An Examination of Maladaptive Perfectionism, Perfectionistic Self-Presentation, Wellbeing and the Disclosure of Mental Health Difficulties

Sonam Patel

D.Clin.Psy Thesis (Volume 1), 2020

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Sonam Patel

Date: 03/07/2020

Overview

The relationship between perfectionism and mental health difficulties has been well-documented. However, widespread mental health stigma, coupled with the need to be, or to appear perfect before others can deter individuals with perfectionism from talking about their experiences of mental health difficulties with others. Despite this, research exploring how perfectionism affects one's propensity to talk about personal or mental health difficulties is limited.

To this end, part one of this thesis examines what is currently known about the link between perfectionism, self-disclosure or concealment, and the experience of mental health difficulties. Part two reports an empirical study examining whether a brief, CBT-based perfectionism workshop can reduce maladaptive perfectionism and perfectionistic self-presentation amongst trainee clinical psychologists, and in turn increase their comfort with and likelihood of talking about personal and mental health difficulties with others within their training context. Results demonstrated that trainees' level of perfectionism reduced following the workshop, a reduction that was maintained at 11-weeks follow-up. Further, trainees' likelihood and comfort with talking about mental health problems also increased following the workshop, though the workshop did not alter trainees' likelihood of and comfort with disclosing personal difficulties, changes which were not maintained at follow-up. Thirdly, trainees' wellbeing also deteriorated over time, and was negatively associated with all four dimensions of perfectionism. Part three is a critical appraisal, which examines some of the wider challenges that arose whilst conducting this research and concludes with personal reflections on the process of undertaking this thesis.

Impact Statement

The conceptual review presented in part one of this thesis provides a detailed investigation into the relationship between perfectionism and the disclosure or concealment of mental health difficulties. Findings from this review suggest that individuals exhibiting high levels of unhealthy perfectionism show greater tendencies to conceal mental health difficulties from others. Such concealment has been found to contribute to the maintenance and exacerbation of psychological distress experienced by individuals with unhealthy forms of perfectionism. Such insights therefore have important implications for the development of effective perfectionism interventions, with evidence suggesting that interventions targeting the belief or drive to conceal mental health difficulties or other negative personal information from others may help to diminish the psychological distress experienced.

However, for those experiencing mental health difficulties, disclosure is not always beneficial, particularly within uncompassionate or stigmatised contexts. Yet the reviewed studies present a unidimensional view of concealment (or non-disclosure) as solely detrimental to the mental wellbeing of individuals with perfectionism, highlighting an apparent dearth of literature examining the potential advantages of maintaining secrecy. This review therefore outlines a critical gap in the literature.

Further, the empirical study reported in part two highlighted elevated levels of unhealthy perfectionism amongst trainee clinical psychologists relative to the general population, as well as high prevalence of mental health problems and difficulties in one's personal life. A deterioration was also noted in trainees' psychological wellbeing over time. These findings therefore underscore the need to do more to safeguard trainees' wellbeing during training, and to support them to

speak about difficulties they may be experiencing. Crucially, this study was the first to demonstrate the effectiveness of a brief CBT-based perfectionism workshop at reducing trainees’ levels of maladaptive perfectionism and perfectionistic self-presentation, and increasing their likelihood of, and comfort with talking about difficulties with others in their training context.

The findings from this thesis therefore underscore the need for the implementation of such a workshop into the training curriculum, in order to protect and promote the mental health and wellbeing of trainees whilst on training. Embedding a workshop of this nature across all training programmes may begin to address the secrecy that often prevails regarding talking about difficulties within the work and learning context, which may facilitate access to social and formal sources of support. This may also promote the development of healthier working practices, thereby improving trainees’ personal and professional functioning whilst on training and ensuring their long-term efficiency as qualified psychologists entering the workforce. Indeed, given the effectiveness of the workshop, the findings from the study may also have a wider impact if implemented in other professions, where levels of perfectionism, and hence psychological distress, may be elevated.

Table of Contents

Overview 3
Impact Statement 4
List of Tables and Figures 8
Acknowledgements 9
Part 1: Conceptual Introduction 10
Abstract 11
Perfectionism 12
The Two Faces of Perfectionism 14
The Public Face of Perfectionism 17
Perfectionism and Mental Health 18
Treatments for Perfectionism 20
Talking about Mental Health Difficulties 21
To Share or Not to Share? 22
Barriers and Facilitators to Sharing 24
Perfectionism and Talking about Mental Health Difficulties 27
Non-disclosure of Imperfections and Psychological Distress 27
Self-Concealment and Disclosure as Mediators 30
Perfectionism and the Concealment of Mental Health Difficulties 33
Limitations 37
Research Aims and Questions 39
References 43
Part 2: Empirical Paper 55
Abstract 56
Introduction 58
Rationale for the Study 62
Methods 63
Participants 63
Design and Procedure 64
Workshop 65
Ethical Considerations 65
Measures 67
Power Analysis 70

Data Analysis ... 71
Results ... 73
Workshop Evaluation ... 75
Perfectionism ... 75
Talking about Mental Health Problems ... 75
Talking about Personal Difficulties ... 76
Wellbeing ... 76
Factors Affecting Disclosure of Mental Health Problems ... 77
Factors Affecting Disclosure of Personal Difficulties ... 82
Discussion ... 86
Change Following the Workshop ... 87
Perfectionism ... 87
Attitudes Towards Disclosure of Difficulties ... 89
Wellbeing ... 90
Factors Affecting Disclosure ... 92
Implications ... 96
Recommendations ... 99
Limitations ... 100
Conclusion ... 102
References ... 104
Part 3: Critical Appraisal ... 111
Overview ... 112
Conclusion ... 127
References ... 128
Appendix A: Email Invitation to Course Directors ... 134
Appendix B: Follow-Up Email to Trainees ... 136
Appendix C: Full Survey ... 138
Appendix D: Confirmation of Ethical Approval ... 147
Appendix E: Clinical Error Vignettes ... 155

List of Tables and Figures

Table 1: Structure of the healthy striving for excellence workshop 66
Table 2: Descriptive statistics: perfectionism scores and disclosure ratings across three time points 74
Table 3: Pearson correlation coefficients: perfectionism and wellbeing 77
Table 4: Multiple regression: change in perfectionism as predictors of change in wellbeing 78
Table 5: Parameter information for significant predictors of likelihood of disclosing mental health problems 79
Figure 1: Graph on time*experience interaction, predicting likelihood of disclosure of mental health difficulties 80
Table 6: Parameter information for significant predictors of comfort with disclosing mental health problems 81
Table 7: Parameter information for significant predictors of likelihood of disclosing personal difficulties 83
Table 8: Parameter information for significant predictors of comfort with disclosing personal difficulties 84

Acknowledgements

I would like to start by thanking my supervisors, Dr Katrina Scior, Professor Roz Shafran and Dr Katherine Sherratt. I feel truly fortunate to have been supported by each of you, and to have benefitted from your time, expertise, as well as your constant words of encouragement throughout this process. Your support and guidance have invaluable for building my confidence as a researcher, and for this, I am incredibly grateful.

Secondly, I would like to thank Dr Rob Saunders, whose knowledge of statistical methods seems vast, and whose tolerance for unrelenting questions about mixed linear modelling seemingly limitless. Thank you for all your help.

Thank you also to all the trainees and researchers who volunteered their time and wisdom to this project, and for those who participated in the workshop. Without you this thesis would not be possible.

To the most amazing parents, brother, grandmother, and to the sweetest dada, thank you for all the love and support you have given me over the years. Also, thank you to my friends, both old and new, for consistently providing me with welcome distractions, and the laughter and reassurance I needed to keep going.

Finally, to Colt: thank you for your undying patience and support as I completed this doctorate. Your calmness, your ambition, and your ability to grow have been a constant source of inspiration to me. Above all, your unwavering belief in me has given me the strength to pursue and achieve my goals, and for that I cannot thank you enough.

Part 1: Conceptual Introduction

An Examination of the Interrelations between Perfectionism, Self-Disclosure, and Mental Health Difficulties

Abstract

Despite experiencing high levels of psychological distress and mental health difficulties, the pervasiveness of mental health stigma can deter individuals with unhealthy forms of perfectionism from talking about mental health problems with others. Yet few studies to date have examined this claim. The following review therefore explored the concept of perfectionism and disclosure or concealment of mental health difficulties and examined what is currently known about the associations between these concepts. The reviewed evidence highlights that the non-disclosure of imperfections is inherent in the interpersonal expression of perfectionism, which is associated with greater severity of depression, social anxiety and eating disorder symptomatology in both adults and young people. Other studies elucidated the mediating effect of self-disclosure or concealment, with unhealthy forms of perfectionism being linked to greater concealment (or reduced disclosure) of distress or negative personal information, in turn resulting in more severe mental health difficulties. Further, unhealthy forms of perfectionism and the non-disclosure of imperfections appear to diminish one's likelihood of and willingness to talk about mental health difficulties and psychological distress with others within one's personal and professional milieus. Crucially, though the function of such concealment or non-disclosure is to maintain an image of oneself as perfect, evidence suggests that such processes contribute to greater psychological distress and to the worsening of mental health and wellbeing. Such evidence therefore suggests that interventions for perfectionism that target the drive to conceal distressing personal information from others may be particularly effective at reducing the level of psychological distress experienced.

Perfectionism

The concept of perfectionism has had varied connotations throughout history. A prominent feature of perfectionism is the setting of, and striving to achieve, high personal standards for ones' performance. Some definitions of perfectionism deem such pursuits as a socially desirable trait, one that is associated with positive qualities such as motivation to achieve one's goals, attention to detail, organisational skills and conscientiousness (see Stoeber & Otto, 2006 for a review). However, when such personal standards are excessively demanding, and when one's self-worth becomes contingent upon productivity and achievement of these standards, the striving for perfection can instead become the source of great psychological distress (Frost et al., 1993; Shafran et al., 2002). Over time, advancements in perfectionism theory and research have demonstrated that perfectionism is best understood as a multidimensional construct.

The seminal work by Frost and colleagues (1990) and by Hewitt and Flett (1991) provided some of the first multidimensional conceptualisations of perfectionism. Through factor analysis, the former authors demonstrated that perfectionism was comprised of six core dimensions, namely personal standards, organisation, concerns over mistakes, doubts about actions, parental expectations and parental criticism. From this, it was suggested that people with perfectionism set high standards for themselves, place great importance on orderliness and organisation, and deem mistakes as a global personal failing, processes that stem from early expectations of excellence from parents, and criticism when such standards were not met. This contributed to the development of the first multidimension measure of perfectionism, the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990), which has received a great deal of empirical support over time (see Shafran &

Mansell, 2001 for a review). Such research has highlighted that of the six core dimensions, concern over mistakes is the key component of perfectionism, accounting for the greatest variance in perfectionism scores and being associated with a range of negative outcomes (e.g. Frost & Steketee, 1997; Sassaroli et al., 2008). In contrast the validity of the other dimensions has been disputed and subsequent researchers have also arrived at divergent solutions regarding the underlying factor structure (e.g. Rhéaume et al., 2000; Stoeber, 1998; Stumpf & Parker, 2000). Despite these limitations however, this remains one the most widely used scales in clinical practice and research.

Hewitt and Flett (1991) subsequently posited another multidimensional model of perfectionism, which informed the development of the other commonly used multidimensional measure, the Hewitt Multidimensional Perfectionism Scale (HMPS). This model emphasised that perfectionism was comprised of both personal and social components and assessed from whom perfectionistic standards originate and towards whom they are directed. This revealed three further dimensions of perfectionism: self-oriented perfectionism, characterised by an expectation of oneself to be perfect, other-oriented perfectionism, defined as requiring perfection from others, and socially prescribed perfectionism, typified by the perception that others require one to be perfect. This model too has received much empirical support (e.g. Cowie et al., 2018; Sherry et al., 2007), though others have argued that only the self-oriented perfectionism dimension accurately describes the construct, whereas the others are associated, though not inherent components of perfectionism (Shafran et al., 2002). Thus, although there is some debate regarding the core facets, such studies nonetheless demonstrate the multifaceted nature of perfectionism.

The Two Faces of Perfectionism

A second important contribution of the research by Frost and colleagues (1990) and by Hewitt and Flett (1991) was the way in which this work delineated the functional and adaptive dimensions of perfectionism from those that had a detrimental impact upon one's functioning and wellbeing. For instance, the personal standards and organisation dimensions from the FMPS (Frost et al., 1990) were found to be linked to positive characteristics such as greater efficiency and healthy striving for achievement, whereas the concern over mistakes, doubts about actions, parental criticism and parental expectation subscales were associated with greater psychological distress. The former, more positive form of perfectionism was later defined as adaptive perfectionism, whereas the latter deemed maladaptive perfectionism (Rice et al., 1998). Similarly, Hewitt and Flett (1991) found self-oriented perfectionism to be associated with a healthy pursuit of high standards and the intrinsic motivation to achieve one's goals, whereas socially prescribed perfectionism was linked to a number of mental health difficulties, including anxiety, dysthymia and psychotic depression. Subsequent analysis of both these multidimensional models identified two higher-order factors: maladaptive evaluation concerns, which subsumed concern over mistakes, parental criticism, parental expectation, doubts about actions and socially-prescribed perfectionism; and positive striving, which encapsulated personal standards, organisation, self-oriented perfectionism and other-oriented perfectionism (Frost et al., 1993). Of these, the maladaptive evaluation concerns factor was significantly correlated with depression and negative affect, whereas the positive striving dimension was associated with greater positive affectivity.

Such research was therefore amongst the first to provide empirical evidence for two distinct forms of perfectionism. The first describes a functional, adaptive form of perfectionism, which is linked to positive affectivity and involves a motivational element that underlies the healthy striving towards one's goals (Frost et al., 1993). This is contrasted with a more negative, maladaptive form of perfectionism, which is characterised by an attempt to achieve excessively high standards of performance, accompanied by overly critical self-evaluative tendencies that can have a detrimental impact upon one's mental health and wellbeing (Frost et al., 1990, 1993; Hewitt & Flett, 1991).

Over time, numerous definitions of these two forms of perfectionism have been offered (see Stoeber & Otto, 2006 for a review), based on which components of perfectionism researchers have considered to be most pertinent for clinical and empirical inquiry. This includes *healthy* and *unhealthy* perfectionism (Stumpf & Parker, 2000), *functional* and *dysfunctional* perfectionism (Rhéaume et al., 2000), and *high standards*, *orderliness* and *discrepancy* between high personal standards and perceived inadequate performance (Slaney et al., 2001), amongst others.

These findings were later synthesised by Stoeber and Otto (2006), who proposed a framework that subsumed the many different conceptualisations of perfectionism under two superordinate dimensions: perfectionistic strivings and perfectionistic concern. The former describes the extent to which one pursues perfection and encompasses *high standards* and *order* from the Almost Perfect Scale-Revised (APS-R; Slaney et al., 2001), *personal standards* and *organisation* from the FMPS (Frost et al., 1990), and *self-oriented* and *other-oriented* perfectionism from the HMPS (Hewitt & Flett, 1991). The latter, perfectionist concern, distinguishes whether such pursuits of perfection are healthy or unhealthy

and is comprised of *concern over mistakes* and *doubts about actions* from the FMPS (Frost et al., 1990), *socially-prescribed perfectionism* from the HMPS (Hewitt & Flett, 1991) and *discrepancy* from the APS-R (Slaney et al., 2001). According to this framework, those scoring high on perfectionistic strivings and low on perfectionistic concern were deemed to display 'healthy' perfectionism, which had a positive influence on one's functioning. In contrast, high levels of perfectionistic concern, as well as high combined levels of perfectionistic strivings and perfectionistic concern were considered 'unhealthy' perfectionism and were linked to relatively poorer functioning and psychological wellbeing. Thus, the framework proposed by Stoeber and Otto (2006) provides a useful way in which to understand the interrelationship between the different facets of perfectionism, and how the unique constellation of these facets can either result in a positive and adaptive from of perfectionism (herein "healthy perfectionism") or a more negative, detrimental form of perfectionism ("unhealthy perfectionism" herein).

Examining the positive aspects of perfectionism, Stoeber and Otto (2006) found healthy perfectionism to be a beneficial trait associated with several positive qualities, including positive affect, higher self-esteem, better and greater satisfaction with academic performance, greater life satisfaction, higher levels of conscientiousness, extraversion and agreeableness, and greater perceived social support compared to those with unhealthy or low levels of perfectionism. It has also been found to promote school engagement in young people in Western societies (Damian et al., 2017) and linked to a growth mindset, greater happiness and life satisfaction in gifted children in China (Chan, 2012). Comparatively, those with unhealthy perfectionism fare less well, with research linking it to greater self-criticism, increased procrastination, higher levels of burnout and poorer academic

performance (Ashby & Kottman, 1996; H. T. Chang et al., 2016; Grzegorek et al., 2004; Rice & Slaney, 2002; Stoeber & Otto, 2006). The link between unhealthy perfectionism and the experience of mental health difficulties has also been well-documented (see Limburg et al., 2017 for a review), which is discussed in greater detail later in this review. Such research therefore further underscores the notion that perfectionism can be both healthy and functional, or unhealthy and dysfunctional.

The Public Face of Perfectionism

Despite their usefulness, the aforementioned models of perfectionism have almost exclusively focused on defining the intrapersonal factors that constitute healthy and unhealthy perfectionism. However, it has been argued that of equal importance to understanding the intrapersonal content of a trait is understanding how the trait is expressed interpersonally, something that seems particularly relevant in the case of perfectionism (Hewitt et al., 2003). To this end, a further multidimensional model that has aimed to capture the interpersonal expression of perfectionism is perfectionistic self-presentation. Hewitt and colleagues (2003) claimed that perfectionism varies both in terms of the factors that internally drive perfectionistic pursuits, and the extent to which it drives individuals to want to appear perfect in front of others. They added that some individuals with perfectionism exhibit a form of impression management that is governed by a need to present a perfect image of oneself before others. This was termed perfectionistic self-presentation, comprised of three facets that describe the way in which a perfect self-image is established and maintained: perfectionistic self-promotion, referring to efforts at presenting an image of perfection and publicising aspects of oneself that are considered to be perfect; non-display of imperfection, involving the concealment and avoidance of outward demonstrations of imperfections; and the non-disclosure of

imperfections, referring to the avoidance of speaking about one's perceived imperfections. This research revealed that higher scores on the three facets were associated with several negative consequences, including poorer general and academic self-esteem, higher levels of self-consciousness, greater need for approval and fear of negative evaluations from others, and impostorism. It was therefore concluded that perfectionistic self-presentation represented a maladaptive self-presentational style employed by individuals with perfectionism in an attempt to portray a perfect self-image to others.

Perfectionism and Mental Health

The relationship between unhealthy perfectionism and mental health difficulties has been well-documented, which has highlighted the transdiagnostic nature of perfectionism (Egan et al., 2011). Unhealthy perfectionism has been implicated in a number of mental health difficulties, including depression, social anxiety, OCD and eating disorders (DiBartolo et al., 2008; Egan et al., 2011; Frost et al., 1990; Limburg et al., 2017; Sassaroli et al., 2008). Unhealthy perfectionism has also been associated with personality disorders (e.g. Ronningstam, 2010; Sherry et al., 2007). Indeed, it has been found to be a core component of narcissistic personality disorder, characterised by a desire to achieve high standards and theorised as serving a self-protective function that allows one to avoid admitting one's imperfections, thereby avoiding harsh self-criticism and feelings of shame and inferiority (Ronningstam, 2011). Such findings have therefore led researchers to argue in favour of incorporating perfectionism as part of the diagnostic criteria for narcissistic personality disorder.

Perfectionistic self-presentation, too, has been found to be a transdiagnostic process linked to a number of mental health difficulties. Further to the negative

consequences outlined above, research by Hewitt and colleagues (2003) found the three facets of perfectionistic self-presentation to be positively associated with depression symptomatology amongst university students and a clinical sample. Research has also linked the three facets to elevated levels of anxiety across a range of participant groups, including social interaction and performance anxiety, state levels of anxiety and social anxiety in university students, and social anxiety in young people, with the non-disclosure of imperfections facet accounting for unique variance in social anxiety in both groups beyond trait perfectionism (Hewitt et al., 2003, 2011; Mackinnon et al., 2014). Thirdly, the three facets of perfectionistic self-presentation also appear to have unique relationships with suicidal ideation. Specifically, perfectionistic self-promotion appears to serve a protective function, with higher scores being linked to lower suicidal ideation, whereas higher scores on non-display and non-disclosure of imperfections were linked to greater suicidal ideation (D'Agata & Holden, 2018).

The relationship between perfectionism and eating disorders is particularly noteworthy and has been the focus of much research. This has resulted in a large body of evidence implicating perfectionism in increased severity of anorexia nervosa and bulimia nervosa (e.g. Cockell et al., 2002; Limburg et al., 2017). Such an association between perfectionism and eating disorders is perhaps not surprising; being thin or having a muscular body has long been regarded as socially desirable and considered synonymous with physical attractiveness, particularly within Western societies. Thus, someone driven by the need to be or to appear perfect may strive to achieve the perfect body shape. Over time, this pursuit can become characterised by excessive preoccupation with and control over one's weight, body shape or eating, thereby increasing the risk of developing an eating disorder (Ferreira et al., 2018).

The link between perfectionistic self-presentation and eating disorders (e.g. Cockell et al., 2002; Stoeber et al., 2017) as well as between perfectionistic concern and eating disorders (see Egan et al., 2011 for a review) is also well-documented. Interestingly however, and seemingly unique to eating disorders, is the finding that perfectionistic strivings is also linked to greater severity of eating disorder symptomatology (Limburg et al., 2017). This suggests that for some individuals with eating disorders, having high personal standards and achievement striving has a detrimental, rather than a beneficial impact upon one's functioning and wellbeing. The domain-specificity of perfectionism may go some way to explain this finding; research suggests that one's perfectionism is usually expressed within a select number of domains, such as work or academia, physical attractiveness, or domestic chores (Stoeber & Stoeber, 2009). Thus, if the pertinent domain is body image, and one is aspiring for perfection in one's weight or physical appearance, then the high personal standards one may be striving to attain will pertain to a self-conceived level of thinness. Thus, within eating disorders, perfectionistic strivings may be characterised by the pursuit of thinness.

Treatments for Perfectionism

In light of the elevated levels of mental health difficulties experienced by individuals with perfectionism, development of effective treatments has been a key focus in research. Interventions for perfectionism have taken many forms based on differing viewpoints regarding what may produce the greatest degree of change. This has included guided self-help interventions (e.g. Shafran et al., 2018; Wimberley et al., 2016), procrastination-targeted coherence therapy (Rice et al., 2011) psychoeducation delivered in group cognitive behavioural therapy (CBT; Steele et al., 2013), brief CBT workshops (LaSota et al., 2017), as well as individual CBT

(e.g. Egan et al., 2014). Overall, CBT appears to be the prevailing treatment modality (see Suh et al., 2019 for a recent review). Such interventions largely aim to reduce the unhealthy aspects of perfectionism that have a detrimental impact upon one's wellbeing and functioning, whilst continuing to cultivate the healthy attributes of perfectionism. Indeed, recent meta-analyses examining the effectiveness of perfectionism interventions have found that these can reduce one's scores on different unhealthy perfectionism dimensions, and in symptoms of depression, anxiety, eating disorders and obsessive compulsive disorder (Lloyd et al., 2014; Suh et al., 2019). In comparison, interventions targeting perfectionistic self-presentation are lacking, though preliminary findings have begun to highlight the effectiveness of cognitive-behavioural interventions at reducing such perfectionism and associated depression symptomatology (Crăciun & Holdevici, 2013).

Talking about Mental Health Difficulties

People experiencing mental health difficulties are often faced with the decision whether to share or conceal their distress from others. Indeed, sharing one's experiences of mental health difficulties can be the precursor to accessing social and formal support. However, stigmatised views of mental health are highly prevalent within society and include discourses that deem a person experiencing mental health difficulties as weak, helpless, or even dangerous, views which can have negative consequences for one's functioning and wellbeing (Angermeyer & Dietrich, 2006; Corrigan et al., 2010; Marie & Miles, 2008). Such stigmatised views of mental health difficulties, as well as other personal, social, environmental, and cultural factors can impede one's ability and willingness to share experiences of mental health

difficulties with others (Clement et al., 2015; Ignatius & Kokkonen, 2007; Rüsch et al., 2012).

Empirical study of willingness to talk about mental health difficulties with others has been approached using two key concepts: self-concealment and self-disclosure. Self-concealment refers to the active suppression of negative aspects of oneself that are considered unacceptable or shameful (Larson & Chastain, 1990). Self-disclosure, on the other hand, is considered an active confrontation of distress, involving the verbal or written expression of negative personal information (Kahn & Hessling, 2001). Although some debate exists as to whether these represent two distinct unidimensional concepts, or whether they are the opposing extremes of a bipolar continuum (see Kahn & Hessling, 2001), such research has nonetheless been vital in extending our understanding of the factors that promote or hinder one's ability to talk about personal experiences of mental health difficulties.

