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**An Internet-Delivered Cognitive Behaviour Therapy
for Clinical Perfectionism**

A thesis presented in partial fulfilment
of the requirements of the degree of
Doctor of Clinical Psychology
at Massey University, Albany,
New Zealand

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To Cam and
our little one we are about to meet,

And to Mum and Dad

Abstract

Aim

Clinical perfectionism has been associated with a number of cognitive and behavioural difficulties including work strain, procrastination, burnout, sleep disturbance, and problems with rumination, intimacy, emotional expressiveness, and assertiveness. In addition, it has been recognised as a vulnerability factor for the development and maintenance of several psychological disorders, such as eating disorders, obsessive–compulsive disorder, social anxiety, and depression. Cognitive behaviour therapy (CBT) is a well-established treatment modality that has been demonstrated to be an effective intervention for clinical perfectionism. Recently, advances have been made in terms of the online delivery of effective CBT-based interventions. This study explored whether an eight-week online, guided self-help treatment for elevated clinical perfectionism produced clinically significant reductions in perfectionism, self-criticism, stress, low mood and anxiety, and increases in self-esteem within an adult New Zealand sample.

Method

The study included mixed methods, using a case series methodology with an A-B plus follow-up design. It included both a reliable and clinically significant change (RCSC) analysis of repeated measures and a thematic analysis of module reflections and interviews completed at follow-up. Twelve participants completed weekly measures of perfectionism, mood, self-criticism and self-esteem over a four-week baseline phase and eight-week intervention, and then completed follow-up measures and an interview two months post-treatment. The intervention included eight weekly online self-help modules of CBT for clinical perfectionism (CBT-P) guided by the lead researcher. Interviews were completed individually with each participant to better understand how they experienced the treatment under investigation and changes to their clinical perfectionism and related difficulties.

Hypotheses

This study explored the hypotheses that: 1) the treatment would produce clinically significant reductions in clinical perfectionism, and 2) the treatment would also produce clinically significant reductions in low mood, anxiety, stress and self-criticism, and increases in self-esteem.

Exploratory Research Question

The study also sought to answer the question regarding how the participants experience the guided ICBT-P.

Results

RCSC was achieved in clinical perfectionism for 90% of the participants. For self-criticism and stress RCSC rates were 73% and 57%, respectively. Lower success rates were observed in the final three phenomena, with RCSC occurring in 27% of participants for self-esteem and 11% of participants for both depression and anxiety.

The analysis of qualitative data resulted in two major clusters of themes. The first cluster described the participants' experiences of the website and included four themes: 1) engagement with the treatment, 2) treatment delivery, 3) the website content, and 4) the guiding therapy. The second cluster of themes, which covered the participants' perceived outcomes of treatment, included six themes: 1) a change in thinking, 2) developing insight, 3) an increase in self-love, 4) interpersonal improvements, 5) improved productivity and 6) a work in progress.

Conclusion

This study provides initial evidence for the effectiveness of an eight-week online, guided self-help treatment for clinical perfectionism within a New Zealand sample. Participants perceived the treatment to be useful and reported experiencing a number of promising outcomes.

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List of Acronyms

CBT	Cognitive behaviour therapy
CBT-P	Cognitive behaviour therapy for clinical perfectionism
CPE	Clinical Perfectionism Examination
CPQ	Clinical Perfectionism Questionnaire
DASS21	Depression Anxiety and Stress Scale - 21
DAS-SC	Dysfunctional Attitude Scale – Self-Criticism
F2F	Face-to-face treatment
FMPS	Frost Multidimensional Perfectionism Scale
CM	Concern Over Mistakes subscale
DA	Doubt About Action subscale
PS	Personal Standards subscale
PE	Parental Expectations subscale
PC	Parental Criticism subscale
O	Organisation subscale
GSH	Guided self-help
HMPS	Hewitt Multidimensional Perfectionism Scale
SOP	Self-Oriented Perfectionism subscale
OOP	Other Oriented Perfectionism subscale
SPP	Socially Prescribed Perfectionism subscale
ICBT	Internet-delivered cognitive behaviour therapy
ICBT-P	Internet-delivered cognitive behaviour therapy for perfectionism
POSH	Pure online self-help
PSH	Pure self-help
RCI	Reliable change index
RCSC	Reliable and clinically significant change
RCT	Randomised control trial
REBT	Rational emotional behaviour therapy
RSES	Rosenberg Self-Esteem Scale
VAS	Visual analogue scale

Chapter One

Literature Review

This chapter will begin with a brief introduction and then an explanation of clinical perfectionism. It then covers alternative forms of perfectionism, followed by an explanation of why the author perceives clinical perfectionism as the preferred model. Next, a description of the evidence supporting clinical perfectionism as a transdiagnostic process is given, which highlights why it is a mental health difficulty that requires psychotherapeutic intervention. Then, evidence demonstrating cognitive behavioural therapy as the treatment of choice for clinical perfectionism is described. This is followed by a description and supporting evidence for the effectiveness and efficacy of a) self-help treatments, b) guided self-help treatments, c) Internet-delivered self-help treatments, and finally d) Internet-delivered self-help treatments for clinical perfectionism. The chapter then concludes with a rationale for the current research project.

Introduction

It seems increasingly so that in today's Western, individualistic society, those who wish to gain a spot on the sports team, place in the university programme, or promotion in the workforce need to stand out (Curran & Hill, 2017). While some may win the lottery, for most, having high standards and aiming to achieve them has become a necessity to getting ahead. Working towards a high performance in areas that are important to an individual is a normal and rewarding part of life, however for some the pressure to succeed can lead to a detrimental pursuit of excessively high standards that can cause considerable distress (Shafran, Egan, & Wade, 2010).

Commonly today, individuals pursuing high standards, be it in sporting, academic, work, or home-keeping arenas, are referred to as perfectionists. This term “perfectionist” can have both positive and negative connotations. On the one hand, it alludes to a conscientious, detail-oriented individual who will work hard to do well. On the other hand, it suggests a neurotic individual who might miss the bigger picture and work hard at the expense of self-care. The discrepancy between these two descriptions has garnered considerable interest in psychological research investigating the healthy or unhealthy pursuit of goals. Of particular interest is the latter description, which appears to be on the rise with younger generations (Curran & Hill, 2017) and can be associated with many other psychological difficulties. Some such difficulties include work strain, procrastination, burnout, sleep disturbance, rumination, and problems with intimacy and assertiveness (Egan, Wade, Shafran, & Antony, 2014a). This negative or unhealthy pursuit of high standards is often referred to as “clinical perfectionism”.

Clinical Perfectionism

While there are various understandings of perfectionism, some of which are considered to be adaptive, “clinical perfectionism” is the form of perfectionism that is deemed detrimental to an individual’s wellbeing and is observed and treated in mental health settings (Shafran, Cooper, & Fairburn, 2002). Such perfectionistic individuals are recognised for their excessive and relentless high standards, standards which seem to be pushed further into the territory of the “unreachable” whenever the individual comes close to achieving them (Hamachek, 1978). These individuals seem to aim for their goals of meeting high standards as if their self-worth depends on it, and harshly criticise themselves if they do not meet them (Shafran et al., 2002). It is theorized that this is

because he or she “sees himself as being judged by what he does, not for what he is” (Hollender, 1965, p.99). Merely meeting the standards of what others would perceive as “acceptable” or “good enough” is considered a failure in the eyes of an individual with clinical perfectionism (Shafran et al., 2010).

Shafran et al. (2002), who coined the term “clinical perfectionism”, described it as “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” (p. 778). This definition was developed to capture the essence of maladaptive perfectionism so that it could be targeted with cognitive behaviour therapy (CBT). It highlights certain necessary qualities that differentiate it from other forms of perfectionism and contribute to its detrimental nature. To begin with, according to Shafran et al. (2002), clinical perfectionism is distinguishable from the “functional pursuit of excellence” (a term they use to describe adaptive forms of perfectionism) by the continued pursuit of high standards despite experiencing adverse consequences. Another feature that this definition highlights is that while clinical perfectionism often develops within a context that promotes high standards, a fundamental quality of clinical perfectionism is that the individual adopts these standards as their own (rather than simply perceiving them as being enforced on them by others). Importantly, these demanding standards are those that are deemed challenging for the individual; it is not necessary that they be considered objectively demanding for all. Finally, critical to the relentless pursuit of high standards is a fear of failure because the individual is placing an excessive amount of their self-evaluation on meeting the standards they have set. This over-dependence of self-worth on achievement is at the crux of clinical perfectionism (Shafran et al., 2002).

It is thought that there are two core ways in which the self-evaluation process is dysfunctional in a person with clinical perfectionism. Firstly, rather than taking into account a wide range of information to evaluate one's self-worth, self-evaluation is almost solely based on the striving for and achievement of high standards. Secondly, domains of importance to the individual, such as academic, career, parenting, or sporting "success", become the focus of perfectionistic goals, and self-evaluation becomes overly, and almost exclusively, dependent on achieving in these domains (Shafran et al., 2002). Having so few domains to base one's self-worth on, and further basing it on meeting exceptionally high standards in these limited domains, results in a situation where the individual's self-evaluation is extremely vulnerable and easily eroded by perceived failure (Shafran et al., 2002).

As a result of this vulnerable self-evaluation process, individuals with clinical perfectionism often hold a negative self-perception and can be excessively self-critical (Riley & Shafran, 2005). To avoid failure, those with clinical perfectionism are argued to have a tendency towards being hypervigilant for mistakes or deficits in their performance (Shafran et al., 2002). Such individuals appear to repeatedly and strictly evaluate their performance in relevant domains. In this hypervigilant state, those with clinical perfectionism are theorised to be biased towards noticing "failures" at the expense of recognising their successes (Shafran et al., 2002). They also seem to have a tendency to develop very rigid rules and dichotomous thinking around what is considered "success" versus "failure", where anything less than "perfect" is a failure (Egan, Piek, Dyck, & Rees, 2007; Riley & Shafran, 2005). This means that opportunities to develop a positive self-image are few and far between. On the other hand, opportunities for self-criticism

are made abundant. This leads to a belief that the individual is not doing well enough and that they need to work harder and perform at a higher standard to be a “worthy” individual (Shafran et al., 2002).

According to Shafran and colleagues (2002), the fact that the individual’s standards are personally demanding in nature (rather than objectively demanding) lends itself to the biased hypervigilance towards faults where achievements are largely ignored. To prove that the individual has done well, the standards have to be personally demanding. However, if the individual is able to achieve that goal then it is reported that the individual with clinical perfectionism is likely to reassess that standard as having been insufficiently personally demanding and will discredit the achievement (Riley & Shafran, 2005; Shafran et al., 2002). Therefore, from the perspective of that individual, meeting the standard they had set provides no evidence of their ability and in turn, their self-worth. This leads to the standard being raised to one that “is” demanding. Furthermore, the extent to which a goal is personally demanding is also judged based on the extent to which the *pursuit* of the goal was demanding (Shafran et al., 2002). Thus, the individual’s performance is also evaluated on the pursuit as well as the outcomes. The individual may hold beliefs around meeting some moral standard of how hard one has to work in order to be “achieving” (Shafran et al., 2010). This means the individual may look for evidence that they are indeed working hard. It is common for those with clinical perfectionism to perceive adverse consequences of their striving as such evidence (Riley & Shafran, 2005).

There are numerous adverse consequences that those with clinical perfectionism can experience as a result of their striving for high standards. Some of the more commonly reported adverse consequences include: limited time to do leisure activities or spend time

with loved ones, social isolation, performance anxiety, low mood, stress, procrastination, insomnia, impaired concentration, and rumination (Egan, Wade, Shafran, & Antony, 2014). These adverse consequences can be perceived by the individual as evidence of striving and can therefore help to maintain the clinical perfectionism (Riley & Shafran, 2005). There are also a number of reported perceived positive consequences that act as maintaining factors, an obvious one being that perfectionism often results in achievement. Other perceived positive consequences include that it: gives structure and control, simplifies life, is socially condoned, and helps the individual avoid failure (Egan et al., 2014). Finally, receiving praise and other rewards (e.g. financial) for performing to a high standard is yet another cluster of positive consequences that act to maintain clinical perfectionism (Shafran et al., 2002). Nevertheless, these positive rewards are often only experienced in the short-term.

Beyond rewarding consequences, and in summary of what is already described above, Shafran et al. (2002) and then Shafran, Egan and Wade (2010) theorised a number of core processes that maintain clinical perfectionism. The first process is the biased evaluation of performance. This draws attention to the individual's flaws and suggests that they need to perform to an even higher standard. Typical cognitive biases contributing to this include black-and-white/dichotomous thinking, catastrophising, discounting the positive, focusing on the negative, and double standards where the individual judges themselves to harsher standards than they would judge others (Riley & Shafran, 2005). Secondly, discrediting high standards that the individual has achieved and re-appraising those standards leads to further striving. Thirdly, reacting to failure with self-criticism maintains the individual's negative self-view and prompts them to continue

striving to prove their self-worth. Fourthly, setting strict rules about how to strive and what is considered success, and then adhering to these rules inflexibly, reinforces dichotomous beliefs that the only possible outcomes available are success or failure. This also increases the biased opportunity for “failure”, which then leads to reduced self-esteem. Finally, the individual engages in avoidance and procrastination of tasks due to the fear of failure. However, this in turn actually leads to feelings of failure, because the individual is not achieving their goals, thus increasing the individual’s negative self-evaluation.

All of these theorised processes were supported in a qualitative self-report study by Riley and Shafran (2005) investigating the features and maintaining factors of clinical perfectionism. However, it should be noted that this study had a relatively small sample size with only fifteen participants judged to have clinical perfectionism. One important feature that Riley and Shafran (2005) highlighted is that although successes are often discredited, individuals with clinical perfectionism can briefly enjoy a positive emotional reaction to these achievements before reappraising the standard. This is believed to temporarily improve the individual’s self-evaluation and intermittently reinforce striving (Slade & Owens, 1998). Other maintaining factors that this study found included safety behaviours such as constant list making and performance checking, and value driven motivation for achieving (e.g. beliefs that it is morally right to put one’s best effort forward). According to the self-reports of individuals with clinical perfectionism in this study, motivation to achieve was primarily due to the fear of failure and the resulting negative self-evaluation, which supports Shafran et al.’s (2002) definition of clinical perfectionism.

A more recent qualitative study by Egan, Piek, Dyck, Rees & Hagger (2013) found support for a number of the features and maintaining factors of Shafran et al.'s (2002, 2010) model of clinical perfectionism. They compared the interview responses of clinical participants with what the authors referred to as “negative” perfectionism with responses of athletes endorsing the functional pursuit of excellence. While the clinical participants equated not meeting their standards to being a failure as a person, the athletes perceived it simply as a mistake from a fallible human being. The clinical group reported that they would often raise their standards if they succeeded or failed at meeting a standard, but the athletes reported that they would keep their standards the same or lower them if they failed. Other features that the clinical group alone reported included catastrophic cognitions about failure if they did not strive for high standards and not being a valuable person if they did not achieve.

Other studies have also found evidence to support the CBT-based model of clinical perfectionism. For example, an earlier article by Egan, Piek, Dyck, Rees (2007) reported that in their study comparing a clinical group with “negative” perfectionism to athletes with “positive” perfectionism and a control group of university students, that dichotomous thinking accounted for “negative” perfectionism at a statistically significant level in all three groups, but this was particularly true of the clinical group. Kobori, Hayakawa, and Tanno (2009) found in their experimental study that maladaptive perfectionism was related to choosing a more challenging second task after successfully completing an initial task: the more maladaptively perfectionistic an individual was the more likely they were to raise their standards after success. Thus, evidence is growing in support of Shafran et al.'s (2002, 2010) CBT model of clinical perfectionism.

Alternative Forms of Perfectionism Described in the Literature

That being said, while Shafran and colleagues (2002, 2010) provided one model of perfectionism, there are many others. The CBT definition described above is considered to be a unidimensional construct that exists on a spectrum. This means that clinical perfectionism is considered to be a continuous construct that individuals can have to varying degrees. Other commonly used continuous models of perfectionism include that described by Frost, Marten, Lahart, and Rosenblate (1990) and by Hewitt and Flett (1991). However, these researchers consider perfectionism to be multidimensional in nature. While clinical perfectionism was developed to describe a pathological process that could be targeted in therapy, the Frost et al. (1990) and Hewitt and Flett (1991) models were developed to describe a type of personality, including a wider range of potentially positive and negative qualities. These various qualities have been empirically determined through factor analysis.

Frost et al. (1990) have argued for six measurable dimensions of perfectionism, which are included in their multidimensional perfectionism scale (FMPS). These include: 1) excessive concerns over mistakes and a tendency to equate them to failure (Concern Over Mistakes: CM), 2) excessive doubts about actions or the quality of one's performance (Doubts About Actions: DA), 3) a tendency to set high personal standards (Personal Standards: PS), 4) a perception of having parents who set high expectations (Parental Expectations: PE), 5) a perception of one's parents as being excessively critical (Parental Criticism: PC), and 6) a tendency to overemphasize the importance of organisation, precision, and order (Organisation: O). These authors have suggested that not all perfectionistic individuals have all the dimensions and that certain combinations

can result in more maladaptive perfectionism versus adaptive perfectionism. They also suggest that some of the dimensions are more essential to the definition of perfectionism than others. For example, O is described as an associated feature but not necessarily a core construct of perfectionism (Frost et al., 1990).

The other prominent multidimensional model of perfectionism was introduced by Hewitt and Flett (1991). They considered perfectionism for its potential intrapersonal versus interpersonal dynamics and argue for three dimensions of perfectionism in their multidimensional perfectionism scale (HMPS). The first dimension is self-oriented perfectionism (SOP), which is a tendency to set rigid and extreme standards for oneself and to inflexibly and harshly evaluate one's behaviour. The second is other oriented perfectionism (OOP), which is a tendency to set excessively high standards for others and to inflexibly and harshly evaluate others' behaviours. The final dimension is socially prescribed perfectionism (SPP), which entails a perception that others have extreme standards for the individual, will evaluate them harshly, and put pressure on them to be perfect. While SOP is considered to be an intrapersonal dimension, OOP and SPP are considered to be interpersonal dimensions of perfectionism. Again, Hewitt and Flett (1991) argue that individuals will vary in the extent to which they are self-oriented, other oriented, or socially prescribed perfectionists. They argue that this will impact on the maladaptive severity and nature of their perfectionism, and their vulnerability for developing other Axis I and Personality Disorders. Based on this, they argue the distinction between dimensions needs to be made in the measurement of perfectionistic individuals (1991; 2003).

Alternatively, a number of researchers have defined perfectionism as a categorical construct (e.g. Bieling, Israeli, & Antony, 2004; Hamachek, 1978; Stoeber & Otto, 2006; Terry-Short, Owens, Slade, & Dewey, 1995). These researchers argue that there are two distinct categories of perfectionism, one is maladaptive/negative/unhealthy and the other is adaptive/positive/healthy. Adaptive perfectionism is described as a striving for high but realistic and flexible standards motivated by the increase in self-satisfaction and self-esteem that can accompany achievement. This category is usually associated with the PS subscale of the FMPS and the SOP subscale of the HMPS. Maladaptive perfectionism is described as a striving for extreme, rigid, and often unrealistic standards motivated by a sense of inadequacy, self-criticism, and a fear of failure (Broman-Fulks, Hill, & Green, 2008; Egan, Wade, Shafran, & Antony, 2014; Hamachek, 1978). This construct is usually measured with CM, DA, PC, and PE of the FMPS and SPP of the HMPS.

Researchers focusing on the various concepts of adaptive versus maladaptive perfectionism have contributed considerably to the body of literature focusing on the outcomes of the two forms of perfectionism. In a review of the literature focusing on categorical conceptualizations of adaptive perfectionism, Stoeber and Otto (2006) found that it was related to greater subjective wellbeing, coping styles, social adjustment, and academic motivation and achievement. Meanwhile, maladaptive perfectionism has been repeatedly associated with psychopathology and other negative outcomes such as eating disorders, obsessive-compulsive disorder, depression, anxiety, stress, suicidality, procrastination, test-taking anxiety, imposterism, work strain, and burnout (Bieling, Israeli, et al., 2004; Cokley et al., 2018; DiBartolo, Li, & Frost, 2007; Hill, Hall, &

Appleton, 2010; Kearns, Forbes, Gardiner, & Marshall, 2008; Ozbilir, Day, & Catano, 2015; Rhéaume et al., 2000; Rice, Richardson, & Clark, 2012).

While these findings are useful in helping to develop a better understanding of the possible benefits and risk factors for different forms of perfectionism, evidence to support the categorical view of the construct is minimal. Firstly, a number of studies (e.g., Enns, Cox, & Borger, 2001; Frost, Steketee, Cohn, & Griess, 1994; Norman, Davies, Nicholson, Cortese, & Malla, 1998; Sassaroli et al., 2008) have found PS and SOP to be related to Axis I disorders such as eating disorders, depression, and anxiety disorders, which undermines the assumption that these are exclusively positive forms of perfectionism (Egan, Wade, & Shafran, 2011). Secondly, researchers who have provided the evidence for the categorical view have tended to use factor analysis to demonstrate the categories. Broman-Fulks et al. (2008) argue that this form of statistical analysis can force a categorical structure that may not be meaningful upon the data.

Instead, Broman-Fulks et al. (2008) used taxometric procedures to explore perfectionism, which are better suited for investigating the categorical versus continuous latent structure of a phenomenon. In support of Egan et al.'s (2014) view, they demonstrated that perfectionism is a continual rather than categorical construct. Therefore, it seems that those researchers investigating so-called categorically distinct maladaptive and adaptive perfectionism may be simply focusing on the two extremes of the spectrum of what is actually a continual perfectionism construct. It seems that the difference between adaptive and maladaptive perfectionism is a “difference in degree rather than type of perfectionism experienced” (Broman-Fulks et al., 2008, p. 488).

Meanwhile, the debate on whether perfectionism is uni- or multi-dimensional is less conclusive and seems to depend on the researchers' intentions.

Clinical Perfectionism: The Author's Preferred Model for Clinical Purposes and for the Current Research Project

Shafran et al. (2002; 2003) have been criticised for not incorporating the interpersonal features described in other forms of perfectionism and for focusing on a unidimensional definition (e.g. Dunkley, Blankstein, Masheb, & Grilo, 2006; Hewitt et al., 2003). While Shafran et al. (2003) did acknowledge that there are other forms of perfectionism, they stated that in their conceptualisation (Shafran et al., 2002) of "clinical perfectionism" (refer to page 3 for the definition) they focused specifically on the type of maladaptive perfectionism that is frequently reported by clinicians to be seen in clinics and in need of treatment. They argued, and continue to argue (see Egan et al., 2014; Shafran et al., 2010), for a parsimonious definition of perfectionism to help encourage a focus on what appears to be the intrinsic, essential mechanisms needed to maintain the psychopathology. This parsimonious definition is necessary to promote the development of focused interventions to successfully treat the psychopathology and produce lasting change. Parsimony is a fundamental principle of Beck's CBT (see J. S. Beck, 2011). Its use has been supported by numerous efficacious CBT treatments for other psychopathologies that have been given similarly parsimonious definitions (e.g. Foa, Keane, & Friedman, 2000; Heimberg et al., 1998; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002).

Shafran et al. (2003) argued that advancements in the research of perfectionism have been stunted by researchers confusing the perfectionism construct with ways of measuring it. They highlighted that the multidimensional conceptualisations of perfectionism promoted by Hewitt and Flett (1991) and Frost et al. (1990) resulted from attempts to create measures of perfectionism for research purposes. In comparison, a stronger clinical focus was provided by Shafran and colleagues (e.g. Egan et al., 2014; Shafran et al., 2002), who are practicing clinicians and developed their model of perfectionism for the practical application of the construct in clinics. This practical application included the formulation and treatment of a clinical form of perfectionism that could interfere with the treatment of Axis I disorders. Shafran et al. (2002) did not intend to define a general personality orientation, as Hewitt and Flett (1991) had for the purpose of their broader research interests. A multidimensional model of perfectionism was not considered clinically useful (Shafran et al., 2003), because it would create too many treatment targets and undermines parsimony. In clinical practice, concise treatment targets are required. Ensuring this allows the client to focus on specific, manageable behavioural and cognitive phenomena that are maintaining difficulties. It is also important due to contemporary restraints, such as financial constraints and limited access and time available to be given to each treatment seeker.

Shafran et al. (2003) and other researchers such as Slaney, Rice, Mobley, Trippi, and Ashby (2001) also argued that researchers such as Hewitt and Flett (1991) and Frost et al. (1990) failed to distinguish between the construct of perfectionism and its antecedents, allied constructs, associated features, and potential consequences. For example, while individuals with perfectionism can have a concern over mistakes and

believe others expect high standards of them, these are related issues that can result from the underlying construct of perfectionism (Shafran et al., 2003). It seems that clinical perfectionism can still be maintained without these mechanisms and therefore, they are not essential to the definition (Egan, Wade, et al., 2014a). Likewise, the interpersonal dynamics described in Hewitt and Flett's (1991) model of perfectionism are considered by Shafran et al. (2003) to be possible but not inevitable consequences of the clinical perfectionism they described. They stated that such interpersonal processes may over time become maintaining mechanisms for some individuals, however such processes are not necessary for the maintenance of the psychopathology. Instead they referred back to the parsimonious definition of "clinical perfectionism", which qualified the intrinsic and essential features and processes of the construct. Those are the features that Shafran et al. (2003; 2002) theorised that, if targeted, could potentially reduce both the core and related psychopathologies of perfectionism.

Therefore, the continuous, unidimensional construct proposed by Shafran et al. (2002) has been considered appropriate for further research of a CBT treatment for perfectionism. Furthermore, because perfectionism is understood to be a transdiagnostic process (as explained below), targeting the purposefully defined form of perfectionism with CBT may be efficacious in reducing symptoms across a range of Axis I disorders (Egan et al., 2011).

Clinical Perfectionism as a Transdiagnostic Process and an Important Treatment

Target

In two reviews, Egan et al. (2011) and Egan et al. (2012) presented evidence to argue that perfectionism is best understood as a transdiagnostic process. Researchers have argued that this is the preferred way of describing perfectionism, as opposed to being understood as a singular disorder or associated with a specific type of disorder (Bieling, Summerfeldt, Israeli, & Antony, 2004; Egan et al., 2011, 2012; Egan et al., 2014). A transdiagnostic process is “an aspect of cognition or behaviour that may contribute to the maintenance of a psychological disorder” (Harvey, Watkins, Mansell, & Shaffran, 2004, p. 14) and contributes in this way to many different disorders. To support this view evidence demonstrating that perfectionism is: 1) elevated across many disorders, 2) a risk and maintaining factor for many disorders, 3) associated with the co-occurrence of disorders, 4) can lead to the reduction of symptoms in many disorders if targeted, and 5) can impede treatment of many disorders if not directly targeted were illustrated by Egan et al. (2011) and are described below. A limitation of this evidence is that it is not generally based on the measurement of clinical perfectionism but instead is largely drawn from research using multidimensional scales. However, there is enough cross-over in these various definitions of perfectionism to draw tentative conclusions from the evidence. Furthermore, PS, CM and SOP, which are the most strongly related subscales to the definition of clinical perfectionism (Shafran et al., 2002), have frequently been cited in the literature.

Initial evidence supporting the view that perfectionism is a transdiagnostic process can be taken from the copious correlational studies demonstrating a relationship

between perfectionism and various mental health disorders. For example, numerous studies have highlighted the relationship between perfectionism and obsessive-compulsive disorder (OCD). Specifically, it has been demonstrated that the PS and CM subscales of the FMPS and the SPP subscale of the HMPS are significantly higher in individuals with clinical OCD compared to controls (Antony, Purdon, Huta, & Swinson, 1998; Buhlmann, Etcoff, & Wilhelm, 2008; Frost & Steketee, 1997; Frost et al., 1994; Sassaroli et al., 2008). Likewise, in other anxiety disorders, CM and SPP have been demonstrated to be significantly elevated in social anxiety samples (Antony et al., 1998; Juster et al., 1996; Saboonchi, Lundh, & Öst, 1999) and again, these subscales plus PS appear to be significantly elevated in panic disorder samples compared to controls (Antony et al., 1998; Frost & Steketee, 1997; Iketani et al., 2002). There is also widespread agreement in the literature that perfectionism is elevated in individuals with eating disorders (Bardone-Cone, Sturm, Lawson, Robinson, & Smith, 2010; Bastiani, Rao, Weltzin, & Kaye, 1995; Cockell et al., 2002; Farstad, McGeown, & von Ranson, 2016; Halmi et al., 2000; Lavender et al., 2016), chronic fatigue syndrome (Deary & Chalder, 2010; White & Schweitzer, 2000), and depression (e.g., Enns et al., 2001; Hewitt & Flett, February 1991a; Huprich, Porcerelli, Keaschuk, Binienda, & Engle, 2008; Norman et al., 1998).

While the numerous aforementioned correlational studies are useful in highlighting a relationship between perfectionism and various disorders, more useful evidence is that which suggests perfectionism is an etiological or maintaining factor of these disorders. This is because such findings can then inform treatment targets (Egan et al., 2011). Support for perfectionism being understood in this manner can be taken from

prospective studies. For example, the three studies demonstrating that perfectionism has predicted the future development of depression four months later (Hewitt, Flett, & Ediger, 1996), three years later (Dunkley, Sanislow, Grilo, & McGlashan, 2006), and six years later (Dunkley, Sanislow, Grilo, & McGlashan, 2009). There are also two studies to suggest that perfectionism is elevated in bipolar disorder (Jones et al., 2005) and predicts the onset of manic and hypomanic episodes (Alloy et al., 2009). Likewise, there is research to suggest that perfectionism is a critical risk and maintaining factor of eating disorders (Bardone-Cone, 2007; Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Pauwels et al., 2018; Stice, 2002) and anxiety disorders, such as OCD (Obsessive Compulsive Cognitions Working Group, 1997; Pinto et al., 2017) and social anxiety (Ashbaugh et al., 2007; Damian, Negru-Subtirica, Stoeber, & Băban, 2017; Heimberg, Juster, Hope, & Mattia, 1995). The fact that perfectionism appears to be a risk and maintaining factor for so many different disorders suggests that it is a process common to many disorders and may indeed be a key linking factor between them.

Support for the view that perfectionism is a transdiagnostic process is increased with research demonstrating that perfectionism is associated with the co-occurrence of psychopathology. For example, Bieling, Summerfeldt, Israeli, & Antony (2004) demonstrated the link between perfectionism and comorbidity in a sample of 345 clients seeking treatment for anxiety. In this study perfectionism scores, as measured by both the HMPS and FMPS, were correlated with the number of comorbid anxiety and mood disorder diagnoses. Of particular note, their measure of negative perfectionism, referred to as Maladaptive Evaluative Concerns, which consisted of CM, PC, PE, and

SPP, predicted greater levels of comorbidity even after controlling for the participants' current symptoms. Likewise, a recent longitudinal study by Campbell, Boone, Vansteenkiste, and Soenens (2018) of 248 youths demonstrated that self-critical perfectionism (i.e., the DA and CM subscales of the FMPS) predicted the co-occurrence of depressive and eating disorder symptomology. Over a six month time frame a mean level decrease in depression was observed across the participants. However, an increase in self-criticism over the same time period correlated with a lesser decrease, as well as a co-occurring increase in eating disorder symptoms. Egan, Wade, and Shafran (2011) argue that in consideration of such evidence, perfectionism, as a transdiagnostic process, helps to explain the high rates of comorbidity between such disorders. This is because it is argued that comorbidity occurs as a result of shared maintaining mechanisms (Harvey et al., 2004).

In line with this premise, Egan, Wade, and Shafran (2011) argue that targeting perfectionism in treatment may effectively reduce symptoms in comorbid disorders, and doing so may be more effective than targeting each disorder individually. Studies such as those by Riley, Lee, Cooper, Fairburn, & Shafran (2007) and Steele and Wade (2008) have demonstrated that targeting perfectionism specifically with CBT can result in the reduction of symptoms across various Axis I disorders, without having to target the symptoms of such disorders directly. For example, the study by Steele and Wade (2008) found that CBT for bulimia nervosa and CBT for perfectionism were both effective at reducing symptoms of bulimia nervosa. However, the CBT for perfectionism was more successful at also reducing symptoms of anxiety and depression. In a recent study, Shu (2017) randomly assigned 94 healthy or sub-clinical female youths to a CBT for

perfectionism, an active control of CBT for nonspecific stress management, or a waitlist control condition. Results indicated a decrease in symptoms of perfectionism, eating disorders, depression, and anxiety, and an increase in self-esteem. Furthermore, these results were significantly larger than either of the other two conditions, which only produced small effects sizes. It appears that targeting the perfectionism in each of the studies described above helped to reduce the comorbid disorders because it was an underlying shared maintaining mechanism.

It seems it is also important to target perfectionism because it has been associated with treatment outcome across disorders (Egan et al., 2014), another line of research demonstrating it to be transdiagnostic in nature. The impact of perfectionism on treatment was demonstrated in five studies based on data from the National Institute of Mental Health Treatment of Depression Collaborative Research Programme trial (Elkin I, Shea M, Watkins JT, & et al, 1989) in which depressed participants received either CBT, interpersonal psychotherapy, or antidepressant medication. One interesting finding was that perfectionism, as measured by the Dysfunctional Attitude Scale - Self Criticism (DAS-SC; Weissman & Beck, 1978), predicted poorer treatment outcome regardless of treatment type (Blatt, Quinlan, Pilkonis, & Shea, 1995), and this was maintained at 18-month follow-up (Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998). In an adolescent sample Jacobs et al. (2009) found that perfectionism predicted poorer treatment response and, in particular, poorer improvement in suicide ideation. Eating disorders are another area of the research that has received focused attention on perfectionism and its relationship to treatment success. Again, perfectionism has been shown to predict poorer outcomes in both adults and youths (Bizeul, Sadowsky, & Rigaud, 2001; Johnston et al.,

2018; Vall & Wade, 2017). It has also been linked with higher rates of treatment dropout in clients with anorexia nervosa (Sutandar-Pinnock, Woodside, Carter, Olmsted, & Kaplan, 2003). In a study investigating CBT for social anxiety, non-responders to treatment had higher pre-treatment perfectionism scores (Lundh & Öst, 2001). Likewise Pinto, Liebowitz, Foa, and Simpson (2011) found that perfectionism predicted poorer outcomes for exposure and response prevention treatment for clinical OCD.

Based on these findings it seems that perfectionism is a transdiagnostic issue that impacts the treatment of many different disorders. Furthermore, this impact has been demonstrated on various treatment models, not just CBT. A number of issues have been proposed as to why perfectionism may impact the treatment of other disorders. Shahar, Blatt, Zuroff, Krupnick, and Sotsky (2004) found that perfectionism was related to poorer social functioning and social networks, and this in turn, predicted poorer response to treatment, which was supported by further research by Miller, Hilsenroth, and Hewitt (2017). It has also been demonstrated that perfectionism is associated with poorer therapeutic alliance (Miller et al., 2017; Van der Kaap-Deeder, Smets, & Boone, 2016; Zuroff et al., 2000), which is widely recognised as an important factor in treatment outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Krupnick et al., 1996; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). Miller, Hilsenroth, and Hewitt (2017) argued that perfectionism negatively affects clients' perceptions of their therapist's Rogerian attributes (i.e., genuine empathy, congruence, and unconditional positive regard), their bond with their therapist, and their engagement in therapy. It was proposed that negative perceptions of the therapist may be, in part, due to increased levels of projected self-criticism and hostility in individuals with perfectionism. However, on a

positive note, Miller, Hilsenroth, and Hewitt (2017) demonstrated that clients of therapists perceived to have higher than average levels of Rogerian attributes experienced greater reductions in perfectionism and depressive symptoms. Finally, engagement in therapy may be stunted by increased perceptions of stigma in individuals with perfectionism. Recently, Shannon, Goldberg, Flett, and Hewitt (2018) demonstrated in a sample of 140 university students, a positive relationship between trait perfectionism and perfectionistic self-presentation and negative beliefs about mental illness and attitudes towards help seeking.

