An Exploration of Perfectionism and Psychological Wellbeing Amongst Undergraduate and Postgraduate Students

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Thesis Portfolio Abstract

Purpose: This thesis aims to explore a) the associations between perfectionism, coping styles and psychological distress in university students, and b) the qualitative experiences of perfectionism and psychological wellbeing in Trainee Clinical Psychologists ('trainees').

Design: The portfolio contains the following sections: a) an introduction to the thesis portfolio, b) a systematic review of the literature on perfectionism, coping styles and psychological distress in university students, c) a bridging chapter summarising the literature on perfectionism and psychological wellbeing in postgraduate and healthcare students, including trainees, d) an empirical paper exploring the qualitative experiences of perfectionism and psychological wellbeing in trainees, e) an additional methodology chapter, and f) an overall discussion and critical evaluation.

Findings: The systematic review provides evidence for coping styles as a mediating factor in the association between perfectionism and psychological distress in university students but identifies a need for exploring qualitative experiences of perfectionism and psychological wellbeing in postgraduate and healthcare students, including trainees. The empirical paper used thematic analysis to identify three over-arching themes: a) The Paradox of Perfectionism, which describes trainees' experiences of perfectionism protecting against negative self-beliefs, defining their self-image and gaining praise, whilst rendering them vulnerable to experiencing imposter syndrome, b) The Struggling Helper, whereby trainees reported experiencing psychological distress, but feeling unable to seek support, and c) Togetherness in Transformation, which describes how the shared experience with trainee and qualified colleagues helps to reduce perfectionistic standards and develop healthy self-relating.

Originality/value: The portfolio provides rich, qualitative accounts of the meanings and experiences of perfectionism in the examined populations, which adds depth to the current theoretical conceptualisations of perfectionism. The portfolio has implications for wellbeing support provided by universities, including UK ClinPsyD training institutions, as well as for the ongoing development of cognitive and third-wave approaches for perfectionism.

Table of Contents

Acknowledgements

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Chapter One – Thesis Portfolio Introduction

This thesis was undertaken as part of the Professional Doctorate in Clinical Psychology at the University of East Anglia.

Chapter one offers an introduction to the thesis portfolio. It first outlines the current literature regarding the conceptualisation of perfectionism, before discussing the definitions of psychological wellbeing and psychological distress and their associations with perfectionism. Next, literature regarding perfectionism and psychological wellbeing in the university student population is discussed, before a rationale for the thesis portfolio is provided. Finally, the structure of the thesis portfolio is outlined.

What is perfectionism?

One of the earliest definitions of perfectionism within the literature is outlined by Burns (1980), who suggested perfectionists to be those "whose standards are high beyond reach or reason, people who strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment […] the effort for excellence is self-defeating." (pp.34). In this definition, Burns (1980) describes perfectionism as a unidimensional construct that is maladaptive in nature, but in later years, debate arose within the field of perfectionism research regarding the complex multidimensional nature of the phenomenon. Ten years later, for example, Frost et al. (1990) proposed the first multidimensional model of perfectionism, which is characterised by six factors: a tendency for organisation (i.e., an emphasis on order and precision), living up to parental expectations, parental criticism (a developmental precursor as well as maintenance factor), having high personal standards (i.e., setting excessively high goals), a concern over mistakes (and fear of failure) and doubts about one's actions.

A year later, this was extended further by Hewitt and Flett (1991), who considered psychodynamic principles, as well as elements of attachment theory, to propose three elements of perfectionism that can be expressed inter- or intra-personally: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. It is suggested that these elements may exist on a continuum of severity, rather than as categorical, discrete constructs (Smith et al., 2021).

What both theories did not explain, though, is that perfectionism is proposed to have both benefits and consequences for psychological wellbeing. Studies using confirmatory factor analyses of the multi-dimensional models found that the multiple factors that define perfectionism could be collapsed into two elements of 'adaptive' and 'maladaptive' types (Limburg et al., 2017; Slade & Owens, 1998; Wang & Zhang, 2017). For example, maladaptive perfectionism was found to be comprised of socially prescribed perfectionism (Hewit et al., 1991), concern over mistakes, doubts about actions and

parental expectations (Frost et al., 1990). Adaptive perfectionism was found to be comprised of self-oriented perfectionism, other-oriented perfectionism (Hewitt-Flett, 1991) and personal/high standards (Dunkley et al., 2000; Frost et al., 1990; Noble et al., 2014; Slaney et al., 2001). Adaptive perfectionism has been associated with healthy psychological wellbeing, notably through increasing self-esteem and self-perception, and attaining set goals (Fallahchai et al., 2019; Perrone-McGovern et al., 2015; Stoeber et al., 2008), whereas maladaptive perfectionism has been suggested to be associated with psychological distress (Egan et al., 2011).

What is psychological wellbeing?

The World Health Organisation (WHO) has defined positive psychological wellbeing as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001).

Ryff and Keyes (1995) proposed a six-factor model of psychological wellbeing, which suggests that healthy psychological wellbeing is comprised of self-acceptance, environmental mastery, positive relationships, personal growth, purpose in life and autonomy. These factors are theoretically grounded in several well-established and highly researched models, such as Maslow's (1943) Hierarchy of Needs, the Personal Development Model (Erikson, 1963) and Rogers' conceptualisation of the Fully Functioning Person (Rogers, 1963). They can be relatively stable throughout an individual's life, and factors such as adaptive perfectionism, in particular, can work to positively influence life satisfaction and maintain psychological wellbeing (Kamushadze et al., 2021; Suh et al., 2017). However, negative life experiences and a predisposition to maladaptive perfectionism can reduce autonomy, environmental mastery, personal growth, and purpose, leading to psychological distress (Anand & Nagle, 2016; Chang, 2006; Ryff & Keyes, 1995; Ryff & Singer, 2008).

Psychological distress and its association with perfectionism

The American Psychological Association (APA, 2021) defines psychological distress as "the negative stress response, often involving negative affect and physiological reactivity: a type of stress that results from being overwhelmed by demands, losses, or perceived threats. It has a detrimental effect by generating physical and psychological maladaptation." Research suggests that maladaptive perfectionism can render an individual vulnerable to generalised anxiety, social anxiety, panic disorder, obsessive compulsive disorder, low mood and eating disorders (Shafran & Mansell, 2001), suicidal ideation (Blatt, 1995; Egan et al., 2011; Smith et al., 2018) and early mortality (Fry & Debats, 2009). This strong association exists across a range of samples in Western and

non-Western cultures, and different ages and genders, suggestive of the universal nature of this phenomenon (Aboalshamat et al., 2017; O'Connor et al., 2007).

One explanation for this association is that perfectionism can negatively impact an individual's psychological wellbeing through reducing autonomy, environmental mastery, growth, and purpose (Anand & Nagle, 2016; Chang, 2006; Ryff & Keyes, 1995). Studies on the Perfectionism Social Disconnection Model, which suggests that perfectionistic individuals suffer damage (and 'disconnection') in relationships due to imposing high standards on others or wishing to appear perfect in others' eyes (Hewitt et al., 2006), have shown that social communication styles and social disconnection indeed play a mediative role in the link between perfectionism and psychological distress (Arce & Polo, 2017; Barnett & Johnson, 2016; Sherry et al., 2016).

However, Egan et al. (2011) also proposed that perfectionism and associated cognitions can play a predisposing and maintaining factor for psychological distress. In their cognitive behavioural model of clinical perfectionism, Shafran and colleagues (2010) suggest that perfectionistic individuals set high goals that are unachievable, or continually 'raise the bar' following achievements, which can lead to constant self-imposed pressure, self-criticism, ruminative thinking (James et al., 2015; Macedo et al., 2015; Xie et al., 2019) and negative coping behaviours (e.g., avoidance and procrastination; Rice et al., 2012), which can give way to perceived failure and self-perpetuate negative core beliefs of inadequacy, a key component in many psychological disorders (Shafran et al., 2010). A clinical focus on the core transdiagnostic element of perfectionism in cognitive behavioural therapy has been shown to reduce levels of psychological distress in trials (Egan et al., 2011), including those for anxiety (Glover et al., 2007), depression (Riley et al., 2007) and anorexia nervosa (Steele & Wade, 2008; Wilksch et al., 2008).

Why research university students, in particular?

A growing body of research suggests that the prevalence of psychological wellbeing difficulties in university students is higher than the general population, with rates of approximately 37% for depression and 46% for anxiety (Jenkins et al., 2020), which have increased over the past decade (McManus & Gunnell, 2020). Alarmingly, a study by Akram et al. (2020) found that 37% of 1273 students were classified as high-risk for suicide.

University is typically a time of change and life transition (Ludtke et al., 2011), which research has found to predict psychological wellbeing (Cleary et al., 2011; Geirdal et al., 2019). Psychological wellbeing has also been found to impact on academic achievement and postgraduate employment opportunities (Marin et al.,2011). Interestingly, however, research has found that personality traits, including perfectionism,

predict psychological wellbeing over and above life events (Diener, 2009; Fowler et al., 2018).

Thus, it is of paramount importance that universities provide timely and adequate support for psychological wellbeing. Indeed, the number of self-referrals made to university student support is ever-increasing (Blancoet al., 2008; Royal College of Psychiatrists, 2011), however little has been researched regarding the specific coping behaviours for perfectionism within this population, or students' qualitative experiences of perfectionism, psychological distress and help-seeking. This information would give a crucial insight for universities to ensure they are continuing to develop cultures of warmth, openness, and curiosity for student wellbeing, in line with national guidance on mental health promotion in higher education (Student Minds, 2019; Universities UK, 2021).

Outline of thesis portfolio

This thesis portfolio outlines research undertaken regarding perfectionism and psychological distress in undergraduate and postgraduate students, including the influence of coping behaviours in this association, as well as qualitative experiences of perfectionism and psychological wellbeing.

Chapter two provides a systematic review of the literature regarding perfectionism, coping and psychological distress in university students. The introduction outlines a brief theoretical account of perfectionism, coping and psychological distress, before providing a narrative synthesis on the mediative effects of coping style on the association between perfectionism and psychological distress in university students.

A brief bridging chapter outlines the current literature on perfectionism and psychological distress in postgraduate and healthcare students, and why this is an important area of investigation, before moving onto chapter three, which includes a qualitative empirical paper exploring trainee clinical psychologists' experiences of perfectionism and psychological wellbeing during their doctoral training.

The portfolio closes with a critical evaluation and discussion of the findings, with reference to the literature in the field, relevant limitations, and implications for clinical practice, the wellbeing support offered to trainee clinical psychologists, healthcare professionals and the wider university student population. A separate reference list and appendices are included.

Chapter Two: Systematic Review

Perfectionism, Coping and Psychological Distress in University Students: A Systematic Review.

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Abstract

Purpose: Research has identified maladaptive perfectionism and coping styles as individual contributing factors to the development and maintenance of psychological distress in university students. However, there is a lack of clarity regarding the relationship between these factors, which is important for informing the continuous development of psychological interventions. This review therefore sought to answer: Does coping style mediate the relationship between perfectionism and psychological distress in university students?

Design: Ten papers were included following a systematic search of the literature and quality rating using the National Heart, Lung and Blood Institute's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies. Data were extracted and a narrative synthesis was conducted.

Findings: The studies were compared on demographics, measures used, and outcomes investigated. Nine of the 10 studies identified coping style as a mediating factor in the positive association between perfectionism and psychological distress, despite the heterogeneity between studies. This suggests perfectionism is an appropriate target for psychological interventions. Directions for future research include the use of longitudinal designs to further clarify the temporal relationship among these factors, and qualitative methods to explore the experience of perfectionism and associated coping behaviours in this population.

Keywords: Perfectionism, coping styles, psychological distress, psychological wellbeing, university students.

Paper type: Literature review.

1. Introduction

1.1 Conceptualisation of perfectionism

Over the past 30 years, there has been ongoing debate regarding the conceptualisation of perfectionism, specifically, whether it is unidimensional or multidimensional, or exclusively maladaptive (Dunkley et al., 2006; Hewitt et al., 1991; Hewitt et al., 2003; Shafran et al., 2002; 2003). These different conceptualisations and associated measures have been used inter-changeably within research (see Appendix A). However, in more recent years, a consensus has emerged regarding perfectionism as a multidimensional personality disposition, characterised by a striving for flawlessness, setting exceptional standards of performance, and evaluating one's behaviour in an overly critical way, which defines self-worth (Flett & Hewitt, 2002, Frost et al., 1990; Shafran et al., 2003). Studies using factor analysis (Limburg et al., 2017; Slade & Owens, 1998; Wang & Zhang, 2017) have proposed that it comprises of both adaptive and maladaptive sub-types (Gotwals et al., 2012; Slaney et al., 2001; Stoeber et al., 2018).

Adaptive perfectionism (AP), which involves "aspects of perfectionism associated with self-oriented striving … and the setting of very high personal performance standards" (Gotwals et al., 2012, p. 264), has been associated with psychological well-being and self-efficacy (Perrone-McGovern et al., 2015; Stoeber et al., 2008). On the other hand, maladaptive perfectionism (MP), characterised by "concerns of making mistakes, fear of negative social evaluation, feelings of discrepancy between one's expectations and performance and negative reactions to imperfection" (Gotwals et al., 2012, p. 264), has been identified as a possible transdiagnostic factor in the development and maintenance of psychological distress (Egan et al., 2011; Maricuțoiu et al., 2019).

1.2 Perfectionism and psychological distress

1.2.1 Research in clinical populations

Research within clinical populations has shown MP to be associated with depression, social anxiety, panic disorder, obsessive compulsive disorder, eating disorders, personality disorders and suicidal ideation (Egan et al., 2011; Egan et al., 2016; Flett & Hewitt, 2002; Hill & Curran, 2016; Limburg et al., 2017; Shafran & Mansell, 2001).

One mechanism proposed account for this association is the understanding that perfectionism is characterised by the inherent need for others' approval, combined with the perceived expectations of others. This may lead to social disconnection and isolation, a precursor and maintenance factor for psychological distress (Hewitt et al., 2017). Setting ever-increasing unrealistic personal standards, coupled with a fear of failure, self-criticism, procrastination and rumination may also contribute to the comorbidity of psychological difficulties (Bieling et al., 2004; Flett & Hewitt, 2015; Shafran et al., 2002; Shafran et al., 2010). Therefore, it is argued that targeting perfectionism in therapeutic interventions

could reduce symptoms of comorbid psychological difficulties (Bieling et al., 2004; Shafran et al., 2010).

1.2.2 Research in non-clinical populations

Studies in non-clinical populations, typically comprising of university student samples, also support the role of MP as a transdiagnostic factor in the development and maintenance of psychological distress. For example, MP has been negatively associated with life satisfaction and positively associated with depression, anxiety, stress, burnout and suicidal ideation in university students (Schweiltzer & Hamilton, 2000; Sherry et al., 2015; Stoeber, 2008). These findings are concerning, given prevalence rates of perfectionism in university students globally have increased substantially over the past 27 years (Curran & Hill, 2019), and rates of psychological difficulties in this population stand at twice as high as the general population (Li et al., 2014).

As well as psychological distress, MP has been suggested to contribute to 'debilitating' outcomes academically for university students (Olsson et al., 2021). This is unsurprising, given perfectionism has been found to be highest in the domains of work and studies (Stoeber, 2008). It is suggested that increased use of avoidant coping (AC) strategies, such as procrastination (Kurtovic et al., 2019), as well as high levels of stress that MP can generate, may partly account for this association (Milyavskaya et al., 2014).

In addition, of notable concern is the finding that MP and associated coping strategies can also pose a potential barrier to help-seeking in university students (Dang et al., 2020; Grice, et al., 2018), through increased stigma and concealment of difficulties, and reduced belief in psychological advice (Niegocki & Aegisdottir, 2019). Thus, further research into perfectionism and coping styles within this population is a priority for ensuring adequate recognition of and support for psychological distress is offered by universities and mental health services (Jung et al., 2016).

1.3 Perfectionism, coping and psychological distress

Coping can be defined as "constantly changing cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984). Within the literature, three types of coping style are proposed: avoidant, emotion-focussed and task-focussed (Chang, 2012; Grant et al., 2013; Higgins & Endler, 1995; Julal, 2013; Larijani & Besharat, 2010; Luo & Wang, 2009; Stoeber & Janssen, 2011; Whatley et al., 1998). AC involves using measures to avoid the stressor, for example, procrastination or using illicit substances. Emotion-focussed coping (EFC) is the tendency to focus on the emotions resulting from the stressor (e.g. anger, sadness, guilt or anxiety) and can take a positive or negative form in increasing or reducing psychological distress, although typically research refers to

negative EFC. Task-focussed coping (TFC) involves problem-solving to reduce or resolve the stressor (Higgins & Endler, 1995).

The demands placed on university students in terms of completing more complex tasks than at high school, managing time and the need to adapt to a new learning and social environment (Macan et al., 1990; Trueman & Hartley, 1996; van-Rooijens, 1986) warrants exploration of coping strategies as an important area of investigation to support student academic performance, and social and emotional adjustment to their university experience. This is supported by research which suggests that university students who identified as maladaptive perfectionists were more likely to utilise EFC and AC whereas adaptive perfectionists were more likely to use TFC styles (Chang, 2012; Larijani & Besharat, 2010; Stoeber & Janssen, 2011). Those who utilised TFC were less likely to experience psychological distress, and when they did, were more likely to access student support services (Julal, 2013; Whatley et al., 1998). University students who utilised AC or EFC were more likely to experience depression, anxiety and difficulties managing anger (Grant et al., 2013; Luo & Wang, 2009; Whatley et al., 1998). One suggested mechanism for this is that AC may generate higher levels of perceived stress (Chao et al., 2012; Jensen et al., 2016), and more events of life stress, which, in turn, can render vulnerability to depression (Moos et al., 2005). This is a notable finding, considering stress has been found to mediate the relationship between perfectionism and psychological distress in university students (Milyavskaya et al., 2014).

1.4 The current systematic review

To date, there have been no systematic reviews investigating the relationship between perfectionism, coping and psychological distress in university students. Clarification of the possible mediating role of coping styles within this relationship would inform the ongoing development of student support service and mental health service provision, particularly as research suggests interventions for perfectionism can reduce psychological distress and minimise the requirements for multiple disorder-specific interventions (Egan et al., 2011; Shafran et al., 2010; Zetterberg et al., 2019). Therefore, this systematic review seeks to answer: Does coping style mediate the relationship between perfectionism and psychological distress in university students?

2. Methods

2.1 Conduct and reporting

This systematic review was conducted and written in accordance with the Centre for Reviews and Dissemination (2009) and Preferred Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009) guidance. A protocol is accessible via PROSPERO (National Institute for Health Research, 2021; ID number CRD42021254453).

2.2 Search strategy

A systematic search, using Boolean operators, was conducted using the following EBSCOhost databases: APA PsychINFO, MEDLINE Complete and Embase. A search of Web of Science, and hand searches were also conducted to identify relevant articles. No time period restriction was applied.

The search terms used were: “perfect*” OR "high standards" OR "high expectations" OR "self-critic*" AND “depress*” OR "low mood" OR "melancholy" OR “anxi*” OR “distress” OR "psychological distress" OR worry AND mediat* OR “coping” OR "perceived stress” OR “stress*” OR "coping style" AND “students” OR “undergraduates” OR “college” OR “university” OR "higher education".

2.3 Inclusion/exclusion criteria

The following inclusion criteria for the systematic review were in keeping with the framework for observational studies proposed by Moola et al. (2015):

- Population: University students in any year of any course in any country, including home and international students.
- Independent and mediating variables: Quantitative studies will include an exposure variable using a standardised measure of perfectionism. At least one mediating variable is a standardised measure of coping style.
- Dependent Variable(s): Quantitative studies that include an outcome variable using a standardised measure of psychological distress.

Studies were excluded if:

- They were not written in English
- They were not peer reviewed
- They were not published in a scientific journal
- Qualitative methodology was used
- Interventions were undertaken
- The exposure variable was not a standardised perfectionism measure
- Perfectionism was a mediating variable
- The outcome variable was not a standardised measure of psychological distress
- No standardised measure of coping styles was included
- Coping Style was not a mediating variable.

Systematic searches identified 4879 articles, resulting in 3291 articles once duplicates were removed. All articles were screened against the specified inclusion criteria by two reviewers separately, with a kappa of 0.9. Disagreements were discussed to form a consensus. Following screening at title level, 227 articles were then screened at abstract level, before 25 full-text articles were screened. A total of 11 articles met the

inclusion criteria for this systematic review, before quality and risk of bias assessment (see Figure 1).

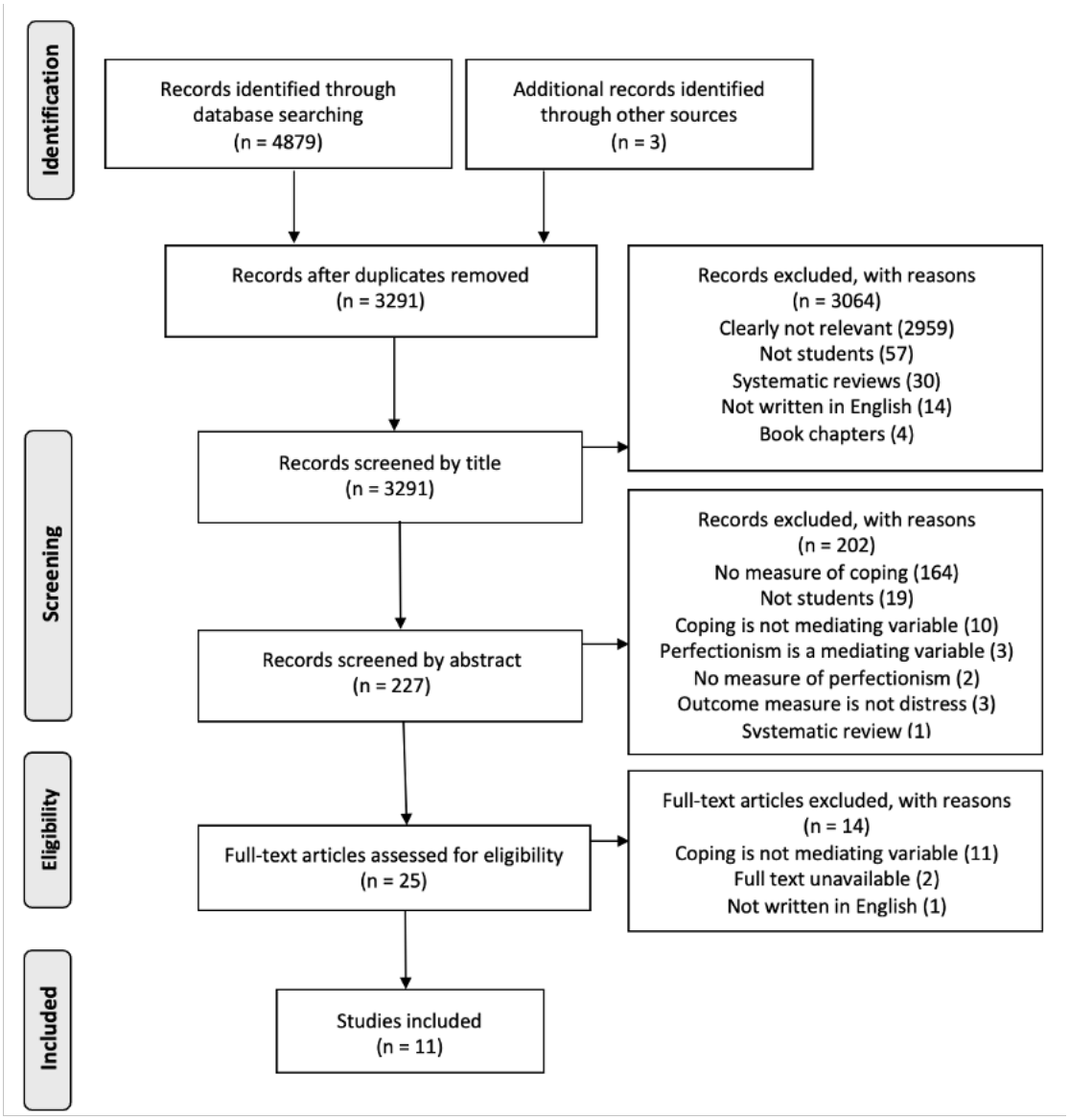

Figure 1. PRISMA (2009) flow chart to show the assessment of eligibility of identified studies.

2.4 Assessment of quality and risk of bias

All 11 articles were assessed for quality and risk of bias, by two independent raters, in line with recommendations from Higgins and Altman (2008), using the National Heart, Blood and Lung Institute's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (2021). The inter-rater reliability of ratings was moderate (k=0.71) before disagreements were discussed and a consensus formed.

This tool assesses quality for observational studies and includes guidance to assist the reviewer when considering the following factors: research question, study

population and sample size, eligibility criteria, study design, data collection and methods, blinding, attrition, statistical analyses and confounders. The rater is required to check "yes" (score of one), "no", "cannot be determined", "not applicable" or "not required" (score of zero) for 14 questions. Total scores range from zero to 14. Quality ratings of six or below indicates poor methodological quality, seven indicates medium quality and above seven, good methodological quality (Sanderson et al., 2007).

One study was excluded (Mirzairad et al., 2017) based upon its poor-quality rating of four and because it did not include justification of, or sufficient information on, methods and the analysis undertaken, had poorly worded results and provided no discussion of findings. Taking this into account, a total of 10 articles were included for data extraction and synthesis. Quality ratings for each study are reported in Table 1 and are considered within the interpretation of the results.

2.5 Data extraction and analysis

Due to a high level of heterogeneity between the 10 studies (see Table 1), a narrative synthesis was conducted, following guidance from the Cochrane Handbook of Systematic Reviews (Higgins, 2011), and Popay et al. (2006).

First, relevant data were extracted and presented in a tabular format (Popay et al., 2006), including brief descriptions of each study (see Table 1). Headings for the table were adapted from a similar narrative synthesis conducted by O'Connor (2007). Following this, qualitative case descriptions were written for each study to summarise their findings, with consideration of the quality and risk of bias of the studies (Popay et al., 2006). The final stage of the analysis involved exploration of the similarities and differences across the studies (Higgins, 2011) to group them according to the outcome being measured (Popay et al., 2006). The overall robustness of the synthesis was then considered, which provided directions for future research.

3. Results

The review identified 10 studies which investigated the possible mediating role of coping style on the relationship between perfectionism and psychological distress in university students. Table 1 summarises the characteristics of each study with reference to sample demographics, measures used, outcomes and quality ratings.

3.1 Study characteristics

3.1.1 Demographics

All studies were published between 2000 and 2018 and were of a cross-sectional design. Studies were conducted in Canada (n=3), the United States (n=3), Portugal (n=1), Malaysia (n=1) and South Korea (n=1), suggesting that this concept has been researched globally. All participants were undergraduate students. Four of the 10 studies specified course type, which were psychology (n=3) and medicine (n=1). The total sample size of

the included studies is 3540 participants, with 61% of participants identifying as female and 39% male. Seven studies reported the ages of participants (M=20.4 years, SD=2.8 years). Of the five studies which reported information on ethnicity, four recruited participants from ethnic minorities. One study recruited participants of mostly White or European American ethnicity (see Table 1).

3.1.2 Measures used

3.1.2.1 Perfectionism. Five studies used just one measure of perfectionism, whilst five used at least two. The measures used in the studies were: The Almost Perfect Scale-Revised (APS-R; Slaney et al., 2001) (n=4), the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990) (n=5), the Hewitt-Flett Multidimensional Perfectionism Scale (HFMPS; Hewit et al., 1991) (n=5), and the Composite Multidimensional Perfectionism Scale (CMPS; Soares et al., 2014) (n=1).