To Share or Not to Share?

In addition to enabling access to various forms of social and formal support, talking about (or 'disclosing' as termed in the existing literature) personal experiences of mental health difficulties with others has been found to have several beneficial effects. Research has found that talking about one's mental health difficulties can help build trust and increase one's perceived level of social support, can improve one's physical health and promote the cognitive processing of emotional experiences, thereby alleviating some of the distress experienced (Bos et al., 2009; Corrigan et al., 2013; Ignatius & Kokkonen, 2007; Kahn & Hessling, 2001; Rüsch et al., 2019). In contrast, concealment of one's mental health difficulties can have enduring detrimental effects. This includes increased preoccupation with one's difficulties, thought intrusions, increased avoidance and isolation, as well as

increased feelings of guilt and shame (Pachankis, 2007). It may also result in reduced utilisation of both formal and informal forms of support, which may perpetuate stress and lead to more significant mental health problems, further highlighting the value of talking about one's difficulties.

The introduction of the Equality Act (2010) in the UK was fundamental in increasing mental health provisions in the workplace, and in advocating for appropriate adjustments and support for people experiencing mental health difficulties. Consequently, for people experiencing mental health difficulties, disclosure of these in the workplace can allow for reasonable adjustments to be made, such as reviewing and adjusting workload, altering one's working hours, or permitting absence for treatment. Furthermore, on a societal level, talking about one's mental health difficulties may invite greater conversations about these issues, in turn starting to normalise such experiences and challenging the widespread stigma linked to mental health difficulties, and empowering those experiencing them (Marino et al., 2016).

However, irrespective of campaigns aimed at changing public perceptions and encouraging conversations about mental health difficulties such as *Time to Change* and the *Get Britain Talking* campaign, mental health stigma and longstanding societal discourses such as "stiff upper lip" continue to prevail. It is therefore perhaps unsurprising that many people choose not to disclose mental health difficulties within personal and professional contexts. It is important to consider that the concealment of mental health difficulties may indeed be adaptive, particularly within hostile, unsympathetic environments. Within such a stigmatised backdrop, the sharing of one's mental health difficulties may lead to greater discrimination and rejection by friends, family and co-workers, reduced self-esteem, increased self-

stigma and consequential stigma stress, which can impact upon one's employability and level of life satisfaction and wellbeing (Brohan et al., 2012; Clement et al., 2015; Ilic et al., 2012; Jones, 2011; Markowitz, 1998; Rüsch et al., 2019). In contrast, concealment can protect individuals experiencing mental health difficulties against the negative effects of stigma, may allow them to maintain important work and social roles, and allow them to feel a sense of control over their difficulties, thereby increasing self-efficacy (Bril-Barniv et al., 2017; Brohan et al., 2012; Elliott & Doane, 2015; Venville, 2010). Thus, there appear to be several advantages and disadvantages associated with the disclosure or concealment of one's mental health difficulties.

Barriers and Facilitators to Sharing

To share one's experiences of mental health difficulties with others can involve a complex decision-making process, one that often involves careful consideration of several personal, social and contextual factors, which may serve as facilitators or barriers to sharing. Indeed, examination of the factors associated with the sharing or concealment of one's mental health difficulties within personal and professional contexts has been an area of keen empirical interest (e.g. Brohan et al., 2012; Clement et al., 2015; Grice et al., 2018a; Jones, 2011).

Stigma and discrimination are amongst the most commonly cited barriers to disclosure. Recent reviews have found that the external and internalised stigma associated with experiencing mental health difficulties, the resultant shame, embarrassment, loss of status and identity, and concerns about discriminatory acts such as social alienation and the removal of children from one's care can deter people from sharing their mental health difficulties with others (Brohan et al., 2012; Clement et al., 2015; Grice et al., 2018a; Jones, 2011). Similar concerns are also

cited when examining sharing within professional contexts, with fears of not being hired, of unfair treatment, loss of status and identity, and gossip being identified as reasons for concealing one's difficulties from supervisors and colleagues (Brohan et al., 2012; Dayal et al., 2015). Negative past experiences of disclosure have also been found to deter people from sharing in the future (Jones, 2011). Further, one's cultural heritage may also influence the degree of stigma experienced, with research suggesting that mental health stigma may be greater amongst people form non-western backgrounds, thereby impeding upon disclosure (Abdullah & Brown, 2011; Memon et al., 2016).

Interpersonal and environmental factors also influence whether one shares or conceals mental health difficulties. For instance, one is more likely to talk about mental health difficulties with people in one's personal context, such as partners and close family members, followed by supervisors or line managers, and least likely to share with work colleagues (Bos et al., 2009; Grice et al., 2018a, 2018b; Jones, 2011). Furthermore, greater perceived social, emotional and tangible support, as well as affection and trust in the person to whom one discloses, and their level of understanding and kindness can facilitate sharing and reduce concealment of one's mental health difficulties (Grice et al., 2018a). Such factors have also been found to be relevant within work contexts, with research suggesting that those working in supportive healthcare settings feel most able to talk about their experiences of mental health difficulties with others, whereas those working in technology, business or educational settings feel least able to do so (Jones, 2011). However, even amongst healthcare professionals, mental health stigma is highly prevalent (Digiuni et al., 2013; Tay et al., 2018).

Within more personal domains, demographic factors that have been found to deter one from sharing within the workplace included being female, younger, and being from non-white backgrounds for those working in Western countries (Brohan et al., 2012; Jones, 2011). However, gender and racial differences do not seem to influence one's decision to talk to friends and family about mental health difficulties (Grice et al., 2018a). Features and characteristics of specific mental health difficulties have also been found to influence whether one shares or conceals such difficulties from others. For instance, having recently been symptomatic and requiring inpatient treatment were found to function as barriers to sharing within personal contexts (Clement et al., 2015; Grice et al., 2018a). Further, compared to those with schizophrenia, those with mood disorders, as well as those without psychotic experiences and those not taking antipsychotic medication were more likely to endorse reasons for concealing their difficulties from others (Brohan et al., 2012; Grice et al., 2018a; Jones, 2011). Although this is somewhat surprising given that schizophrenia is more stigmatised than mood disorders (Angermeyer & Dietrich, 2006; Marie & Miles, 2008), that one can more easily conceal and self-manage mood disorders may explain such a finding. Furthermore, personal beliefs about experiencing mental health difficulties have also been found to promote or impede upon disclosure processes. For instance, beliefs such as mental health difficulties being private affairs, and that others would not want to know, accounted for greater concealment of difficulties in the workplace (Brohan et al., 2012). Similarly, amongst friends and family, a review conducted by Grice and colleagues (2018a) found negative views of depression as stigmatising and disabling to be linked to decreased sharing, whereas beliefs such as "people with depression deserve support

from friends and/or family" and "anybody can suffer from depression" facilitated the sharing of one's difficulties.

Perfectionism and Talking about Mental Health Difficulties

Despite the large body of literature delineating the relationship between perfectionism and mental health difficulties, there appears to be limited research examining the likelihood and willingness of individuals with perfectionism to share personal experiences of mental health difficulties with others. Given the highly stigmatised social climate regarding mental health, coupled with beliefs commonly endorsed by people with perfectionism regarding the need to be or to appear perfect before others, it seems conceivable that people with high levels of unhealthy perfectionism or perfectionistic self-presentation may be less willing or likely to talk about mental health difficulties with others. Further, if perfectionism is linked to reduced talking about mental health difficulties, this also raises the question as to whether this has a helpful or harmful effect on one's mental health and wellbeing.

Non-disclosure of Imperfections and Psychological Distress

Insights offered by the concept of perfectionistic self-presentation (Hewitt et al., 2003) highlight that not talking about one's perceived flaws, specifically the non-disclosure of imperfections, plays a central role in the way unhealthy forms of perfectionism manifest interpersonally. This suggests that those with unhealthy perfectionism are motivated to maintain a perfect self-image in front of others, and one way this may be achieved is by concealing or not speaking about those aspects of themselves that they consider to be less than perfect. Thus, non-disclosure of perceived imperfections appears to be an intrinsic process underlying the interpersonal expression of unhealthy forms of perfectionism.

This raises the question as to how such non-disclosure relates to the experience of mental health difficulties. Indeed, whilst developing the concept of perfectionistic self-presentation, and validating the perfectionistic self-presentation scale (PSPS; Hewitt et al., 2003), Hewitt and colleagues investigated how the three facets of perfectionistic self-presentation related to experiences of depression and anxiety in different samples. Across a number of studies, participants completed the FMPS, the HMPS, the PSPS, as well as other measures examining psychological distress, including the Beck Depression Inventory (Beck et al., 1996) and the Social Phobia and Anxiety Inventory (Turner et al., 1989) amongst others. Firstly, in a sample of 136 university students and 632 psychiatric outpatients, higher scores on the trait perfectionism dimensions, specifically self-oriented, other-oriented and socially prescribed perfectionism positively correlated with scores on all three perfectionistic self-presentation facets. Within this, non-disclosure of imperfections was most strongly correlated with socially prescribed perfectionism in both samples. Regression analyses also revealed that non-disclosure of imperfections predicted greater severity of state and social anxiety in 152 university students. It also predicted greater depression symptomatology amongst a clinical sample of 468 participants, and amongst 163 university students after controlling for the FMPS dimensions. From this, it was concluded that the non-disclosure of imperfections facet represented a maladaptive form of impression management. It was also concluded that the relationship between non-disclosure and socially prescribed perfectionism suggests that a desire to avoid social rejection and criticism from others who are perceived to demand perfection from oneself may underlie such non-disclosure. Paradoxically however, despite intending to avoid negative consequences, such non-disclosure seems to contribute to greater psychological distress.

The work of Hewitt and colleagues (2003) has since been extended to examine the manifestation of perfectionistic self-presentation across the lifespan and with different mental health difficulties. Such research has further underscored the negative relationship between non-disclosure of imperfections and mental health difficulties. Indeed, non-disclosure of imperfections appears to be a core way in which perfectionistic self-presentation manifests in children and adolescents (Hewitt et al., 2011). Here too, the non-disclosure of imperfections was associated with greater symptoms of depression and social anxiety, as well as problematic anger suppression.

The detrimental impact of non-disclosure of imperfections has also been demonstrated within the domain of body image and eating-related disorders, which has resulted in the development of the Perfectionistic Self-Presentation Scale-Body Image (PSPS-BI; Ferreira et al., 2018). For instance, Stoeber and colleagues (2017) examined the relationship between perfectionistic self-presentation and eating disorder symptomatology, specifically dieting, oral control, bulimia and food preoccupation. Amongst a sample of 393 female university students, those scoring highly on the three facets of perfectionistic self-presentation showed stricter dieting behaviours. However, those scoring high on non-disclosure of imperfections also exhibited greater oral control, and symptoms of bulimia and food preoccupation, further highlighting the negative influence of non-disclosure of imperfections on one's mental health. Finally, research has also shown that women with anorexia nervosa score significantly higher on non-disclosure of imperfections (as well as on self-oriented and socially prescribed perfectionism) than a healthy control group, or women experiencing major depressive disorder, bipolar disorder or dysthymic disorder (Cockell et al., 2002). Such findings therefore suggest that the drive to

present a perfect self-image and to conceal perceived imperfections from others may be a particularly salient concern for women experiencing body image and eating-related disorders.

Notwithstanding the evidence highlighting the negative influence of non-disclosure of imperfections on one's mental health, it should be noted that research examining the potentially protective function of such non-disclosure is lacking. As aforementioned, concealment may be beneficial and indeed favourable in particular contexts. Thus, further research is needed to determine whether non-disclosure of imperfections is solely detrimental or whether it has a more varied influence upon one's mental health and wellbeing.

Self-Concealment and Disclosure as Mediators

Beyond perfectionistic self-presentation, researchers have sought to understand the role of sharing or concealment in the relationship between unhealthy forms of perfectionism and mental health difficulties. Indeed, results from a number of studies suggest that disclosure and self-concealment may mediate this relationship. For instance, Kawamura and Frost (2004) were interested in examining the relation between perfectionism, self-concealment and the experience of mental health difficulties. In their study, 116 female undergraduate students completed a shortened version of the FMPS (Frost et al., 1990), comprised of the four subscales considered to reflect maladaptive perfectionism, specifically concerns over mistakes, doubts about actions, parental criticism and parental expectation, as well as the personal standards items as a measure of the more adaptive features characterising the pursuit of high standards. They also completed the self-concealment scale (SCS; Larson & Chastain, 1990), a self-report questionnaire that assesses one's tendency to conceal negative personal information from others, and the Hopkins symptom checklist

(Green et al., 1988), a general measure of psychological distress that assesses the extent to which individuals have experienced particular symptoms associated with different mental health difficulties. Here, the personal standards dimension was unrelated to both concealment and psychological distress. However, path analysis revealed that self-concealment fully mediated the relationship between maladaptive perfectionism and psychological distress. Specifically, maladaptive perfectionism was associated with higher levels of self-concealment, which in turn was associated with greater psychological distress. Indeed, self-concealment has also been found to fully mediate the relationship between maladaptive evaluation concerns (Frost et al., 1993) and severity of eating disorder symptomology (DiBartolo et al., 2008).

Other studies examining the relationship between perfectionism, self-concealment and mental health difficulties suggest that self-concealment may be a partial, rather than a full mediator (DiBartolo et al., 2008; Williams & Cropley, 2014). For instance, Williams and Cropley (2014) explored how maladaptive perfectionism and self-concealment related to psychological distress and engagement with preventative health behaviours in undergraduate and postgraduate university students. Here, maladaptive perfectionism, derived using the concerns over mistakes and doubts about actions subscales from the FMPS, was positively correlated with greater self-concealment, which in turn was linked to greater psychological distress. However, this relationship was only partially mediated by self-concealment. Further, although research by DiBartolo and colleagues (2008) found self-concealment to fully mediate the relationship between maladaptive evaluation concerns and eating disorder symptomatology, self-concealment only partially mediated the relationship between maladaptive evaluation concern and depression severity. This finding may be attributable to the more influential role of concealment in the relationship between

unhealthy forms of perfectionism with eating disorders (e.g. DiBartolo et al., 2008; Ferreira et al., 2018), than with mood disorders (Cockell et al., 2002).

Despite the usefulness of the self-concealment scale (Larson & Chastain, 1990) in demonstrating that those with unhealthy forms of perfectionism feel less able to share negative personal information with others, its usefulness is somewhat limited when investigating their communication of personal and mental health difficulties. To elaborate, the self-concealment scale is a 10-item questionnaire that examines the degree to which one hides negative personal information from others, and includes items such as “I’m often afraid I will reveal something I don’t want to” and “when something bad happens to me, I tend to keep it to myself”. Thus, although the SCS is a useful tool for examining possible motivations underlying concealment, as well as the extent to which someone will conceal personal information, it provides little insight into one’s propensity to talk about psychological distress specifically. Indeed, while it may be argued that mental health difficulties fall into the category of personal information that one deems negative or distressing, such experiences are not explicitly explored in the questionnaire.

As such, to more closely examine beliefs and attitudes people with unhealthy perfectionism may hold towards talking about their experiences of psychological distress, a more mood-specific measure of concealment or disclosure is needed. One such measure is the Distress Disclosure Index (DDI; Kahn & Hessling, 2001), a 12-item questionnaire that assesses one’s general tendency to share with (or conceal from) others negative or distressing thoughts and emotions, and includes items such as “when I feel depressed or sad, I tend to keep those feelings to myself” and “I am willing to tell others my distressing thoughts”. Indeed, the utilisation of the DDI in perfectionism research offers insight into the attitudes held by those with unhealthy

perfectionism regarding talking about mental health difficulties. As part of an unpublished doctoral thesis by Garrison (2015), 745 university students completed a number of questionnaires, including the DDI, as well as the discrepancy items from the APS-R (Slaney et al., 2001) as a measure of unhealthy perfectionism, the emotion regulation questionnaire (Gross & John, 2003) to assess individuals' degree of emotional avoidance, and measures of depression such as the depression subscale from the inventory of anxiety and depression symptoms (Watson et al., 2007). Firstly, higher levels of unhealthy perfectionism correlated positively with depression severity. Further analysis revealed that this relationship was also partially mediated by emotional avoidance and emotional disclosure. More specifically, higher levels of unhealthy perfectionism were associated with greater emotional avoidance, which in turn was linked to reduced sharing of distressing thoughts and emotions, and this related to greater severity of depression symptoms. It was therefore concluded that unhealthy perfection motivated individuals to supress and avoid negative emotions and cognitions, perhaps as they deemed them to be unacceptable and/or evidence of imperfection. It was hypothesised that such avoidance may have contributed to a detachment from one's emotional experiences, leading to limited awareness of one's distress and hence reduced disclosure of one's difficulties, thereby worsening depression.

Perfectionism and the Concealment of Mental Health Difficulties

It is evident from the aforementioned studies that the well-documented relationship between perfectionism and mental health difficulties is partly driven by the desire to not share perceived imperfections and negative or distressing personal information with others. Further, research by Richardson and Rice (2015) has highlighted that unhealthy perfectionism (as derived from the discrepancy subscale

of the APS-R; Slaney et al., 2001) moderates the relationship between daily stress and emotional disclosure, whereby following highly stressful events, those scoring high on unhealthy perfectionism are considerably less likely to talk about the distress they experience than are those who scored low on unhealthy perfectionism. What the above studies therefore do well is highlight the reciprocal relationships between unhealthy perfectionism, concealment or avoidance of sharing, and the level of psychological distress, or the severity of mental health difficulties experienced.

Notwithstanding these valuable insights, what these studies do less well is elucidate the beliefs and attitudes held by individuals with perfectionism regarding talking about mental health difficulties they may be experiencing. Indeed, although the DDI claims to evaluate the extent to which one feels able to share personally distressing information with others, the items appear to examine one's ability to discuss problems and do not explicitly pertain to talking about mental health difficulties.

To address this gap in the literature, researchers in recent years have begun to examine whether perfectionism, and particularly unhealthy forms of perfectionism, influence one's likelihood and willingness to share mental health difficulties with others. For instance, researchers have examined the relationship between the three facets of perfectionistic self-presentation and the concealment of psychache, defined as the unbearable psychological pain arising from unmet psychological needs, which is theorised to be linked to suicidal ideation (D'Agata & Holden, 2018). It was found that higher scores on perfectionistic self-promotion were correlated negatively, whereas the non-display and non-disclosure of imperfections correlated positively with concealment of psychache. From this, the researchers concluded that the drive to promote an image of perfection, compared to the avoidance of appearing imperfect

has a differential impact upon the extent to which one conceals psychological distress.

This research has also permitted meaningful consideration of interpersonal and contextual factors that may influence the decision of people with unhealthy forms of perfectionism to share or disclose mental health difficulties. For instance, a study conducted by Grice and colleagues (2018) examined how perfectionism in trainee clinical psychologists ("trainees" hereafter) influenced their propensity to talk about mental health difficulties with others within personal and professional contexts. Trainees completed the FMPS, with adaptive perfectionism being measured using the personal standards subscale, and maladaptive perfectionism using the concern over mistakes, doubt about actions, parental criticism and parental expectation subscales. Trainees were also asked to indicate whether they had lived experience of mental health difficulties. Those with lived experience subsequently rated their likelihood of discussing their experiences of mental health difficulties with a friend, family member, member of their training cohort, member of course staff, placement supervisor or a healthcare professional. Consistent with previous findings, trainees were more likely to discuss their mental health difficulties with a friend or family member, rather than someone within their professional and/or training contexts. Crucially, it was found that as maladaptive perfectionism increased, the likelihood of talking about one's mental health difficulties decreased, and upon further inspection, excluding talking about a specific phobia with a friend, maladaptive perfectionism was negatively linked to disclosure of all mental health difficulties with all recipients. Such research thus demonstrates that unhealthy forms of perfectionism can serve as barriers to talking about experiences of mental health difficulties with others, particularly within the training context.

Similar findings were observed in trainee counsellors with lived experience of eating disorders (Dayal et al., 2015). Through a series of semi-structured interviews, it was ascertained that trainee counsellors with lived experience of eating disorders kept such difficulties concealed from others in their work and training context, in an attempt to maintain an image of oneself as perfect and in control. Such concealment functioned to protect oneself from feelings of shame, and social and professional rejection, and was particularly maintained with course staff and supervisors. This was partly attributed to the evaluative nature of these relationships and a desire to be seen as perfect, as well as the perceived lack of utility of sharing this information, as trainee counsellors believed that course staff and supervisors would be unable to do anything even if they did talk openly about their experiences.

Summary

Taken together, the above studies have underscored the transdiagnostic nature of both perfectionism and perfectionistic self-presentation, and have evidenced the varied interrelations between perfectionism, the experience of mental health difficulties and one's perceived likelihood and willingness to share personal information with others. Research examining the way in which perfectionism manifests interpersonally, namely perfectionistic self-presentation, has demonstrated that the drive to conceal one's perceived imperfections is inherent in the interpersonal expression of perfectionism, and is a core strategy employed by both young people and adults who are motivated to present a perfect self-image (Hewitt et al., 2003, 2011). Several unhealthy intrapersonal forms of perfectionism have also been linked to greater concealment of negative personal information, as well as to reduced sharing of personal distress, in turn being associated with the experience of mental health difficulties (DiBartolo et al., 2008; Garrison, 2015; Kawamura &

Frost, 2004; Richardson & Rice, 2015; Williams & Cropley, 2014). Other evidence suggests that unhealthy perfectionism, and non-display and non-disclosure of imperfections may be linked to the concealment or reduced disclosure about one's experiences of mental health difficulties with others in one's personal and professional circles (D'Agata & Holden, 2018; Dayal et al., 2015; Grice et al., 2018b). Crucially, the intention of such concealment and reduced talking about one's perceived imperfections and mental health difficulties is to maintain a perfect self-image in front of others and to appear in control and competent. Although research on the potential benefits experienced by individuals with perfectionism of not disclosing or concealing mental health difficulties from others is lacking, such processes appear to have a predominantly detrimental effect on their mental wellbeing and appear to be linked to greater psychological distress.

Limitations

The ability to draw meaningful inferences from empirical research rests upon the robustness of the methodology employed. The research presented herein has been fundamental in extending our understanding of the relationship between perfectionism and the experience of mental health difficulties, and the influence of sharing or concealment within this relationship. However, due to the correlational designs utilised in the aforementioned studies, one is unable to deduce whether perfectionism plays a causal role. Specifically, it cannot be concluded that perfectionism causes one to be less willing to share negative personal information or experiences of mental distress with others, and whether this leads to a deterioration in one's mental health and wellbeing. Indeed, given the widespread stigma associated with mental health difficulties, causality may operate in the inverse; it could be

argued that the experience of mental health difficulties may result in increased concealment of one's perceived imperfections, distressing or negative personal information, as well as one's mental health difficulties in an attempt to maintain a public image of oneself as perfect. Therefore, although it is beyond the scope of the present research, longitudinal research is essential in order to ascertain whether reducing unhealthy perfectionistic tendencies can increase one's propensity to talk about one's mental health difficulties or negative personal information, and whether this can improve one's mental health.

Beyond the design of the studies, there are some drawbacks to the way in which the sharing and concealment of personal information has been measured. With the exception of the research conducted by Grice and colleagues (2018b) and Kawamura and Frost (2004), the remaining studies administered measures that capture one's general tendency towards sharing or concealing personal information from others. Considering the SCS, DDI and the non-disclosure of imperfections subscale of the PSPS, these measures assess the extent to which one conceals negative personal information, personal problems or distress, and one's perceived imperfections from others respectively, across different situations and contexts. In doing so, they overlook, and therefore are unable to account for the unique, context-specific factors that may influence the decision to share or to conceal personal information. Indeed, in the study by Grice and colleagues (2018b), through administration of a disclosure measure tailored to incorporate different key figures in the personal and professional life of participants, the authors were able to draw more precise conclusions about how the specific mental health difficulty, as well as the relationship with the person with whom one might talk about one's mental health difficulties influenced the decision-making process. Similarly, by administering the

College Issues Questionnaire, a measure that explores a range of difficulties commonly reported by university students, Kawamura and Frost (2004) gained more detailed insight into which difficulties students most commonly discussed with one's friends, family and therapist, which revealed that maladaptive perfectionism was linked to reduced willingness to discuss college-related issues with friends and family. As such, measures such as the SCS, DDI and the non-disclosure of imperfections subscale of the PSPS are useful for providing a general overview of one's tendency to share or conceal negative or distressing personal information and imperfections from others. However, more tailored and specific measures are required if one is to better understand and account for the role of other factors in the decision to share or conceal personal information and mental health difficulties from others.

