhibited higher perfectionism scores. In addition, CPQ scores were highest in the OCD group compared with the MDD and healthy control groups. These findings support the reliability, construct validity, and known-groups validity of the CPQ-TR, and the results are summarized in Table 6.

## DISCUSSION

In this study, the psychometric properties of the CPQ-TR were evaluated in a mixed sample comprising both clinical and non-clinical participants. The findings contribute to the growing international literature on the assessment of clinical perfectionism. Clinical perfectionism is conceptualized as a transdiagnostic process that plays a role in the onset and maintenance of several psychiatric disorders, including OCD, depression, and anxiety (Egan et al. 2011, Limburg et al.

**Table 6.** Summary of the psychometric properties of the CPQ-TR

Property	Value	Interpretation
Cronbach's $\alpha$	0.756	Acceptable internal consistency (10-item form; 12-item form borderline: $\alpha=0.677$ )
Factor structure	Single-factor	Tested using CFA
CFI / TLI	0.853/0.811	Poor-to-moderate model fit
RMSEA	0.089	Poor-to-moderate model fit
Convergent validity	$r=0.593$ (FMPS)	Strong

CFI: comparative fit index; TLI: Tucker-Lewis index; RMSEA: root mean square error of approximation; CFA: confirmatory factor analysis.

2017), and may lead to emotional distress and functional impairment through maladaptive cognitive and behavioral patterns. Therefore, the development of valid and reliable assessment tools across different cultural contexts is crucial for early identification, prevention, and intervention efforts.

With the validation of the Turkish version of the CPQ, the present study extends previous cross-cultural adaptation research (Fairburn et al. 2003, Moloodi et al. 2017, Roth et al. 2021, Parks et al. 2021, Alyami et al. 2022, İnözü et al. 2022, Skupova et al. 2024) and contributes to a cross-cultural understanding of the clinically relevant dimensions of perfectionism.

The CPQ-TR generally demonstrated satisfactory psychometric properties. The internal consistency of the 12-item form was found to be borderline acceptable ( $\alpha=0.68$ ), and internal consistency increased substantially following the removal of Items 2 and 8 ( $\alpha=0.76$ ). This finding is consistent with results reported in other language adaptations (Chang and Sanna 2012, Moloodi et al. 2017, Roth et al. 2021, Parks et al. 2021). Notably, Items 2 and 8 showed low or negative factor loadings and reduced internal consistency. Similar problems have been reported in the Persian, German, and Swedish adaptations; the repeated psychometric weakness of these items suggests that the issue may be conceptual rather than linguistic in nature. This may be related to ambiguity in self-evaluative processes or to the multidimensional nature of perfectionistic striving.

Confirmatory factor analysis indicated that, after the removal of Items 2 and 8, the remaining items loaded significantly onto a single latent factor, supporting a unidimensional model. This finding does not fully align with the two-factor structure reported in several adaptations (Chang and Sanna 2012, Moloodi et al. 2017, Roth et al. 2021). However, this discrepancy is not unexpected. Parks et al. (2021) noted that even in two-factor solutions, model fit indices were often only moderate and substantial cross-loadings persisted, suggesting that the factor structure of the CPQ may not be stable across cultures. Similarly, in the Persian adaptation, Item 8 was

removed to achieve acceptable model fit (Moloodi et al. 2017). In a recent Russian adaptation, a three-factor solution diverging from the original two-factor structure was obtained, and this differentiation was attributed to culturally specific conceptual distinctions (Skupova et al. 2024). Taken together, these findings suggest that clinical perfectionism in the Turkish sample may exhibit a more holistic structure, with perfectionistic striving and evaluative concerns converging under a shared mechanism. Alternatively, the unidimensional structure may reflect a higher-order latent construct encompassing both motivational and self-critical components of perfectionism.