For the included studies where the English versions of the APS-R, HFMPS, FMPS and CMPS were used, Cronbach's alphas of 0.8 and above were reported, suggestive of good internal consistency of these measures. In a study by Castro et al. 2017), the Portuguese translated versions of the HFMPS, FMPS and CMPS reportedly had 'good' internal reliability and validity, but no figures were provided. The HFMPS and FMPS were translated into Chinese for a study by Zhang & Cai (2012) and Cronbach's alphas ranging from 0.69 to 0.86 and 0.76 to 0.84 were reported, respectively. Similarly, in a study by Park et al. (2010), a Korean translation of the FMPS produced Cronbach's alphas of 0.67 to 0.86. Thus, translated versions of the HFMPS and FMPS demonstrate variable internal consistency compared to the English versions.

In addition, there were differences in how perfectionism is categorised within the studies. Overall, positive aspects of perfectionism (Limburg et al., 2017; Slade & Owens, 1998; Wang & Zhang, 2017) were described as AP (n=4), personal standards (n=3) and positive strivings (n=1). Negative aspects of perfectionism were described as MP (n=4), evaluative concerns (n=4) and self-critical perfectionism (n=2). Eight studies investigated both aspects of perfectionism, whereas two studies investigated negative aspects of perfectionism only (see Table 1). For the purposes of consistency within this review, the terms AP and MP are used.

3.1.2.2. Coping. Each of the 10 studies used one measure of coping only, which were the COPE Inventory (Carver et al., 1989) (n=4), the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1990) (n=2), the Problem-Focussed Style of Coping (PF-SOC; Heppner et al., 1995) (n=1), the Simplified Coping Questionnaire (SCQ; Xie, 1998) (n=1), the Ways of Coping Questionnaire-Revised (WOC-R; Folkman & Lazarus, 1985) (n=1) and the Cognitive Emotion Regulation Questionnaire (CERQ; Feliu-Soler et al., 2017) (n=1).

The CISS demonstrates Cronbach's alphas of 0.8 and above for the included studies, whereas the COPE ranged from 0.62 to 0.84 and the WOC-R, 0.56 to 0.76. The PF-SOC was translated into Korean (Park et al., 2010), the CREQ into Portuguese (Castro et al., 2012) and the SCQ into Chinese (Zhang & Cai, 2012), and each demonstrated variable Cronbach's alphas of 0.61-0.75, 0.70-0.89 and 0.81-0.83, respectively.

There were also variations in the ways coping styles were described between studies, reflective of the ongoing differences in conceptualisations of coping within the literature (Stanislowski, 2019). One study using the CISS, and studies using the WOC-R and PF-SOC categorised coping styles into TFC, EFC and AC (Abdollahi et al., 2018; Gnilka et al., 2012; Park et al., 2010). Another study using the CISS categorised TFC and AC into the term 'maladaptive coping' (Dunkley & Blankstein, 2000). Two studies using the COPE categorised coping styles into active coping and AC (Dunkley et al., 2000; Noble et al., 2014), whilst one study categorised styles into problem-focussed, EFC and dysfunctional coping (Rice & Lapsley, 2001) and another into self-blame coping, AC and problem-focussed coping (Dunkley et al., 2003). The study using the CERQ investigated perceived coping only (Castro et al., 2017), whereas the study using the SCQ (Zhang & Cai, 2012) investigated the categories of positive and negative coping.

3.1.2.3 Psychological distress. The included studies investigated depression (n=5), depression and anxiety (n=2), depression and anger and psychosomatic symptoms (n=1), anxiety (n=1) and emotional adjustment (n=1).

Measures used include the Beck Depression Inventory – First Edition (BDI; Beck et al., 1961) and Second Edition (BDI-II; Beck et al., 1996) (n=2), The Positive and Negative Affect Scale (PANAS; Watson et al., 1988) (n=1), the Portuguese Profile of Mood States (P-PMS; Viana et al., 2001) (n=1), the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) (n=2), the Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991) (n=1), the Personal Emotional Adjustment subscale of the Student Adaptation to College Questionnaire (SACQ; Baker & Siryk, 1984) (n=1), the State Trait Anxiety Inventory (STAI; Spielberger et al., 1983) (n=1), the Brief Symptom Inventory (BSI; Dergoatis & Spencer, 1982) (n=1), the Anger Subscale of

the State-Trait Anger Expression Inventory (STAXI; Spielberger, 2010) and the Inventory of Interpersonal Problems-Short Circumplex Form (IIIP-SC; Soldz et al., 1995).

The STAI, CES-D, PANAS, MASQ and STAXI demonstrate good internal consistency with Cronbach's alphas of 0.92, 0.9, 0.83-0.89 and 0.79-0.89, respectively (Dunkley & Blankstein, 2000; Dunkley et al., 2000; Dunkley et al., 2003; Gnilka et al., 2012; Noble et al., 2014; Spielberger, 2010). The BSI, translated into Korean (Park et al., 2010) and the BDI-II, translated into Chinese (Zhang & Cai, 2012) both reported good internal consistency, with Cronbach's alphas of 0.97 and 0.82, respectively.

Table 1

A table to summarise the characteristics and findings of the 10 studies included in this systematic review.

Author(s) and Country	Course Type	Gender and Age	Ethnicity	Perfectionism Measure(s)	Perfectionism Conceptualisation	Psychological Distress Variable	Psychological Distress Measure(s)	Mediating Variable	Mediator Measure(s)	Results				Quality Rating
										Significant relationship between perfectionism and coping?	Significant relationship between coping and psychological distress?	Significant relationship between perfectionism and psychological distress?	Indirect effect observed?	
Abdollahi et al. (2018) Malaysia	UG Not specified	279 female, 230 male Mean age = 20.2 years (SD = 2.9)	Not specified	APS-R	Personal standards and evaluative concerns	Depression	BDI-II	TFC, EFC and AC	CISS	Y	Y	Y	Y	9
Castro et al. (2017) Portugal	UG Medicine	235 female, 109 male Mean age = 20.7 years (SD = 1.6)	Not specified	Portuguese translated – HFMPS, FMPS, CMPS	Positive strivings and evaluative concerns	Positive and negative affect	Portuguese PMS	Perceived stress; perceived coping	Portuguese PSS, CERQ	Y	Y	Y	Y	7
Dunkley & Blankstein (2000) Canada	UG Psychology	130 females, 103 males Mean age = 21.0 years (SD = 4.4)	Not specified	HFMPS, DESQ, SAS-R	Self-critical perfectionism	Depression, anger, psychosomatic distress	CES-D, STAXI, PSC	Maladaptive coping (TFC, EFC, distraction), Hassles (general, academic, social)	CISS, GASHSS	Y	Y	Y	Y	7
Dunkley et al. (2003) Canada	UG Not specified	306 females, 137 males Mean age = 20.4 years (SD = 4.1)	European (n = 111), Asian (n = 28), East Indian (n = 13), South American (n = 5), African (n = 4), and Caribbean (n = 2).	HFMPS, DESQ, SAS-R	Self-critical perfectionism	Positive and negative affect	PANAS	Self-blame coping, AC, problem-focussed coping, positive reinterpretation and growth; Event Appraisals; Social Support	GASHSS, EAQ, COPE, SSQ	Y	Y	Y	Y	8
Dunkley et al. (2000) Canada	UG Psychology	99 females, 64 males Mean age = 20.0 years (SD = 2.3)	Not specified	HFMPS, FMPS	Evaluative Concerns	Distress (depression, anxiety, anxious arousal, anhedonic depression)	MASQ	AC, active coping, social support, hassles	COPE, SPS, GASHSS	Y	Y	Y	Y	6
Rice & Lapsley (2001) US	UG Not specified	131 females, 73 males Mean age not provided	White European American (n=193), Black African American (n=3),	FMPS	AP and MP	Emotional adjustment	SACQ	Problem-focussed, EFC and dysfunctional coping	COPE	Y	Y	Y	N	7

Gnilka et al. (2012) US	UG Psychology	217 females, 108 males, 2 unspecified Mean age not provided	Caucasian (n=76) , African American (n=68), multiracial (n=20), Hispanic (n=14), Asian American (n=13), other ethnicity (n=5), Native Hawaiian/Pacific Islander (n=4), declined (n=4)	APS-R	Adaptive and ;maladaptive perfectionists; non-perfectionists	Anxiety	STAI	TFC, EFC and AC	WOC-R	Y	Y	Y	Y	7
Noble et al. (2014) US	UG Not specified	267 females, 138 males, 5 unspecified Mean age not provided	Caucasian (n=151), African American (n=136), multi-racial (n=41), Hispanic (n=29), Asian American (n=26), other ethnicity (n=12), Native Hawaiian/Pacific Islander (n=1), declined (n=9)	APS-R	AP and MP	Depression	CES-D	Active TFC and AC	COPE	Y	Y	Y	Y	7
Park et al. (2010) Korea	UG Not specified	233 female, 275 male Mean age = 20.6 years (SD = 2.2)	Not specified	FMPS	Evaluative concerns perfectionism	Anxiety, depression, somatisation	BSI, IIP-SC	TFC, EFC and AC	PF-SOC, RSES	Y	Y	Y	Y	8
Zhang & Cai (2012) China	UG Not specified	222 female, 190 male Mean age = 20.1 years (SD = 2.0)	Han (n=364), other ethnic group (n=48)	HFMPS, FMPS, APR-S	AP and MP	Depression	BDI	Positive and negative Coping, self-esteem	SCQ, RSES	.Y	Y	Y	Y	7

Note: AC = Avoidant Coping; AP = Adaptive Perfectionism; APS-R = Almost Perfect Scale – Revised; BDI = Beck Depression Inventory – First Edition; BDI-II = Beck Depression Inventory – Second Edition; BSI = the Brief Symptom Inventory; CERQ = Cognitive Emotion Regulation Questionnaire; CESD = Center for Epidemiological Studies Depression Scale; CISS = Coping Inventory for Stressful Situations; CMPS = Composite Multidimensional Perfectionism Scale; COPE = COPE Inventory; DESQ = Depressive Experiences Questionnaire; EAQ = Event Appraisal Questionnaire; EFC = Emotion-focussed Coping; FMPS = Frost-Hewitt Multidimensional Perfectionism Scale; GASHSS = General, Academic, and Social Hassles; HFMPS = Hewitt-Flett Multidimensional Perfectionism Scale; IIP-SC = Inventory of Interpersonal Problems-Short Circumplex Form; MASQ = Mood and Anxiety Symptom Questionnaire; MP = Maladaptive Perfectionism; PANAS = The Positive and Negative Affect Scale; PF-SOC = Problem-Focussed Style of Coping; PMS = Portuguese Profile of Mood States; PSS = Portuguese Perceived Stress Scale; RSES = Rosenberg Self-Esteem Scale; SACQ = Personal Emotional Adjustment subscale of the Student Adaptation to College Questionnaire; SAS-R = Sociotropy– Autonomy Scale for Students; SCQ = Simplified Coping Questionnaire; SPS = Social Provisions

Scale ; SSQ = Social Support Questionnaire; STAI = State Trait Anxiety Inventory; STAXI = Anger Subscale of the State-Trait Anger Expression Inventory; TFC = Task-focussed Coping; UG = Undergraduate Student; WOC-R = Ways of Coping Questionnaire;

3.2 Quality assessment of studies

The mean quality rating for the 10 included studies was 7.3 (SD=0.82). Three studies were rated as ‘good’, six as ‘medium’ and one as ‘poor’. All studies clearly specified a research question or aim. All studies stated the location of the sample, but not clear inclusion criteria. Three studies did not describe participant ages, five studies did not state the ethnicities of participants, and six studies did not report the university course type, thus rendering replication difficult. No studies described justification of sample size or a power calculation, meaning an inflated risk of Type I errors may have been apparent. Two studies recruited from the same university, meaning generalisability of findings of these studies is limited. Standardised measures of perfectionism, coping styles and psychological distress were used in all studies, although the internal consistency of translated measures and measures of coping styles were questionable. Due to the cross-sectional designs of all studies, all but one study measured the exposure variable just once, and all studies measured the independent and dependent variables at the same time, meaning cause and effect cannot be inferred.

3.3. Narrative summary of findings

Overall, despite the heterogeneity of studies, nine of the 10 included studies investigating anxiety, depression, anger, psychosomatic symptoms and affect found coping styles to either partially or fully mediate the relationship between perfectionism and psychological distress. This finding also withstood despite the differences in quality ratings between the studies, including those rated as ‘good’ and the one rated as ‘poor’, suggesting moderate evidence overall to support the research question. The one ‘medium’ quality study measuring emotional adjustment did not find such results, however, suggesting this relationship may not exist for emotional adjustment, in particular.

3.3.1 Depression

Three medium to high-quality studies investigated the relationship between perfectionism and depression, with the influence of coping styles as a mediating variable, though used different statistical analyses to explore these. Using structural equation modelling (SEM) in a sample of Malaysian undergraduates, Abdollahi et al. (2018), found a significant negative relationship between AP and depression and a significant positive relationship between MP and depression. MP was significantly negatively associated with TFC and positively associated with EFC and AC styles. TFC style was significantly negatively associated with depression and EFC and AC styles were significantly positively associated with depression. Overall, a partial mediation was found on the relationship between perfectionism and depression, with adaptive perfectionists using a TFC style and having lower levels of depression and maladaptive perfectionists using EFC and AC styles and subsequently having higher levels of depression.

Similarly, Zhang and Cai (2012) used SEM in a sample of Chinese undergraduates to find that 'negative coping' (i.e. AC) partially mediated the positive relationship between MP and depression, and 'positive coping' (i.e. TFC) partially mediated the negative relationship between AP and depression. Interestingly, when adding self-esteem into the model, they found MP to significantly negatively associate with self-esteem, and positive coping partially mediated this relationship (i.e., a negative association between MP and positive coping and a positive association between positive coping and self-esteem). Self-esteem did not mediate the relationship between perfectionism and depression. This suggests that maladaptive perfectionists may be vulnerable to lower self-esteem when they do not use positive coping strategies during stressful events.

One study, (Noble et al., 2014), in sample of undergraduates from the United States, used a control group of 'non-perfectionists', compared with adaptive and maladaptive perfectionists in a MANOVA analysis. Non-perfectionists had levels of AC comparable to maladaptive perfectionists, which were significantly higher than adaptive perfectionists. Maladaptive perfectionists had significantly higher levels of depression than non-perfectionists, who had significantly higher levels of depression than adaptive perfectionists. Using bootstrapping analysis, AC was found to partially mediate the positive relationship between MP and depression.

In summary, the consistency of findings in the three medium to high quality studies, provide moderate evidence to suggest that, across country and cultures, adaptive perfectionists may be more likely to use TFC styles, which might serve as a protective factor against depression, whereas maladaptive perfectionists may be more likely to use AC styles, and in turn, can experience lower self-esteem, which may render them vulnerable to experiencing depression.

3.3.2 Depression, anger and psychosomatic symptoms

One medium quality study examined the mediating role of 'adaptive' coping (TFC) or maladaptive coping (AC and EFC) on the relationship between MP and depression, anger and psychosomatic symptoms, as well as daily hassles, in a sample of Canadian undergraduates (Dunkley & Blankstein, 2000). Using SEM, they found MP to be significantly positively associated with maladaptive coping. MP was also significantly positively associated with depression, anger and psychosomatic symptoms, as well as daily hassles. Overall, maladaptive coping fully mediated this relationship.

3.3.3. Depression and anxiety

Two studies investigated the mediating role of coping on depression and anxiety (Dunkley et al., 2000; Park et al., 2010). In a poor quality study, Dunkley et al. (2000) found, using SEM, in a sample of Canadian undergraduates, that MP significantly

positively related with AC, as well as daily hassles, which in turn positively related with depression and anxiety. AC and daily hassles fully mediated this relationship. In addition, lower levels of perceived social support also served as a full mediator in the positive relationship between MP and depression and anxiety.

A high quality study by Park et al. (2010) yielded similar results in their sample of South Korean undergraduates, finding that MP was significantly positively related with anxiety and depression through a partial mediation of AC. Self-esteem was also found to be a partial mediator between AC and depression and anxiety. This provides good evidence to suggest that maladaptive perfectionists may be more likely to use maladaptive coping, which can reduce self-esteem and increase psychological distress.

Taken together, it can be concluded that there is moderate evidence to suggest AC and self-esteem may mediate the relationship between maladaptive perfectionism and depression and anxiety. There is some evidence to suggest that daily hassles and social support also impact this relationship, although due to the poor quality of this study, these results need to be interpreted with more caution.

3.3.4 Anxiety

One medium quality study sought to investigate the mediating role of coping on the relationship between AP and MP and anxiety in a United States sample of undergraduates (Gnilka et al., 2012). Using ANOVA analysis, they found no significant difference between non-perfectionists and maladaptive perfectionists in styles of coping – both groups were more likely to use AC and EFC. Adaptive perfectionists had significantly lower levels of anxiety than non-perfectionists, who had significantly lower levels of anxiety than maladaptive perfectionists. In a bootstrapping multiple mediation analysis, coping style did not mediate the relationship between AP and anxiety, but did mediate the relationship between MP and anxiety. This gives moderate evidence to suggest that maladaptive perfectionists are more likely to use maladaptive coping, which in turn, is associated with higher levels of anxiety.

3.3.5 Affect

Two studies investigated affect (Castro et al., 2017; Dunkley et al., 2003). Castro et al. (2017), in their medium quality study of Portuguese undergraduates, found a partial mediation of perceived coping between four elements of multidimensional perfectionism and negative affect. Notably, these elements of multidimensional perfectionism were associated with lower levels of perceived coping, which were in turn associated with higher levels of negative affect. Similarly, in a high-quality study by Dunkley et al. (2003), a sample of Canadian undergraduates completed measures of self-critical perfectionism, daily hassles, event appraisal, coping and daily affect for seven consecutive days. They found, using SEM, a full mediation of AC (which was positively associated with negative

affect indirectly through daily hassles and event stress) on the positive relationship between self-critical perfectionism and negative affect. Self-blame, perceived efficacy and perceived criticism also fully mediated the relationship between self-critical perfectionism and AC. Perceived social support fully mediated the negative relationship between self-critical perfectionism and positive affect.

These studies provide moderate to strong evidence to suggest that maladaptive perfectionists may experience a higher tendency to self-blame when they feel criticised or experience low perceived efficacy, and that using AC may increase stress generated from daily hassles, which in turn may increase the likelihood of negative affect. Perceived social support may serve as a buffer in this relationship.

3.3.6 Emotional adjustment

One medium quality study examined the associations between perfectionism and emotional adjustment in a United States sample of undergraduates (Rice & Lapsley, 2001). An ANOVA analysis found adaptive perfectionists to have significantly higher TFC than non-perfectionists. Adaptive perfectionists had significantly less dysfunctional coping than non-perfectionists and maladaptive perfectionists. Adaptive perfectionists and non-perfectionists had higher levels of emotional adjustment than maladaptive perfectionists. Following Holmbeck's (1997) regression analysis, they found strong direct effects between perfectionism and emotional adjustment, however these were not changed when coping styles were added to the model. Therefore, coping did not significantly mediate the relationship between perfectionism and emotional adjustment.

4. Discussion

4.1. Does coping style mediate the relationship between perfectionism and psychological distress?

This review investigated whether coping styles played a mediating role in the relationship between perfectionism and psychological distress in university students. Ten papers were identified through a systematic search which were reviewed using a narrative synthesis. Overall, nine of 10 studies, using different measures and sampling from university students internationally, with different ethnicities, identified genders and ages, consistently found coping styles to either partially or fully mediate the relationship between perfectionism and depression, anxiety, psychosomatic symptoms and anger. This is suggestive of a relationship that exists across the cultures, ethnicities, ages and identified genders of undergraduate students, and one that withstands despite the different measures of perfectionism, coping and psychological distress used. Taking into consideration the quality of the included studies, and the overall robustness of the synthesis, discussed below, this provides moderate evidence for perfectionism and

associated coping styles as possible transdiagnostic factors in the development and maintenance of psychological distress in university students (Shafran et al., 2010).

Specifically, the nine studies found a positive relationship between AP and TFC styles, which mediated a negative relationship with variables of psychological distress. This suggests that adaptive perfectionists, who strive to achieve, are more likely to problem-solve in difficult scenarios, including seeking the social support of others, which is found to be a buffer for psychological distress (Cohen, 1985; Li et al., 2018). However, maladaptive perfectionists may be more likely to use AC or EFC styles, which mediate a positive relationship with variables of psychological distress. Interestingly, in three studies, daily hassles, event stress and self-esteem also played mediating roles within this relationship, suggesting that maladaptive perfectionists' use of AC (e.g., procrastination, denial, or use of illicit substances), may generate higher levels of stress and negatively impact on self-esteem, rendering such individuals vulnerable to psychological distress. Thus, this suggests that the relationship between perfectionism, coping and psychological distress exists through a complex interplay of multiple factors, which warrants further investigation.

4.2. Implications of the current review

The findings from this systematic review have implications for the ongoing development of psychological wellbeing support for university students. Firstly, it is important that perfectionism is not viewed solely as a negative personality construct, given that AP might lead to more academic success (Gnilka et al., 2012; Olsson et al., 2021; Rice et al., 2006). However, it also needs to be acknowledged that MP, through maladaptive coping styles, may lead to psychological distress and difficulties engaging academically. Differentiating between these types of perfectionism, and associated coping styles, when supporting university students with their psychological wellbeing, is essential in ensuring support is tailored to their individual needs.

Secondly, therapeutic interventions for MP could be considered as a viable possibility for student wellbeing services. Recent literature regarding cognitive behavioural therapy for perfectionism and associated anxiety, depression and eating disorders (Bieling et al., 2004; Galloway et al., 2022; Shafran et al., 2010), has suggested this as an effective transdiagnostic intervention. In addition, Compassion Focussed Therapy techniques (Gilbert, 2009) also show promise at reducing low mood and burnout within student populations (Ong et al., 2021). This may provide a cost-effective and time-saving option, compared to multiple disorder-specific interventions. As previous research has identified that perfectionism can be a barrier to help-seeking (Grice et al., 2018), however, anonymised support (e.g., online computerised interventions) may be a more tangible option for some individuals (Kothari et al., 2019; Levin et al., 2018; Stoll et al., 2020;

Zetterberg et al., 2019). The type and format of such interventions for perfectionism require further research, considering interventions for perfectionism remain in their infancy.

4.3 Limitations

Despite the review offering a contribution to the field, several limitations reduce the robustness of the synthesis and require the findings of the review to be understood with some degree of caution. Firstly, due to the included studies being observational and associational in design, it is not possible to infer cause and effect of the study findings. This is reflected in the average quality ratings of the studies. For example, it has been shown in longitudinal research that some types of psychological distress evoke more perfectionistic tendencies, as found in a 12-month longitudinal study on perfectionism and social anxiety (Gautreau et al., 2015). Secondly, despite the use of SEM, the design of the studies means that it would be impossible to control for all potential confounding variables. This is evidenced by factors such as self-esteem and stress also playing mediating roles in the included studies, suggesting that additional factors not explored (e.g., personality traits), may also have mediated the relationship. Thus, it is important that these factors are considered in the interpretation of the study findings and addressed in future research designs.

In addition, several measures of perfectionism and coping styles were used to measure these constructs. Although the findings are mostly consistent, which offers weight to the current agreed definition of perfectionism (Stoeber, 2018), it is important to consider that the Cronbach's alpha coefficients for some measures of perfectionism and coping style were variable, in particular, those translated into other languages. This may reflect that the dominant conceptualisations of perfectionism and coping have emerged from westernised cultures. Some questions within the measures may not accurately translate across cultures, adding to the ongoing debate within the literature about refining a universally agreed concept of both perfectionism and coping (Stanistawski, 2019; Woloshyn, 2007), and highlights the requirement for further research to develop and validate measures of perfectionism and coping styles across cultures.

Another limitation is that due to the cross-sectional nature of the designs and the use of self-report measures, participants may have been subject to some level of social desirability bias. Not all studies stated the order of which the measures were completed, which reduces transparency in this issue and reduces credibility of findings of the included studies.

Lastly, a limitation for the robustness of the narrative synthesis is that it offers the perspective of one researcher only. This was unavoidable due to the constraints of which this review was conducted. Despite this, the review does have strength in that multiple

databases (and hand searches) were used for the systematic search, and two independent reviewers were used to assess inclusion criteria, and quality and risk of bias (Popay et al., 2006). This was important in ensuring all relevant research in the field was captured, and only the highest quality research was included to answer the research question (Hartling et al., 2012).

4.4. Future research

This review highlighted that the perfectionism literature remains in its infancy, as demonstrated by the included studies being published from the year 2000 onwards, being limited in number and heterogeneous. Although this review offers a significant contribution to the literature, for this reason the results of this review are difficult to generalise. However, with the understanding that university students experience levels of psychological distress twice as high as the general population (Li et al., 2014), and that perfectionism within this population is increasing (Curran & Hill, 2019), this warrants ongoing research to be conducted in the field.

Longitudinal research is required to study the definition, development and maintenance of perfectionism, and its temporal relationship with the development and maintenance of psychological distress. Qualitative research around the coping behaviours undertaken by perfectionists, and their perception of these would be helpful in determining the specific coping behaviours or associated cognitions that may account for this relationship.

Additionally, the possibility of other confounding factors, such as self-esteem (Park et al., 2010; Zhang & Cai, 2010), stress (Moos et al., 2005), social support (Dunkley et al., 2000) and socio-economic status (Lyman & Luthar, 2014) cannot be ignored, and exploring these, using SEM or group-comparison designs, would help further explain this complex relationship. Findings would contribute to the developing understanding of perfectionism and coping as constructs and would inform the ongoing development of appropriate recognition and effective support for perfectionism and psychological distress within universities and mental health service settings.

4.5 Conclusions

This systematic review offers preliminary evidence for coping styles as a mediating factor in the association between perfectionism and psychological distress. However, further longitudinal and qualitative research is required to identify additional contributing factors in this association, and how these are experienced. This would help to inform further our understanding of this phenomenon and highlight areas for ongoing development in wellbeing support within universities and mental health services.

CRedIT authorship contribution statement

The first two authors conceptualised the research question. The first author completed the systematic review and initial write-up. The second and third authors contributed to proof reading of the paper. The fourth and fifth author assisted with second reviewing of inclusion/exclusion criteria for the articles. The fifth author contributed to the quality ratings of the included articles.

Declaration of interest

Declarations of interest: none

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Chapter Three: Bridging Chapter

Perfectionism and psychological distress in postgraduate students

The previous chapter provides evidence to suggest that the relationship between perfectionism and psychological distress in university students is a complex one, which exists through a mediating factor of coping styles, specifically emotion-focussed and avoidant coping (Egan et al., 2011). This provides support for the cognitive model of perfectionism proposed by Egan et al. (2011) and highlights the potential benefit of transdiagnostic therapeutic interventions for maladaptive perfectionism within this population (Bieling et al., 2004; Egan et al., 2011).

However, existing research in the field of perfectionism has mostly been undertaken in unspecified undergraduate student populations. Research on postgraduate students is in its infancy but is suggestive of poor psychological wellbeing within this population. For example, a meta-analysis of 52 articles, by Hazell et al. (2020), found higher levels of stress in postgraduate researchers than the general population, and more recently, Milicev et al. (2021) found, in a sample of 479 UK postgraduate researchers, that maladaptive perfectionism, workaholism and being in the fifth year of study or above, contributed to psychological distress. Despite this, it is reported that disclosure of a mental health condition in UK postgraduate researchers remains low (Berry et al., 2021). These findings are concerning and warrant the need for further research to be undertaken to deepen our understanding of this phenomenon (Brohan et al., 2012) and inform the ongoing development of wellbeing support offered by universities.