Research Aims and Questions

The present review sought to examine what is currently known about the interrelations between perfectionism, the sharing or concealment of personal information and the experience of mental health difficulties. The varied ways in which these concepts interact have been discussed, which has underscored the link between perfectionism, particularly unhealthy forms of perfectionism, greater concealment (or reduced disclosure), and increased severity of mental health difficulties. Nonetheless, a number of questions remain unanswered. Firstly, despite a large body of literature linking perfectionistic self-presentation and non-disclosure of imperfections with mental health difficulties, few studies to date have examined how perfectionistic self-presentation and non-disclosure may relate to one's ability to discuss one's mental health difficulties with others (but see D'Agata & Holden,

2018). Indeed, a negative association would have important implications for access to timely and appropriate support. Further, although findings from the above studies appear to suggest that interventions targeting perfectionism may be particularly effective at alleviating psychological distress if they target the drive to conceal negative or distressing personal information from others, such interventions are yet to be trialled.

To address some of the limitations and gaps in the literature, and in light of evidence highlighting the effectiveness of CBT treating perfectionism (Suh et al., 2019), the following study aimed to examine whether a brief CBT-based perfectionism workshop could reduce levels of unhealthy perfectionism, and in turn alter one's likelihood of, and comfort with talking about personal difficulties and mental health problems. The study also sought to explore how the recipient, experience of difficulties, and perfectionism influenced trainees' likelihood of and comfort with talking about difficulties.

This research was conducted with a group that has previously been shown to display high levels of perfectionism, specifically trainee clinical psychologists, as measured using the FMPS (Grice et al., 2018b). Of the six dimensions of the FMPS, concern over mistakes has been demonstrated to be the core dimension of perfectionism, one that is closely linked to the experience of psychological distress (e.g. Frost et al., 1990; Limburg et al., 2017; Sassaroli et al., 2008). Further, as the disclosure of mental health difficulties involves a social exchange, the interpersonal components of perfectionism (i.e. perfectionistic self-presentation) were deemed particularly relevant in the present study, as it was believed that a greater need to appear perfect in front of others would deter trainees from talking about difficulties with others. As such, trainees' level of concern over mistakes and perfectionistic

self-presentation were assessed in the empirical study, and these elements were addressed in the workshop.

As part of the study, trainees attended a half-day CBT-based perfectionism workshop. Prior to the workshop, their level of concern over mistakes and perfectionistic self-presentation were assessed using self-report measures, specifically the PSPS (Hewitt et al., 2003) and the concern over mistakes subscale from the FMPS (Frost et al., 1990), and they completed the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007), a general measure of wellbeing. Trainees were also asked to indicate whether they were currently experiencing a distressing difficulty in their personal life, and whether they had past or current lived experience of mental health difficulties. They were then asked to indicate their likelihood of, and comfort with talking about actual or hypothetical experiences of these difficulties with three recipients: their placement supervisor, a member of course staff, or a fellow trainee. Following delivery of the workshop, trainees' levels of perfectionism, wellbeing, and their comfort with and likelihood of talking about personal and mental health difficulties was reassessed, and repeated 11 weeks later.

It was hypothesised that over time, the workshop would bring about a reduction in trainees' level of unhealthy perfectionism, specifically concern over mistakes, and perfectionistic self-presentation. It was also predicted that this decrease in unhealthy perfectionism and perfectionistic self-presentation would result in improved wellbeing, as well as increased comfort with, and likelihood of talking about one's personal and mental health difficulties with others. It was hypothesised that the changes in trainees' level of perfectionism and in their likelihood of and comfort with disclosure would be maintained at follow-up.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948. https://doi.org/10.1016/j.cpr.2011.05.003

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163–179. https://doi.org/10.1111/j.1600-0447.2005.00699.x

Ashby, J. S., & Kottman, T. (1996). *Inferiority as a Distinction between Normal and Neurotic Perfectionism*. *52*(3), 237–246. http://repository.upi.edu/1360/1/s_d5451_0604180_chapter1.pdf

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck depression inventory-II*. San Antonio, TX: Psychological Corporation.

Bos, A. E. R., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing*, *30*(8), 509–513. https://doi.org/10.1080/01612840802601382

Bril-Barniv, S., Moran, G. S., Naaman, A., Roe, D., & Karnieli-Miller, O. (2017). A Qualitative Study Examining Experiences and Dilemmas in Concealment and Disclosure of People Living with Serious Mental Illness. *Qualitative Health Research*, *27*(4), 573–583. https://doi.org/10.1177/1049732316673581

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., Slade, M., & Thornicroft, G. (2012). Systematic review of beliefs, behaviours

and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry*, *12*(1), 11. https://doi.org/10.1186/1471-244X-12-11

Chan, D. W. (2012). Life Satisfaction, Happiness, and the Growth Mindset of Healthy and Unhealthy Perfectionists Among Hong Kong Chinese Gifted Students. *Roeper Review*, *34*(4), 224–233. https://doi.org/10.1080/02783193.2012.715333

Chang, H. T., Chou, Y. J., Liou, J. W., & Tu, Y. T. (2016). The effects of perfectionism on innovative behavior and job burnout: Team workplace friendship as a moderator. *Personality and Individual Differences*, *96*, 260–265. https://doi.org/10.1016/j.paid.2016.02.088

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Cockell, S. J., Hewitt, P. L., Seal, B., Sherry, S., Goldner, E. M., Flett, G. L., & Remick, R. A. (2002). Trait and self-presentational dimensions of perfectionism among women with anorexia nervosa. *Cognitive Therapy and Research*, *26*(6), 745–758. https://doi.org/10.1023/A:1021237416366

Corrigan, P., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S., Batia, K., & Rusch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology*, *38*(5), 607–621. https://doi.org/10.1002/jcop

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, *103*(5), 794–800. https://doi.org/10.2105/AJPH.2012.301037

Crăciun, B., & Holdevici, I. (2013). Cognitive-behavioural Intervention in Diminishing Perfectionistic Self-presentation and Depression. *Procedia - Social and Behavioral Sciences*, *78*, 476–480. https://doi.org/10.1016/j.sbspro.2013.04.334

D'Agata, M. T., & Holden, R. R. (2018). Self-concealment and perfectionistic self-presentation in concealment of psychache and suicide ideation. *Personality and Individual Differences*, *125*, 56–61. https://doi.org/10.1016/j.paid.2017.12.034

Damian, L. E., Stoeber, J., Negru-Subtirica, O., & Băban, A. (2017). Perfectionism and school engagement: A three-wave longitudinal study. *Personality and Individual Differences*, *105*, 179–184. https://doi.org/10.1016/j.paid.2016.09.044

Dayal, H., Weaver, K., & Domene, J. F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research*, *25*(2), 153–167. https://doi.org/10.1177/1049732314551988

DiBartolo, P. M., Li, C. Y., & Frost, R. O. (2008). How do the dimensions of perfectionism relate to mental health? *Cognitive Therapy and Research*, *32*(3), 401–417. https://doi.org/10.1007/s10608-007-9157-7

Digiuni, M., Jones, F. W., & Camic, P. M. (2013). Perceived social stigma and attitudes towards seeking therapy in training: A cross-national study. *Psychotherapy*, *50*(2), 213–223. https://doi.org/10.1037/a0028784

Egan, S. J., van Noort, E., Chee, A., Kane, R. T., Hoiles, K. J., Shafran, R., & Wade, T. D. (2014). A randomised controlled trial of face to face versus pure online self-help cognitive behavioural treatment for perfectionism. *Behaviour Research and Therapy*, *63*, 107–113. https://doi.org/10.1016/j.brat.2014.09.009

Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. *Clinical Psychology Review*, *31*(2), 203–212. https://doi.org/10.1016/j.cpr.2010.04.009

Egan, S. J., Wade, T. D., Shafran, R., & Antony, M. M. (2016). *Cognitive-behavioural treatment of perfectionism.* Guildford Publications.

Elliott, M., & Doane, M. J. (2015). Stigma Management of Mental Illness: Effects of Concealment, Discrimination, and Identification on Well-Being. *Self and Identity*, *14*(6), 654–674. https://doi.org/10.1080/15298868.2015.1053518

Ferreira, C., Duarte, C., Pinto-Gouveia, J., & Lopes, C. (2018). The Need to Present a Perfect Body Image: Development of a New Measure of Perfectionistic Self-Presentation. *Current Psychology*, *37*(3), 559–567. https://doi.org/10.1007/s12144-016-9537-9

Frost, R. O., Heimberg, R. G., Holt, C. S., Mattia, J. I., & Neubauer, A. L. (1993). A comparison of two measures of perfectionism. *Personality and Individual Differences*, *14*(1), 119–126. https://doi.org/10.1016/0191-8869(93)90181-2

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research*, *14*(5), 449–468. http://link.springer.com/article/10.1007/BF01172967

Frost, R. O., & Steketee, G. (1997). Perfectionism in obsessive-compulsive disorder

patients. *Behaviour Research and Therapy*, *35*(4), 291–296. https://doi.org/10.1016/S0005-7967(96)00108-8

Garrison, A. M. (2014). *Testing a model of maladaptive perfectionism and depression symptoms: The roles of emotional disclosure, emotion regulation strategies, adult attachment, and shame* [Unpublished doctoral dissertation]. Western Michigan University.

Green, D. E., Walkey, F. H., McCormick, I. A., & Taylor, A. J. W. (1988). Development And Evaluation Of A 21-Item Version Of The Hopkins Symptom Checklist With New Zealand And United States Respondents. *Australian Journal of Psychology*, *40*(1), 61–70. https://doi.org/10.1080/00049538808259070

Grice, T., Alcock, K., & Scior, K. (2018a). Factors Associated With Mental Health Disclosure Outside of the Workplace: A Systematic Literature Review. *Stigma and Health*, *3*(2), 116–130. https://doi.org/10.1037/sah0000079

Grice, T., Alcock, K., & Scior, K. (2018b). Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical Psychology and Psychotherapy*, *25*(5), 721–729. https://doi.org/10.1002/cpp.2192

Gross, J. J., & John, O. P. (2003). Individual Differences in Two Emotion Regulation Processes: Implications for Affect, Relationships, and Well-Being. *Journal of Personality and Social Psychology*, *85*(2), 348–362. https://doi.org/10.1037/0022-3514.85.2.348

Grzegorek, J. L., Slaney, R. B., Franze, S., & Rice, K. G. (2004). Self-Criticism, Dependency, Self-Esteem, and Grade Point Average Satisfaction among Clusters of Perfectionists and Nonperfectionists. *Journal of Counseling*

Psychology, *51*(2), 192–200. https://doi.org/10.1037/0022-0167.51.2.192

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the Self and Social Contexts. *Journal of Personality and Social Psychology*, *60*(3), 60:456-470. https://doi.org/10.1037/0022-3514.60.3.456

Hewitt, Paul L., Blasberg, J. S., Flett, G. L., Besser, A., Sherry, S. B., Caelian, C., Papsdorf, M., Cassels, T. G., & Birch, S. (2011). Perfectionistic Self-Presentation in Children and Adolescents: Development and Validation of the Perfectionistic Self-Presentation Scale-Junior Form. *Psychological Assessment*, *23*(1), 125–142. https://doi.org/10.1037/a0021147

Hewitt, Paul L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., McMurtry, B., Ediger, E., Fairlie, P., & Stein, M. B. (2003). The Interpersonal Expression of Perfection: Perfectionistic Self-presentation and Psychological Distress. *Journal of Personality and Social Psychology*, *84*(6), 1303–1325. https://doi.org/10.1037/0022-3514.84.6.1303

Ignatius, E., & Kokkonen, M. (2007). Factors contributing to verbal self-disclosure. *Nordic Psychology*, *59*(4), 362–391. https://doi.org/10.1027/1901-2276.59.4.362

Ilic, M., Reinecke, J., Bohner, G., Hans-Onno, R., Beblo, T., Driessen, M., Frommberger, U., & Corrigan, P. W. (2012). Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. *International Journal of Social Psychiatry*, *58*(3), 246–257. https://doi.org/10.1177/0020764010392058

Jones, A. M. (2011). Disclosure of mental illness in the workplace: A literature review. *American Journal of Psychiatric Rehabilitation*, *14*(3), 212–229.

https://doi.org/10.1080/15487768.2011.598101

Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology*, *20*(1), 41–65. https://doi.org/10.1521/jscp.20.1.41.22254

Kawamura, K. Y., & Frost, R. O. (2004). Self-concealment as a mediator in the relationship between perfectionism and psychological distress. *Cognitive Therapy and Research*, *28*(2), 183–191. https://doi.org/10.1023/B:COTR.0000021539.48926.c1

Larson, D. C., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement and health implications. *Journal of Social and Clinical Psychology*, *9*(4), 439–455. https://doi.org/10.1521/jscp.1990.9.4.439

LaSota, M. T., Ross, E. H., & Kearney, C. A. (2017). A Cognitive-Behavioral-Based Workshop Intervention for Maladaptive Perfectionism. *Journal of Rational - Emotive and Cognitive - Behavior Therapy*, *35*(3), 314–328. https://doi.org/10.1007/s10942-017-0261-7

Limburg, K., Watson, H. J., Hagger, M. S., & Egan, S. J. (2017). The Relationship Between Perfectionism and Psychopathology: A Meta-Analysis. *Journal of Clinical Psychology*, *73*(10), 1301–1326. https://doi.org/10.1002/jclp.22435

Lloyd, S., Schmidt, U., Khondoker, M., & Tchanturia, K. (2014). Can Psychological Interventions Reduce Perfectionism? A Systematic Review and Meta-analysis. *Behavioural and Cognitive Psychotherapy*, *29*(4). https://doi.org/10.1017/S1352465814000162

Mackinnon, S. P., Battista, S. R., Sherry, S. B., & Stewart, S. H. (2014).

Perfectionistic self-presentation predicts social anxiety using daily diary methods. *Personality and Individual Differences*, *56*(1), 143–148. https://doi.org/10.1016/j.paid.2013.08.038

Marie, D., & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian and New Zealand Journal of Psychiatry*, *42*(2), 126–133. https://doi.org/10.1080/00048670701787545

Marino, C., Child, B., & Krasinski, V. C. (2016). Sharing Experience Learned Firsthand (SELF): Self-disclosure of lived experience in mental health services and supports. *Psychiatric Rehabilitation Journal*, *39*(2), 154–160. https://doi.org/10.1037/prj0000171

Markowitz, F. E. (1998). The Effects of Stigma on the Psychological Well-Being and Life Satisfaction of Persons with Mental Illness. *Journal of Heath and Social Behaviour*, *39*(4), 335–347. https://doi.org/10.2307/2676342

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open*, *6*(11), 1–9. https://doi.org/10.1136/bmjopen-2016-012337

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, *133*(2), 328–345. https://doi.org/10.1037/0033-2909.133.2.328

Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in Clinical Psychology Trainees: Current Research Status and Future Directions. *Australian Psychologist*, *47*(3), 147–155. https://doi.org/10.1111/j.1742-

9544.2012.00070.x

Rhéaume, J., Freeston, M. H., Ladouceur, R., Bouchard, C., Gallant, L., Talbot, F., & Vallières, A. (2000). Functional and dysfunctional perfectionists: Are they different on compulsive-like behaviors? *Behaviour Research and Therapy*, *38*(2), 119–128. https://doi.org/10.1016/S0005-7967(98)00203-4

Rice, K. G., Ashby, J. S., & Slaney, R. B. (1998). Self-Esteem as a Mediator between Perfectionism and Depression: A Structural Equations Analysis. *Journal of Counseling Psychology*, *45*(3), 304–314. https://doi.org/10.1037/0022-0167.45.3.304

Rice, K. G., Neimeyer, G. J., & Taylor, J. M. (2011). Efficacy of Coherence Therapy in the Treatment of Procrastination and Perfectionism. *Counseling Outcome Research and Evaluation*, *2*(2), 126–136. https://doi.org/10.1177/2150137811417975

Rice, K. G., & Slaney, R. B. (2002). Clusters of perfectionists: Two studies of emotional adjustment and academic achievement. *Measurement and Evaluation in Counseling and Development*, *35*(1), 35–48. https://doi.org/10.1080/07481756.2002.12069046

Richardson, C. M. E., & Rice, K. G. (2015). Self-critical perfectionism, daily stress, and disclosure of daily emotional events. *Journal of Counseling Psychology*, *62*(4), 694–702. https://doi.org/10.1037/cou0000100

Ronningstam, E. (2010). Narcissistic personality disorder: A current review. *Current Psychiatry Reports*, *12*(1), 68–75. https://doi.org/10.1007/s11920-009-0084-z

Rüsch, N., Evans-Lacko, S., & Thornicroft, G. (2012). What is a mental illness?

Public views and their effects on attitudes and disclosure. *Australian and New Zealand Journal of Psychiatry*, *46*(7), 641–650. https://doi.org/10.1177/0004867412438873

Rüsch, N., Malzer, A., Oexle, N., Waldmann, T., Staiger, T., Bahemann, A., Wigand, M. E., Becker, T., & Corrigan, P. W. (2019). Disclosure and quality of life among unemployed individuals with mental health problems: A longitudinal study. *Journal of Nervous and Mental Disease*, *207*(3), 137–139. https://doi.org/10.1097/NMD.0000000000000914

Sassaroli, S., Romero Lauro, L. J., Maria Ruggiero, G., Mauri, M. C., Vinai, P., & Frost, R. O. (2008). Perfectionism in depression, obsessive-compulsive disorder and eating disorders. *Behaviour Research and Therapy*, *46*(6), 757–765. https://doi.org/10.1016/j.brat.2008.02.007

Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, *40*(7), 773–791. https://doi.org/10.1016/S0005-7967(01)00059-6

Sherry, S. B., Hewitt, P. L., Flett, G. L., Lee-Baggley, D. L., & Hall, P. A. (2007). Trait perfectionism and perfectionistic self-presentation in personality pathology. *Personality and Individual Differences*, *42*(3), 477–490. https://doi.org/10.1016/j.paid.2006.07.026

Slaney, R. B., Rice, K. G., Mobley, M., Trippi, J., & Ashby, J. S. (2001). The revised almost perfect scale. *Measurement and Evaluation in Counseling and Development*, *34*(3), 130–145. https://doi.org/10.1080/07481756.2002.12069030

Steele, A. L., Waite, S., Egan, S. J., Finnigan, J., Handley, A., & Wade, T. D. (2013).

Psycho-education and group cognitive-behavioural therapy for clinical perfectionism: A case-series evaluation. *Behavioural and Cognitive Psychotherapy*, *41*(2), 129–143. https://doi.org/10.1017/S1352465812000628

Stoeber, J., Madigan, D. J., Damian, L. E., Esposito, R. M., & Lombardo, C. (2017). Perfectionism and eating disorder symptoms in female university students: the central role of perfectionistic self-presentation. *Eating and Weight Disorders*, *22*(4), 641–648. https://doi.org/10.1007/s40519-016-0297-1

Stoeber, J., & Otto, K. (2006). Positive Conceptions of Perfectionism: Approaches, Evidence, Challenges. *Personality and Social Psychology Review*, *10*(4), 295–319. https://journals.sagepub.com/doi/pdf/10.1207/s15327957pspr1004_2%0Ahttps://journals.sagepub.com/doi/pdf/10.1207/s15327957pspr1004_2?casa_token=Nlx6sL4sHisAAAAA%3AX6SdA8-gudUuvkOz6KajYkEzC1fA84pdMqRu_wP-L5njq5Em6hzPTbunRlgDLnBu8N27Y3-WJJV1

Stoeber, J., & Stoeber, F. S. (2009). Domains of perfectionism: Prevalence and relationships with perfectionism, gender, age, and satisfaction with life. *Personality and Individual Differences*, *46*(4), 530–535. https://doi.org/10.1016/j.paid.2008.12.006

Stumpf, H., & Parker, W. D. (2000). A hierarchical structural analysis of perfectionism and its relation to other personality characteristics. *Personality and Individual Differences*, *28*(5), 837–852. https://doi.org/10.1016/S0191-8869(99)00141-5

Suh, H., Sohn, H., Kim, T., & Lee, D. G. (2019). A review and meta-analysis of perfectionism interventions: Comparing face-to-face with online modalities.

Journal of Counseling Psychology, *66*(4), 473–486. https://doi.org/10.1037/cou0000355

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology*, *74*(9), 1545–1555. https://doi.org/10.1002/jclp.22614

Turner, S. M., Beidel, D. C., Dancu, C. V., & Stanley, M. A. (1989). An Empirically Derived Inventory to Measure Social Fears and Anxiety: The Social Phobia and Anxiety Inventory. *Psychological Assessment*, *1*(1), 35–40. https://doi.org/10.1037/1040-3590.1.1.35

Venville, A. (2010). Risky business: Mental illness, disclosure and the TAFE student. *International Journal of Training Research*, *8*(2), 128–140. https://doi.org/10.5172/ijtr.8.2.128

Watson, D., O'Hara, M. W., Simms, L. J., Kotov, R., Chmielewski, M., McDade-Montez, E. A., Gamez, W., & Stuart, S. (2007). Development and Validation of the Inventory of Depression and Anxiety Symptoms (IDAS). *Psychological Assessment*, *19*(3), 253–268. https://doi.org/10.1037/1040-3590.19.3.253

Williams, C. J., & Cropley, M. (2014). The relationship between perfectionism and engagement in preventive health behaviours: The mediating role of self-concealment. *Journal of Health Psychology*, *19*(10), 1211–1221. https://doi.org/10.1177/1359105313488971

Wimberley, T. E., Mintz, L. B., & Suh, H. (2016). Perfectionism and Mindfulness: Effectiveness of a Bibliotherapy Intervention. *Mindfulness*, *7*(2), 433–444. https://doi.org/10.1007/s12671-015-0460-1

Part 2: Empirical Paper

Maladaptive Perfectionism, Perfectionistic Self-Presentation and the Disclosure of Difficulties amongst Trainee Clinical Psychologists: A Cognitive-Behavioural Intervention

Abstract

Aims. Clinical psychology training is demanding, and the multiple competing demands can negatively affect trainees' wellbeing. This study explored trainees' levels of wellbeing, maladaptive perfectionism and perfectionistic self-presentation, and explored the relationship between perfectionism and wellbeing. It evaluated the effectiveness of a brief CBT-based perfectionism workshop in reducing unhealthy perfectionism and perfectionistic self-presentation, and altering trainees' likelihood of, and comfort with, disclosing mental health problems and personal difficulties to others. It also examined whether these changes persisted over time.

Methods. The workshop was delivered at four UK clinical psychology doctoral programmes. At the start of the workshop, 117 trainees completed an online survey examining wellbeing, maladaptive perfectionism, perfectionistic self-presentation, and their likelihood of, and comfort with talking about mental health problems and personal difficulties with three recipients: placement supervisor, a member of course staff and a fellow trainee. The survey was repeated immediately after the workshop, and at 11-weeks follow-up (n = 35).

Results. Wellbeing deteriorated over time and was negatively correlated with maladaptive perfectionism and perfectionistic self-presentation. The workshop reduced maladaptive perfectionism and perfectionistic self-presentation and, excluding comfort with disclosing mental health problems to course staff, increased trainees' likelihood and comfort with disclosing mental health problems to all recipients. Conversely, the intervention had no effect on disclosure of personal difficulties. At follow-up, only changes in perfectionism were maintained.

Conclusions. The results demonstrate the effectiveness of the workshop at reducing perfectionism and breaking down barriers to disclosure in the training environment. Future research should therefore seek to evaluate the effectiveness of this workshop with larger and more diverse trainee cohorts.

Introduction

Mental health problems appear to be common amongst mental health professionals. In a national survey, almost 63% of the 678 UK clinical psychologists surveyed reported having experienced at least one mental health problem at some point in their life (Tay et al., 2018). Elevated levels of mental health problems have also been observed in some individuals undertaking clinical training. In a survey of UK-based trainees, 67% of 348 trainees reported lived experience of mental health difficulties, of whom 29% were experiencing at least one mental health problem at the time of completion (Grice et al., 2018b). While surveys such as these are likely to over-estimate the prevalence of mental health problems among clinical psychologists due to self-selection bias, greater levels of depression, anxiety and self-esteem issues were also noted amongst trainee clinical psychologists (hereafter 'trainees') relative to the general population by Brooks et al. (2002) and McManus et al. (2016).

The Impact of Clinical Training

Clinical training itself can be stressful, and the multiple competing demands placed upon trainees may exacerbate existing mental health problems, as well as reduce trainees' wellbeing. In a survey of 287 trainees in the UK, 75% reported feeling moderately or very stressed as a result of training, and 59% met caseness for a mental health problem (Cushway, 1992). Commonly cited sources of stress include academic deadlines, high clinical and academic workloads, frequent placement changes, professional self-doubt and switching between attending lectures, delivering therapy and conducting research (Cushway, 1992; El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012). Moreover, evidence from the USA suggests that trainees from ethnic minority backgrounds face additional stressors in the form of academic barriers and lower rates of satisfaction with clinical training than their

European-American colleagues (Maton et al., 2011). Time constraints and demands of training can also give rise to difficulties in one's personal life, such as poor work-life balance, financial strain, relationship difficulties and health problems which may further compound stress and mental health problems experienced (El-Ghoroury et al., 2012). In a survey of 387 trainees in the USA, over 70% felt that training-related stressors adversely affected their level of functioning (El-Ghoroury et al., 2012). Such impaired functioning may result in a decline in the quality of care provided to clients, may diminish one's ability to adapt and meet the requirements of training, and may increase the risk of burnout (Brooks et al., 2002; Huprich & Rudd, 2004; Kaeding et al., 2017). Indeed, such difficulties also invariably impact upon the training experience.