In conclusion, these findings which highlight that perfectionism is a risk and maintaining factor for numerous disorders, is associated with the co-occurrence of such disorders, can lead to the reduction of symptoms in many different disorders when targeted, and if not targeted directly can impede treatment of other disorders, illustrates the importance of developing efficacious treatments for perfectionism. Doing so would be in line with the contemporary focus on transdiagnostic processes as a means of targeting mental health problems in a parsimonious, cost-, and time-efficient manner (e.g., Barlow et al., 2017). Moreover, perfectionism has been demonstrated to cause many difficulties for individuals in and of itself. For example, perfectionism has been associated with work strain (Ozbilir et al., 2015), self-handicapping such as procrastination in university students (Kearns et al., 2008), athlete burnout (Demirci & Çepikkurt, 2018; Hill et al., 2010), sleep disturbance (Azevedo et al., 2010), reduced self-efficacy after failure (Stoeber, Hutchfield, & Wood, 2008), suicidality (Flett, Hewitt, & Heisel, 2014; Jacobs et al., 2009), self-harm (Claes, Soenens, Vansteenkiste, & Vandereycken, 2012; O'Connor, Rasmussen, & Hawton, 2010), and problems with rumination, control,

intimacy, emotional expressiveness, and assertiveness (Hewitt, Habke, Lee-Baggle, Sherry, & Flett, 2008; Mackinnon & Sherry, 2012; Xie, Kong, Yang, & Chen, 2019). Thus, further necessitating its need for an effective and efficacious treatment.

CBT for Perfectionism

Once understood as an important transdiagnostic factor and a process in need of psychotherapeutic intervention, the next concern is discerning how best to treat it. A recent meta-analysis of all available empirical studies investigating psychological interventions to reduce perfectionism recommended the use of CBT (CBT-P; Lloyd, Schmidt, Khondoker, & Tchanturia, 2014). It should be noted, however, that at the time no empirical studies were available on any other therapeutic modality other than CBT-P. Nevertheless, Lloyd et al.'s (2014) findings supported theory suggesting biased cognitions are important in the development and maintenance of perfectionism, as Shafran et al. (2002) originally argued. The authors also argued for the transdiagnostic nature of perfectionism. They demonstrated that targeting perfectionism with CBT-P may indeed help reduce symptoms across a range of psychological disorders, as was argued by Egan et al. (2012; 2011).

A second point worth keeping in mind is that even though CBT-P is the current treatment of choice, to date there have been only a relatively small number of randomised control trials (RCTs) conducted investigating the use of CBT-P. Nevertheless, these trials have investigated CBT-P offered under a number of different formats. Such formats have included face-to-face, group, self-help, and guided self-help CBT-P, all of which have produced promising results (Handley, Egan, Kane, & Rees, 2015; Pleva & Wade, 2007;

Riley et al., 2007; Steele & Wade, 2008). Riley et al. (2007) conducted an RCT that compared ten sessions of individual, face-to-face CBT-P versus a waitlist control for individuals with elevated clinical perfectionism and comorbid depression and/or anxiety disorders. They found that CBT-P was superior to waitlist in reducing perfectionism and comorbid disorders. However, with only 20 participants, the study was underpowered. The RCT by Handley et al. (2015) examined group CBT-P in 40 participants with mixed anxiety disorders, depression and eating disorders. They demonstrated statistically significant improvements in perfectionism and symptoms of the comorbid Axis I disorders post-treatment and at 6-month follow-up compared to controls. A pilot study for a short (two lesson) group intervention for perfectionism in pre-adolescent children demonstrated a significant difference in self-oriented perfectionism-striving, hyperactivity, and emotional problems between the intervention and control group at post-intervention and four-week follow-up. A second study (Vekas & Wade, 2017) found support for these initial findings in a similar intervention for children consisting of three lessons (self-compassion content was added to the programme). However, the children were not randomly allocated to conditions, therefore the study was only quasi-experimental in design.

In another RCT, Pleva and Wade (2006) compared CBT-P given as guided self-help (GSH) versus it being given as pure self-help (PSH). Both treatment conditions produced clinically significant reductions in perfectionism. Overall, the GSH condition produced greater symptom improvement than the PSH condition. Of concern, twenty percent of PSH participants experienced clinically significant increases in symptoms of depression by post-treatment and at follow-up (compared to 0% in the GSH condition).

However, a major limitation of this study was that participants were privy to which condition they were assigned to at the baseline phase. This was associated with a significantly greater symptom improvement over the baseline, no treatment phase for the GSH group and a significantly higher dropout rate in the PSH group. Also, the authors did not report the diagnostic status of participants, therefore generalisation of results to a clinical population cannot be assumed (Egan et al., 2014). Thus, further research of guided and unguided self-help treatments for perfectionism is needed and are currently under investigation.

Self-Help Therapy

Williams and Whitfield (2001) identified several potential advantages of using self-help treatments. One simple advantage is that they are popular and acceptable to many clients. This is possibly because they are usually less costly and such treatments can allow for increased client privacy and avoidance of stigma, which clients may perceive when attending formal psychotherapy. Furthermore, self-help treatments allow clients to work in their own time and at their own pace, which also reduces therapist contact hours. They also allow clients to renew or revise treatment whenever they desire, usually at no extra cost.

Self-help is defined as “the delivery of materials that employ a media based format to treatment such as book, computer or video tape. However delivered, self-help materials aim to increase the users’ knowledge about a particular problem, and also equip them with skills to better self-manage their difficulties” (Williams, 2003, p. 173). A shortcoming of specialist face-to-face therapies is that they are usually expensive and

time-consuming and the demand for treatment greatly exceeds available resources (Perkins, Murphy, Schmidt, & Williams, 2006). To bridge this gap there is a current trend towards developing self-help or guided self-help interventions based on established efficacious psychological treatments (Andersson, 2018; Delgadillo, 2018). This is notably the case in countries such as the United Kingdom, Canada, and Australia. There, government led stepped-care programmes such as Improving Access to Psychological Therapies (IAPT) have been implemented to deliver low-intensity and self-help therapies to individuals deemed to have mental health concerns of mild severity (Clark, 2011).

Self-help books and manuals have been a popular delivery of self-help treatments over the past forty years, although recently mobile phone and Internet-delivered treatments have been gaining significant interest (Delgadillo, 2018). The “Overcoming” series (Little Brown Book Group, 2018), for example, is a series of over thirty CBT self-help books, which are recommended by the National Health Service in the United Kingdom for self-directed use and prescribed treatment (National Health Service, 2017). Evidence supporting CBT-based self-help treatments is extensive, with over fifty rigorous RCT’s completed demonstrating its efficacy, particularly for acute-phase symptoms of depression and anxiety disorders (Delgadillo, 2018). Other disorders for which self-help CBT has been demonstrated to be efficacious include insomnia (Hagatun et al., 2017), eating disorders (Agras, Fitzsimmons-Craft, & Wilfley, 2017), and obsessive-compulsive disorder (Wootton, 2016), for example.

Given the aforementioned cost- and time-saving advantages of self-help treatments, developing such treatments for transdiagnostic processes in particular, such as clinical perfectionism, could be a significant resource-saving venture for the reduction

of multiple psychopathologies simultaneously. In an RCT by Egan et al. (2014) participants were randomly assigned to face-to-face (F2F) CBT-P, pure online self-help (POSH) CBT-P, or a waitlist control group. The CBT-P treatments were based on the self-help book *Overcoming Perfectionism* by Shafran, Egan and Wade (2010). Each week the POSH group received emails instructing the participants to read a specific chapter from the book that corresponded with the material the F2F group had worked on in session. Both CBT-P treatments produced statistically significant reductions in perfectionism at the end of the treatment period, which was maintained at 6-month follow-up. The waitlist group showed no statistically significant change on any of the outcome measures. Notably, the F2F group showed statistically significant reductions in comorbid issues of anxiety, stress and depression, and a significant improvement in self-esteem, but the POSH group had no statistically significant changes on these outcomes. Furthermore, at follow-up the F2F group was statistically superior to the POSH group on two measures of perfectionism: PS and CM of the FMPS.

These results for the POSH group could be due to the lack of guidance provided by a trained therapist. Accompanying guidance is thought to be important to the online delivery of psychological interventions (Baumeister, Reichler, Munzinger, & Lin, 2014; Delgado, 2018). It has been demonstrated that guided self-help improves recovery rates of Axis I disorders over and above that of online self-help treatments without guidance (Andersson & Cuijpers, 2009). Another issue is that the POSH treatment in this study can only be minimally perceived as an online treatment. It was, in fact, a book-based treatment delivered via email. Therefore, it may be the case that a guided self-help therapy delivered via an interactive website may more effectively simulate face-to-face therapy

than email instructions to read a book chapter. This may then produce similar results to that of the F2F group in the Egan et al. (2014) study, as has been suggested by some more recent studies to be discussed shortly (Rozental et al., 2018; Rozental, Shafran, et al., 2017; Shafran et al., 2017a).

Guided Self-Help Therapy

Guided self-help therapy is that which includes regular or on-demand support in completing a self-help treatment programme, provided by a mental health professional or trained layperson. This support can be technical or therapeutic in nature, and can be provided via email, text message, phone calls, online messenger services, or video conferencing (Andersson & Titov, 2014). Depending on the mode of delivery, it is either described as synchronous (i.e., provided in real time) or asynchronous (provided with a delay between client input and therapist's response e.g. via email) (Andersson & Titov, 2014). Some researchers have even argued that automated personalised responses generated by a computer system can be considered a form of guided self-help, and that this too, may have potential (Kelders, Bohlmeijer, Pots, & van Gemert-Pijnen, 2015; e.g. Titov et al., 2013). However, the research available on such a format is minimal.

Therapeutic guidance provided by a mental health professional - or post-graduate student, as is often the case within the research literature – is the main focus of this review. However, there is some evidence to support the effectiveness of laypersons providing technical and very minimal therapeutic support under supervision of mental health professionals (Titov, Andrews, Davies, et al., 2010). However, this raises some ethical

concerns regarding the safety of clients, particularly if they experience an increase in their distress (Andersson, 2016).

To date, there are no clinical guidelines available for the delivery of therapeutic guidance. However, common tasks of a guiding therapist described in the literature include: completing an assessment for diagnosis and the development of a formulation; monitoring client progress; providing encouragement, warmth, and concern; answering clients' questions and checking understanding; providing personalised feedback on tasks completed in the recent module, such as thought challenging diaries and behavioural experiments; helping clients design personalised tasks such as behavioural experiments; and sending prompts to complete modules (Andersson & Titov, 2014; Hadjistavropoulos et al., 2017; Holländare et al., 2016; Kothari, Egan, Wade, Andersson, & Shafran, 2016). Holländare et al., (2016) suggested that guiding therapists do less teaching than traditional face-to-face therapists because the psychoeducation is embedded in the self-help modules. Therefore, the onus for acquiring theoretical knowledge is placed on the client, who achieves this through reading, watching, or listening to the self-help material. In general, it appears that therapists spend approximately fifteen minutes a week on each client, and if this guidance is text-based, this translates to approximately two paragraphs in length (Andersson, 2016; Hadjistavropoulos et al., 2017; Kothari et al., 2016).

A potential benefit of asynchronous support is that there is less administration required, as there is no need to schedule appointments. Also, therapists have more time to consider their responses and can seek supervision before responding, if needed (Andersson, 2016). However, asynchronous support, which usually comes in the form of emails or text messages, does provide greater opportunity for misunderstanding and

negative reactions on the part of the client. Furthermore, these can be harder for the therapist to detect and respond to quickly, in order to avoid ruptures in alliance (Andersson, 2016). Synchronous support, on the other hand, allows for clearer expression of the therapist's tone and greater recognition of the above concerns through facial expressions and voice intonations. However, there is some opportunity to imply emotional tone in asynchronous support emails or text messages through the application of capital letters, bolding, and the use of symbols (Holländare et al., 2016).

A number of meta-analyses now exist, mostly for Internet-delivered therapies, demonstrating that the addition of guidance to self-help therapies results in significantly greater and more sustained symptom improvement than self-help therapies delivered alone (e.g., Andersson & Cuijpers, 2009; Baumeister et al., 2014; Palmqvist, Carlbring, & Andersson, 2007; Richards & Richardson, 2012; Spek et al., 2007). Further to this, one systematic review of thirty-three controlled trials of Internet-delivered self-help therapies for depression found a positive linear relationship between degree of clinician contact provided and treatment outcomes (Johansson & Andersson, 2012). The between-group Cohen's *d* effect size was $d = 0.21$ when no therapist contact was provided, $d = 0.44$ when therapists only made contact before treatment for assessment purposes, $d = 0.58$ when therapists contacted participants during treatment only, and $d = 0.76$ when therapists made contact with participants both prior to and during the treatment.

In line with these findings, a qualitative study (Beattie, Shaw, Kaur, & Kessler, 2009) of an Internet-delivered treatment for depression reported that many participants highlighted the guiding therapy as an important and appreciated element of the intervention for them. It seems also, that including a guiding therapist leads to reduced

drop-out rates compared to unguided self-help, which too frequently appears to be afflicted by high drop-out rates (Christensen, Griffiths, & Farrer, 2009). Moreover, it has been argued that when guidance is included, the therapist can recognise when further support is needed for a client and facilitate access to other services, such as social services, health services, and crisis teams (Andersson & Titov, 2014).

Two recent, mixed methods studies have explored what therapist behaviours specifically have positive effects on the outcomes of guided CBT self-help therapies. The first study (Paxling et al., 2013) examined an Internet-delivered self-help therapy for generalised anxiety disorder, which included three guiding therapists sending a total of 490 emails to forty-four clients. A content analysis highlighted eight key behaviours: deadline flexibility, task reinforcement, alliance bolstering, task prompting, psychoeducation, self-disclosure, self-efficacy shaping, and empathetic utterances. Of those behaviours, a positive correlation was found between module completion and reinforcement, task prompting, self-efficacy shaping, and empathetic utterances. Whereas, only task reinforcement had a positive correlation with outcome and deadline flexibility had a negative correlation, as measured by changes on the Penn State Worry Questionnaire.

The second study (Holländare et al., 2016) examined an Internet-delivered self-help therapy for symptoms of depression and used similar methods. In this study 664 emails sent from five therapists to forty-two clients were analysed for the therapists' behaviours. Through content analysis, nine behaviours were recognised. Providing encouragement was the most frequent behaviour (31.5%), followed by affirming statements (25.1%), CBT theory-based guidance (22.2%), and urging (9.8%). Then, to a

lesser extent, therapists clarified the Internet treatment framework (5.9%), informed about module content (3.4%), made self-disclosures (0.9%), emphasised the importance of patient responsibility (0.7%), and confronted patients (0.4%). Completion of modules was strongly correlated with affirming, encouraging and guiding. Module completion also had significant, yet weaker correlations with therapist self-disclosure, clarifying the framework, and emphasising patient responsibility. Affirming, encouraging, and self-disclosure positively correlated with outcome at post-treatment (measured with the self-rating version of the Montgomery–Åsberg Depression Rating Scale; MADRS-S), while affirming was the only behaviour that positively correlated with outcome at the two-year follow-up.

In both these studies, it should be noted that the findings are simply correlational. It could be the case, for instance, that those participants who promptly completed the modules were better liked by their therapists, and as such received more encouragement, affirmations, and even self-disclosures from their therapist. Together, these studies only reflect the behaviours of eight therapists within two self-help protocols. Furthermore, some of the authors were involved with both of the studies. Therefore, more research is required to make any substantiated claims for generalisability.

Meta-analyses have now also been completed to compare guided Internet-delivered therapies with face-to-face treatment. Andersson, Cuijpers, Carlbring, Riper, and Hedman completed their first meta-analysis of guided Internet-delivered CBT (ICBT) in 2014 (see Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014), this was recently followed up by the same team (Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlöf, 2018) with an updated meta-analysis. Consistent with the first study,

the second study found that in the case of social anxiety disorder, panic disorder, depressive symptoms, body dissatisfaction, insomnia, tinnitus, male sexual dysfunction, spider phobia, snake phobia, and fibromyalgia, both CBT delivery formats were equally as effective.

Of the original 2078 articles screened, the authors found 20 studies that met their inclusion criteria. Those included were RCTs that compared therapist-guided ICBT to a full-length face-to-face treatment for a psychiatric or somatic disorder in adults. Their results demonstrated a pooled effect size at post-treatment of Hedges $g = .05$ (95% CI, $-.09$ to $.20$), thus indicating equivalence. Furthermore, there was no relationship found between drop-out rates and either delivery format. An overall drop-out rate of 15.7% across studies was demonstrated, which matched a recent meta-analysis of face-to-face treatment of major depression (Cooper & Conklin, 2015).

Nevertheless, only ICBT treatments were included, thus no commentary can be made on other guided self-help delivery formats or treatment modalities. Secondly, the studies of spider and snake phobias did show favour for face-to-face treatment, but due to the studies' small sample sizes the findings were non-significant. Therefore, it may be that phobias are still better treated by face-to-face treatment. Also, studies were included whether they used individual or group face-to-face treatments. It may be the case that group treatments are inferior to individual face-to-face treatments, particularly in regards to client preferences, and this may have impacted the results of the meta-analysis (Carlbring et al., 2018). Finally, only the primary outcome measures within each study were analysed. It could still be the case that face-to-face treatments are better at targeting comorbid disorders and accompanying transdiagnostic issues.

Internet-Delivered Self-Help Therapies

Throughout the literature, there exists a wide variation within what has been referred to as an Internet-delivered therapy. This has included client-therapist videoconferencing, book chapters received via email, and multi-page interactive websites, amongst other variations. Within this review, Internet-delivered therapy will largely refer to interactive website-based treatments, unless stated otherwise. A further differentiating factor is whether the Internet-delivered therapy is intended to treat a mental health problem or prevent its development. Thirdly, as discussed above, the treatments can either be guided or unguided.

Barak and colleagues (2009), provided the following definition: “A web-based intervention is a primarily self-guided intervention program that is executed by means of a prescriptive online program operated through a website and used by consumers seeking health- and mental-health related assistance. The intervention program itself attempts to create positive change and or improve/enhance knowledge, awareness, and understanding via the provision of sound health-related material and use of interactive web-based components” (p. 5).

Some advantages of Internet-delivered therapies, beyond those which have already been described for self-help therapies more generally, include: increased accessibility because clients can connect to the therapy wherever they are, provided they have a computer, smart phone, or tablet; improved communication between therapist and client compared to some other self-help therapies; and the relative ease of making cross-cultural adaptations to how material is presented in different countries (Shafran et al.,

2017a; Wallin, Mattsson, & Olsson, 2016). Potential disadvantages include: ethical and risk-related concerns due to increased anonymity; impoverished therapist-client communication compared to face-to-face treatment; computer literacy requirements; and concerns about confidentiality and data security (Wallin et al., 2016).

While most studies have been on ICBT, there are also a growing number of studies on Internet programmes based on other psychotherapeutic orientations, such as psychodynamic (e.g., Johansson et al., 2017), Acceptance and Commitment Therapy (ACT; e.g., Dahlin et al., 2016; Pots et al., 2016; Strandskov et al., 2017), mindfulness (e.g., Hearn, Cotter, & Finlay, 2018; Messer, Horan, Turner, & Weber, 2016), positive psychology (e.g., Peters et al., 2017), and interpersonal therapies (e.g., Dagöo et al., 2014). The first studies of ICBT, which included email-delivered treatments, were conducted in the 1990s (Andersson, Carlbring, & Lindefors, 2016). Since then efficacious ICBT website treatments have been developed for a number of psychiatric or somatic disorders, such as mood and anxiety disorders and tinnitus, and confounding mental health issues, such as procrastination (see Andersson & Titov, 2014; Andersson et al., 2016; Carlbring et al., 2018; Rozental, Forsell, Svensson, Andersson, & Carlbring, 2017).

Access to an ICBT usually requires an initial diagnostic screening to match the appropriate treatment programme to the client. As well as this, it is used to assess severity of issues such as suicide ideation, which may lead to a recommendation for face-to-face treatment (Carlbring et al., 2018). It is recommended that clients first meet the clinician face-to-face for these initial assessments, as evidence does not currently support self-assessment via the Internet or otherwise (Andersson & Titov, 2014). This means that some of the benefits of Internet-delivered therapies are lost (Andersson & Titov, 2014),

such as requiring a scheduled appointment, more of the clinician's time, and travel issues for the client. To overcome this to some extent, a number of studies have opted for assessments completed via phone calls (e.g., Rozental, Forsell, et al., 2017), nevertheless face-to-face is still considered the gold standard.

Within ICBT, clients must login to a secure website – usually once a week - to access online therapeutic material organised into set modules (Andersson & Titov, 2014). Efforts have been made to ensure ICBTs reflect face-to-face treatments as closely as possible (Andersson et al., 2014). Treatments tend to be between six and fifteen modules long. A module is a text-based chapter that corresponds with a face-to-face session described in treatment manuals, and includes interactive elements such as video clips, audio files, and embedded worksheets where clients can record their responses (Andersson et al., 2014). As expected of all delivery formats of CBT (see J. S. Beck, 2011), the treatment aims to integrate the client's learning into their day-to-day lives through the use of tasks such as thought records, surveys, and behavioural experiments, which are incorporated into each module (Kothari et al., 2016). Specific between-session tasks (A.K.A homework) are usually set (Andersson et al., 2014), as this is also an expected CBT practice to encourage the transference of new knowledge gained in treatment into the client's lived life (J. S. Beck, 2011). Other CBT elements included in modules are psychoeducation and various means for assisting cognitive restructuring and relapse prevention (Andersson et al., 2014).

In the case of guided ICBT, a clinician reviews worksheets and other tasks completed by the client (Andersson & Titov, 2014). They then provide individualised feedback, clarifications, and suggestions as needed. Communication between clinician

and client usually occurs via email, however within some ICBTs there is facility to exchange messages directly through the website (Kothari et al., 2016). For example, there may be imbedded text boxes at the end of modules, eliciting client feedback or providing opportunity for them to ask questions. This, again, follows recommended practices for face-to-face CBT (J. S. Beck, 2011). Clients may also be required to complete intermittent computer administered questionnaires and standardized scales, which allows clinicians to monitor progress and intervene if safety concerns arise (Andersson & Titov, 2014).

Notably, participants' ratings of therapeutic alliance have tended to be high in studies of ICBT programmes; as high or even higher than reported ratings in traditional face-to-face therapies (Berger, 2017; Pihlaja et al., 2018; Sucala et al., 2012). Therapeutic alliance refers to "the positive emotional bond between therapist and client, and their mutual agreement on the goals and tasks of the treatment" (Pihlaja et al., 2018, p. 2). Nevertheless, it has been suggested that therapeutic alliance can develop between the client and the ICBT programme itself (Cavanagh, 2010; Kate Cavanagh & Millings, 2013; Pihlaja et al., 2018). Barazzone and colleagues (2012) argued that relational features exist within these programmes as the text itself can convey warmth, understanding, and empathy. Therefore, it could be that the proposed client-programme alliance may be being confounded with the client-therapist alliance in some studies (Pihlaja et al., 2018).

Therapeutic alliance is widely accepted as an important element of therapy that contributes significantly to treatment outcomes (Krupnick et al., 1996). Nevertheless, there is disagreement amongst the literature as to whether therapeutic alliance predicts

outcomes in guided ICBT (see Andersson & Titov, 2014). However, a recent meta-analysis by Pihlaja and colleagues (2018) argued that it does.

Following a thorough search, Pihlaja and colleagues (2018) found only six published RCTs of adults receiving a guided ICBT for a mental health disorder that investigated the relationship between therapeutic alliance and treatment outcomes. A positive, significant relationship between alliance and outcome was found in the three most recent studies (Andersson et al., 2015; Bergman Nordgren, Carlbring, Linna, & Andersson, 2013; Herbst et al., 2016). However, in the Herbst et al. (2016) study alliance was only measured at treatment end. Therefore, the results cannot suggest alliance was a predictor of outcome, because it could be that the positive outcome increased feelings of alliance in the participants. A positive, non-significant relationship was found within the other three studies (see Andersson et al., 2012). Pihlaja and colleagues (2018) argued that the non-significant results were possibly due to a methodological issue, since all three studies were completed by the same research team. Furthermore, the three latter trials may have achieved a significant, positive relationship because they had prolonged therapist contact time, which may have strengthened the alliance, and thus the alliance-outcome association.

Three issues for generalisation were highlighted in the limitations of this meta-analysis (Pihlaja et al., 2018). Firstly, it is reasonable to presume that a similar type of ICBT was delivered by the included studies, as most of them were completed by the same Swedish research group. Secondly, only ICBTs for depression or anxiety disorders were investigated amongst the six RCTs. Thirdly, participants throughout the studies were mostly self-referred, therefore the studies do not adequately reflect a clinic setting.

Another issue is that all six studies used the Working Alliance Inventory (WAI; Bordin, 1979), which is a measure of the client-therapist alliance. There is yet no scale available to differentiate between this form of alliance and the potential client-programme alliance factor.

As discussed earlier, a recent meta-analysis (Carlbring et al., 2018) demonstrated guided ICBT for an array of psychiatric and somatic disorders to be as effective as face-to-face treatment. There is also growing research to support maintained positive treatment effects up to five years post treatment (Carlbring, Nordgren, Furmark, & Andersson, 2009; Hedman et al., 2011). Additionally, it appears that deterioration rates unguided ICBTs for depression (5.8%; Karyotaki et al., 2018) are significantly lower than that of control groups (9.1%). Similarly, a recent meta-analysis of mostly guided ICBTs of various mental health disorders reported deterioration rates on primary measures (5.8%; Rozental, Magnusson, Boettcher, Andersson, & Carlbring, 2017) that were much lower than that of control groups (17.4%). The results of both these studies demonstrate consistency with face-to-face treatment (5-10%; Hansen, Lambert, & Forman, 2002).

Although these findings are promising, it is worth also bearing in mind the potential negative effects of ICBTs. Rozental, Boettcher, Andersson, Schmidt, and Carlbring (2015) completed a qualitative content analysis of four clinical trials of ICBT (both guided and unguided) for 558 participants with social anxiety disorder, panic disorder, major depressive disorder, or chronic and severe procrastination. Fifty-two participants (9.3%) reported experiencing at least one adverse effect of their treatment. Amongst those individuals, they reported: 1) participant-related negative effects, comprising of a) adverse emotional and psychological responses to increased awareness

of their condition, and b) further deterioration or the emergence of new symptoms following this increased insight or related to troubles with completing the treatment, and 2) treatment related negative effects, which included c) difficulties with adhering to the treatment and completing tasks, and d) difficulties with the online format, including time pressure, lack of flexibility, and lack of/perceived inadequate therapist guidance or communication. The authors highlighted that these findings did not reflect treatment outcomes. Many of the adverse patient-related effects were not enduring nor necessarily problematic, for example, experiencing anxiety related to an exposure task. In fact, a number of participants described their adverse experiences as meaningful to them in the long run.

Also of note, in spite of the previously discussed overwhelmingly positive findings for ICBTs, research evidence overall suggests that both treatment-seeking and non-treatment-seeking clients prefer face-to-face therapy (Berle et al., 2015; Gun, Titov, & Andrews, 2011; Klein & Cook, 2010; Tarrier, Liversidge, & Gregg, 2006) and perceptions of ICBT amongst those who have not used it tend to be negative (Carper, McHugh, & Barlow, 2013). Reported concerns include issues with confidentiality and data security (Klein & Cook, 2010), and that face-to-face treatments will better meet treatment needs such as perceived helpfulness and credibility (Musiat, Goldstone, & Tarrier, 2014).

In comparison, a recent two-part study reported a majority of their participants indicated a favourable perception and interest in accessing an ICBT for depression or anxiety (Soucy, Owens, Hadjistavropoulos, Dirkse, & Dear, 2016). This supported findings of an earlier study by Wootton and colleagues (2011). It could be that the

recruitment of the participants of these studies, which occurred via the Internet, led to a biased selection of individuals who held positive perceptions of the Internet and possibly, Internet-delivered treatments. However, it could also be that familiarity and knowledge of such treatments are slowly improving amongst the general population (Soucy et al., 2016). Given the relative newness of Internet-delivered therapies, it seems reasonable to presume that as evidence supporting the efficacy of ICBT grows, so too will clients' favourable perceptions (Soucy et al., 2016). However, this is yet to be supported by the literature, and more research is needed regarding what could lead to more preferable perceptions.

ICBTs for Clinical Perfectionism.

An ICBT for clinical perfectionism (ICBT-P) may be particularly useful because, given it is not a diagnostic disorder and is a relatively new transdiagnostic concept, there are comparatively few therapists available who are trained in the face-to-face CBT protocol (Shafran et al., 2017a). Furthermore, as previously mentioned, targeting a transdiagnostic issue such as clinical perfectionism seems to be effective in reducing symptoms of other comorbid disorders. Which again, could result in reduced burden on already strained health-care systems because more people would be able to receive easy to access and affordable, efficacious treatments that target multiple issues.

Four studies with small sample sizes (Arpin-Cribbie, Irvine, & Ritvo, 2012; Egan et al., 2014; Radhu, Daskalakis, Arpin-Cribbie, Irvine, & Ritvo, 2012; Valentine et al., 2018) provided initial evidence to support the efficacy and effectiveness of ICBT-Ps. However, the delivery formats of these studies appear to be early attempts at Internet-

delivered therapies, not true ICBTs with interactive websites, as described in this review. The Radhu et al. (2012) study did not describe how their treatment was delivered, but referred to it as a “web-based” treatment non-the-less. The Arpin-Cribbie, et al. (2012) study appears to have been a series of PDFs made accessible online. Finally, the Egan et al. (2014) study was discussed earlier in this review and consisted of emailed book chapters, as was the more recent study by Valentine and colleagues (2018). All four treatments were unguided. The results of these studies, nevertheless, provided some early indication that an ICBT-P can reduce clinical perfectionism, as well as depression, anxiety, and compulsive exercise.

Arpin-Cribbie and colleagues (2012) and Radhu and colleagues (2012) veered away from the usual Beckian CBT protocols provided in ICBTs. Their protocols were informed by the work of Albert Ellis (see Ellis, 2002), who developed a variation of CBT called rational emotive behaviour therapy (REBT). In both cases, a specific order for completing the treatment modules was suggested to the participants but they were given freedom to complete them in any order they preferred. Arpin-Cribbie and colleagues (2012) stated that they did not have a means of tracking adherence to module completion, as they only took pre- and post-treatment measures. It seems this may have also been the case for Radhu and colleagues (2012). Importantly, in both studies the control groups also demonstrated significant reductions in some measures of perfectionism post-treatment. Therefore, the results of these two studies should be interpreted with caution.

Furthermore, in the case of the Arpin-Cribbie et al. (2012) study, statistically significant reductions in perfectionism were demonstrated by the ICBT group, but only minimal clinically significant reductions were observed. The authors used Jacobson and

Truax's (1991) methods for assessing reliable and clinically significance change (RCSC). Only one time-point for the baseline was measured for their calculations. Given each participant acts as their own control in this method of assessment, a single baseline measure cannot demonstrate baseline stability (Barlow, Nock, & Hersen, 2009; Kazdin, 2011) and thus, does not provide an adequate control. Therefore, again, conclusions about treatment effectiveness should be viewed with caution, even if they appeared to be minimal in this case.

Aside from the Arpin-Cribbie et al. (2012) and Radhu et al. (2012) studies, most ICBT-Ps have been based on the treatment protocol provided by Egan and colleagues (2014). In general, these treatments include approximately eight modules incorporating psychoeducation about CBT and clinical perfectionism, developing a personalised maintenance model, and exercises to target issues such as maladaptive beliefs, rigid thinking styles, procrastination and other unhelpful behaviours, increasing self-compassion, and relapse prevention. Exercises include, for example: cost-benefit analyses, thought records, behavioral experiments, continuums, graded exposure, surveys, problem-solving skills, values clarification, positive data logs, cue cards, and goals development.

Very recently, two RCTs have investigated guided ICBT-Ps delivered as interactive website treatments (Rozenal, Shafran, et al., 2017; Shafran et al., 2017a). The first study (Rozenal, Shafran, et al., 2017) was completed in Sweden. In this study, 156 adult participants (18 years plus) were randomised to either an eight-week guided ICBT-P intervention (n = 78) or a waitlist control condition (n = 78). Participants were included if they were fluent in Swedish and their primary concern was perfectionism. However,

meeting cut-off scores for perfectionism was not required. Using intent-to-treat statistical analysis, the study explored the effects of the treatment on perfectionism, depression, anxiety, self-criticism, self-compassion, and quality of life. To achieve this, the FMPS, Clinical Perfectionism Questionnaire (CPQ; Egan et al., 2015), Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002), Generalised Anxiety Disorder – 7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006), Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978), Self-Compassion Scale – Short Form (SCS-SF; Raes, Pommier, Neff, & Gucht, 2011), and Brunnsvikien Brief Quality of Life Scale (BBQ; Lindner et al., 2016) were used.

Within the ICBT-P, the treatment modules were provided in the following order: 1) understanding perfectionism, 2) a personalised model, values, and motivation, 3) surveys and experiments, 4) dealing with perfectionistic behaviors, 5) new ways of thinking, 6) self-criticism or self-compassion, 7) self-worth, and 8) maintaining and continuing positive change. Participants were given their module each Monday, regardless of whether they had completed their last one, and were expected to complete this by Thursday and their homework by Sunday. The guiding therapists were six supervised clinical psychology master's degree students, with at least one and a half years of CBT training. On average, these therapists spent seventeen minutes a week on each participant.

For the primary perfectionism measures, the FMPS subscales of Concerns over Mistakes and Personal Standards, moderate to large between-group effect sizes were demonstrated, Cohen's $d = 0.68-1.00$, 95% Confidence Interval (CI; 0.36-1.33). In fact, significant between-group effect sizes were obtained on all of the primary and secondary

outcome measures, except for the FMPS Parental Expectations and Parental Criticism subscales. Furthermore, using Jacobson and Truax's (1991) methods, RCSC was assessed for the FMPS-CM. This was achieved for thirty-five (44.9%) of the participants in the intervention condition, compared to nine (11.5%) in the waitlist group. This is comparable to ICBTs for anxiety disorders at 46% (Nordgren et al., 2014), and response rates reported for anxiety disorders in face-to-face CBT, which have achieved within 43.3% to 52.7% (Loerinc et al., 2015).

It should be noted however, that the individuals were not required to be above a clinical cut-off score for perfectionism to participate in the study. This resulted in 18.6% of participants being below the calculated cut-off score (<29) on the FMPS-CM at pre-treatment. Therefore, it could be that perfectionism severity levels were not particularly high amongst the sample to begin with. Furthermore, the education level amongst the participants was high, with all participants having at least a university degree, and further to this, 86.5% of participants were women. The authors reported that this is higher than other recent studies of ICBTs. They argued that this skewness in the recruitment may be due to women and higher educated individuals potentially identifying themselves as perfectionists more readily.

The second study (Shafran et al., 2017a) of a guided ICBT-P delivered as interactive website treatment was completed in the United Kingdom. In this study, 120 adult participants were randomised to either an eight-week guided ICBT-P intervention (n = 62) or a waitlist control condition (n = 58). Participants were included if they scored one standard deviation above published norms on the FMPS-CM (<29; Suddarth & Slaney, 2001), were fluent in English, and agreed to be randomised. Unlike the Swedish

study, participants were not excluded if they were currently receiving treatment for another mental health disorder. Again, using intent-to-treat statistical analysis, the study explored the effects of the treatment on perfectionism and negative affect (a combination of depression, anxiety, and stress). They used the FMPS and CPQ to measure perfectionism, and the Depression, Anxiety, and Stress Scale – 21 (DASS21; Lovibond & Lovibond, 1995b) to measure the combined negative affect variable.