The CPQ-TR demonstrated moderate-to-high convergent validity, showing a significant association with the FMPS ( $r=0.593$ ,  $p < 0.001$ ). The scale also exhibited moderate concurrent correlations with obsessive-compulsive symptom severity as well as with levels of depression, anxiety, and stress ( $r=0.30-0.35$ ,  $p < 0.001$ ). These findings are consistent with results reported in previous studies (Chang and Sanna 2012, Moloodi et al. 2017, Roth et al. 2021, Parks et al. 2021, Alyami et al. 2022) and indicate that the scale is sensitive to the maladaptive and self-critical dimensions of perfectionism associated with emotional distress. In line with the transdiagnostic model of clinical perfectionism (Egan et al. 2011), these associations suggest that the CPQ effectively captures cognitive-behavioral processes that contribute to psychopathology, such as the contingency of self-worth on achievement and fear of failure.

The CPQ-TR also showed significant associations with demographic and clinical variables. Higher perfectionism scores among younger and unemployed participants suggest that perfectionistic tendencies may be reinforced by developmental processes and stressors related to employment and productivity. The absence of significant differences according to sex, education level, and marital status is consistent with findings reported in European samples (Roth et al. 2021, Parks et al. 2021). Notably, although the groups were not fully matched on demographic characteristics — with significant differences observed in age, marital status, and education level across groups — the absence of significant differences in CPQ-TR scores according to these variables is a noteworthy finding. This suggests that the scale functions independently of these sociodemographic factors and provides comparable measurements across individuals with varying demographic profiles. Furthermore, CPQ scores were significantly higher in the OCD group than in both the MDD and healthy control groups, supporting the discriminant validity of the scale and its sensitivity to obsessive-compulsive symptoms. This pattern parallels the consistent associations observed between perfectionism and obsessive-compulsive features in previous CPQ validation studies and suggests that clinical perfectionism may function as a maintaining mechanism in anxiety-related disorders.

The findings of the present study are consistent with previous evidence indicating that the CPQ captures specific dimensions of perfectionism that are independent of general negative affect. Chang and Sanna (2012) reported that the CPQ accounted for additional variance in maladaptive functioning beyond that explained by multidimensional perfectionism scales (MPS, FMPS) and broader personality constructs such as negative affect. Similar findings have been reported in European samples (Roth et al. 2021, Parks et al. 2021), further strengthening the value of the CPQ as a brief, clinically focused assessment tool with incremental validity. Within this framework, the CPQ-TR appears to be sensitive to the self-critical and excessively evaluative components of maladaptive perfectionism in both clinical and community samples.

From a clinical perspective, the CPQ-TR provides a brief, reliable, and culturally appropriate instrument for assessing perfectionism components that are directly relevant to cognitive-behavioral and schema-focused interventions. Consistent with prior research demonstrating that the CPQ is sensitive to treatment-related change (Riley et al. 2007, Egan et al. 2016), the brevity of the Turkish version and its focus on maladaptive cognitions offer a clear advantage for therapeutic monitoring and the evaluation of treatment response. The successful application of the scale in non-clinical samples also indicates its potential utility as a screening tool for identifying individuals at risk for perfectionism-related psychopathology.

Despite its strengths, this study has several limitations. First, the poor-to-moderate fit observed in the confirmatory factor analysis suggests that the factor structure should be further examined using more advanced models, such as bifactor or hierarchical models. Second, the weak psychometric performance of Items 2 and 8—a recurrent finding across multiple language adaptations—may reflect conceptual ambiguity or difficulties associated with the interpretation of reverse-worded items rather than linguistic equivalence. The reporting of similar results in German, Swedish, and Japanese studies (Roth et al. 2021, Parks et al. 2021) suggests that revising or removing these items may enhance internal consistency. Third, the non-clinical sample was recruited using convenience and snowball sampling methods, which limits the generalizability of the findings to the general population due to the non-probabilistic nature of these approaches.

In addition, although the overall sample size was statistically adequate for psychometric analyses, the relatively small sizes of the clinical subgroups may have reduced statistical power in comparisons across diagnostic groups. A fourth limitation is the cross-sectional design of the study, which precluded the assessment of test-retest reliability and sensitivity to treatment-related change. Finally, although conducting psychometric analyses on the combined clinical and non-clinical sample

was useful for evaluating discriminant properties, this methodological approach may limit the generalizability of the findings when considered separately for each group. In light of these limitations, future studies should aim to replicate and extend these findings using larger and more representative samples to further validate the psychometric properties of the CPQ-TR.