Despite working in the field, mental health professionals often feel unable to talk about and seek help for any psychological distress they may be experiencing. Amongst clinical psychologists, research on factors that influence attitudes towards talking about mental health problems within the work context points to stigma, shame and embarrassment as key motivators for concealment (Tay et al., 2018). Other potential barriers to disclosure identified by trainees include the fear that talking about difficulties will have a negative impact on one's self-image and career progression, and fear of being viewed as less competent by course staff and supervisors (Dayal et al., 2015; Digiuni et al., 2013).

Perfectionism as a Barrier

Novel insights into factors affecting attitudes towards talking about mental health problems come from the field of perfectionism. Perfectionism is a transdiagnostic, multi-dimensional construct, associated with both positive and negative outcomes. Positive forms of perfectionism are considered protective and

believed to underlie the healthy pursuit of one's goals. This is contrasted with a more negative form of perfectionism, believed to have a more detrimental impact on one's functioning and wellbeing. Over the years, this distinction has been conceptualised in different ways, including maladaptive and adaptive perfectionism (Rice et al., 1998) and perfectionistic concern and perfectionistic striving (Stoeber & Otto, 2006). Hewitt and colleagues (2003) posited the concept of perfectionistic self-presentation, characterised by the pursuit to appear perfect before others, which consists of three core facets: perfectionistic self-promotion, non-display of imperfections, and non-disclosure of imperfections. Indeed, the relationship between maladaptive forms of perfectionism, as well as perfectionistic self-presentation (collectively 'unhealthy perfectionism' hereafter) and psychological distress has been well-documented (e.g. Hewitt et al., 2003; Limburg et al., 2017; Shafran & Mansell, 2001; see Part 1 for a review).

Such forms of perfectionism have been found to impede upon one's ability to talk about mental health difficulties. Indeed, higher levels of perfectionistic self-presentation have been linked to greater self-stigma and reduced likelihood of help-seeking for mental health problems amongst university students (Shannon et al., 2018). Amongst trainee clinical psychologists, higher maladaptive perfectionism more broadly has been linked with reduced likelihood of disclosing mental health problems, particularly to a member of the course staff or one's placement supervisor (Grice et al., 2018b). Further, unhealthy forms of perfectionism may also impact trainees' personal and professional functioning, with research finding other-oriented perfectionism, socially prescribed perfectionism and perfectionistic self-presentation to be associated with poorer academic performance in graduate students (Cowie et

al., 2018), and maladaptive perfectionism with reduced clinical efficacy in therapists (Presley et al., 2017).

Promoting Wellbeing

Professional and statutory bodies in the UK have acknowledged the demanding nature of clinical training and have made recommendations to training providers for increased prioritisation of trainee wellbeing, and for the provision of support structures that promote talking about difficulties with others within the training context. This includes the British Psychological Society's Charter for Psychological Staff Wellbeing and Resilience (Rao et al., 2016) which calls for the development of compassionate workplaces that promote the wellbeing of the workforce. Furthermore, a report by Health Education England (HEE; 2019) focused on 'learners' across the healthcare professions outlines several recommendations for training providers, including training for course staff and supervisors to support trainees through the disclosure process, and incorporating training in self-awareness and self-care as part of the training curriculum. Researchers have also advocated for self-care training to be embedded within training programmes, to enhance trainees' resilience and ability to cope with the demands of training (e.g. Myers et al., 2012; Pakenham & Stafford-Brown, 2012). A number of self-care practices, including regular exercise, mindfulness, and training in acceptance and commitment therapy have been found to effectively alleviate distress in trainees (Colman et al., 2016; Pakenham, 2017).

However, self-care training is not an essential part of UK training curricula, and is often made solely the responsibility of individual trainees, who may inaccurately assess their level of psychological need. Researchers have examined ways in which self-care training can be embedded within the training programme,

though this has involved attending multiple training sessions over a number of weeks, which may not be feasible as part of a busy training curriculum or in one's personal time (Boellinghaus et al., 2013; Pakenham, 2017). Further, despite reducing distress, it remains unclear whether increased engagement in such self-care practices can subsequently empower trainees to raise difficulties with course staff and supervisors should they be experienced. Finally, the role of unhealthy perfectionism on trainee wellbeing and functioning, and on trainees' attitudes towards talking about difficulties with others in their training context remains unclear.

Rationale for the Study

Researchers and professional bodies are calling for more to be done by training providers to safeguard trainee wellbeing and address potential barriers to disclosure and help seeking. One way in which this may be achieved is through formalised self-care training as part of the training curriculum. Given the potentially detrimental impact of unhealthy perfectionism on trainees' psychological wellbeing, professional functioning and willingness to talk about difficulties with others in the training context, the question is raised as to whether reducing unhealthy perfectionism can improve wellbeing and empower trainees to talk about difficulties and access support. The effectiveness of brief cognitive-behavioural therapy (CBT) workshops at reducing maladaptive perfectionism in university students has been demonstrated by LaSota and colleagues (2017). However, to date there is a dearth of evidence for effective, brief interventions for trainees who may be negatively affected by perfectionism.

The principal aim of this study was to evaluate the effectiveness of a brief, CBT-based perfectionism workshop at reducing trainees' levels of unhealthy perfectionism, specifically concern over mistakes and perfectionistic self-

presentation, and in turn, altering their likelihood of and comfort with disclosing mental health problems and personal difficulties to others in their training context. Further, this study also sought to explore trainees' psychological wellbeing, the prevalence of maladaptive perfectionism and perfectionistic self-presentation, and how changes in perfectionism following the workshop corresponded to changes in wellbeing. Finally, the study examined the factors that determined trainees' likelihood of and comfort with talking about mental health problems and personal difficulties. It was hypothesised that:

1) There would be a reduction in maladaptive perfectionism, perfectionistic self-promotion, non-display of imperfections and non-disclosure of imperfections immediately following the workshop.
2) Trainees' likelihood of and comfort with talking about mental health problems and personal difficulties with all three recipients would increase following the workshop.
3) Changes in trainees' level of unhealthy perfectionism, as well as in their likelihood of and comfort with disclosure would be maintained at follow-up.
4) A decrease in perfectionism would be associated with an increase in wellbeing.

Methods

Participants

First year trainees in the first academic term of clinical training were recruited for the present study. Four workshops were delivered in total, one at University College London (*n* = 49), University of Oxford (*n* = 25), Royal Holloway (*n* = 26), and King's College London (*n* = 23). A total of 123 trainees attended the workshop, with 117 completing the baseline measures, and 114 (97%) completing

the post-workshop measures. The follow-up survey was started by 42 and completed by 35 trainees, resulting in a response rate of 30%.

Design and Procedure

A within-subjects, quasi-experimental design was employed in the present study. An email outlining the details of the study was sent to the course directors of nine Clinical Psychology doctoral programmes based in London and South East England (see Appendix A), to establish their interest in contributing to the research and hosting the workshop as part of their first year curriculum. Four training providers expressed an interest, namely University College London, Royal Holloway, University of Oxford and King's College London. A study information sheet containing the researcher's contact details was subsequently emailed to the course directors and administrators one week prior to the workshop, for dissemination to first year trainees.

On the day of the workshop, the session began with an introduction and a brief review of the research aims, the voluntary nature of the study was reiterated, and trainees were given an opportunity to ask questions. Trainees who consented to taking part then completed either a paper-copy of measures or accessed them online in the form of a Qualtrics survey using a website link on their smartphones, tablets or laptops. Demographic information, specifically the trainee's age range and gender, was also collected as part of the baseline survey. The workshop commenced once the baseline measures were completed.

At the end of the workshop, trainees completed the post-workshop survey in the same format as the baseline survey. Finally, approximately 11-weeks following completion of the workshop, participants were asked to complete the follow-up

survey via an email (Appendix B) sent by the respective course administrators. This email briefly restated the aims of the study, thanked participants for their contribution and offered a monetary incentive for the completion of the follow-up survey (see Appendix C for all items used in the three surveys). A final reminder email was sent to participants three weeks later.

Workshop

The "Healthy Striving for Excellence" workshop was a half-day, CBT-based perfectionism workshop, the content of which was informed by the cognitive-behavioural treatment for perfectionism manual (Egan et al., 2016; see Table 1 for session structure). The duration of the workshops ranged from two hours 20 minutes, to three hours, inclusive of a 20-minute break. The workshop was delivered by one of two qualified, BABCP-accredited clinical psychologists. The first workshop was delivered by the workshop developer and the following three by the second psychologist, in line with the first workshop. The workshop was delivered with the aid of a visual presentation and was an interactive session consisting of didactic teaching as well as experiential tasks and practice of CBT strategies, and participants were encouraged to share their ideas and reflections throughout the workshop.

Ethical Considerations

The UCL ethics committee granted ethical approval for the present study (Appendix D). The study information sheet was distributed by training course administrators one week before the workshop. It informed trainees that while the workshop was part of their curriculum, and thus attendance non-optional, participation in the research was voluntary. To ensure anonymity only minimal demographic information was gathered and participants were asked to generate a

Table 1.

Topic structure and components of the Healthy Striving for Excellence workshop.

Workshop Topic	Topic Components
1. Background	1.1 Examination of healthy and unhealthy forms of perfectionism 1.2 Definitions of perfectionism
2. Negative Impact of Perfectionism	2.1 Negative impact of perfectionism on functioning 2.2 Association between perfectionism and mental health difficulties 2.3 Impact of perfectionism on professional functioning 2.4 Perfectionism and the concealment of mental health difficulties
3. Assessment of Perfectionism	3.1 Characteristics of clinical perfectionism 3.2 Completion of the Clinical Perfectionism Questionnaire (Fairburn et al., 2003) 3.3 Formulation
4. Strategies to manage unhealthy forms of perfectionism	4.1 Monitoring and psychoeducation 4.1.1 Performance checking 4.1.2 Avoidance and procrastination 4.1.3 Counterproductive safety behaviours 4.1.4 Stress and performance: Yerkes-Dodson Law 4.2 Addressing self-criticism 4.3 Behavioural experiments 4.4 Surveys 4.5 Reduction of concealment 4.6 Reducing checking 4.7 Reducing avoidance and procrastination 4.8 Cognitive restructuring 4.9 Self-compassion 4.10 Problem-solving and time-management
5. Ending reflections	5.1 Summary and questions 5.2 Reflections on key take-home messages

four-digit identifier (using the last four digits of their telephone number), in order to link their responses across the three data collection points.

Measures

Perfectionistic Self-Presentation Scale

The extent to which participants were driven by the need to appear perfect was measured using the Perfectionistic Self-Presentation Scale (PSPS; Hewitt et al., 2003). This scale is comprised of 27 items, rated on a seven-point Likert scale ranging from one (disagree strongly) to seven (agree strongly). The PSPS does not specify a timeframe to consider when providing responses and was therefore administered at all three time points. The PSPS consists of three subscales: perfectionistic self-promotion, non-display of imperfection, and non-disclosure of imperfection, each considered maladaptive forms of impression management, achieved through the presentation of a perfect public image, avoidance of public displays of imperfections and avoidance of verbal admissions of imperfections, respectively. Higher scores on each subscale reflect greater pursuit of a perfect social image.

The scale's reliability in the current study was very good, with Cronbach's α for the three subscales of .91 for perfectionistic self-promotion, .89 for non-display, and .83 for non-disclosure. Hewitt and colleagues (2003) have also demonstrated the three subscales to have good test-retest reliability of .83, .84 and .74 respectively amongst university student within a three-week period, and good discriminant and convergent with other measures of perfectionism, such as trait perfectionism.

Concern over Mistakes

Maladaptive perfectionism was measured using the Concern over Mistakes subscale, a 9-item subscale of the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990). The full FMPS consists of 35 statements, scored on a five-point Likert scale from one (strongly disagree) to five (strongly agree), with higher scores indicating higher levels of perfectionism. As a timeframe for responses is not specified, the concern over mistakes subscale was administered at all three time points. Concern over mistakes is believed to be a core facet of maladaptive perfectionism, accounting for 25% of the variance in the FMPS (Frost et al., 1990). This subscale has been found to have good convergent validity and internal reliability (.91; Frost et al., 1990) and adequate test-retest reliability (.78) within a 10-week period (Rice & Dellwo, 2001). This subscale also demonstrated good internal consistency in the present study (Cronbach's α = .87).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

Participants' psychological wellbeing was measured using the WEMWBS (Tennant et al., 2007), a unidimensional, 14-item scale designed to capture positive aspects of mental wellbeing. It includes items such as "I've been feeling optimistic about the future" and "I've been feeling close to people" and asks responders to complete the items based on their experience in the last two weeks. Responses are provided on a five-point Likert scale, ranging from one (none of the time) to five (all of the time), with higher scores reflecting better psychological wellbeing. As the WEMWBS asks about the preceding two-week period, it was only administered at baseline and follow-up, and not immediately after the workshop. The mean wellbeing score for adults in the UK is 49.9 (Morris et al., 2017). The measure has been shown to have good construct validity, high test-retest reliability (.83) within

one week, as well as high internal consistency (Cronbach's α = .91). The internal consistency of this measure was also high in the present study (Cronbach's α = .89).

Experience of Mental Health Problems and Personal Difficulties

To ascertain whether trainees' likelihood of, and comfort with talking about mental health problems and personal difficulties varied as a function of lived experience, participants were asked to indicate whether or not they had lived experience of mental health problems, and whether they were currently experiencing some form of significant personal difficulty prior to the start of the workshop. Lived experience of mental health problems was assessed using a question adapted from Grice and colleagues (2018), in which trainees responded either 'yes' or 'no' to the following question: "Have you ever experienced a mental health problem?", with the supporting explanation: "This includes but is not limited to mental health problems as defined by DSM and ICD criteria, whether or not you have received a diagnosis. For the purpose of this question mental health problems refer to psychological and behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life." Those responding 'yes' were subsequently asked whether this referred to mental health difficulties they experienced in the past, were experiencing currently or both.

This question was subtly rephrased to explore trainees' current experience of personal difficulties and read as follows: "Are you currently experiencing any personal difficulties, such as (but not limited to) relationship breakdown, financial difficulties, and personal injury or illness? For the purpose of this question, personal difficulties refer to any stressful event currently occurring in your life that you are

particularly preoccupied by, and which is diminishing your ability to cope with the demands of the training programme."

Talking about Mental Health Problems

Participants' likelihood of, and comfort with talking about mental health problems were examined using questions from Grice and colleagues (2018), who asked trainees to rate how likely they would be to talk about three mental health problems with six different individuals within their personal and professional milieu. This question was adapted in the current study to examine both trainees' likelihood of and comfort with talking about mental health problems with the following people (herein 'recipients'): 1) their placement supervisor, 2) a member of course staff (herein 'course staff') and 3) a fellow trainee. Responses were provided on a seven-point Likert scale ranging from one (very uncomfortable / unlikely) to seven (very comfortable / likely).

Talking about Personal Difficulties

The talking about mental health problems question was rephrased to examine trainees' likelihood of and comfort with talking about personal difficulties. The question read as follows: "In general, (how likely is it that you would talk / how comfortable would you feel talking) to the following people about personal difficulties you may be experiencing and how they affect you?" Responses were made using the same seven-point scale.

Power Analysis

As the primary aim of this study was to evaluate the effectiveness of a perfectionism workshop at reducing unhealthy forms of perfectionism, the power analysis for this study was informed by previous research conducted by LaSota and

colleagues (2017). Consistent with the present study, the authors administered the FMPS to university students, to examine whether maladaptive perfectionism reduced following a brief perfectionism workshop. The change between pre and post workshop, and between pre-workshop and three-month follow-up revealed a small-medium (Cohen's $d = .43$) and medium effect size ($d = .64$) respectively. Based on this, a power calculation was completed using the G*Power 3.1 computer programme (Faul et al., 2007), specifying desired power of 80% at alpha level of 5%, which indicated a required sample size of 107 participants for detecting change between pre and post workshop, and 50 for detecting change at follow-up.

Data Analysis

The high rate of non-completion of the follow-up survey meant an intention-to-treat analysis was deemed inappropriate. As such, the primary analyses focused on examining differences between baseline and post-workshop data, with subsidiary analyses conducted to examine differences in the subgroup that completed the follow-up survey. One participant's scores on the concern over mistakes and non-disclosure of imperfections scales at post-workshop were identified as outliers, falling 3.47 and 4.45 standard deviations above the respective group means. The distribution of the concern over mistakes subscale was neither skewed nor kurtotic ($z < 1$). However, the non-disclosure distribution was kurtotic ($z = 2.57$), which improved following the removal of the respective outlier. Thus, only the non-disclosure of imperfection outlier was removed in subsequent analyses.

The change in trainees' wellbeing between baseline and follow-up was investigated through paired-samples t-tests, and the relationship between the four perfectionism dimensions and wellbeing examined using correlational analysis. Regression analysis was conducted to determine whether, following the workshop, a

reduction in any of the four dimensions of perfectionism between baseline and follow-up resulted in an increase in wellbeing. Furthermore, the effectiveness of the workshop in reducing trainees' levels of unhealthy perfectionism was assessed through paired samples t-tests comparing scores at baseline and post-workshop, with subsidiary analysis examining differences at follow-up. Similarly, t-tests were also conducted to examine the change in trainees' likelihood and comfort of talking about difficulties to the three key recipients following the workshop.

Finally, mixed linear model analyses were conducted to examine the influence of the following factors on trainees' likelihood of, and comfort with talking about mental health problems and personal difficulties: 1) time, 2) recipient, 3) lived experience of mental health difficulties, 4) maladaptive perfectionism (concern over mistakes), 5) perfectionistic self-promotion, 6) non-display of imperfections, and 7) non-disclosure of imperfections. In the first model, each variable was specified as a fixed-effect predictor. The model was then incrementally built to include a Time*Lived experience interaction as a fixed effect, following which trainees were added as *random slope*, and time and recipient as *random intercepts*. A heterogeneous and then homogeneous first-order autoregressive covariance structure was initially fitted to the data, as it was predicted that covariances would vary systematically over time. Where these failed to provide a good fit, a diagonal and ultimately scaled identity structure was fitted (Heck et al., 2013). A maximum likelihood method was applied to estimate the parameters in the model, and Schwarz's Bayesian criterion (BIC) used for model comparison and to identify the best fit. Factors that did not contribute significantly were removed from the final model.

Results

Of the 117 participants that completed the baseline survey, 98 (84%) were female and 19 (16%) male, numbers which were comparable to the proportion of females to males in UK doctoral training programmes (males made up 18% of 2018 intake, Leeds Clearing House, n.d.). Eighteen participants (15%) were below the age of 25, 96 (82%) aged between 25-34 and three (3%) aged between 35-44.

Table 2 presents participants' mean scores and standard deviations on the four perfectionism dimensions, and mean ratings for their likelihood of and comfort with disclosing mental health problems and personal difficulties to the three recipients at baseline, post-workshop and follow-up. Interestingly, participants' scores on the each of the perfectionism dimensions were higher than those observed in a comparative community adult sample and amongst university students (Hewitt et al., 2003; Stoeber, 1998).

Systematic differences between completers and non-completers of the follow-up survey were examined. Firstly, a significant association was found between experience of a personal difficulty and completion of the follow-up survey, $\chi^2(1) = 6.32$, $p = .012$, suggesting that the odds of participants completing the follow-up survey were four times higher if they were not currently experiencing personal difficulties. Furthermore, independent samples t-tests revealed significantly higher baseline levels of non-display of imperfections in participants completing ($M = 50.16$, $SD = 10.75$) compared to those not completing the follow-up survey ($M = 45.52$, $SD = 10.01$), $t(115) = -2.16$, $p = .033$. Similarly, significantly higher post-workshop non-display of imperfections scores were observed in participants completing ($M = 45.82$, $SD = 10.28$) relative to those not completing the follow-up survey ($M = 41.36$, $SD = 10.29$), $t(112) = -2.10$, $p = .038$.

Table 2.

Participants' mean scores on the four perfectionism dimensions, and likelihood of and comfort with talking about mental health problems and personal difficulties over time, standard deviations parenthesised

	Perfectionism				Mental Health						Personal Difficulty					
					Likelihood			Comfort			Likelihood			Comfort		
	CM	PSP	DISP	DISC	SUP	CRS	TRN	SUP	CRS	TRN	SUP	CRS	TRN	SUP	CRS	TRN
Baseline (n = 117)	24.74^{A} (6.93)	40.18^{A} (11.85)	46.75^{A} (10.42)	25.24^{A} (5.79)	3.25^{A} (1.78)	3.40^{A} (1.78)	4.38^{A} (1.86)	3.24^{A} (1.54)	3.44 (1.67)	4.43^{A} (1.80)	4.07 (1.79)	3.93 (1.84)	5.34 (1.72)	3.88^{A,B} (1.68)	3.95 (1.68)	5.21 (1.68)
Post-workshop (n = 114)	21.69^{B} (6.72)	33.16^{B} (9.79)	42.65^{B} (10.44)	20.23^{B} (5.64)	3.86^{B} (1.71)	3.81^{B} (1.81)	4.96^{B} (1.78)	3.54^{B} (1.56)	3.69 (1.72)	4.93^{B} (1.74)	4.17 (1.70)	4.06 (1.69)	5.54 (1.43)	3.98^{A} (1.51)	4.03 (1.60)	5.54 (1.35)
Cohen's d	.45	.65	.39	.88	.34	.21	.33	.16		.27						
Follow-up (n = 35)	23.63^{B} (7.38)	37.06^{B} (12.29)	45.00^{B} (10.18)	21.86^{B} (7.67)	3.09^{A,B} (1.92)	3.43^{A,B} (1.96)	3.97^{A} (2.05)	3.23^{A,B} (1.91)	3.43 (1.87)	4.11^{A,B} (2.01)	3.77 (1.83)	3.71 (1.96)	5.31 (1.83)	4.37^{B} (1.61)	4.06 (1.73)	5.57 (1.54)
Cohen's d	.50	.44	.37	.69			.36							.52		
Hewitt et al. (2003)† (n = 501)	-	38.86 (12.19)	41.31 (12.14)	22.41 (7.82)												
Stöeber (1998)†† (n = 243)	20.35 (6.98)	-	-	-												

Note: Within columns, means with the same superscripts, or those without superscripts denote a statistically non-significant difference at Bonferroni corrected significance level (p = .017). Effect sizes are reported for the significant group differences.

CM = Concern over mistakes; PSP = Perfectionistic self-presentation; DISP = Non-display of imperfections; DISC = Non-disclosure of imperfections; SUP = Placement supervisor; CRS = Course staff; TRN = Fellow trainee

†Study used for comparison of perfectionistic self-presentation scores with community adult sample; ††Study used for comparison of concern over mistakes scores with university student sample.

Workshop Evaluation

Perfectionism

Given that the analysis primarily focused on change between baseline and post-workshop, Bonferroni corrected paired-samples t-tests were conducted to examine whether the participants' levels of perfectionism reduced between baseline and post-workshop. As can be seen from Table 2, a significant reduction was observed across all four perfectionism dimensions, indeed falling to levels similar to those of the comparative samples.

To examine whether the reduction in perfectionism was maintained at follow-up, further pairwise comparisons were conducted using the data from the subsample (n = 35) of participants who completed the follow-up survey. This revealed that participants' scores on all four perfectionism dimensions at follow-up were lower than those at baseline, and did not differ significantly from post-workshop scores, suggesting the beneficial effects were maintained over time (see Table 2).

Talking about Mental Health Problems

At the time of the workshop, 68 participants (58%) reported lived experience of a mental health problem, of whom 16 (14%) were experiencing a mental health problem at the time of completion.

Paired samples t-tests with Bonferroni correction were conducted to examine changes in participants' likelihood and comfort with talking about mental health problems over time. As can be seen in Table 2, except for comfort with talking about mental health problems with course staff, participants' likelihood of and comfort with talking about mental health problems increased between baseline and post-workshop. However, this change was not maintained at follow-up; amongst

participants completing the follow-up survey, likelihood and comfort ratings appeared to regress and at follow-up were not significantly different from baseline or post-workshop ratings. The exception was likelihood of talking about mental health problems with another trainee, where a significant decrease was observed between post-workshop and follow-up.

Talking about Personal Difficulties

At the time of the workshop, 36 participants (29%) indicated that they were experiencing a difficulty in their personal life that was having a detrimental impact upon their ability to cope with the demands of the training programme.