While the Swedish study included a preliminary assessment interview over the telephone, the UK study did not. Also, after completing the baseline measures, participants were automatically randomised to one of the two conditions without explicitly seeking confirmation that they still wanted to participate. Furthermore, participants began taking part in the study as soon as they completed the screening measure, rather than waiting to begin altogether. There were differences in the treatment and guided therapy delivery from the Swedish study, too. The modules were delivered in a slightly different order (see Shafran et al., 2017a) and contained less explanation and fewer behavioural experiments. Also, the participants were given twelve weeks to complete the eight modules and the guiding therapists did not send their feedback on specifically scheduled days, because all guidance had to be approved by a supervisor first (Shafran et al., 2017a). Details of the guiding therapists were not provided, however guidance was based on the same manual as the Swedish study (i.e., Egan et al., 2014) and a range of sample responses for each module were initially provided to each guiding therapist for training purposes (Kothari et al., 2016).

Of note, 49% of participants ($n = 47$) did not complete the post-treatment measures, resulting in significant non-completion for the intervention condition (50%)

compared to waitlist controls (28%). Nevertheless, using the intent-to-treat analysis, significant between group differences at treatment end were demonstrated for the primary outcome measure FMPS-CM ($d = 0.98$, 95% CI [0.60-1.36]) and for the CPQ ($d = 1.04$, 95% CI [0.66-1.43]) in favour of the intervention group. No significant difference was found for the total DASS21 score or any of the DASS21 subscales. In review of module completion, it was found that the number of modules completed moderated the rate of change in clinical perfectionism (as measured by the CPQ) over time, with a minimum of three modules completed resulting in a significant decrease in CPQ scores. A greater number of modules completed was related to an overall lower mean CPQ score ($M = 26.34$, $SE = 1.11$) compared to fewer modules completed ($M = 29.14$, $SE = 0.86$).

Again, using Jacobson and Truax's (1991) methods, RCSC was assessed for the FMPS-CM. RCSC was attained by 31 (50%) of participants in the intervention group compared to 6 (10%) of wait-list controls. This equates to over an eight-fold likelihood of achieving recovery following treatment compared to being on the waitlist, ($OR = 8.67$, 95% CI [3.25-23.11]). Moreover, deterioration on the FMPS-CM occurred for only one participant in the intervention condition, compared to eight in the waitlist group ($OR = 8.55$, 95% CI [1.03-70.50]). However, both this study and the Rozental et al. (2017) study had only one time-point representing baseline for the RCSC analysis. As previously explained, this means conclusions about treatment effectiveness should be viewed with caution.

A major limitation of the above study, as noted by the authors (Shafran et al., 2017a), was the considerable non-engagement and non-completion of modules, with 71% completing less than half of the modules. Furthermore, weekly measures of the CPQ fell

from a completion rate of 74% in the first week to only 18% at the final time point. This attrition rate means the intent-to-treat results should also be interpreted with caution, as the use of multiple imputation (MI) and restricted maximum likelihood (REML) to estimate missing data may have resulted in the overestimation of treatment efficacy (Shafran et al., 2017a). Nevertheless, the significant between group differences remained for the FMPS-CM and CPQ when data of completers alone were analysed.

Shafran and colleagues (2017a) did attempt to provide possible explanations for the high attrition rate observed in their study. Firstly, it was acknowledged that meeting the guiding therapist, or at least having a telephone interview with them, may have increased the participants' sense of therapeutic alliance with the therapist and commitment to completing the treatment. Likewise, confirming participants still wished to participate before randomisation may have increased retention. The authors also noted that anecdotal evidence from the guiding therapists suggested that the participants experienced the behavioural experiments in Module Four as particularly challenging. They argued that "there was a sense in this study that the 'all or nothing' thinking characterising perfectionism made the behavioural task particularly difficult to implement and led to an increase in attrition rates" (Shafran et al., 2017a, p. 105). Finally, it was suggested that the requirement to complete the weekly CPQ measure may have been a deterrent for some participants who had busy lives and chose to partake in an ICBT rather than a face-to-face treatment for this reason.

Promisingly nonetheless, positive large effects of the intervention on perfectionism were demonstrated for both studies of ICBT-P's at treatment end. These findings were comparable with effect sizes reported in the Lloyd et al (2014) meta-

analyses, which was described earlier in this review and investigated CBT for perfectionism more generally. Furthermore, a recent study (Rozenal et al., 2018) reported encouraging findings for the outcome measures at follow-up for both these studies. Follow-up data was collected at 6 months post-treatment for the UK study and at 12 months post-treatment for the Swedish study.

No significant difference in attrition rates was found between the two studies, with 49% completion for the Swedish study and 57% for the UK study. Attrition was defined as the number of participants initially randomly assigned to a condition who did not complete the final follow-up measures. On the other hand, analysis of adherence, defined as number of modules completed, did show a significant difference between the two studies. Participants of the Swedish study completed significantly more modules, with a mean difference between the two studies at 3.14 modules. ($d = 0.98$, 95% CI [0.60-1.36]).

For further analysis of follow-up data, both intent-to-treat and completer analysis was used. In regards to intention-to-treat analysis, significant large within-group effect sizes for the FMPS-CM were demonstrated for the Swedish study ($d = 1.21$, 95% CI [0.86-1.54]) and the UK study ($d = 1.24$, 95% CI [0.85-1.62]) at follow-up. This was also the case for the CPQ (Swedish study; $d = 1.32$, 95% CI [0.97-1.66], and the UK study; $d = 1.49$, 95% CI [1.09-1.88]). Furthermore, on the FMPS-CM, RCSC was achieved for 29 (59%) of the participants in the Swedish study and 15 (43%) of the participants in the UK study. Significant moderate effects sizes were found for all other secondary measures. For the Swedish study this included the PHQ-9 ($d = 0.60$, 95% CI [0.28-0.92]) and GAD-7 ($d = 0.67$, 95% CI [0.34-0.99]), and for the UK study this included the DASS21 ($d =$

0.50, 95% CI [0.13-0.85]). Completer analysis provided comparable results, if not more favourable (see Rozental et al., 2018).

Again, the follow-up results for these two studies may have been inflated by the high attrition rates observed. Further research is also required to support the cut-off score calculated for the FMPS-CM (<29) as sensitive enough for determining clinically significant change (Rozental et al., 2018). Nevertheless, this study, along with the Rozental et al. (2017) and Shafran et al. (2017a) studies, provides compelling evidence that a guided ICBT-P can reduce clinical perfectionism, depression and anxiety.

Rationale for the Current Study

In conclusion, perfectionism is a growing mental health problem (Curran & Hill, 2017), which requires therapeutic intervention. The most useful model for conceptualising perfectionism for clinical purposes is the CBT model of clinical perfectionism, originally described by Shafran and colleagues (2002). This model now has a strong evidence base supporting it (e.g., Egan et al., 2007, 2013; Lloyd et al., 2014; Riley & Shafran, 2005). Following CBT guiding principles, the definition of clinical perfectionism is parsimonious in nature. Thus, the definition provides clear and limited treatment targets, which is a necessity for working within contemporary clinical restraints. Furthermore, it is argued that by targeting the maintaining mechanisms within the unidimensional model of clinical perfectionism, secondary processes and difficulties described in the FMPS and HMPS multidimensional models can also be reduced (Egan et al., 2014).

There is now a large and growing pool of literature demonstrating that perfectionism is a transdiagnostic process (Egan et al., 2011). The evidence available highlights that perfectionism is 1) elevated across many disorders, 2) a risk and maintaining factor for many disorders, 3) associated with the co-occurrence of disorders, 4) can lead to the reduction of symptoms in many disorders if targeted, and 5) can impede treatment of many disorders if not directly targeted. These lines of evidence support the need for the development of effective and efficacious treatments for clinical perfectionism. By targeting the transdiagnostic process of perfectionism with a specialised intervention there is the potential to prevent the development of future Axis I disorders, intervene with already existing disorders (even multiple simultaneously) and other mental health problems, and improve client engagement with future psychological therapies, thus improving treatment outcomes for many Axis I disorders and mental health problems (Egan et al., 2011). Therefore, targeting perfectionism may be helpful towards reducing the burden on a currently strained New Zealand healthcare system.

The recent change in New Zealand government to the Labour Party has drawn much needed attention to the struggling and underfunded New Zealand mental health services. In particular, the need for earlier intervention and improved access to mental health services has been highlighted as core concerns. To capitalise on available resources it seems prudent to focus research attention on the development of treatments for transdiagnostic processes such as clinical perfectionism for the reasons stated above. In addition, focusing on treatment delivery formats that require fewer resources to implement and are easily accessible to a wider range of individuals also seems vital.

Current findings recommend that the relatively short-term treatment modality of CBT is most suitable for targeting clinical perfectionism (Lloyd et al., 2014). One delivery format of CBT that appears to be as effective as face-to-face therapy is guided, Internet-delivered, self-help CBT (Carlbring et al., 2018). The inclusion of therapist guidance to the self-help format has been demonstrated to improve treatment outcomes (e.g., Andersson & Cuijpers, 2009; Baumeister et al., 2014; Palmqvist et al., 2007; Richards & Richardson, 2012; Spek et al., 2007), and is therefore, recommended. A guided ICBT is less resource draining for both the client and therapist than face-to-face therapy. It can be completed in the client's own choice of place, time, and pace, and requires less contact hours with the therapist. Furthermore, it affords the client increased privacy and avoidance of stigma related to visiting mental health services. This might be particularly useful for clients with clinical perfectionism, as increased perceptions of stigma have been found in such individuals (Shannon et al., 2018). Finally, few therapists are trained in the face-to-face CBT protocol for clinical perfectionism, therefore developing a guided ICBT-P to meet treatment needs may help to fill this gap (Rozenal, Shafran, et al., 2017).

Therefore, extending the research of guided ICBT-P interventions described in the previous section (see pages 41 to 50), the proposed study will explore a similar guided ICBT-P targeting a New Zealand sample. It is expected that, in line with the previous two trials of guided ICBT-Ps delivered as interactive website treatments (i.e., Rozenal, Shafran, et al., 2017; Shafran et al., 2017a), the current treatment will reduce clinical perfectionism. Also, as a result of clinical perfectionism being recognised as a

transdiagnostic process, it is hypothesised that the treatment will reduce symptoms of depression, anxiety, and stress, and increase self-esteem.

The proposed study will complement the two European studies by providing further idiographic information. It will explore the clinical significance of the treatment on all five variables of interest (i.e., clinical perfectionism, depression, anxiety, and stress, and increase self-esteem) not just the primary outcome measure, as was done in the Rozental et al. (2017) and Shafran et al. (2017a) studies. The study will also be the first known study of an ICBT-P to include a qualitative analysis to better understand the participants' experiences of the treatment. This can provide initial evidence for the change mechanisms within the intervention and inform future development of ICBT-Ps.

To improve upon the Rozental et al. (2017) and Shafran et al. (2017a) trials a number of additional methodological steps will be ensured. Firstly, participants will be required to be above a specified cut-off score in clinical perfectionism to be included. Secondly, the primary outcome measure will be the Clinical Perfectionism Questionnaire, as this is the measure that has been specifically developed using the same theoretical underpinnings as the CBT model of clinical perfectionism. Next, four time points will be measured for the baseline of each participant to provide a valid control for the RCSC analysis. Each participant will start this baseline phase in a staggered manner when they become available, thus controlling for history factors that may impact internal validity. Finally, the initial assessment will be completed face-to-face with each participant, as this is the gold-standard recommendation for ICBTs (Andersson & Titov, 2014) and may help to improve treatment adherence.

The intention is that this study will aid in the development of a cost- and time-efficient therapy that could be disseminated in New Zealand to reduce the transdiagnostic process referred to as clinical perfectionism. In doing so it is thought that it could also help to reduce difficulties across numerous psychopathologies. At present, there is very little research completed on ICBTs, or ICBTs for transdiagnostic processes specifically, in New Zealand. Therefore, the findings of this study could meaningfully contribute towards the current governmental focus on improving access to affordable mental health treatments for all New Zealanders.

Quantitative research hypotheses

- I. The guided ICBT-P intervention will produce clinically significant reductions in perfectionism, which will be maintained at follow-up.
- II. Hypothesis two: The guided ICBT-P intervention will produce clinically significant reductions in self-criticism, depression, anxiety, and stress, and increases in self-esteem, which will be maintained at follow-up.

Qualitative exploratory research question

- I. How did the participants experience the guided ICBT-P?

Chapter Two

Method

This chapter will first describe the research design, materials and the role of the guiding therapist, and the measures used. Next the development of the website is explained. Following this, a description of the pilot study and outcomes from that trial are given, followed by an outline of further websites adaptations made. After this, the primary study is described, which includes details of the recruitment process, inclusion/exclusion criteria, participants, procedure, data collection and preparation for analysis, and data analysis. Finally, the process for obtaining ethical approval from the Massey University Human Ethics Committee is explained.

Research Design

This study was conducted within a realist/post-positivist epistemology. It used a case series methodology with a multiple baseline, single case series, A-B-A design. As a mixed methods study, it included both quantitative and qualitative analysis. Statistical analysis of repeated measures was performed to detect reliable and clinically significant change (RCSC). Within this case series design, each individual's baseline acted as their own control. Thematic analysis of feedback gathered through the guided therapy and interview data was completed to explore the participants' experiences of using the Internet-delivered guided self-help treatment.

Materials and Personnel

The website. The treatment website, called (I'm)perfectly Me, was adapted from a website called Be-you-tiful, created at Curtin University by Chloe Yu Shu and Sarah

Egan, and was based on the self-help book “Overcoming Perfectionism: A Self-Help Guide Using Cognitive Behavioural Techniques” by Shafran, Egan, and Wade (2010). (I’m)perfectly Me contains eight interactive treatment modules that cover the various psychoeducation and skills training elements presented in the self-help book. Using the Be-you-tiful website as a framework, (I’m)perfectly Me was re-created and specifically developed for this study. Adaptations were made to improve the overall quality of the website and ensure its appropriateness for a New Zealand, adult, male and female sample. Further details about the website development and its content can be found in sections to follow in this chapter.

The guiding therapist. The author acted as the guiding therapist. The role involved individually emailing participants at the beginning of each week (Monday) to remind them to complete their weekly questionnaire and treatment module. Midweek reminders were sent every three days until the questionnaire/module was completed. The guiding therapist collated and read all responses to treatment tasks and provided feedback within three days of the participant completing the weekly module. Feedback included general encouragement, motivation, validation, challenges to unhelpful thinking (presented as Socratic, rhetorical questions), collaborative problem solving, trouble shooting of barriers to completing a module, and answers to any queries or confusion participants had. The guiding therapist also monitored the participants’ levels of mood, anxiety, and stress on a weekly basis to ensure their mental wellbeing was at an appropriate level for continued involvement in the self-help programme or to intervene and suggest alternative treatment, if necessary.

Measures

Psychiatric Diagnostic Screening Questionnaire. The Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman & Mattia, 2001b) was used to screen for psychiatric symptomatology. This measure was specifically designed to screen for the thirteen most common DSM-IV Axis I disorders found in outpatient settings (Zimmerman & Mattia, 2001b). The PDSQ is a brief (approximately 15 to 20 minutes), self-report, yes/no scale with 126 items. The measure was chosen because it is relatively quick to administer and easy to understand (Zimmerman & Mattia, 2001b). It also has overall good reliability and validity (Zimmerman & Chelminski, 2006; Zimmerman & Mattia, 2001b). The subscales used for determining exclusion in this study included the Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder, Psychosis, Alcohol Abuse/Dependence, Drug Abuse/Dependence, and Hypochondriasis subscales (please see the Inclusion/Exclusion Criteria section of this chapter for a detailed explanation of why these subscales were selected). For these subscales, the mean of the internal consistency alpha coefficients was 0.85, the mean of the test-retest correlation coefficients was 0.82, and the means of the correlations demonstrating convergent and discriminant validity were 0.63 and 0.20 respectively (Zimmerman & Mattia, 2001b). Of note, for the Psychosis subscale, the internal consistency of the subscale was slightly less than is usually satisfactory (.66), as was the test-retest reliability (.73). Nevertheless, Zimmerman and Mattia (2001b) stated that due to the importance of detecting psychotic symptoms this subscale was retained in the screening measure. In this study, it was determined that if on occasion an individual with psychotic features was not detected by the PDSQ, they could be deemed ineligible at the initial interview phase of the screening

process. Within the sample for this study, Cronbach's alpha could not be calculated because too many of the items within subscales had zero variance. This was because most people who completed the screening measure did not report having difficulties with the severe issues being screened for.

Cut-off scores were calculated based on 80% specificity for each of the PDSQ subscales, which meant a minimum of 70% sensitivity was retained. The PDSQ manual recommended cut-off scores on the basis of 90% sensitivity (Zimmerman & Mattia, 2001a). However, the authors of the PDSQ stated that "depending on the instrument's purpose cutoff scores might be selected to optimize the sensitivity or specificity of the scale" (Zimmerman & Mattia, 2001a, p. 789). Within the PDSQ manual a table is provided to select appropriate cutoff scores depending on the user's pre-selected level of sensitivity or specificity. Choosing to base cut-off scores primarily on sensitivity or specificity depends on what the author's initial assumption is. In the case of the PDSQ development, the authors held the assumption that the psychiatric outpatients *did* have mental health issues of concern and the authors were using the measure to identify what disorders the participants had. Therefore, their focus was on sensitivity. Whereas the assumption within the recruitment phase of this study was that the general members of the public interested in participating in the study *did not* have mental health issues (aside from potential clinical perfectionism), but the author wanted to identify those individuals who did and prevent them from taking part. Therefore, the focus within this study needed to be on specificity.

Given the purpose of using the PDSQ within this study. The author did not wish to eliminate individuals at the first screening phase (i.e., the self-report questionnaire) that

only possibly had an Axis I disorder but were actually very unlikely to (i.e., false positives). This is because doing so would have unnecessarily exclude eligible participants. Within this study, those who did indeed have an Axis I disorder but responded to the PDSQ items as if they only might have one were able to be identified at the initial interview (i.e., the second screening phase). The intention of the original recommended cut-off scores was to to identify every individual who *might* have an Axis I disorder for further screening to be admitted to a mental health service. Therefore, counter to the current study, false positives were not a concern because they could be identified at a subsequent interview stage.

Choosing the specificity percentage to base cut-off scores on is a somewhat arbitrary process. There are no known rules for setting this (Zimmerman & Mattia, 2001a). It is instead based on what risk the author is willing to take. Changing the cut-off scores based on 80% specificity meant that the author of this study increased the chances of recruiting participants. It also meant that they sacrificed 20% of the healthy population that completed the self-report screening measure and could have actually been participants but were false positives. However, this is a necessary sacrifice because it retained at a minimum a 70% sensitivity, which meant 30% false negatives being deemed eligible for the study. Nevertheless, these individuals were able to be screened at the initial interview phase for the severity of their particular Axis I disorder and clinical judgement was used to decide whether their participation in the study was appropriate.

Finally, the Alcohol subscale cutoff score was increased from 1 to 3, which had a specificity score of 92% and a sensitivity score of 69%. This was done because it seemed reasonable, based on face validity, clinical experience, and feedback from pilot

participants, that individuals could answer two particular items (i.e., items 80 and 83) as “yes” without having alcohol abuse/dependence. Both items appeared subjective and open to interpretation (i.e., “*During the past 6 months did you think you were drinking too much?*” and “*During the past 6 months did you think about cutting down or limiting your drinking?*”). It was concluded that someone who does not drink very much but still thinks they drink too much could respond to Item 80 with “yes”. Likewise, someone who wished to cut down on their drinking may not be a heavy drinker. It seems possible that individuals with perfectionism, who are overly self-critical and tend to have black and white thinking patterns (Shafran, Cooper, & Fairburn, 2002), may be harsher in their responses and think that they should indeed cut down on their drinking. Furthermore, the New Zealand binge drinking culture could mean that New Zealand individuals tend to drink more socially than some individuals of other cultures (Kypri et al., 2009; O’Brien, Ali, Cotter, O’Shea, & Stannard, 2007), and on reflection some individuals may respond that they wish to cut down on this drinking. Nevertheless, this can occur without having alcohol abuse/dependence. Again, questions were able to be asked at the initial interview to screen for problems related to alcohol consumption.

Clinical Perfectionism Questionnaire. The Clinical Perfectionism Questionnaire (CPQ; Fairburn, Cooper, & Shafran, 2003) has 12 items delivered on a four-point Likert scale ranging from 1 (not at all) to 4 (all the time). It assesses an individual’s level of clinical perfectionism, which involves the measurement of “striving to meet standards and effects on self-evaluation when standards are not met” (Egan et al., 2015, p. 80) over the past 28 days.

The CPQ has been shown to have good reliability and validity (Egan et al., 2015). Evidence for construct validity was demonstrated by Egan et al. (2015) by comparing clinicians' ratings of their clients' severity of clinical perfectionism to the clients' self-reported CPQ scores. Participants who were rated as having "major" clinical perfectionism scored significantly higher on the CPQ ($s = 0.26, p = .005$) than those who had "none" according to their clinician's rating. It has good internal consistency ($\alpha = .83$) and convergent validity with CM and PS subscales of the FMPS (Frost et al., 1990), when measured in an outpatient setting (Chang & Sanna, 2012). Within this study, the Cronbach's alpha coefficient was .83, when calculated using all responses to the measure at the screening phase.

A cut-off score of 28.4 was calculated using Jacobson and Truax's (1991) criteria C (see Procedure section for further explanation). Thus, participants were eligible if they attained a score equal to, or greater than, 29.

Frost-Multidimensional Perfectionism Scale. To remain consistent with previous comparable research (e.g., Egan & Hine, 2008; Steele et al., 2013) the Concerns over Mistakes (CM) and Personal Standards (PS) subscales of the Frost-Multidimensional Perfectionism Scale (FMPS; Frost, Marten, Lahart, & Rosenblate, 1990) were used. The two subscales, which include 16 items and reflect a tendency towards evaluative concerns and self-criticism (CM) and personally set high standards for performance (PS), were chosen because they best capture the CBT definition of clinical perfectionism. These subscales have been demonstrated to have good internal consistency, with $\alpha = .88$ for CM and $\alpha = .83$ for PS (Frost et al., 1990). They were also demonstrated by Frost et al. (1990) to be the two subscales that best correlated with other

validated measures of perfectionism, including the Burns Perfectionism Scale (Burns, 1980) and the Eating Disorder Inventory Perfectionism Scale (Garner, Olmstead, & Polivy, 1983). Within this study, Cronbach's alpha coefficients were .85 for CM and .75 for PS, when calculated using all responses to the measure at the screening phase.

To be eligible for the study individuals must have reported high levels of perfectionism on the CM subscale, based on cut-off scores calculated using Jacobson and Truax's (1991) criteria C, which was 27.64 and rounded up to ≥ 28 (see Procedure section for further explanation). Those who did not meet this cut-off but scored high on the PS subscale (≥ 26) were considered ineligible, as their perfectionism appeared to be adaptive.

Clinical Perfectionism Examination. The Clinical Perfectionism Examination (CPE; Riley, Cooper, Fairburn, & Shafran, in preparation) is a 12-item, semi-structured interview designed to assess the severity of an individual's clinical perfectionism. The CPE has good inter-rater reliability ($r = .98$), test-retest reliability ($r = .85$), and internal consistency ($\alpha = .90$) (Riley, Lee, Cooper, Fairburn, & Shafran, 2007). It has been compared to the Clinical Perfectionism Questionnaire (CPQ) and found to have adequate convergent validity ($r = .57$).

Dysfunctional Attitude Scale - Self Criticism. The Self Criticism subscale of the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978) is a 15-item measure of the self-critical aspects of the perfectionism construct. Independent factor analyses of the original 40-item DAS identified a 15-item self-criticism subscale (DAS-SC; Cane, Olinger, Gotlib, & Kuiper, 1986; Imber et al., 1990). Further studies confirmed that this construct is indicative of the maladaptive self-criticism described in maladaptive perfectionism, rather than the positive achievement striving aspect of perfectionism

(Dunkley, Sanislow, Grilo, & McGlashan, 2004), thus providing evidence for its adequate construct validity. The DAS-SC has been reported to have good internal consistency with $\alpha = .82$ (Blatt & Zuroff, 2005). Within this study, Cronbach's alpha coefficient was .69, when calculated using all responses to the measure at baseline one. The 15-item scale is answered on a seven-point Likert scale ranging from 1 (*totally disagree*) to 7 (*totally agree*) and was selected for its brief administration.

Depression Anxiety and Stress Scale – 21. The Depression Anxiety and Stress Scale – 21 (DASS21) is a shortened version of the original 42-item Depression Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995b). This shortened version is a 21-item self-report measure of depression, anxiety, and stress. Each of the three scales contains seven items, which are answered using a four-point Likert scale ranging from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much or most of the time*). The items are intended to be considered within the context of the past week and are therefore designed to be a measure of emotional states rather than traits. The Depression scale measures feelings of dysphoria and hopelessness, devaluation of life, self-depreciation, lack of interest, anhedonia, and loss of initiative. The Anxiety scale is sensitive to autonomic arousal, skeletal muscle effects, worry about performance and loss of control, and subjective experience of apprehension and panic. Finally, the Stress Scale assesses difficulty relaxing, nervous arousal, agitation, irritability, and impatience, which all reflect a state of chronic non-specific arousal.

The DASS21 was selected because of its brief nature and because it contains the core symptoms of depression, anxiety and stress specifically selected to ensure the maximum discrimination between the three states. The internal consistency reliabilities

of the DASS21 scales are .88 for Depression, .82 for Anxiety, .90 for Stress, and .93 for the Total scale (Henry & Crawford, 2005). Within this study, Cronbach's alpha coefficients were .88 for Depression, .66 for Anxiety, and .83 for Stress, when calculated using all responses to the measure at the baseline one. The DASS21 has been demonstrated to have adequate construct validity through tests of confirmatory factor analysis showing good fit to the three factor model, which was derived from theoretical and empirical sources (Henry & Crawford, 2005). The convergent and discriminant validity of the DASS21 was shown through comparisons with the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), the Personal Disturbance Scale (Bedford, Foulds, & Sheffield, 1976), and the Positive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988). Whilst the authors, Henry and Crawford (2005), did not report the correlations, they described the DASS21 as having achieved good convergent and discriminant validity.

The DASS21 was used not only as an outcome measure but also as a means of monitoring the participants' wellbeing on a weekly basis throughout the intervention.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (RSES; M. Rosenberg, 1965) is a frequently used, brief, 10-item measure of global self-esteem. Responses are recorded on a 4-point Likert scale ranging from 0 (*Strongly disagree*) to 3 (*Strongly agree*). The scale has adequate internal consistency ($\alpha = .77$) (McCarthy & Hoge, 1982) and good test-retest reliability ($r = .88$) (Robins, Hendin, & Trzesniewski, 2001). Within this study, Cronbach's alpha coefficient was .86, when calculated using all responses to the measure at baseline one. Convergent validity has been demonstrated via

a strong correlation ($r_s = .76$) with the Harter's Self-Perception Profile for Adolescence Global Self-Worth subscale (Hagborg, 1993; Harter, 1988).

Visual analogue scales. The final measure was a set of ten visual analogue scales (VAS) assessing elements of clinical perfectionism, whereby participants responded by placing a cross on a ten centimeter horizontal scale anchored by the words “*not at all*” or “*never*” at one end (left) and “*extremely*” or “*all the time*” at the other (right). The scales were measured in 1 millimeter intervals (not visible to the participant), producing a 100-point scale. As is recommended, intermediate points were not defined by numbers of phrases because it has been demonstrated that clustering can occur around such intervals (McCormack, Horne, & Sheather, 1988).

VAS were included in this study because they are considered to be a sensitive, subjective measure of change of continuous phenomena (McCormack et al., 1988). Various studies have demonstrated the reliability and validity of VAS in a range of settings, showing test-retest reliability, inter-rater reliability, and convergent and discriminant validity (see McCormack et al., 1988).

The ten scales included:

- a. Eight scales originally developed by Glover et al. (2007) to assess the maintaining mechanisms of clinical perfectionism described by Shafran, Cooper, and Fairburn (2002). These maintaining mechanisms are: (1) striving, (2) fear of failure, (3) over-evaluation of performance, (4) checking, (5) avoidance, (6) narrow interests, (7) all-or-nothing thinking, and (8) selective attention.

Two changes were made to the scales developed by Glover et al. (2007). Firstly, the original scales consisted of seven scales, as one scale (*How often have*

you checked how well you are doing at meeting your standards or avoided tests of your performance?) referred to both checking and avoidance, i.e., maintaining mechanisms (4) and (5). Feedback from participants of this study's pilot study (see the "Pilot study" subsection below) suggested the question was difficult to interpret and answer because one could, theoretically, wish to respond differently to the two halves of the question. For example, respond "*never*" to the first half of the question and simultaneously "*all the time*" to the second half. Based on this feedback, the question was separated into two, resulting in eight scales dedicated to the maintaining mechanisms of clinical perfectionism. Secondly, Glover et al. (2007) did not provide a timeframe for the scales. As the scales were being administered weekly throughout the baseline and treatment phases, the words "Over the past week..." were added to the beginning of each question.

- b. One scale asking the participant to report their perception of their perfectionism that week (*Based on the past week, how unhelpful do you think your perfectionism-related behaviours are?*).
- c. One scale asking the participant to report how motivated they were to reduce their perfectionism that week (*How much do you want to change these perfectionism-related behaviours?*).

Qualitative feedback. Individual semi-structured follow-up interviews were conducted with each participant. The interviews focused on their experience of the intervention. Participants were asked to respond to a range of questions regarding 1) which aspects of the intervention they perceived to be more or less helpful, engaging, and/or enjoyable, 2) any components of the intervention that they experienced as difficult

to understand or complete, 3) how they experienced the support provided by the guiding therapist, and 4) any differences noted in their day to day life as a result of the skills learned through the intervention.

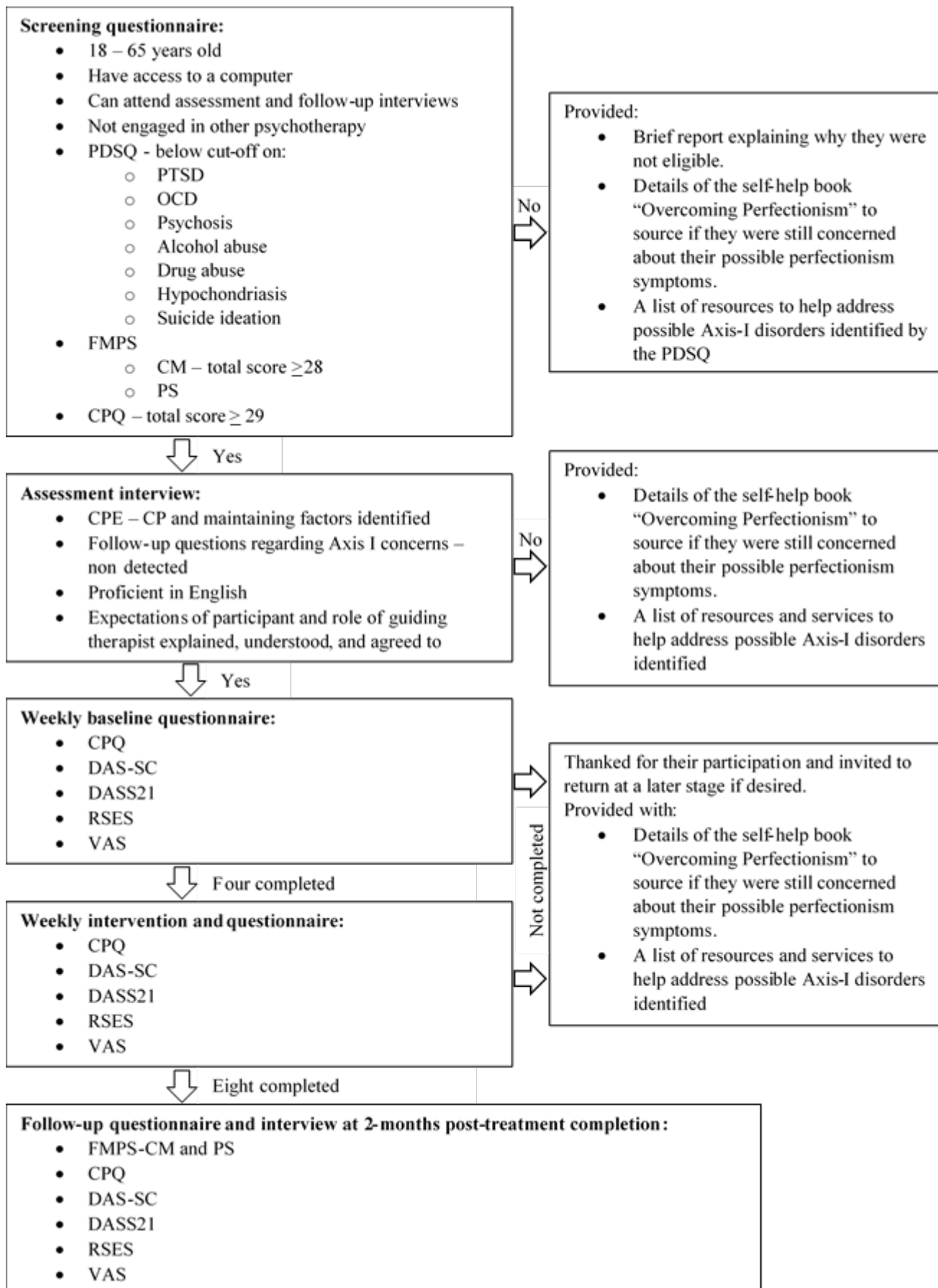


Figure 1. Flow-chart of study phases and corresponding measures provided.

Website Development Procedure

Initial website development and description of technical use. As a brief introduction, the self-help book “Overcoming Perfectionism: A Self-help Guide Using Cognitive Behavioural Techniques” (Shafran et al., 2010) was developed for home use outside of or as an adjunct to face-to-face treatment with a therapist. It is a part of the *Overcoming* series of self-help guides edited by Professor Peter Cooper, which use CBT techniques to treat maladaptive psychological and related physical conditions. “Overcoming Perfectionism” (2010) is made up of two parts. Part One provides psychoeducation about clinical perfectionism; what it is, what causes it, and what maintains it. Part Two provides CBT strategies for how to reduce problems related to clinical perfectionism and prevent future relapse.

Based on this book, the original website (*Be-you-tiful*) was developed at Curtin University by PhD Student Chloe Yu Shu and Doctor Sarah Egan for Australian females aged fourteen to seventeen years old. The author received permission from Yu Shu and Egan to adapt their website for this study, provided the original website and Curtin University were acknowledged on the re-created Massey University website.

Be-you-tiful was hosted on a web content management system called Squarespace, which has proprietary templates and other associated design features requiring hosting of content on computer servers controlled by the Squarespace providers. The original website design also included a number of surveys and worksheets for participants to complete, which were created using the Qualtrics online survey system and embedded in various web pages for access. Various options were considered to make use of the existing *Be-you-tiful* design work using a copy-and-paste-type technique of coding. However, the

complexity of the design and coding, and requirement to make various editing changes for this new research study required the creation of a completely separate and new set of web pages and associated worksheets created from basic principles on a Massey University web server.

The pages were hosted on a standard Apache based web system situated on one of the web servers within the Information Technology Services infrastructure at Massey University. The pages were developed as a set of standard independent web pages using HTML and CSS coding. The text and images of the pages were created within the HTML section of the pages, while design and layout were controlled by CSS coding. Adobe Dreamweaver CC software was used for authoring the pages offline and these were then uploaded to the server for access via the World Wide Web. Examples of the pages are shown in Appendix A.

The web address of <http://imperfectlyme.massey.ac.nz/> was created as a reverse proxy web alias address to enable simplified access to the home page of the site and an easy to remember web address. A standard user/password combination was required for users to gain access to the site in order to maintain some control over access to the various pages and their content. The access codes were given to participants by email correspondence following the screening process using a preliminary Qualtrics survey.