Perfectionism and psychological distress in healthcare students

As well as postgraduate students, similar findings are also emerging in the healthcare student population, who undertake clinical duties whilst studying as university students (McLean et al,. 2018). For example, a study by Kelly and Clark (2017) found nursing students to have 40% higher perfectionism levels than the general population (Kelly & Clark, 2017). Compared to arts students, medical students have been reported to experience higher levels of perfectionism, of which adaptive perfectionism correlated with academic performance, whilst maladaptive perfectionism correlated with depression and hopelessness (Evans et al., 2018). Maladaptive perfectionism has also been found to predict suicidal ideation, via the mediating factor of imposter syndrome, in medical students (Brennan-Wydra et al., 2021).

Further, the NHS Staff Survey (2013), which investigated the prevalence of psychological distress amongst mental health nurses, learning disabilities nurses, adult nurses and paediatric nurses, found mental health nurses to have higher rates of work-related stress. Rates were impacted by years of experience, with newly qualified staff experiencing higher levels of psychological distress (Tsaras et al., 2018). Moreover,

mental health nurses are reported to be more likely to engage in emotion-focussed coping than problem-focussed coping during times of distress when compared with trainee medics (Galvin & Smith, 2015). However, specific coping behaviours, and first-hand experiences of these, remain unknown.

For the student mental health professional population, in particular, seeking help during training can be perceived by some as a sign of weakness, or that the individual cannot cope with the demands of the job (Goff, 2011). This was found to be exacerbated by a lack of support from mentors or trainers for student mental health nurses (Galvin & Smith, 2017), and for trainee clinical psychologists, Grice et al. (2018) found non-disclosure to be associated with perfectionistic tendencies, despite 67% of their sample disclosing having lived experienced a mental health problem, and levels of stress being as high as 75% in this population (Cushway, 1992).

Why research trainee clinical psychologists?

Trainee clinical psychologists have a unique and relatively senior role during UK-based training, being paid at NHS band six for undertaking direct clinical work, supervising and training colleagues and informing service development, whilst also being a postgraduate researcher conducting research at a doctoral level (UK Clinical Psychology Clearing House, 2021). Trainee clinical psychologists typically undertake such duties in an under-resourced psychological workforce. In a recent survey of 281 UK Clinical Psychologists, 85% of the sample reported an inequity between the resource provision of physical and mental healthcare services, with 96% stating that they felt they did not have the resources to provide the best psychological care, leaving 41% feeling demoralised (Association of Clinical Psychologists UK, 2020). Entering this workplace environment to train, after the competitive selection process (UK Clinical Psychology Clearing House, 2021) may serve to exacerbate psychological distress (e.g., moral injury) for perfectionistic trainee clinical psychologists (Sales et al., 2021), as Stovall et al. (2020) note, an individual “striving for perfection in an imperfect environment will find himself or herself experiencing moral distress” (pp.321). However, this remains currently under-researched within this population.

Thus, the need for rich, first-hand experiences of perfectionism and associated psychological wellbeing of trainee clinical psychologists is of paramount importance in gaining a fuller understanding of this relationship, in order to inform the ongoing development of wellbeing support offered by UK training institutions. Chapter four outlines a qualitative study investigating UK trainee clinical psychologists’ experiences of perfectionism and psychological wellbeing during their training. This is the first known qualitative study to explore this phenomenon within this population.

Chapter Four: Empirical Paper

Title: Exploring Trainee Clinical Psychologists' Experiences of Perfectionism and Psychological Wellbeing During Training: A Qualitative Study

Short title: Trainee Perfectionism and Wellbeing

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Abstract

Objectives: The prevalence of psychological wellbeing difficulties in Trainee Clinical Psychologists ('trainees') is found to be high, and emerging literature suggests this to be partly associated with perfectionistic tendencies. However, little is currently known regarding the rich, first-hand experiences of perfectionism and associated psychological distress amongst trainees, including how it is understood and managed during training. This study therefore aimed to explore trainees' experiences of perfectionism and associated psychological wellbeing during training.

Methods: 11 UK trainees, who self-identified as perfectionists, were recruited via social media and word-of-mouth. Semi-structured interviews were conducted via an online video platform. Data was analysed using thematic analysis.

Results: Three over-arching themes were identified: a) The Paradox of Perfectionism, which describes trainees' experiences of perfectionism protecting against negative self-beliefs, defining their self-image and gaining praise, whilst rendering them vulnerable to experiencing imposter syndrome, b) The Struggling Helper, where trainees reported experiencing psychological distress, but feeling unable to seek support, and c) Togetherness in Transformation, which describes how the shared experience with trainee and qualified colleagues helps to reduce perfectionistic standards and develop healthy self-relating.

Conclusions: This is the first qualitative study to provide rich, in-depth accounts of trainees' experiences of perfectionism and psychological wellbeing, including how this relationship can be impacted by stigma, coping styles, and relationships with trainee and qualified colleagues. The study has implications for wellbeing support provided by UK training institutions (e.g., teaching, supervision and reflective practice), as well as for the ongoing development of cognitive and third wave therapeutic approaches for perfectionism.

Practitioner points

- Trainees can experience perfectionism and associated psychological distress (e.g., anxiety, low mood, burnout) during training. Trainees can engage in negative coping behaviours (e.g., procrastination, avoidance, blaming) and rigid self-care routines. Trainees reported that flexible self-care and self-compassion was more achievable when qualified staff acted as healthy role models.
- Trainees reported experiencing stigma regarding psychological distress and perfectionism can prevent them from help-seeking. Trusting one-to-one relationships with course staff and clinical supervisors, as well as staff sharing

lived experiences, provided a sense of safety for trainees to discuss personal experiences.

- Trainees emphasised the importance of cohort relationships in humanising psychological distress. Peer-led reflective practice may provide a containing space for experiences to be discussed.
- The findings of this study provide support for perfectionism as a transdiagnostic factor for psychological distress, thus supporting the use of cognitive therapies for perfectionism and associated shame and self-criticism in this population.

Keywords: Perfectionism, psychological wellbeing, psychological distress, trainee clinical psychologists, thematic analysis.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Exploring Trainee Clinical Psychologists' Experiences of Perfectionism and Psychological Wellbeing During Training: A Qualitative Study

Training as a Clinical Psychologist in the UK is a long and competitive process, with the expectation that applicants have a high level of academic success and have pre-training clinical and/or research experience (UK Clinical Psychology Clearing House, 2021). The application success rate in 2021 was 22%, which was lower than on similar courses such as Medicine, Nursing, PhD Psychology and MSc Clinical and Health Psychology (Medical School Council, 2021; UK Clinical Psychology Clearing House, 2021; University and Colleges Admissions Services, 2021). Some argue that this reinforces perfectionistic tendencies in applicants (Gengoux et al., 2020) as Bettney (2017) describes, "this fosters a desire for perfectionism long before training begins" (pp. 373).

Once a trainee has gained a place on clinical psychology training, their multiple roles as a student and professional, as well as a doctoral-level researcher and therapist, is proposed to exacerbate existing perfectionistic tendencies (Kanazawa & Iwakabe, 2016) and can contribute to psychological distress, such as burnout, anxiety and low mood (Schwartz-Mette, 2009). Working with complex client groups may also increase professional self-doubt, feelings of incompetence and perceived stress in trainees (Jones & Thompson, 2017), which can continue post-qualification (Colli et al., 2014).

Psychological wellbeing difficulties in trainee clinical psychologists

Previous research has shown that work demand and associated stress, anxiety, depression were higher in trainee clinical psychologists than in mental health nursing, medical, dental and PhD students (Galvin & Smith, 2015). A recent systematic review by Weller (2018) found that 60% of 240 trainees anonymously disclosed experiencing psychological distress during training, which supports previous evidence from Swords and Ellis (2017), who found a burnout rate of 75% in trainee clinical and counselling psychologists, and Richardson et al. (2018), who found high rates of depression associated with perfectionism within this population. Similarly, ruminative thinking, associated with perfectionism (Flett et al., 2016), also predicted psychological wellbeing in a longitudinal study of trainees by Dereix-Calonge et al. (2017), and in a qualitative study, Clinical Psychologists linked their experiences of distress to perfectionism: "It's about having to do things right…grade A, first-class standard…an instant recipe for difficulties…this thing of psychology about being perfect all the time…" (Charlemagne-Olde et al., 2014, pp. 244).

One mechanism proposed to account for this association is that those with perfectionistic traits tend to spend less time on self-care and can deny its benefits

(Gengoux et al., 2020), although evidence suggests that self-care can facilitate improved quality of life for trainees (Goncher et al., 2013). The use of third-wave cognitive therapy techniques have been found to facilitate self-care (Pakenham, 2017) and reduce burnout in trainees (Richardson et al., 2018). However, training courses have been criticised for suggesting, but not scaffolding a culture of self-care to trainees (Christopher, et al., 2006; Goncher et al., 2013; Munsey, 2006; Theriault & Gazzola, 2006).

In addition, a recent study by Grice et al. (2018) found that perfectionistic trainees may find it difficult to seek support for psychological distress, due to a perceived "taboo" and stigma surrounding distress in the profession (Charlemagne-Odle et al., 2014; Tay et al., 2018; Weller, 2018). This stigma is suggested to prevent trainees from seeking personal therapy outside of the training course (Wilson et al., 2015) and notably, one of the largest concerns regarding help-seeking, was a perceived negative impact on career development (Tay et al., 2018). A reflective account by a former trainee, states that "to struggle or ask for help [during training], was, in some ways, admitting failure" (Bettney, 2017, p. 373) and that perfectionism served a function of proving their worth and protecting their idealised image as a trainee.

This is concerning, given that perfectionism may serve to impede the development of a professional identity in therapists (Robinson et al., 2018) and have negative outcomes for clients through the setting of high standards, or avoiding problems they feel are outside of their skillset (Presley et al., 2017). Additionally, feeling too overwhelmed or burnt out to provide a containing space for clients to engage effectively in the therapeutic process can also lead to poorer client experience, client disengagement and increased NHS costs (Harling et al., 2020; NHS Benchmarking Network, 2019; Thériault & Gazzola, 2006).

Gaps in the literature and current study

The existing literature surrounding perfectionism and psychological wellbeing in trainees is currently in its infancy and is mostly quantitative in nature. Although quantitative studies provide generalisable findings more representative of this population, rich, first-hand experiences of trainees remain unresearched. Qualitative approaches are required to further understand the nuances that underpin this complex relationship for trainees, and would inform the ongoing development of wellbeing support provided by UK training institutions (Charlemagne-Olde et al., 2014; D'Souza et al., 2011; Jones & Thompson, 2017).

A small and valuable amount of qualitative research has explored trainees' experiences of stress, psychological wellbeing and identity development during training and, despite perfectionism arising as a theme associated with difficulties in these areas (Jones & Thompson, 2017; Kanazawa & Iwakabe, 2016), it has not yet been the specific focus of a qualitative exploration. The current study therefore used a qualitative approach

with a small sample of UK trainees, who self-identified as 'perfectionists', to answer the following research question: What are trainee clinical psychologists' experiences of perfectionism and associated psychological wellbeing during training?

Material and methods

Ethical Approval

The current study was granted ethical approval by the UEA Faculty of Medicine and Health Sciences Research Ethics Committee.

Design and Epistemology

This study used a cross-sectional qualitative design, adopting a thematic analysis (Braun & Clarke, 2013) framework, due to its suitability for capturing a broad range of concepts. A critical realist epistemological stance was selected, which proposes that the "real" world exists independently of individuals' different, but equally valid, perceptions of the "observed" world, which are bound by contexts such as culture, language, traditions, or particular situations (Bhaskar et al., 1998). The researcher acknowledges that within this context, their interpretation of the data was, in some part, bound by their own individual experiences (Fine, 2002), therefore the researcher ensured reflexivity via a reflective journal and regular supervision (Yardley, 2000).

Participants and recruitment

A volunteer sample of 11 participants was recruited (Clarke, 2010) via social media platforms and word of mouth. Inclusion criteria for the study were: (a) UK-based trainees currently studying on a UK Professional Doctorate in Clinical Psychology course (ClinPsyD), and (b) trainees self-identifying as a "perfectionist" in accordance with the following definition: "Researchers have defined perfectionists as individuals who set very high standards and live by rigid rules to achieve these in order to feel worthy, and to prevent failure. This can evoke feelings of self-doubt and self-criticism if these standards are not achieved. If they are achieved, these standards can be re-evaluated as not being sufficiently demanding" (Frost et al., 1990; Riley & Shafran, 2005; Shafran et al., 2002; Stoeber, 2018; Woloshyn, 2007).

Exclusion criteria were: (a) trainees studying at UEA, and (b) peers known to the researcher. Written informed consent and demographic information (see Table 1) were gained, via an online questionnaire, prior to the interviews taking place via videocall. Videocalls were selected to cover a wider geographical area and to keep to social distancing measures during the COVID-19 pandemic. Participants received a £10.00 Amazon voucher as payment for their time.

Data collection

A semi-structured interview schedule of 12 questions (see Table 2) was developed following guidance from Braun and Clarke (2013). Semi-structured interviews, of

approximately 90 minutes, were selected in keeping with the broad aims of this research. The topic areas were informed by the research question, existing research and discussions with trainee colleagues and the researcher's supervisor. All interviews were audio recorded and transcribed verbatim by the lead researcher, to allow for familiarisation with the dataset.

Analysis

A semantic inductive thematic analysis (Frith & Gleeson, 2004; Patton, 1990) was conducted following guidance from Braun and Clarke (2013). This approach was selected as it is data-driven, meaning that the themes are closely linked to the raw data themselves, reflecting participants' experiences and meanings as closely as possible, in line with a critical realist stance (Patton, 1990). Upon coding extracts from the transcripts, the researcher paid close attention to the language used, in order to capture participants' realities as closely as possible, in line with a critical realist approach (Braun & Clarke, 2013). The researcher acknowledges, however, that this represents their interpretation of the data, thus a reflective journal was used to minimise bias and ensure rigour (Yardley, 2000).

Over 300 codes were first generated, before the researcher and their lead supervisor jointly refined the framework to 80 codes dependent on their similarities, differences, and whether they provided data that answered the research question. Following this, codes that represented similar phenomena and experiences were grouped into themes and sub-themes. Lastly, thematic maps were created to examine the relationships between themes and define subsequent over-arching themes (see Figure 1).

Results

Thematic analysis led to the development of three overarching themes: a) The Paradox of Perfectionism, b) The Struggling Helper and c) Togetherness in Transformation, each containing themes and sub-themes (see Figure 1). Pseudonyms are used throughout to maintain anonymity.

Overarching Theme One: The Paradox of Perfectionism

This over-arching theme contained themes of a) Perfectionism as protective, b) Perfectionistic idealised psychologist and c) Imposter syndrome (IS).

Perfectionism as protective

Trainees described perfectionism as serving a protective function against beliefs of inadequacy and associated shame. As Alice notes "If you aim to avoid […] feeling not good enough then you're just going to […] strive for perfectionism […] what would be underneath that, may be feelings of inadequacy, or feelings of not being good enough at a core level".

Perfectionistic striving protected some from the possibility of “intolerable” failure (Alice), which could evoke feelings of distress associated with exposure of vulnerabilities.

> Isabella: “I guess the perfectionism is my trying to avoid things going wrong, so it's my defence against those […] uncomfortable predictions that I'm making about what might happen […] it is my safety behaviour, I suppose, to avoid the uncomfortable possibility that I might get something wrong or do badly or something and then that would challenge my sense of self.”

Similarly, avoiding failure through perfectionistic striving ensured success for trainees. For example, Mike described perfectionism as “motivating to do more, to achieve more, to go that one step further” and for some, this brought a sense of satisfaction: “You do achieve those things […] you get a paper published, and you think it was all worth it” (Jade).

Perfectionistic idealised psychologist

Trainees described how perfectionistic striving had shaped their self-image as a high achiever over time, bringing them closer to their perceived ideal of a Clinical Psychologist. Some trainees were seen by their families and peers as being “competent […] people think ‘look at her. She's got it all down. She's got it all together’” (Dina) and that being perfectionist demonstrated that they were passionate about their role, which received praise from others.

> Jade: “I do try really hard and I can't allow myself to just do a half-baked job of things. I really have to try to do it really well, so it gets me good, positive feedback from people that I work with.”

However, despite praise, trainees reported that aspiring to a perceived ideal can be unrealistic and unachievable. Jade reported “I'm not really comparing myself to a real person. It's some ridiculous, the perfect-self version of a trainee”. Hetti described “never really feeling like you can achieve that, 'cause when you achieve it, you could aim higher […] it is a very stressful thing. I tend to feel like I’m under quite a lot of pressure.”

Trainees also explained that they felt unseen regarding the amount of effort and associated stress that maintaining a perfectionistic image involves. They reported that this can be “really frustrating, because people don’t always get it” (Gill), and this can render them vulnerable to unintentional exploitation.

> Dina: “It can be frustrating because I don't think they see behind the scenes and what goes into that […] The course staff as well, I’ve always been praised for doing well. I'm regularly asked do extracurricular stuff, which I guess is good for perfectionism because it shows me that I'm valued, but then at the same time it builds up all my list of things that I need to do, so I think it can also open you up to burning out […] on the extreme end it can feel exploitative […] it can feel sometimes like I'm doing too much and that the people who I would hope would nurture me are not protecting me from that.”

Imposter Syndrome

Trainees reported that perfectionistic striving during the beginning of training, when expectations are unknown, evoked feelings of imposter syndrome, stress and anxiety. As Jade notes “I think I felt quite stressed and very uncertain […] I have no idea what I’m doing.”

The competitive nature of gaining a training place was reported to have exacerbated imposter syndrome for trainees, with the course described as a “pedestal” (Dina), leading to trainees engaging in self-comparison to prove their worth (“I feel like I need to prove that I can do it. I need to prove that people have let me on the course for a reason” Caroline), and increasing psychological distress.

> Emily: “Imposter syndrome was just through the roof when I first started […] I compared myself […] and how limited experience I had in comparison with other people who worked in the NHS for years. So, I think when I first started, I definitely felt like, ‘I’ve been given this opportunity […] I really have to go for it. I have no choice now.’ So, I was very quickly…started to reach the point of potential burnout when I first started the course.”

Overarching Theme Two: The Struggling Helper

This overarching theme comprises two themes: a) Wellbeing difficulties, containing sub-themes of stress and burnout, anxiety and low mood and maladaptive coping, and b) Helpers cannot ask for help, containing sub-themes of perfectionism as a barrier, implicit course messages and stigma.

Wellbeing difficulties

Stress, burnout and maladaptive coping. Some trainees described becoming “physically quite unwell … just feeling quite burnt out” and that this negatively impacted their ability to engage in basic self-care routines.

> Dina: “I won't be sleeping, I will be staying up most of the night or waking up frequently in the night […] I think the point where I was probably feeling the worst […] I wasn't eating as much. And all those things that I know contributes to my wellbeing were just completely falling by the wayside […] my basic needs aren't being met.”

Others added how self-care could become perfectionistic when rigid rules and high expectations were applied, which could prevent them from engaging in self-care and exacerbate psychological distress. For instance, Mike reported that “If I don’t get eight and a half hours sleep, that makes me really angry at myself”. Trainees explained how the narratives around self-care may need to be adapted to encourage the promotion of healthy wellbeing in perfectionistic trainees.

> Dina: “The narratives around self-care in terms of training […] this idea of not self-caring hard enough and not exercising, or healthy eating, or whatever it is that we prescribe people to do and not doing it hard enough if things are not going well, and I think that can be a really dangerous message for people […] it insinuates you should be doing more and sometimes, someone just really needs to hear ‘you need to stop, or you need to do less, you need to breathe, you need to sleep, you need to eat’, I really think there could be more narratives around space and actually the system creating space.”

Anxiety, low mood and maladaptive coping. When low mood and anxiety were present, trainees described feeling “unmotivated, really hopeless” (Becky) and guilty. Trainees also reported that their inner self-critic grew a stronger voice, including “lots of […] self-criticism, lots of judgment. Lots of ‘oh you should...’ I noticed it for me, ‘should’s’” (Jade). This sense of frustration with the inner self-critic was shared amongst trainees, and for some, fuelled feelings of shame.

> Mike: “it just feels very frustrating, very stuck and jarring […] I suppose it compounds the negative self-views […] and again back to that I’m not achieving what I should be achieving for that idealised state for a doctoral student […] I suppose it can be shaming as well.”

In addition, trainees described how the inner critic’s high expectations and associated stress could lead to engagement in procrastination and intensify psychological distress.

> Dina: “I've been so debilitated by stress, I haven't done anything, and what's interesting is when I'm talking to you about it now, I think ‘what are the things I could have done?’ [laughs], you know, I could’ve gone away from it for a while I could’ve gone for a walk, whatever, but I always feel like…’no, I just have to get this done’ […] I'm so overwhelmed by the high standards that I need to meet for this to be considered a doctorate level piece of work that sometimes I will just sit for hours and do the most minimal amount of work because I'm stressed.”

Other trainees coped with difficult feelings by self-blame, which may serve to reinforce inner shame, as Mike states “when I'm struggling […] I’m like ‘why are they…?’ just blaming, and then I think ‘well I can’t blame them’ and then I just blame myself”. Thus, trainees were aware that these negative coping strategies were unhelpful, but perhaps felt unable to use alternative strategies when experiencing psychological distress.

Helpers Cannot Ask for Help

Perfectionism as a barrier. Trainees reported that they felt unable to seek help when experiencing psychological distress. Some described a perfectionistic self-image as a barrier.

> Isabella: “I haven't felt comfortable to ask for support […] associated with that is wanting to be a good trainee, whatever that is, or a perfect trainee and not causing any trouble or kick up a fuss […] just wanting to be good and in my head having difficulties in my mental health or having days when I'm really sad or feel like I'm not coping, doesn't fit with that idea of what I think a good trainee is.”

Being assessed throughout training was reported to exacerbate perfectionistic tendencies and difficulties with help-seeking, due to predicted negative consequences of needing support on self-image and reputation.

> Jade: “I think it's part of just not wanting to seem like I can't do it, or to let out my vulnerability of ‘I’m finding this really hard’, and then to be seen as not doing very well, or not as able to do it.”

For others, seeking support can expose inner vulnerabilities and shame, that perfectionism can serve to protect, as Mike states: “really shaming, really exposing…just exposing some of those flaws, that I’m not in the right place.”

Course messages. Support was perceived by some to be “something else, something extra” (Isabella) to what some courses already offer, and struggling with psychological distress was reported to be normalised as part of the training experience by some courses. Some reported that this could unintentionally cause an “invalidation within that, because […] if the course takes the position of normalising it too much, people feel like maybe it’s not as emotive as it is.” (Emily). For others, perfectionistic tendencies were seen as a benefit to producing ‘good’ clinical psychologists for prospective employers.

> Isabella: “There's a lot of ‘oh, yes, but you know, […] our employers in the local area say that their trainees do best at interviews’ and it’s almost like that, ‘yes we traumatise you, but look at benefits! […] they're almost feeding that the perfectionistic narrative, because that’s almost what it is, you need to be better than what you are.”

Thus, seeking help within these contexts was, for some, reported to have been perceived as a weakness, implicitly, but unintentionally, reinforced by course messages, as well as the multiple demands of training.

> Hetti: “You get told from the course to say to your clients ‘it's OK if you're not feeling 100% […] just take care, just take time off’ but then you, yourself, are not meant to do that 'cause you're meant to be a little robot, that just keeps on going. You know, it just feels like very much the […] message you’re trying to give other people […] is so different in the message that you're getting yourself.”

Stigma. A number of trainees associated these perceived implicit messages with the effects of wider societal stigma of psychological distress in helping professions as a whole.

> Becky: “There is often a sort of a weird twisted ‘oh if you work in mental health, you shouldn’t have any of your own struggles’, and this idea of ‘well if you are struggling you aren’t able to handle other people’s emotional distress’”.

Trainees added that this societal stigma may have been reinforced in their interactions with qualified clinical psychologists, who were not open regarding their own experiences of psychological distress, as Mike explains: “they tend to leave stuff at the door and maybe find it difficult, or even a little bit inappropriate, to talk about personal stuff at work, so I suppose that's contributed to my idea of what a psychologist is.”

Trainees hoped that “trying to have cultures where people can bring their various different life experiences” (Emily), combined with an increased openness and discussion of lived experience of psychological distress within the profession, may help to increase the availability and ease of help-seeking.

> Dina: “I think we could do a lot more around lived experience and normalising struggling with your mental health as a psychologist. […] I think that is still something that feels quite taboo? I think having an open and honest conversation about it would be beneficial.”

For some, qualified mentors, who had recently completed the same training course, sharing their experience of psychological distress facilitated trainees help-seeking.

> Becky: “I was assigned a mentor when I started and I remember when talking to her she mentioned how the course were really helpful when she started training because she had been attending [therapy] and they were just really accommodating about that, and there was something that was really important for me to hear […] when I was struggling, it just made it so much easier to seek help.”

Overarching Theme Three: Togetherness in Transformation

This overarching theme comprises the themes of a) Shared experience: Together in the journey (containing sub-themes of safety in small trainee groups and supportive staff) and b) Developing healthy self-relating (containing sub-themes of reducing perfectionistic standards, practising boundaries, connecting with other self-identities and developing balanced thinking).

Shared experience: Together in the journey

Safety in small trainee groups. Trainees described feeling comfortable reflecting on their identities and experiences within small groups, as Frances states: “You're all in the same boat, so perfectionism […] we speak about all the time […] we try and encourage each other […] at difficult times of the course. I think those relationships are really important.” They reported that this experience built a “sense of connection” (Alice), was validating and normalising, and that this helped to reduce competitiveness.

> Becky: “there’s a nice shift within our cohort, slowly, about it being less about pleasing everyone and trying to show off, or be competitive, that I think was

> definitely there at the start […] we are accepting that we aren't evaluating and judging each other."

Informal groups, co-created and co-facilitated by trainees, where mutual support can be provided, were reported to be most valued and helped to reduce the internalisation of psychological distress.

> Becky: "We set up those spaces […] to complain and laugh and a bunch of other things, we needed to have those. We were all internalising all of the difficulties that we were having, and then we suddenly realised that we're all in the same boat and we all have difficulties with x,y and z, so we have made more of those spaces and they're really helpful. Even if I complain a lot in them, it's nice to complain to people who understand!"

Supportive staff. Validation and normalisation of perfectionism and associated psychological distress was described as part of the course ethos of several courses.

> Caroline: "Our course director, I remember her saying to us […] 'Obviously we want you to be amazing clinical psychologists, but there's 24 doctorates, you need to reassess your levels of perfection and your expectations of yourself, because we have expectations, but they are not probably as high as the ones you are holding for yourself, just the level we want you to be trained to, that's what we expect, we want you to learn, we want you to do well, but we're not… we don't want you to be perfect, because nobody is perfect', so that felt very supportive."

Feeling safe in one-to-one interactions with course staff and clinical supervisors were also seen as important in supporting the majority of trainees to become comfortable to share vulnerabilities, own uncertainty and expose gaps in knowledge and experience.

> Alice: "Now I feel a lot more comfortable saying things like 'well I don't know that, I'll find out', or being able to acknowledge a mistake or acknowledge that I didn't know something or reflect on something being difficult. […] I think that's totally helped in why I'm probably in the position I am now, in feeling more comfortable in who I am and expose my identity which has probably come from mainly those supervisory experiences."

Developing healthy self-relating

Reducing perfectionistic standards. Through the support of staff and trainee peers, trainees were able to reflect on reducing their perfectionistic standards and develop healthier ways of self-relating to support their psychological wellbeing.

> Dina: "I had a conversation with her [supervisor] about it and she made it clear that what she was saying was actually 'you need to look after yourself' and 'this course is not your whole life' […] it was taking some time to think 'what has this cost me?', you know, 'what has being a perfectionist, cost me and what will it continue to cost me if I continue on this cycle of just…ongoing perfectionism?'"