## CONCLUSION

This study demonstrated that the Turkish version of the Clinical Perfectionism Questionnaire (CPQ-TR) is a valid and acceptably reliable assessment tool for use in both clinical and non-clinical samples. Psychometric analyses indicated that the 10-item form obtained after the removal of Items 2 and 8 provided higher internal consistency and a more stable factor structure. The findings support the notion that clinical perfectionism predominantly exhibits a unidimensional structure in the Turkish sample.

Evidence for convergent and concurrent validity showed that the scale adequately reflects perfectionism-related cognitive processes and emotional distress. Owing to its brief and practical format, the scale appears suitable for both clinical assessment and the monitoring of treatment processes.

Based on these results, the 10-item CPQ-TR can be considered a practical and appropriate option for assessing perfectionism-related cognitive patterns in both research and clinical practice. Future studies examining test–retest reliability and treatment sensitivity in larger samples would further strengthen the utility and applicability of the instrument.

**Ethics Committee Approval:** The study protocol was approved by the Health Sciences University Erenköy Mental and Neurological Diseases Training and Research Hospital Ethics Committee on June 26, 2025, with decision number60.

**Conflict of Interest:** The authors declare no conflicts of interest.

**Funding:** This research received no external funding.

## REFERENCES

- Alyami M, Krägeloh CU, Al-Amri L ve ark. (2022). Examining and enhancing the reliability of the Arabic version of the Clinical Perfectionism Questionnaire. *Middle East Curr Psychiatry* 29, 93. <https://doi.org/10.1186/s43045-022-00261-6>
- Beaton DE, Bombardier C, Guillemin F et al. (2000) Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine (Phila Pa 1976)* 25:3186–91. <https://doi.org/10.1097/00007632-200012150-00014>
- Chang EC, Sanna LJ (2012). Evidence for the validity of the Clinical Perfectionism Questionnaire in a nonclinical population: More than just negative affectivity. *J Pers Assess*, 94(1), 102-108. <https://doi.org/10.1080/00223891.2011.627962>
- Egan SJ, Shafran R, Lee M et al. (2016). The reliability and validity of the clinical perfectionism questionnaire in eating disorder and community samples. *Behav Cogn Psychother*, 44(1), 79–91. <http://dx.doi.org/10.1017/S1352465814000629>.
- Egan SJ, Wade TD, Shafran R (2011) Perfectionism as a transdiagnostic process: a clinical review. *Clin Psychol Rev* 31:203–12. <https://doi.org/10.1016/j.cpr.2010.04.009>
- Fairburn CG, Cooper Z, Shafran R (2003) *Clinical Perfectionism Questionnaire*. Oxford, Department of Psychiatry, University of Oxford. <https://doi.org/10.1037/t59141-000>
- Frost RO, Marten P, Lahart C et al. (1990) The dimensions of perfectionism. *Cogn Ther Res* 14:449–68. <https://doi.org/10.1007/BF01172967>
- Goodman WK, Price LH, Rasmussen SA et al. (1989) The Yale-Brown Obsessive Compulsive Scale: I. Development, use, and reliability. *Arch Gen Psychiatry* 46:1006–11. <https://doi.org/10.1001/archpsyc.1989.01810110048007>
- Hewitt PL, Flett GL (1990) Perfectionism and depression: a multidimensional analysis. *J Soc Behav Pers* 5:423–38.