The initial screening survey used for recruitment purposes, the weekly surveys for participants to complete, and the short worksheets embedded within each treatment module were all also created using Qualtrics. The worksheets were embedded as “iframes” in the web pages, which permitted an external active web page to be embedded as part of the module web page within the *(I'm)perfectly Me* website.

The surveys were all created as separate Qualtrics online surveys. Massey University has a site license for the use of this cloud-based survey system which is fully described on their associated site of qualtrics.com. The Qualtrics survey system is accessed via a secured network web connection and all surveys, with their associated data, are held online in cloud-based storage. Access is limited to licensed users and secured by email address and an associated password. Harvey Jones, the programmer/analyst within the School of Psychology, has sole access to this survey and its results. He would download the data and encrypt it with a secure password before sending it on to the author.

The DASS21 (Lovibond & Lovibond, 1995b) scores from the weekly surveys and responses from each of the embedded worksheets were automatically sent to the author upon completion of those particular surveys using a “trigger message” facility available in the Qualtrics system. This enabled data with an associated Subject ID to be immediately passed on to the author without the need to download the data from the Qualtrics server, which would have required manual intervention by the license holder, Harvey Jones.

This research project was conducted over a number of weeks and required repeated access to weekly surveys and a number of Internet-delivered modules. In order to enable the data responses from independently accessed modules to be collated into their respective subject data sets, a reliable subject identifier had to be passed on as a parameter between each set of web pages and the associated Qualtrics surveys. This parameter, referred to as Subject ID, was incorporated into the associated web page’s URL address as a trailing parameter and could also be used in the address of the relevant

Qualtrics survey. This parameter was stored with the responses from each completed survey and worksheet, along with the associated code for the current module and page being completed. JavaScript coding in the background content of each web page read and stored this Subject ID and Module Code and passed it on to successive web pages and surveys as required. The Subject ID was also presented in the header of each web page. To ensure that data was being collated into the correct subject data set, the participants were asked to check that their Subject ID was displaying correctly every time they entered the website and to enter their personal Subject ID if required.

Website adaptation process. To adapt the website from the original, all of the *Be-you-tiful* website pages were copied and pasted into Word documents. Using this, the author then amended the text and imagery and left comments related to design, spacing, and order. The programmer/analyst then used this to create the initial version of the *(I'm)perfectly Me* website. As each module was created the author reviewed it and kept an Excel spreadsheet of all further amendments required and this was returned to the programmer/analyst. The author completed all module tasks herself to gain an experiential perspective of completing the module. This process was repeated multiple times until the author was satisfied with the text, appearance, and order of the modules and overall website.

Website amendments. A number of changes were made from the original website. These are described below.

General improvements. Under the direction of the author, the website was substantially changed from the original version (i.e., the *Be-you-tiful* website). To begin

with, spelling and grammatical errors were corrected. Sentences were re-written to improve the tone and flow of the text and run-on sentences were separated into multiple sentences to improve the reader's experience. The original website contained frequent use of exclamation marks. These were mostly removed to prevent the reader from interpreting the text as shouting. Some exclamation marks were retained to portray a sense of enthusiasm, where appropriate.

Website imagery. All imagery within the website was changed from the original. This was to ensure there was no infringement on copyright of images used by the authors of the original website. It was also done to increase the relatability of the website with New Zealand adults (as described below). All images were sourced from dreamstime.com, which is a website that provides royalty-free stock photos that are permitted to be used for website purposes.

Adaptation for a New Zealand sample. To appeal specifically to a New Zealand audience, changes were made from the original version created in Australia. For example, every survey and module began with the Māori greeting “kia ora”, which is a commonly used term in New Zealand meaning “hello”. New Zealand imagery, including landscapes, flora, and fauna, were included amongst the images to give the website a recognisable New Zealand appearance. Further to this, the names of people used in examples were changed to include those common to New Zealand citizens/residents, including names typical of Maori New Zealanders. These changes were made to increase the relatability of the website content to the New Zealand-based sample.

Adaptation for an adult sample. While the original website was created for a teenage sample, the new website for this study was intended for adults. Therefore, a range of changes were made to suit this population. Firstly, the language used was revised to communicate a more mature tone. This included extending the range of vocabulary used and using more formal terms. For example the phrase “Being alone: *cutting* yourself away from friends and family” was changed to “Being alone: *isolating* yourself away from friends and family”.

As mentioned above, all images used in the website were changed. Images selected were chosen based on their appeal to an adult population. This included choosing images that contained adult figures and those involving activities commonly enacted by adults, such as hiking, working at a desk, travelling, playing sports, or creating artwork. In general, images were chosen to portray a more mature aesthetic. For example, unlike the original website, no cute cartoons or pop-culture references were included. Instead, images of such things as coffee/tea, books, reading glasses, landscapes, leaves, sunrises, and the like were used.

The examples given in the worksheets were also revised to relate more closely to an adult sample. This meant changing case examples and worksheet options to activities done at work or university (e.g. writing a report or talking to a boss/lecturer), domestic chores, and parenting, rather than activities done at secondary school or at extra-curricular activities. The activities were chosen to align with domains in which adults were likely to experience clinical perfectionism.

Adaptation for a mixed-gender sample. Changes were also made to accommodate both men and women. The original website was created specifically for

teenage girls. Therefore, with the creation of the new website, it was necessary to consider content appropriateness for a male audience as well. This included changing some of the names used in case examples to male names. It also included ensuring that male figures were represented in the imagery used. Furthermore, the overall colour scheme (i.e. white background, the Massey University blue header and footer, and black text) and images selected were chosen to create what was considered to be a gender-neutral tone.

Revision of therapeutic content. Finally, the therapeutic content was also revised. This involved a thorough reading of the self-help book, “Overcoming Perfectionism: A Self-Help Guide Using Cognitive Behavioural Techniques” (Shafran et al., 2010), to more closely reflect the content and process as delivered in the book. To achieve this, the order of some content was rearranged. For example, the module concerned with preparing for change and motivation for change was moved to the second rather than third module, to fit with the original text. Some modules were separated and others combined to ensure topics and skills training covered within each module were of a similar theme and also to ensure completion of each module would not exceed one hour. Within shorter modules, worksheets and tasks offered in the book but not offered within the original website were added to increase learning opportunity and the practice of skills.

Other changes were also made to the content to incorporate elements that research suggests is best practice CBT. The first element added was a homework component at the end of each module. This involved one task to be completed in the time between modules. Including a between-session task (i.e., homework) has been demonstrated to enhance treatment outcomes in CBT (Kazantzis, Whittington, & Dattilio, 2010). The second element added was a save option for each worksheet completed so participants could have

a record of what they had done and reflect on it later, if they wished. A reflection task reviewing the content covered was also added at the end of each module. Finally, an overall reflection of the entire treatment programme and an opportunity to create an action plan for the future was added to the final module. Frequent reflection at the end of each therapy session and at the treatment termination stage, as well as a post-treatment action plan collaboratively devised between the therapist and client, are all core elements of CBT to consolidate learning and prevent relapse (J. S. Beck, 2011).

Pilot Study

An expedited version of the full study was completed using four participants. Rather than completing the intervention over eight weeks, the participants completed the weekly measures and modules every other day over the course of twenty-four days and received feedback from the guiding therapist on the alternative days.

Aim of the pilot study.

1. To discern any challenges in the execution of the intervention and guided therapy and resolve these prior to the primary study commencing.
2. Evaluate the participants' experiences of the treatment to inform further changes needed to be made to the website.
3. To present the findings at the 8th World Congress of Behavioural and Cognitive Therapies in Melbourne, Australia, to receive feedback to include in the final changes made to the website prior to the primary study.

Pilot study participants. The participants consisted of four Doctor of Clinical Psychology students from Massey University who volunteered to take part. All

four participants were acquaintances of the author. They were all female and aged between 25 to 28 years old. Three of the participants described themselves as Pākehā (New Zealand European) and one participant described herself as Māori. Three scored above the cut-off score for maladaptive, clinical perfectionism on the FMPS and CPQ and one did not but scored within the adaptive range for perfectionism on the FMPS.

Using Doctor of Clinical Psychology students as participants was thought to enhance the quality of feedback given to inform further website amendments. This was because they provided the dual value of not only being consumers of the intervention but also doing so as trainee CBT clinicians who could provide feedback on the CBT intervention and guided therapy.

Ethical approval to complete the pilot study was obtained from the Massey University Human Ethics Committee (MUHECN 15/054, Dec 2015) at the same time as the primary study was approved (see the “Ethics” section below for more detail).

Pilot study procedure. The pilot study replicated the procedure to be used in the primary study but in the shortened timeframe of twenty-four days (please see the primary study procedure for further details). The essential purposes of the pilot study were to highlight any challenges in the execution of the intervention and guided therapy and receive feedback from the participants in regards to their experience of using the website, in order to inform final improvements that could be made. It was deemed that these aims did not require the full intended timeframe of the primary study. The shortened timeframe also allowed for the results to be presented at the 8th World Congress of Behavioural and Cognitive Therapies. This was useful as it created another platform for

feedback to be collected to make changes and enhance the treatment website before commencing the primary study.

Pilot study results. The participants' feedback from the end of each module and feedback given on completion of the entire treatment programme was collated and analysed to explore the commonalities and differences described. Three themes were found that would inform the final adaption of the website, the delivery of the intervention, and the delivery of the guided therapy in the primary study. These three themes (1. Usefulness and relatability, 2. Importance of the guiding therapist, and 3. Engagement with treatment elements and perceived relevancy) are described below.

Usefulness and relatability. Overall the treatment was well received. Participants reported that they enjoyed the treatment programme, and described gaining a more in-depth understanding of clinical perfectionism and that they gained strategies and skills to overcome it. They also each reported that some modules and parts thereof were perceived as more challenging than others. However, no pattern between participants was found in regards to which parts of the treatment were more or less challenging. This appeared to be specific to each individual. Likewise, responses varied amongst participants as to which elements, modules, or tasks were more or less useful and which were more or less relatable. Consensus was found for only one element described. All participants reported that the reflection and action planning at the end of each module and at the end of the treatment overall was useful.

Importance of guided therapy. All of the participants reported that they found the guiding therapy useful. The guiding therapy was described as being important

because it provided opportunity for the participants' experiences to be normalised and validated. The participants also stated that they appreciated that the guiding therapist could challenge enduring maladaptive beliefs evident in the participants' worksheet responses to encourage the development of new, alternative, more adaptive beliefs. Related to this, the guiding therapy was also described as being a means of creating the sense of collaboration between the participant and guiding therapist. The participants reported appreciating that the guiding therapist could provide encouragement to enhance motivation and also help troubleshoot barriers to completing the treatment. Finally, the participants reported that they had difficulty completing the homework task at the end of each module. They suggested that the guiding therapist could send mid- and/or end-of-week follow-up emails querying homework completion to increase the likelihood that the homework would be done.

Engagement with treatment elements and perceived relevancy. A majority of the participants reported that they did not listen to the audio material included in the modules. They stated that this was because they found the content "unrelatable". Reasons given for this included that: 1) the voices used had Australian accents, 2) the case studies were of teenage girls, and 3) the case studies focused on activities where teenage girls experience issues with clinical perfectionism, such as school and extracurricular activities. It should be noted that while imagery and text content had been adapted for New Zealand adults prior to the pilot study, the audio recordings had not.

The participants also reported that they had difficulty sustaining engagement with Module Six because it was too long. They queried whether the module could be shortened.

Pilot study outcomes. The feedback from the four participants in the pilot study provided helpful directives to inform final changes to be made to the website before the primary study and to inform the delivery of the guiding therapy during that study. Firstly, as a result of there being no consensus amongst the participants in regards to which parts of the treatment were more or less enjoyable or useful, it appeared to be suggested that usefulness and enjoyability was unique to the individual and the presentation of their clinical perfectionism. It seemed that, covering a wide range of issues, strategies and skills related to clinical perfectionism within the self-help treatment was important in order to accommodate every participant's needs. As no consensus was met in regards to any particular modules or parts thereof being described as not useful or unenjoyable, no content was deemed to be unhelpful or inappropriate and in need of removal. This was anticipated, as all content was taken directly from the self-help book, “Overcoming Perfectionism: A Self-help Guide Using Cognitive Behavioural Techniques” (Shafran et al., 2010), which has been scientifically validated (see: Egan et al., 2014).

The collaborative nature of the guiding therapy was highlighted as an important element appreciated by the participants. The collaborative relationship is considered to be an essential precondition for effective CBT (J. S. Beck, 2011). Also based on the feedback, using the guided therapy to normalise and validate experiences, challenge unhelpful thinking, encourage engagement in the treatment, and troubleshoot difficulties to completion were all considered important elements to incorporate and to further improve upon in the primary study.

The feedback for the guiding therapist to include a mid-week follow-up email prompting homework completion was taken note of and included within the oral presentation given at the 8th World Congress of Behavioural and Cognitive Therapies. An audience member there suggested that rather than send extra emails, a set of follow-up questions in a worksheet format at the beginning of the next module could be included. This suggestion was adopted and included in the changes to be made to the website because it was recognised that this more closely reflected the check-in and homework review stage at the beginning of a face-to-face CBT session (J. S. Beck, 2011). It was also thought that it would lessen the weekly workload of the guiding therapist, while also increasing a sense of accountability for the participant to complete the homework.

Finally, as a result of participant feedback, two further changes were made. Firstly, all audio clips within the website were re-recorded using voices with New Zealand accents and including case studies relevant to adults of both genders. Secondly, the sixth module was reviewed and one worksheet was removed from the module to reduce the length of time it took to complete the module. These changes are discussed in more detail below.

Further website adaptations. Final website adaptations were made using the same process as with the original website design of creating spreadsheets detailing amendments to be made in each module, and extensive email correspondence between the author and the programmer/analyst. To begin with, further improvements were made to the punctuation and grammar as a result of mistakes noted by the pilot study participants and by the author/guiding therapist. Following that, Module Six was revised and shortened. Again, the author completed the module herself to gain an experiential

perspective of completing the module. All worksheets in Module Six were re-considered for their impact within the overall learning objectives of the module. The second worksheet was removed because it contained elements repeated in other worksheets and because it was a more time-intensive exercise.

Next, all of the audio clips were revised. Case examples were re-written, based on examples provided in the self-help book (Shafran et al., 2010), to include male and female voices, and the vignettes were modified to be applicable to a wider range of ages, genders, and domains in which clinical perfectionism can feature. The author then recruited friends and family members of varying genders and ages to read the vignettes, which were audio-recorded and emailed to the programmer/analyst to replace the existing recordings. The author then checked the sound quality of the recordings on various computers, to ensure the quality remained consistent.

Lastly, the homework reflection worksheet was added to the beginning of each module after the welcome and before the page that sets the agenda for the current module. Within this worksheet the participants were asked to answer each of the following questions in one or two sentences: 1) “What was most important to you about the last session?”; 2) “What did you learn from the between session task?”; 3) “Based on what you learnt, how might you use this information moving forward?”. These questions were asked with the intention of serving a double purpose. Firstly, it provided a means of checking whether the participant had done the homework task and set an expectation that they will have to report back on it to the guiding therapist. Secondly, the questions were phrased as reflective questions to consolidate the participants’ learning and translate this learning into future action within their daily lives.

The Primary Study

Recruitment. Participants were recruited via posters (see Appendix B) displayed around Massey University, Albany, and at general practitioner reception areas, libraries, and cafes in Albany and in the immediate surrounding suburbs. These posters included a web link to an information page about the study, and within that, a link to the screening measure. Snowballing recruitment also took place via a Facebook post (see Appendix C), which was posted on the author's profile page and shared by her network of friends. Invitation to participate also occurred via an email (see Appendix D) that was sent to colleagues of the author and her supervisors and requested to be forwarded on to people who may be interested. Finally, the author gave oral presentations about the project at two events. The first event was the Aotearoa New Zealand Association for Cognitive Behavioural Therapies 2016 conference. The second event was Nerd Nite – Auckland, which is a monthly free public event held at a pub in Auckland for people to listen to short presentations about various topics of interest. Contact details were given out at both events for recruitment purposes.

Between ten to twenty individuals were sought to participate in the study. This is in line with suggested sample sizes to achieve saturation when conducting a thematic analysis of interview data (Ando, Cousins, & Young, 2014; Braun & Clarke, 2006; Guest, Bunce, & Johnson, 2006). No specific sample size is required for RCSC analysis, as it is an analysis at the individual level.

Inclusion/exclusion criteria. To be eligible for participation individuals were required to have elevated clinical perfectionism, as measured by the Clinical Perfectionism Questionnaire and the Frost Multidimensional Perfectionism Scale. They

were also required to be between the ages of 18 and 65 years, be proficient in English, and able to attend assessment and follow-up interviews at the Centre for Psychology in Albany, Auckland. To increase the internal validity of the study, individuals could not be receiving another form of psychotherapy whilst participating. They also could not have a pre-existing close relationship (i.e. family member or friend) with the principal investigator. This was to rule out possible relationship effects on outcomes and to preserve ethical standards expected of a professional therapeutic relationship.

Individuals were excluded if they met the cutoff criteria for any of the following subscales of the Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman & Mattia, 2001b): Posttraumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), Alcohol Abuse/Dependence, Drug Abuse/Dependence, Hypochondriasis, Psychosis, or Suicide Ideation. The PDSQ screens for thirteen of the most common Axis I disorders plus suicidal ideation. It was deemed to be the most efficient measure to screen and exclude the most number of potential comorbid disorders and potential related confounding factors possible without requiring excessive time to complete it, as this could have deterred potential participants. Of the fourteen subscales, the seven aforementioned subscales (i.e., PTSD, OCD, Alcohol Abuse/Dependence, Drug Abuse/Dependence, Hypochondriasis, Psychosis, and Suicide Ideation) were selected for use in exclusion criteria for a number of reasons. Firstly, it was believed that these disorders could be excluded without seriously reducing the number of clinical perfectionists able to take part. Secondly, the treatment under investigation was not designed to treat these disorders directly and these disorders were deemed to be serious issues that needed treatment tailored specifically to them. Also, it was unknown how these disorders may interact with the treatment and affect outcomes. There was no known way of measuring how this might

affect outcomes if these disorders increased or decreased in severity over the course of treatment. Whilst not every possible disorder could be controlled for, the aim was to exclude as many of the most likely disorders as possible in order to increase the chances that outcomes were due to the treatment and its impact on clinical perfectionism.

Individuals were also excluded if they were deemed to have severe Major Depressive Disorder, Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder, or Somatisation Disorder, and moderate to severe Bulimia, Anorexia Nervosa, Binge-Eating Disorder according to the initial clinical interview conducted by the principal investigator. The PDSQ was not used to exclude these disorders because those with mild to moderate levels of the disorders were considered to be acceptable participants and the PDSQ only measures possible presence of disorders, not their severity (Zimmerman & Mattia, 2001b). Due to the fact that clinical perfectionism is a transdiagnostic process (Egan, Wade, & Shafran, 2011) it was expected that some mood, anxiety, and eating disorders or symptoms related to these disorders would be present amongst the participants. If clinical perfectionism is having an adverse influence on an individual it can be reasonably expected that it would be impacting on the individual's level of distress in the form of low mood or anxiety. Thus, excluding individuals with perfectionistic tendencies with low levels of mood- and anxiety-related disorders would likely result in the inadvertent recruitment of a group of individuals who were not adversely affected by clinical perfectionism and instead likely had a healthy pursuit of excellence.

Eating disorders, especially Anorexia Nervosa and Bulimia Nervosa, have been described by Shafran et al. (2002) as being a direct expression of clinical perfectionism

channeled into the domain of eating and body weight and shape. Therefore, if the individual had clinical perfectionism, low levels eating disorders were not excluded because they were not considered to be a confounding factor but rather an expression of the perfectionism. However, higher levels of mood, anxiety, and eating disorders were excluded because in these cases those disorders were considered to be the primary presenting problem and the related symptoms could have interfered with the CBT-P treatment in unpredictable ways. Furthermore, the intervention was not developed to treat such issues directly and therefore, to protect the wellbeing of the individual they were advised to seek treatment for those disorders first.

Participants. Of the forty-six people who completed the screening questionnaire, only fifteen meet the criteria to participate. Ten people were ineligible because they reported they were engaged in or seeking other therapy and another six were ineligible because they could not attend the assessment or follow-up interviews. On the PDSQ, twenty-five people scored above the cut-off scores for at least one of the seven specified eligibility subscales as follows: PTSD (4), OCD (7), psychosis (4), alcohol abuse/dependence (2), drug abuse/dependence (1), hypochondriasis (1), and suicide ideation (6). Therefore, these individuals were deemed ineligible. Finally, six people were below the cut-off score on the CPQ and six were below the cut-off on the FMPS-CM (four were below the cut-off scores for both the CPQ and FMPS).

The final sample of fifteen consisted of twelve females and three males, with the majority of participants in their 30s (mean age = 34, SD = 8.9, range = 25-61). Most participants described themselves as Caucasian/Pākehā/English ($n = 11$), whilst other ethnicities included Taiwanese ($n = 1$), Russian ($n = 1$), Chinese ($n = 1$), and Middle

Eastern ($n = 1$). All but one participant (who had completed NCEA Level 3) had completed a minimum of a Bachelor degree. Overall the level of education was high, with three having completed a Bachelor degree, two had completed an Honours degree, two had completed a Bachelor of Medicine, two had completed a Master's degree, three were current Doctoral candidates, and two held Doctorates of Philosophy. One participant reported they were on medication for depression. This participant reported they had been on a stable dose for over a year and did not change their dosage during their participation in the study.

Procedure. All participants who responded to the recruitment approaches were directed to the website whereby they completed an online screening questionnaire. This questionnaire included an initial five questions: one confirming their informed consent to participate, and four more checking their computer access, ability to attend the interviews, whether they were receiving any other psychotherapy, and their age. Once they had responded and it was confirmed they met this criteria they subsequently completed the PDSQ, FMPS and CPQ.

After completing the questionnaire, results were automatically calculated and a pop up response was automated to inform the individual of their eligibility status. Ineligible individuals received a brief report explaining why they were not eligible (see Appendix E). If they scored high in other mental health disorders (as identified by the PDSQ), they were given a list of resources to help address these difficulties. This included advice to contact their General Practitioner; Mental Health Services contact details; online resources; and contact details for the Centre of Psychology, Massey University. Those who did not meet the cut-off score on the FMPS-CM but did on the PS subscale

were informed that their self-reported perfectionism appeared to be adaptive and a brief explanation of adaptive versus maladaptive perfectionism was provided. Similarly, this was done for those who did not meet the cut-off score on the CPQ. They received feedback explaining that their perfectionism was not elevated enough to be included in the study, and were given details of the self-help book “Overcoming Perfectionism” to source if they were still concerned about their symptoms.

Eligible individuals received a message telling them so and were asked to enter their name and email address and click submit if they wished to continue to participate. This information along with their questionnaire results were then sent to the Qualtrics database and an email alert was sent to the author. The author then sent the individual an email welcoming them to the study. Through email correspondence the author and participant negotiated an appropriate time within clinic hours to meet for the initial interview.

Interviews. An initial 50-minute clinical assessment interview was then conducted. All interviews occurred at the Centre for Psychology in Albany, Auckland. The interview included a review of what the study involved, an explanation of what was expected of the participant throughout the study, and education about the role of the guiding therapist. The CPE was used to assess the participant’s clinical perfectionism. Further questions were asked if there was concern about the possible presence of other Axis-I disorders or mental health difficulties. The initial interview was used to confirm participation eligibility and to inform the personalised guided therapy. To enhance the personalised treatment, following the interview the guiding therapist wrote a case

conceptualisation for each participant detailing the participant's problem presentation and what factors were potentially maintaining it.

Baseline. The interview was immediately followed by a four-week baseline period, which consisted of a weekly online questionnaire. Every Monday, the author emailed each participant a link to the questionnaire, which contained their allocated Subject ID. The questionnaire included the CPQ, DAS-SC, DASS21, RSES, and VAS. Reminder emails were sent on Wednesday, Friday, and Sunday until the participant completed the measure. On completion of the fourth questionnaire the participant received a link to the treatment website, as well as their user name and password to be able to enter the website and begin Module One of the treatment.

As explained by Barlow, Nock and Hersen (2009), the baseline phase (i.e., Phase A) provided both descriptive and predictive information. It provided a description of the natural occurrence of the phenomena of interest when no intervention was applied, and a prediction of the levels of the phenomena likely obtained in each individual in phases post-baseline (Barlow et al., 2009). This information was then used to decide whether a stable baseline had occurred. It is argued that a minimum of three baseline observation points are required to demonstrate an absence of variability and trend within the baseline phase (Barlow et al., 2009; Kazdin, 2011). In this study, four observation points were obtained.

To inspect the baselines for the presence of variability or trend, two methods were adopted. Firstly, the first and fourth baseline measures were compared using modified Brinley plots, as was suggested by Blampied (2017). This demonstrated if any reliable

change, and hence trend, had occurred during the baseline phase. Secondly, visual analysis of line graphs created for each scale highlighted the presence of any variability (relative to that scale) within the four baseline time points. If a trend or relative variability was not present, then a stable baseline had occurred. If this was the case, then comparisons could be made between the baseline and later phases, so that conclusions about treatment effectiveness could be drawn. However, if the baseline was not stable, then further analysis was not completed (which is discussed further in the Results chapter).

Intervention. The eight-week intervention consisted of one module a week for eight weeks plus weekly guided therapy. Following the same schedule as in the baseline, the author sent the participants email reminders until the module was completed. Participants also completed a weekly online questionnaire of the same measures as during the baseline phase. The weekly questionnaire occurred at the beginning of the following week, before completing the next treatment module. Below is a brief description of the content of each module:

Module One: Intro to clinical perfectionism and its maintaining factors

- Quiz: Do you have unhelpful perfectionism?
- Psychoeducation: Negative effects and rewards of clinical perfectionism
- Developing a personalised formulation diagram
- Homework: Noticing clinical perfectionism

Module Two: Motivation to change

- Pros and Cons of keeping versus changing clinical perfectionism
- Goal development
- Recognising domains impacted by clinical perfectionism

- Identify negative effects of clinical perfectionism
- Homework: Thought diary to recognise unhelpful clinical perfectionism thoughts and their impact

Module Three: Facts/myths of clinical perfectionism

- Fact or fiction quiz - debunking the clinical perfectionism myths
- Development of a survey to challenge unhelpful clinical perfectionism beliefs
- Homework: Survey

Module Four: Changing all-or-nothing thinking

- Behavioural experiment to challenge unhelpful clinical perfectionism beliefs
- All-or-nothing thinking checklist
- Continuum experiment to challenge all-or-nothing thinking mistakes
- Changing "musts" and "shoulds" into flexible guidelines
- Homework: Behavioural experiment

Module Five: Noticing the positive & changing thinking styles

- Recognising negative thoughts and broadening attention training
- Noticing the positive
- Understanding and recognising unhelpful thinking styles
- Thought diary to challenge unhelpful thinking styles
- Homework: Thought diary

Module Six: Procrastination, problem solving, & pleasant activities

- Monitoring procrastination
- Pros & cons of procrastination
- Procrastination behavioural experiment to challenge related unhelpful beliefs
- Problem solving training
- Pleasant activities checklist
- Homework: Pleasant activity scheduling

Module Seven: Self-criticism & self-compassion

- Self-criticism checklist
- Monitoring self-criticism
- Values charts
- Thought diary: Replacing self-critical thoughts with self-compassion
- Homework: Thought diary

Module Eight: redefining self-worth and preparing for setbacks (relapse prevention)

- Developing flexible markers of self-worth not based on achievement
- Goals and planning
- Reflection of treatment and personal growth
- Acknowledging continued difficulties and action planning

The guiding therapy. Within three days of completing the weekly module the guiding therapist contacted each participant via email with feedback to their worksheet responses. The guiding therapist kept a separate document for each participant

that included all of the participant's worksheet responses and all of the guiding therapist's feedback.

To monitor participant progress and ensure participants completed tasks within the specified timeframe, as well as to ensure timely responses from the guiding therapist, the guiding therapist kept a detailed spreadsheet. This spreadsheet detailed all tasks that needed to be completed by the participant and by the guiding therapist and by what date. Colour coding was used to signify complete versus incomplete tasks and dates were revised when tasks became overdue.

Special care was also taken to note any indication of risk of suicide or self-harm or increased psychopathology expressed through responses to the weekly modules and/or through the guided therapy communication. The guiding therapist monitored this and kept another spreadsheet of the participants' weekly DASS21 scores. If a participant's mental wellbeing deteriorated, as indicated by scores beginning to fall within the moderate severity level or higher for more than two weeks on the DASS21 Depression Scale, or the guiding therapist had reason for concern based on her observation, then the following occurred:

1. Within one week, the guiding therapist consulted her supervisor, a registered clinical psychologist, to determine the best course of action for the participant.
2. If deemed necessary based on Step 1, options were discussed with the participant, which included such options as:
 - a. Consulting their General Practitioner
 - b. Sending a referral to the Centre of Psychology for psychotherapy
 - c. Withdrawal from the study

Follow-up. Two months post-treatment a follow-up occurred, which included an online questionnaire of all repeated measures plus the FMPS CM and PS subscales and a 50-minute interview (see Qualitative Feedback within the Measures section for further details of the interview). Again, a time for each participant's interview was organised via email, and these occurred at the Centre for Psychology during normal clinic hours. On completion of the interview, all participants received a \$40 petrol voucher as a small compensation for their time.

Data collection and preparation for analysis.

Quantitative data. All of the repeated self-report measures (i.e. the CPQ, FMPS CM and PS subscales, DAS-SC, DASS21, RSES and VAS) were delivered online using Qualtrics software. The data was then collated into an SPSS file, prepared for analysis, and then transferred to Excel 2016 for analysis. To ensure anonymity no names were included in the files, only Subject IDs.

Preparation of the data in SPSS involved checking for recording errors (i.e., that no values fell outside of the possible range of values), inspecting for missing data, and imputing missing values, where appropriate. The expectation maximisation function was used within SPSS to impute missing values. Only single missing item responses within a completed scale were imputed. If an entire scale or VAS response was not completed by a participant, then this was left missing. This was because in multi-item scales a single imputed item has more data available to support a more accurate estimation and it is also less likely to affect the overall interpretation. On the other hand, imputing an entire missing scale or VAS score (which is a standalone item) is more vulnerable to error and likely to impact the final interpretation.

Qualitative data. Qualitative data was collected from the feedback given by participants at the end of each module and from the follow-up interviews held two months post-treatment. The follow-up interviews lasted between 27 minutes and 65 minutes. Participants were asked to respond to a range of questions about their experience of the treatment (see Qualitative Feedback within the Measures section for further details). All interviews were audio-recorded and transcribed by the author. The author checked all transcriptions for accuracy by comparing them with the audio files. To ensure anonymity each participant was given a pseudonym (i.e., their participant ID).

Data analysis.

Quantitative data. In line with the single case series method (Barlow & Hersen, 1984), visual inspection of the graphical plots of repeated measures was used to assess whether the pattern of changes reported by participants were consistent with the author's hypotheses. This was conducted using line graphs and modified Brinley plots produced using Excel 2016.

Development of the modified Brinley plots consisted of, first, collating norms and reliability statistics from the literature in order to calculate 1) reliable change indices and 2) cut-off scores for each measure. Table 2 presents this information and where it was sourced from. Wherever possible, recent Australasian norms were selected, and if these were not available, then recent norms were selected. Sample size was also taken into account, with larger samples being selected over smaller ones.

Following instructions provided by Jacobson and Truax's (1991), the reliable change indices and cut-off scores were calculated for all repeated measures. This was

calculated to assess for reliable and clinically significant change (RCSC), respectively, in each participant at selected time points (i.e., treatment one, treatment four, treatment end, and follow-up). Cut-off scores were calculated using Jacobson and Truax's (1991) formulations for criteria C. Jacobson and Truax defined criteria C as "the level of functioning subsequent to therapy places that client closer to the mean of the functional population than it does to the mean of the dysfunctional population" (1991, p. 13). For the DASS21, however, cut-off scores had previously been provided by Lovibond and Lovibond (1995b) to indicate "normal" levels of depression, anxiety, and stress. After calculating the cut-off scores using Jacobson and Truax's (1991) criteria C for the DASS21 subscales, it was found that the outcome was very similar to those provided by Lovibond and Lovibond (1995b), as demonstrated in Table 1. Therefore, for this study it was decided to use the cut-off scores already established in the literature.

Table 1

DASS21 Cut-Off Scores Using Jacobson and Truax's (1991) Criteria C Versus Cut-Off Scores Provided by Lovibond and Lovibond (1995B)

Subscale	Jacobson and Truax (1991) criteria "C" cut-off score	Lovibond and Lovibond's (1995b) cut-off score
DASS21_D	8.81	9
DASS21_A	5.9	7
DASS21_S	11.99	14

Table 2

Statistics and Sources or Methods of Calculation for the Means and Standard Deviations of Normal and Clinical Populations, Reliability Statistics, and Cut-Off Scores.

Scale	Normal population mean (standard deviation)	Clinical population mean (standard deviation)	Reliability statistic	Cut-off score
CPQ	25.25 (4.65)	32.1 (5.36)	0.71	28.43
Source	Egan et al. (2015)	Handley, Egan, Kane, and Rees (2015)	Egan et al. (2015))	Calculated using Jacobson and Truax (1991) Criterion C
FMPS-CM	20.53 (7.83)	33.14 (6.05)	0.88	27.64
Source	Egan et al. (2015)	Handley et al. (2015)	Frost et al. (1990)	Calculated using Jacobson and Truax (1991) Criterion C
FMPS-PS	22.5 (5.89)	28.86 (4.77)	0.83	26.01
Source	Egan et al. (2015)	Handley et al. (2015)	Frost et al. (1990)	Calculated using Jacobson and Truax (1991) Criterion C
DAS_SC	38.81 (15.15)	68.43 (12.55)	0.88	55.01
Source	Dunkley and Kyparissis (2008)	Handley et al. (2015)	Dunkley and Kyparissis (2008))	Calculated using Jacobson and Truax (1991) Criterion C
DASS21_D	5.66 (7.74)	13.32 (11.1)	0.82	9
Source	Henry and Crawford (2005)	Ronk, Korman, Hooke, and Page (2013) - used outpatient norms.	Henry and Crawford (2005)	Lovibond and Lovibond (1995b)
DASS21_A	3.76 (5.9)	9.09 (8.82)	0.9	7
Source	Henry and Crawford (2005)	Ronk et al. (2013) - used outpatient norms.	Henry and Crawford (2005)	Lovibond and Lovibond (1995b)
DASS21_S	9.46 (8.4)	15.01 (10)	0.93	14
Source	Henry and Crawford (2005)	Ronk et al. (2013) - used outpatient norms.	Henry and Crawford (2005)	Lovibond and Lovibond (1995b)
RSES	22.62 (5.8)	19.64 (4.75)	0.81	20.98
Source	Sinclair et al. (2010)	Grzegorek, Slaney, Franze, and Rice (2004)	Schmitt and Allik (2005)	Calculated using Jacobson and Truax (1991) Criterion C

Qualitative data. Focusing specifically on the participants' experience of the intervention, feedback gathered through the guided therapy and follow-up interviews was analysed using a deductive form of thematic analysis within a realist/post-positive epistemology (Braun & Clarke, 2006). The purpose of the analysis was to identify the commonalities and highlight the differences in the participants' experiences to give an overall impression of how the treatment was received. The initial coding involved reviewing each participant's transcript line-by-line for the semantic meaning and dissecting the responses into meaningful pieces of data. These pieces of data were assigned descriptive code names. Codes were then organised within and across interviews into thematic groups. From this, themes were defined through multiple readings of the data, ensuring they reflected a commonly held perspective across participants, had a singular focus, and were related but did not overlap with other themes. Quotations were selected from the transcripts that captured the essence of each theme/subtheme to describe how the participants experienced the treatment.