As well as reflecting on psychological wellbeing, and realising that "I wasn't willing to sacrifice my health for the job" (Emily), others reported actively reducing their effort across the multiple demands of training, due to the "unsustainable" (Hetti) impact of having high standards on wellbeing and work-life balance, as Emily explains "You have to let it go or there's a cost to yourself […] you can't give 100% to each thing, you might have to sometimes just give 40% or 30%."

Practising boundaries. With the reduction of perfectionistic standards, trainees were able to improve their work-life balance through healthy boundaries, as Emily stated "I guess what I've realised is that you can always give more to it, no matter how good it gets, there's always more that you can add […] thinking about what is realistic and what is asking too much" and Frances, who adds regarding assignments "once it's submitted I'm not going back to it […] once it's done, it's done."

Connecting with other self-identities. Trainees stated that connecting with other parts of themselves beyond their 'trainee' role, was important for work-life balance and developing new perspectives, as Mike reflected "I think for me the main thing is trying to engage in stuff outside of training […] just having some time to have an identity outside of being a trainee is really important." Connecting with their role as a family member or friend, as well as hobbies and interests, was particularly helpful, as Becky notes: "there was something about having the book club so I can just talk about what my opinions are as opposed to what me, the trainee, should be saying!".

Developing balanced thinking. Some trainees used their own time to attend private therapy for their "journey of self-exploration" (Dina), and added that it was important to understand "the links […] with early life experiences and current mental state" (Dina) and to explore how to respond differently in particular situations.

> Emily: "…getting to know my ways of being as a person, but also as a therapist, as a person who works in a team, and then just having that space to step back and think about my own procedures […] I think it can feel hard to have space on the ClinPsyD so creating that space that's run alongside it has been just invaluable, really. Not sure what I'd have done without it!"

Such experiences throughout training allowed trainees to embody self-compassion, as Mike explained: "what I've tried to do is bring compassion into that, so bringing in that compassionate voice, that compassionate feeling." This was especially important for those coping with difficult personal circumstances, failure, or not reaching unachievable standards.

> Alice: "As training's gone on, I've used supervision a lot more to focus on aspects of the self and in developing that awareness I can see the patterns that play out and I think in the exact same way that we've worked with our clients, having developed a bit of a formulation and understanding of my own patterns helps me to not get stuck in them […] I can try and make more informed choices. […] Maybe in first year (following a failed assignment) or before that I just would have spiralled into 'oh well I'm just s**t!", but actually I could rationalise it and notice actually 'no you're not, you're doing absolutely fine in quite tricky circumstances, you're all right.'"

Discussion

The aim of this research was to explore the experiences of perfectionism and associated psychological wellbeing of trainees during their training journey. Thematic analysis identified three overarching themes: 1) The paradox of perfectionism, 2) The struggling helper and 3) Togetherness in transformation. These are discussed below with reference to the current literature, implications for the development of wellbeing support on professional training courses, relevant limitations and future research.

Novel findings and implications

The overarching theme of 'the paradox of perfectionism' supports the two-factor model of perfectionism, in having both adaptive and maladaptive outcomes (Slade & Owens, 1998). Trainees described a theme of "perfectionism as protective" against inner beliefs of inadequacy, that it produced success, maintained self-esteem and moved them towards their idealised image of a clinical psychologist (Ashby & Rice, 2011), but that it could render them vulnerable to imposter syndrome and associated psychological distress (Clark et al., 2021; Parkman et al; 2016; Wang et al., 2019).

This extends findings by Jones and Thompson (2017), who found a theme of imposter syndrome in trainee clinical and counselling psychologists, by being the first study to identify that trainees explicitly associated imposter syndrome with perfectionism, particularly around the beginning of training, when expectations are unknown and levels of intra-cohort competition are high. Given this experience was shared across the majority of the 11 trainees interviewed, naming imposter syndrome and levelling expectations from the beginning of training may be of benefit to trainees.

Similarly, the overarching theme of 'the struggling helper' indicates that trainees experienced psychological distress during different phases of their training journeys, and some specifically associated this with perfectionism. This adds an important contribution to the literature which suggests high levels of psychological distress can be experienced by trainees (Cushway et al., 1992; Galvin & Smith, 2015; Richardson et al., 2018; Swords and Ellis, 2017; Tay et al., 2018; Weller, 2018), and can be impacted by perfectionistic tendencies (D'Souza et al., 2011). This study is also the first to find qualitatively that trainees can engage in negative coping behaviours associated with perfectionism, and that self-care routines can become rigid and perfectionistic. Trainees emphasised the importance of 'doing less' for maintaining a healthy work-life balance and that this felt achievable when staff acted as healthy role models (Grice et al., 2018). Previous research has criticised training courses as not teaching appropriate self-care to trainees (Christopher et al., 2006), but we argue that it is not the explicit teaching of self-care strategies, but the wider narratives and culture fostered by training courses regarding the meaning of self-care that requires further exploration and development (Baker & Gabriel, 2021).

The theme 'helpers cannot ask for help' described how perfectionistic trainees can experience internalised self-stigma around experiencing psychological distress, reinforced by societal expectations, as well as perceived implicit course messages. This adds to research by Grice et al. (2018), who found that perfectionism can be a barrier to trainees seeking help, but what this study adds over and above this is that trainees proposed possible benefits from the shifting of perceived implicit stigmatising messages to a culture of reflection and the normalisation of lived experience during training. Indeed, research by Turner et al. (2021) found that enablers to disclosure and help-seeking in trainees were trusting relationships, feeling safe and having an 'in-road' in conversations with staff. Notably, the British Psychological Society (BPS, 2020) has recently recognised the value of lived experience in the profession and highlights that qualified role models can be helpful in validating and humanising psychological distress in trainees. Inter-institution examples of good practice from UK training institutions are also encouraged to be shared to ensure consistency within this area (BPS, 2020).

Additionally, the overarching theme of ‘togetherness in transformation’ extends findings by Jones and Thompson (2017), by highlighting the importance of safe connection during one-to-one interactions, to explicitly name, challenge and reduce perfectionism, develop an appropriate work-life balance and grow self-compassion. As self-compassion is suggested to buffer against burnout (Coaston, 2017), this highlights the importance of the integration of self-compassion practises during trainee supervision (BPS, 2020).

As well as one-to-one interactions with course staff and clinical supervisors, trainees found that a shared sense of togetherness amongst cohorts helped to enable experiences of perfectionism and associated psychological distress to be validated and normalised. In particular, trainees stated that small, peer-facilitated reflective groups felt one of the safest spaces to enable such processes to occur. Thus, consideration of the amount of, and format of, reflective practice groups during training is important moving forward.

Limitations and future research

There are several limitations to the research. Firstly, due to being the first qualitative study to explore experiences of perfectionism and wellbeing in trainees, the researcher aimed to cover a broad range of concepts. Therefore, what this study does not offer is an in-depth account of each area. Future qualitative studies are warranted, particularly regarding trainees’ experiences of coping, help-seeking and the development of healthy self-relating during training. Such studies may benefit from using methods such as online surveys, using open-ended questions, to gain anonymous responses from a larger, more generalisable sample and reduce the possibility of stigma posing a barrier to participation (Grice et al., 2018).

In addition, this study did not use a quantitative measure of perfectionism to clarify the prevalence of perfectionism within the specified population before undertaking interviews. Using a measure such as the Clinical Perfectionism Questionnaire (Stoeber & Damian, 2014), may have been helpful to provide a prevalence estimate, as well as to guide further interview questions.

Further, this study did not explicitly explore potential differences in experiences amongst under-represented groups. Future quantitative studies, to investigate the prevalence of perfectionism and associated psychological distress in larger, more generalisable trainee samples, including under-represented groups, are needed to provide further weighting to the ongoing development of wellbeing guidance for UK training institutions, and to improve diversity within the profession.

Lastly, this study explored the experiences of perfectionism and psychological wellbeing from trainees’ perspectives. Future research focusing on the experiences of

qualified clinical psychologists, who support trainees, is required to identify and share good practice, and to inform the ongoing development of wellbeing support.

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Tables and Figures

Table 1

A table showing the demographics of participants, including age, identified gender, year of training and years of applying to gain a place on training.

Demographic	n	%
Age		
< 25	1	9.1
25 – 34	10	90.9
Identified Gender		
Male	1	9.1
Female	10	90.9
Training Year		
1	5	45.5
2	2	18.2
3	4	36.4
Years Applying		
1	1	9.1
2	7	63.6
3	2	18.2
4	0	0
5	1	9.1

Table 2

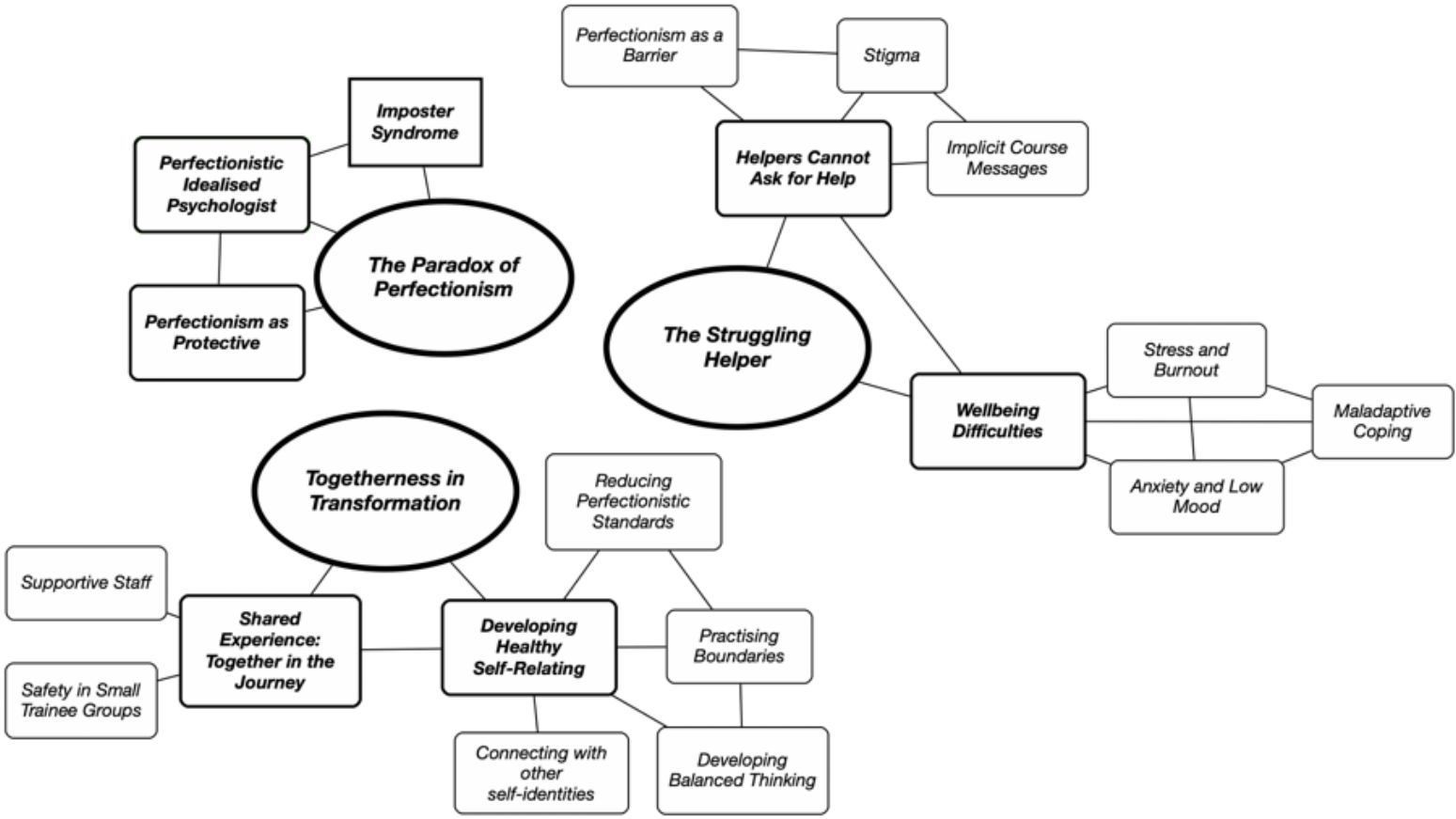
Interview guide.

Broad Topic Area	Interview Question
Introduction and rapport building	• Inform participant of what the study is about. Remind them of confidentiality, expectations (no right or wrong), risk of distress, right to a break or to withdraw, length of interview, payment of voucher. • Could you tell me a little about why you volunteered for this study? • Is there anything you'd like to ask before we begin?
Definitions and meanings assigned to perfectionism	1. What does perfectionism mean to you? o How do you make sense of it? o How would you describe it? 2. In what way do you personally identify as a perfectionist? o Could you please tell me a little more about that? o What is being a perfectionist like for you? 3. What are the positives and challenges of your perfectionism? o Are there any good things about it? Are there any not so good things about it?
Aspects of training where perfectionism is identifiable	4. Where do you notice your perfectionism [*or* participant's own words e.g. high standards/expectations] in your work as a Trainee Clinical Psychologist (e.g. academic, clinical, research)? o Could you please give me an example? o What is this like for you? o What is this like for others (e.g. personal and work relationships? o What are the pros and cons of this? Does it make anything easier or harder? o How do you manage this? 5. What areas do you notice variations in your perfectionism [*or* participant's own words e.g. high standards/expectations]? o Why do you think this difference exists? o Has this changed? 6. Has your perfectionism [*or* participant's own words e.g. high standards/expectations] ever been raised by someone else (e.g. staff, peers, family) during your training? o How was this spoken about? o What was suggested? o How did you perceive this? o How did you feel? o What did you do about this? 7. Have there been changes in perfectionism [perfectionism [*or* participant's own words e.g. high standards/expectations] over your training journey so far? If so, in what way? o What do you think has enabled this? o What has this been like? 8. How would you describe your relationship with the course generally? o Could you tell me a little more about that?
Experiences of psychological wellbeing, in the context of perfectionism, during training	9. In light of identifying with perfectionism in X area of the course, how would you describe your mental health throughout your training journey so far? o E.g. mood, behaviour, cognition o What has this been like for you? o What has this been like for others (e.g. personal and work relationships)? 10. Has this changed throughout training? If so, what has influenced this?

	○ Mental health support? Where? How? ○ Fluctuations in workload? Grades? ○ Challenging/'letting go' of perfectionism?
Experiences of support for psychological wellbeing and/or perfectionism during training	11. How would you describe your general approach to supporting your mental health during training? ○ What have you done/not done? ○ What has this been like? ○ What works well? What doesn't work so well? ○ What might be helpful to have?
Ending	12. Is there anything you would like to share that we have not covered in this interview? • Thank participant for their time. Ask if they would like a copy of the transcript to check for accuracy.

Figure 1

A thematic map showing the three overarching themes, together with their themes and sub-themes.



Chapter Five: Additional Methodology for the Empirical Paper

Qualitative methodologies

Qualitative research aims to understand individuals' meanings and experiences of their realities (Willig, 2008). Unlike quantitative methodologies, which objectivity test hypotheses to understand particular phenomena, qualitative research focuses on "understanding by people" (Stiles, 1993, pp.1).

What is Thematic Analysis?

Thematic analysis is a method for identifying common themes of meaning within a dataset, based upon coded extracts of selected data. It can be seen as a method within itself, or as a foundational approach to other analyses, such as Grounded Theory or Interpretative Phenomenological Analysis. Thematic analysis can therefore sit within different epistemological frameworks, from realist to constructionist (Braun & Clarke, 2013).

In addition, thematic analysis can a take top-down, deductive approach, or a bottom-up, inductive approach, to generate themes (Braun & Clarke, 2013; Frith & Gleeson, 2004). Typically, a deductive approach involves coding data in line with a specific research question and is often underpinned by an existing theoretical framework of the subject area. An inductive approach involves coding data in a way that is not determined by the researcher's theoretical understandings of the subject area (i.e., the researcher does not fit the codes into a pre-existing coding framework). An inductive thematic analysis is therefore data-driven, meaning that the themes are closely linked to the raw data themselves (Patton, 1990).

In addition, a thematic analysis can take a semantic or latent approach to developing themes (Boyatzis, 1998). Semantic thematic analysis involves coding from the surface meanings of the data, before later interpretation (Patton, 1990), whilst a latent approach goes beyond this, exploring underlying ideas, assumptions and ideologies in relation to a theoretical framework. Analysis of the former approach typically fits with a realist paradigm, whereas the latter approach a constructionist paradigm (Braun & Clarke, 2013). For this study, the researcher conducted an inductive, semantic thematic analysis using a critical realist epistemology.

The process of thematic analysis involves six steps: 1. Familiarising oneself with the dataset, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, and 6. Writing the paper. Step one can be achieved through the processes of transcribing and reading the resulting transcript. Step two involves coding extracts of data that are of interest to the researcher and answer the research question. Codes can be described as "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way, regardless of the

phenomenon" (Boyatzis, 1998, p. 63). Step three involves collating codes into broader themes. A thematic map can be devised to explore the relationships between codes and themes, and between themes. In step four, coded extracts are read to ensure the themes describe the dataset and answer the research question. Themes may be broken into smaller ones, or collated into larger ones. In step five, themes are named and given definitions about what aspect of the data they capture. It is important to describe the story that the themes are telling about the dataset. Step six involves describing each theme, with quotes from the initial dataset, to tell the story of participants.

The researcher's epistemological stance

The researcher adopted an epistemological approach of critical realism to undertake this research. Critical realism proposes that the inaccessible "real" world exists independently of individuals' different, but equally valid, perceptions of the "observed" world, which are bound by contexts such as culture, language, traditions, or particular situations (Bhaskar et al., 1998). A critical realist approach assumes a unidirectional relationship between an individuals' language and meaning, therefore an inductive semantic approach to thematic analysis was appropriate for this research (Braun & Clarke, 2013).

In the design of this research, alternative epistemological stances were considered, such as social constructionism (Berger & Luckman, 1966). However, social constructionism proposes that knowledge is constructed by social processes, specifically, the interactions individuals have with one another (Berger & Luckman, 1996). Due to the individualistic nature of perfectionism, and therefore the different meanings individuals can potentially assign to the phenomenon, it seemed inappropriate to use an approach which seeks truth as a "social convention, playing by the rules of a particular group" (Ratner, 2006). Therefore, critical realism appeared the most relevant epistemological stance to answer the research question.

The researcher acknowledges that despite adopting a critical realist approach, the interpretation of the data was, in some part, bound by their own individual experiences (Fine, 2002), therefore several steps were undertaken to ensure researcher reflexivity and validity and rigour of data, outlined below (Yardley, 2000).

Reflexivity and the reflective journal

Berger (2015) described researcher reflexivity as:

> "turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation" (p. 220).

Throughout the research process, the lead researcher acknowledged their own context when interpreting participants' realities. The researcher attempted to give voice to the participants' experiences with the researcher's own biases, judgements and theories being separated as much as possible (Yardley, 2000).

One method of ensuring this was achieved was via the use of a reflective journal (Braun & Clarke, 2013; Ortlipp, 2008). The reflective journal enabled the researcher to document their experiences and reflections in a structured but meaningful way to allow them to understand how their context may impact on the research process (Yardley, 2000).

Acknowledgement of the lead researcher's context

An acknowledgement of the researcher's experiences and perspective when undertaking qualitative research is critical in ensuring validity and rigour of qualitative data (Braun & Clarke, 2013; Yardley, 2000). The lead researcher conducted this study as a requirement of the Professional Doctorate in Clinical Psychology. The lead researcher was interested in this study due to self-identifying with perfectionistic tendencies, before and during training, as stated in their reflective journal:

> "Reflecting on my own identity, I realise I have likely always been a perfectionist, working tirelessly to achieve good grades at school, college and university, which was unintentionally reinforced by messages given to me by my family growing up. I was the first of my, White British, working-class, family to go to university, and with this comes high expectations, imposed by myself, and perhaps, again, unintentionally imposed by those close to me. Perfectionism has helped me to gain success throughout my career thus far, securing a clinical job straight after my undergraduate degree, and gaining experience to secure a place on clinical training. At times, however, I can still feel a little lost in the world of academia, and perhaps perfectionism can creep in more here, to bridge the gap between my home and work identities. That being said, I realise that in some ways, I do represent the majority of trainees, and I wonder what the experiences of those from under-represented groups might be." (29.02.2021)

The lead researcher is passionate about the wellbeing of trainees and how training courses can best support trainees during their journey, and is a cohort representative for the UEA ClinPsyD Wellbeing Committee. The lead researcher reflects on their interest in their reflective journal:

> "During my time on training so far I have noticed perfectionistic tendencies within myself. This applies to both clinical work and research work, particularly with things I am less experienced in and therefore less confident about. At the beginning of training, especially, I experienced imposter syndrome, feeling a need to prove myself as a trainee. This led to feelings of anxiety and frustration. Speaking with trainee and qualified colleagues from different socio-economic and cultural backgrounds, I realise that I am not alone, and that perfectionism appears to be a phenomenon that is anecdotally shared amongst the profession. I am surprised that this has not been researched to a wider extent at this point in time, given its links with psychological distress, and the potential impact that this might have on clinical practice. I am really looking forward to exploring more about what perfectionism means to other trainees, how it might associate with their own wellbeing, and how they manage this during training. I hope that this research can more formally recognise experiences of perfectionism amongst the profession, and that changes can be made, if needed, to support trainees on this unique journey." (29.02.2021)

These quotes highlight a potential bias in wishing to provide a voice for trainees and to ensure the support provided by training courses can be considered and continually refined if needed. This may lead the researcher to attune to the negative experiences of participants, rather than the positives. This was discussed with the researcher's supervisory team and documented in the reflective journal as an ongoing process to tease out the researcher's and participants' experiences when interpreting the data.

Method

This study was conducted and written in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007; see Appendix E). This checklist was selected due to its inclusion of reflexivity, study design, analysis and findings as domains for consideration.

Ethical issues and ethical approval

This research study had a number of ethical considerations, outlined below, following guidance from: The British Psychological Society's (BPS) Code of Human Research Ethics (2014), The BPS Code of Ethics and Conduct (2018), The University of East Anglia (UEA) Faculty of Medicine and Health Sciences (FMH) Research Ethics Committee (2020), The Data Protection Act (2018) and the UEA Research Data Management Policy (2019).

Confidentiality and Anonymity

Storage of participants' demographic information and emails. The demographic information of participants who met the inclusion criteria for the study was temporarily stored in a password protected Jisc Online Surveys account and were permanently removed from this account and stored on an IBM SPSS Statistics for Macintosh version 25.0 database once an interview was booked. Demographic information of potential participants who did not meet inclusion criteria for the study were permanently deleted. All files were encrypted and will be destroyed after 10 years. Emails to and from participants were stored in a password protected folder in a Microsoft Outlook account and will be destroyed once the study is complete and findings have been emailed to participants and courses.

Storage of audio recordings and transcripts. All audio recordings and transcripts were saved in an encrypted folder on a password protected computer for the purposes of analysis and will be destroyed after 10 years in accordance with the guidelines outlined above.

Anonymity. Audio recordings and transcripts were saved using pseudonyms as titles. Transcripts replaced real names with false names. False names were also used in the empirical project paper. The names of the universities where participants are training were not included, but gender ratio, age and year of study were included. Participants were informed of a risk that quotes from the interviews may be identifiable to them, but the risk of being identified by others is low.

Consent

All participants were trainees and had capacity to consent to take part in the study. Participants were fully informed of the purpose of the study, the study's expectations and requirements, potential risks, their right to withdraw, how their data were collected and stored and their rights of ownership of their data. This was outlined in the participant information sheet and consent form on Jisc Online Surveys. Informed consent was obtained before the interviews were booked.

Coercion

Participation in the study was voluntary and participants were thanked for their time with a payment of a £10.00 Amazon voucher. Participants were made aware that should they have withdrawn from the interview at any point, they would still have received the voucher. Therefore, coercion was not used at any point during the study.

Disclosure and deception

Participants were informed of the researcher's identity from the point of advertisement. The researcher had no expectations about the content of findings and the participants were invited to openly discuss their experiences. A full debrief was therefore not needed.

Participant distress

There was a risk that the content of the interview may have evoked feelings of distress for participants. Participants were informed of their right to pause or to withdraw from the interview at any time. Participants were also informed of their right to refuse to answer questions.

Despite this not occurring, the researcher had prepared for the potential for participants to become distressed. The researcher would have suggested that as trainees, participants could have sought support from their course Personal Tutor/Advisor, Clinical Supervisor, hosting university Student Support Service, General Practitioner, or their local Primary or Secondary Mental Health Service, as appropriate. Contact details for charities such as the Samaritans, CALM and MIND, would also have been provided to participants if required.

Ethical approval

This study received ethical approval from the UEA FMH Research Ethics Committee (ref 2020/21-050; see Appendix F).

Development of the interview guide

Interviews were selected as the method of data collection. Interviews allow for a rich description of participants' experiences (Patton, 2002), which fits with the research question and the exploratory nature of the research, being novel in the field. Individual interviews were selected, as opposed to focus groups, due to the knowledge that perfectionistic self-presentation may prevent disclosure of particular experiences, particularly those that are negative (Grice et al., 2018; Tay et al., 2018).

Semi-structured, rather than structured or unstructured interviews, were selected in keeping with the broad aims of this research and the approach of thematic analysis in exploring themes across the dataset (Braun & Clarke, 2013). Strengths and weaknesses of each approach were also considered, as shown in Table 1 (Patton, 2002).

Table 1

A table showing the strengths and weaknesses of different interview types, as outlined by Patton (2002).

Interview type	Strengths	Weaknesses
Unstructured	Content can be tailored to the individual.	Topics and questions may vary greatly from one participant to the next.
Semi-structured	Interviews cover the desired topics, whilst keeping to a conversational style under the interviewer's lead.	Salient topics could missed. Difficulties comparing responses across participants.
Structured	Comparability across responses is improved. Reduces interviewer bias. Ensures all pre-determined topics are covered.	Lack of flexibility in responding to individuals. Pre-conceived ideas of the researcher may impact data.

A semi-structured interview schedule of 12 questions was developed following guidance from Braun and Clarke (2013). The broad topic areas were informed by the research question, existing research and discussions with trainee colleagues and the researcher's supervisor. The interview schedule began with broader questions to engage and build rapport with participants, before narrowing to their experiences of perfectionism and psychological wellbeing during training (Braun & Clarke, 2013). The interview schedule was piloted with the first participant but following a review of the data and discussions with the researcher's supervisor, no further changes to the interview were made and the data from this participant were included in the analysis (see Appendix G).

Participants and recruitment

A volunteer sample of 11 participants was recruited (Braun & Clarke, 2013). Inclusion criteria were (a) UK-based trainee clinical psychologists currently studying on a UK ClinPsyD course, and (b) Trainee clinical psychologists must self-identify as a "perfectionist". A perfectionist can be defined as an individual who sets very high standards and lives by rigid rules to achieve these in order to feel worthy, and to prevent failure, which can evoke feelings of self-doubt and self-criticism if these standards are not achieved (Frost et al., 1990; Riley & Shafran, 2005; Shafran et al., 2002; Stoeber, 2018;

Woloshyn, 2007). Exclusion criteria were (a) Trainee clinical psychologists studying at UEA, and (b) peers known to the researcher.

Recruitment took place online through (a) A written advertisement posted on the social media platform Facebook, using the following groups: UK Based Clinical Psychology Facebook Group, the Trainee Clinical Psychologist Group UK and Assistant Psychologists UK, all of which state in their group rules or administrator posts that the groups can be used to recruit research participants, and (b) a written advertisement posted on the social media platform Twitter, allowing for re-tweets. Recruitment also took place using word of mouth.