Examining the changes in participants' attitudes towards talking about personal difficulties between baseline and post-workshop, paired-samples t-tests revealed no change in participants' likelihood of or comfort with talking about personal difficulties with any of the three recipients. However, amongst those completing the follow-up survey, a significant increase was observed in participants' comfort with talking about personal difficulties with their placement supervisor between post-workshop and follow-up (see Table 2). Aside from this, there were no changes in participants' likelihood or comfort ratings for the three recipients.

Wellbeing

For reasons aforementioned, wellbeing was only measured at baseline and follow-up. Given the high non-completion rate and systematic differences between completers and non-completers, these findings should be interpreted with caution.

Participants' wellbeing appeared to deteriorate within 11-weeks of the workshop, which at follow-up fell below that of the UK adult population (Morris et al., 2017). A paired-samples t-test conducted on participants' wellbeing scores

Table 3.

Pearson correlation coefficients for the relationship between all four perfectionism dimensions and wellbeing.

Variable	WEMWBS	
	Baseline (n = 117)	Follow-Up (n = 37)
Concern over Mistakes	-.34***	-.54***
Perfectionistic Self Presentation		
Perf. Self-Promotion	-.29***	-.42**
Non-display of Imperfections	-.39***	-.38**
Nondisclosure of Imperfections	-.433***	-.40**

**p < .01; ***p < .001.

highlighted a significant deterioration between baseline (M = 50.41, SD = 7.27) and follow-up (M = 45.97, SD = 8.60), $t(36) = 4.08$, $p < .001$, d = .56. Further, all four perfectionism dimensions were found to be negatively correlated with wellbeing at baseline and follow-up (see Table 3).

The change in participants' scores on the four perfectionism dimensions between baseline and follow-up was subsequently calculated and regressed onto the change in wellbeing scores. From this, a decrease in the non-disclosure of imperfections dimension was uniquely associated with increase in participants' wellbeing between baseline and follow-up (see Table 4 for regression coefficients). No other predictors were significant, though it should be noted that given the small sample, it is possible that the analysis lacked sufficient power to detect effects of a smaller magnitude.

Factors Affecting Disclosure of Mental Health Problems

Likelihood of Disclosure

Table 4.

Multiple regression of the dimensions of perfectionism that predict change in wellbeing.

Variable	*B*	*SE B*	β
Constant	-6.57	1.42	-
Concern over Mistakes	.26	.29	.20^{ns}
Perfectionistic Self-Presentation			
Perf. Self-Promotion	-.00	.18	-.00^{ns}
Non-display of Imperfections	.38	.24	.39^{ns}
Non-disclosure of Imperfections	-.90	.30	-.84**

$R^2 = .28$; **$p < .01$; ^{ns}Not significant at $p < .05$ level.

A mixed linear model was subsequently conducted to investigate the influence of the aforementioned factors on participants' likelihood of talking about mental health problems. Inspection of BIC indicated that the model was improved by including time and recipient as random intercepts, and trainees as random slope. The intercept for the relationship between time and likelihood of disclosure, and between recipient and likelihood varied significantly across trainees. The parameter information for the final model is displayed in Table 5.

The model revealed a significant effect of time, suggesting participants were more likely to talk about mental health problems following the workshop. Recipient type also influenced participants' likelihood ratings, with participants being significantly more likely to talk about mental health problems with another trainee than with their placement supervisor or course staff. Subsequent t-tests using a Bonferroni corrected significance level (α = .025) found no differences in participants' likelihood of talking about mental health problems with their placement supervisor or course staff, $t(110.40) = -.41$, $p > .05$. Concern over mistakes and the non-disclosure of imperfections dimensions also negatively predicted participants'

likelihood ratings, suggesting that as such forms of perfectionism increase, participants' likelihood of talking about mental health problems decreases. Further, participants without lived experience of mental health difficulties rated themselves as more likely to talk about mental health problems than those with lived experience.

A significant Time*Experience interaction was also observed, which was examined further using two separate mixed linear models with participants with and without lived experience of mental health problems. These analyses revealed that for participants without lived experience of mental health problems, there was no change in their likelihood ratings between baseline and post-workshop, $b = .05$, $t(65.47) = .32$, $p > .05$. However, participants with lived experience were significantly more likely to talk about mental health problems post-workshop, $b = .32$, $t(90.93) = 2.10$, p

Table 5.

Parameter information for predictors of likelihood of disclosing a mental health problem

Variable	*B*	*SE B*	*95% CI of B*
Time			
Baseline[a]	-	-	-
Post-Workshop	.36**	.13	.10, .62
Recipient			
Fellow Trainee[a]	-	-	-
Placement Supervisor	-1.12***	.16	-1.43, -.82
Course Staff	-1.07***	.16	-1.38, -.76
Lived Experience			
Yes[a]	-	-	-
No	.55*	.27	.02, 1.07
Time x Experience	-.40**	.17	-.74, -.07
Concern over Mistakes	-.03*	.02	-.06, -.00
Non-disclosure of Imperfections	-.05**	.02	-.09, -.02

[a]Reference group; *$p < .05$; **$p < .01$; ***$p < .001$

= .038. The significant interaction therefore reflects the difference in slopes of lived experience as a predictor of likelihood of talking about mental health problems, of those with and without lived experience (see Figure 1).

Follow-Up. A further mixed linear model was run to explore the changes in the pattern of results following inclusion of the follow-up data (n = 35). The relationship between recipient and likelihood of disclosure remained unchanged; participants were significantly more likely to talk about mental health problems with another trainee compared to their placement supervisor, b = -1.11, t(553.69) = -8.55, p < .001, or course staff, b = -1.00, t(396.42) = -8.31, p < .001, with no significant differences observed in likelihood ratings between the latter two recipients, t(396.40) = 1.07, p > .05. Non-disclosure of imperfections, though not concern over mistakes, remained a significant negative predictor of likelihood of disclosure, b = -.07, t(365.98) = -4.30, p < .001. However, the inclusion of follow-up data resulted in non-

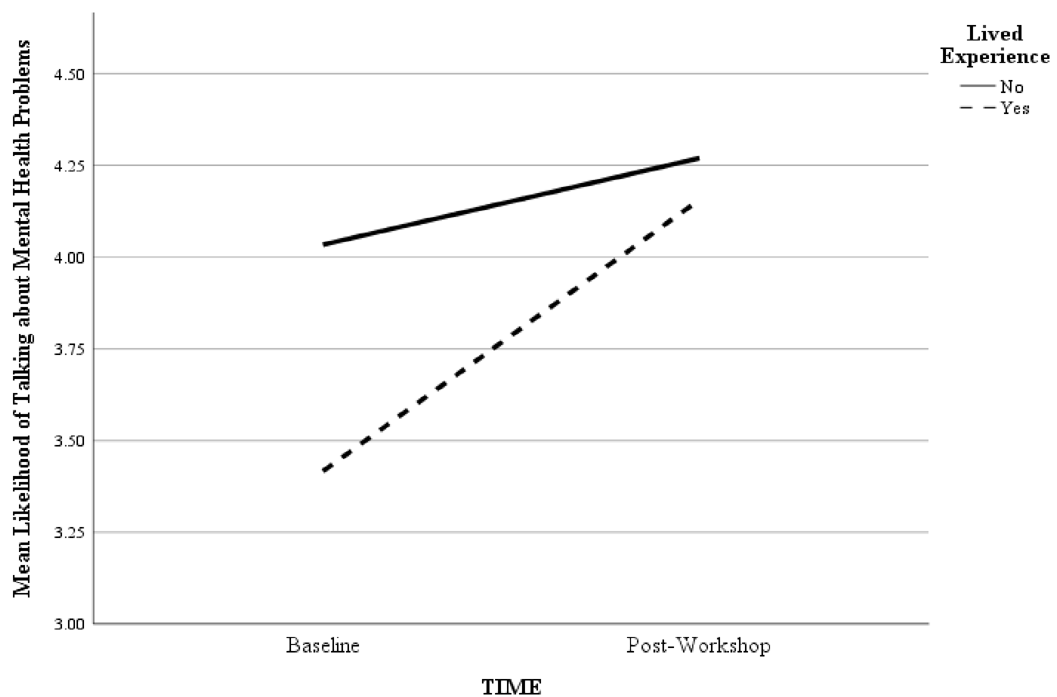

Figure 1. Graph showing mean likelihood of talking about mental health problems amongst trainees with and without lived experience of mental health difficulties at baseline and post workshop.

significant differences between baseline and post-workshop scores $b = .20$, $t(435.98) = 1.37$, $p > .05$, and between baseline and follow-up scores, $b = -.34$, $t(476.97) = -1.56$, $p > .05$. Participants were also found to be significantly more likely to talk about mental health problems post-workshop than at follow-up, $t(456.71) = 2.66$, $p = .024$. No other predictors were significant.

Comfort with Disclosure

Table 6 displays the parameter information for the final model, which indicates that participants felt more comfortable talking about mental health difficulties following the workshop. The effect of recipient was also significant, whereby participants felt more comfortable speaking with another trainee than with their placement supervisors or course staff. Subsequent Bonferroni corrected pairwise comparisons revealed no significant differences between participants' comfort with talking to their placement supervisor and course staff, $t(147.38) = .1.48$, $p > .05$. Finally, non-display of imperfections negatively predicted participants' comfort ratings, suggesting that as participants' scores on non-display of

Table 6.

Parameter information for predictors of comfort with talking about a mental health problem.

Variable	*B*	*SE B*	*95% CI of B*
Time			
Baseline[a]	-	-	-
Post-Workshop	.18*	.08	.01, .34
Recipient			
Fellow Trainee[a]	-	-	-
Placement Supervisor	-1.31***	.15	-1.60, -1.02
Course Staff	-1.11***	.15	-1.41, -.81
Non-display of Imperfections	-.04***	.01	-.06, -.02

[a]Reference group; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$; [ns]Not significant at $p < .05$ level.

imperfection increased, their comfort with talking about mental health problems decreased.

Follow-Up. The inclusion of follow-up data in the model indicated that participants felt significantly more comfortable talking about mental health problems after the workshop than before, $b = .18$ $t(136.12) = 2.28$, $p = .024$. However, the difference between baseline and follow-up comfort ratings was not significant, $b = -.07$, $t(35.96) = -.32$, $p > .05$, nor was the change between post-workshop and follow-up, $t(34.75) = 1.19$, $p > .05$. The effect of recipient remained significant, with participants feeling more comfortable talking about mental health problems with another trainee than with their placement supervisor, $b = -1.27$, $t(158.61) = -8.91$, $p < .001$, or course staff, $b = -1.05$, $t(138.05) = -7.16$, $p < .001$. No differences were observed in participants' comfort with talking to their placement supervisor or course staff, $t(145.52) = -1.72$, $p > .05$. Finally, non-display of imperfection also negatively predicted participants' comfort with talking about mental health problems, $b = -.04$, $t(251.83) = -4.64$, $p < .001$. All other factors were non-significant.

Factors Affecting Disclosure of Personal Difficulties

Two mixed linear model were subsequently conducted to examine the effect of the seven aforementioned factors on participants' likelihood of and comfort with talking about personal difficulties. In these analyses, lived experience of mental health difficulties was replaced with experience of personal difficulties.

Likelihood of Disclosure

The intercepts and slopes for the relationship between time, and between recipient and likelihood of talking about personal difficulties varied significantly across trainees. As can be seen from the parameter information in Table 7, a

Table 7.

Parameter information for predictors of participants' likelihood of talking about a personal difficulty.

Variable	*B*	*SE B*	*95% CI of B*
Time			
Baseline[a]	-	-	-
Post-Workshop	.14[ns]	.13	-.12, .39
Recipient			
Fellow Trainee[a]	-	-	-
Placement Supervisor	-1.33***	.13	-1.59, -1.07
Course Staff	-1.44***	.13	-1.70, -1.18

[a]Reference group; *$p < .05$; **$p < .01$; ***$p < .001$; [ns]Not significant at $p < .05$ level.

significant effect of recipient was observed, with participants being significantly more likely to talk about personal difficulties with another trainee than their placement supervisor or course staff. Subsequent Bonferroni corrected pairwise t-tests revealed that participants' likelihood of talking about personal difficulties with a placement supervisor did not vary significantly from their likelihood of talking to course staff, $t(548.53) = .80$, $p > .05$. No other factors were significant.

Follow-Up. Following the inclusion of the follow-up data, recipient was the only significant predictor. Specifically, participants were more likely to talk about personal difficulties with a fellow trainee than with their placement supervisor, $b = -1.35$, $t(605.10) = -10.36$, $p < .001$, or course staff, $b = -1.44$, $t(605.10) = -11.06$, $p < .001$. There was no difference between participants' likelihood of talking to their placement supervisors or course staff, $t(605.10) = .71$, $p > .05$. No other factors significantly predicted participants' likelihood ratings.

Comfort with Disclosure

Table 8.

Parameter information for predictors of participants' comfort with talking about personal difficulties.

Variable	*B*	*SE B*	*95% CI of B*
Time			
Baseline[a]	-	-	-
Post-Workshop	.45**	.15	.15, .76
Recipient			
Fellow Trainee[a]	-	-	-
Placement Supervisor	-1.44***	.15	-1.73, -1.15
Member of Course Staff	-1.39***	.14	-1.67, -1.10
Experience of Personal Difficulty			
Yes[a]	-	-	-
No	.62*	.25	.13, 1.11
Time x Experience	-.43*	.18	-.79, -.07

[a]Reference group; $*p < .05$; $**p < .01$; $***p < .001$; [ns]Not significant at $p < .05$ level.

Parameter information for this model can be seen in Table 8. Here too, the relationship between time, and between recipient and comfort with talking about personal difficulties varied significantly across trainees. The model indicated that participants' comfort ratings increased significantly following the workshop. Recipient type also predicted participants' comfort ratings, with participants being most comfortable talking to another trainee, and no difference being observed in participants' comfort with talking to one's placement supervisor and course staff, $t(154.90) = .16$, $p > .05$. Further, participants not experiencing a personal difficulty rated themselves as significantly more comfortable with talking than those who were experiencing a personal difficulty at baseline.

A significant Time*Experience interaction was also observed, which was examined through two separate mixed linear models on participants who were and

were not experiencing a personal difficulty. Amongst participants not experiencing a personal difficulty, there was no change in their comfort ratings between baseline and post-workshop, $b = .02$, $t(78.24) = .26$, $p > .05$. However, for participants experiencing a personal difficulty, there was an increase in comfort ratings, though this change marginally failed to reach significance, $b = .46$, $t(122.60) = 1.89$, $p = .06$. The significant interaction therefore likely reflects the difference in slopes for those experiencing and not experiencing a personal difficulty, though the small sample sizes in this analysis may have resulted in insufficient power to detect an effect.

Follow-Up. Time remained a significant predictor when follow-up data were included, whereby compared to baseline, participants' comfort ratings were significantly higher post-workshop, $b = .45$, $t(112.13) = 2.94$, $p = .004$, and at follow-up, $b = -1.30$, $t(33.38) = 2.37$, $p = .024$. The change in participants' comfort scores between post-workshop and follow-up was not significant, $t(31.82) = 2.06$, $p > .05$. The effect of recipient also remained significant, with participants reporting feeling more comfortable talking to another trainee about personal difficulties than to their placement supervisor $b = -1.41$, $t(149.80) = -9.79$, $p < .001$, or course staff, $b = -1.38$, $t(117.73) = -9.63$, $p < .001$, with no differences observed in the comfort ratings for the latter two recipients, $t(146.98) = .22$, $p > .05$. Furthermore, participants not experiencing a personal difficulty were significantly more comfortable talking about personal difficulties than those who were, $b = .61$, $t(125.68) = 2.48$, $p = .014$.

Finally, the Time*Experience interaction remained significant, and was examined using the same approach as in the main analysis. Again, participants not experiencing a personal difficulty showed no change in comfort rating over time, $F(2, 357.87) = 1.27$, $p > .05$, whereas comfort ratings appeared to increase for participants experiencing a personal difficulty, though this increase failed to reach

significance, $F(2, 125.77) = 2.70$, $p = .07$. Here too, it is believed that the sample size resulted in insufficient power to detect an effect.

Discussion

The principal aim of this study was to evaluate the effectiveness of a brief, CBT-based perfectionism workshop at reducing maladaptive perfectionism and perfectionistic self-presentation, as well as altering trainees' attitudes towards talking about mental health problems and personal difficulties with others in their training context. It also sought to understand the prevalence of unhealthy perfectionism amongst trainees, determine the relationship between perfectionism and wellbeing, and explore the factors that predicted trainees' likelihood of and comfort with disclosure.

This appears to be the first study to evaluate a brief self-care intervention of this nature for trainees, and to address potential barriers to talking about difficulties within the training context. Results from this study are promising. Firstly, a significant reduction in perfectionism was observed across all four perfectionism dimensions following the workshop, findings which support hypothesis one. Hypothesis two was partially support whereby, with the exception of trainees' likelihood of talking about personal difficulties and their comfort with talking about mental health problems with a member of course staff, their likelihood and comfort with talking about mental health problems with the three recipients increased between baseline and post-workshop. Results also partially support hypothesis three. Specifically, at follow-up, the reduction in the four perfectionism dimensions appeared to persist, whereas changes in trainees' likelihood of and comfort with disclosing difficulties attenuated. Further, trainees' wellbeing deteriorated in the 11-

weeks between baseline and follow-up, though within this, a reduction in non-disclosure of imperfections uniquely predicted better wellbeing, partially supporting hypothesis four. Finally, examining the factors that affected disclosure of difficulties, in line with previous research (Grice et al., 2018b), trainees were consistently more likely and comfortable talking to a fellow trainee than to their placement supervisor or course staff about difficulties, whereas more nuanced relationships were observed for the remaining factors. These results, as well as their implications are discussed further below.

Change Following the Workshop

Perfectionism

Relative to the general population or a university sample, trainees in the present study demonstrated elevated levels of unhealthy perfectionism (Hewitt et al., 2003; Stoeber, 1998). Indeed, at baseline, trainees' scores on the three facets of perfectionistic self-presentation were comparable to levels observed in a large clinical sample of outpatients with affective, anxiety and adjustment disorders (Hewitt et al., 2003). Similarly, trainees' levels of concern over mistakes mirrored those reported by individuals experiencing major depression, though were lower than those reported by individuals with obsessive-compulsive disorder or eating disorders (Sassaroli et al., 2008). Given the relationship between such forms of perfectionism and psychological distress, such findings underscore the need for an intervention of this nature.

Crucially, following the workshop, there appeared to be a reduction in trainees' maladaptive perfectionism and perfectionistic self-presentation from clinical levels to levels consistent with or below those observed in the general

population. This reduction may partly be attributable to the workshop raising awareness of the prevalence and ubiquity of perfectionism and the experience of difficulties during clinical training, and challenging perceptions that trainees are expected to be perfect. This may have permitted the establishment of more realistic standards, thereby diminishing trainees' concerns regarding making mistakes and attempts at maintaining a perfect self-image before those in their training context.

The cognitive-behavioural strategies incorporated into the workshop may have also produced the reduction in perfectionism. The workshop aimed to challenge the psychological processes believed to maintain perfectionism (see Egan et al., 2016). Such exercises may have provided trainees with novel opportunities to gather normative information to dispute beliefs that may be maintaining unhealthy perfectionism. This may have consequently modified trainees' beliefs about the implications of making mistakes and the need to appear perfect before others within the training context, leading to the observed decline in perfectionism. This is consistent with previous research that has highlighted the effectiveness of CBT at decreasing concern over mistakes (Lloyd et al., 2014; Suh et al., 2019), and with preliminary evidence of the benefits of CBT at attenuating perfectionistic self-presentation (Crăciun & Holdevici, 2013).

It should be noted, however, that the above explanations are speculative and indeed based on mechanisms of change observed in longer interventions for perfectionism. This is amongst the first studies to demonstrate the effectiveness of a brief intervention at reducing concern over mistakes (see also LaSota et al., 2017) and the first at reducing perfectionistic self-presentation. Thus, future research is needed to identify the specific cognitive-behavioural strategies that elicit change in response to brief interventions for perfectionism. Further, given the high rate of non-

completion of the follow-up measures and a sample size that fell below that indicated by the power calculation, the follow-up analysis was considerably underpowered. Such lack of power may have contributed to a Type 1 error (Christley, 2010), which coupled with the systematic bias in the follow-up sample makes it difficult to determine the long-term effectiveness of the workshop. Future research that addresses these issues is therefore needed to examine whether the observed changes in perfectionism are attributable to the workshop, and to verify whether such reduction truly persists over time.

Attitudes Towards Disclosure of Difficulties

The workshop had minimal impact upon trainees' attitudes towards talking about personal difficulties, with only trainees' levels of comfort talking to their placement supervisor increasing between post-workshop and follow-up. In contrast, both trainees' likelihood of and comfort with talking about mental health problems increased following the workshop. Indeed, aside from comfort with talking about mental health problems with course staff, trainees were more likely and comfortable talking about mental health problems with all recipients following the workshop.

Stigma associated with the experience of mental health problems may account for this finding. Such stigma can deter people, including mental health professionals, from talking about mental health difficulties within professional contexts (Bos et al., 2009; Tay et al., 2018). Conversely, personal difficulties are not typically stigmatised and therefore possibly easier to talk about, hence the limited effect of the workshop. In light of this, the increase in trainees' likelihood and comfort with talking about mental health problems following the workshop suggests it may be effective at breaking down potential barriers to the disclosure process.

However, scores from trainees who completed the follow-up survey revealed that likelihood and comfort ratings reverted to baseline. Although some attenuation is expected with time, in the present study it is unclear whether this reflects a genuine finding of solely short-term benefits of the workshop, or whether this reflects a type 2 error given the small follow-up sample. Thus, future replications of this study, with more robust methods for recording follow-up data are needed to more accurately study the longer-terms effects of such a workshop on trainees' attitudes towards talking about difficulties.

Wellbeing

Trainees' wellbeing worsened over time, and at follow-up fell below that of the general UK adult population (see Morris et al., 2017). However, given the bias in the follow-up sample, it is possible that trainees' true wellbeing score at follow-up was indeed lower than that observed herein. To elaborate, the odds of completing the follow-up survey were four times lower amongst trainees experiencing a personal difficulty at baseline than those who were not. Trainees experiencing personal difficulties may have therefore been underrepresented in the follow-up sample, thereby inflating wellbeing ratings at follow-up. Thus, this potential bias, as well as the high rate of non-completion of the follow-up survey which meant this analysis was also underpowered, somewhat limit the conclusions that can be drawn.

Nonetheless, findings from this study suggest that unhealthy perfectionism may influence trainees' wellbeing. In the present study, higher levels of concern over mistakes and perfectionistic self-presentation were linked to significantly poorer wellbeing. Such findings are in keeping with a large body of evidence that has linked such forms of perfectionism with negative affectivity, greater distress, and greater incidence of mental health difficulties (e.g. Hewitt et al., 2003; Limburg et al., 2017;

Shafran & Mansell, 2001). Considered in conjunction with the finding that trainees present with higher levels of unhealthy perfectionism than others in the general population, this suggests that trainees may be particularly vulnerable to experiencing poorer wellbeing. Importantly, within this relationship this study demonstrated that a reduction in non-disclosure of imperfections following the workshop contributed to an increase in wellbeing. This finding provides ways in which support for trainees may be tailored to better meet their needs and promote wellbeing. Previous research has highlighted the benefits of self-care in the form of accessing social support at lowering psychological distress experienced by trainees (Colman et al., 2016). Indeed, inherent to a reduction in the non-disclosure of imperfections is an increase in talking about one's perceived shortcomings. This may have increased the level of social support experienced by trainees, thereby improving their wellbeing and potentially explaining the observed findings. Future replications of this study, with a larger follow-up sample, are needed to better understand the specific mechanisms by which non-disclosure of imperfections affects wellbeing, and to better understand the role of the remaining perfectionism dimensions.

Despite these positive findings, the overall decline in trainees' wellbeing over a three-month period in their first year of training is striking and suggests that factors beyond unhealthy perfectionism influenced trainees' wellbeing. Some variation in wellbeing during training is perhaps to be expected, and it is possible that in the present study, the timing of the follow-up survey coincided with particularly busy or stress-inducing times in the training programme, thereby contributing to the poor wellbeing observed. Nonetheless, this finding is consistent with, and extends previous research by elucidating the timeframe within which such change occurs (Cushway, 1992; El-Ghoroury et al., 2012). This highlights that the demands and

stresses associated with clinical training manifest early and can have a rapid and profound impact on trainee wellbeing. Under such conditions, the workshop alone was insufficient at ameliorating the detrimental impact of the stresses of training on trainees' wellbeing. Such findings therefore underscore the need to do more to support trainees during clinical training. It also raises the question as to how wellbeing varies over the full course of training and the impact of this on trainees' functioning and ability to seek support, thus warranting further longitudinal study.