Ethics

The author read and familiarised herself with the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. After extensive discussions with her supervisors about potential ethical issues that could arise out of the research it was agreed that the participants were likely to be considered a "vulnerable" population, and an ethics application was submitted to Massey University Human Ethics Committee. As a part of the application process careful advice was sought from the author's Maori cultural advisor, Doctor Simon Bennett, to ensure the proposed

study satisfactorily met all cultural obligations. Ethical approval was obtained from the Massey University Human Ethics Committee (MUHECN 15/054, Dec 2015).

Chapter Three

Results

This chapter reports the results of the study. It is presented in five main sections. The first section describes those participants that did not complete the study. The second section provides a description of the stability of baseline data, and how these baselines were treated within the analysis. Then, presenting each scale separately, the third section provides a visual inspection of the nature of change and reports the reliable and clinically significant change (RCSC) analysis from baseline to follow-up for each participant. The fourth section reports the time spent on each module by participants and the average time spent providing therapy each week by the guiding therapist. Finally, the last section reports the qualitative findings of the module reflections and interviews completed with each participant at follow-up.

Attrition

Three participants (205, 206, and 214) did not complete the treatment and were not included in the analysis. Participant 205 withdrew after the third baseline measure and participant 206 withdrew after the fourth baseline measure. Therefore, neither completed any of the treatment modules. Both participants reported being too busy to continue participating in the study. Participant 214 completed treatment module four before withdrawing from the study. They contacted the lead researcher stating that they needed to return to their home country to help relocate their family away from war. It was agreed that they could complete the rest of the treatment when it suited them on their return to New Zealand, without contributing their data to the study.

Baseline Stability

As previously described, each participant's baseline acted as his or her own control. Using these baselines, comparisons to treatment and follow-up phases were made. However, to ensure such comparisons were valid, the stability of each baseline was first analysed.

The stability of each participant within each measure was assessed using modified Brinley plots (see Figure 2) and visual inspection of line graphs (see sections to follow, e.g., Figure 3). The majority of baselines were found to be stable, however there were some exceptions to this. Figure 2 presents modified Brinley plots of scores at the baseline one and baseline four time-points for each of the measures administered. These plots demonstrate that while most of the participants on each measure did not show reliable change during the baseline phase, some did show reliable improvement or reliable deterioration. In the incidences of reliable deterioration, it was deemed appropriate to use the baseline for further analysis. This was because it predicted a trend that moved in the opposite direction to that desired by treatment. Therefore, improvement following intervention could be considered to be due to the treatment. Alternatively, in the instances of improvement during the baseline phase, further analysis of treatment effects were considered with caution. This was because it was difficult to evaluate whether continued improvement was due to the treatment or due to the participant's natural progression. In sections of this chapter to follow, those participants who demonstrated reliable improvement during the baseline phase are indicated with an asterisk and discussed further in that section.

Assessing reliable change between baseline one and baseline four, as seen in the modified Brinley plots presented in Figure 2, obscured possible variation in baseline time-points two and three. Therefore, visual inspection of baseline phases in line graphs was also conducted to assure stability. Where relative excessive variability was noted, these participants were also indicated with an asterisk and considered with caution (see sections to follow).

When comparing the baseline phase to later phases, a single score was required to represent the baseline phase. Several options for a single representative baseline score have been suggested in the literature, for example the mean score or the participant's last baseline score can be used (Blampied, 2017). Blampied (2017) argued that "when baseline is stable, baseline data can be averaged to give each individual an X-axis value". Given that the majority of the baselines were stable, the baseline mean for each participant in each measure was used to evaluate reliable change from baseline to treatment one, treatment four, treatment end, and follow-up phases.

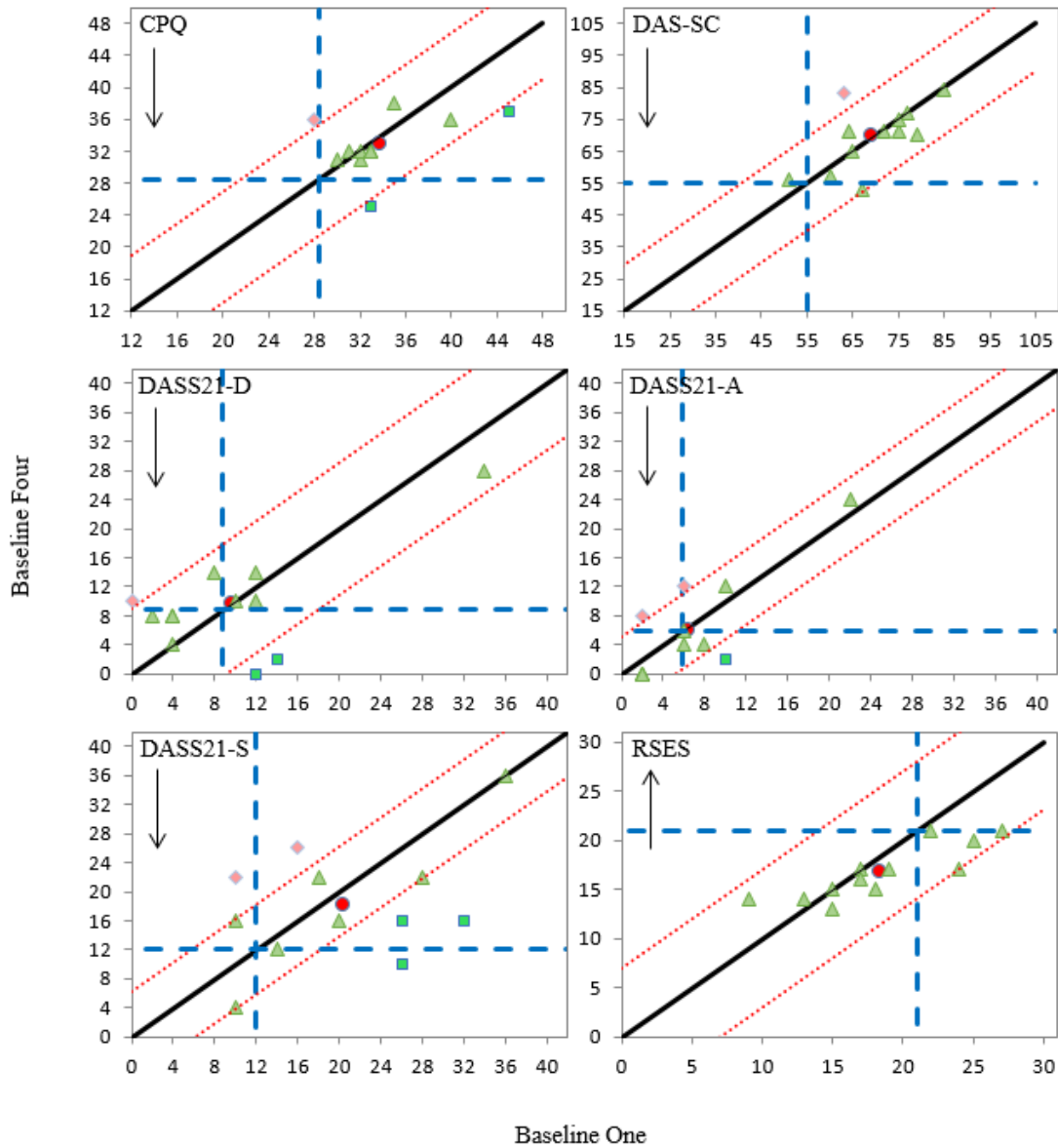


Figure 2. Modified Brinley plots of baseline one and baseline four scores on the CPQ, DAS-SC, DASS21 subscales, and RSES to demonstrate stability over the baseline phase.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991) for the CPQ, DAS-SC, and RSES, and were sourced from Lovibond and Lovibond (1995b) for the DASS21.

Clinical Perfectionism Questionnaire

Figure 3 graphically displays the results of the twelve participants who were administered the CPQ across the baseline, treatment, and follow-up phases. From baseline to follow-up, an overall downward trend was observed.

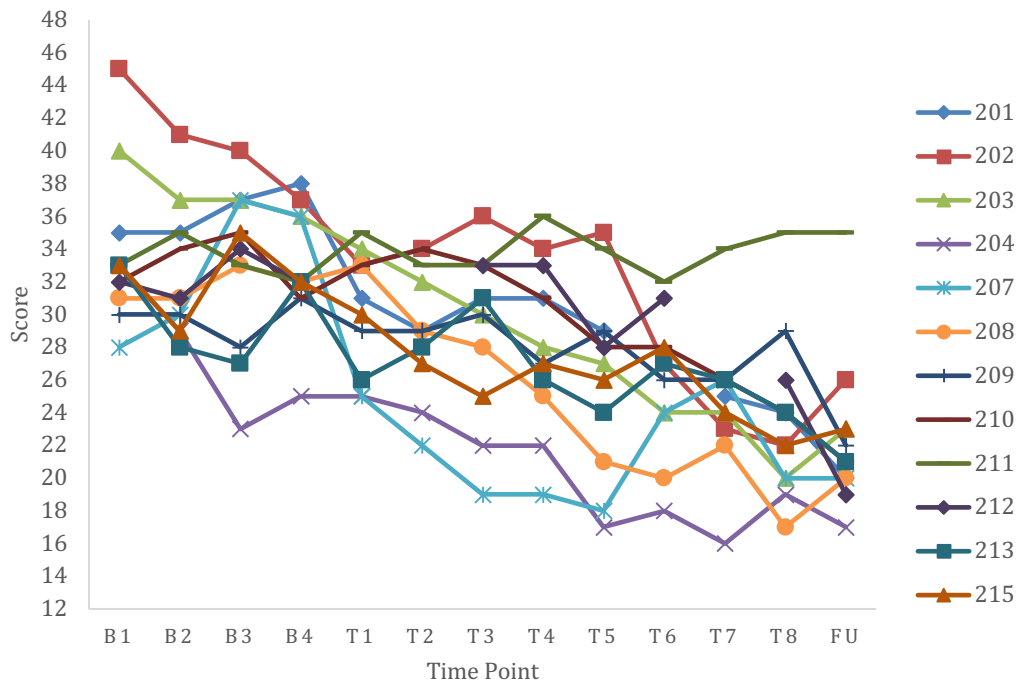


Figure 3. Changes in CPQ scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up.

Table 3

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the CPQ at Each Time-Point

CPQ	N	Minimum	Maximum	Mean	Standard Deviation	Skewness	Kurtosis
BL1	12	28	45	33.75	4.575	1.588	2.769
BL2	12	28	41	32.50	3.920	.951	.314
BL3	12	23	40	33.25	4.920	-.906	.273
BL4	12	25	38	32.83	3.512	-.559	1.152
W1	11	25	35	30.36	3.668	-.474	-1.328
W2	10	22	34	28.70	3.773	-.376	-.287
W3	12	19	36	29.25	4.975	-.939	.293
W4	12	19	36	28.25	4.993	-.246	-.405
W5	11	17	35	26.36	5.870	-.265	-.690
W6	10	18	32	26.10	4.408	-.696	.009
W7	9	16	34	24.67	4.717	.223	2.624
W8	11	17	35	23.82	4.976	1.043	1.607
Follow-up	12	17	35	22.25	4.615	2.119	5.549

All participants were above the cut-off score of 28.4 at baseline one. However, participant 204 demonstrated reliable improvement during the baseline phase, resulting in their mean baseline score being below the cut-off score, at 27.5. Participant 202 also showed reliable improvement during baseline. Therefore, these two participants were not included in further analysis.

Of the remaining ten participants, six (60%) had recovered by treatment end, and nine (90%) had recovered at follow-up. This meant that by follow-up nine participants had achieved reliable (i.e., their RCI was greater than 1.96) and clinically significant change (i.e., their treatment end/follow-up score was below the cut-off score of 28.4). Table 4 and Table 5 present each participant's CPQ scores, RCI's, and change statuses at treatment end and follow-up, respectively. Figure 4 presents a series of modified Brinley plots graphically displaying the change over time.

Table 4

Individual Scores and Change Status at Treatment End on CPQ Measures

ID	Baseline	Treatment End	RCI	Achieved Cut-off	Recovered	Improved	Un-changed	Deteriorated
201	36.25	24	3.46	Y	+			
202*	40.75	22	5.29	Y	N/A			
203	37.5	20	4.94	Y	+			
204*	27.5	19	2.4	Y	N/A			
207	32.75	20	3.6	Y	+			
208	31.75	17	4.17	Y	+			
209	29.75	29	0.21	N			+	
210	33	24	2.54	Y	+			
211	33.25	35	-0.49	N			+	
212	32.25	26	1.76	Y			+	
213	30	24	1.69	Y			+	
215	32.25	22	2.89	Y	+			

Table 5

Individual Scores and Change Status at Two-Month Follow-Up on CPQ Measures

ID	Baseline	Follow-up	RCI	Achieved Cut-off	Recovered	Improved	Un-changed	Deteriorated
201	36.25	20	4.59	Y	+			
202*	40.75	26	4.17	Y	N/A			
203	37.5	23	4.09	Y	+			
204*	27.5	17	2.96	Y	N/A			
207	32.75	20	3.6	Y	+			
208	31.75	20	3.32	Y	+			
209	29.75	22	2.19	Y	+			
210	33	21	3.39	Y	+			
211	33.25	35	-0.49	N			+	
212	32.25	19	3.74	Y	+			
213	30	21	2.54	Y	+			
215	32.25	23	2.61	Y	+			

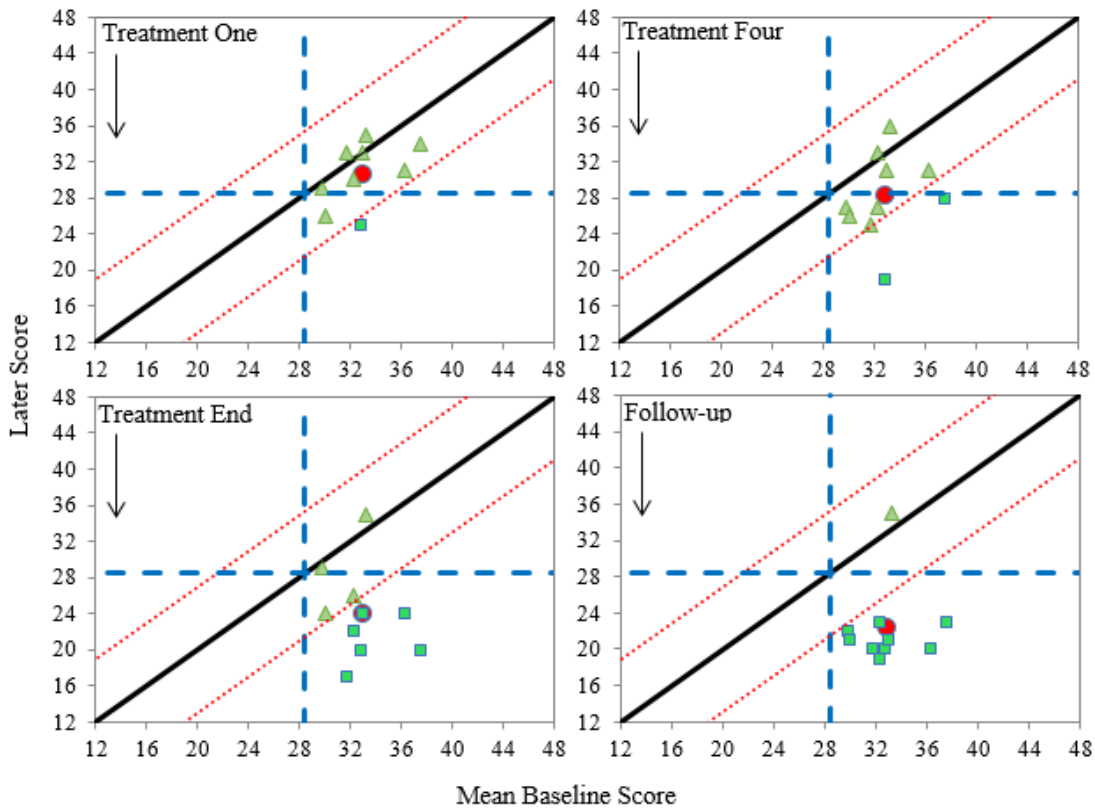


Figure 4. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the CPQ.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991).

Frost-Multidimensional Perfectionism Scale

Measures of the FMPS were taken once pre-treatment (in the screening survey) and once post-treatment (at follow-up). As previously explained, the measure was included as an alternative measure of perfectionism, to allow comparisons to be made with existing literature more extensively.

Concern Over Mistakes subscale. The cut-off score for the FMPS-CM subscale was 28. At baseline, all participants exceeded this, as was required for inclusion in the study. At follow-up eight (67%) participants had recovered (i.e., they had achieved both reliable and clinically significant change). Participants 209 and 213 both reported scores below the cut-off at follow-up, but their change in scores were not large enough to be considered reliable. Participants 202 and 211 demonstrated no change, neither reliable nor clinically significant. Table 7 presents each participant’s FMPS-CM scores, RCI’s, and change statuses at follow-up. Figure 5 presents a modified Brinley plot graphically displaying the change over time.

Table 6

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the FMPS-CM at Each Time-Point

FMPS-CM	N	Minimum	Maximum	Mean	Standard Deviation	Skewness	Kurtosis
Screening	15	26.00	42.00	34.8000	4.98856	-.218	-1.245
Follow-up	12	16	38	24.50	6.654	1.107	.635

Table 7

Individual Scores and Change Status at Two-Month Follow-Up on FMPS-CM Measures

ID	Baseline	Follow-up	RCI	Achieved Cut-off	Recovered	Improved	Un-changed	Deteriorated
201	30	22	2.09	Y	+			
202	40	36	1.04	N			+	
203	38	23	3.91	Y	+			
204	32	22	2.61	Y	+			
207	35	19	4.17	Y	+			
208	38	27	2.87	Y	+			
209	30	24	1.56	Y			+	
210	42	19	6	Y	+			
211	37	38	-0.26	N			+	
212	41	16	6.52	Y	+			
213	30	27	0.78	Y			+	
215	35	21	3.65	Y	+			

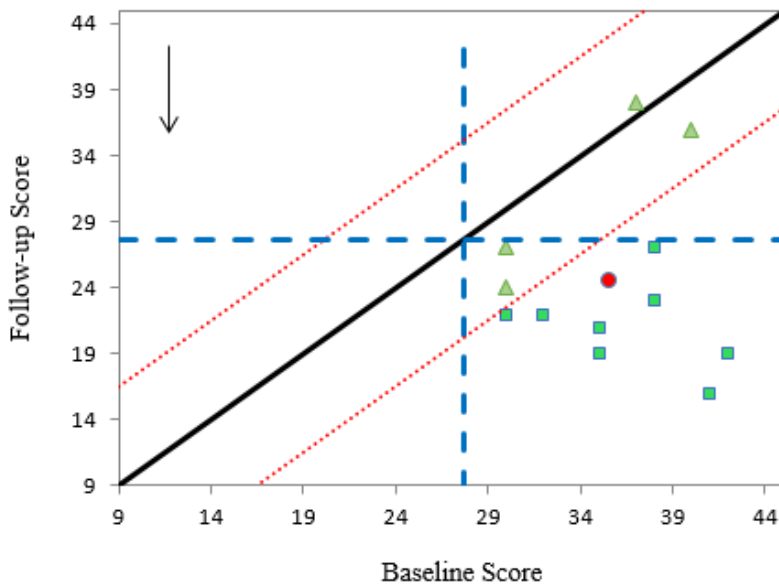


Figure 5. Modified Brinley plot of baseline and two-month follow-up scores on the FMPS-CM subscale. Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991).

Personal Standards subscale. The cut-off score for the FMPS-PS subscale was 26, although a score greater than this was not required to be included in the study. At baseline, all participants exceeded 26, except participant 201. At follow-up seven (58%) participants had achieved both reliable and clinically significant change. Participants 201, 204, 209 and 211 all reported scores below the cut-off at follow-up, but their change in scores were not large enough to be considered reliable. Participant 202 demonstrated no change, neither reliable nor clinically significant. Table 9 presents each participant's FMPS-PS scores, RCI's, and change statuses at follow-up. Figure 6 presents a modified Brinley plot graphically displaying the change over time.

Table 8

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the FMPS-PS at Each Time-Point

FMPS-PS	N	Minimum	Maximum	Mean	Standard Deviation	Skewness	Kurtosis
Screening	15	20.00	33.00	28.2000	3.87667	-.794	-.139
Follow-up	12	13	32	20.17	5.184	.708	1.514

Table 9

Individual Scores and Change Status at Two-Month Follow-Up on FMPS-PS Measures

ID	Base-line	Follow-up	RCI	Achieved Cut-off	Recovered	Improved	Unchanged	Deteriorated
201	25	22	0.87	Y			+	
202	31	32	-0.29	N			+	
203	32	14	5.24	Y	+			
204	26	21	1.46	Y			+	
207	29	14	4.37	Y	+			
208	30	20	2.91	Y	+			
209	25	24	0.29	Y			+	
210	32	20	3.49	Y	+			
211	29	23	1.75	Y			+	
212	29	13	4.66	Y	+			
213	28	19	2.69	Y	+			
215	32	20	3.49	Y	+			

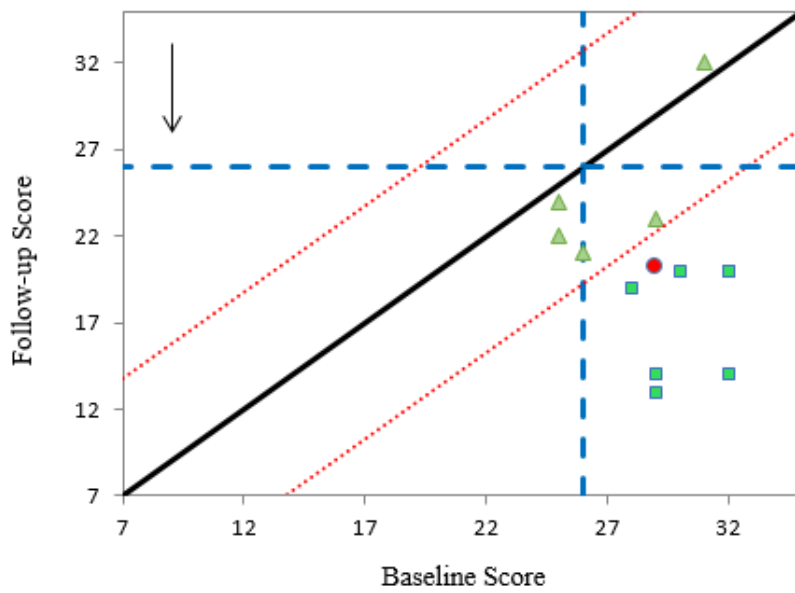


Figure 6. Modified Brinley plot of baseline and two-month follow-up scores on the FMPS-PS subscale. Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991).

Dysfunctional Attitude Scale - Self Criticism

Figure 7 graphically displays the results of the twelve participants who were administered the DAS-SC across the baseline, treatment, and follow-up phases. From baseline to follow-up, an overall downward trend was observed.

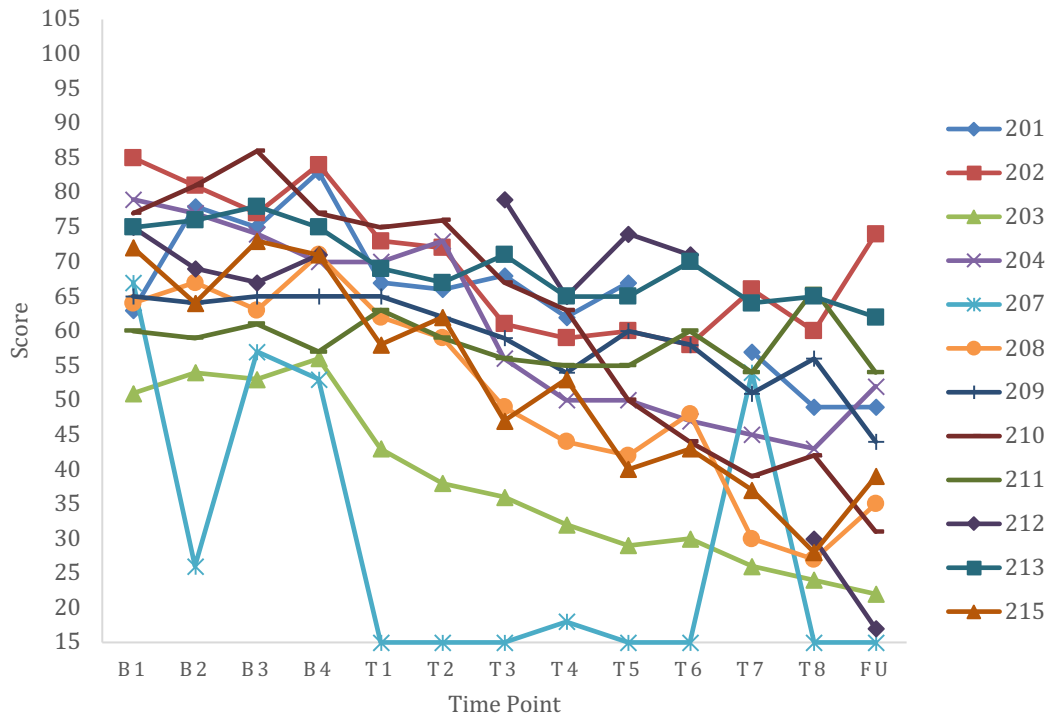


Figure 7. Changes in DAS-SC scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up.

Table 10

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the DAS-SC at Each Time-Point

DAS-SC	N	Minimum	Maximum	Mean	Standard Deviation	Skewness	Kurtosis
BL1	12	51	85	69.42	9.462	-.275	-.130
BL2	12	26	81	66.33	15.447	-1.713	3.731
BL3	12	53	86	69.08	9.681	-.039	-.654
BL4	12	53	84	69.42	10.077	-.278	-.782
W1	11	15	75	60.00	17.263	-2.097	4.676
W2	10	15	76	58.30	18.583	-1.677	2.745
W3	12	15	79	55.33	17.212	-1.128	1.734
W4	12	18	65	51.67	14.285	-1.440	1.764
W5	12	15	74	50.58	16.898	-.789	.355
W6	11	15	71	49.45	16.699	-.725	.482
W7	10	26	66	49.30	12.561	-.503	-.323
W8	12	15	66	42.08	17.302	.015	-1.390
Follow-up	12	15	74	41.17	18.205	.144	-.659

All but two participant's mean baseline scores were above the cut-off score of 55. Participant 207 showed relative excessive variability during baseline. Therefore, they were not included in further analysis. Of the remaining eleven participants, seven (64%) had recovered by treatment end, and eight (73%) had recovered at follow-up. Table 11 and Table 12 present each participant's DAS-SC scores, RCI's, and change statuses at treatment end and follow-up, respectively. Figure 8 presents a series of modified Brinley plots graphically displaying the change over time. Both participants 202 and 209 made further improvement between treatment end and follow-up. Participant 202 had reliably improved but did not meet the cut-off score, whereas participant 209 reliably improved and fell below the cut-off score, therefore reaching the status of recovered.

Table 11

Individual Scores and Change Status at Treatment End on DAS-SC Measures

ID	Base-line	Treatment End	RCI	Achieved Cut-off	Recovered	Improved	Un-changed	Deterior-ated
201	74.75	49	3.47	Y	+			
202	81.75	60	2.93	N		+		
203	53.5	24	3.97	Y	+			
204	75	43	4.31	Y	+			
207*	50.75	15	4.82	Y	N/A			
208	66.25	27	5.29	Y	+			
209	64.75	56	1.18	N			+	
210	80.25	42	5.15	Y	+			
211	59.25	66	-0.91	N			+	
212	70.5	30	5.46	Y	+			
213	76	65	1.48	N			+	
215	70	28	5.66	Y	+			

Table 12

Individual Scores and Change Status at Two-Month Follow-Up on DAS-SC Measures

ID	Baseline	Follow-up	RCI	Achieved Cut-off	Recovered	Improved	Un-changed	Deteriorated
201	74.75	49	3.47	Y	+			
202	81.75	74	1.04	N			+	
203	53.5	22	4.24	Y	+			
204	75	52	3.1	Y	+			
207*	50.75	15	4.82	Y	N/A			
208	66.25	35	4.21	Y	+			
209	64.75	44	2.8	Y	+			
210	80.25	31	6.64	Y	+			
211	59.25	54	0.71	Y			+	
212	70.5	17	7.21	Y	+			
213	76	62	1.89	N			+	
215	70	39	4.18	Y	+			

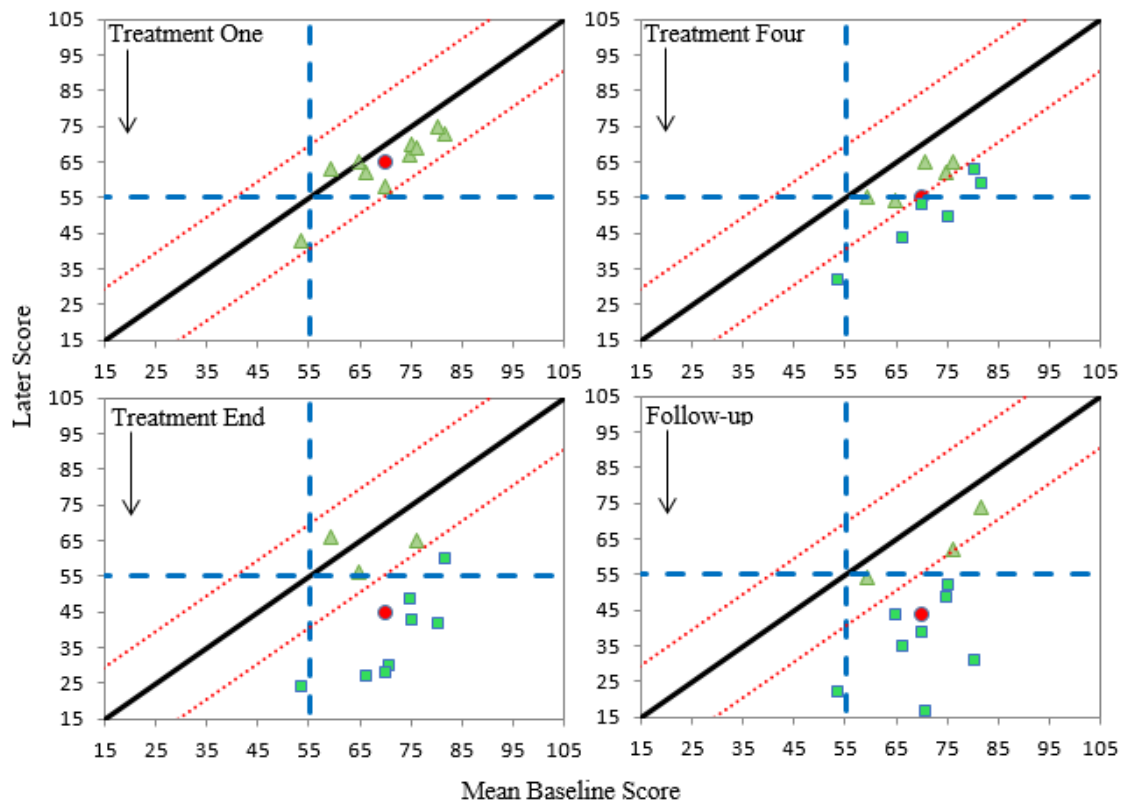


Figure 8. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the DAS-SC. *Note:* Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991).

Depression Anxiety and Stress Scale – 21

Depression subscale. Figure 9 graphically displays the results of the twelve participants who were administered the DASS21-D across the baseline, treatment, and follow-up phases. Overall, no strong trend was observed from baseline to follow-up.

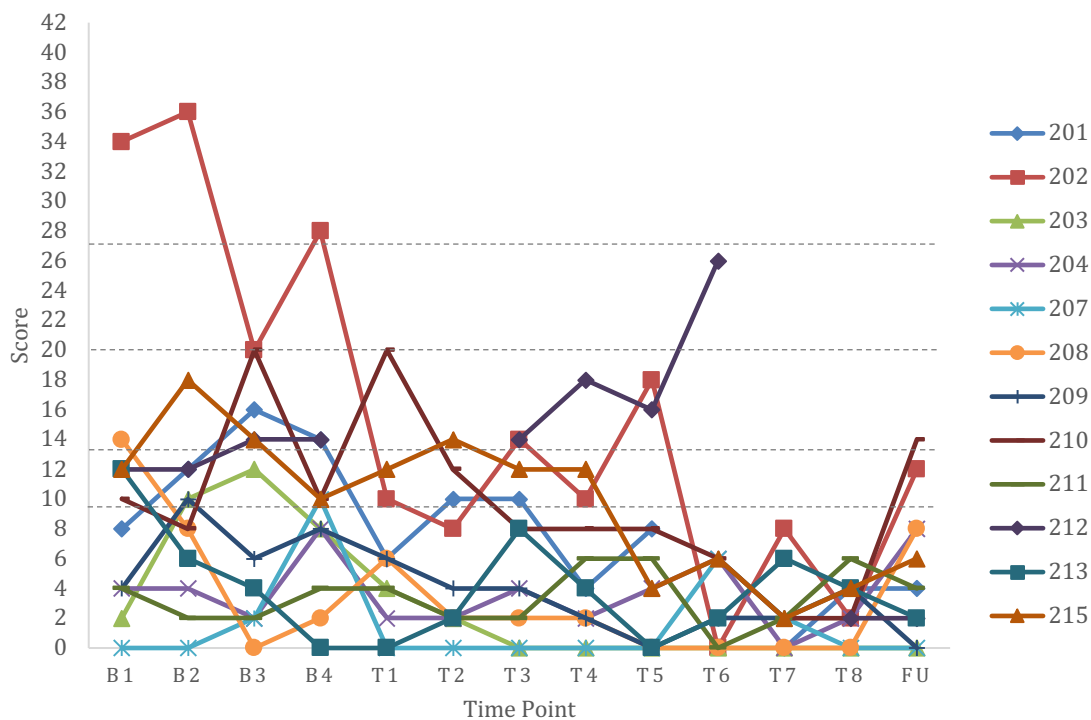


Figure 9. Changes in DASS21-D subscale scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up. Grey dashed lines indicate cut-off scores for severity levels suggested by Lovibond and Lovibond (1995b); “normal”= 0-9; “mild”= 10-13; “moderate”= 14-20, “severe”= 21-27, “extremely severe”= 28+.

Table 13

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the DASS21-D at Each Time-Point

DASS21-D	N	Minimum	Maximum	Mean	Standard Deviation	Skewness	Kurtosis
BL1	12	0	34	9.67	8.937	1.929	5.013
BL2	12	0	36	10.50	9.386	1.958	5.016
BL3	12	0	20	9.33	7.451	.201	-1.678
BL4	12	0	28	9.67	7.177	1.409	3.503
W1	11	0	20	6.36	5.853	1.303	2.000
W2	10	0	14	4.80	4.826	1.191	.005
W3	12	0	14	6.50	5.196	.231	-1.467
W4	12	0	18	5.67	5.449	1.148	.925
W5	10	0	18	6.00	6.667	.878	-.365
W6	11	0	26	4.91	7.503	2.565	7.425
W7	11	0	8	2.18	2.601	1.466	1.641
W8	12	0	6	2.50	1.931	.136	-.770
Follow-up	12	0	14	5.00	4.710	.727	-.458

Seven of the twelve participants had mean baseline scores below the cut-off score of 9. This placed them in the “normal” range at the beginning of therapy, according to Lovibond and Lovibond’s (1995b) scoring guidelines. Participants 201, 210, 212, and 215 all had mean baseline scores in the “mild” range. Whereas participant 202 had a mean baseline score in the “extremely severe” range. However participant 202 achieved reliable improvement during the baseline phase, along with participants 208 and 213. Thus, their data was not included in further analysis.