Participants expressed their interest in participating in the study by clicking on the advertisement's link to the online expression of interest form, using Jisc Online Surveys (see Appendix H). The expression of interest forms were reviewed by the researcher, and participants who met the inclusion criteria were emailed within two weeks with a further link for an online participant information sheet, consent form and demographic questionnaire (see Appendix I). If the inclusion criteria were not met (which occurred on two occasions), the participants were not contacted. Advertisements were removed from social media, and the expression of interest form was de-activated, once the maximum number of participants was recruited.

Following receipt of informed consent and demographic information, participants were contacted by email to arrange a mutually convenient time for the research interview to take place. A confirmation email and Microsoft Teams video link was then emailed to each participant ahead of their interview.

Interviews

At the participant's interview time, the researcher and participant joined the video call using the Microsoft Teams link in the confirmation email. Videocall was the selected medium for the interviews due to restrictions on face-to-face contacts during the COVID-19 pandemic, and to cover a larger geographical radius.

The interviews lasted up to 90 minutes and were audio recorded using the dictate function on Microsoft Word as well as via a Dictaphone. All participants were reminded that they could pause or withdraw from the interview at any time, but no participants asked to. Following each interview, each participant was immediately emailed a £10.00 Amazon voucher as payment for their time. Each participant asked for a lay summary of the results to be shared with them via their preferred emails once the research is completed.

Transcription

The audio recordings and transcripts were anonymised throughout with pseudonyms (Eatough & Smith, 2007). The transcripts were screened for errors and amendments were made by the researcher, through listening to the audio recordings in

real time, using Express Scribe. The researcher immersed themselves in transcription, rather than recruiting a professional transcriber, to allow themselves to become familiar with the data and make initial reflections in their reflective journal (Braun & Clarke, 2013; Reissman, 1993). Participants were given a choice to read their transcripts to check for accuracy, before analysis, but no participants accepted this offer. Transcripts were then uploaded to Nvivo v.12 for analysis.

Analysis

The researcher undertook an inductive semantic thematic analysis following guidance from Braun and Clarke (2013). The researcher therefore followed the six key steps of analysis: 1. Familiarising oneself with the dataset, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, and 6. Writing the paper.

The researcher first familiarised themselves with the dataset through the process of transcription, making initial notes of their thoughts in their reflective journal (Yardley, 2000). The researcher paid close attention to language used, as well as tone of voice, in their initial sense making of the data, in order to capture participants' individual experiences as closely as possible, in line with a critical realist approach (Potter & Wetherell, 1987; Widdicombe & Wooffitt, 1995).

In step two, initial codes were generated, using Nvivo v.12 (see Appendix J) giving rise to over 300 codes. To ensure rigour at this stage of the data analysis, the researcher and their lead supervisor met a number of times to review the coding framework (Yardley, 2000). This involved reviewing the quotes for each code (see Appendix K), the names of the codes and their relationships with one another. At this stage, many codes were deleted due to capturing phenomena that did not answer the research question, or for having a small number of quotes that did not serve to answer the research question with clarity. Some codes contained very similar extracts, and so were merged (Braun & Clarke, 2013). This left the analysis with approximately 80 codes (see Appendix L).

In steps 3 and 4, the researcher and their lead supervisor met to search for themes within the data-set, grouping codes that represented similar phenomena and experiences, into themes, and separating themes of a different entity (Braun & Clarke, 2013). A number of thematic maps, (see Appendix M) using Nvivo v.12, assisted in this process to visually represent the themes, their sub-themes and their codes. At this stage, it was agreed that three over-arching themes best served to represent the data coherently (Braun & Clarke, 2013).

In step 5, the over-arching themes were named and defined accordingly (see Table 2) along with a final thematic map (see Figure 1; Braun & Clarke, 2013).

Finally, in step six, the researcher selected a number of quotes for each over-arching theme to tell a narrative of participants' experiences.

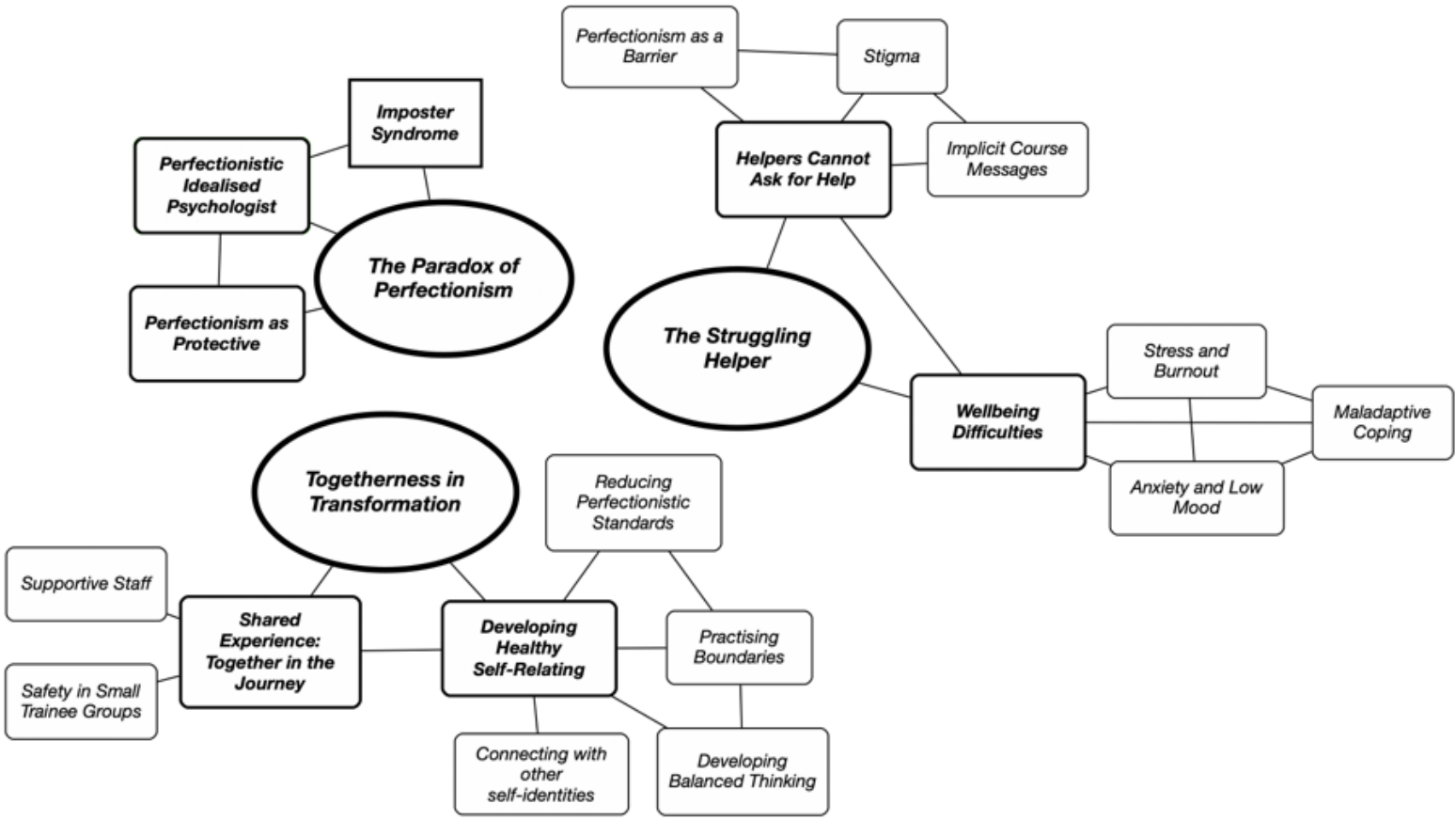
Table 2

A table showing the theme definitions from the thematic analysis (Braun & Clarke, 2013).

Over-arching Theme	Definition
The Paradox of Perfectionism	Themes: Perfectionism as Protective; Imposter Syndrome; Perfectionistic Idealised Psychologist. Within this over-arching theme, trainees describe how perfectionism ensures success, and protects against failure and associated inner negative self-beliefs and shame. Perfectionism can define self-image and bring trainees closer to their perceived ideal, but can evoke feelings of imposter syndrome.
The Struggling Helper	Themes: Wellbeing difficulties (sub-themes: Stress and Burnout, Anxiety and Low Mood, Negative Coping); Helpers Cannot Ask for Help (sub-themes: Perfectionism as a Barrier, Stigma and Course Messages). Overall, this over-arching theme describes how trainees experience psychological distress during training, including stress, anxiety, low mood and burnout, which are exacerbated by negative coping behaviours, stigma and implicit course messages. Trainees felt unable to ask for help due to their own perfectionistic self-image, and internalised stigma reinforced by perceived implicit course messages and societal beliefs and expectations.
Togetherness in Transformation	Themes: Shared Experience: Together in the Journey; (sub-themes: Supportive Staff, Safety in Small Trainee Groups); Developing Healthy Self-Relating (sub-themes: Reducing Perfectionistic Standards, Practising Boundaries, Developing Balanced Thinking and Connecting with Other Identities). In summary, this over-arching theme captures that through safety in shared experience with cohort members, course staff, supervisors and family/friends, trainees experience a shift in self-relating from self-criticism to self-compassion, through reducing perfectionistic standards, developing balanced thinking, practising boundaries and connecting with their non-trainee selves.

Figure 1

A final thematic map to show the three over-arching themes, themes and sub-themes of the analysis.



A personal reflective account of the research process

A personal reflective account is provided below to summarise the lead researcher's interaction between their personal context and the research process. This extract is taken from the researcher's reflective journal, written following the completion of the empirical paper, whereby the researcher had had sufficient opportunity to step back from the data and reflect on the research process as a whole.

> "Reflecting on the interview process, I felt privileged to learn about the experiences of other trainees who self-identify as perfectionists, where anecdotally, such topics are acknowledged but not always discussed openly or readily. I was saddened to hear about how some trainees had experienced psychological wellbeing difficulties alone, not seeking support for these. I wondered about how common this might be within the profession and what steps could be taken to address this? I was also aware that some experiences of participants resonated with my own. Given this, I was careful to remain neutral throughout the interviews so as to not bias the questions I asked, and any interpretation of the answers participants provided. It was also helpful to have space for reflection and self-care following the interviews.
>
> During some interviews, I wondered if perfectionism might have prevented some trainees from being completely honest about their psychological wellbeing. For example, some trainees often began a sentence, then stopped and reverted to another topic. I wondered if this was an avoidant coping strategy that aids them to function on a day-to-day basis? When this occurred, I found it difficult to strike a balance between asking follow-up questions or letting things be, so as to not cause further distress. Being a trainee myself, I am also curious as to whether this may have impacted upon how readily participants felt able to share their own experiences. I feel for some, this may have allowed a shared understanding and a reduced power imbalance, thus enabling information to be shared more openly, but for others, I wondered if this led them to predict that I would judge their experiences? Interestingly, at times during such interviews I did experience transference of a desire to be the 'perfect' trainee researcher.
>
> Upon analysing the data, I was struck by a sense that perfectionism and associated feelings were perceived as negative by most trainees, and something to be rid of. I was also surprised by how there seemingly appeared to be a high level of responsibility placed on courses to, perhaps, in some ways, become "more perfect" for trainees - an almost impossible task, as it is an individual experience for each. I found this very interesting, with knowledge that blaming others and self-

blame can be a coping mechanism used by some perfectionists. I am curious as to how these data will be perceived by training institutions, who try to provide the best possible experiences for trainees, as well as trainees who do not experience perfectionism. As I came towards the end of the analysis and write up, I noticed my own perfectionistic tendencies at work. I also felt a responsibility to provide an accurate account of participants' experiences. Upon reflection, I learnt that the process of qualitative research can be infinite, with no clearly defined end, and that I needed to curb my own perfectionistic tendencies to "draw a line" under it. Further, despite keeping to a reflexive approach, the analysis provides my interpretation of the data, in line with a critical realist epistemological stance." (07.02.2021)

Write-Up and Dissemination

The findings of this research are written in the form of an empirical paper, to be submitted to the peer-reviewed British Journal of Clinical Psychology. Findings will also be shared with all 11 participants, who provided their chosen email addresses, via a lay summary. It is also hoped that findings can be shared within appropriate Clinical Psychology conferences and webinars.

Chapter Six: Discussion and Critical Evaluation

This chapter provides a discussion and critical evaluation of the entire thesis portfolio. It begins with a detailed discussion of the findings of the systematic review and empirical paper with reference to existing literature and theory. Clinical implications of the portfolio are then discussed, as well as the relevant strengths and limitations of the research, before suggestions for future research are outlined. The chapter ends with an overall conclusion of the portfolio.

Discussion of findings in a theoretical context

Two-factor model of perfectionism

The systematic review provides moderate support for the two-factor model of perfectionism (Slade & Owens, 1998), and strengthens previous research undertaken within the university student population, by finding positive associations between maladaptive perfectionism and psychological distress (e.g. anxiety, low mood, emotional adjustment and psychosomatic symptoms) and negative associations between adaptive perfectionism and psychological distress (Ashby et al., 2012; Enns et al., 2001; Burnham et al., 2014; Enns et al., 2001; Rice et al., 1998; Schweiltzer & Hamilton, 2000; Sherry et al., 2015; Stoeber, 2008). This relationship existed across cultures, ethnicities, ages and identified genders, and withstood despite the different types of perfectionism measures used, reflective of the universal nature of this phenomenon and adding weight to the validity of the two-factor model.

Additionally, the empirical paper adds novel qualitative evidence to support further the two-factor model of perfectionism. The over-arching theme ‘the paradox of perfectionism’ describes perfectionism as being both adaptive in gaining success and defining self-image (e.g., securing a place on the course, passing assignments and gaining good feedback from staff), whilst maladaptive in contributing to experiences of imposter syndrome. Additionally, the over-arching theme of ‘the struggling helper’ described participants’ experiences of anxiety, low mood, stress and burnout associated with setting unachievable standards, a poor work-life balance, and a tendency for self-criticism, self-doubt and self-blame, as well as associated behaviours of avoidance and procrastination. This is the first qualitative study to identify these specific experiences in a trainee clinical psychologist (hereafter ‘trainee’) sample and adds a significant contribution to the emerging literature base, which has previously made speculative comment regarding perfectionism in this population, but has not yet been the focus of specific empirical investigation (Charlemagne-Olde et al., 2014; Jones & Thompson, 2017; Kanazawa & Iwakabe, 2014). Thus, these findings also inform clinical implications regarding the provision of wellbeing support for university students, including trainees.

Despite this, it must be highlighted that it would be too simplistic to determine from the findings of this research portfolio alone, that other factors, such as coping styles, do not contribute to the experiencing or buffering of psychological distress for maladaptive and adaptive perfectionists, respectively. Therefore, findings must be interpreted with caution and within the context of additional theories discussed in this chapter.

Theories of coping

Although there is ongoing debate regarding the conceptualisation of coping styles (see Carver & Smith, 2010, for a review), the findings of the systematic review support those of the existing literature in that avoidant coping and negative emotion-focussed coping were found to associate with maladaptive perfectionism as well as psychological distress, whilst adaptive perfectionism was found to associate with task-focussed coping and positive emotion-focussed coping, which act as buffers against psychological distress (Chang, 2012; Grant et al., 2013; Julal, 2013; Larijani & Besharat, 2010; Luo & Wang, 2009; Stoeber & Janssen, 2011). In addition, the empirical paper supports the existing literature by finding that for the majority of participants, perfectionism was associated with negative coping behaviours of rumination, blame (towards the self and others) and self-criticism (i.e., negative emotion-focussed coping), as well as avoidance and procrastination (i.e., avoidant coping). What is novel is that this is the first study explicitly to outline that perfectionistic trainees can engage in negative coping strategies, despite the knowledge that they are unhelpful, suggesting that alternative coping strategies may have felt inaccessible for trainees. This is concerning and warrants further exploration into the qualitative experiences of coping behaviours and as to why they may feel inaccessible, particularly with the understanding that clinical psychology training can be a stressful experience for some (Cushway, 1992; Jones & Thompson, 2017). Such exploration would help inform how training institutions can continue to refine a supportive culture for trainees, as well as to determine how coping behaviours could be targeted in therapeutic interventions (Egan et al., 2011).

The cognitive-behavioural model of clinical perfectionism

The cognitive-behavioural model of perfectionism focusses on clinical perfectionism as psychopathology, that "distinguishes […] from the healthy pursuit of excellence" by the over-reliance on self-evaluation, which can render an individual vulnerable to "self-criticism that can result from perceived failure" (Shafran, 2002, pp. 778). When standards are met, they are re-appraised as insufficiently demanding. New, higher standards are then set, and behaviours such as avoidance and procrastination can contribute to failure and associated self-criticism, low mood, anxiety (Shafran, 2002).

Although Dunkley et al. (2006) critique the cognitive-behavioural model of clinical perfectionism as one of a unidimensional nature, this does not detract from how the

findings of the empirical paper provide support for the model. For example, in the over-arching theme of 'the paradox of perfectionism', perfectionism was described to define a positive self-image and protect against inner negative beliefs of inadequacy, whilst simultaneously rendering participants vulnerable to imposter syndrome. Likewise, in the over-arching theme of 'the struggling helper', participants described how their tendency for rumination and self-criticism, as well as negative coping behaviours of avoidance and procrastination, which they associated with perfectionism, served to exacerbate their experiences of psychological distress through strengthening negative self-beliefs. This supports previous literature regarding the model, which found self-beliefs of inadequacy to be a core component of the clinical perfectionist, and that rumination, self-criticism and procrastination, served to strengthen these beliefs (Shafran et al., 2002; Shafran & Mansell, 2001). Thus, the findings from the portfolio would support the use of this model when tailoring interventions to target specific behaviours associated with this transdiagnostic component to psychological distress (Egan et al., 2011; Riley et al., 2011).

Compassion-focussed therapy

The third over-arching theme of 'togetherness in transformation' provides evidence to support the use of compassion-focussed theoretical frameworks (Gilbert, 2009) in understanding how perfectionism and associated psychological distress can be maintained and reduced. For example, in the over-arching theme 'togetherness in transformation', participants discuss how having an unconditional acceptance and a humanisation of experience can be helpful in building a safe environment to build inner self-compassion and strategies to reduce perfectionism, which in turn contributed to improved psychological wellbeing. This supports the work of Gilbert (2009; 2010) and Neff et al. (2019), who found that by applying the key principles of common humanity (vs. isolation) and self-kindness (vs. self-judgement), students can begin to build a compassionate stance and achieve a healthier psychological wellbeing (Smeets et al., 2014).

Indeed, compassion has been found to buffer the relationship between maladaptive perfectionism and low mood and eating disorders in university students (Barnett & Sharp, 2016; Mehr & Adams, 2016; Stoeber et al., 2019) and compassion fatigue and burnout in trainee psychotherapists (Beaumont et al., 2016). Recent research has also found a specific reduction in shame and self-criticism following a course of compassion-focussed therapy, both in an individual and group formats, face-to-face and online (Gilbert, 2006; Krieger et al.,2019; Matos & Steindl, 2020) suggesting that the use of transdiagnostic compassion-focussed therapy principles could be applied to wellbeing support for trainees.

Clinical implications

The findings of this thesis portfolio, together with the knowledge that the prevalence of psychological distress is higher in university students and healthcare students than the general population, and that perfectionism is increasing in this population (Bidwal et al., 2015; Curran & Hill, 2017; Hazell et al., 2020; Kelly & Clark, 2017; Li et al., 2014), provides further support for the current drive to increase psychological wellbeing in UK universities as is evidenced by recent national university initiatives.

University wellbeing initiatives

The University Mental Health Charter (Hughes & Spanner, 2019) was created, following the UK Mentally Healthy Universities initiative (2017), to provide a whole UK university approach to mental health support. This proposes that universities must "provide an environment and culture that reduces poor mental health, as well as supporting good mental health, and facilitating staff and students to develop insight, understanding and skills to manage and maintain their own wellbeing". Within UK universities, student wellbeing support services typically aim to meet this need by offering low-intensity psychological therapies (Stallman et al., 2016; Worsley et al., 2020). However, the uptake of these interventions remains low, particularly for individuals who can identify with perfectionistic traits (Dang et al., 2020; Stergiopoulos et al., 2021). Research suggests such individuals can be prone to experiencing stigma (Clement et al., 2015) and associated feelings of shame and self-blame (Corrigan, 2004; Tucker et al., 2013), as found in the sample of trainees in the empirical paper.

Therapeutic approaches

Therefore, it is important to consider the type of therapeutic approaches for clinical perfectionism and associated psychological distress that could be utilised by university students, including trainees. Given the growing evidence base for perfectionism as a transdiagnostic factor for psychological distress (Egan et al., 2011), the emerging support for CBT as an effective intervention for perfectionism (Egan & Hine, 2008; Egan et al., 2016; Handley et al., 2015), and for CFT for self-criticism, shame and self-blame (Gilbert, 2006; Krieger et al., 2019; Matos & Steindl, 2020), these could be viable options offered by university student support services. However, thought is needed regarding the format of such interventions (Broglia et al., 2017). One option to reduce barriers to accessing interventions is self-directed online support (e.g., CBT and third-wave cognitive therapies). However, evidence regarding its effectiveness, in comparison to face-to-face delivery, is mixed (Egan et al., 2014; Radhu et al., 2012; Suh et al., 2019) and requires further investigation.

Clinical supervision

With regards to trainees specifically, the empirical paper identified that seeking help was felt to be easier when safe, trusting relationships were built amongst small trainee groups, or one-to-one with course staff or supervisors (e.g., in clinical supervision). This finding is of significance when considering the format of clinical supervision, which can provide an experiential learning process that allows trainees to actively interact with emotions and cognitions with the support of their supervisor, and build new perspectives (Prouty, 2014). Nelson et al. (2017) suggested that clinical training is the "perfect time" for this to be practiced, and McCrea and Bulanda (2008) suggested that a supervisor first modelling how they would demonstrate self-compassion with a client may be useful for trainees to observe and begin to direct towards themselves. It is suggested that a solid understanding of self-compassion practises is needed for clinical supervisors to facilitate this in sessions. Attending courses such as Mindful Self-Compassion Training (Germer & Neff, 2013) have been found to strengthen the development of a compassionate supervisee-supervisor relationship (Coaston, 2019). Thus, the integration of compassionate mind training in existing supervisor training, offered by UK training institutions, may be a beneficial and resource-efficient way of enabling this. Likewise, encouraging course staff to incorporate self-compassion practises into interactions with trainees in teaching or on a one-to-one basis may be a useful tool to begin to shift positively the narrative of self-care via healthy role modelling.

Healthy role models

As well as modelling self-compassion, findings from the current research suggest that trainees may benefit from the modelling of appropriate self-disclosure of lived experience of psychological distress from qualified clinical psychologists. Importantly, the BPS (2020) has recently recognised, from existing research, the value of lived experience in the profession and highlights that self-disclosure by qualified staff may be beneficial to trainees in humanising psychological distress and aiding professional identity development (Clevinger et al., 2019; Knox et al., 2011). Thus, the use of self-disclosure may be an important factor to incorporate into supervisor training, as well as into teaching, meetings and more informal interactions with course staff.

Reflective practice

Reflective practice, defined as clinical psychologists being "cognisant of the importance of self-awareness and the need to appraise and reflect on their own practice" (BPS, 2018, pp.8) has been found to be an important component to developing clinical wisdom, expertise and improved client care (Gates & Senediak, 2017; Lavender, 2003; Sendiack, 2013). The findings of the current research suggest that some trainees felt safe to disclose personal experiences during peer-led reflective practice groups, in particular.

This supports the emerging evidence base that suggests peer-led reflective practice helps to reduce 'blind spots' of qualified facilitators, as well as power dynamics (Carter, 2021). Moreover, peer-led facilitators who self-disclosed personal experiences were perceived positively by group members in a study by Rothwell et al. (2019), as it helped to humanise group members' experiences and perspectives. Thus, the integration and evaluation of peer-led reflective practice groups is of importance to determine if trainees would benefit from this approach being adopted more widely during training.

Strengths, limitations and considerations for future research

Strengths

The systematic review is the first of its kind to bring together findings from existing studies that identified coping styles as a mediating factor in the relationship between perfectionism and psychological distress in university students. Several measures were undertaken throughout the systematic review process to ensure its validity and rigour, including the searching of a number of databases, two raters reviewing articles for inclusion criteria, and assessing quality and risk of bias (Moher et al., 2009). This methodology ensured that a sound synthesis was produced, giving moderate evidence to support the existing literature regarding perfectionism, coping and psychological distress in university students.

Likewise, the empirical paper is the first study to explore, using a qualitative approach, the experiences of perfectionism and associated psychological distress in trainees. A comprehensive and thorough approach throughout was adopted throughout the research process, including the interview design and conduct and the analysis. Firstly, the interview schedule was developed in consultation with the lead researcher's supervisor, as well as trainee colleagues and a qualitative researcher within a qualitative research forum. This ensured that the topics selected were appropriate to the research question, whilst keeping true a critical realist epistemology and a thematic analysis methodology. Secondly, the choice of semi-structured interviews enabled the interview topic guide to be adhered to, to ensure information was gathered for all areas relevant to the research question, whilst allowing for appropriate flexibility where needed to gather salient and rich information unique to participants' experiences and building and maintaining rapport with the participants (Patton, 2002; Prior, 2018). The researcher also facilitated rapport by relying on their clinical skills within the interviews, using core skills of warmth, kindness, curiosity and unconditional positive regard (Prior, 2018; Rogers, 1957), in addition to skills gained by attending a number of qualitative research courses held by the university (e.g., summarising, reflecting and using the participants' own words and phrases). The researcher was also conscious to reduce any power imbalance by being transparent about their fellow role as a trainee.

The above strategies enabled the researcher to gather a rich dataset that answered the research question and provided a detailed insight into the experiences of the participants. Throughout the analysis, codes, sub-themes, themes and over-arching themes were discussed with the researcher's supervisor, as well as trainee colleagues and a qualitative researcher in the qualitative forum, allowing for discrepancies to be amended if needed. This helped to reduce possible researcher bias. The resulting analysis having quotes from most participants in each sub-theme, theme and over-arching theme indicates a degree of validity.

Lastly, the researcher made good use of their reflective journal throughout the research process, to document their own thoughts, reflections, queries and decision-making. This provided a useful tool to prevent as much potential bias as possible, in line with Yardley's (2000) principles of good qualitative research.

Limitations and future research

Despite the systematic review adding a contribution to the research field, the results must be interpreted with some degree of caution. For example, due to the included studies being observational and associational in design, it is impossible to infer cause and effect of each study's findings. This is reflected in the average quality ratings of the studies. It must also be noted that as well as coping styles, additional factors may contribute to the relationship between perfectionism and psychological distress in university students. For instance, self-esteem and stress have also been found to play mediating roles in previous research (D'Souza et al., 2011; Hewitt & Dyck, 1986). Thus, further structured equation modelling or group-comparison designs may help to explain this complex relationship and inform interventions to reduce psychological distress related to perfectionism.

Similarly, although the studies included in the systematic review were conducted in both Western and non-Western cultures, this does not mean that there are no cultural differences between the conceptualisations of perfectionism. The measures included in each study were predominantly developed in Western countries and only adapted for use in non-Western samples. Thus, future research on the conceptualisation of perfectionism in non-Western cultures is required before stronger conclusions can be made.