Factors Affecting Disclosure

Perfectionism and Talking about Mental Health Problems

The present study highlighted the impact of unhealthy perfectionism on trainees' attitudes towards talking about mental health problems, but not personal difficulties, with others within the training context. Specifically, the non-disclosure of imperfections and concerns over mistakes dimensions appeared to negatively predict trainees' likelihood, and non-display of imperfections predicted trainees' levels of comfort with talking about mental health problems. This highlights that non-disclosure and non-display extend beyond perceived imperfections to incorporate mental health difficulties, and are linked to reduced likelihood of and comfort with mental health disclosure respectively. It also underlines that these forms of perfectionistic self-presentation describe distinct constructs that uniquely effect trainees' attitudes towards talking about mental health difficulties with others in their training context.

The negative relationship between the concern over mistakes dimension and likelihood of talking about mental health problems in this context is perhaps unsurprising. The evaluative nature of clinical training, alongside professional

guidelines and fitness-to-practice procedures necessitate good performance and highlight the potential consequences of errors in one's professional practice. Within such a context, it is conceivable that elevated levels of concern over mistakes may diminish trainees' likelihood of talking about mental health problems for fear that disclosure may adversely affect others' judgements of their competence (Tay et al., 2018). Further qualitative research is needed to disentangle the unique relationships between unhealthy perfectionism and trainees' attitudes towards talking about mental health problems, and to understand why this differs from talking about personal difficulties.

Recipient Type

The most consistent finding from this study was that participants were invariably more likely and comfortable talking to another trainee than to their placement supervisor or course staff about difficulties they were experiencing. This is largely in agreement with previous research, which has found that trainees are most likely to talk about actual and hypothetical mental health problems with another trainee within the training context (Grice et al., 2018b).

The evaluative nature of clinical training can give rise to power imbalances within trainees' relationships with their placement supervisor and course staff. Research has suggested that such imbalances contribute to increased concealment of mental health difficulties from supervisors and course staff, in an attempt to maintain a competent image of oneself, and out of fear of being judged, seen as weak, or being treated differently (Dayal et al., 2015). This may explain why trainees feel more able to speak to a fellow trainee. Alternatively, whereas trainees typically only have one placement supervisor with whom to talk about difficulties, trainees' ability to

personally select another trainee from a pool of classmates may have allowed them to select the trainee with whom they have the closest, most trusting relationship, thereby facilitating disclosure.

Crucially, trainees demonstrated a willingness to talk to someone. Given the high prevalence of mental health problems and personal difficulties amongst trainees in the present study, such disclosure may allow trainees to gain new information and access social support, which may validate and normalise their experiences. Research has also shown that disclosure can improve academic performance, reduce feelings of stress, isolation and shame, and challenge the perception that one may be judged negatively for such difficulties (Colman et al., 2016; Dayal et al., 2015). Thus, that trainees felt more able to talk about difficulties with others in their training context following the workshop is a welcome finding.

Experience of Difficulties

Lived experience of mental health problems, and experiences of personal difficulties were found to uniquely influence trainees' attitudes towards talking about difficulties. Trainees with lived experience of mental health problems reported being less likely, though not less comfortable, talking about mental health problems relative to those without lived experience. Conversely, trainees experiencing a personal difficulty were less comfortable, though not less likely to disclose than those not experiencing a personal difficulty at the time of the workshop.

Given the dearth of literature investigating the disclosure of personal difficulties, research examining the decision-making processes of people experiencing mental health problems was consulted to explain the observed findings. It is known that different factors influence the disclosure decision-making processes

of those considering a hypothetical mental health problem and those with lived experience (Bell et al., 2011). In the present study, disclosure decisions for trainees without lived experience of mental health problems were hypothetical, due to which they may have rated themselves as being more likely to talk to others than if the mental health problems were actually experienced. The findings also suggest that trainees do not have to feel comfortable in order to be likely to talk about difficulties with others in the training context, suggesting that such processes are determined by different underlying factors. Further, stigma and fear of the potential consequences of disclosure can prevent trainee counsellors with lived experience from talking about mental health problems with supervisors and course staff (Dayal et al., 2015). Extended to the present study, such concerns may have determined the decision of trainees with lived experience of mental health problems or personal difficulties to a greater extent than for trainees without such experience, thereby decreasing their likelihood of and comfort with disclosure respectively.

Notwithstanding this difference, a significant interaction with time was also noted in both cases, suggesting greater increases in the likelihood and comfort ratings of those with lived experience of mental health problems or personal difficulties respectively, relative to those without. This is a promising finding as it suggests that a workshop of this nature can empower trainees experiencing a mental health problem or personal difficulty to talk and seek support. Examining this further in future studies may provide valuable insight into the specific components of the workshop that promoted such increases in the likelihood and comfort ratings of trainees experiencing such difficulties.

Implications

Gaining entry onto clinical training can require a great deal of persistence, and the steep competition for funded positions in the UK may further encourage the setting of and drive to achieve high personal standards amongst aspiring clinical psychologists. In this way, perfectionism can be functional and can facilitate the pursuit and achievement of one's goals. However, perfectionism commonly manifests within the domain of work and academia (Stoeber & Stoeber, 2009), and the evaluative nature of clinical training may trigger the rise of more unhealthy forms of perfectionism. This may have a detrimental effect on trainees' wellbeing, and on their personal and professional functioning.

To recognise distress and engage in self-care has typically been made the responsibility of individual trainees. Yet individuals often knowingly or unconsciously downplay difficulties they may be experiencing, which coupled with beliefs about caring for others can mean trainees and psychologists continue to work despite experiencing significant levels of distress (Johnson et al., 2012). Researchers over the years have advocated for support structures and particularly self-care training to be embedded within the training curriculum to promote trainees' resilience and ability to cope with the demands of training (Myers et al., 2012; Pakenham, 2017; Pakenham & Stafford-Brown, 2012). Professional and statutory bodies in the UK have also made suggestions for systemic-level change, calling for organisations to build more compassionate workplaces that prioritise the wellbeing of staff (Rao et al., 2016). In addition, training providers have been urged to do more to attend to the wellbeing of those training in the healthcare professions and to support those who experience distress during training (HEE, 2019).

Within this context then, the benefits of offering a workshop of this nature are potentially manifold. Firstly, the delivery of such a workshop can allow for the nurturing of the healthy and adaptive aspects of perfectionism, whilst also helping trainees to adopt the strategies needed to recognise and challenge unhealthy forms of perfectionism. Further, as a training-provider endorsed session, such a workshop has the power to formalise self-care practices as part of training, and to place the impetus for self-care on both trainees and training providers. Such a workshop may also communicate an acknowledgement by the training provider of the challenging nature of training, which may be even more successfully achieved if the workshop were to be delivered by facilitators within, rather than external to, the respective training programmes. This may break down the secrecy that often prevails regarding the experience of difficulties during clinical training, which can be validating and normalising, and enable trainees to seek support. It may also promote the reestablishment of more realistic expectations of trainee performance, challenging commonly held perceptions of the need to be "perfect" to get into, or remain in clinical training.

The effectiveness of the workshop at reducing levels of unhealthy perfectionism and at increasing trainees' likelihood of and comfort with talking about mental health difficulties with others in the training context also has important implications. It suggests that such a workshop can potentially address factors that may serve as additional barriers to the disclosure and help-seeking process, including personal (unhealthy perfectionism, experience of difficulties), systemic (high expectations, consequences of disclosing impaired performance) and possibly even societal factors (stigma).

Implementing such a workshop into training curricula is therefore in keeping with statutory guidance calling for increased action by training providers to safeguard trainee wellbeing. This includes recommendations made within the HEE (2019) report, calling for self-awareness and self-care training to be explicitly incorporated into training curricula, for educators and supervisors to be trained in how to allay fears that talking about one's difficulties may hinder one's career prospects, and placing greater responsibility on training providers to proactively support trainees during known stressful transitions, such as changing placements and taking up one's first graduate role.

Despite such recommendations, there exists little guidance on how these may be fulfilled by individual training providers. A workshop of this nature provides an important way forward. Embedding such a workshop across all training programmes may trigger a change in the existing culture surrounding talking about difficulties in the work and learning environment. It has the power to depathologise the experience of difficulties and can engender the development of more compassionate work and learning environments, in which trainees feel well supported and empowered to talk about and seek help for difficulties they may be experiencing. This can promote the development of more sustainable work habits, which may in turn permit the long-term efficiency of future psychologists entering the workforce.

Finally, unique to this workshop was its ability to dovetail self-awareness and self-care training with the teaching of cognitive-behavioural therapeutic skills to assess and treat unhealthy perfectionism. In light of growing criticism of disorder-specific approaches, there has been increased empirical interest and shift towards interventions targeting the transdiagnostic processes thought to underlie distress, such as low self-esteem, transdiagnostic approaches to anxiety and indeed,

perfectionism (Fennell, 2006; McManus & Shafran, 2014; Shafran et al., 2010). In this way, integrating such a workshop into the training curriculum would meet both the personal and academic needs of trainees, thereby further enriching the training experience.

Recommendations

Despite some of the limitation of the present study, the findings reported herein provide helpful avenues for future intervention and research. Firstly, trainees demonstrated a clear preference to speak with other trainees about difficulties they may be experiencing. Given the aforementioned benefits of accessing such peer support (e.g. Colman et al., 2016; Dayal et al., 2015), training providers should consider embedding trainee peer-support spaces into the training programme, to increase the level of support available to trainees during training, and to allow trainees to formally access such support with greater ease.

Further, training providers may also benefit from exploring and addressing the specific barriers that trainees experience in discussing difficulties with members of the course team. For instance, from feedback gathered from trainees during the open discussion at the end of the workshop, and in the course lecture feedback, a number of trainees raised that although the workshop helped to normalise the experience of difficulties during training, power imbalances in the relationship and the potential to be considered incompetent or unfit for training by course tutors hindered disclosure. To address such power imbalances, courses may benefit from assigning trainees, and scheduling regular review sessions, with a personal tutor who has no supervisory responsibilities and whose role may exclusively be to offer trainees support with their wellbeing and development, which may promote trainees' ability to raise difficulties.

Thirdly, feedback from some trainees indicated that they felt the length of the workshop was too short to be able to challenge more longstanding perfectionistic beliefs and behaviours. Although timetable demands limited the length of the workshop, future interventions may be more effective if delivered as a full-day session. Alternatively, it may be more beneficial to spend more time in the workshop on psychoeducation and completing cognitive-behavioural exercises. Specifically, in the present study half of the workshop was dedicated to examining the background and theory of perfectionism, and half on cognitive-behavioural skills practice. Thus, reducing the time spent on the former, perhaps by directing trainees to relevant key papers, and dedicating more time to completing the cognitive-behavioural exercises believed to bring about change in perfectionism (Egan et al., 2016), may increase the effectiveness of the workshop in future replications, and indeed increase participant satisfaction.

Limitations

There are a number of limitations of the present study. Perhaps the most troublesome of these is the high non-completion rate of the follow-up survey, which greatly limited the conclusions that could be drawn regarding the longevity of the observed findings. Further, the underrepresentation of trainees experiencing a personal difficulty and higher levels of non-display of imperfection amongst trainees completing the follow-up survey further threaten the generalisability of the findings. There are several possible reasons for the observed rate of non-completion, including increased academic and clinical workload at follow-up, as well as practical elements such as the increased volume of emails requiring trainees' attention meaning the survey invitation may have been missed. Such competing demands, coupled with the worsening in wellbeing observed herein, may have diminished trainees' abilities to

undertake an additional task. Further, several trainees began, but did not complete the follow-up survey, potentially suggesting the survey was excessively time-consuming or cumbersome. Shortening the length of the survey, sending additional reminder emails, or varying the follow-up time to coincide with less busy times of the academic year may address this limitation in future replications of this study.

A further limitation is the focus on hypothetical disclosure decisions. Although the study highlighted the effectiveness of the workshop at altering trainees' attitudes towards talking about mental health problems and personal difficulties, how this translates into behavioural change remains unclear. Indeed, this may explain why wellbeing at follow-up was poor, as despite change in attitudes following the workshop, trainees may not have talked to others within the training context. Practical and time constraints meant it was not possible to undertake more longitudinal study of whether trainees did subsequently talk to and seek help from others in their training environment for difficulties they were experiencing. However, ascertaining whether such a workshop cultivates behavioural change is vital, as provision of support is highly contingent upon trainees being able to recognise and talk about difficulties with others. Thus, more longitudinal examination of behaviour change following the workshop is needed to determine whether such a workshop does truly address the barriers experienced by trainees to the disclosure process within the training context.

Thirdly, although a welcome finding, it is somewhat surprising that trainees' level of maladaptive perfectionism and perfectionistic self-presentation reduced so markedly following the brief workshop. This is because perfectionism is widely considered a longstanding personality trait, and interventions typically involve multiple sessions over several weeks. Similarly, the degree of increase in trainees'

likelihood of and comfort with talking about mental health difficulties is also surprising. It is possible that the observed findings may therefore be the result of demand characteristics, particularly given the degree of transparency regarding the workshop aims. Further, it is also possible that the demanding nature of clinical training may inherently attenuate perfectionistic pursuits, and the focus on talking about mental health difficulties may normalise such conversations and consequently promote trainees' willingness to talking about mental health difficulties. This may have accounted for the observed findings, though in the absence of a control group of trainees who did not participate in the workshop, it was not possible to test this hypothesis, Thus, these are important consideration for future researchers hoping to verify whether maladaptive perfectionism and perfectionistic self-presentation do reliably attenuate, and whether trainees' likelihood or and comfort with talking about mental health difficulties increases following brief interventions.

Conclusion

The present study highlights the nuanced and complex relationship between trainee wellbeing, maladaptive perfectionism, experience of difficulties, recipient type and likelihood and comfort with talking about difficulties with others in the training context. It provides evidence of the detrimental impact of training upon trainees' wellbeing and functioning, and crucially appears to be amongst the first to demonstrate the effectiveness of a brief CBT-based perfectionism workshop at reducing unhealthy perfectionism and increasing likelihood of disclosure. Although further research is needed to verify some of the conclusions drawn from this study, these findings nonetheless underscore the need to do more to safeguard trainees' wellbeing during training. To that end, interweaving a workshop of this nature into clinical training may be fundamental in placing the onus of self-care on both trainees

and training providers, and formalising self-care practices. It is hoped that such action will promote personal and systemic-level change, which breaks down barriers to disclosure and help-seeking within the training context, promotes a sense of transparency and produces more compassionate working and learning environments that safeguard trainees' wellbeing during training and beyond.

References

Bell, R. A., Franks, P., Duberstein, P. R., Epstein, R. M., Feldman, M. D., Garcia, E. F., & Kravitz, R. L. (2011). Suffering in silence: Reasons for not disclosing depression in primary care. *Annals of Family Medicine*, *9*(5), 439–446. https://doi.org/10.1370/afm.1277

Boellinghaus, I., Jones, F. W., & Hutton, J. (2013). Cultivating self-care and compassion in psychological therapists in training: The experience of practicing loving-kindness meditation. *Training and Education in Professional Psychology*, *7*(4), 267–277. https://doi.org/10.1037/a0033092

Bos, A. E. R., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing*, *30*(8), 509–513. https://doi.org/10.1080/01612840802601382

Brad Johnson, W., Barnett, J. E., Elman, N. S., Forrest, L., & Kaslow, N. J. (2012). The competent community: Toward a vital reformulation of professional ethics. *American Psychologist*, *67*(7), 557–570. https://doi.org/10.1037/a0027206

Brooks, J., Holttum, S., & Lavender, A. (2002). Personality style, psychological adaptation and expectations of trainee clinical psychologists. *Clinical Psychology and Psychotherapy*, *9*(4), 253–270. https://doi.org/10.1002/cpp.318

Christley, R. M. (2010). Power and errorincreased risk of false positive results in underpowered studies. *The Open Epidemiology Journal, 3(*1). https://doi.org/10.2174/1874297101003010016

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., &

Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, *10*(4), 188–197. https://doi.org/10.1037/tep0000130

Cowie, M. E., Nealis, L. J., Sherry, S. B., Hewitt, P. L., & Flett, G. L. (2018). Perfectionism and academic difficulties in graduate students: Testing incremental prediction and gender moderation. *Personality and Individual Differences*, *123*(November 2017), 223–228. https://doi.org/10.1016/j.paid.2017.11.027

Crăciun, B., & Holdevici, I. (2013). Cognitive-behavioural Intervention in Diminishing Perfectionistic Self-presentation and Depression. *Procedia - Social and Behavioral Sciences*, *78*, 476–480. https://doi.org/10.1016/j.sbspro.2013.04.334

Cushway, D. (1992). Stress in clinical psychology trainees. *British Journal of Clinical Psychology*, *31*(2), 169–179. https://doi.org/10.1111/j.2044-8260.1992.tb00981.x

Dayal, H., Weaver, K., & Domene, J. F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research*, *25*(2), 153–167. https://doi.org/10.1177/1049732314551988

Digiuni, M., Jones, F. W., & Camic, P. M. (2013). Perceived social stigma and attitudes towards seeking therapy in training: A cross-national study. *Psychotherapy*, *50*(2), 213–223. https://doi.org/10.1037/a0028784

Egan, S. J., Wade, T. D., Shafran, R., & Antony, M. M. (2016). *Cognitive-behavioural treatment of perfectionism.* Guildford Publications.

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6*(2), 122–134. https://doi.org/10.1037/a0028768

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). The clinical perfectionism questionnaire. *Unpublished scale.*

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods*, *39*(2), 175-191.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research*, *14*(5), 449–468. http://link.springer.com/article/10.1007/BF01172967

Grice, T., Alcock, K., & Scior, K. (2018). Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical Psychology and Psychotherapy*, *25*(5), 721–729. https://doi.org/10.1002/cpp.2192

Health Education England. (2019). *NHS Staff and Learners ' Mental Wellbeing Commission*. *February*, 1–96. https://www.hee.nhs.uk/sites/default/files/documents/NHS %28HEE%29 - Mental Wellbeing Commission Report.pdf

Hewitt, Paul L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., McMurtry, B., Ediger, E., Fairlie, P., & Stein, M. B. (2003). The Interpersonal Expression of Perfection: Perfectionistic Self-presentation and Psychological Distress. *Journal of Personality and Social Psychology*, *84*(6), 1303–1325. https://doi.org/10.1037/0022-3514.84.6.1303

Huprich, S. K., & Rudd, M. D. (2004). A National Survey of Trainee Impairment in Clinical, Counseling, and School Psychology Doctoral Programs and Internships. *Journal of Clinical Psychology*, *60*(1), 43–52. https://doi.org/10.1002/jclp.10233

Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional Burnout, Early Maladaptive Schemas, and Physical Health in Clinical and Counselling Psychology Trainees. *Journal of Clinical Psychology*, *73*(12), 1782–1796. https://doi.org/10.1002/jclp.22485

LaSota, M. T., Ross, E. H., & Kearney, C. A. (2017). A Cognitive-Behavioral-Based Workshop Intervention for Maladaptive Perfectionism. *Journal of Rational - Emotive and Cognitive - Behavior Therapy*, *35*(3), 314–328. https://doi.org/10.1007/s10942-017-0261-7

Leeds Clearing House (n.d.) *Equal opportunities.* https://www.leeds.ac.uk/chpccp/equalopps.html

Limburg, K., Watson, H. J., Hagger, M. S., & Egan, S. J. (2017). The Relationship Between Perfectionism and Psychopathology: A Meta-Analysis. *Journal of Clinical Psychology*, *73*(10), 1301–1326. https://doi.org/10.1002/jclp.22435

Lloyd, S., Schmidt, U., Khondoker, M., & Tchanturia, K. (2014). Can Psychological Interventions Reduce Perfectionism? A Systematic Review and Meta-analysis. *Behavioural and Cognitive Psychotherapy*, *29*(4). https://doi.org/10.1017/S1352465814000162

Maton, K. I., Wimms, H. E., Grant, S. K., Wittig, M. A., Rogers, M. R., & Vasquez, M. J. T. (2011). Experiences and Perspectives of African American, Latina/o, Asian American, and European American Psychology Graduate Students: A

National Study. *Cultural Diversity and Ethnic Minority Psychology*, *17*(1), 68–78. https://doi.org/10.1037/a0021668

Morris, S., Earl, C., & Neave, A. (2017). Health Survey for England 2016 Well-being and mental health. *Health and Social Care Information Centre*, *December*, 1–20. http://healthsurvey.hscic.gov.uk/media/63763/HSE2016-Adult-wel-bei.pdf

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. *Training and Education in Professional Psychology*, *6*(1), 55–66. https://doi.org/10.1037/a0026534

Pakenham, K. I. (2017). Training in acceptance and commitment therapy fosters self-care in clinical psychology trainees. *Clinical Psychologist*, *21*(3), 186–194. https://doi.org/10.1111/cp.12062

Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in Clinical Psychology Trainees: Current Research Status and Future Directions. *Australian Psychologist*, *47*(3), 147–155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Presley, V. L., Jones, C. A., & Newton, E. K. (2017). Are Perfectionist Therapists Perfect? the Relationship between Therapist Perfectionism and Client Outcomes in Cognitive Behavioural Therapy. *Behavioural and Cognitive Psychotherapy*, *45*(3), 225–237. https://doi.org/10.1017/S1352465817000054

Rice, K. G., & Dellwo, J. P. (2001). Within-semester stability and adjustment correlates of the multidimensional perfectionism scale. *Measurement and Evaluation in Counseling and Development*, *34*(3), 146–156.

https://doi.org/10.1080/07481756.2002.12069031

Sassaroli, S., Romero Lauro, L. J., Maria Ruggiero, G., Mauri, M. C., Vinai, P., & Frost, R. O. (2008). Perfectionism in depression, obsessive-compulsive disorder and eating disorders. *Behaviour Research and Therapy*, *46*(6), 757–765. https://doi.org/10.1016/j.brat.2008.02.007

Shafran, R., & Mansell, W. (2001). Perfectionism and psychopathology: A review of research and treatment. *Clinical Psychology Review*, *21*(6), 879–906. https://doi.org/10.1016/S0272-7358(00)00072-6

Shannon, A., Goldberg, J. O., Flett, G. L., & Hewitt, P. L. (2018). The relationship between perfectionism and mental illness stigma. *Personality and Individual Differences*, *126*, 66–70. https://doi.org/10.1016/j.paid.2018.01.022

Stoeber, J. (1998). The Frost Multidimensional Perfectionism Scale revisited: More perfect with four (instead of six) dimensions. *Personality and Individual Differences*, *24*(4), 481–491. https://doi.org/10.1016/S0191-8869(97)00207-9

Stoeber, J., & Otto, K. (2006). Positive Conceptions of Perfectionism: Approaches, Evidence, Challenges. *Personality and Social Psychology Review*, *10*(4), 295–319.

Stoeber, J., & Stoeber, F. S. (2009). Domains of perfectionism: Prevalence and relationships with perfectionism, gender, age, and satisfaction with life. *Personality and Individual Differences*, *46*(4), 530–535. https://doi.org/10.1016/j.paid.2008.12.006

Suh, H., Sohn, H., Kim, T., & Lee, D. G. (2019). A review and meta-analysis of perfectionism interventions: Comparing face-to-face with online modalities.

Journal of Counseling Psychology, *66*(4), 473–486. https://doi.org/10.1037/cou0000355

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology*, *74*(9), 1545–1555. https://doi.org/10.1002/jclp.22614

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, *5*, 1–13. https://doi.org/10.1186/1477-7525-5-63

Part 3: Critical Appraisal

Overview

The research study outlined in Part Two of this thesis aimed to examine whether a brief, CBT-based perfectionism workshop could reduce trainees' level of unhealthy perfectionism and perfectionistic self-presentation, and increase their likelihood and comfort with talking about difficulties with others in their training context. It also set out to understand the changes in trainees' wellbeing during the course of training, and to determine the way in which unhealthy forms of perfectionism, as well as other factors, influenced trainees' likelihood of and comfort with talking about difficulties they may be experiencing with others in their training context. The following critical appraisal offers personal and practical reflections relating to the process of undertaking this research project. It outlines the process by which the key constructs for investigation were selected and discusses some of the wider challenges of undertaking this research. It ends with personal reflections on the experience of being a trainee-researcher and on the way in which my understanding of the concepts of disclosure and self-care has evolved whilst undertaking this research project.