Of the remaining nine participants, three (33%) had recovered by treatment end (participants 210, 212, and 215), but only one (11%) had recovered at follow-up (participant 212). Participants 210 and 215 no longer demonstrated reliable and clinically significant change at follow-up. Nevertheless, participant 215 continued to remain in the “normal” range, whilst participant 210 moved from the “normal” range at treatment end to the “moderate” range at follow-up. All of the nine participants, except participant 210,

remained in the “normal” range between treatment end and follow-up. Table 14 and Table 15 present each participant’s DASS21-D scores, RCI’s, and change statuses at treatment end and follow-up, respectively. Figure 10 presents a series of modified Brinley plots graphically displaying the change over time.

Table 14

Individual Scores and Change Status at Treatment End on DASS21-D Measures

ID	Base-line	Treatment End	RCI	Achieved Cut-off	Recovered	Im-proved	Un-changed	Deterior-ated
201	12.5	4	1.83	Y			+	
202*	29.5	2	5.92	Y	N/A			
203	8	0	1.72	Y			+	
204	4.5	2	0.54	Y			+	
207	3	0	0.65	Y			+	
208*	6	0	1.29	Y	N/A			
209	7	4	0.65	Y			+	
210	12	2	2.15	Y	+			
211	3	6	-0.65	Y			+	
212	13	2	2.37	Y	+			
213*	5.5	4	0.32	Y	N/A		+	
215	13.5	4	2.05	Y	+			

Table 15

Individual Scores and Change Status at Two-Month Follow-Up on DASS21-D Measures

ID	Base-line	Follow-up	RCI	Achieved Cut-off	Re-covered	Im-proved	Un-changed	Deterior-ated
201	12.5	4	1.83	Y			+	
202*	29.5	12	3.77	N	N/A			
203	8	0	1.72	Y			+	
204	4.5	8	-0.75	Y			+	
207	3	0	0.65	Y			+	
208*	6	8	-0.43	Y	N/A			
209	7	0	1.51	Y			+	
210	12	14	-0.43	N			+	
211	3	4	-0.22	Y			+	
212	13	2	2.37	Y	+			
213*	5.5	2	0.75	Y	N/A			
215	13.5	6	1.61	Y			+	

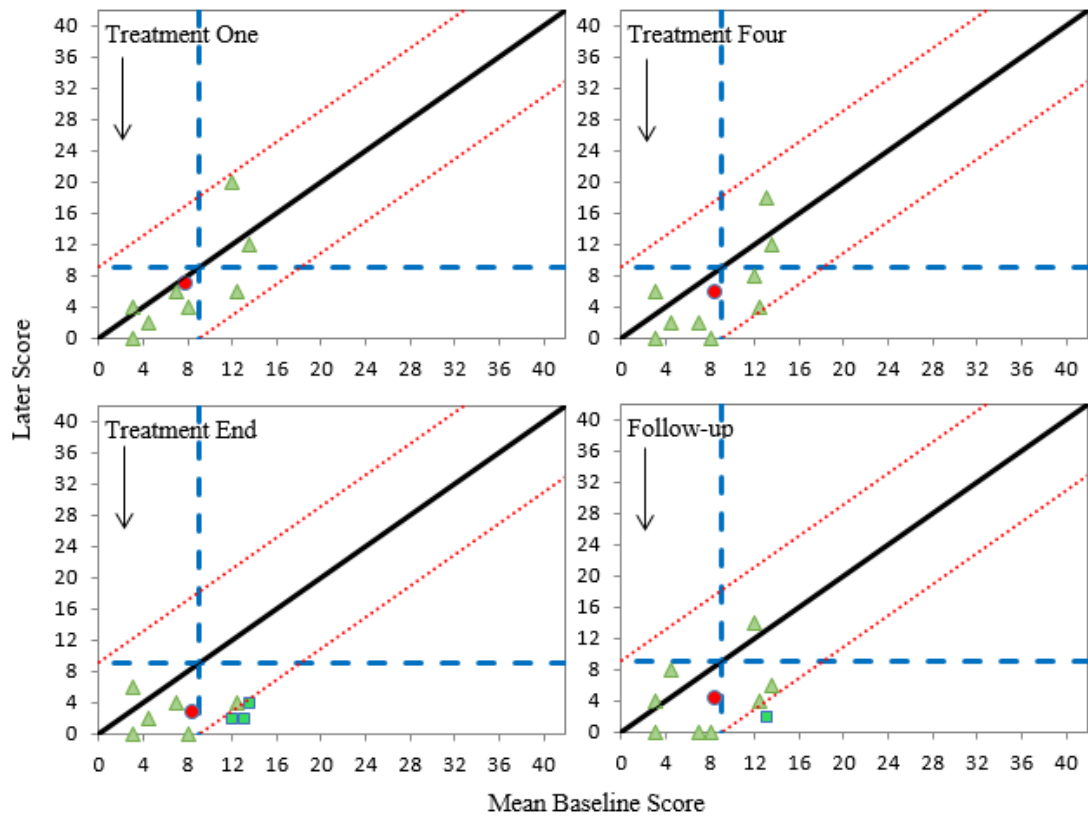


Figure 10. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the DASS21-D subscale.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were sourced from Lovibond and Lovibond (1995b).

Anxiety subscale. Figure 11 graphically displays the results of the twelve participants who were administered the DASS21-A across the baseline, treatment, and follow-up phases. Overall, no strong trend was observed from baseline to follow-up.

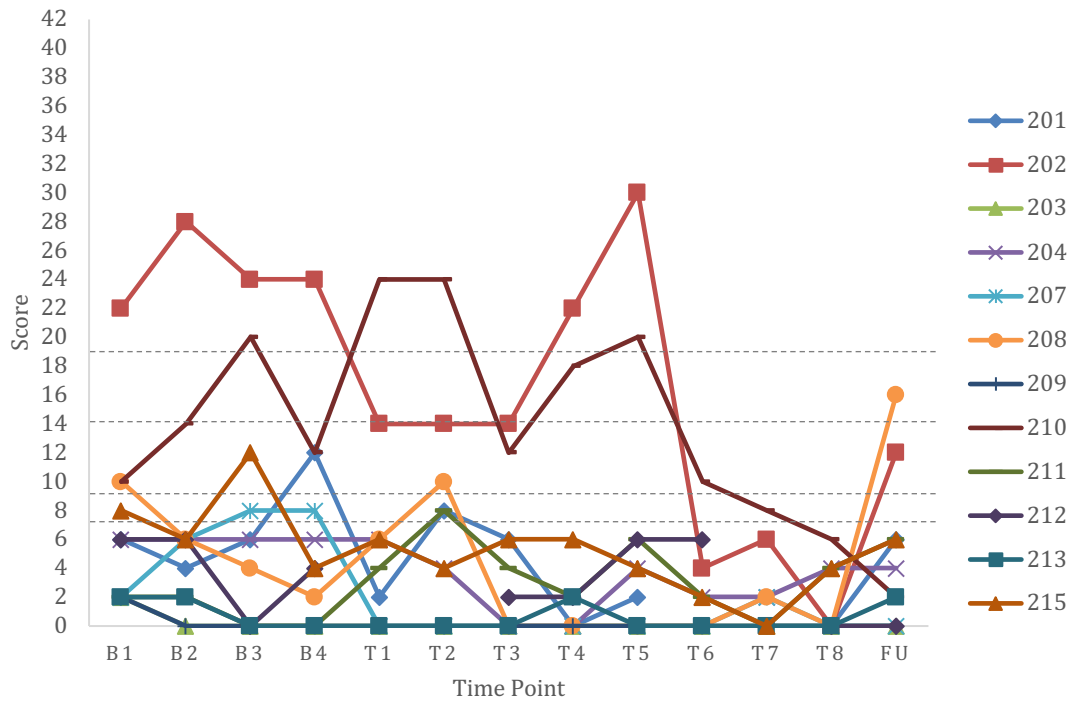


Figure 11. Changes in DASS21-A scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up. Grey dashed lines indicate cut-off scores for severity levels suggested by Lovibond and Lovibond (1995b); “normal”= 0-7; “mild”= 8-9; “moderate”= 10-14, “severe”= 15-19, “extremely severe”= 20+.

Table 16

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the DASS21-A at Each Time-Point

DASS21-A	N	Minimum	Maximum	Mean	SD	Skewness	Kurtosis
BL1	12	2	22	6.50	5.792	1.885	4.379
BL2	11	0	28	7.09	7.918	2.115	5.127
BL3	12	0	24	6.67	8.195	1.235	.601
BL4	12	0	24	6.00	7.186	1.566	2.648
W1	10	0	24	5.60	7.820	1.763	2.880
W2	10	0	24	6.40	7.877	1.383	1.684
W3	12	0	14	3.67	4.960	1.258	.489
W4	12	0	22	4.33	7.572	1.896	2.415
W5	12	0	30	6.00	9.420	2.011	3.512
W6	11	0	10	2.36	3.202	1.606	2.351
W7	11	0	8	1.82	2.750	1.606	1.703
W8	12	0	6	1.50	2.276	1.027	-.702
Follow-up	12	0	16	4.50	5.126	1.261	1.077

Nine of the twelve participants had mean baseline scores below the cut-off score of 7. According to Lovibond and Lovibond's (1995b) scoring guidelines, this placed them (participants 201, 203, 204, 207, 208, 209, 2011, 212, and 213) in the "normal" range for anxiety at the beginning of therapy. Participant 215 had a mean baseline score in the "mild" range, participant 210 was in the "moderate" range, and participant 202 was in the "extremely severe" range. Participant 208 achieved reliable improvement during the baseline phase, whilst participants 210 and 215 showed relative excessive variability. Therefore, the data of these three participants were not included in further analysis.

Of the remaining nine participants, three (33%) had recovered by treatment end (participants 201, 202, and 207), but only one (11%) had recovered at follow-up (participant 207). Participant 202 still demonstrated reliable change but no longer demonstrated clinically significant change at follow-up (i.e., they were no longer below the cut-off score and were in the "moderate" range, which was still a reliable improvement from baseline). Conversely, participant 201 no longer demonstrated reliable or clinically significant change, yet they remained in the "normal" range. Table 17 and Table 18 present each participant's DASS21-A scores, RCI's, and change statuses at treatment end and follow-up, respectively. Figure 12 presents a series of modified Brinley plots graphically displaying the change over time.

Table 17

Individual Scores and Change Status at Treatment End on DASS21-A Measures

ID	Base-line	Treatment End	RCI	Achieved Cut-off	Re-covered	Im-proved	Un-changed	Deterior-ated
201	7	0	2.65	Y	+			
202	24.5	0	9.29	Y	+			
203	0.5	0	0.19	Y			+	
204	6	4	0.76	Y			+	
207	6	0	2.27	Y	+			
208*	5.5	0	2.08	Y	N/A			
209	0.5	0	0.19	Y			+	
210*	14	6	3.03	Y	N/A			
211	1	4	-1.14	Y			+	
212	4	0	1.52	Y			+	
213	1	0	0.38	Y			+	
215*	7.5	4	1.33	Y	N/A			

Table 18

Individual Scores and Change Status at Two-Month Follow-Up on DASS21-A Measures

ID	Base-line	Follow-up	RCI	Achieved Cut-off	Recovered	Im-proved	Un-changed	Deterior-ated
201	7	6	0.38	Y			+	
202	24.5	12	4.74	N		+		
203	0.5	0	0.19	Y			+	
204	6	4	0.76	Y			+	
207	6	0	2.27	Y	+			
208*	5.5	16	-3.98	N	N/A			
209	0.5	0	0.19	Y			+	
210*	14	2	4.55	Y	N/A			
211	1	6	-1.89	Y			+	
212	4	0	1.52	Y			+	
213	1	2	-0.38	Y			+	
215*	7.5	6	0.19	Y	N/A			

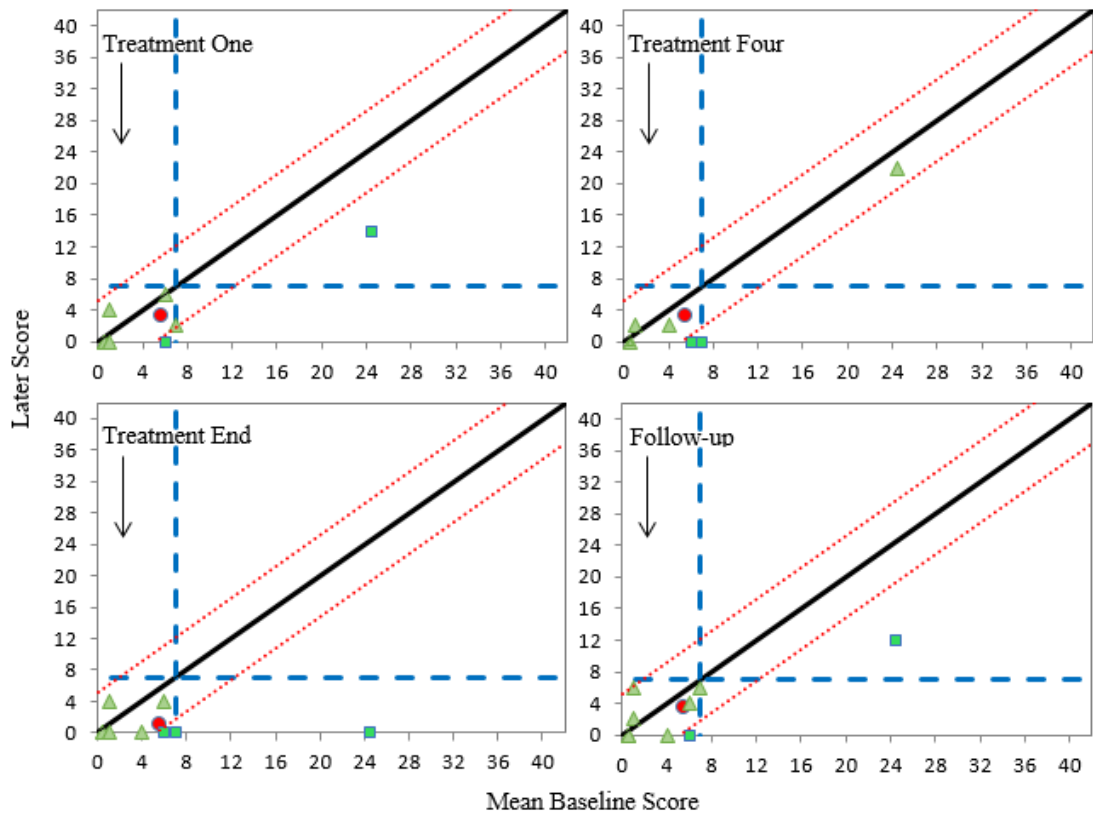


Figure 12. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the DASS21-A subscale.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were sourced from Lovibond and Lovibond (1995b).

Stress subscale. Figure 13 graphically displays the results of the twelve participants who were administered the DASS21-S across the baseline, treatment, and follow-up phases. Overall, from baseline to follow-up, a small downward trend was observed.

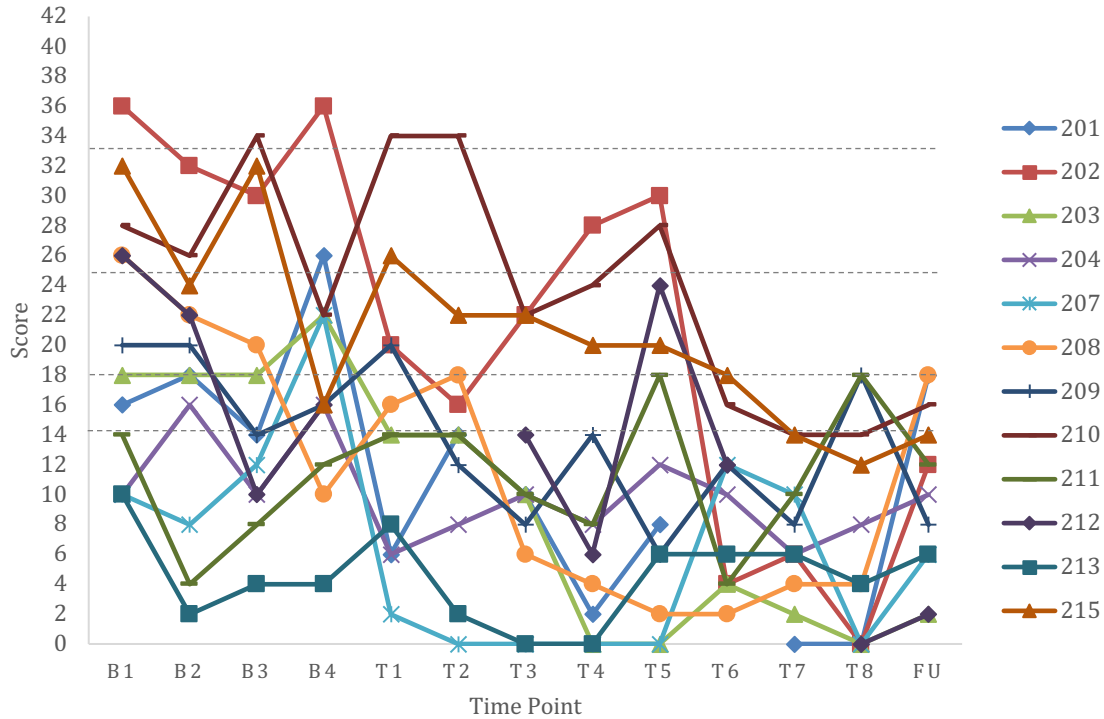


Figure 13. Changes in DASS21-S scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up. Grey dashed lines indicate cut-off scores for severity levels suggested by Lovibond and Lovibond (1995b); “normal”= 0-14; “mild”= 15-18; “moderate”= 19-25, “severe”= 26-33, “extremely severe”= 34+.

Table 19

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the DASS21-S at Each Time-Point

DASS21-S	N	Minimum	Maximum	Mean	SD	Skewness	Kurtosis
BL1	12	10	36	20.50	8.990	.322	-1.165
BL2	12	2	32	17.67	8.978	-.505	-.317
BL3	11	4	34	17.45	10.357	.581	-1.100
BL4	12	4	36	18.17	8.244	.517	1.145
W1	11	2	34	15.09	9.565	.585	-.033
W2	10	0	34	14.00	9.798	.574	.985
W3	12	0	22	11.17	7.697	.210	-.742
W4	12	0	28	9.50	9.803	.859	-.576
W5	12	0	40	13.67	12.529	.824	.013
W6	11	2	18	9.45	5.145	.153	-.949
W7	11	0	14	6.91	4.763	.205	-1.050
W8	12	0	18	6.67	7.101	.651	-1.234
Follow-up	12	2	18	10.33	5.646	-.116	-1.162

Four of the twelve participants (participants 204, 207, 211, and 213) had mean baseline scores below the cut-off score of 14. According to Lovibond and Lovibond's (1995b) scoring guidelines, this placed them in the "normal" range for stress at the beginning of therapy. Five participants were not included in further analysis. This was because participants 208 and 212 achieved reliable improvement during the baseline phase, whilst participants 201, 210, and 215 showed relative excessive variability.

Of the remaining seven participants, three (43%) had recovered by treatment end (participants 202, 203, and 207), and four (43%) had recovered at follow-up (participants 202, 203, 207, and 209). Participants 202, 203 and 207 continued to demonstrate reliable and clinically significant change at follow-up. Participant 209 improved between treatment end and follow-up, resulting in them achieving reliable and clinically significant change. Table 20 and Table 21 present each participant's DASS21-S scores, RCI's, and change statuses at treatment end and follow-up, respectively. Figure 14 presents a series of modified Brinley plots graphically displaying the change over time.

Table 20

Individual Scores and Change Status at Treatment End on DASS21-S Measures

ID	Base-line	Treatment End	RCI	Achieved Cut-off	Recovered	Im-proved	Un-changed	Deterior-ated
201*	18.5	0	4.94	Y	N/A			
202	33.5	2	8.42	Y	+			
203	19	0	5.08	Y	+			
204	13	8	1.34	Y			+	
207	13	0	3.47	Y	+			
208*	19.5	4	4.14	Y	N/A			
209	17.5	18	-0.13	N			+	
210*	27.5	14	3.61	Y	N/A			
211	9.5	18	-2.27	N				+
212*	18.5	0	4.94	Y	N/A			
213	5	4	0.27	Y			+	
215*	26	12	3.74	Y	N/A			

Table 21

Individual Scores and Change Status at Two-Month Follow-Up on DASS21-S Measures

ID	Base-line	Follow-up	RCI	Achieved Cut-off	Re-covered	Im-proved	Un-changed	Deterior-ated
201*	18.5	18	0.16	N	N/A			
202	33.5	12	6.84	Y	+			
203	19	2	5.41	Y	+			
204	13	10	0.95	Y			+	
207	13	6	2.23	Y	+			
208*	19.5	18	0.48	N	N/A			
209	17.5	8	3.02	Y	+			
210*	27.5	16	3.66	N	N/A			
211	9.5	12	-0.8	Y			+	
212*	18.5	2	5.25	Y	N/A			
213	5	6	-0.32	Y			+	
215*	26	14	3.82	Y	N/A			

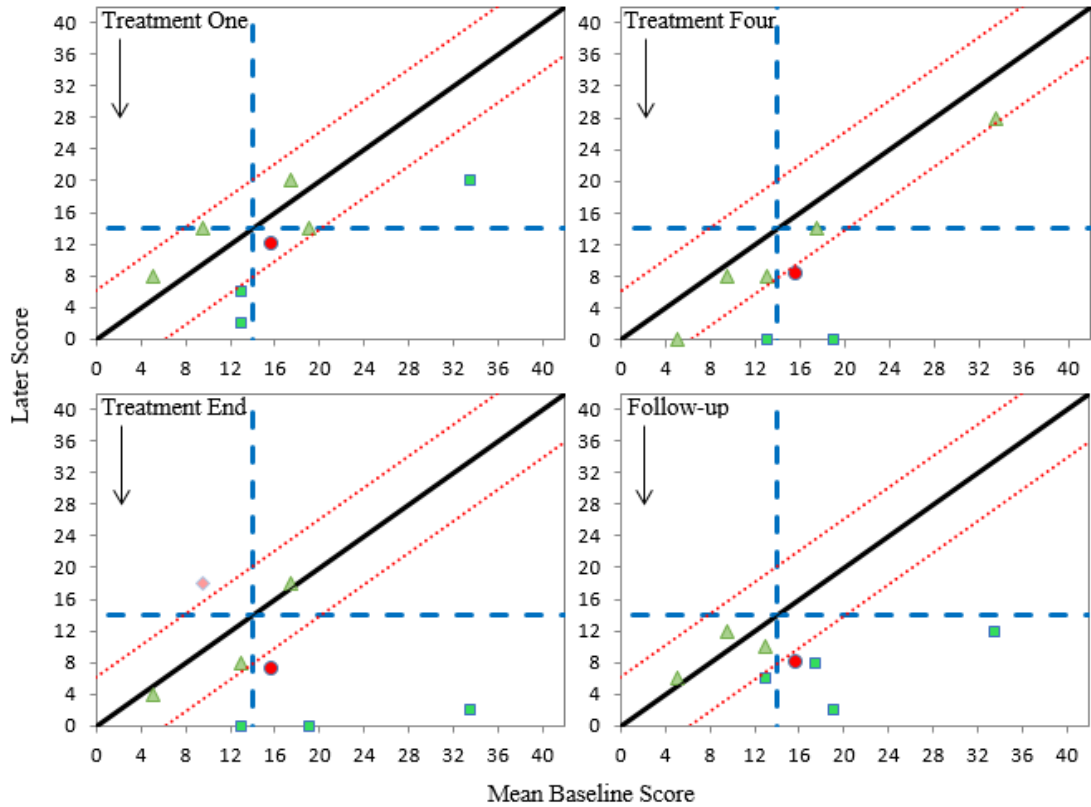


Figure 14. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the DASS21-S subscale.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were sourced from Lovibond and Lovibond (1995b).

Rosenberg Self-Esteem Scale

Figure 15 graphically displays the results of the twelve participants who were administered the RSES across the baseline, treatment, and follow-up phases. From baseline to follow-up, an overall small upward trend was observed.

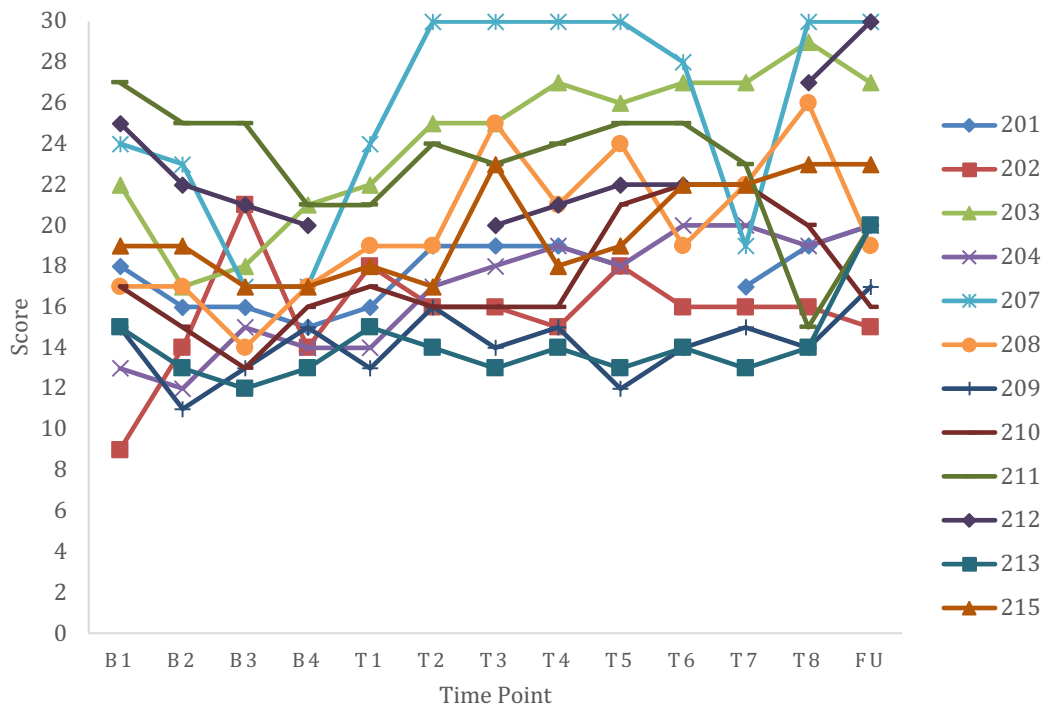


Figure 15. Changes in RSES scores over baseline, treatment and follow-up phases.

Note: B1= baseline one, B2= baseline two, etc.; T1= treatment one, T2= treatment two, etc.; FU= two-month follow-up.

Table 22

Range, Mean, Standard Deviation, Skewness, and Kurtosis Statistics for the RSES at Each Time-Point

RSES	N	Minimum	Maximum	Mean	SD	Skewness	Kurtosis
BL1	12	9	27	18.42	5.282	.043	-.502
BL2	12	11	25	17.00	4.472	.512	-.760
BL3	12	12	25	16.83	3.904	.799	.108
BL4	12	13	21	16.67	2.741	.546	-.891
W1	11	13	24	17.91	3.419	.351	-.613
W2	10	14	30	19.40	5.168	1.168	.363
W3	12	13	30	20.17	5.132	.374	-.561
W4	12	14	30	19.92	4.999	.819	-.052
W5	12	12	30	20.50	5.266	.056	-.317
W6	11	14	28	20.82	4.813	-.074	-.987
W7	11	13	27	19.64	4.105	.032	-.432
W8	12	14	30	21.00	5.862	.296	-1.451
Follow-up	12	15	30	21.42	5.089	.751	-.552

Ten participants were below the cut-off score of 21 at baseline. However, participants 202 and 212 had mean baseline scores already above the cut-off score. Participant 202 showed reliable improvement during the baseline phase. Therefore, they were not included in further analysis.

Of the remaining eleven participants, three (27%) had recovered by treatment end (participants 203, 207, and 208), and three (27%) had recovered at follow-up (participants 203, 207, 212). Participants 203 and 207 continued to demonstrate reliable and clinically significant change at follow-up. Participant 212 continued to improve between treatment end and follow-up, resulting in them achieving reliable and clinically significant change. On the other hand, participant 208 demonstrated a reduction in their score between treatment end and follow-up, so they no longer showed reliable or clinical change. Table 23 and Table 24 present each participant's RSES scores, RCI's, and change statuses at treatment end and follow-up, respectively. Figure 16 presents a series of modified Brinley plots graphically displaying the change over time.

Table 23

Changes in RSES Scores Over Baseline, Treatment and Follow-Up Phases

ID	Base- line	Treatment End	RCI	Achieved Cut-off	Re- covered	Im- proved	Un- changed	Deterior- ated
201	16.25	19	-0.77	N			+	
202*	14.5	16	-0.42	N	N/A			
203	19.5	29	-2.66	Y	+			
204	13.5	19	-1.54	N			+	
207	20.25	30	-2.73	Y	+			
208	16.25	26	-2.73	Y	+			
209	13.5	14	-0.14	N			+	
210	15.25	20	-1.33	N			+	
211	24.5	15	2.66	N				+
212	22	27	-1.4	Y			+	
213	13.25	14	-0.21	N			+	
215	18	23	-1.4	Y			+	

Table 24

Individual Scores and Change Status at Two-Month Follow-Up on RSES Measures

ID	Base- line	Follow -up	RCI	Achieved Cut-off	Re- covered	Im- proved	Un- changed	Deterior- ated
201	16.25	20	-1.05	N			+	
202*	14.5	15	-0.14	N	N/A			
203	19.5	27	-2.1	Y	+			
204	13.5	20	-1.82	N			+	
207	20.25	30	-2.73	Y	+			
208	16.25	19	-0.77	N			+	
209	13.5	17	-0.98	N			+	
210	15.25	16	-0.21	N			+	
211	24.5	20	1.26	N			+	
212	22	30	-2.24	Y	+			
213	13.25	20	-1.89	N			+	
215	18	23	-1.4	Y			+	

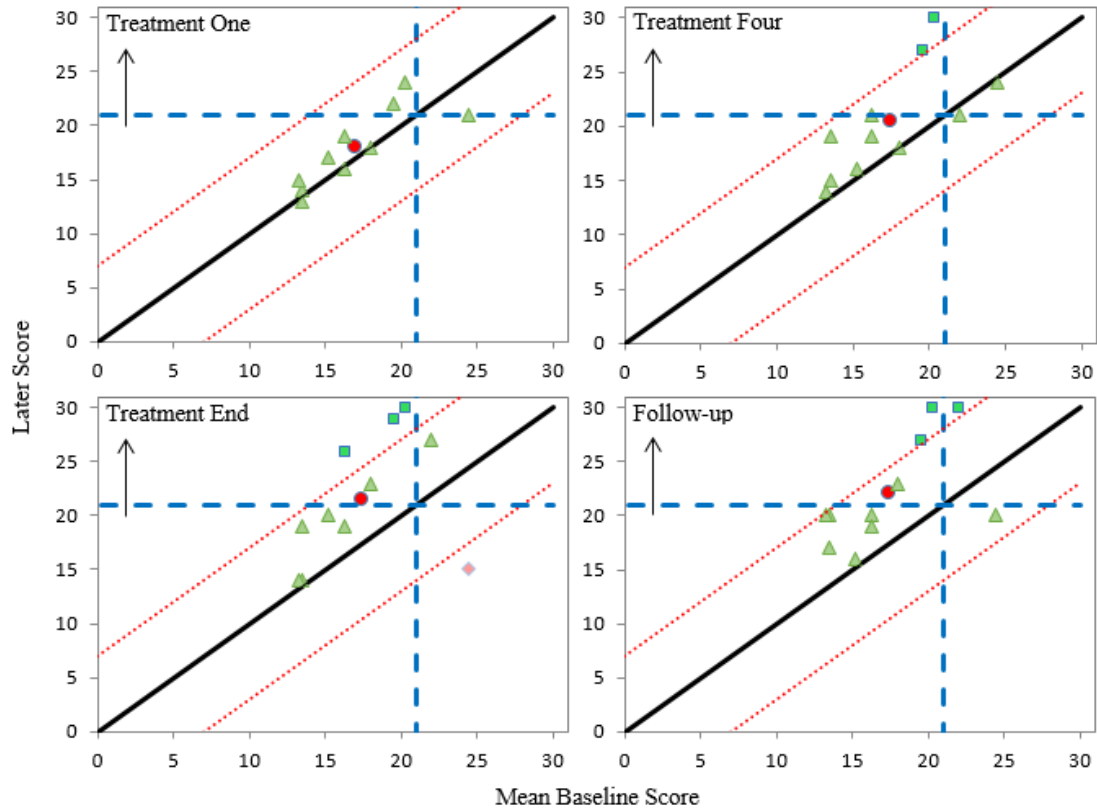


Figure 16. Modified Brinley plots of baseline, treatment one, treatment four, treatment end, and two-month follow-up scores on the RSES.

Note: Red dotted band = reliable change index; blue dashed lines = cut-off score; red circle = mean of group; triangle = no change; square = reliable improvement; diamond = reliable deterioration; arrows are placed on graph to indicate intended direction of change. Cut-off scores were calculated using Criterion C (Jacobson & Truax, 1991).

Visual Analogue Scales

Analysing the VAS data was considered highly problematic, and therefore, was not completed. Initial visual inspection showed extreme variability within each participant's responses week by week, with no trends observed. Two issues were considered key to the data's interpretability. Firstly, there were considerable gaps in the data where participants did not complete the VAS. As previously explained (see Methods chapter), missing data on the VAS were not imputed in SPSS. Secondly, further reflection

highlighted that the VAS were not appropriately anchored. Whilst participants measured their responses on scales ranging from “*not at all*” or “*never*” at one end (left) to “*extremely*” or “*all the time*” at the other (right), the scales were not anchored in terms of stable comparisons. For example, interpretation of the response option “*extremely*” may have drifted over the course of the weeks, as participants’ perspectives of their perfectionism shifted. Therefore, the VAS data could not be reliably compared from one measurement point to the next.

Table 25

Recovered Status on the CPQ, DAS-SC, DASS21, and RSES Scales at Two-Month Follow-Up

ID	CPQ	DAS-SC	DASS21-D	DASS21-A	DASS21-S	RSES
201	Y	Y	X	X	N/A	X
202	N/A	X	N/A	X	Y	N/A
203	Y	Y	X	X	Y	Y
204	N/A	Y	X	X	X	X
207	Y	N/A	X	Y	Y	Y
208	Y	Y	N/A	N/A	N/A	X
209	Y	Y	X	X	Y	X
210	Y	Y	X	N/A	N/A	X
211	X	X	X	X	X	X
212	Y	Y	Y	X	N/A	Y
213	Y	X	N/A	X	X	X
215	Y	Y	X	N/A	N/A	X

Note: Y= recovered; X= did not recover; N/A= not included in analysis due to instability at baseline.

Table 26

Percentages of Recovered, Improved but Not Recovered, Unchanged, and Deteriorated Participants on CPQ, FMPS, DAS-SC, DASS21, and RSES Scores at Two-Month Follow-Up

Measure	N	Percentage recovered	Percentage improved but not recovered	Percentage unchanged	Percentage deteriorated
CPQ	10	90.0%	0.0%	10.0%	0.0%
FMPS-CM	12	66.7%	0.0%	33.3%	0.0%
FMPS-PS	12	58.3%	0.0%	41.7%	0.0%
DAS-SC	11	72.7%	0.0%	27.3%	0.0%
DASS21-D	9	11.1%	0.0%	88.9%	0.0%
DASS21-A	9	11.1%	11.1%	77.8%	0.0%
DASS21-S	7	57.1%	0.0%	42.9%	0.0%
RSES	11	27.3%	0.0%	72.7%	0.0%

Time Spent on Modules and Guiding Therapy

Participants were advised to spend no more than one hour on each module, with some modules expected to take less time than this. However, time spent on modules varied considerably amongst participants. This was self-reported at the end of each module in approximate minutes. Table 27 presents the mean time and range of minutes spent on each module by the participants.