With regards to the empirical paper, although it provides findings that contribute to the ongoing development of wellbeing support offered by UK DClinPsy training institutions, there are a number of limitations that require acknowledgement. Firstly, due to the study taking a thematic analysis approach, this, unavoidably, involves some reduction of the data and loss of depth and uniquity of each individual participant's experiences. An alternative approach to retain this as much as possible could have been Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). With its roots in Husserl's

phenomenology (Zahavi, 2003) and ideography, IPA allows for individual, internal experiences to be explored in depth, to gain a rich understanding of a specific phenomenon. However, this approach would not have appropriately answered the broad research question (covering both experiences of perfectionism and associated psychological wellbeing), which was essential due to the novelty of this research within this population. In addition, the qualitative study offers interpretations mainly from the perspective of the lead researcher, due to this research being a doctoral thesis. Whilst the lead researcher made all attempts to keep to a reflexive approach (e.g., using a reflective journal, having joint coding sessions with their supervisor and discussing analysis in a qualitative forum), it must be acknowledged that interpretation from the perspectives of multiple researchers may have yielded some differences in the analysis.

Furthermore, a well-recognised limitation of most interview studies is that they typically involve an unnatural environment that could contribute to social desirability bias, which may have been exacerbated given that the participants and the researcher were trainees. With the knowledge that perfectionism may limit the disclosure of psychological distress (Grice et al., 2018), this may also have impacted what participants chose to disclose. Future studies requesting anonymous contributions (e.g., via open-ended survey questions), regarding perfectionism, psychological distress and help-seeking may yield more detailed findings regarding trainees' experiences in these areas, and to ensure appropriate changes can be made to increase resources and ability to access support for this population.

Likewise, all participants who volunteered for this research self-identified as perfectionists. However, not every trainee is a likely to be a perfectionist. Understanding the prevalence of perfectionism within this sample, using quantitative or mixed methods, may provide a useful insight into how we can understand the trainee experience more broadly. In addition, the cross-sectional nature of the research offers a snapshot of perfectionism for different participants at one stage in time. Given the findings of this research, that over time, some trainees can begin to reduce self-criticism and improve self-compassion, as well as reduce perfectionistic standards, tracking perfectionism over time, in a longitudinal study, is important to gain a further understanding of the facilitators and barriers to these changes.

It is also important to recognise that the empirical paper did not investigate any potential differences in experiences dependent on age, gender, ethnicity, disability, or social class. With increasing evidence that under-represented groups within the profession may face different challenges during clinical training (Paulraj, 2016; Wood & Patel, 2017), it is imperative that this is explored further so that equality and diversity can continue to be improved for the psychological workforce.

Additionally, given the limited but growing evidence base regarding effective psychological interventions for perfectionism (Egan et al., 2008; Egan et al., 2011; Egan et al., 2016; Handley et al., 2015; Gilbert, 2006; Krieger et al., 2019; Matos & Steindl, 2020), research on the use of adapted therapeutic strategies to manage perfectionism and associated psychological distress for trainees, is important in establishing whether the integration of such approaches into DClinPsy training programmes would be beneficial.

Lastly, it must be acknowledged that the empirical paper offered the perspectives of trainees only. Gathering perspectives from qualified colleagues who support the development of trainees (e.g., course staff and supervisors) is important to identify and share good practice, and highlight potential areas for ongoing development.

Overall conclusion

The relationship between perfectionism and associated psychological distress in university students, including trainees, is complex, involving many factors including maladaptive coping styles. Throughout the journey of training to become qualified Clinical Psychologists, some trainees can experience perfectionism and associated psychological distress, as well as barriers to help-seeking, including stigma and perceptions of wider course narratives. Critical to the quietening of the inner self-critic and building self-compassion are trusting relationships with cohort peers, course staff and clinical supervisors.

This research offers preliminary evidence in the context of limited but growing evidence regarding the psychological wellbeing of trainees, and has clinical implications for the development of wellbeing support for trainees, including teaching, supervision and reflective practice. Further research is required to explore in more depth the prevalence of perfectionism in trainees, their experience of coping styles and help-seeking behaviours, and effective transdiagnostic interventions for perfectionism. Future research on the perspectives of qualified colleagues is also important to understand their experiences of supporting trainees, and to identify and share good practice, as well as highlight any potential areas for the ongoing development of wellbeing support available to trainees.

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Appendices

Appendix	Description
A	A table showing the conceptualisations of perfectionism
B	National Heart, Blood and Lung Institute's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (2021)
C	Author guidelines for the Journal of Personality and Individual Differences
D	Author Guidelines for the British Journal of Clinical Psychology
E	The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist
F	A letter from the UEA FMH Ethics Committee granting ethical approval
G	An excerpt of a transcript, together with personal reflections from the reflective journal
H	Expression of Interest Form
I	Participant Information Sheet, Consent Form and Demographic Questionnaire
J	An example of a transcript with initial codes using Nvivo v.12
K	An example of coded extracts for the code 'unreachable expectations' using Nvivo v.12
L	A table showing the over-arching themes, sub-themes and codes in the final analysis
M	A series of thematic maps demonstrating the development of three over-arching themes
N	Additional quotes table
O	A table showing summarising the results of studies included in the systematic review

Appendix A

A table to show the conceptualisations of perfectionism and their associated measures.

Conceptualisation	Other Descriptors	Definition	Measures
Multidimensional Perfectionism	-	A multidimensional personality trait characterised by striving for flawlessness, setting exceedingly high standards of performance, and evaluating one's behaviour in an overly critical way (Flett & Hewitt, 2002, Frost et al., 1990).	Hewitt-Flett Multidimensional Perfectionism Scale (HFMPS; Hewitt et al., 1991): Self-oriented perfectionism, other-oriented perfectionism and socially-prescribed perfectionism. Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990): Organisation, parental expectations and parental criticism, personal standards, concern over mistakes and doubts about actions.
Maladaptive Perfectionism	Perfectionistic Concerns Evaluative Concerns Self-Critical Perfectionism	“Aspects associated with concerns of making mistakes, fear of negative social evaluation, feelings of discrepancy between one’s expectations and performance and negative reactions to imperfection (Gotwals et al., 2012, p. 264).	HFMPS: Socially-prescribed perfectionism. FMPS: Concern over mistakes, doubts about actions, parental expectations. APS-R: Discrepancy.
Adaptive Perfectionism	Perfectionistic Strivings Personal Standards	“Aspects of perfectionism associated with self-oriented striving for perfection and the setting of very high personal performance standards” (Gotwals et al., 2012, p. 264).	HFMPS: Self-oriented perfectionism, other-oriented perfectionism. FMPS: Personal standards. Almost Perfect Scale – Revised (APS-R; Slaney et al., 2001): High standards.
Clinical Perfectionism	-	“The overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences” (Shafran et al., 2002, p. 778).	Clinical Perfectionism Questionnaire (CPQ; Fairburn, Cooper and *Shafran*, 2003b)

Appendix B

National Heart, Blood and Lung Institute's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (2021).

Criteria	Yes	No	Other (CD, NR, NA)*
1. Was the research question or objective in this paper clearly stated?			
2. Was the study population clearly specified and defined?			
3. Was the participation rate of eligible persons at least 50%?			
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants?			
5. Was a sample size justification, power description, or variance and effect estimates provided?			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?			
7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?			
8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related			

Criteria	Yes	No	Other (CD, NR, NA)*
to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?			
9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
10. Was the exposure(s) assessed more than once over time?			
11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
12. Were the outcome assessors blinded to the exposure status of participants?			
13. Was loss to follow-up after baseline 20% or less?			
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?			

*CD, cannot determine; NA, not applicable; NR, not reported

Guidance for Assessing the Quality of Observational Cohort and Cross-Sectional Studies

The guidance document below is organized by question number from the tool for quality assessment of observational cohort and cross-sectional studies.

Question 1. Research question

Did the authors describe their goal in conducting this research? Is it easy to understand what they were looking to find? This issue is important for any scientific paper of any type. Higher quality scientific research explicitly defines a research question.

Questions 2 and 3. Study population
Did the authors describe the group of people from which the study participants were selected or recruited, using demographics, location, and time period? If you were to conduct this study again, would you know who to recruit, from where, and from what time period? Is the cohort population free of the outcomes of interest at the time they were recruited?

An example would be men over 40 years old with type 2 diabetes who began seeking medical care at Phoenix Good Samaritan Hospital between January 1, 1990 and December 31, 1994. In this example, the population is clearly described as: (1) who (men over 40 years old with type 2 diabetes); (2) where (Phoenix Good Samaritan Hospital); and (3) when (between January 1, 1990 and December 31, 1994). Another example is women ages 34 to 59 years of age in 1980 who were in the nursing profession and had no known coronary disease, stroke, cancer, hypercholesterolemia, or diabetes, and were recruited from the 11 most populous States, with contact information obtained from State nursing boards.

In cohort studies, it is crucial that the population at baseline is free of the outcome of interest. For example, the nurses' population above would be an appropriate group in which to study incident coronary disease. This information is usually found either in descriptions of population recruitment, definitions of variables, or inclusion/exclusion criteria.

You may need to look at prior papers on methods in order to make the assessment for this question. Those papers are usually in the reference list.
If fewer than 50% of eligible persons participated in the study, then there is concern that the study population does not adequately represent the target population. This increases the risk of bias.

Question 4. Groups recruited from the same population and uniform eligibility criteria
Were the inclusion and exclusion criteria developed prior to recruitment or selection of the study population? Were the same underlying criteria used for all of the subjects involved? This issue is related to the description of the study population, above, and you may find the information for both of these questions in the same section of the paper.
Most cohort studies begin with the selection of the cohort; participants in this cohort are then measured or evaluated to determine their exposure status. However, some cohort studies may recruit or select exposed participants in a different time or place than unexposed participants, especially retrospective cohort studies–which is when data are obtained from the past (retrospectively), but the analysis examines exposures prior to outcomes. For example, one research question could be whether diabetic men with clinical depression are at higher risk for cardiovascular disease than those without clinical depression. So, diabetic men with depression might be selected from a mental health clinic, while diabetic men without depression might be selected from an internal medicine

or endocrinology clinic. This study recruits groups from different clinic populations, so this example would get a "no."

However, the women nurses described in the question above were selected based on the same inclusion/exclusion criteria, so that example would get a "yes."

Question 5. Sample size justification

Did the authors present their reasons for selecting or recruiting the number of people included or analyzed? Do they note or discuss the statistical power of the study? This question is about whether or not the study had enough participants to detect an association if one truly existed.

A paragraph in the methods section of the article may explain the sample size needed to detect a hypothesized difference in outcomes. You may also find a discussion of power in the discussion section (such as the study had 85 percent power to detect a 20 percent increase in the rate of an outcome of interest, with a 2-sided alpha of 0.05). Sometimes estimates of variance and/or estimates of effect size are given, instead of sample size calculations. In any of these cases, the answer would be "yes."

However, observational cohort studies often do not report anything about power or sample sizes because the analyses are exploratory in nature. In this case, the answer would be "no." This is not a "fatal flaw." It just may indicate that attention was not paid to whether the study was sufficiently sized to answer a prespecified question–i.e., it may have been an exploratory, hypothesis-generating study.

Question 6. Exposure assessed prior to outcome measurement

This question is important because, in order to determine whether an exposure causes an outcome, the exposure must come before the outcome.

For some prospective cohort studies, the investigator enrolls the cohort and then determines the exposure status of various members of the cohort (large epidemiological studies like Framingham used this approach). However, for other cohort studies, the cohort is selected based on its exposure status, as in the example above of depressed diabetic men (the exposure being depression). Other examples include a cohort identified by its exposure to fluoridated drinking water and then compared to a cohort living in an area without fluoridated water, or a cohort of military personnel exposed to combat in the Gulf War compared to a cohort of military personnel not deployed in a combat zone. With either of these types of cohort studies, the cohort is followed forward in time (i.e., prospectively) to assess the outcomes that occurred in the exposed members compared to nonexposed members of the cohort. Therefore, you begin the study in the present by looking at groups that were exposed (or not) to some biological or behavioral factor, intervention, etc., and then you follow them forward in time to examine outcomes. If a cohort study is conducted properly, the answer to this question should be "yes," since the exposure status of members of the cohort was determined at the beginning of the study before the outcomes occurred.

For retrospective cohort studies, the same principal applies. The difference is that, rather than identifying a cohort in the present and following them forward in time, the investigators go back in time (i.e., retrospectively) and select a cohort based on their exposure status in the past and then follow them forward to assess the outcomes that occurred in the exposed and nonexposed cohort members. Because in retrospective

cohort studies the exposure and outcomes may have already occurred (it depends on how long they follow the cohort), it is important to make sure that the exposure preceded the outcome.

Sometimes cross-sectional studies are conducted (or cross-sectional analyses of cohort-study data), where the exposures and outcomes are measured during the same timeframe. As a result, cross-sectional analyses provide weaker evidence than regular cohort studies regarding a potential causal relationship between exposures and outcomes. For cross-sectional analyses, the answer to Question 6 should be "no."

Question 7. Sufficient timeframe to see an effect

Did the study allow enough time for a sufficient number of outcomes to occur or be observed, or enough time for an exposure to have a biological effect on an outcome? In the examples given above, if clinical depression has a biological effect on increasing risk for CVD, such an effect may take years. In the other example, if higher dietary sodium increases BP, a short timeframe may be sufficient to assess its association with BP, but a longer timeframe would be needed to examine its association with heart attacks.

The issue of timeframe is important to enable meaningful analysis of the relationships between exposures and outcomes to be conducted. This often requires at least several years, especially when looking at health outcomes, but it depends on the research question and outcomes being examined.

Cross-sectional analyses allow no time to see an effect, since the exposures and outcomes are assessed at the same time, so those would get a "no" response.

Question 8. Different levels of the exposure of interest

If the exposure can be defined as a range (examples: drug dosage, amount of physical activity, amount of sodium consumed), were multiple categories of that exposure assessed? (for example, for drugs: not on the medication, on a low dose, medium dose, high dose; for dietary sodium, higher than average U.S. consumption, lower than recommended consumption, between the two). Sometimes discrete categories of exposure are not used, but instead exposures are measured as continuous variables (for example, mg/day of dietary sodium or BP values).

In any case, studying different levels of exposure (where possible) enables investigators to assess trends or dose-response relationships between exposures and outcomes–e.g., the higher the exposure, the greater the rate of the health outcome. The presence of trends or dose-response relationships lends credibility to the hypothesis of causality between exposure and outcome.

For some exposures, however, this question may not be applicable (e.g., the exposure may be a dichotomous variable like living in a rural setting versus an urban setting, or vaccinated/not vaccinated with a one-time vaccine). If there are only two possible exposures (yes/no), then this question should be given an "NA," and it should not count negatively towards the quality rating.

Question 9. Exposure measures and assessment

Were the exposure measures defined in detail? Were the tools or methods used to measure exposure accurate and reliable–for example, have they been validated or are they objective? This issue is important as it influences confidence in the reported

exposures. When exposures are measured with less accuracy or validity, it is harder to see an association between exposure and outcome even if one exists. Also as important is whether the exposures were assessed in the same manner within groups and between groups; if not, bias may result.

For example, retrospective self-report of dietary salt intake is not as valid and reliable as prospectively using a standardized dietary log plus testing participants' urine for sodium content. Another example is measurement of BP, where there may be quite a difference between usual care, where clinicians measure BP however it is done in their practice setting (which can vary considerably), and use of trained BP assessors using standardized equipment (e.g., the same BP device which has been tested and calibrated) and a standardized protocol (e.g., patient is seated for 5 minutes with feet flat on the floor, BP is taken twice in each arm, and all four measurements are averaged). In each of these cases, the former would get a "no" and the latter a "yes."

Here is a final example that illustrates the point about why it is important to assess exposures consistently across all groups: If people with higher BP (exposed cohort) are seen by their providers more frequently than those without elevated BP (nonexposed group), it also increases the chances of detecting and documenting changes in health outcomes, including CVD-related events. Therefore, it may lead to the conclusion that higher BP leads to more CVD events. This may be true, but it could also be due to the fact that the subjects with higher BP were seen more often; thus, more CVD-related events were detected and documented simply because they had more encounters with the health care system. Thus, it could bias the results and lead to an erroneous conclusion.

Question 10. Repeated exposure assessment
Was the exposure for each person measured more than once during the course of the study period? Multiple measurements with the same result increase our confidence that the exposure status was correctly classified. Also, multiple measurements enable investigators to look at changes in exposure over time, for example, people who ate high dietary sodium throughout the followup period, compared to those who started out high then reduced their intake, compared to those who ate low sodium throughout. Once again, this may not be applicable in all cases. In many older studies, exposure was measured only at baseline. However, multiple exposure measurements do result in a stronger study design.

Question 11. Outcome measures
Were the outcomes defined in detail? Were the tools or methods for measuring outcomes accurate and reliable–for example, have they been validated or are they objective? This issue is important because it influences confidence in the validity of study results. Also important is whether the outcomes were assessed in the same manner within groups and between groups.

An example of an outcome measure that is objective, accurate, and reliable is death–the outcome measured with more accuracy than any other. But even with a measure as objective as death, there can be differences in the accuracy and reliability of how death was assessed by the investigators. Did they base it on an autopsy report, death certificate, death registry, or report from a family member? Another example is a study of whether dietary fat intake is related to blood cholesterol level (cholesterol level being the

outcome), and the cholesterol level is measured from fasting blood samples that are all sent to the same laboratory. These examples would get a "yes." An example of a "no" would be self-report by subjects that they had a heart attack, or self-report of how much they weigh (if body weight is the outcome of interest).

Similar to the example in Question 9, results may be biased if one group (e.g., people with high BP) is seen more frequently than another group (people with normal BP) because more frequent encounters with the health care system increases the chances of outcomes being detected and documented.

Question 12. Blinding of outcome assessors
Blinding means that outcome assessors did not know whether the participant was exposed or unexposed. It is also sometimes called "masking." The objective is to look for evidence in the article that the person(s) assessing the outcome(s) for the study (for example, examining medical records to determine the outcomes that occurred in the exposed and comparison groups) is masked to the exposure status of the participant. Sometimes the person measuring the exposure is the same person conducting the outcome assessment. In this case, the outcome assessor would most likely not be blinded to exposure status because they also took measurements of exposures. If so, make a note of that in the comments section.

As you assess this criterion, think about whether it is likely that the person(s) doing the outcome assessment would know (or be able to figure out) the exposure status of the study participants. If the answer is no, then blinding is adequate. An example of adequate blinding of the outcome assessors is to create a separate committee, whose members were not involved in the care of the patient and had no information about the study participants' exposure status. The committee would then be provided with copies of participants' medical records, which had been stripped of any potential exposure information or personally identifiable information. The committee would then review the records for prespecified outcomes according to the study protocol. If blinding was not possible, which is sometimes the case, mark "NA" and explain the potential for bias.

Question 13. Followup rate
Higher overall followup rates are always better than lower followup rates, even though higher rates are expected in shorter studies, whereas lower overall followup rates are often seen in studies of longer duration. Usually, an acceptable overall followup rate is considered 80 percent or more of participants whose exposures were measured at baseline. However, this is just a general guideline. For example, a 6-month cohort study examining the relationship between dietary sodium intake and BP level may have over 90 percent followup, but a 20-year cohort study examining effects of sodium intake on stroke may have only a 65 percent followup rate.

Question 14. Statistical analyses
Were key potential confounding variables measured and adjusted for, such as by statistical adjustment for baseline differences? Logistic regression or other regression methods are often used to account for the influence of variables not of interest.
This is a key issue in cohort studies, because statistical analyses need to control for potential confounders, in contrast to an RCT, where the randomization process controls for potential confounders. All key factors that may be associated both with the exposure of

interest and the outcome–that are not of interest to the research question–should be controlled for in the analyses.

For example, in a study of the relationship between cardiorespiratory fitness and CVD events (heart attacks and strokes), the study should control for age, BP, blood cholesterol, and body weight, because all of these factors are associated both with low fitness and with CVD events. Well-done cohort studies control for multiple potential confounders.

Some general guidance for determining the overall quality rating of observational cohort and cross-sectional studies

The questions on the form are designed to help you focus on the key concepts for evaluating the internal validity of a study. They are not intended to create a list that you simply tally up to arrive at a summary judgment of quality.

Internal validity for cohort studies is the extent to which the results reported in the study can truly be attributed to the exposure being evaluated and not to flaws in the design or conduct of the study–in other words, the ability of the study to draw associative conclusions about the effects of the exposures being studied on outcomes. Any such flaws can increase the risk of bias.

Critical appraisal involves considering the risk of potential for selection bias, information bias, measurement bias, or confounding (the mixture of exposures that one cannot tease out from each other). Examples of confounding include co-interventions, differences at baseline in patient characteristics, and other issues throughout the questions above. High risk of bias translates to a rating of poor quality. Low risk of bias translates to a rating of good quality. (Thus, the greater the risk of bias, the lower the quality rating of the study.)
In addition, the more attention in the study design to issues that can help determine whether there is a causal relationship between the exposure and outcome, the higher quality the study. These include exposures occurring prior to outcomes, evaluation of a dose-response gradient, accuracy of measurement of both exposure and outcome, sufficient timeframe to see an effect, and appropriate control for confounding–all concepts reflected in the tool.

Generally, when you evaluate a study, you will not see a "fatal flaw," but you will find some risk of bias. By focusing on the concepts underlying the questions in the quality assessment tool, you should ask yourself about the potential for bias in the study you are critically appraising. For any box where you check "no" you should ask, "What is the potential risk of bias resulting from this flaw in study design or execution?" That is, does this factor cause you to doubt the results that are reported in the study or doubt the ability of the study to accurately assess an association between exposure and outcome?
The best approach is to think about the questions in the tool and how each one tells you something about the potential for bias in a study. The more you familiarize yourself with the key concepts, the more comfortable you will be with critical appraisal. Examples of studies rated good, fair, and poor are useful, but each study must be assessed on its own based on the details that are reported and consideration of the concepts for minimizing bias.

Appendix C

Author guidelines for the Journal of Personality and Individual Differences.

Note: The paper will be edited to be double spaced upon submission to the journal.

PERSONALITY AND INDIVIDUAL DIFFERENCES

The Official Journal of the International Society for the Study of Individual Differences (ISSID)

AUTHOR INFORMATION PACK

TABLE OF CONTENTS

ISSN: 0191-8869

DESCRIPTION

Personality and Individual Differences is primarily devoted to the publication of articles (experimental, correlational, theoretical, expository/review) which enhance our understanding of the structure of personality and other forms of individual differences, the processes which cause these individual differences to emerge, and their practical applications. Accessible methodological contributions are also welcome. The Editors invite papers that focus on the genetic, biological, and environmental foundations of individual differences, and possible interaction effects. While we recognize the importance of questionnaires for the measurement of individual differences, we encourage their link to experimental and behavioural measures. Ultimately the editors of PAID view human beings as bio-social organisms and that work on individual differences can be most fruitfully pursued by attending to both these aspects of our nature.

AUDIENCE

Social, experimental, educational, clinical and industrial psychologists.

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Section Editors

Section Editor for Psychometrics, Measurement, and Methodology

Colin Cooper, Queen's University Belfast, United Kingdom
We invite papers which facilitate the assessment of important psychological constructs in personality, cognition, mood and motivation, particularly those dealing with measurement, methodological and practical assessment issues, as long as these contributions are accessible to non-specialists. We also welcome papers developing important new tests and scales in English if they have a sound theoretical basis, strong evidence for their validity and include the items as an Appendix. Routine psychometric analyses of self-report data, studies of invariance, or investigations of language-translated questionnaires will not be prioritised unless they make a major contribution to our understanding of core psychological constructs.

Section Editor for Personality (including affective, behavioral, and motivational) Development and Processes

Peter Jonason, University of Padova School of Psychology, Italy
In this section we are concerned with research on the underpinnings of personality traits (e.g., motivation, affect) and the consequences of those traits in terms of attitudes, behaviors, and cognitions. We are especially interested in the causal processes of personality development and how traits lead to outcomes like interpersonal (e.g., romantic relationships) and social (e.g., prejudice) outcomes. In this section, personality traits can be conceived of from various epistemological models but of particular interests are trait theory (i.e., traits lead to outcomes) and socioanalytic theory (i.e., traits are associated with outcomes) and come in narrowband and broadband conceptualizations and "light" and "dark" manifestations, but we take no firm stance on theoretical perspectives like evolutionary or sociocultural models and, instead, lean towards Popperian processes of testing competing hypotheses.

Section Editor for Personality Differences and Structure

Julie Aitken Schermer, The University of Western Ontario, Canada
This area will focus on articles which enhance our understanding of the structure of personality and other forms of individual differences including affective, behavioral, cognitive, and motivational differences. Considered articles will be experimental, correlational, and/or theoretical.

Section Editor for New Perspectives and Directions

Paul Barrett, Advanced Projects R&D Ltd., New Zealand
This section seeks contributions from those proposing a new perspective/a novel approach to understanding, explaining, or even predicting human psychological phenomena or events. We are looking for contributions which challenge existing thinking in areas as diverse as measurement theory (as it affects the validity of individual differences assessment), through alternatives to conventional statistical trait models, to novel ways of investigating causal explanatory theory and the computational modeling of individual differences. In this respect, contributions encompassing computational psychographics, agent-based modeling/emergent phenomena detection, web-scraping predictive analytics, and substantive phenomena-detection using social-media text-mining/activity indicators, are all encouraged.

Section Editor for Intelligence, Cognitive Processes

Aljoscha Neubauer, University of Graz, Austria
The section invites submission on all kinds of cognitive constructs like intelligence, creativity, executive functions, working memory, attention, and others. Submissions should make substantial empirical or theoretical contributions to the field that go beyond translations of scales, descriptive findings like gender, country comparisons etc. Research on relations/interactions with other traits/states and with real-life outcomes is welcome. We encourage especially experimental, genetic and neuroscience approaches but also assessment-related papers are welcome if they make theoretical/conceptual contributions.

Section Editor for Evolutionary, Genetic, Neurological, and Environmental Sources of Individual Differences

Todd Shackelford, Oakland University, United States of America
We will consider in this section empirical research that is primarily concerned with addressing or advancing an evolutionary psychological perspective on personality and individual differences, in both humans and nonhumans.

GUIDE FOR AUTHORS

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article.
To find out more, please visit the Preparation section below.

INTRODUCTION

The Official Journal of the International Society for the Study of Individual Differences (ISSID).

Neither the Editors nor the Publisher accept responsibility for the views or statements expressed by authors.

All incoming papers are subject to the refereeing process, unless they are not appropriate for the Aims and Scope of the journal as outlined, do not follow the Guide for Authors, or clearly suffer from methodological problems (e.g. unsatisfactory sample size). Correspondence regarding decisions reached by the editorial committee is not encouraged.
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Manuscripts must be submitted using double-spacing including line and page numbers. These should not exceed the word count provided below. The word count includes: title, abstract, full text, tables, references, and footnotes/acknowledgements. Figures and figure captions are not considered in the word count.

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Review articles: These papers are typically in the 5,000-10,000 word range and provide a critical analysis of important and new topics related to personality and individual differences. Please select Review Article from the dropdown menu upon submission.

Single study research articles: Single study research articles should not exceed 5000 words.

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Brief Reports: These articles should not exceed a total of 2,500 words (including tables, figures, and references). Additional tables or figures can be included in Supplementary Material.

Correspondence Section

Personality and Individual Differences now invites three additional types of submission in a "correspondence section". This section allows substantive issues to be raised following publication of papers in the journal. It also provides a forum where readers may be alerted to important developments in other areas which may have implications for research and practice. These contributions will be reviewed by an editor but to speed publication will not normally go out for external review. Dr. Colin Cooper, Senior Associate Editor, will be overseeing this new section. We invite three types of contribution, which should be submitted to the journal in the same way as papers.