- İnöz M, Keser E, Erel S et al. (2022) Obsesif inançların tanılar üstü rolünün incelenmesi: obsesif-kompulsif bozukluk, kaygı bozuklukları ve depresyon tanısı almış klinik grupların üniversite öğrencileri ile karşılaştırılması. *Türk Psikiyatri Derg* 33(1):22–31. <https://doi.org/10.5080/u25933>
- Kağan M (2011) Frost Çok Boyutlu Mükemmeliyetçilik Ölçeği'nin Türkçe formunun psikometrik özellikleri. *Anadolu Psikiyatri Derg* 12:192–7.
- Limburg K, Watson HJ, Hagger MS et al. (2017) The relationship between perfectionism and psychopathology: a meta-analysis. *J Clin Psychol* 73:1301–26. <https://doi.org/10.1002/jclp.22435>
- Lovibond PF, Lovibond SH (1995a) The structure of negative emotional states: comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behav Res Ther* 33:335–43. [https://doi.org/10.1016/0005-7967\(94\)00075-u](https://doi.org/10.1016/0005-7967(94)00075-u)
- Lovibond SH, Lovibond PF. (1995b). *Manual for the Depression Anxiety Stress Scales* (2nd ed). Sydney: Psychology Foundation.
- Moloodi R, Pourshahbaz A, Mohammadkhani P ve ark. (2017). Psychometric properties of the Persian version of Clinical Perfectionism Questionnaire: Findings from a clinical and non-clinical sample in Iran. *Pers Individ Dif* 119:141-6. <https://doi.org/10.1016/j.paid.2017.07.003>
- Parks A, Leur JC, Strååt M ve ark. (2021). A Self-Report Measure of Perfectionism: A Confirmatory Factor Analysis of the Swedish Version of the Clinical Perfectionism Questionnaire. *Clin Psychol Eur* 3(4), e4581. <https://doi.org/10.32872/cpe.4581>
- Riley C, Lee M, Cooper Z ve ark. (2007) A randomized controlled trial of cognitive-behavioral therapy for clinical perfectionism: A preliminary study. *Behav Res Ther* 45(9):2221-31. doi: 10.1016/j.brat.2006.12.003
- Roth I, Cludius B, Egan SJ et al. (2021). Evaluation of the Factor Structure and Psychometric Properties of the German Version of the Clinical Perfectionism Questionnaire: The CPQ-D. *Clin Psychol Euro* 3(2), e3623. <https://doi.org/10.32872/cpe.3623>
- Sarıçam H (2018) The psychometric properties of the Turkish version of the Depression Anxiety Stress Scale–21 (DASS–21) in Health Control and Clinical Samples. *JCBPR* 7:19–30 <https://doi.org/10.5455/JCBPR.274847>
- Shafran R, Cooper Z, Fairburn CG (2002) Clinical perfectionism: a cognitive-behavioural analysis. *Behav Res Ther* 40:773–91. [https://doi.org/10.1016/s0005-7967\(01\)00059-6](https://doi.org/10.1016/s0005-7967(01)00059-6)
- Skupova AM, Turkina IS, Aslanova MS et al. (2024) Russian adaptation of the Clinical Perfectionism Questionnaire. *Zh Nevrol Psikhiatr Im S S Korsakova* 124(7):112–8. <https://doi.org/10.17116/jnevro2024124071112>
- Sousa VD, Rojjanasrirat W (2011) Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. *J Eval Clin Pract* 17:268–74. <https://doi.org/10.1111/j.1365-2753.2010.01434.x>
- Stoeber J, Otto K (2006) Positive conceptions of perfectionism: approaches, evidence, challenges. *Pers Soc Psychol Rev* 10:295–319. [https://doi.org/10.1207/s15327957pspr1004\\_2](https://doi.org/10.1207/s15327957pspr1004_2)
- Tek C, Uluğ B, Rezaki BG et al. (1995). Yale-Brown Obsessive Compulsive Scale and US National Institute of Mental Health Global Obsessive Compulsive Scale in Turkish: reliability and validity. *Acta Psychiatr Scand* 91(6):410-3. doi: 10.1111/j.1600-0447.1995.tb09801.x.
- Yılmaz Ö, Boz H, Arslan A (2017). Depresyon anksiyete stres ölçeğinin (DASS 21) Türkçe kısa formunun geçerlilik-güvenilirlik çalışması. *Finans Ekonomi ve Sosyal Araştırmalar Dergisi* 2(2):78–91.