Table 27

Time Spent in Minutes on Each Module by the Twelve Participants

Module	Mean	Standard Deviation	Range
1	40	30.0	10-120
2	55	32.7	15-120
3	25	11.0	10-40
4	50	39.0	20-160
5	59	33.4	30-120
6	62	41.7	30-180
7	45	27.0	20-120
8	66	48.2	20-180

Participants were also requested to complete one module a week. Nevertheless, some participants did not achieve this. This resulted in reminder emails being sent to the participant every three days until the module was completed. Weeks taken to complete all eight modules ranged from eight weeks to sixteen weeks. An average of 10 weeks and 5 days was taken by the twelve participants to complete the treatment.

An average of seventeen minutes of guiding therapy was spent on each participant per session completed.

Qualitative Feedback

The analysis of follow-up interview and module reflections data resulted in two major clusters of themes. The first cluster provides a detailed report of the participants' experiences of the website. The second cluster explores the participants' subjective accounts of the outcomes of the treatment for them. Within each clusters of themes, further subthemes were organised to convey greater detail and complexity. The cluster of themes concerning the participants' experiences of the website included four themes in total: 1) engagement with the treatment, 2) treatment delivery, 3) the website content, and 4) the guided therapy. The second cluster of themes, which covers the participants' perceived outcomes of treatment, included six themes: 1) a change in thinking, 2) developing insight, 3) an increase in self-love, 4) interpersonal improvements, 5), improved productivity and 6) a work in progress. It was within these ten themes and various subthemes that the twelve participants described their experience of the guided ICBT for clinical perfectionism and what they learned from it. Each theme will be discussed in detail below.

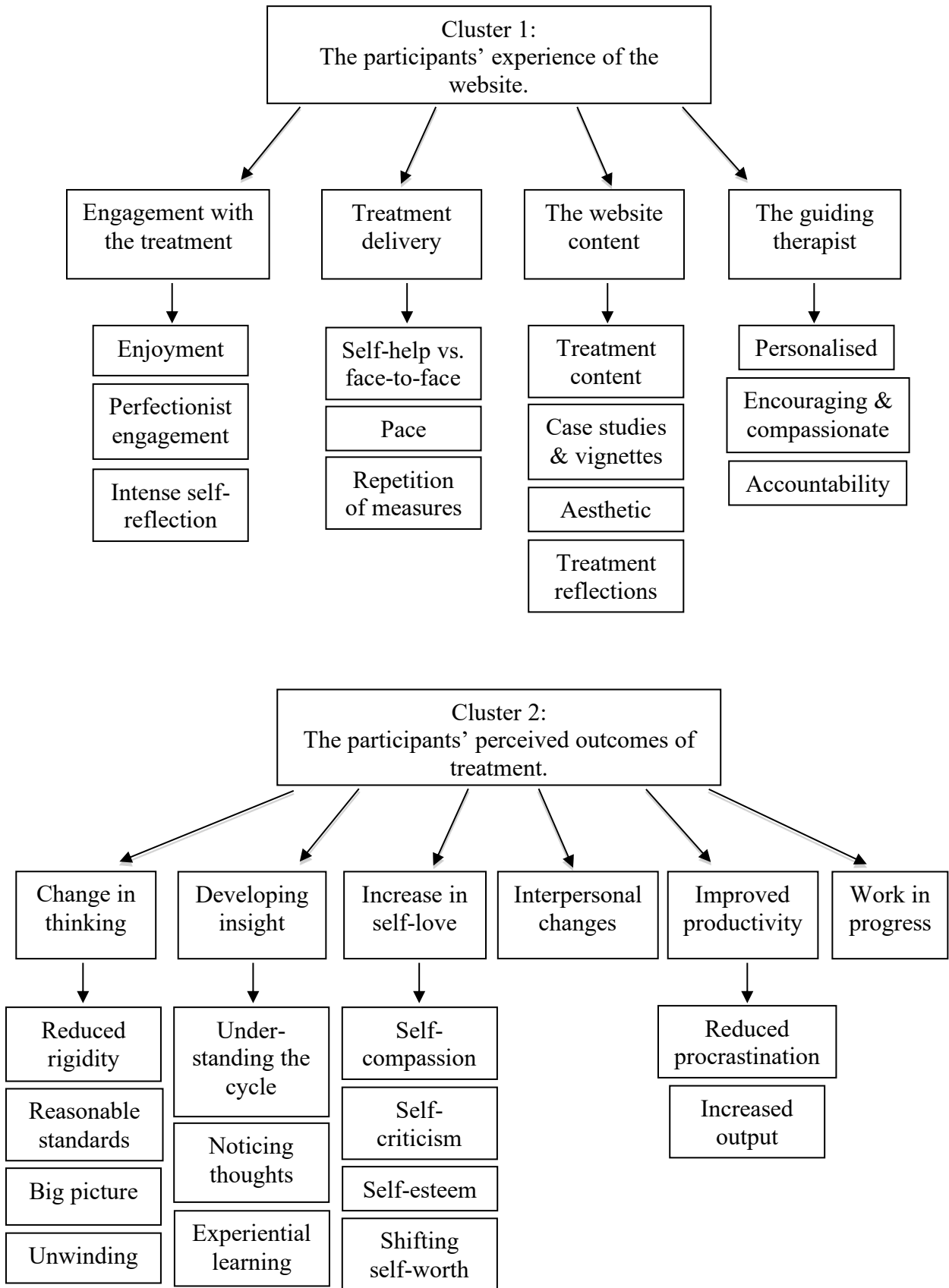


Figure 17. Diagram depicting the two clusters of themes and subthemes.

Cluster One: The participants' experience of the website. As described above, the four themes within this cluster illustrated how the participants' experienced the website. This included how they engaged with the treatment, their feedback on how it was delivered, what elements of the website they appreciated or found useful (or not), and their experience of having a guiding therapist included as a part of the self-help treatment.

1. Engagement with the treatment. The first theme, which explored the participants' engagement with the treatment, was discussed in three key ways. Participants described enjoying the treatment, but also described having difficulties engaging at times because their clinical perfectionism interfered or because they found the self-reflection aspect of the treatment intense and challenging.

1.1 Enjoyment. Very simply, a sense of appreciation and enjoyment in engaging with the treatment was expressed by a majority of the participants. As reported by participant 202 and then participant 208:

I loved looking through the treatment and what I have to do each week and I really enjoyed it.

Participant 208:

I think it was nice to consistently be looking at my perfectionism; nice to get to know it a bit better, using the different strategies and things ... it was really nice to sit down for an hour/an hour and a half and actually just work through something and think about it and reflect on stuff I'd done the previous week. ... It was helpful, as I said, at that

time of my life when I was working through bits and pieces. It fit with what I was challenging so it was nice.

As with the participant 208's statement above, participant 203 also suggested that the difficulties targeted in the treatment reflected those she was experiencing in real life. It seems that this match created a sense that the treatment was well-timed for helping them to overcome their struggles, and this increased their sense of appreciation and enjoyment:

I think it was really good. It was productive, I was pleased. This may be just how I feel, I think it came at a really good time for me so I think I probably got so much out of it because of that timing but it may be that everybody could get that out of it if they want to.

Also highlighted by this comment, is a need for the individual to have a desire to engage and make changes. Without this desire, it could be difficult to develop an appreciation and sense of enjoyment in a treatment that is otherwise challenging.

1.2 A perfectionistic engagement with the therapy. As reported in the literature (Blatt, 1995; Jacobs et al., 2009) and suggested by Shafran et al. (2017b), the participants' clinical perfectionism did appear to interfere with their engagement with the treatment at times. For example, a desire to provide thorough responses resulted in some participants procrastinating (a common clinical perfectionism compensatory behaviour) on starting and completing modules, as described by participant 201 and then participant 211:

Also, because I was so thorough, sometimes I would wait until the last minute to get things done because I knew it was gonna take me a while to write all those thorough

answers and explore all the things that I needed to explore to actually get value out of the programme. I wanted to give it the full attention. I knew that would require me to set aside a good chunk to just concentrate on it. That probably played into it a little bit – the perfectionism.

Participant 211:

I think as I said to you a few times, again, my perfectionism would affect even me completing the session. ... It made me put it off cos I was like no, I need to find space in my life to sit down and allow like a solid hour where I can sit down and complete it but it's so hard to find that time and I would probably fill my time with other things. I was worried about doing it thoroughly.

Issues with clinical perfectionism also affected participants' engagement with specific tasks and resulted in participants spending too long on modules. This was illustrated by participant 209:

I think it was possibly the creation of some behavioural experiment which I couldn't think of, so I had to go back to the start and because of my perfectionism, I couldn't just skip that part and do the other parts. Then I was stuck. Finally, I eventually found a solution to it, but the struggle was not pleasant.

Finally, the tendency to be overly self-critical in those with clinical perfectionism appeared to affect engagement with the treatment. As exemplified by participant 204 in this statement:

I felt like I used the exercise about my negative behaviours (procrastination, etc.) to beat myself up a little.

The guided therapy was often used to draw attention to and challenge these perfectionistic ways of engaging with the treatment programme. For example, participant 213 was challenged to only provide responses in sections of worksheets that fit with their experience and to restrict these responses to bullet points. Following this, participant 213's time spent on modules dramatically reduced to within the recommended time and their subjective engagement with the treatment also appeared to improve:

Really nice, easy to do. I think it was partly because I got feedback that I don't have to fill in all the boxes, and also felt more that I was doing this for myself rather than 'reporting back' all the details.

Using engagement with the treatment itself as an opportunity to challenge clinical perfectionism appeared to be a helpful learning opportunity, as illustrated by participant 201:

I did notice that when I did go through the programme that I was being a perfectionist about a perfectionist programme But because I was going through the programme, I also recognised when I was doing that and sometimes backed off a little bit. It was really helpful.

Thus, whilst clinical perfectionism did create barriers to treatment engagement, acknowledgement of this through the treatment material or the guiding therapy provided extended learning opportunities for challenging the participants' stuck points.

1.3 Intense self-reflection. Participants also reported that their engagement with the treatment required an intense self-reflection that was at times challenging for them. This challenge was described in two key ways. The first was as a task that was intellectually challenging, which was illustrated in a statement from participant 212:

It's not an easy thing to do and it does require you to really think quite hard about what you're doing and come up with examples and think of things going on in your life and think about them in a way that you probably don't really want to cos no one wants to be using that amount of mental resources with that when they've got everything else on. It's really hard.

The second way in which the self-reflection was described as challenging was as an emotional challenge, as reported by participant 204:

I think while I was doing the course, I found it quite emotionally hard because it was quite confronting to be like this is who I am and I have to delve into it all the time. I found it really quite emotionally intense which I didn't expect it to be. I thought it would be pretty sweet. I thought it was like answering questions about yourself and stuff like that but I would get quite emotional doing it.

Some examples were provided as to why participants found it emotionally intense. For example, participant 210 described how recognising how hard they were on themselves was cause for an emotional response:

I had to split this week's session over two days as I ran out of brain capacity after the behavioural experiment part. I had an emotional response (became quite upset) to the

acceptance part, I'm not sure what that was about – perhaps it's because I find it hard to acknowledge that I can give myself a break and deserve breaks as much as other people.

In another example, participant 215 reported that recognising the possible causes of their perfectionism and recalling difficult memories resulted in feelings of distress for them:

Drawing the diagram was illuminating but hard. Thinking about the childhood roots of the problem was distressing but helpful.

These participants' descriptions of their engagement with the treatment highlighted the potential benefits of including a guiding therapist in a self-help treatment. The therapist could provide empathy and encouragement during times when the client is finding the treatment mentally or emotionally taxing. They could also draw attention to times when the client was engaging in the therapy in a perfectionistic manner and could collaboratively develop ways with the client to overcome this. More about the benefits of including a guiding therapist will be presented in the guided therapy theme later in this chapter.

2. Treatment delivery. Three subthemes were highlighted related to the second theme, which concerned how the treatment was delivered. These subthemes included opinions about the benefits of the online self-help format versus the benefits of face-to-face treatment, subjective experiences related to the pace of the treatment, and reactions to the repetition of the research measures that the participants were required to fill out before completing each module.

2.1 Self-help versus face-to-face therapy. A number of participants detailed reasons why they appreciated the self-help format of treatment delivery. A common suggestion was that this allowed them to complete the modules in their own time and at their own pace. Participant 208:

I quite like that kind of work where you can do it in your own time and at your own pace.

In the following statement participant 210 extended the commentary about increased controllability of pace within self-help treatment to highlight why they preferred it as an interactive website rather than in book format:

I like that it was self-help because then it felt really under my control and not like I'm being pushed along. I was doing it cos I wanted to. I quite like how structured it was. It was all like neat and could kind of fit in a box, which was really enjoyable and easy to understand. Better than a self-help book, that's for sure. I think because it was interactive and you had to write in the answers, whereas in a self-help book you'd be like, oh, I'll just do that in my head. Because there was somebody reading your responses and you had to submit a response then it forced you to do the exercises even if you didn't want to, like your defenses were getting in the way of wanting to do them.

This reflects concepts considered in the guiding therapy theme about increased accountability to complete treatment, which is discussed shortly.

In regards to having a sense of control over their engagement with the treatment, participants also described what tasks they chose to complete and how they completed

them. For example, participant 202 decided their self-compassionate letter was too personal for the guiding therapist to read, so chose to write it off-line:

I wanted to write the letter to myself but it felt too personal so I decided not to write on the website and just print it off and write it to myself instead.

In face-to-face therapy it is possible that a stronger sense of obligation to share the letter with the therapist could occur as a result of increased social desirability (Heerwegh, 2009).

Finally, participant 215 provided personal insight from their work as a general medical practitioner as to why they appreciated the treatment being delivered through a cost-effective means:

Generally, I think it is very worthwhile and the truth is, a lot of the people that need this type of thing can't afford it and that is huge because people cannot afford face-to-face therapy. This is just the truth but particularly because I work in west Auckland. If we haven't got high needs funding for a person because they're not the right ethnic group or not living in the right street, if they're not actively suicidal then they don't get proper therapy. ... Things have got to change to reach more people. Something's gotta change so I think that this type of thing is a big step forward.

The above statement aligned with a key motivator for developing the treatment currently under investigation. This was to provide a treatment for a transdiagnostic issue that could be more accessible to a greater proportion of New Zealanders than face-to-face treatment is currently able to be.

Nevertheless, participants alternatively provided several benefits to the traditional face-to-face treatment delivery. For example, although the self-help treatment allowed the participants to complete each module at their own pace, it also appeared to allow more opportunity for the clinical perfectionism compensatory behaviour of procrastination. Participant 212 described how face-to-face treatment might intervene with procrastination more effectively:

It would have made me do that thinking on the spot. That's the whole thing about being in a social situation is it's a lot harder and you can't procrastinate and you have to do that kind of processing even if there's a high load. If you were saying, "[Participant 212], come up with three examples of where you judge yourself to a high standard," I would do it then and there on the spot but getting someone to sit there and generate it, it gives them the opportunity to say, "That's really, really hard," and therefore not do it. I think the social pressure side of it would probably definitely have helped a lot. I think that would be my thought there just because you're getting busy people to sit down and you force them to think.

Participant 213 also shared thoughts about the benefits of face-to-face treatment. They highlighted the enhanced flexibility of the delivery format and the therapist's ability to respond and adapt treatment to the client more readily:

I feel like I remember there were a few times when I did a module a week or two weeks after I had already struggled with the thing and I went, oh, I wish I had that two weeks earlier. I think the arrangement of the modules, that said, I found the flow or the order of the modules okay. I didn't feel there was anything that felt out of place or that I

didn't understand. Maybe I felt a bit like, oh, I really wanted to do that one down there and an earlier module wasn't as important. Maybe if it was something like, compared to a therapy session, I guess a therapist would be adapting and putting in what the modules would be most relevant for us to do. I guess it was definitely more of a gradual learning process and then it's designed at the end when you have all the information but you don't necessarily have that information on a week-by-week basis.

It was also highlighted how support from the therapist was more limited than it would be in face-to-face treatment. This was illustrated in two ways. Firstly, participant 209 described in the following statement how they found it difficult to take on the objective view of the therapist to develop treatment tasks, such as behavioural experiments:

It's easier when someone else helps you to create the behavioural experiment. It's like having two hats on when you're trying to create it for yourself. You need to look at yourself as a person then get your psychologist hat on and create for this person an experiment, and then do it. I found it took quite a lot of effort for me. Also, when you have some difficulties with something, generally, you go and talk to someone about the difficulty, and then they give you a perspective from the outside. So, when you're inside such difficulties, it takes a lot of effort to see it from someone else's eyes and see what would be effective for the situation.

This difficulty could be overcome through email engagement with the guiding therapist, however it would be less timely than in face-to-face therapy. Another time-sensitive issue is the ability to respond in the moment to client's emotional reactions to

the treatment and to provide useful rationales to help the client complete a treatment task. For example some participants reported feeling anxious or sad completing certain tasks, as with participant 204:

It is good to learn to identify my compassionate voice. I found it hard writing down negative thoughts that I have as it feels like I'm reiterating them. I definitely felt anxious and sad writing them down.

In the case of participant 204, a face-to-face therapist could have expressed empathy and provided psychoeducation about thoughts and the usefulness of recalling them to create change. This, again, could have been achieved via email in the self-help format. However, what would have been missed was the time-sensitive opportunity to follow this with an exercise to improve the client's mood before finishing the session.

In all, it seems that each delivery format has its benefits and pitfalls, and that these will need to be considered when deciding which format is appropriate for a given client.

2.2 Treatment pace. For some participants, it appears that the schedule of one session a week was too frequent. Whilst the average time for the twelve participants spent on a module was approximately fifty minutes, four participants averaged over an hour. One participant spent on average approximately two hours a module. It was those participants who spent longer than an hour on modules that made comments about desiring the schedule to be more spread out. Statements about the need for more time tended to be about a desire to have more time to process and assimilate the new information they had acquired. A number of strategies were suggested for how this could be achieved. For example, participant 201 reported that a mid-treatment break and review would have been helpful:

There was one point where I think I gave that feedback to you where I was like, "Argh, I could've used more time." I think it was probably week five, halfway through. I was just like, wow okay, I'm making a lot of realisations, I don't know what to do with this information. How do I figure this out and incorporate it into my life but the programme is moving on? I was like, I think I need to go back and review stuff. I feel like a midterm break.

Taking initiative, participant 209 described spacing out a module that they found particularly challenging over the course of the week:

I felt like it's too much in one session. I actually took a break after every big exercise to try to action what I've learned. Otherwise I don't think I would be able to remember the techniques for future use.

These two participants, plus participant 204, also reported that a module once a fortnight might have suited them better. Participant 204:

I think to me, personally, fortnightly would work quite well cos it gives me time to do it and then process and then maybe try and implement and start the next adding on.

Another issue that was raised was that the time required to complete the sessions conflicted with commitments outside of the treatment programme.

Participant 209:

Just the amount of time I have, I usually do everything in the evening. ... It was a pressure, I would say, because with the weekly email, it would sit on top of my email list until I actually completed the session. So every time I opened my emails I would be like, "I have to do it".

Participant 212:

I struggled massively with the pace but I just feel like that was because of everything else that was going on. I just really, really struggled to fit everything in. ... Basically, you should've put a four month gap in your treatment plan because I was busy is the honest answer but that's not an actual thing.

Nevertheless, many other participants reported that the pace of the programme was appropriate. For example, participant 208 stated

It never took me too long. Sitting down and doing that – that was usually round about an hour, which is good. It was a nice time. Just sit down and reflect. Wasn't too

quick but also didn't mean you had your whole afternoon gone or morning gone. It was a good size because when I got to the end of them, I was, yep, ready to finish. ... I liked it and I thought eight weeks was quite good. I ended up getting a bit of a routine where I'd do it on a certain day of the week; usually on a Sunday afternoon, I'd do it then. That was quite good as well. I like the once a week.

Similarly, participant 215 described the schedule of one module a week sufficient for them to do the required processing of information:

I think that's probably about right cos you need time to process it and try and do some of the activities that you've been prompted to do.

The range of time used and desired to complete the modules varied between participants. It appears that for some the amount of material in each module and the schedule of one a week suited them and was manageable. Alternatively, others found this to be a challenge and may have benefitted from a schedule specialised to them.

2.3 Repetition of the research measures. A number of comments were made about the weekly questionnaire that consisted of the research measures and tracked change from one module to the next. Whilst this was not a part of the treatment, and was instead an element of the research project, it appears that this may have impacted the participants' experience of the treatment programme. Participants reported experiencing a number of emotions related to completing the weekly questionnaire. For instance, participant 211 described feeling uncomfortable emotions:

I think the hardest part I found of it was the weekly questionnaire where I had to think about where I sat on the scale for a number of the questions because they did force

me to sit with some really uncomfortable feelings in terms of how my perfectionism was affecting me or how I was feeling.

Participant 207 and then 215 described annoyance and boredom, respectively:

Questionnaires every week were like, oh, for goodness sake!

Participant 215:

I thought it was quite good except that it seemed to be fairly boring sometimes because the questions that you do every week are just the same.

However, two participant reported that their reaction to the weekly questionnaire helped them to recognise the changes they had made for the better. For example, participant 204:

You know how you do that beginning quiz every week and it's the same – as I progressed along it, I would remember what I would've put before and I felt actually pretty good. I remember at the beginning, I definitely was saying things like, "Yes, I feel useless. Yes, I'm not worth much. Yes, blah, blah, blah." I really had a very, very low thing of myself. Then at the end I felt, for me, it was a huge step to be able to say, "You are actually okay. You are worth something without all that other stuff." That was so major for me because I really felt like I truly didn't feel like I was worth anything at the beginning properly.

Thus, it may have been useful for some participants to complete the weekly questionnaire but may have impeded treatment engagement for others.

In sum, the three subthemes described above draw attention to three important considerations that may impact a client's subjective experience and engagement with a treatment programme. It appears that this is specific to the individual, as consensus was not found within any of the subthemes.

3. The website content. The third theme described within the cluster concerning experiences of the website was the content of the website itself. Within this, four subthemes were highlighted, namely: 1) the treatment content, 2) the case studies and vignettes, 3) the website aesthetic, and 4) the treatment reflection tasks. These are discussed in detail below.

3.1 Treatment content. All participants commented on certain sections of the treatment that they particularly enjoyed for its content and what they learned from it. In fact, no participant highlighted areas they did not find useful or relevant, even when asked. Participant 201, for instance, stated:

I liked the flow chart thing we had to do at the beginning. The behaviour test was really good. The flexibility and guidelines one was really good because it changed my behaviours and how I felt. Those were the things that I keep thinking of but the whole thing was useful. Everything was useful in some way to link it all together.

As well as having favourite sections, participants also commented on liking it as a whole, and that as a whole, a sense of coherency was achieved. As made clear by participant 201 above and in general statements made by the likes of participant 212 here:

Obviously, again, I thought it was really good and you put a lot of time into the modules and the tone of them was really great and upbeat and fun, that kind of stuff so in terms of the intellectual content on there, I thought it was really, really good.

The way in which the content was presented also appears to have been important to the clients. Above, participant 212 talked about the tone in which it was delivered was helpful, in the following statement participant 210 expressed that the communication and flow of the self-compassion content was particularly useful for them:

I was thinking about going back on and going through the self-compassion one. The way that it was written really resonated with me, more so than a lot of the other self-compassion stuff that I've been looking at. Just the way that it was written and the flow of it. I don't know what was different but I really liked it.

Many participants commented on the self-compassion component of the treatment. In particular, a number of participants recalled the task to consider how they would talk to a friend experiencing a similar situation as a “light bulb” or revealing moment. Nevertheless, there was a large array of content sections mentioned as useful, and all content appears to have been considered relevant.

3.2 *Case studies and vignettes.* Overall, participants described the case examples embedded throughout the website as particularly useful to their learning. The usefulness of these examples was discussed in a number of different ways. Firstly, according to participants, the case studies and vignettes further enabled them to relate to the content and thus recognise their own clinical perfectionism tendencies more easily. As described by participant 204:

I thought that was really good actually having specific, like, this person, this is how they're doing it and then you can either identify with it or be like, "Oh, I'm not as bad as that. I wouldn't have done that." But mostly, I was like, "Yeah, that's me." I thought that was really good to have, with the concepts and stuff; have a real-life example. To be able to work out what's going on.

The case examples also helped to illustrate concepts, which aided comprehension. Participants 210 and then 209 provided examples of this:

That was 100% me. I didn't really realise that that was a perfectionism thing until I read the example and linked it.

Participant 209:

It was actually great to have examples to find my own examples. After listening to the audios, I was like, okay, that's what we're talking about. It was much easier after the examples.

As suggested by participant 209 above, and by participant 213 in the next statement, the case examples also made it easier for participants to find their own examples when completing worksheets:

I think the stories and the anecdotes overall were good because some of them were really related to what I was struggling with, like the academic stuff or the procrastination and things like that. ... It felt like starting with an interesting case and one that I can relate to and then it made it easier for me to then just adapt from the material that was already there.

In relation to this, participant 212 highlighted how this support in finding their own examples helped them to overcome procrastination, which was interfering with treatment engagement:

When you've got the work through example you can kind of take the easy road for one of them and be like, okay, I can come up with an example that's kind of similar to that and then you have to think a bit deeper so again, in terms of having a slippery slope to get people that are procrastinating and people that are really busy to actually start putting in the mental effort. If a task seems pretty easy to begin with then you've got 'em! ...whenever there was a work through example that really, really helped.

Nevertheless, one participant stated that the case studies and vignettes were not a useful addition to the treatment content for them. Participant 211:

I guess I wasn't so interested in hearing other people's stories around it. I'm so aware of what I need to work on that I personally don't need to relate to someone else's story to feel better.

It seems then, that for most participants but not all, the case examples aided their understanding of their clinical perfectionism difficulties and engagement in the treatment.

3.3 Website aesthetic. Another element of the website that was widely discussed by the participants was the aesthetic presentation of the website. In general, this was received positively. For example, participants 208 and 210 said:

I liked it, I found it quite soothing. I liked how there were little images and little quotes and different bits and pieces amongst the work.

Participant 210:

I respond well to imagery and that helps me a lot more than words so probably just the fact there's an image on the page and pretty colours and they were relaxing images.

The aesthetic presentation appeared to have a calming quality for many participants, which they appreciated. For one participant, this aesthetic helped to encourage them to engage in self-care activities whilst completing the weekly module.

Participant 209:

I loved the pictures at the beginning. Before the daunting questionnaire at the beginning of each session, it was like, get yourself a cup of tea, find a comfortable space, with a nice picture – I loved it! That's exactly what I did. I went and got myself a cup of tea and then got into it.

Participant 201 also highlighted an interesting effect of the choice of imagery for them. They described how it conveyed a sense of empathy from the author:

I liked the pictures. It was very calming. Every time I logged in, it was a new lovely picture, there was always something really nice. I could picture you picking the picture to put in the perfect place. I was like, oh, she really cares.

Once again, however, participant 211 held a differing view from the other participants. They felt the aesthetic presentation reminded them of self-help therapy, which did not appeal to them:

It wasn't really my style in terms of it did feel very like of the self-help genre but that didn't stop me or deter me.

That being said, for the majority of participants, careful consideration of the website aesthetic, and in particular images that helped to relax them and communicate a sense of care appeared to be important to them.

3.4 Treatment reflections. A final element of the website that was frequently discussed by the participants was the inclusion of text boxes to reflect on the treatment at the beginning and end of each module and a larger, overall reflection of the treatment in Module Eight. These opportunities to reflect appear to have played a number of important roles for the participants. For instance, they were commonly discussed as an opportunity to notice change participants had achieved and to recognise areas of difficulty requiring further attention. Participants 201 and 211 describe this:

That was really good to put into words. I was like, oh, yeah, I have changed this week and I was working on that this week, that's good. I do see changes. It was good to look back cos again, sometimes it was hard to remember what I had done especially when

I got towards the end. It was good to review. Like, okay, this is what we learned last week. Okay and then we're building on that.

Participant 211:

Just to recall what I had learned and also to properly analyse where I was at and think about what I wanted to achieve each time.

Participant 207 reported that the reflections helped them to pay attention to clinical perfectionism concerns they were still struggling with. They highlighted that the reflections were an opportunity to practice the CBT skill of noticing thoughts, feelings and physiological responses to be able to enact change:

The self-reflection was useful as it helped me to record how I felt about my relapse and also what I was feeling in my body at the time of the relapse. I really hope to continue that noticing practice in order to reduce my anxiety and desire to control things that I can't control.

Taking the time to reflect on the changes occurring seems to have helped participants to link all the treatment material together, as mentioned by participant 212:

They were good because they made it a coherent whole. I wanted to just rock up, quickly do some stuff and then get on but it was like, no, I've gotta think about what did I do last week. It made me procrastinate more because I had to go back and had to think about things but that's what you want so that was good.

Of note, the time taken to recall material led to procrastination for participant 212. However, this review of previous material appears to have been useful towards the

consolidation of information. As participant 203 described, the reflections forced participants to review the previous week's information:

I think I probably wrote on all the reflection ones a pretty good bit cos that's really the time I actually utilise it to think about it, too. ... it was hard for me to think back about what the last one before was and I'm, like, what's the last one? Several times I had to go in and see it and be like, oh, yeah, this is what I did for that one and then had to go back and write it.

Another, alternative use of the end-of-module reflections text boxes was described by participant 204. They described using them as an opportunity to communicate their experience and reactions to the treatment to the guiding therapist:

I think in particular, I mostly used it to talk about how it made me feel emotionally. How I really struggled with it or how I was in tears or whatever. I thought it was good to be able to have a little space where I could communicate with you directly. I thought that was quite good.

Thus it seems that the reflection spaces within the website were a useful treatment tool for the participants to notice change and achievements, recognise areas of further work, practice the CBT skill of noticing, consolidate their learning, and communicate with the guiding therapist.

In summary, the website was well received. Many aspects of the treatment content itself was described as useful by the participants, with each participant describing a variety of sections they particularly liked, and no sections being described as irrelevant or not useful. Of particular note, the case examples and treatment reflections embedded

in the treatment were highlighted as useful. Finally, the website aesthetic also appeared to play an important role in the participants' experience of the treatment.

4. The role of the guiding therapist. The final theme within the cluster of themes related to the website details reports on participants' experiences of the guiding therapist. Three subthemes were recognized within this. These subthemes described how the guiding therapy 1) personalized the treatment, 2) provided encouragement and compassion, and 3) increased a sense of accountability in the participants.

4.1 A personalised treatment. Participants reported that the inclusion of the guiding therapist created what was experienced as a more personal approach to self-help therapy. This was achieved by an awareness that the guiding therapist was reading each participant's responses and then developing a personalised reply based on these. Please note that in the statements to follow, the "you*" refers to the author, who also acted as the guiding therapist. Participants 208:

You could tell that you had a look over what had been done that session and used that as a way to get a summary, a reflection out of it. ... It makes you feel heard, it makes you feel understood, you've* gotten what I was putting there.*

Participant 204:

I think it's good that you were reading through it and I felt like you're* reading it and you* know what I'm thinking with regards to all this stuff and how I'm feeling and then your* response to it. I think it was good having those.*

Also adding to the experience of a personal approach was the perception that there was another human experiencing their journey through the treatment with them. For example, participant 210 and then 201 stated:

Yeah, it was nice that somebody was there with you.

Participant 201:

Just acknowledging that my responses were being read by a real human – that helped, too. ... It was nice to get the acknowledgement that someone was reading it, honestly.

Participant 213 described how through the course of the treatment the participant and guiding therapist developed a shared understanding of the participant's experience and difficulties:

Yeah, because it took place over weeks, that was a good process because it began to feel like a dialogue over time.

There is a sense in this statement of a relationship developing between participant and guiding therapist, which too would have increased the perception of a more personalised treatment.

4.2 *Encouraging and compassionate.* Many participants reported that they found the interaction with the guiding therapist a source of encouragement and compassion. Related to the previous subtheme, participant 215 stated that the personal approach of the guiding therapy encouraged them to persevere with the treatment:

I thought that was quite an encouragement cos it's a more personal approach. It was more an encouraging factor.

Others talked about how the strengths based feedback was positive reinforcement for them. For example participant 208, followed by participant 209:

I guess just the summary and the strength-based approach in terms of I'm doing something good and something's coming from this. That I'm reflecting on it and not it's just nice to get a reminder email but then you also get this email saying, "You're doing things well." It was a nice touch of it, I think.

Participant 209:

It's nice, I think it was positive reinforcement for me. I was waiting because it was always something positive because I am so harsh on myself, it was really nice to read something good. I think probably that's what I was waiting for, to read something positive.

Given that the participants all tended to be harsh self-critics, a compassionate weekly email from the guiding therapist appears to have been appreciated, and this too was motivating. Participant 213:

It was actually quite good to get feedback from you, I think, especially that feedback we talked about. I think it was good to have that aspect and also because you would come across as quite compassionate about the things that I've written in so I think that's also a nice reflection to get at the end of the modules. I suppose it wasn't entirely problem focused so you get a bit more of, "It sounds like you've done this," but put in a compassionate way so that was quite good, I think.

Developing self-compassion was a key goal of the treatment. The participants perceiving the guiding therapist's correspondence as compassionate could likely have been useful modeling of language that could be used in compassionate self-talk.

4.3 Increased accountability. The final way in which the participants experienced the guiding therapist as useful was as a means of increasing a sense of accountability to complete the weekly therapy tasks. A number of participants described how they felt they had entered into an agreement with the guiding therapist and there was an expectation placed on each to complete their roles. For example, participant 212 stated:

It was really nice and obviously it added a personalised touch to it so it felt much more like someone was attending and paying attention so it made me feel more responsible getting things done and knowing that you were actually gonna do your side of things.

Further to this, having the expectation of a specified time when modules would be completed increased the participants' sense of accountability, as illustrated by participants 204 and 209:

I was like, oh, she's so nice, oh, shit! You were always so sweet and you sounded so understanding and I was like, oh my gosh! Whenever I saw it, I was like, dammit, I really need to do this. I knew that you were probably like, "Can you please freaking do it, please, I really need it." I was like, oh man! I think that was good. I definitely needed it. Half the time, I'd be like, I've gotta do that, yep, I've gotta do that and then I'd get the reminder and I'd be like, shit, has it been an entire week already?

Participant 209:

The fact that somebody was waiting for me within this specified time limit, I thought, "I committed to it, so I have to do it". ... Yeah, it was my promise to someone, kind of thing.

Participant 201 illustrated how the sense of accountability was particularly useful during times of increased resistance and procrastination:

The accountability thing. I could've done it on my own but the fact that you were sending me the email every week, the fact that I'm getting responses, especially with the behaviour test – the thing that I was most resistant to. The only reason I ended up doing it was because I knew you needed me to get it done. That was the main point where I really needed that accountability just because on my own, I probably wouldn't have done it.

To summarise, it seems that for the participants the inclusion of a guiding therapist played the key roles of providing a personalised, encouraging, and compassionate approach to the therapy, and increasing the participants' sense of accountability to complete treatment tasks.

Cluster two: The participants' perceived outcomes of treatment.

As previously described, the second cluster of six themes presents the twelve participants' accounts of the outcomes of the treatment, as they perceived experiencing them. This included a change towards more flexible thinking, the development of new insight into their difficulties, an increase in self-love, a recognition of interpersonal improvements, an increase in productivity, and an understanding that their improvement continued to be a work in progress.

1. A change in thinking: flexible thinking. The first theme portrays the participants' reported change in thinking following the treatment. Within this theme, four subthemes are presented: a) a reduction in rigid thinking, b) the development of more reasonable standards, c) greater big picture awareness, and d) an experience of unwinding.

Participant 212 provided a general statement of how this change in thinking was experienced:

I think it has been really positive. I did it because I thought it would be interesting and didn't really think I was a perfectionist at all, in any way, and then actually it's been really, really good for me to see that there is another way. It's very interesting, the kind of bubble. Even though I felt like I made a nice life for myself, I'd also created a mental bubble around that, that wasn't particularly helpful and starting to break that has been pretty good. So thank you very much.