Technical Comments. These comment on a paper published recently in PAID (normally in the last 12 months). Titles must be "Technical comment on (reference of original paper in APA format)". They should be no longer than 1000 words plus an abstract. Comments should focus on substantive methodological or statistical issues. They should not present new data or other previously unpublished work nor be based on new findings/concepts that would not have been accessible to the authors when the paper was written. Nor should they cover the same ground as previous commentators. Authors of technical comments should show their contribution to the corresponding author of the paper before submitting their manuscript, and should seek their feedback. This correspondence (in English) should be submitted alongside the main text to facilitate the review process; it will not be published.

Matters Arising. These highlight issues with material published recently in PAID (normally in the last 12 months). Titles must be "Matters arising from (reference of original paper in APA format)". They will normally be up to 300 words long, and will not have an abstract. These submissions could for example mention an alternative explanation for the original authors' conclusions, point out some highly relevant literature which was not considered, suggest some possible extensions of the work or possible applications of the findings. They must make a substantive contribution and should not cover the same ground as previous commentators. Authors should show their contribution to the corresponding author of the paper before submitting their manuscript, and should seek their feedback. This correspondence (in English) should be submitted alongside the main text to facilitate the review process; it will not be published.

Perspectives. These highlight recent exciting research from PAID or other journals, but do not primarily discuss the author's own work. They should be up to 1000 words long (plus abstract) and may provide context for the findings within a field, integrate the findings from several papers, or draw readers' attention to work in other areas which may have implications for individual differences. They should add a dimension to the research and not merely summarise other work.

PREPARATION

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Reporting Requirements:

All empirical submissions are required to: (a) provide sufficient detail on the samples studied and the population from which they constitute a random or convenience sample; (b) compile basic descriptive statistics of all variables of relevance used in the study (e.g., indices of central tendency and dispersion; reliability coefficients for scale scores); and (c) report effect sizes for focal tests (correlations r and regression weights beta count as effect size measures). In addition to these

required reporting practices, we encourage but do not strictly require (a) providing 95% CIs around focal effect size estimates, (b) detailing any a priori power considerations made that led to the final sample size, and (c) whether and where any data, materials, code or syntax, or additional analyses of the reported studies can be found openly accessible; authors may include such information as supplemental information for inclusion in the online publication.

Power:

For empirical studies, we recommend but do not strictly require at least 80% power for focal statistical tests.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/ book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

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Divide the article into clearly defined sections.

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This journal operates a double blind review process. All contributions will be initially assessed by the Editor-in-Chief for suitability for the journal. Papers deemed suitable are then typically sent onto a (Senior) Associate Editor for assessment and then to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The handling editor is responsible for the final decision regarding acceptance or rejection of articles, and the editor's decision is final.

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Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.

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Subdivision - numbered sections

Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated by a reference. If quoting directly from a previously published method, use quotation marks and also cite the source. Any modifications to existing methods should also be described.

Theory/calculation

A Theory section should extend, not repeat, the background to the article already dealt with in the Introduction and lay the foundation for further work. In contrast, a Calculation section represents a practical development from a theoretical basis.

Results
Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions
The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices
If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

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• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
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Highlights are optional yet highly encouraged for this journal, as they increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract

An abstract, not exceeding 200 words should constitute the first page of the article.

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Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.
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Fitzgerald, M. (2004). Autism and creativity: Is there a link between autism in men and exceptional ability? Hove and New York: Brunner-Routledge.
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Appendix D

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1. SUBMISSION

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- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

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Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

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More information about the Open Research Badges is available from the Open Science Framework **wiki**.

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Author Guidelines updated 23 July 2021

Appendix E

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	77
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	1
Gender	4	Was the researcher male or female?	1
Experience and training	5	What experience or training did the researcher have?	71
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	76
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	154
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	71
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	49, 69
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	49, 76
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	49, 76
Sample size	12	How many participants were in the study?	49, 76
Non-participation	13	How many people refused to participate or dropped out? Reasons?	NA
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	77
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	NA
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	67
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	150
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	77
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	77
Field notes	20	Were field notes made during and/or after the inter view or focus group?	152
Duration	21	What was the duration of the inter views or focus group?	77
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	77
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	50, 89
Description of the coding tree	25	Did authors provide a description of the coding tree?	68, 164, 169,
Derivation of themes	26	Were themes identified in advance or derived from the data?	49, 50, 69, 77
Software	27	What software, if applicable, was used to manage the data?	77
Participant checking	28	Did participants provide feedback on the findings?	NA
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	50-59
Data and findings consistent	30	Was there consistency between the data presented and the findings?	50-59
Clarity of major themes	31	Were major themes clearly presented in the findings?	50-59
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	50-59

Appendix F

A letter from the UEA FMH Ethics Committee granting ethical approval.

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Jasmine Taylor
Norwich Medical School
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Norwich Research Park
Norwich
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NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational Building
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University of East Anglia
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Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

4th January 2021

Dear Jasmine

Title: Exploring Trainee Clinical Psychologists' Experiences of Perfectionism and Psychological Wellbeing During Training: A Qualitative Study

Reference: 2020/21-050

Thank you for your email 17th December 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Dr Jackie Buck
Chair
FMH Research Ethics Committee

COVID-19: The FMH Research Ethics Committee procedures remain as normal. Please note that our decisions as to the ethics of your application take no account of changes in Government measures and UEA guidelines relating to the coronavirus pandemic and all approvals granted are, of course, subject to these.

Appendix G

An excerpt of transcript (participant 1 – Alice [pseudonym]) together with personal reflections from the reflective journal.

The below excerpt, which starts from question one on the interview schedule, demonstrates the researcher's style of interviewing, and the keeping to the semi-structured interview format. The researcher uses techniques of open questions and summarising throughout, to encourage lengthy and detailed answers from the participant.

R: […] So, if we begin I just wondered firstly what perfectionism means to you?

P: Ahh, things like I suppose when I think of perfectionism in terms of my own characteristics and I think it probably one of the things that comes to mind is a kind of probably… quite black and white way of thinking that either things that I do are perfect, I'm acceptable, or they are rubbish and they - and I struggle sometimes to find that middle ground, I think that's the thing that kind of pops into my mind when, when it kind of first mentioned … actually, is it - I think there's probably something as well about my expectations of myself and then my expectations of other people.

R: Yeah.

P: I reckon I probably have quite high… I have the highest expectations for myself definitely and I'm not… I wouldn't class myself as someone who's kind of, typically kind of competitive with others, but I'm very competitive with myself. You know, in terms of, what, having to do better? And kind of build on… on those kind of things …

R: Sure. So a bit around kind of a bit black and white, either perfect or rubbish, and then of having high expectations of yourself, maybe other people as well?

P: Yeah I think, I think as well when I think about perfectionism there's something in there about it probably feels quite… and that feels quite reassuring… they…

R: Okay, yeah, that makes sense. So bit about kind of organisation and being in control?

P: Yeah.

R: Thank you, it's a really good summary and I guess you kind of have answered the next question really … in sort of what way do you personally identify as a perfectionist? That we kind of have gone over that, but is there anything else you want to add to that?

P: Ah, how do I put it… my.. I think, yeah, it's probably the, the main thing would be probably the way the way I kind of think. I think… I think perfectionism, it feels more kind of cognitive in some ways in terms of, like, the way I might think about things. So I'm thinking about that kind of like, black and white thinking, but I think there's probably an underlying kind of emotional place in which what would I… what would be underneath

that, may be feelings of inadequacy maybe feelings of not being good enough at kind of core level. But definitely what I notice on the day to day basis is probably the more kind of cognitive or automatic thought types.

R: So maybe it's more the core stuff around being inadequate or not good enough but then on the surface level is the stuff you notice more?

P: Yeah, I think so, because I'm thinking about… I'm thinking about that kind of idea that everything I say “things are great and fantastic” even not happy with stuff when I do it either “it's okay or it's rubbish” and then I'm just thinking about the kind of lack of middle ground there for me sometimes. Yeah, it might not make sense, but there's something around if I “if it's not perfect it's rubbish”. I have kind of rubbish myself first then someone else then I've kind of already protected myself when someone else does it if that makes sense?

R: Yeah, yeah, I think so …

P: That's the kind of half formed thought that just occurs that feels like there's something in that around, yeah, I'm trying to work out why and I'm not quite sure why. I think it just … think so, I don't know if this is quite answers the question, but to give an example, if I was to get feedback on something … constructive feedback, I could take on that feedback and accept that feedback as useful, but then what I would do is then criticise myself … kind of tenfold, so I could take on the feedback of “you’re okay, there's things I can improve”… that I understand rationally that bit, really, and that this kind of… I mean, there's lots of learning to be done and I can take that. Then probably privately in my own mind, a kind of inner critic probably comes about quite a bit, I think. That's the perfectionist that as kind of as well “you should already know that”, but rationally and I think “well I can't because I'm a training and I don't … don't know a lot of things”.

R: Okay, no, I think that answers it really well actually, so bit about kind of being black and white. Either things are really good or they're not, having high expectations, I need the kind of control and organisation. Maybe at a deeper level feeling inadequate or not enough… good enough…but then sort of everyday an example might be if you get feedback you can take it on but it seems to be that you might slip into that kind of critical self …critic mode underneath?

P: It'll… yeah, yeah. I think that that inner self critic I’ve definitely become more aware of it recently. So I think probably before training, no, I wasn't really aware of it, but it must have been next. I think it’s right that probably like spurred me on teenage pursuant triggering clinical psychology.

R: Thank you, I will come back to that in a minute if that's alright? So I wondered kind of what we've mentioned some of maybe the challenges of perfectionism but I wondered if there was any … any, kind of, positives about it? Or any good things?

P: Yeah, I think perfectionism… I do think overall there's probably more negatives than positives to it and I think if I was kind of drawn to any positives to being perfectionist it would probably be that generally speaking, I… I can kind of attain things that I worked for …

R: Yeah.

P: I haven't had many experiences of failing things. That might be like job interviews or my driving test or things like that. It kind of protects me from failure, and so that because I act because I'm striving so hard I'm supposed to be perfect or good at things and that creates its own difficulties in fear of failure. But if we're sticking on the positives, and yeah, that's probably…. that's probably one of the main positives of perfectionism, I think, so in some ways it can kind of prevent you from failing at stuff and means you can kind of achieve well, but that comes with some consequences as well that we've just discussed.

> Reflective journal (02.03.2021): "I felt anxious as to whether I have written my interview schedule well enough, and whether I would gather data that would answer the research question appropriately. I know this was my own perfectionistic standards 'live' in action here. After a few minutes, the interview went better than expected and I immediately relaxed into it, and very much enjoyed it. The similarities in experiences between the participant and myself were evident. It was difficult at times to 'hold back' and not say 'me too!' to keep biases to a minimum, but I felt this was achieved in my reflections, summarising and open-ended questions. I was grateful to the participants' time and enthusiasm for participating in this research. I felt that their passion for giving a voice to this topic was as strong as mine, and that they had given a lot of thought into what they wished to say before the interview went ahead."

Following discussions with the researcher's supervisor, it was agreed that the interview schedule did not need adapting in order to gather data relevant to the research question. The interview schedule enabled a good flow in conversation, and used flexibly together with follow-up questions, reflections and summaries, enabled rich, qualitative data to emerge. For these reasons, this transcript was included as part of the full analysis.

However, the researcher did reflect with their supervisor that being a trainee themselves, interviewing other trainees, may lead some participants to feel somewhat uncomfortable to share their experiences openly at times, perhaps due to perfectionistic tendencies or fear of judgement. Therefore, it was agreed that where required, the researcher would provide praise and encouragement in their feedback, whilst keeping a stance of unconditional positive regard (Rogers, 1951). In addition, the researcher agreed to tentatively share their own experiences where invited or appropriate, if they felt that this would build rapport and encourage a genuine and open conversation (Lamb, 2013).

Appendix H

Expression of Interest Form using Jisc Online Surveys

Faculty of Medicine & Health Sciences
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University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email:J.Taylor10@uea.ac.uk

Web: www.uea.ac.uk

Ethics Reference Number:
Study Identifier:

EXPRESSION OF INTEREST FORM

Title of Project: Exploring Trainee Clinical Psychologists' Experiences of Perfectionism and Psychological Wellbeing During Training: A Qualitative Study

Name of Researcher: Jasmine Taylor

Please enter your full name below:

Please enter your email address below:

Are you a student currently studying on a UK Professional Doctorate in Clinical Psychology?

Yes ☐ No ☐

Name of Training Institution:

Do you self-identify as a perfectionist?
Researchers have defined perfectionists as individuals who set very high standards and live by rigid rules to achieve these in order to feel worthy, and to prevent failure. This can evoke feelings of self-doubt and self-criticism if these standards are not achieved. If they are achieved, these standards can be re-evaluated as not being sufficiently demanding (Frost, Marten, Lahart, & Rosenbate, 1990; Riley & Shafran, 2005; Shafran, Fairburn, & Cooper, 2002; Stoeber, 2018; Woloshyn, 2007).

Yes ☐ No ☐

Submit

Thank you for completing the expression of interest form. Jasmine will review your responses and will contact you via email within the next two weeks should you meet the criteria to participate in the research study.

Should you have any questions regarding the study, please contact the Jasmine on J.Taylor10@uea.ac.uk.

Appendix I

Participant Information Sheet, Consent Form and Demographic Questionnaire using Jisc Online Surveys

Page 1

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Email:J.Taylor10@uea.ac.uk

Web: www.uea.ac.uk

Ethics Reference Number:
Study Identifier:

PARTICIPANT INFORMATION STATEMENT

Title of Project: Exploring Trainee Clinical Psychologists' Experiences of Perfectionism and Psychological Wellbeing During Training: A Qualitative Study

Name of Researcher: Jasmine Taylor

(1) What is this study about?

You are invited to take part in a research study about UK Trainee Clinical Psychologists' experiences of perfectionism during training. We are interested in hearing about how Trainee Clinical Psychologists understand perfectionism and its association with psychological wellbeing, and how this interacts with demands throughout training. Findings from the study may help to contribute towards the ongoing development of appropriate psychological wellbeing support prior to, during and following Clinical Psychology training. You have been invited to participate in this study because you are a Trainee Clinical Psychologist studying on a UK-based Professional Doctorate in Clinical Psychology training programme. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.
- ✓ You can request a copy of this Participant Information Statement to keep.

(2) Who is running the study?

The study is being carried out by the following researchers:
Jasmine Taylor, Trainee Clinical Psychologist, Department of Clinical Psychology and Psychological Therapies, Faculty of Medicine and Health Sciences, University of East Anglia.

Dr Imogen Rushworth, Clinical Psychologist and Clinical Associate Professor in Clinical Psychology, Department of Clinical Psychology and Psychological Therapies, Faculty of Medicine and Health Sciences, University of East Anglia.

(3) What will the study involve for me?
Your participation will involve having one interview with Jasmine. This will take part over a video call on Microsoft Teams, at a date and time that is convenient for you. Jasmine will use your email address to contact you at your chosen interview time and you will be required to answer the video call should you wish for the interview to go ahead. The interviews will be audio recorded using a dictaphone. You will be asked questions relating to your understanding and experiences of perfectionism, your approach to and experiences of training, including academic and placement work, and your psychological wellbeing throughout training. You will be able to review the transcript of your interviews, if you wish to ensure they are an accurate reflection of the discussion.

(4) How much of my time will the study take?
It is expected that the interview will take up to 90 minutes to complete.

(5) What are the possible benefits of taking part?
To thank you for your participation in the research study, we will provide you with a £10 Amazon voucher. You will still receive this voucher if you withdraw from the study. We also hope that by sharing your experiences of perfectionism and psychological wellbeing during training, we can begin to develop a refined understanding of the requirements of effective psychological wellbeing support for individuals prior to, during and following Clinical Psychology training.

(6) What are the possible disadvantages or risks or taking part?
Discussing issues relating to perfectionistic tendencies and/or psychological wellbeing might bring up issues of concern. We are able to stop the interview at any time should you feel uncomfortable. We will encourage you to seek support from your course personal tutor/advisor, clinical supervisor, hosting university student support service, general practitioner, or local primary or secondary mental health service if this is indicated to be appropriate. We will also signpost you to charitable organisations, such as the Samaritans, MIND or CALM if necessary.

Participating in this study will take up to 90 minutes of your time. As stated above, if you wish to withdraw your participation in the study, you can do so at any time.

(7) Do I have to be in the study? Can I withdraw from the study once I've started?
Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia. If you decide to take part in the study and change your mind later, you are free to withdraw at any time. You can do this by emailing J.Taylor10@uea.ac.uk.You are free to stop the interview at any time and you may also refuse to answer any questions that you do not wish to answer during the interview. In the event that you withdraw from the study, any recordings and personally identifiable information will be erased. However, there is a risk that it may not be possible to remove anonymised data from the analysis and it could be included in the study's results.

(8) What will happen to information about me that is collected during the study?
By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise. Data management will follow the 2018 General Data Protection Regulation Act and the University of East Anglia Research Data Management Policy (2019). All information about you, including audio recordings and transcripts, will be encrypted and stored securely on a password protected computer. Your identity/information will be kept strictly confidential, except as required by law. Study findings, including quotes from transcripts, may be published (e.g. in a

doctoral thesis, academic journal and conference presentations). Although every effort will be made to protect your identity, there is a risk that you might be identifiable due to the nature of the study and/or results. In this instance, data will be stored for a period of 10 years and then destroyed. However, you are able to request a copy of your transcript if you wish.

(9) What if I would like further information about the study?
When you have read this information, Jasmine will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Jasmine on J.Taylor10@uea.ac.uk.

(10) Will I be told the results of the study?
You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by providing a contact detail on the consent section of this information sheet. This feedback will be in the form of a one page lay summary. You will receive this feedback when the study is finalised.

(11) What if I have a complaint or any concerns about the study?
The ethical aspects of this study have been approved under the regulations of the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee.

If there is a problem please let us know. You can contact Jasmine Taylor via the University at the following address:

Jasmine Taylor
Department of Clinical Psychology and Psychological Therapies
Faculty of medicine and Health Sciences
Norwich Medical School
University of East Anglia
NORWICH NR4 7TJ
J.Taylor10@uea.ac.uk

If you would like to speak to someone else you can contact Jasmine's supervisor, Dr Imogen Rushworth, I.Rushworth@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the Programme Director, Professor Niall Broomfield, N.Broomfield@uea.ac.uk.

(3) OK, I want to take part – what do I do next?

☐ **I have read the participant information sheet and wish to take part in the study. Proceed to consent form.**

If you do not wish to take part in the study, please exit this webpage.

If you would like a copy of this participant information sheet for your records, please email the researcher, Jasmine, at J.Taylor10@uea.ac.uk.

Page 3

Faculty of Medicine & Health Sciences
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email:J.Taylor10@uea.ac.uk
Web: www.uea.ac.uk

DEMOGRAPHIC INFORMATION

Thank you for volunteering to participate in the above study. Please fill in the demographic information requested below. Please refer to Section 8 of the Participant Information Sheet for more information about how your details will be stored and used as part of the study.

1. **What year of UK Professional Doctorate in Clinical Psychology training are you currently?**

Yes ☐ No ☐

2. **Please tick what age group you belong to.**

< 25 ☐ 25-34 ☐ 35-54 ☐ > 54 ☐

3. **What is your gender?**

M ☐ F ☐ Other ☐

4. **How many times did you apply before being offered a place on a UK Professional Doctorate in Clinical Psychology?**

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 5+ ☐

Thank you. Jasmine will email you soon to schedule an interview. You can now exit the survey.

Exit Survey »

Appendix J

An example of Dina's (pseudonym) transcript with initial codes using NVivo v.12.

Note: P4 is Dina and R is researcher.

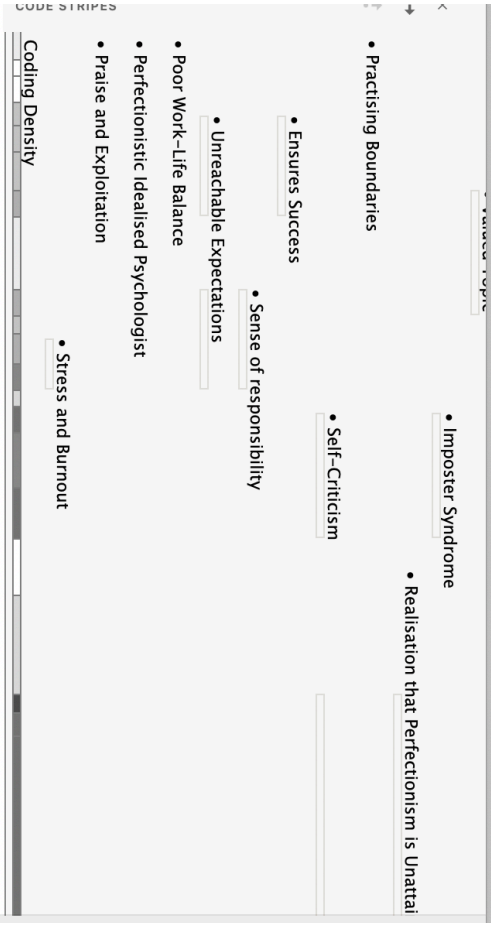
P4: Right. Good things…The good things I think are that I…Take pride in my work, 100%. So when I do something I do it properly.

R: Mm.

P4: My work is of a high standard. You know I'm not person here, even when I'm writing drafts for my thesis, I will take forever because I'm writing it as if it's the final draft. [R: Mm.]. It has to be "the one", which it can be a negative or worse… But um… But yes, so I do write to a high standard and also in my clinical work as well, you know I go the extra mile. I'm currently on placement in a refugee service. And I'm very passionate about doing everything I can for that client. Great, so I'll be writing all these letters to the Home Office and I'll be in liaising with the solicitors and trying to do all of these extra things. [R: Mm.] That, you know, some people might say on the role of a psychologist, but I say, it is, because if its affecting my client's wellbeing then it's my business. The positives are, I do go the extra mile for people. I do show that I care. I'm not just closed off and I'm just like, oh, I'm just a training psychologist like I do. XYZ that's it. I do kinda push the boundaries.Um, the not so good points, I tie myself up in knots trying to get my work done. So procrastination [laughs], I'm the queen of procrastination! [laughs] [R: laughs, yeah]. And nobofly believes me because I do get my work done in the end, but make no mistake, I am still that person who will be the night before… still doing parts of the work or still meticulously checking my work and it is because I think like… like this isn't going to be my best piece, like even when I know I've done a good job, I'll consistently kind of…my inner critic just comes into play, so I'm very, very self-critical. And I think that really does work against me because it can then be quite difficult to celebrate the wins.

R: Mm.

P4: If I get good mark in something or I'm celebrating something, it's actually very short lived, I think because I …I also think that's partly to do with me and also partly to do with the nature of being a trainee, because you have so many things that are one after the other and in conjunction with each other that actually it's really hard to take break after you done really well in something, finished a placement, for example like, you've just gotta go straight onto the next one, so quite difficult actually. And then I guess more recently. So I…I actually failed an assignment for the first time and that was not a good time. I had a project fall through, so this was for my small-scale research project. My project fell through due to COVID and I had to get one together in a crazy amount of time, like a couple of weeks, and through the process of trying to get extenuating circumstances and stuff, I was kind of encouraged to get something in anyway, which is completely like, against [laughs] what I wanna do! And then I knew I was going to fail it because I knew that I just hadn't had the time. Luckily I did get extenuating circumstances and I was allowed to resubmit as if it was my first admission, but at the point that I failed, that felt like the end of the world.



Appendix K

An example of coded extracts for the code 'unreachable expectations' using Nvivo v.12.

Note: P10 is Jade (pseudonym)

Files\\Interviews\\P10 Transcript
4 references coded, 2.63% coverage

Reference 1: 0.73% coverage

I guess just like really, trying a bit overly hard to try to make everything to the absolute highest standard you possibly can and maybe doing that to to a slightly excessive extent and yeah, so going above and beyond kind of what is good enough and just really trying very hard and to make everything absolutely perfect um… And yeah, being very sort of like detailed focus as well.

Reference 2: 0.59% coverage

I think it's it's that sort of thing, so I have not just like on the training, but I've always been that sort of person who tries…who has really, really high standards for myself, probably higher than the standards that other people hold for me and really try very hard to make everything absolutely perfect.

Reference 3: 0.43% coverage

It's the unachievability as well, I think, because obviously nothing is ever going to be perfect, but still sort of trying to try to get there and then be really disappointed if it's not quite as you know, as I'd hoped it to be.

Reference 4: 0.87% coverage

It's stressful! [laughs]. That's the sort of thing I notice it's like a, it's a very stressful thing. I tend to feel… I tend to feel like I'm under quite a lot of pressure, but then I realized that actually it's not, it's not necessarily the course that's put me under that pressure, it's myself, it's my own kind of expectations of you know this, this is a standard that you should…again with the shoulds… um, this is a standard that you should be setting…

Appendix L

A table to show the over-arching themes, sub-themes and codes in the final analysis (Braun & Clarke, 2013).

Overarching Theme	Theme	Sub-Theme	Codes
The Paradox of Perfectionism	Perfectionism as Protective		Ensures success; Family Perfectionistic Attitudes, Perfectionism Reinforced at School; Perfectionism Required to Gain a Training Place; Protects against failure; protects against inner shame and inadequacy; negative feedback is personal attack
	Perfectionistic Idealised Psychologist		Praise; Exploitation; Sense of Responsibility; Unnoticed Unspoken; Unreachable Expectations; Getting Things Just Right; Poor Work-Life Balance; Self-Imposed Pressure; High Expectations of Others
	Imposter Syndrome		Course is Pedestal; Discounting Achievements; Proving Self; Reputation of Difficulty; Rigid Thinking, Self-Comparison to Trainee Peers; Competitiveness
The Struggling Helper	Wellbeing Difficulties	Stress and Burnout	Alienation; Frustration
		Anxiety and Low Mood	Exhaustion; Guilt; Losing Sense of Self; Rumination; Self-Criticism; Self-Doubt
		Negative Coping	Blaming; Cognitive Dissonance; Procrastination; Self-Care Turns Perfectionistic
	Helpers Cannot Ask for Help	Perfectionism as a Barrier	Being Assessed
		Stigma	
		Course Messages	Conflicting Messages; Feeling Unheard; Supervisor High Expectations; Course Not Diverse; Availability of Course Support; Normalising is Invalidating

Togetherness in Transformation	Shared Experience – Togetherness in the Journey	Safety in Small Trainee Groups	Competitiveness Decreases, Reflective Practice Helpful; Informal Trainee Support Normalises
		Supportive Staff	Course Ethos Highlights Wellbeing; Healthy Role Models; Safety in Supervision; Staff Open About Perfectionism
	Developing Healthy Self-Relating	Reducing Perfectionistic Tendencies	Negative Impact on Wellbeing; Known Expectations; Multiple Demands, Perfectionism Raised by Others
		Practising Boundaries	Self-Care Basics
		Developing Balanced Thinking	Building Self-Compassion
		Connecting with Other Identities	Private Therapy Helpful; Family Connections; Faith; Peer Connections

Appendix M

A series of thematic maps demonstrating the development of three over-arching themes.

Figure 1

An initial thematic map demonstrating the initial clustering of themes, sub-themes and codes.