Helping the Helper

Caring for others in distress is important and meaningful work. However, the emotional and interpersonal demands of the role, as well as work-related factors such as high workload can contribute to elevated stress levels and burnout in healthcare professionals (Bria et al., 2012; Kaeding et al., 2017; Pakenham & Stafford-Brown, 2012; Yang et al., 2015). This in turn has been linked to feelings of hopeless and depression, and can also give rise to compassion fatigue in healthcare professionals (Cocker & Joss, 2016; Pompili et al., 2006). In the UK, sickness absence rates were higher in the NHS than in any other sector, with nearly four million sick days taken

due to reasons of stress or other psychological distress between 2017 and 2018 (NHS Digital, 2019). This highlights the extent of the personal impact of caring for others. Having previously worked on an adolescent inpatient ward prior to embarking upon clinical training, I have witnessed first-hand how working with individuals experiencing significant distress can greatly influence one's personal and professional functioning. I have also experienced the restorative effects of staff support programmes, through attending reflective practice, formal service-led wellbeing programmes as well as accessing informal sources of support. Such experiences stimulated my interest in ways in which services may 'help the helper' and promote staff wellbeing. This coupled with the personal resonance of conducting research for the benefit of fellow trainees piqued my interest in undertaking this particular research project.

Development of the Study

Previous research examining the factors that influence trainees' likelihood of talking about mental health difficulties demonstrated the hindering role of perfectionism, in particular maladaptive perfectionism (Grice et al., 2018b). This study formed the basis for the present research and as such, perfectionism and trainees' attitudes towards talking about mental health difficulties were deemed central concepts for further investigation. Specifically, the research aimed to examine whether reducing maladaptive perfectionism and perfectionistic self-presentation could in turn alter trainees' attitudes towards talking about mental health problems.

Unhealthy forms of perfectionism can be characterised by a heightened concern about making mistakes, which has been found to be elevated in trainees (Grice et al., 2018b), and by an unhealthy pursuit to maintain a perfect image of oneself in front of others. This raised the question as to whether such forms of

perfectionism, namely maladaptive perfectionism and perfectionistic self-presentation, also hindered trainees from talking about other difficulties or issues they may be experiencing, in an attempt to maintain a perfect self-image. For instance, the concealment of an error occurring in one's clinical practice has potentially harmful implications for the quality of client care, and for trainees' professional development. However, the potential for negative appraisal, as well as the shame and embarrassment associated with disclosure of an error to one's supervisor (Ladany et al., 1996; Yourman & Farber, 1996), may deter trainees with high levels of unhealthy perfectionism from raising such issues. Given this, the relationship between unhealthy perfectionism and the disclosure of clinical errors was considered an important area for investigation. Indeed, research with medical students and doctors revealed that societal expectation of perfection from health professionals often served as a barrier to the disclosure of clinical errors (Kaldjian et al., 2006), though similar research with (trainee) psychologists was lacking.

I subsequently spent time familiarising myself with the literature on the disclosure of clinical errors. Through this, I noted that this phenomenon was typically studied through presenting participants with short vignettes in which a clinical error had occurred, and asking participants to rate their likelihood of disclosing to one's supervisor or a senior member of staff, if this had occurred to them (e.g. Lawton & Parker, 2002). A similar methodology was therefore deemed suitable for the present study. With the support of a small focus group of trainees and course staff, three clinical error scenarios were developed. These aimed to reflect anxiety-provoking errors which were likely to occur within clinical practice, and which would generate a range of responses in terms of trainee' disclosure, whilst attempting to detect perfectionism-based variations in the responses. The vignettes

described a therapeutic rupture, a procedural error and risk-related error (see Appendix E for scenarios).

These scenarios were subsequently piloted with a group of 27, second-year trainee clinical psychologist. Trainees were presented with the three scenarios and asked to rate on a seven-point Likert scale, "how likely is it that you would discuss this with the following people (current placement supervisor, a colleague at placement and fellow trainee), if it were to happen to you?" Scored ranged from one (very unlikely) to seven (very likely). They were also provided an open comment box, to elaborate upon their answer.

Upon review of the results and trainees' comments however, several issues were highlighted. Firstly, a ceiling effect was noted in the responses, suggesting that the scenarios did not adequately activate perfectionism in trainees' responses, or that the scenarios were not sufficiently anxiety-provoking, shameful or embarrassing for trainee to consider concealing the errors from others. This also meant that we would not be able to capture any potential increases in trainees' likelihood of disclosure of clinical errors following the workshop, as was hypothesised, if used in the empirical study. There also appeared to be several factors beyond perfectionism that influenced the responses to the scenarios, such as level of risk and rules and regulations, such as GDPR, which necessitated disclosure. The responses also appeared to be confounded by trainees' level of conscientiousness. Potential changes to the vignettes were considered, though none seemed to adequately address these issues identified.

Upon reflection, the primary aim of the workshop was on targeting unhealthy perfectionism and examining how such forms of perfectionism influenced trainees' mental health and wellbeing, and their attitudes towards talking about mental health

difficulties. It was therefore felt that in adapting the workshop to also include disclosure of clinical errors may dilute the potential benefits of the workshop, or may result in the workshop being entirely ineffective at achieving either aims. Thus, it was decided for the focus of the workshop to remain on perfectionism and on maximising the change on measures of disclosure. The decision was then made to include a measure trainees' attitudes towards talking about personal difficulties, as these are also commonly experienced by trainees during training, and which too have a considerable impact on their wellbeing and functioning.

Nonetheless, there appears to be a critical gap in the literature examining the role of perfectionism in shaping trainees' attitudes towards disclosing errors that occur in clinical practice, particularly to one's placement supervisors. One may speculate that the power imbalances and evaluative nature of the trainee-supervisor relationship may mean that those with high levels of maladaptive perfectionism and perfectionistic self-presentation may feel particularly unable to talk about errors occurring in their clinical work. Regrettably, there was insufficient time to develop appropriate scenarios to examine this further in the present thesis. However, as reported in part two, trainees display elevated levels of maladaptive perfectionism and perfectionistic self-presentation relative to community samples and levels comparable to clinical samples (Paul L. Hewitt et al., 2003; Sassaroli et al., 2008; Stoeber, 1998). This coupled with the potential consequences of concealment of clinical errors underlines the need for further research to examine whether perfectionism does indeed impede trainees' ability to disclose clinical errors, and for the development of interventions or forms of support that may reduce the influence of such perfectionism.

Challenges and Limitations

In the interest of brevity, part two of this thesis outlined three key limitations of the study that affected the generalisability of the observed findings. These included the high drop-out rate at follow-up that limited the validity of the findings, practical issues that necessitated a focus on change in trainees' perceived likelihood and comfort with disclosure rather than on direct observation of behaviour change and thirdly, the lack of measurement of adaptive forms of perfectionism and potential demand effects. Wider challenges of conducting this research are discussed below.

Maintaining Anonymity

Considering a way in which to incorporate demographic factors without compromising anonymity posed a notable challenge in the present research. Being from a South Asian background but born in the UK, I was mindful of the cultural variations in the understanding of, and degree of stigma associated with the experience of mental health problems and to help-seeking. Indeed, I had also begun to note the role of culture and ethnicity whilst familiarising myself with the key literature on perfectionism and disclosure of mental health problems. For instance, several studies conducted in Westernised countries have found that individuals from ethnic minority backgrounds express greater concern about being stigmatised for having mental health difficulties (Cooper-Patrick et al., 1997; Memon et al., 2016) and hold more stigmatised views of others experiencing mental health difficulties (Angermeyer & Dietrich, 2006; Anglin et al., 2006; see Abdullah & Brown, 2011) than their white counterparts. Such stigmatised views can deter individuals from ethnic minority backgrounds from talking about mental health problems within the workplace and seeking formal help (Jones, 2011; Memon et al., 2016), though other research suggests that individuals of African American heritage perceive greater

benefits from disclosing (P. Corrigan et al., 2010). Similar cultural differences have also been observed in the manifestation of perfectionism. Research has found higher levels of self-oriented perfectionism in Americans than in British or Canadian college students, though the latter two groups display higher levels of socially prescribed perfectionism (Curran & Hill, 2019), the trait perfectionism dimension that is more closely associated with psychological distress (Limburg et al., 2017). Further, it has been suggested that individuals from more collectivist cultures, for instance Asian Americans, endorse higher levels of maladaptive perfectionism than Caucasian Americans (E. C. Chang, 1998) and African Americans (Castro & Rice, 2003).

Although aware that there may be some difference in the views held by trainee clinical psychologists towards mental health difficulties than by others in the general population, I was keen to examine the role of culture in shaping trainees' attitudes towards talking about difficulties in the present study. However, discussing these ideas with my supervisor highlighted how they may compromise anonymity, particularly when considered in conjunction with other demographic factors, such as gender, age and university of attendance. That inclusion of such demographic factors would mean trainees from ethnic minority backgrounds, and particularly who were older and/or male would be particularly identifiable, and thus information about one's ethnicity was omitted from the study. However, given the cross-cultural variation in perfectionism and attitudes towards disclosure, it is unclear whether cultural factors influenced the way in which trainees responded to workshop. It therefore seems important for future replications of this study to consider the role of culture, to ascertain whether such a workshop would be equally effective when delivered to a more diverse group of trainees, or in other countries.

Similarly, in order to maintain trainee anonymity, it was also not possible to analyse data between each training institution, despite the strength of the utilised statistical analysis technique, namely mixed linear modelling, at analysing within-subjects, nested data (Field, 2013). The investigation of university-level differences seems of particular importance, as there is likely to be considerable variation across each institution on several factors, such as in the levels of perfectionism, culture of self-care, as well as in elements of the training programme, which may have influenced how trainees responded to the workshop. For instance, whilst introducing the workshop, trainees at one university shared that they were accustomed to thinking about their own needs, were aware of whom they may approach for help with different issues and of the self-care focus of the workshop. In contrast, trainees at other universities expressed that they were unaware that this workshop was aimed at supporting them and expressed that there had been little focus on their wellbeing until that point in training. Such differences in the culture of self-care and trainee support may have contributed to university-level differences in trainees' attitudes towards disclosure, which could not be captured in the present study. It may also be argued that the opt-in nature of the present study may have given rise to a selection bias, with training providers that place greater emphasis on the promotion of trainee wellbeing opting to host the workshop and participate in the research. Hence, it is possible that trainees' likelihood and comfort ratings across the four universities may comparatively have been higher than those of trainees at programmes that did not express an interest in hosting the workshop. To address this, it may have been useful to distribute the survey amongst trainees who did not attend the workshop to act as a control, though this would have posed ethical challenges relating to withholding a

potentially beneficial intervention from trainees. Nonetheless, these are important considerations for future research.

Statistical Analysis

Anticipating that some trainees may not complete the follow-up survey, a number of actions were put in place to increase the completion rate and account for missing data. This included offering an incentive for completion, reminder emails and a method of data analysis that would account for missing data, specifically an intention-to-treat analysis. However, when I came to analyse the data, it became apparent that the completion rate was too low (30%) for the intention-to-treat analysis to be valid and produce meaningful results for interpretation, as it would require imputation of a large amount of data, and would mitigate the systematic differences observed between completers and non-completers (Gupta, 2011). This meant I had to reconsider the statistical analysis. In doing so, the complexity of the data set became apparent. Indeed, there were several levels to the two disclosure-related outcome variables, namely likelihood of disclosure and comfort with disclosure. This included, time (baseline, post-workshop and follow-up), recipient (placement supervisor, member of course staff and fellow trainee) and type of difficulty (mental health problem and personal difficulty), each of which were stored in separate columns on the SPSS data file.

A repeated-measures ANOVA, as was originally planned, would therefore not allow me to examine the relative influence of each these factors on trainees' likelihood of and comfort with disclosure ratings. It would also mean that a large amount of data would be excluded when running the analysis, which may introduce bias in the data. I considered several different statistical techniques, including

ANCOVA, MANCOVA and multiple regression, but none offered a viable solution that adequately accounted for all the aforementioned variables, until eventually discovered mixed linear modelling, a statistical technique that is particularly effective at analysing within-subjects data that is clustered within other variables (Field, 2013). At this stage, the support that I received from Rob Saunders in navigating through the complexity of the analysis was invaluable, who helped me consider how best to treat the missing data, guided me on the appropriateness of conducting a mixed linear model, and recommended several useful online resources that offered guidance on how to conduct this analysis.

Learning how to conduct a mixed linear model analysis was a long and complex process, made more challenging by the apparent lack of clear and consistent guidance on the different elements and key variables that are needed to run a mixed linear model analysis. Indeed, at times I felt overwhelmed by a sense of despair and dread regarding the analysis, though eventually reached a working understanding of the method. However, I was unable to identify a way in which to restructure the data that accounted for all three the grouping factors, specifically time, recipient and type of difficulty, due to which I eventually decided to conduct separate analyses for mental health problems and personal difficulties. I believed this provided the best way in which to examine the hypotheses relating to changes over time, and regarding differences in disclosure to different recipients.

Experiencing such difficulties with the statistical analysis has demonstrated the importance of considering the type of data one will gain, and in particular, the specific statistical analysis that will need to be conducted at the start of the research. Upon reflection, the planned analysis, namely a repeated-measures ANOVA, only addressed two of the three hypotheses of the present research and more careful

consideration of all hypotheses at the planning stage may have permitted me more time to familiarise myself with mixed linear modelling. Furthermore, I have become more aware of the degree of imprecision involved when conducting mixed linear models, which involves the inclusion and removal of fixed and random-effect parameters and interactions that produce the lowest Schwarz's Bayesian Information Criterion (BIC) value. In this way, it is possible that an untested constellation of parameters may have provided a better fit of the data. Conducting such an analysis therefore emphasised to me the importance of drawing upon theory and being guided by one's hypotheses when testing different models.

Reflections on Being a Trainee-Researcher

As the topic of research aligned with an area of personal interest and focused on an intervention aimed at supporting a group of which I was a part meant I was particularly keen to undertake this research. This degree of personal resonance served as great motivator throughout the journey of completing this research project. However, it also posed unique challenges that I had not anticipated.

There were several benefits of being a trainee through this research process. Notably, my position as a trainee helped me think critically and guided my decision making on elements of the research, including the language used in the workshop and the measures that were included in the empirical study. For instance, with its use of positive language and focus on wellbeing rather than illness, trainees' psychological wellbeing was measures using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007), rather than a more well-established measure such as the Patient Health Questionnaire, 9-items (PHQ-9; Kroenke et al., 2001). This was because it was felt that the latter would be very familiar to trainees participating in the study, and with is focus on depression-related

symptomatology, perhaps experienced as pathologising. Further, I believe that as the workshop formed part of a trainee research project, and having personally attending each workshop may have, this may have facilitated a shift away from the notion that the research, and by extension the workshop, was being 'done to' them, to a view of this being 'done with' them, for trainees participating in the study. It is felt that this may have promoted trainees' level of engagement with the content of the workshop, thereby increasing the success of the intervention.

Despite these benefits, there were a number of challenges that accompanied being a trainee whilst conducting this research. Firstly, the initial plan was for the developer of the workshop to deliver two of the sessions, and for me to deliver the remainder. However, upon review, it was felt that a trainee delivering teaching to other trainees may differentially impact the effectiveness of the workshop (than if delivered by a qualified clinician or researcher) and thus would introduce a confound into the research. As such, support with delivering the workshop was therefore sought from the wider clinical and research team. Further, it is possible that my presence at the workshops, and position as a fellow trainee may have given rise to social desirability bias or demand effects, which may have accounted for the observed findings. Thus, future replication is needed in order to ascertain if and how my position as a trainee influenced the responses of trainees participating in the research.

Reflecting upon this experience has highlighted to me the extent to which aspects of one's identity and life experiences can influence one's perspective and orientation as a researcher. Indeed, it was not until I was revising my empirical paper, when a comment from one of my supervisors, to refer to trainees as 'participants' in line with convention, revealed to me the extent to which I had

identified with the trainee aspect of my identity in this work, and comparatively, how I felt less connected with my identity as a researcher. I believe this difference has greatly shaped the way in which I approached the research questions, as well as the conclusions and implications drawn from the obtained results. Looking forward, I am curious how my developing confidence as a researcher, and experience of having been a trainee will influence my perspective and approach in the future.

From an Individual to Systemic View of Disclosure and Self-Care

At the commencement of this research project, I regarded the decision to disclose or conceal any difficulties one may be experiencing as a personal process, driven by a series of internal factors that were shaped through one's life experiences. In this way, I believed the research aimed to promote trainees' ability to talk about difficulties through the attenuation of one such internal factor, namely perfectionism, which has been found to impede upon one's ability to talk about difficulties with others (e.g. D'Agata & Holden, 2018; Grice et al., 2018; Kawamura & Frost, 2004; Stoeber et al., 2017; see Part 1 for a review).

This aim was achieved, with the workshop outlining the strategies that trainees may be able to employ to challenge more unhealthy forms of perfectionism, and notably, increasing trainees' likelihood and comfort with talking about difficulties they may be experiencing, and seek support from others in their training context. In light of the evidence of the benefits of seeking social support, such as reduced psychological distress, reduced feelings of shame and better academic performance (Colman et al., 2016; Dayal et al., 2015), this is a welcome finding as it suggests that a workshop of this nature can increase trainees' ability to seek help, which can promote their wellbeing and functioning in the long-term.

As the research progressed however, I became increasingly aware of the systemic influences on trainees' wellbeing and abilities to raise difficulties with others in their training context. This underscored the need for collaboration with training and placement providers, and with the wider system to promote trainee wellbeing. As discussed in part one of this thesis, disclosure is not always beneficial, particularly within demanding, unsympathetic or hostile environments (e.g. Brohan et al., 2012; Ilic et al., 2012; Jones, 2011). Thus, it became apparent that for trainees to feel safe to raise any difficulties they may be experiencing, training and placement providers also need to build compassionate and supportive environments that invite conversations about trainees' mental health and wellbeing. It also highlighted to me that equipping trainees with the strategies to self-manage distress was insufficient, and instead there needed to be a wider systemic change in the culture of clinical training to ensure trainees' wellbeing was prioritised. One solution may be to reduce the number of demands placed on trainees during training. However, this is unlikely to be feasible given the breadth of material that needs to be covered to meet accreditation requirements. Given this, delivering the perfectionism self-care workshop as part of an existing training programme seems fundamental in beginning to build a more compassionate training environment and offers a way to promote trainees' wellbeing and help-seeking, without adding further content to the curriculum or increasing the demands placed upon trainees.

Despite research outlining the detrimental impact of clinical training on trainee wellbeing (Cushway, 1992; El-Ghoroury et al., 2012), and calls by researchers and professional and statutory bodies for more to be done by training providers to safeguard trainees' wellbeing during training, few training providers expressed an interest in hosting the workshop. Indeed, even amongst the four

universities where the workshop was delivered, there was considerable variation in relation to the nature and depth of discussions with the trainee cohorts regarding the demanding nature of clinical training, self-care, and the importance of timely help-seeking. Yet to not address the impact of training on trainees' mental health and wellbeing, and to not offer ways in which to promote trainees' abilities to cope with the demands of training is to disregard the harm that training can cause. This is particularly pertinent given the results obtained in the empirical study reported herein, which highlights the high rates of mental health problems and personal difficulties, and elevated levels of perfectionism amongst trainees.

The potential ramifications of inaction for trainees' wellbeing therefore underscore the importance of disseminating the findings from this thesis, and of widely implementing the workshop. Seeking publication therefore seems imperative, though of equal importance seems to be the dissemination of these findings amongst course directors, course staff, placement supervisors and importantly, other trainees. It is hoped that in doing so can begin to open conversations between trainees, and training and placement providers about trainees' mental health and wellbeing during training. It is also hoped that this will provide training institutions with a viable option for how to implement self-care training into the curriculum, thereby building more compassionate training environments and enriching trainees' experience of clinical training. Finally, beyond training providers, such findings perhaps also call for policy-level change, for the promotion of wellbeing during training to be made a key priority for training providers, and even for training in self-care to be made a mandatory part of the training curriculum.

Conclusion

Through conducting this research, I have developed my understanding of the concepts of perfectionism and of issues relating to trainee wellbeing, disclosure of difficulties, and help-seeking within the training context. I have also become increasingly aware of, and learned how to navigate, some of the challenges that are associated with conducting research with trainee clinical psychologists. Some of these challenges have made me reflect upon the wider issues of the lack of diversity in trainee cohorts, and the extent to which this may be inhibiting the more in-depth study of the needs of trainees from diverse backgrounds. Indeed, this experience has highlighted to me the extent to which aspects of one's identity and one's values can shape how one understands and chooses to study particular issues and topics. Above all, conducting research has highlighted to me how close collaboration between trainees, training providers and indeed policy makers is essential for the success of any self-care intervention offered to trainees. Only then will it be possible for there to be meaningful and sustainable change in the way mental health problems and personal difficulties are communicated, and for the promotion and maintenance of trainee wellbeing to become a key priority within clinical training.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948. https://doi.org/10.1016/j.cpr.2011.05.003

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163–179. https://doi.org/10.1111/j.1600-0447.2005.00699.x

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services*, *57*(6), 857–862. https://doi.org/10.1176/ps.2006.57.6.857

Bria, M., Baban, A., & Dumitrascu, D. L. (2012). Systematic review of burnout risk factors among european healthcare professionals. *Cognition, Brain, Behavior*, *16*(3), 423–452.

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., Slade, M., & Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry*, *12*(1), 11. https://doi.org/10.1186/1471-244X-12-11

Castro, J. R., & Rice, K. G. (2003). Perfectionism and ethnicity: Implications for depressive symptoms and self-reported academic achievement. *Cultural Diversity and Ethnic Minority Psychology*, *9*(1), 64–78. https://doi.org/10.1037/1099-9809.9.1.64

Chang, E. C. (1998). Cultural differences, perfectionism, and suicidal risk in a college population: Does social problem solving still matter? *Cognitive Therapy and Research*, *22*(3), 237–254. https://doi.org/10.1023/A:1018792709351

Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*(6), 1–18. https://doi.org/10.3390/ijerph13060618

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, *10*(4), 188–197. https://doi.org/10.1037/tep0000130

Cooper-Patrick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (1997). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine*, *12*(7), 431–438. https://doi.org/10.1046/j.1525-1497.1997.00075.x

Corrigan, P., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S., Batia, K., & Rusch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology*, *38*(5), 607–621. https://doi.org/10.1002/jcop

Curran, T., & Hill, A. P. (2019). Perfectionism is increasing over time: A meta-analysis of birth cohort differences from 1989 to 2016. *Psychological Bulletin*, *145*(4), 410–429. https://doi.org/10.1037/bul0000138

Cushway, D. (1992). Stress in clinical psychology trainees. *British Journal of Clinical Psychology*, *31*(2), 169–179. https://doi.org/10.1111/j.2044-

8260.1992.tb00981.x

D'Agata, M. T., & Holden, R. R. (2018). Self-concealment and perfectionistic self-presentation in concealment of psychache and suicide ideation. *Personality and Individual Differences*, *125*, 56–61. https://doi.org/10.1016/j.paid.2017.12.034

Dayal, H., Weaver, K., & Domene, J. F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research*, *25*(2), 153–167. https://doi.org/10.1177/1049732314551988

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6*(2), 122–134. https://doi.org/10.1037/a0028768

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th edition). London: Sage.