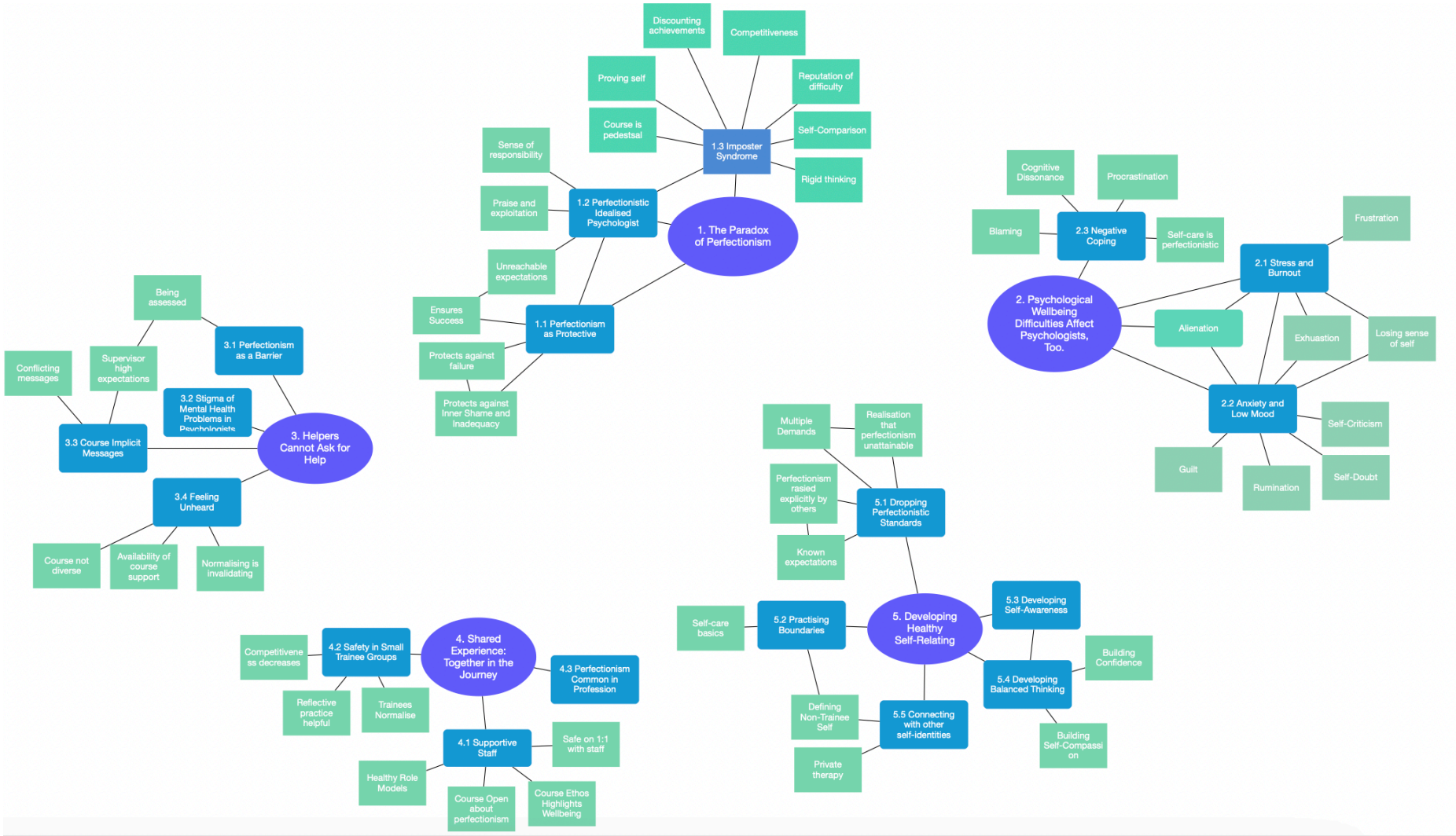


Figure 2

A second thematic map demonstrating the initial clustering of themes and sub-themes. Note: Some themes and sub-themes were re-named at this stage.

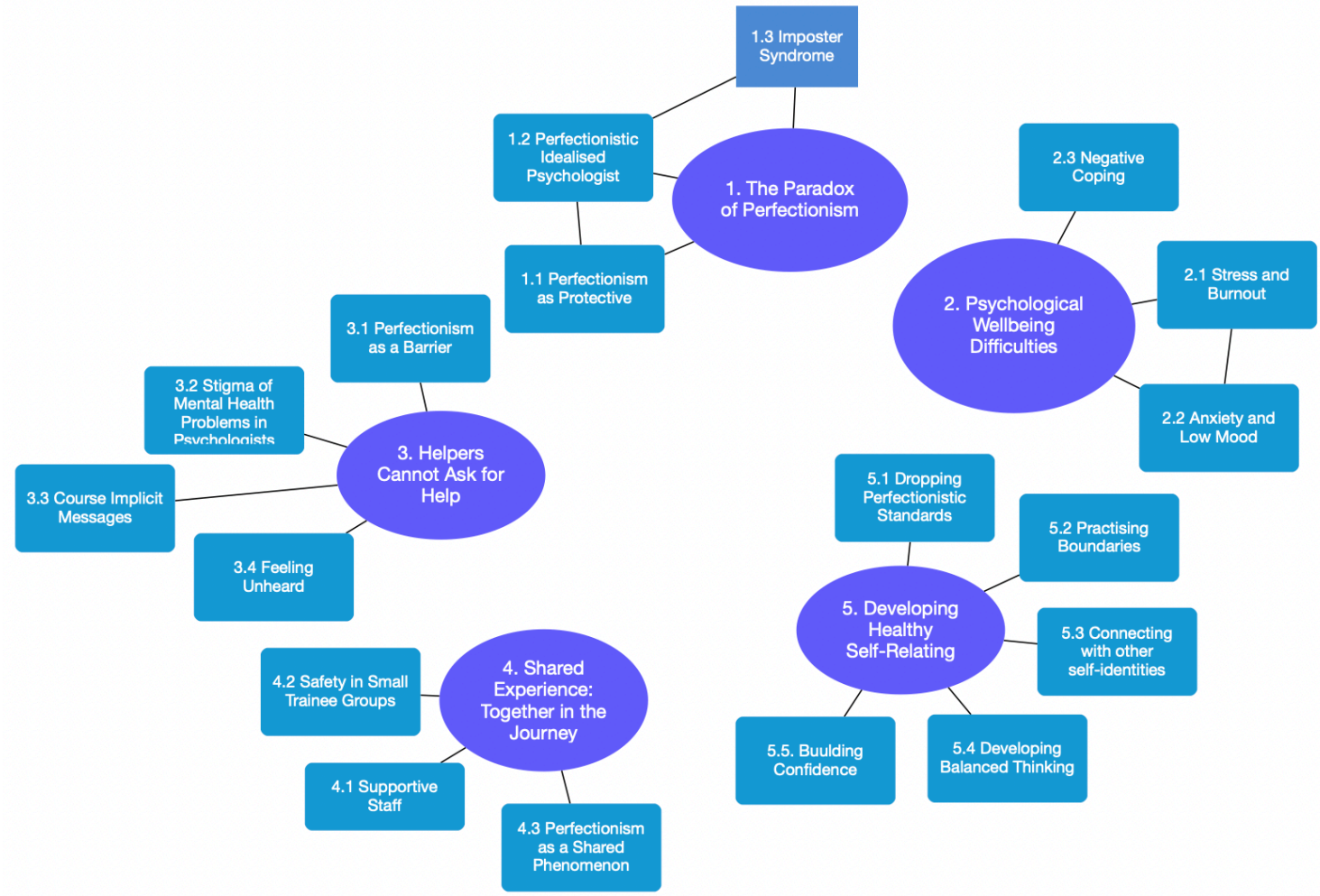
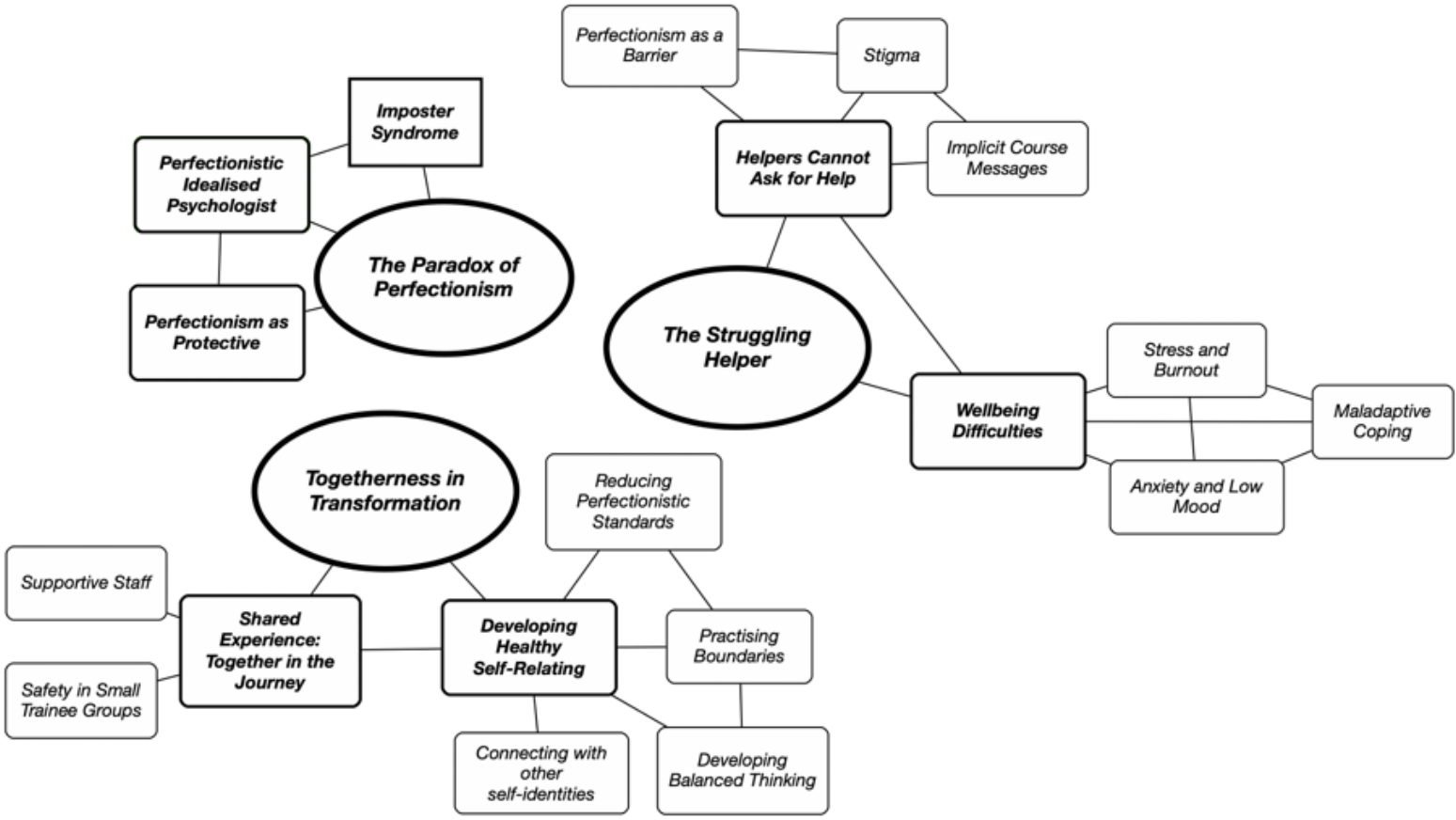


Figure 3

A final thematic map to show the three over-arching themes, themes and sub-themes of the analysis. Note: some themes and sub-themes were merged due to similarity amongst coded extracts.



Appendix N

A table to show additional quotes for each over-arching theme, theme and sub-theme.

Overarching theme	Theme	Sub-theme	Quotes
The paradox of perfectionism	Perfectionism as protective		Mike: there was something about the self-critic, that like really kind of struck a cord um… and for me it was like 'well, my self-critic has always been useful in some ways because it motivates me to do better, to try more, to go, you know, that one step further, and I suppose without that, I can go into being very apathetic, kind of going into a non-state, you know, where you're just not striving, no motivation. Whereas I suppose that self-critic can be really motivating, really kind of driving me to achieve and to keep doing things so… that's very well…very much linked to the perfectionism, it is that self-critic, so I suppose the perfectionism can be good… it's [sigh]… it's motivating me to do more, to achieve more, to just, to just to like go that one step further. Isabella: So it's easier or maybe safer to just not let that happen, and, and to be a bit of a perfectionist and sort of try to control stuff to the extent that actually it's not… It's less of a possibility for things to go wrong. Alice: I think in in not failing in many things failure feels like an absolute. It's just something that's probably quite scary and that's probably cause if failure would trigger all that stuff around not being good enough
	Perfectionistic idealised psychologist		Jade: Yeah, I guess it's like that comparison of like I'm comparing myself to some imaginary, absolutely perfect trainee that's doing everything wonderfully and doing all this read and getting all the…. Yeah, getting all the research done in like the first month or yeah…and I think it's that sort of comparison then, but that I'm doing, but I'm not really comparing itself to a real person. It's like some ridiculous, the perfect-self version of a trainee, but I guess is what I'm trying to be. Jade: Yeah, I guess in some ways I think it sometimes helps in my clinical work. I'm just thinking about feedback I got from somebody that I just worked with on my most recent placement that like, 'oh, you're always like, seem to put lots of effort in and always have things you know ready for the appointments' and I think sometimes people appreciate that if they feel like you've… because if I was always again overdoing it a little bit with, you know, making sure I was really prepared for sessions had to like lots of… brought lots of resources with me and, you know, make sure I was, you know, prepared for everything. I think some people appreciated that because it made them feel kind of like I was, at least, you know, interested in, you know, working with them and being at sessions and stuff, so I guess it helps with that as well. Emily: From my personal tutor are kind of comments on the detail that I'll put into forms that we do together and I always feel like that for the majority of interactions I have with staff on the course that the perfectionism is almost positively reinforced by, like every encounter? Uhm, which I get because everybody wants somebody that works hard and gets stuff done.
	Imposter syndrome		Caroline: I think I want to prove… I feel like I have to prove something, a little bit myself or to other people. I feel like I need to prove that I can do it. Gill: Urm, it's horrible really, because everyone who's on the course is qualified to be here, not just like with qualifications, but with … Urm, competencies and things like that, so everyone who's on the course has earned the right to be here, from working hard and learning lots of different things and putting things into practice so … really, it shouldn't be a case of all lucky to be here, it should be a case of, you know, work so hard and 'I deserve this opportunity to learn', whereas it doesn't feel that way, it feels like I've been given something really precious, and I've gotta care for it.

			Mike: I'm constantly comparing myself to other people that I'm training with, and I feel like I want to try and match or, if possible, exceed the amount of work and the amount of effort they're putting in, because I feel like that's, that's kind of the only gauge I have to go on at the moment to, sort of how…how I should be performing on training.
The struggling helper	Wellbeing difficulties	Stress and burnout	Gill: If you've always got your best, you've gotta put in 100%, and sometimes you end up doing that and then running on empty. So yeah, it's tricky. Emily: I think I probably jumped into training with both feet um… and towards the end of the first year beginning and seconder started to really feel the effects of that. So I got physically quite unwell and just went through periods of getting physically unwell. Yeah, and just being quite… just feeling quite burnt out and not doing great at that period Emily: There were times when those kind of… either conflict or just wanted to like shut off from my relationships because…It just felt like people didn't get it and it was like, 'oh, I've got all this work to do like just go away' [laughs]. 'You don't get it, go away'.
		Anxiety and low mood	Mike: Then there's like, depressive elements, an inability to enjoy things etc., wanting to withdraw and avoid people […] I think it's infuriating, really. I just feel like I let myself down again, got back in a bad cycle. I should have been…so I should have been…it's a lot of 'should', you know, working productively, I should've been wrong more….balancing my time, I should've started earlier.' Becky: Feeling unmotivated, feeling really hopeless, all of those type of things. Jade: Disappointment and frustration and things that … and sometimes, I think, oh sometimes, even like guilt and I just feel myself… it's quite strong… I feel like, oh, you know, 'I've not quite worked hard enough', or 'I've quite not… it's not come off very well', then and I tend to feel quite guilty as well, and that's when the 'shoulds' come in, like oh, 'you should have done this a bit better', or… yeah. Jade: I really try…. Especially having like worked in mental health and that, I really try to sort of practice what I preach. But I notice myself just doing the 'shoulds' and like oh, 'you should have done this, you should have done that and you shouldn't have done this'. Yeah, the 'shoulds' for me are quite…quite strong! Mike: The perfectionism comes up like, 'why aren't I achieving what I need to be achieving? If I'm struggling with this, why am I even on the course?', and then through that, as those processes come into play, like I said, the mood dips, increased anxiety.
	Negative coping		Dina: I'm already thinking there that there is a lot of perfectionism within that. Um, so you know, um, like getting the best sleep cycle. I always put myself down for not eating healthy enough etc. So although it does help me, there's always a tilting to well, 'it's not good enough'. Becky: I can be a little bit inflexible with it… and quite rigid around it, which is unhelpful, and I guess that sort of fits back to that perfectionism as well, so if I've set myself that I'm not going to work outside of hours that I've dedicated to work and there's no flexibility within that. Then like sometimes realistically like you are going to have to maybe do something on a weekend and like, that can be okay… but I can't do that […] so I'm just super stressed throughout the week …
	Helpers cannot ask for help	Perfectionism as a barrier	Isabella: But yeah, I think I think the majority of my worry is around the assessment and, and just not wanting, not wanting to give them any ammo... If you like, to kind of not give me a good grade at the end of it, you know any anything I can do to, to contribute to like an overall good impression of me as a trainee and I will, I will try to do.

			Jade: It takes like a little while to really show like myself and to show vulnerabilities. I it's part of the perfectionism, especially in a work, or I guess in now, training context, of wanting to do really well, but also, wanting to be seen to do really well so I want to show people that I can do the work and I am professional. Caroline: I think that's part of my standards, that I don't want people to think I'm not coping,
		Stigma	Isabella: I wouldn't feel comfortable at all talking to my supervisor on placement about how it was, how, how, my well-being was or even really talking to my manager, I wouldn't want to talk too much about if I was having a bad mental health day […] I probably resent it a bit. I probably feel a bit like I shouldn't have to do this. Now I should, in an ideal world, I'd be able to communicate this to the other people I'm working with or yeah, and not even necessarily to get support, but just so that people are kind of aware. Emily: I think in any sort of working environment there's never going to be 100% safety or, you know, there's always going to be social risks in whatever group or organization that you're in and limits to what you can bring. Urm, but I think trying to think about being in environments where we're not promoting shame-based responses, so we're not um, trying to value one characteristic over another, potentially leaving you know the other characteristic is being shamed.
		Course messages	Frances: I think daunting, that it was definitely a case where they just expected me to just crack on and get on with things and I felt like I needed someone to hold my hand. Hetti: If you have other supervisors who are, maybe themselves, are a bit like, you know, workaholics, perfectionists, then I think it just bounces off, and I think that's a huge problem. It just kind of spirals into this whole mess of doing so much work but never getting anywhere. Emily: So yeah, I think there's something about just the staff feeling the need to get all of these things done as well, and what that might mean if they were to then say to trainees, 'You should slow down and not do as much', what that would mean in terms of their needs to get things done.
Togetherness in transformation	Shared experience: together in the journey	Supportive staff	Mike: They do try to kind of encourage people coming forward and asking questions and asking for support if they need it and…and they do, you know, encourage people to be really reflective about their needs. Caroline: My tutor did mention to me one time [laughs] when I was like 'I need to get ethics done, I need to get this done, this done' and she was like 'chill out it's gonna be ok' she said to me like 'I can see you want things to be done well and you've got your standards, remember it's a marathon and not a sprint, you've got three years, you'll be ok, don't burn yourself out yet, or at all'. Dina: It's sometimes taken my supervisor to say […] I'm on annual leave next week and she was like 'make sure you turn your emails off', like she feels that she needs to tell me that…um, 'make sure you put your out of office on', constantly reminding me of boundaries. And that's not because…it doesn't come across in a way that I am breaching anything and I'm doing things wrong. It feels like it's coming more from like a nurturing, caring, supervisor. I've been very privileged to have all very lovely supervisors across my training.
		Safety in small trainee groups	Alice: The course set up smaller reflective peer support groups and we have a clinical tutor in them and there's not really a format for them but they're just a space to talk about whatever we want to talk about and understand… to feel a sense of connection within the group

		Emily: I mean, we have personal and professional development sessions at uni….so that's a time that can be offered for trainees, where they can access…you know, whether that's a group based facilitated space […] I think it's really important that as psychologists, we think about what we bring and how are our dynamics and how we interact with teams and the type of responses that we elicit and things like things like that for us to be effective clinically. Hetti: It was less about the uni but then in my cohort like we started like a peer support kind of thing. Not peer supervision, but more like, I don't know, basically we can randomly vent about placement [laughs], which was really helpful. But that was more like what the trainees did. I think a lot of the things really come from like our cohort rather than the uni […] I think that's been helpful. I think the most helpful thing is really talking to other trainees, having that if they feel similar, I think it makes just such a difference, you know, then you just know that you're not by yourself and then some people are stressed as well and that some people are having worse placements than you are and it just really helps knowing that.
Developing healthy self-relating	Dropping perfectionistic standards	Emily: There's something about that at the beginning I was really all right about it being an all-consuming experience, and I think in the middle I got to the part of like, actually, 'I don't want it to be like this. I want to be able to do this work that I love doing, but I want to also have that, my life outside of it'. Hetti: I realized it's just not sustainable like having those high standards like… I mean, there's some people on the course we literally like, just don't give them up and when you see them working all weekends and everything just to get a bit of a better grade than…or, just so they can please their supervisors…I just feel like that's just not enough for me. Becky: I don't think I'd survive in the NHS If I continue to strive to achieve those standards.
	Practising boundaries	Jade: One other thing I have noticed for me is just like the really basic things of keeping, like exercise, and going outside. So even if it's like raining, making sure that I'm like outside at least once a day. I live near an area where there's a river and a canal quite near. So I make sure that I go outside and go walking and like all those…just the very basic self-care things that that I should do. Caroline: Maybe because I'm trying to be a bit more like, 'well, keep your work-life balance…and it is gonna get stressful, it's three years'. Emily: There's something about not wanting to give all of my time to it. Frances: Just always having something to look forward to outside of the course, there's always something in the diary, then it's exciting. Or you know that you're going to look forward to.
	Connecting with other self-identities	Dina: I'm in a friendship group that we celebrate each other's wins […] being part of a friendship group that is just vibrant, fun, that I can just kinda forget things for a while. That definitely helped. And also my faith, so I'm a Christian and sometimes I just have to hand over to God and be like 'do you know what God, I am, I'm very stressed and you know I just need some comfort'. Whether that's in prayer or gospel, music…
	Developing balanced thinking	Jade: I did notice that when i started my placement, I was able to sort of say to one of my supervisors 'i feel like I don't what I'm doing with working with young people. I don't feel like I know how to engage with them' and that was….that ended up being really helpful, so I'm starting to get a little bit better about it. Realizing that actually 'you know it's ok to ask for help, this is what I'm here for'. Trying to remind myself that 'it's training and you are here to learn, so you can ask people for help and it's ok. Do it now before you're fully qualified and everyone expects you to just know everything!'

Frances: I think just saying that like learning from previous mistakes and I think realizing…and having a tricky caseload. I think I wanted to have a tricky observation so that I can think about what… like get that support that …what I could do differently rather than being like 'this is perfect, you can't change', being like, "actually, this wasn't an ideal session, and what can we do about it?' And I think I've just been thinking that that would help me grow as a psychologist a lot more than having a perfect observation.

Mike: Actually, I think it's easier for me these days than it than it has been before. I think I've reached, I don't know, maybe reached a point or reached… I feel maybe more comfortable within myself or something, but I find it easier now to say 'I can only do what I can do', and you know 'if I put everything into it and it's not good enough, then that's, that's ok, that was all I could do.'

Alice: 'You're not doing a good enough job. You shouldn't be a trainee', whereas, whereas now if something like that was to happen the emotional, kind of, the emotional mind, I suppose… I'm used to… it wouldn't be activated in the same way because I know what it is and…and I can observe it a bit more rather than being in it and being driven by it, I can kind of step back from it and see it. And I still have the feelings, and that self-critical voice, and that feeling within my body, and it feeling quite uncomfortable, but can… I don't get into so much inside of it. I can kind of see and step back and kind of break that a bit quicker now.

Appendix O

A table showing a summary of the results of studies included in the systematic review.

Study	Summary of Results
Abdollahi et al. (2018)	• Personal standards negatively associated with depression, EFC and AC and positively associated with TFC coping. • Evaluative concerns positively associated with depression, EFC and AC and negatively associated with TFC coping. • TFC coping negatively associated with depression and EFC and AC positively associated with depression. • Partial mediation of AC style on positive association between evaluative concerns and depression.
Castro et al. (2017)	• Concern over mistakes, socially-prescribed perfectionism, doubts about actions, evaluative concerns positively associated with negative affect, and negatively associated with perceived coping. • Partial mediation of perceived coping on positive relationship between multidimensional perfectionism and negative affect.
Dunkley & Blankstein (2000)	• Self-critical perfectionism positively associated with daily hassles through maladaptive coping. • Self-critical perfectionism positively associated with depression, anger and psychosomatic symptoms through a full mediation of maladaptive coping. • Maladaptive coping positively associated with depression, anger and psychosomatic symptoms.
Dunkley et al. (2003)	• Self-critical perfectionism positively associated with negative affect and negatively associated with positive affect. • Self-critical perfectionism positively associated with AC. This relationship was fully mediated by self-blame, perceived efficacy and perceived criticism. • AC positively associated with negative affect indirectly through daily hassles and event stress. • Full mediation of AC on the relationship between self-critical perfectionism and negative affect. • Perceived social support fully mediated the negative association between self-critical perfectionism and positive affect.
Dunkley et al. (2000)	• Evaluative concerns positively associated with AC, daily hassles, depression and anxiety. • Daily hassles positively associated with depression and anxiety. • AC positively associated with depression and anxiety. • AC and daily hassles fully mediated positive association between evaluative concerns and depression and anxiety. • Perceived social support fully mediated the positive association between evaluative concerns and depression and anxiety.
Rice & Lapsley (2001)	• Adaptive perfectionists had significantly higher levels of problem-focussed coping than non-perfectionists. • Adaptive perfectionists had significantly less dysfunctional coping than non-perfectionists and maladaptive perfectionists. • Adaptive perfectionists and non-perfectionists had significantly higher levels of emotional adjustment than maladaptive perfectionists. • Strong direct effects between perfectionism and emotional adjustment. Coping did not significantly mediate the relationship between perfectionism and emotional adjustment.
Gnilka et al. (2012) US	• No significant difference between non-perfectionists and maladaptive perfectionists on use of CS. • Non-perfectionists and maladaptive perfectionists had higher levels of avoidant and EFC style than adaptive perfectionists. • Adaptive perfectionists had significantly lower levels of anxiety than non-perfectionists, who had significantly lower levels of anxiety than maladaptive perfectionists. • Coping did not mediate the relationship between AP and anxiety. • AC acted as a partial mediator in the relationship between MP and anxiety.

Noble et al. (2014) US	• No significant difference between non-perfectionists and maladaptive perfectionists in use of AC. • Maladaptive perfectionists had significantly higher levels of AC than adaptive perfectionists. • Maladaptive perfectionists had significantly higher levels of depression than non-perfectionists, who had significantly higher levels of depression than adaptive perfectionists. • Partial mediation of AC in the relationship between MP and depression.
Park et al. (2010) Korea	• Evaluative concerns positively associated with anxiety and depression, and avoidant and EFC coping. • AC and EFC coping positively associated with anxiety and depression. • Partial mediation of avoidant and EFC coping on the positive association between evaluative concerns and anxiety and depression. • Self-esteem partially mediated the relationship between avoidant and EFC coping and anxiety.
Zhang & Cai (2012) China	• MP positively associated with negative coping. • AP positively associated with positive coping. • Negative coping positively associated with depression. • Positive coping negatively associated with depression. • Partial mediation of negative coping on the positive relationship between MP and depression. • Partial mediation of positive coping on the negative relationship between AP and depression. • MP negatively associated with self-esteem. • Positive coping positively associated with self-esteem. • AP positively associated with self-esteem. • Partial mediation of positive coping on the negative relationship between MP and self-esteem.