Grice, T., Alcock, K., & Scior, K. (2018). Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical Psychology and Psychotherapy*, *25*(5), 721–729. https://doi.org/10.1002/cpp.2192

Gupta, S. (2011). Intention-to-treat concept: A review. *Perspectives in Clinical Research*, *2*(3), 109. https://doi.org/10.4103/2229-3485.83221

Hewitt, Paul L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., McMurtry, B., Ediger, E., Fairlie, P., & Stein, M. B. (2003). The Interpersonal Expression of Perfection: Perfectionistic Self-presentation and Psychological Distress. *Journal of Personality and Social Psychology*, *84*(6), 1303–1325. https://doi.org/10.1037/0022-3514.84.6.1303

Ilic, M., Reinecke, J., Bohner, G., Hans-Onno, R., Beblo, T., Driessen, M., Frommberger, U., & Corrigan, P. W. (2012). Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. *International Journal of Social Psychiatry*, *58*(3), 246–257. https://doi.org/10.1177/0020764010392058

Jones, A. M. (2011). Disclosure of mental illness in the workplace: A literature review. *American Journal of Psychiatric Rehabilitation*, *14*(3), 212–229. https://doi.org/10.1080/15487768.2011.598101

Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional Burnout, Early Maladaptive Schemas, and Physical Health in Clinical and Counselling Psychology Trainees. *Journal of Clinical Psychology*, *73*(12), 1782–1796. https://doi.org/10.1002/jclp.22485

Kaldjian, L. C., Jones, E. W., Rosenthal, G. E., Tripp-Reimer, T., & Hillis, S. L. (2006). An Empirically Derived Taxonomy of Factors Affecting Physicians' Willingness to Disclose Medical Errors. *Journal of General Internal Medicine*, *0*(0), 060721075157049-??? https://doi.org/10.1111/j.1525-1497.2006.0489.x

Kawamura, K. Y., & Frost, R. O. (2004). Self-concealment as a mediator in the relationship between perfectionism and psychological distress. *Cognitive Therapy and Research*, *28*(2), 183–191. https://doi.org/10.1023/B:COTR.0000021539.48926.c1

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, Extent, and

Importance of What Psychotherapy Trainees Do Not Disclose to Their Supervisors. *Journal of Counseling Psychology*, *43*(1), 10–24. https://doi.org/10.1037/0022-0167.43.1.10

Lawton, R., & Parker, D. (2002). Barriers to incident reporting in a healthcare system. *Quality and Safety in Health Care*, *11*(1), 15–18. https://doi.org/10.1136/qhc.11.1.7

Limburg, K., Watson, H. J., Hagger, M. S., & Egan, S. J. (2017). The Relationship Between Perfectionism and Psychopathology: A Meta-Analysis. *Journal of Clinical Psychology*, *73*(10), 1301–1326. https://doi.org/10.1002/jclp.22435

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open*, *6*(11), 1–9. https://doi.org/10.1136/bmjopen-2016-012337

NHS Digital, (2019, February 21). *Stress related sickness absence in the NHS.* https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/stress-related-sickness-absence-in-the-nhs

Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in Clinical Psychology Trainees: Current Research Status and Future Directions. *Australian Psychologist*, *47*(3), 147–155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Pompili, M., Rinaldi, G., Lester, D., Girardi, P., Ruberto, A., & Tatarelli, R. (2006). Hopelessness and Suicide Risk Emerge in Psychiatric Nurses Suffering From Burnout and Using Specific Defense Mechanisms. *Archives of Psychiatric*

Nursing, *20*(3), 135–143. https://doi.org/10.1016/j.apnu.2005.12.002

Sassaroli, S., Romero Lauro, L. J., Maria Ruggiero, G., Mauri, M. C., Vinai, P., & Frost, R. O. (2008). Perfectionism in depression, obsessive-compulsive disorder and eating disorders. *Behaviour Research and Therapy*, *46*(6), 757–765. https://doi.org/10.1016/j.brat.2008.02.007

Stoeber, J. (1998). The Frost Multidimensional Perfectionism Scale revisited: More perfect with four (instead of six) dimensions. *Personality and Individual Differences*, *24*(4), 481–491. https://doi.org/https://doi.org/10.1016/S0191-8869(97)00207-9

Stoeber, J., Madigan, D. J., Damian, L. E., Esposito, R. M., & Lombardo, C. (2017). Perfectionism and eating disorder symptoms in female university students: the central role of perfectionistic self-presentation. *Eating and Weight Disorders*, *22*(4), 641–648. https://doi.org/10.1007/s40519-016-0297-1

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, *5*, 1–13. https://doi.org/10.1186/1477-7525-5-63

Yang, S., Meredith, P., & Khan, A. (2015). Stress and burnout among healthcare professionals working in a mental health setting in Singapore. *Asian Journal of Psychiatry*, *15*, 15–20. https://doi.org/10.1016/j.ajp.2015.04.005

Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy*, *33*(4), 567–575. https://doi.org/10.1037/0033-3204.33.4.567

Appendix A: Email Invitation to Course Directors

Dear Colleagues,

We are writing to seek your support for an exciting new project aimed at improving support for trainee clinical psychologists. We know that clinical training places a high level of demand on clinical psychology trainees. The evaluative nature of training, coupled with the need to perform well, can often deter trainees from speaking with supervisors, course staff and fellow trainees about personal experiences of mental health difficulties they may experience and/or about errors they might make in clinical practice. This can have a significant impact upon trainees' personal and professional growth during training, and upon the quality of client care. Due to this, training courses are now being encouraged to do more to support trainees to share such difficulties and seek support where needed.

Coverage in the media (such as this helpful blog: https://www.smarten.org.uk/blog/student-mental-health-perfectionism-worry-and-anxiety) and our group's previous research (attached for your information) has shown that perfectionism appears to be an important influence on some trainees' reluctance to talk about difficulties they may be experiencing and to seek support. We are pleased that we've been able to join forces with Professor Roz Shafran from the Institute of Child Health, whose important work on perfectionism has gained a lot of attention. Roz will be working with us on a pilot study we will be conducting during the autumn term of the 2019-20 academic year – the study will explore whether a CBT-informed workshop focused on perfectionism can increase trainees' ability and willingness to share potential mental health difficulties and clinical errors with supervisors, course staff and fellow trainees.

Roz and a small team of other clinical psychologists will deliver a half-day, CBT-informed perfectionism workshop to year 1 trainees during the autumn term at training courses that are interested in joining this pilot. We would hope that the workshop can be integrated into the training programme and have therefore kept it half a day in length. The workshop will offer psychoeducation about perfectionism, will support trainees to develop a formulation of potential perfectionism-related strengths and difficulties they may experience, help them address some of the difficulties they may have identified using CBT techniques, and will end with relapse prevention. Data will be collected at the start of the workshop, following the workshop and at one-month follow-up. Whilst it is our intention to offer the workshop to all first year trainees on courses that sign up, trainees will be able to opt-out of partaking in the evaluation, should they wish to do so. The evaluation will be conducted by Sonam Patel, one of our 2nd years trainees. Sonam will not be involved in delivering the workshops and will pay close attention to the sensitive nature of the data collected, making sure that all data collected is anonymous.

At this stage, we are writing to see whether you might be interested in the study, and to ask whether you feel it would be possible to incorporate this workshop into your course timetable. We would be more than happy to discuss this further, and to discuss any queries or questions you may have. We are in the process of securing ethical approval for the study but thought we'd contact you now to ensure there is plenty of time to plan for the workshops.

We look forward to hearing from you.

Best wishes,
Dr Katrina Scior

Appendix B: Follow-Up Email to Trainees

Dear trainees,

As you may remember <FACILITATOR NAME> and I came to deliver the "Healthy Striving for Excellence" perfectionism workshop on <DATE OF WORKSHOP>. This workshop formed part of a wider study examining how perfectionistic, self-critical and self-compassionate trainee clinical psychologists are, and exploring ways in which to support trainees' mental health and wellbeing during training.

I am emailing you today to follow-up on the workshop and to request your support with the final part of the study. I have included here the link for the follow-up survey and would be very grateful if you could spare a few moments to complete it:

https://uclpsych.eu.qualtrics.com/jfe/form/SV_3pXB47fIgxktnhz

Participation is entirely voluntary. We anticipate that this survey will take approximately 10 minutes to complete. Also, to help us to link your responses to the different surveys, please ensure that you use the same four-digit unique identifier (last four digits of your phone number) that you used in the previous survey.

To thank you for taking the time to complete this survey, you will be entered into a draw with the chance to win one of two £50 prizes, paid out as either a voucher for a high street or online retailer, or as a contribution towards a cause of your choosing.

Thank you again for your contributions during the workshop, and for your support with this project. I have attached the information sheet to this email for your reference, though please do feel free to contact me if you have any questions about this survey, or the study.

Best wishes,

<NAME>

Trainee Clinical Psychologist

UCL Doctorate in Clinical Psychology

<EMAIL>

Appendix C: Full Survey

Title of Study

An investigation into the effects of a brief, CBT-informed intervention for perfectionism on altering attitudes towards sharing personal difficulties and mental health problems among trainee mental health professionals.

Thank you for taking part in this study. We anticipate that the survey will take 15 minutes to complete. We are interested in your genuine responses, so please answer the questions as honestly and as instinctively as possible.

You may find some of the questions in the survey distressing. In this case, please prioritise your own wellbeing, and remember you can stop and withdraw from the survey at any time by closing the tab on your web browser. Information for further sources of support are also provided at the end of the survey.

This survey has received ethical approval from UCL (ID: CEHP/2019/576). Should you have any questions and wish to contact the research team please email **sonam.patel.10@ucl.ac.uk**

Please enter your **unique identifier** (this is the last 4 digits of your mobile phone number): ___________

Gender (please tick):

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

Age:

- ☐ < 25
- ☐ 25 – 34
- ☐ 35 – 44
- ☐ 45 +

For the following statements, please select the box that best describes your experience of each **over the last 2 weeks**

Please give your immediate, instinctive response to each statement.

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Listed below are a group of statements. Please indicate your agreement with each of the following statements.

Please give your immediate, instinctive response to each statement.

	Disagree strongly			Neutral			Agree Strongly
It is okay to show others that I am not perfect	1	2	3	4	5	6	7
I judge myself based on the mistakes I make in front of other people	1	2	3	4	5	6	7
I will do almost anything to cover up a mistake	1	2	3	4	5	6	7
Errors are much worse if they are made in public rather than in private	1	2	3	4	5	6	7
I try always to present a picture of perfection	1	2	3	4	5	6	7
It would be awful if I made a fool of myself in front of others	1	2	3	4	5	6	7
If I seem perfect, others will see me more positively	1	2	3	4	5	6	7
I brood over mistakes that I have made in front of others	1	2	3	4	5	6	7
I never let others know how hard I work on things	1	2	3	4	5	6	7
I would like to appear more competent than I really am	1	2	3	4	5	6	7
It doesn't matter if there is a flaw in my looks	1	2	3	4	5	6	7
I do not want people to see me do something unless I am very good at it	1	2	3	4	5	6	7
I should always keep my problems to myself	1	2	3	4	5	6	7
I should solve my own problems rather than admit them to others	1	2	3	4	5	6	7
I must appear to be in control of my actions at all times	1	2	3	4	5	6	7
It is okay to admit mistakes to others	1	2	3	4	5	6	7
It is important to act perfectly in social situations	1	2	3	4	5	6	7

I don't really care about being perfectly groomed	1	2	3	4	5	6	7
Admitting failure to others is the worst possible thing	1	2	3	4	5	6	7
I hate to make errors in public	1	2	3	4	5	6	7
I try to keep my faults to myself	1	2	3	4	5	6	7
I do not care about making mistakes in public	1	2	3	4	5	6	7
I need to be seen as perfectly capable in everything I do	1	2	3	4	5	6	7
Failing at something is awful if other people know about it	1	2	3	4	5	6	7
It is very important that I always appear to be "on top of things"	1	2	3	4	5	6	7
I must always appear to be perfect	1	2	3	4	5	6	7
I strive to look perfect to others	1	2	3	4	5	6	7

Please indicate your agreement with each of the following statements.

Please give your immediate, instinctive response to each statement.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
If I fail at work/school, I am a failure as a person.	1	2	3	4	5
I should be upset if I make a mistake.	1	2	3	4	5
If someone does a task at work/school better than I, then I feel like I failed the whole task.	1	2	3	4	5
If I fail partly, it is as bad as being a complete failure.	1	2	3	4	5
I hate being less than the best at things.	1	2	3	4	5
People will probably think less of me if I make a mistake.	1	2	3	4	5
If I do not do as well as other people, it means I am an inferior human being.	1	2	3	4	5
If I do not do well all the time, people will not respect me.	1	2	3	4	5
The fewer mistakes I make, the more people will like me.	1	2	3	4	5

The following part of the questionnaire relates to difficulties you may be experiencing in your personal life.

Are you currently experiencing any personal difficulties, such as (but not limited to) relationship breakdown, financial difficulties, and personal injury or illness?

For the purpose of this question, personal difficulties refer to any stressful event currently occurring in your life that you are particularly preoccupied by, and which is diminishing your ability to cope with the demands of the training programme.

Y / N

In general, how comfortable would you feel talking to the following people about personal difficulties you may be experiencing and how they affect you?

	Very uncomfortable						Very comfortable
Placement supervisor	1	2	3	4	5	6	7
Member of course staff	1	2	3	4	5	6	7
A fellow trainee	1	2	3	4	5	6	7

In general, how likely is it that you would talk to the following people about personal difficulties you may be experiencing and how they affect you?

	Very unlikely						Very likely
Placement supervisor	1	2	3	4	5	6	7
Member of course staff	1	2	3	4	5	6	7
A fellow trainee	1	2	3	4	5	6	7

The following part of the questionnaire relates to mental health problems you may be experiencing yourself or may have experienced in the past.

Have you ever experienced a mental health problem?
This includes, but is not limited to, mental health problems as defined by the DSM and ICD criteria, whether or not you have received a diagnosis. For the purpose of this question, mental health problems refer to psychological and behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life.

Y / N

If yes, please indicate whether this was in the past and/or current (select all that apply).

Past Current

In general, how comfortable would you feel talking to the following people about mental health problems you may be experiencing, for example, telling them you have a mental health diagnosis and how it affects you?

	Very uncomfortable						Very comfortable
Placement supervisor	1	2	3	4	5	6	7
Member of course staff	1	2	3	4	5	6	7
A fellow trainee	1	2	3	4	5	6	7

In general, how likely is it that you would talk to the following people about mental health problems you may be experiencing, for example, telling them you have a mental health diagnosis and how it affects you?

	Very unlikely						Very likely
Placement supervisor	1	2	3	4	5	6	7
Member of course staff	1	2	3	4	5	6	7
A fellow trainee	1	2	3	4	5	6	7

Thank you for taking part in this research.

If any of the above questions have caused you any concern or distress, it may be helpful to talk to a loved one you trust, such as a family member, or close friend. There are also various sources of support available which you may wish to consider, some of which are listed below. You are also welcome to discuss any concerns with the researchers, either in person, or by emailing **sonam.patel.10@ucl.ac.uk**

Within universities:

- *University Student Mental Health and Wellbeing Psychological and Counselling Services*: a free service providing short-term psychological therapy or counselling or psychoeducation groups to help you manage a range of personal, emotional or psychological difficulties.
- *University Student Funding and Financial advice and guidance*: confidential support and advice on managing money, financial issues or funding difficulties, amongst other things.
- Speaking to members of the course and academic staff

External support:

- If you need formal support with your mental health, you should *discuss this with your GP*
- *IAPT:* provide evidence-based psychological therapy for people experiencing mental health difficulties. Website: https://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008
- *Samaritans*: a free, 24-hour confidential listening service for anyone experiencing feelings of distress. Phone number: 116 123; Website: https://www.samaritans.org
- *Nightline*: a confidential listening service, run by students for student between 6pm and 8am every night of term. They offer support and practical information. Phone: 0207 631 0101; Text: 07717 989 900; Email: listening@nightline.org.uk

Appendix D: Confirmation of Ethical Approval

Email Confirmation of Ethical Approval

Approval amendment to CEHP/2019/576

Pingault, Jean-Baptiste
Mon 04/11/2019 12:42
To: Scior, Katrina; Pingault, Jean-Baptiste; VPRO.Ethics
Cc: Patel, Sonam

Sonam Patel - PALS Ethical A...
259 KB

Dear Katrina,

I'm happy to approve your amendment to CEHP/2019/576 (attached)

Best wishes,

Jean-Baptiste

Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: CEHP/2019/576

Title of Study:

An investigation into the effects of a brief, CBT-informed intervention for perfectionism on altering attitudes towards sharing personal difficulties and mental health problems among trainee mental health professionals

Department: UCL Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher(s): Ms Sonam Patel (**XXXX**); Dr Katrina Scior (**XXXX**)

1. **Invitation Paragraph**
   As a trainee mental health professional, you are being invited to participated in this doctoral research project. As part of the study you will be invited to participate in a half-day workshop and asked to complete some questionnaires. Participation in this study is voluntary, and you have the option to opt-out of this study at any time during the research period, should you wish to do so. All data will be handled in accordance with the Data Protection Act 1998 and with GDPR and will kept anonymous. Before you decide to participate, it is important for you to understand why the research is being conducted and what participation will involve. Please therefore read this information sheet carefully and discuss with it others if you wish. You may also contact us if anything is unclear or if you have any questions.

2. **What is the project's purpose?**
   The aim of the present study is to examine how perfectionistic, as well as self-compassionate and self-critical trainee clinical psychologists are towards themselves, and to examine the extent to which such qualities impact upon trainees abilities to talk about personal difficulties and mental health problems.

3. **Why have I been chosen?**
   Information about this study was circulated to Clinical Psychology training programmes.

   - **Inclusion Criteria** – this study is open to any
     - Trainee clinical psychologist who is currently completing the first year of a UK-based doctorate in clinical psychology
   - **Exclusion Criteria**
     - Individuals who are not currently studying on the above mentioned training programme.

4. **Do I have to take part?**
   Whilst it is our intention to offer the workshop to all first-year trainee clinical psychologists, participation in the study is entirely voluntary. If you do decide to participate in this study, you will be given this information sheet to keep and will be asked to sign a consent form. Alternatively, you may opt-out of partaking in the study at any stage, should you wish to do so, without giving a reason. You also have the right to

leave unanswered any demographic questions or other questions within the survey for which you prefer not to indicate a response. However, if you do decide to withdraw from the study, as data collected from the survey will be anonymised it will not be possible to delete your existing, already provided responses to the questionnaires up to the point of withdrawal.

5. **What will happen to me if I take part?**
   As part of this study, you will be asked to complete a survey at three time points and complete a three-hour, in-person workshop. You will initially be asked to complete a survey electronically, which will ask for demographic information, specifically your gender, age and ethnicity, will consist of some questions and three scenarios, each of which will require you to indicate the most appropriate response, and completion of which is anticipated to take 15 minutes. The workshop will be delivered following this, during which you will be taught and supported to employ cognitive-behavioural strategies to promote healthy striving for your work-related goals; you will then be asked to repeat the survey immediately following the workshop. You will then be contacted 6-8 weeks after the workshop and asked to complete the survey one last time, at which point you will have the opportunity to be entered into a prize draw for a chance to win either one of two £50 Love2Shop vouchers, or for a donation to be made to a charity of your choice, should you complete the survey. The research is anticipated to be completed by June 2020.

6. **Will I be recorded and how will the recorded media be used?**
   The first workshop will be video recorded exclusively to train other qualified professionals on how to deliver the workshop. The content of the video will not be analysed, and no other use will be made of the video recording will be made without your written consent, and no-one outside the project will be allowed access to the original recording.

7. **What are the possible disadvantages and risks of taking part?**
   During the study, we will be asking you about your personal experiences of mental health difficulties, experiences relating to perfectionism and self-compassion and about your general wellbeing, which may generate some distress for some participants. At the end of the survey, we will provide information about support that can be accessed to help with some of the distress experienced, if needed.

8. **What are the possible benefits of taking part?**
   Studies conducted with other professional groups and with students have found that perfectionism and lower self-compassion are linked to a reduced willingness to speak about personal difficulties, and poorer overall wellbeing. However, there has been no research into how perfectionism and self-compassion impact trainee clinical psychologists, nor into how perfectionism and self-compassion may be addressed in trainees in order to promote ongoing personal and professional functioning.

   Although not guaranteed, it is hoped that through the workshop, participants will develop strategies that may help to reduce perfectionism and increase self-compassion, thereby improving overall wellbeing and increasing participants' willingness to share personal difficulties and experiences of mental health problems. It is also hoped that through this work, we may be able to develop a better understanding of the needs of trainee clinical psychologist and examine effective ways in which to support trainees during training.

9. **What if something goes wrong?**
   If you wish to raise a complaint about the study, please contact:

   Dr Katrina Scior
   Doctorate in Clinical Psychology

University College London
Gower Street
London WC1E 6BT
email: **XXXX**

If you feel that the above individual was unable to handle your complaint to your satisfaction, please contact the Chair of the Research Ethics Committee of the Division of Psychology & Language Sciences (Jean-Baptiste Pingault,**XXXX**).

10. Will my taking part in this project be kept confidential?

The information in this study will be collected through an online web survey, hosted using a programme called Qualtrics. All the information collected during the course of this research will be kept strictly confidential and will be anonymous, in line with the Data Protection Act 1998, and data will only be accessed by the research team. You will not be asked any questions that could make identifiable, though in order to link your responses across the three time-points, we will ask you to generate a unique identifier at the start of the survey. You will also not be identifiable in any ensuring reports or publications.

Please note that confidentiality will be maintain as far as it is possible, unless evidence of wrongdoing or potential harm is uncovered. In such cases, the university may be obliged to contact relevant statutory bodies.

11. What will happen to the results of the research project?

The present study aims to gather baseline data on levels of perfectionism and self-compassion in trainee clinical psychologists. Data from this study will be used to examine whether a brief, CBT-informed workshop can alter levels of perfectionism and self-compassion, in turn improving overall wellbeing, as well as increasing willingness to speak about personal difficulties and experiences of mental health problems. The findings from this study will provide insight into trainees needs and inform considerations for the type of support that training providers should make available to trainees, to promote their personal and professional development during training. Sonam Patel will write up the results for their doctoral thesis, and we also aim to publish the results in a peer reviewed journal within one year of completion of the study. Please contact the researchers directly, using the contact details provided at the start of this information sheet, to request a copy of any publications of the data,

12. Local Data Protection Privacy Notice

Notice:

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at **XXXX**

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice, which can be found here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows:

Gender

Age band

Training Course

The lawful basis used to process your *personal data* will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at **XXXX**.

13. Who is organising and funding the research?
This research is being organised by the Research Department of Clinical, Educational and Health Psychology, University College London (UCL).

14. Contact for further information
If you have any further questions about this study before or after participation, please feel free to contact us and we will be happy to answer any questions:

Sonam Patel
Doctorate in Clinical Psychology
University College London
Gower Street
London WC1E 6BT
Email: **XXXX**

Thank you for reading this information sheet and for considering to take part in this research study.

UCL

Consent Form

CONSENT FORM FOR TRAINEE CLINICAL PSYCHOLOGISTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

An investigation into the effects of a brief, CBT-informed intervention for perfectionism on altering attitudes towards sharing personal difficulties and mental health problems among trainee mental health professionals

Department: UCL Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher(s): Ms Sonam Patel (**XXXX**)

Name and Contact Details of the Principal Researcher: Dr Katrina Scior (**XXXX**)

Name and Contact Details of the UCL Data Protection Officer: Lee Shailer (**XXXX**)

This study has been approved by the UCL Research Ethics Committee: Project ID number: CEHP/2019/576

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction. I would like to take part in the workshop and the online survey.	
2.	I consent to participate in the study. I understand that my personal information *(i.e. gender, age, ethnicity and training course)* will be used for the purposes explained to me. I understand that according to data protection legislation, 'scientific and historical research or statistical purposes' will be the lawful basis for processing.	
3.	**Use of the information for this project only** I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that	

	my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications. I also understand that Qualitrics only records the date and time of responses; no other identifiable information is recorded.	
4.	I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	
5.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
6.	I understand the direct/indirect benefits of participating. However, no promise or guarantee of benefits have been made.	
7.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
8.	I understand that I will not benefit financially from this study or from any possible outcome it may result in, in the future.	
9.	I agree that my anonymised research data may be used by others for future research. No one will be able to identify you when this data is shared.	
10.	I understand that the information I have submitted will be published as a report and I know I can contact the researchers undertaking this study if I wish to receive a copy.	
11.	I consent to the workshop being video recorded for the purposes of training other professionals on the delivery of the workshop, and understand that the recordings will be stored anonymously, using password-protected software and will be used for training, quality control, audit and specific research purposes. To note: If you do not want your participation recorded you can still take part in the study.	
12.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
13.	I hereby confirm that: (a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and (b) I do not fall under the exclusion criteria.	
14.	I am aware of who I should contact if I wish to lodge a complaint.	
15.	Use of information for this project and beyond I would be happy for the data I provide to be archived at the Research Department of Clinical, Educational and Health Psychology. I understand that other authenticated researchers will have access to my anonymised data.	

________________________ ________________ _______________________

Name of participant Date Signature

________________________ ________________ _______________________

Name of researcher Date Signature

Appendix E: Clinical Error Vignettes

Scenario 1 – Therapeutic rupture

You are currently working at an IAPT service and have a number of clients on your case load. During your session with one of your clients who had experienced physical abuse as a child, you are discussing their formulation and accidently refer to the abuser by the incorrect name. The client corrects you and becomes visibly hurt and upset by the mistake. Despite your attempts to address this mistake with the client, they do not wish to talk about it further, and for the remainder of the session, you struggle to engage your client with the therapeutic task. The following week, your client does not attend their scheduled session, nor has called to cancel.

Scenario 2 – Procedural

You are coming to the end of your adult placement and have just completed your final assessment at a client's home. You return to the office and send a brief assessment report to the client's GP and enter your notes from the assessment onto the service's electronic client record system. Later, whilst shredding and clearing your paperwork you are unable to locate some of the documents from the earlier home assessment and are unsure whether you have already shredded them, or whether you lost them on your way back to the office. Although you know that the documents did not contain any identifiable information, they did contain the client's initials, a simple cross-sectional CBT formulation (hot cross bun) and outcome measures, specifically the PHQ-9 and the GAD-7.

Scenario 3 – Risk / Safeguarding

You are at placement on an acute mental health ward and have started working with a client with longstanding difficulties with low mood and self-harm. During one of your sessions, your client discloses that another service-user has been

intimidating and bullying them and therefore, you focus the remainder of your session on developing a comprehensive safety plan with your client. You also inform the ward staff, and following a discussion with your team, raise a safeguarding concern. However, focused on reducing the risk posed to your client by the other service-user, you forget to assess their risk of self-harm. Four days later, your client's key worker approaches you and expresses their concerns about two new cuts they have noticed on your client's left arm.