Below, the four subthemes are described in detail.

1.1 Reduction in rigid thinking. All of the participants described a shift in their thinking from rigid rules to more flexible guidelines as being a noticeable benefit of completing the treatment. This shift from black and white thinking to recognising most phenomena lie on a continuum of possibilities was described in a number of situations and as having varying positive effects on the individuals' thought patterns and behaviours. For instance, participant 204 described reframing their exercise rule, which resulted in reduced procrastination and a greater likelihood of achieving their goal to practice yoga:

It sounds funny but if I don't say to myself, for example, I wanted to start doing yoga, watching a YouTube chick at home. I knew if I say in my head – and this is the way I always tend to operate – if I say to myself, “Oh, I'm gonna start doing yoga and I'm gonna try and do it every single day,” that I wouldn't do it because in my head, if I skip a day or two, then it's written off. That's the way I've always been or it's like I procrastinate starting because I know it's not possible for me to do it every day. What I've said is in the moment, I might be like, “Oh, I have a free hour, I'll just put it on,” and then I find that naturally, I manage to actually do it just whenever and I don't have that underlying, I must achieve this thing.

This experience of actually managing to do the desired activity was a commonly reported outcome. Another was having more time for activities that were truly important to the participant, as described by participant 209:

For example, his meals, so at first I was thinking mums should cook fresh meals every day. And then I realised that it was taking time away from actually playing with

him – I'm cooking and he has to spend time on his own. So then I start freezing some meals. I'd cook for few days and freeze them and then this gave me time to play with him instead of cook. I think with all this process of being more relaxed about the rules, sometimes, it's happened maybe one or two times in the past two months where I didn't have a meal cooked or frozen, and yet, it still was okay. I didn't fall apart or anything, I just quickly did something with what I had in the fridge. Which is totally unplanned, which is totally not me – the old me – but I was so surprised that actually, I didn't fall apart because normally I would.

Yet another outcome frequently described, and illustrated above, was the discovery that one coped better with situations that they perceived they would not have in the past. This may in part, be a result of a shift in the black and white thought process that ultimately meant the participants no longer felt like a failure if they did not meet their rigid goals. Participant 215 described this:

Also, as I said before, challenging my habits and attempting to change behaviours, even if the thinking was still screwed up a bit. I thought to myself, I can do something different and see what happens. That was actually quite good and I didn't see it as a pass/fail like I would've in the past. When I went for the chairman's job I thought to myself, I don't care if I don't get this and it was the same with the other job that I did the CV for. I actually believed that, I actually really felt that I knew it would be fine if I didn't get it. That was a very new experience cos normally I would see it as some kind of test that I had to pass at all costs. I thought to myself, this is a good experience for me to write my CV and fly a kite, as it were. It was very productive.

Overall, a perception of a reduction in the rigidity of thinking appears to have been an essential outcome for the twelve participants.

1.2 Reasonable standards. Again, every participant reported noticing a shift in their standards to ones that were considered more realistically achievable. For instance, participant 208 stated:

When I think about my house tidiness standards and my work standards, I wouldn't say they're lower, I'd say they're more realistic and they're more fitting to the situation. If there's a presentation or there's a report I need to get done, I'm doing it properly but I'm not overthinking it and spending excessive amounts of time on it or procrastinating and not doing it at all. I'm going, I'm going to allocate two hours to this, I wanna get it done and get it out to this person and that's what I've been doing. I've been much more strategic. I feel like my standards have slipped but the quality of the work is probably the same. Maybe it's just more realistic.

In the following account, participant 207 described how they took active steps to remind themselves of their new, more reasonable standards:

I made adjustments on my vision board, actually. I have one of those, I think I may have told you about that, too, but I made adjustments on that and it's interesting. All my previous ones have been all very much I want this this year; I want to achieve this this year; I want to achieve that this year and I'm like that's just driving this perfectionism. You look at it every morning and you're just fueling this perfectionism. Whereas now I'm going, I've got things on, you don't have to act on your social anxiety now, you don't have a say over other people, stop getting wound up by that. It's okay to be wrong, it's

okay to practise with compassion and humility, accept that there might be some people that are better than you out there. That's cool. Don't try and push yourself and strive to be them because they're not stagnant, they will keep going as well so if there are gonna be five hurdles in front of you okay, there's gonna be five hurdles in front of you. Big deal. So those are the things that I've now seen on my vision board that I'll look at doing, I think that's better for me.

A number of participants described realisations they had that helped them to review their standards and develop more realistic ones. The most common being that others are flawed and the participant would not hold others to the same impossible standards. Participant 212 and then 207 gave good examples of this:

I think this is the other thing, part of my hyper-criticalness comes from the fact that I'm just making this stupid assumption that everyone else isn't making mistakes and isn't doing stuff and it's just accepting the fact that I do, we all do, it's really not a big deal and it isn't, the standards only in my head. It's really, really, really not out there so you don't have to stress about it or try to work really, really hard to hold yourself to that standard.

Participant 207:

I think basically the realisation that I wouldn't expect these standards from anyone else, ever. I did have very high standards and I guess I had this idea of who you are and again, if you're closely tying that to work and to achievement then everything's all intertwined, right? It's like you are valuing yourself based on what you're achieving and therefore you've really gotta hit those high standards because they're really critical

to your ego. Whereas if you realise that you wouldn't hold anyone else to those standards, it sounds obvious but you're still a good person even though you haven't met those standards and there's other aspects to your life where you have value.

Some participants recognised that their standards were still high, yet more realistic. For example, participant 203:

I think I still have a high standard. I think I'll always have a high standard and I think that's okay but there's so many more sides to the story. I'm not gonna hold everyone else to that standard until I work with them and I'm not gonna push that standard so hard that I am sick or that I'm miserable because the truth is the standard's high enough that I don't really have to do that. It's going to be fine regardless so that's probably the biggest thing. It'll be fine, I can do this. You don't have to push that hard which I'll still probably have to fight that feeling of that's a conceited thought process or prideful but it's okay, I can do that. I'll work on it.

No participant reported that their standards had dropped dramatically, rather they had become more realistic whilst still achieving their goals. It seems likely that the participants' standards still remain high relative to the general population, as suggested by participant 203. However, it seems that the participants were acting in line with a healthy pursuit of excellence, also referred to as adaptive perfectionism.

1.3 *Big picture awareness.* Along with reduced rigidity and more realistic guidelines, participants also reported developing a greater awareness of the big picture and what is truly important to them in a given situation. For example, participants 204 and then 208 explained:

I think I have been a lot lighter and easier on myself. Also, I am able to put it into perspective of like, well, in the grand scheme of things, does it really matter long term? No, it doesn't.

Participant 208:

I think it's realising the people are more important than a clean house. In the past, I fixated on things and I fixated on everything is clean, that I'm a good grown up and that I run the household well. Fixating on this idea of that being important and, actually, what's important is being a host and sitting down and having a drink and food with my friends. Doesn't matter how clean the couch is. Just really shifting. I think I'm really concentrating on the bigger things and what's necessary rather than getting stuck in details that don't matter. ... I think maybe some of the ruminating that I went through in the last couple of weeks was that again focusing on those details rather than where I've come and where I'm at. I notice it quicker now so it does still happen but I notice it and then I challenge it and look at the bigger picture and breathe it out!

As participant 208 suggested, this new more flexible way of thinking is a skill that takes practice. It was not that participants miraculously achieved an absolute new perspective on the world, but rather that they were able to notice and challenge unhelpful thought patterns more easily. A further example is provided by participant 210:

Yeah, don't need to try so hard and I can still achieve really highly and actually other things are more important. I think that's another overall message. Oh, definitely challenging my thinking cos I'm still a really black and white thinker so that's one that I have to challenge constantly, catching myself going what's the point in playing netball when I suck so much when it's like, actually, there's lots of reasons to play, even if I'm not good. Being good at it wasn't the reason that I chose to play.

The ability to recognise a relapse into old thinking or behaving patterns is a guiding principal of CBT, where the client learns to be their own therapist (J. S. Beck, 2011). This is an important skill to learn because it is recognised that this leads to lasting change in a client.

1.4 Unwinding. When describing their shift towards more flexible thinking, participants frequently also described how they felt more relaxed. As thoughts began to shift away from rigid and unattainable expectations, a reduction in anxiety and stress appears to have been simultaneously experienced, as explained by participant 204:

I think mostly it's that I'm a bit more gentle on myself and not so high strung. I couldn't ever unwind because I felt constant anxiety; that constant feeling, like butterflies kind of thing, all the time, about what I hadn't done and what I hadn't completed. I don't really have that anymore.

In return, participants also reported how feeling more relaxed resulted in them engaging in more adaptive thinking styles. For example, participant 209:

I'm more relaxed and it helps me to put thinking into perspective. I don't have these rigid rules anymore, like when it must be this way. It's not necessary that it has to

be this way. ... The point is I still have those rules but then when they break it's not such a big deal. I think I'm much more relaxed.

As with the previous subtheme, it was highlighted that this new found relaxation was not achieved all the time. Rather, as participant 213 described, feelings of stress were less frequent and lasted for shorter periods of time:

Instead of having long periods where I was stressed and focused for days or weeks or long periods in a row, I might do one day or half a day that was more like that and then I'd be able to snap out of it a little bit or I'd have other things on.

Again, this reduction in stress appears to be linked to the ability to notice unhelpful thought patterns and behaviours, and make the conscious decision to challenge these with more adaptive ones.

Whilst all of the participants reported they had noticed changes in their thinking patterns towards more flexible thinking, one participant reported that they believed the treatment may have had less of an impact on them than others. Participant 211 provided the following possible explanation as to why they may not have experienced a clinically recognisable shift:

I think perhaps since I have seen psychologists over the years, I think it probably would've had a lesser effect on me than someone who hadn't been to a psychologist or anything before because I already knew how to recognise my thought patterns or try and talk myself out of it. Just a lot of the tools and I guess just from doing CBT over the years. It was helpful that it was something that I was so familiar with, it did make it easier to do it. I think that it would've contributed to it not having a huge effect on me.

The fact that participant 211 had experienced much of the treatment material before in face-to-face treatment and it had not been successful may help to explain why they were the only participant not to achieve a clinically significant change in clinical perfectionism following the treatment.

2. Developing insight. The second theme the participants described was a new-found insight into their clinical perfectionism and what maintained it. This theme has been broken down into four subthemes that cover: a) an understanding of the clinical perfectionism cycle, b) development of the skill to notice clinical perfectionism-related thoughts, c) development of this skill through experiential learning, and d) recognising similar difficulties in others.

2.1 Understanding the cycle. All but one participant reported that they had acquired an in-depth understanding of their personal clinical perfectionism cycle, which they found useful. This involved understanding the common clinical perfectionism-related thoughts, emotional and physiological responses, and behaviours, and then linking them all together to understand how their difficulties were maintained for them personally, as illustrated by participant 201:

Yeah. It was like, this is your cycle. I was like, oh, yeah, that is my cycle, okay. That's what I do then that means I feel like this and that's bad and then I end up doing that. It was just really good to work through. ... I could see where it all fit in in terms of my emotions and behaviours. That was really key in recognising that I have this thought and then I think it's fact – the fact or fiction thing. Then therefore I feel this way but is it based on real facts? No. Then because I feel that way, I act this way. Putting it all together was really, really useful.

Further to this, participants described developing a greater understanding of their experience of other difficulties such as depression, anxiety or stress by connecting the dots between clinical perfectionism and how it acts to maintain their other problems. For example, participant 208 stated:

Not realising how much my anxiety and stress links to my perfectionism. That was an interesting thing to realise. The behaviours are so strongly linked to how you end up feeling about yourself and thinking about yourself and others. That was cool to start realising that and seeing. ... All the different ways that your beliefs and everything, all the way back to their impact, everything. Making lots of connections and links.

The participants then highlighted how understanding their clinical perfectionism cycle enabled them to take action to create change. Participant 209:

It does help to cope and do something about it because there are strategies we did in the treatment that I do use. I can't even name them but I do use them and then when I notice something about my difficulties which link to perfectionism, I know I can use certain strategies, which does help. Originally, probably before treatment it would seem to be completely unrelated so I wouldn't know what to do, but now I do. I think this is the biggest thing I took from the treatment.

Thus, participants were able to understand the clinical perfectionism cycle, recognise when and how it was at play for them, and then understand how engaging in alternative thoughts and behaviours could act to break the cycle and lead to positive change.

2.2 *Noticing the thoughts.* Participants talked at length about their new-found skill of being able to notice a maladaptive clinical perfectionism-related thought, in order to be able to respond differently. This, for instance, was described in simple terms by participant 203:

Acknowledging a critical thought in itself is a major step for me...because from there I can realize what I'm doing...and stop it.

Examples of how participants learned to respond differently to unhelpful thoughts included challenging the thoughts through questioning to recognise its incongruences, as described next by participant 211, or outright noticing the thought's unhelpfulness and dismissing it, as then described by participant 210:

I think it has given me more language and tools to better understand and manage my perfectionism. Definitely has helped me to use the tools to stay on top of it in terms of writing things down better helps me to stop negative thinking and ask myself why I'm thinking those things. Am I being unfair on myself in terms of the standards I hold to myself?

Participant 210:

I'm like, mm, that thought's not required but thanks anyway.

In terms of specific thoughts, participant 204 reported that they were able to notice the more general impact of them in the past and their influence on the participant's wellbeing:

I think that I'm at a new level of happiness and peace in general but I think that's probably the key thing. I realised as I was doing the course that that's the reason I probably got depression in the first place – because I was just telling myself the whole time that I wasn't a good mother and that I had all these things I needed to live up to that I couldn't.

Alternatively, some participants, such as participant 207, described not just noticing specific thoughts but also noticing more general thinking styles:

I think that's the thing that the perfectionism study has brought out in me as well. I've identified how black and white I am.

All of these types of noticing are considered important towards developing an understanding of the clinical perfectionism cycle and the creating change. In CBT, as previously mentioned, this skill of noticing is recognised as an essential skill to develop for the sake of the individual becoming their own therapist, as a means of creating lasting change and reducing the chance of relapse.

2.3 Experiential learning. When discussing the development of insight, many participants reported that they found learning through doing was important to their increased understanding. For example participant 207 and then participant 215 stated:

I found the content of the modules to be helpful just from reading through that and then more from going away and attempting to implement that from an experience perspective was helpful. I liked that side of things.

Participant 215:

I've been experimenting a lot more. I really took up with the idea of – I can't remember which session it was – but about experimenting with different things. So I do that quite a lot. I did a few things that I wouldn't normally do.

When encouraging an individual with clinical perfectionism to engage with a new way of behaving, reframing it as an experiment may be particularly useful because it allows the individual to take a risk without committing permanently to a new way of behaving. Therefore, it does not fit as easily within the black and white, pass/fail construct and instead, helps to generate an awareness of a number of different possible options and outcomes (i.e., shades of grey).

An example of experiential learning leading to increased insight was provided by participant 201:

The one with the behaviour tests – week six. Those were very eye-opening. ... It was work on my PhD for “try it” for five minutes and see how far I get, something like that. The issue was that I procrastinated on just doing the behaviour test. My resistance to it was so high, I couldn't believe how resistant I was even just trying it. I was like, what is wrong? Something is clearly going on, that I'm not even willing to sit down and do this for five minutes. I ended up doing it and it was fine. My ideas about what it would be like were so much worse than what it was and it was fine and I felt so much better afterwards.

This example allowed the participant to witness a real-life outcome and recognise that it did not match their predictions. It allowed the participant to experience change in both their thoughts and their emotions following a behavioural change. Experiencing the change rather than just theorising or talking in the abstract about possible change is

thought to be more convincing for the individual and lead to a greater likelihood of lasting change (Kennerley, Kirk, & Westbrook, 2017).

2.4 Noticing it in others. A final way in which the development of insight was discussed by the participants was within a new tendency to notice unhelpful clinical perfectionism-related thought patterns and behaviours in others. This too appears to have acted as a mechanism to increase the participants' understanding of the clinical perfectionism cycle and how it might be negatively affecting them. Participant 212, for example, described how they noticed others thinking in unhelping ways and how this helped them to recognise the unhelpfulness of it for themselves:

It was surprising seeing lots of other people I knew doing it and not just in a work environment. Some of the guys I surf with are super-laid back and then you're driving back from the beach and they're really annoyed at themselves for having not done this or this and it's like, well, hold on a second, you just had a really, really good surf. Normally, they're pretty positive people but it's interesting to see them doing it. As soon as you start seeing other people doing it to themselves, again, it really helps noticing that process with yourself.

Another way in which noticing clinical perfectionism in others was reported was recognising these tendencies in family, friends, or colleagues and then acknowledging how those individuals' behaviours may have been acting to maintain the participant's clinical perfectionism. For example, participant 210 stated:

I left my husband and I think actually the programme helped with that cos he was quite unhelpful in that sense. He was very perfectionistic as well and he expected

perfection from me to make his image look more perfect. I was like a status symbol to him, I think, so it was important that I looked good all the time. He wasn't very helpful with the self-care things I was trying to do and there was that dissonance of I'm just trying to better myself and love myself and you're not gonna support me with that? What's that about? So that's part of the picture obviously.

Overall, it appears from the participants' reports that a key outcome of the treatment was an increased understanding and recognition of clinical perfectionism, what maintains it, and the negative effects it did and could have on their lives. As well as a newly developed ability to apply this knowledge and notice when they were engaging with unhelpful clinical perfectionism-related thought patterns and behaviours in order to stop the clinical perfectionism cycle.

3. An increase in self-love. The next theme related to the participants' perceived outcomes from therapy was an increase in positive self-image and self-talk. This was discussed within four subthemes: a) increased self-compassion, b) reduced self-criticism, c) increased self-esteem, and d) a sense of a shifting self-worth. An example of this increase in self-love was provided by participant 210:

It just helped me like myself a bit more and appreciate myself and go, actually, I'm gonna come first. ... I feel very excited about actively being kind to myself more.

The four subthemes are described in detail below.

3.1 Increased self-compassion. Many participants described engaging more with self-compassion following the treatment. Participant 215, for instance, described how they came to the realisation through the treatment that they should challenge themselves to do this:

For one thing, I realised that what I think about other people and what I think about myself is definitely far more critical of myself. I've realised that it wasn't logical though. I think what they call the cognitive dissonance was quite obvious. With doing this questionnaire over and over I thought, stuff this, I know that I'm not answering this in a logical way, it wasn't rational. The way that I think about myself is not the way that I think about other people and that I'm far more compassionate about other people. That was helpful to realise that. That was a bit of a revelation cos I thought to myself, if I can treat other people with compassion, why can't I treat myself with compassion? I started asking those sort of questions.

An engagement with self-compassion was described by the participants in two key ways. Firstly, participants reported described thinking more kinder and generous thoughts towards themselves, particularly when they made a mistake. For example, participant 204:

I feel like I let things be a lot more; things are the way they are; people are the way they are. I've always tried to be quite non-judgmental of people anyway but I think I haven't been very good with that about myself and even perceiving of people's view of me. I did make a little mistake at work and I did feel a little bit bad about it but at the

same token, I was also like, “Well, anyone would’ve made that mistake as well, it wasn’t actually super obvious.”

The second way in which engaging with self-compassion was described was through increased acts of self-care. For example, participant 208:

When I was sick, telling work and telling them I needed some more time and it’s going, right now I need to concentrate on doing what’s right by me. Not this pressure I put on myself or expectations I put on myself. It’s going, this is what I need right now and it’s not selfish, it’s not bad. It’s actually being kind to myself and giving myself some time off or some reduced hours and going, I need to go home and have a bath, that’s what I need to do right now. That’s important. It’s more important than work. That self-care has been an important thing that I have prioritised.

Creating time for oneself for self-care activities and increase a sense of balance in life was an important aspect of increased self-compassion for many participants. Further to this, the realisation that this was not being lazy or selfish appears to have been important towards allowing the participants to engage with such behaviours.

3.2 Reduced self-criticism. Along with increased self-compassion, participants also talked about experiencing a decrease in self-criticism. For example, participant 201 reported:

I don’t beat myself up as much as I did before. I’d make mistakes and it would bother me a lot more and now I just shrug it off and say, “Okay, well that’s how I learn how to do things. Next time I won’t do it.” That’s really good. That is a definite positive outcome from the treatment.

For a number of participants, this decrease in self-criticism was one of the most obvious changes in them post-treatment. Participants, like participant 204, described how they had not been previously aware of the extent of their self-criticism or how it might differ from other people, and their ability to now notice it and challenge it was important to them:

I think particularly the main noticing factor that I think I've had is that critical voice that I always had there, I've been able to pretty much shut it off. When you live with something for your whole life, you don't realise that people don't have that; that for everyone else they don't have a little horrible gremlin that's telling them they're crap all the time. For me to be able to say to it, "No, this isn't cool. I'm not okay with this," it's been really, really good.

It seems that the softening of the self-critical lens also meant that participants were able to notice the positives in themselves and what they had achieved more easily. Participant 203, for instance, described how they had been concerned that noticing their positive attributes meant they had become conceited, but then instead realised that they were observing themselves without their usual clinical perfectionism-influenced perspective:

I've felt that I'm almost 'bragging' or being prideful about myself the last few weeks, because I've noticed more of the good things than the bad things....now I realize it's just me seeing it myself without a perfectionist/self-critical lens. It's been crazy.

This concern of becoming self-absorbed, arrogant, or lazy is a common obstacle for individuals with clinical perfectionism to letting go of self-criticism, being kinder

towards oneself and engaging in self-care (Egan, Wade, Shafran, & Antony, 2014b). Nevertheless, according to the participants' reports, a reduction in self-criticism was achieved for the majority of participants.

3.3 Increased self-esteem. Participants also described an increase in confidence in themselves and their abilities. For example, participant 203 stated:

I realise that I'm pretty good at what I do.

Some participants provided more specific examples of areas in which their self-esteem had improved and how they had achieved this. In the next example, participant 208 described how they consciously made use of the treatment material to challenge old beliefs about themselves and develop new ones:

My old thinking was I'm gonna fail at things so I won't give them a try. I'm not good enough, I'm not good at things. I had a summer fling and going into that, I was like, it's not gonna last, it's gonna be this and that, anyway. I was putting all these projections onto it that were just not helpful so I used quite a lot of the material to look at the thinking around that. That challenged my belief about being ready to move on and start a new relationship. It's fizzled out with that guy but it's given me this idea that I'm ready for that and that I can do it and there's nothing wrong with me. Things have failed in the past for their own reasons but actually, I am fully capable of trying that again. That was a quite a nice realisation.

Participant 215 also reported how the treatment encouraged them to explore new activities that impacted their sense of self-esteem:

As a result of the treatment I did write my CV for these two jobs – the chairman role and this other role. Writing the CV twice and writing cover letters and whatnot, that was very helpful though it did boost my self-esteem. ... Writing the CV was very helpful to give me a sense of what I've achieved and then saying to myself, do I need to keep pushing myself? And deciding probably not. Why? Asking these questions. Why keep pushing yourself? What are you trying to prove? Those sort of questions and I think that actually did help my self-worth a lot. That process was probably a direct response to the perfectionism course cos normally I wouldn't have done that, I don't think. My normal response would be just to avoid those things and think of it as too hard and why bother and all that sort of thing. It was really doing something new that was actually very helpful and it gave me a much stronger position to go into the wage dispute with.

Both of the above two examples highlight how participants' engagement in activities they usually would have avoided had positive outcomes that contributed to their perceived increase in self-esteem.

3.4 A shifting self-worth. The final way in which an improvement in self-love was described was in a recognisable shift in what participants attributed their self-worth to. As participant 201 described, it was no longer simply about achievements:

Being able to separate my humanity or my self-worth from my achievements and the mistakes I've made has really been a key change. I'd say I'm very happy with how that went.

How this shift was achieved for participants was described in a number of different ways. Some participants reported focusing more on the value they give and receive from relationships. For example, participant 212:

I have noticed that shift in me of just realising that very little of my self-worth comes from these achievements and it's really not a big deal. That was just like a little wall put up that helped you work even harder and protect yourself when, in reality, self-worth isn't really about those achievements. I'm still not perfect but I have tried harder to just focus on developing and maintaining my friendships and relationships and actually trying to do things that are just more about putting my worth into those kind of things rather than into the achievements.

Another way participants actively increased the contributing factors to their self-worth was to increase engagement in activities they enjoyed, as participant 209 described:

It was one of the sessions where we, I think one of the last session explaining how we shouldn't base our self-esteem just on a few areas, and that's exactly as I was doing. I had a family, study and work – that was my three areas. I would base my self-esteem on these three areas. I think today would be the third time I went back to dancing. I thought it totally makes sense, I believe in it and I should try to do something because I'm better than I thought I am, I think.

Finally, yet another way by which the shift was achieved was through the specific letter writing task in the eighth module, which required the participants to describe what made them worthwhile, without mentioning their achievements. Participant 210 reported on this:

It totally blew my mind to have to write why I am worthwhile without talking about achievements. That was so hard. It made me realise how different my standards are for myself than others because I had never even thought about it like that for myself but I could easily do it for my friends.

However it was achieved, it seems that one of the key messages of the treatment, that the individual is worth more than their achievements, was effectively communicated, understood, and accepted by the majority of the participants.

4. Interpersonal improvements. Another theme participants discussed as a perceived outcome of the treatment was the experience of a positive change in interpersonal interactions and dynamics. It appears that participants felt they were able to develop closer connections with people and were able to manage others in work settings better and with greater ease. Participant 208, for example, described a sense of increased closeness with friends, and attributed this to a new-found openness and expression of vulnerability:

I think reaching out to friends has been a really massive one and I've had feedback from five or six friends saying that they've never seen me as open and honest and just sure of myself than in the last couple of months. Over summer and things, I saw people I hadn't seen for a while and I was saying, "It feels quite vulnerable to be talking about things that are difficult for me," and they said, "It makes you stronger and it makes us feel better that you're talking about things because we all worry about you when you don't talk about things." All these things I was trying to protect my friends from any stress

or worry, was actually causing them stress and worry. I think it's really strengthened my friendships and my relationships and that's something that will be ongoing.

The statement above describes the participant allowing trusted others to see a (subjectively perceived) imperfect version of themselves. Within relationships this acceptance of imperfection was also described in reverse. Participants reported how they had begun allowing others to be imperfect too. For example, participant 203 described becoming less critical of others, which improved their relationships:

There's another senior manager – we were very different personality types and we did not get along well. Over the last year that relationship has changed drastically and that has to do with her, too, it's not just this but I think it is to a certain extent. I don't quite judge her as harshly on the things that I did before. I definitely judged her harshly on it and now I see a broader picture of her and I see what she's doing about things. So that's probably changed even more than anything else.

Participants also reported engaging in less micromanaging of others. This included trusting others to do a good enough job, as described by participant 201:

It's something I hadn't thought about but I have someone that helps me part time with my job and I found I've leaned on her a little bit more the past few months. I didn't even realise that. I have been giving her more stuff to do and not trying to control what she does or the quality or the outcome. I just say, "Could you please do this," and then maybe it's not what I would do but if it's something that needs to be addressed, I have her address it. If it's good enough, it's fine. It's taken a little bit off my plate in terms of work.

This is likely to be, in part, due to a change in the participants from black and white thinking (the common unhelpful thinking pattern in clinical perfectionism) to recognising “good enough” is, in fact, sufficient. As well as recognising that if the job done is not perfect, it does not reflect on them (the participant) as harshly as they anticipated (i.e., they are not a failure).

Overall, it appears that allowing others to see their imperfections, allowing imperfections in others, and refraining from micromanagement led to participants experiencing an improvement in their valued relationships.

5. Improved productivity. The fifth theme presents changes in perceived productive output, as described by the participants. The participants discussed this in terms of a) a decrease in procrastination and b) an increase in productivity.

5.1 Reduced procrastination. A majority of the participants described improvements in their ability to overcome procrastination as a result of the treatment. Procrastination is recognised as a significant compensatory behaviour and maintenance factor within clinical perfectionism (Egan, Wade, et al., 2014b), and was directly targeted in the sixth module of the treatment. Participant 212 provided a good understanding of the procrastination cycle and a description of the skills provided in the treatment to overcome it:

Dealing with procrastination and chunking things down into smaller blocks that I can actually achieve ended up just being a bit of a game changer for me – it really, really helped. I’ve been insanely busy but I’ve managed to juggle everything. I’m not sure if I’d have been able to juggle everything without having had some of these tips cos I was

struggling and had so many things on and then being able to chunk things down and actually feel good about achieving small goals which then leads to you feeling good about doing the next chunk and the next chunk and the next chunk rather than trying to do something really massive and not really working out and then getting really frustrated and then either procrastinating or working on a project that actually is easier to do or fun to do and ignoring the big stuff. So that's been one of the big ones for me.

Learning to problem solve and break tasks down into smaller achievable chunks was a key part of the treatment intended to intervene with procrastination difficulties. Another aspect was challenging black and white (also known as all or nothing) thinking in regards to the participants' standards and their motivation to complete a task, as described by participant 204:

I think making my brain realise that there's more than one way of doing things. I think there was one key thing in particular that I had struggled with which was to do with my black and white thinking. If you can't do it well, then there's no point in doing it and it was like, no, it's better to have done it in any capacity than to have it not done at all. That key thing quite helped me with regards to my procrastination as well because it took that bar down.

Based on these reports and others, it seems that participants were able to understand the treatment material targeting procrastination and apply the knowledge and skills to their lives to overcome it.

5.2 *Increased output.* In direct relation to the previous subtheme, participants noted that they were managing to achieve more than they were before they received the treatment. For example, participant 201 described managing to keep a tidier home by lowering the expectation of how much they would achieve in one go and turning that expectation into an aim rather than a rigid rule:

Yeah, and the guidelines thing was really helpful, too, not being “I have to clean the entire house this weekend”. Like it would be nice if I cleaned a little bit. Just reframing things and I end up cleaning more than I did before, it’s not as hard. That really helps, too.

Similarly, participant 211 described achieving more at work because they had more reasonable expectations:

I have been writing more and publishing more. ... Previously, I partly was slow cos I would just struggle and agonise over making it really, really good. I’ve definitely sped up because now I’m just okay with being confident in that what I’m doing is good enough anyway so I can just submit it to the editor and not fuss about it.

Not only did participants describe achieving more, but they also described this occurring under less perceived pressure. For participant 203, for example, this was experienced as having had more time to complete the same tasks because they were more organised:

I actually find myself asking that a lot – what do I actually need to work on now and then I do that. I’m also finding that I get to points where I can pick because I’ve planned things out. That’s done and you’ve already done enough of that and you had two

days to do that so what do you need to do now? I need to do this. Which I don't have any more time than I had before and I guess I prioritise it better probably. Yeah, it definitely feels like I have more time now.

Additionally, participants perceived that they were actually performing at a higher standard as a result of completing more tasks, as reported by participant 207:

Actually, I think I'm probably performing better. I've started to write blogs again, I would say I'm probably a little bit more organised in my work.

This supports a fundamental message within the treatment programme; that challenging excessive, rigid standards to develop more reasonable ones will not result in a performance decrease (as feared by many individuals with clinical perfectionism) and may actually result in an improvement.

6. *A work in progress.* The final theme discussed within the perceived outcomes of the treatment highlighted that overcoming perfectionism was an ongoing process for the participants. The participants recognised that they had made considerable improvements but also continued to have clinical perfectionism-related difficulties they needed to persist with challenging and moments of relapse that required their attention. For example, participant 212 described making considerable gains towards overcoming procrastination in the previous theme but also reported it was an area of continued focus, as was unreasonable standards:

I still procrastinate, I still sometimes switch into that mindset of trying to attach worth to achieving very high standards but I think I'm getting better at catching my high standards. I noticed it during surfing or particularly during kite boarding sessions where

I'll be getting frustrated at myself for messing something up and then I'll be like you're lucky that you get to do this and it's really good fun even if you just go up and down and don't do something. It's just re-setting what I'm doing. I'm pretty sure it's gonna be a battle forever but that's fine, I have lots of battles!

Whilst participants reported that they continued to have areas of difficulty, the important difference was that since completing the treatment they could recognise the unhelpful thoughts or behaviours that they were engaging with. This meant they were then able to respond with skills learned through the treatment to affect change. Participant 213 stated:

I think something I would still be working towards is still that time management and having boundaries around that but I would say that at least I'm a lot more aware of it now and I think I'm a lot more aware of when I'm being self-critical when I talk to people as well.

Further to this, participant 208 described a recent time when they reverted to their old clinical perfectionism cycle, and recognised that increased stress was a vulnerability factor for them:

Yeah, there's been quite a lot of stresses going on. I think I've gone to my default again. I was being quite mindful of being really aware of those behaviours and tendencies and habits and thoughts but then when a few stresses happened at the same time, I went into default mode and now I'm just getting back on the horse after a couple of weeks. Starting to really notice my thinking and my critical voice and all that.

Increased external stressors are likely to be a realistic catalyst for relapse (Egan, Wade, et al., 2014b). The final module of the treatment provides education on the likelihood of relapse and that this is a natural and expected part of overcoming any problem. It is presented in a way to challenge black and white thoughts about relapse and interpreting it as failure. Based on participants' reports it appears that the participants were able to develop reasonable expectations of their ongoing improvement and had developed the skills to intervene when difficulties arouse.

Chapter Four

Discussion

The current research investigated the effectiveness of a guided ICBT-P, *(I'm)perfectly Me*, based on the self-help book “Overcoming Perfectionism: A Self-Help Guide Using Cognitive Behavioural Techniques” (Shafran, Egan, & Wade, 2010). Namely, it investigated whether it would reduce clinical perfectionism, self-criticism, depression, anxiety, and stress, and increase self-esteem in a sample of adults in New Zealand. As a mixed methods, case series design, it included both quantitative and qualitative analysis. Statistical analysis of repeated measures was performed to detect reliable and clinically significant change. Thematic analysis of data gathered at the end of each module and at follow-up interviews was completed to explore the participants’ experience of using the ICBT-P intervention.

This chapter explores the main findings of the current study. First, a discussion of the results pertaining to the original hypotheses and exploratory research question is presented. Following this is a reflection from the perspective of the guiding therapist. This is followed by a discussion of the limitations of the study. Next, an explanation of the contributions to the existing literature is provided and suggestions for future research are given. Finally, the potential clinical implications of the study are described.

Principal Findings

Hypothesis one: The guided ICBT-P intervention will produce clinically significant reductions in perfectionism, which will be maintained at follow-up. The guided ICBT-P intervention appeared to successfully treat clinical perfectionism, as measured by the CPQ. In fact, all of the participants included in the analysis but one had recovered by the two-month follow-up, demonstrating a 90% recovery rate. Notably, three of the participants who had not met recovery criteria at treatment end continued to improve over the following two months, and had achieved recovery by the final time point. This continued improvement post treatment may reflect participants' feedback that the treatment was a gradual learning process that required time for the assimilation of information and practice in real life scenarios. Overcoming perfectionism difficulties was reported to be an ongoing endeavor for many, and this was likely more strongly the case for some participants than others. However long participants took to reach recovery, this study has produced promising results for the effectiveness of the guided ICBT-P at reducing clinical perfectionism.

Overall, the pattern of treatment response observed was a gradual decline in CPQ scores between baseline and follow-up (refer to Figure 3 in Chapter Three: Results). By half-way through, at Module Four, only two of the participants had demonstrated reliable improvement. Given almost all of the participants recovered by follow-up, this pattern of improvement contradicts the meta-analytic findings for guided self-help treatments, whereby reliable improvement in the first four sessions has been found to predict the best chance for recovery (Delgadillo, 2018). The gradual improvement trend again supports

the participants' reports that the learning process and process of change was a gradual and accumulative one.

One participant, participant 211, did not demonstrate reliable change from baseline to treatment end or follow-up in clinical perfectionism. Their CPQ score remained relatively stable throughout the study (refer to Figure 3 in Chapter Three: Results). This particular participant reported in their initial interview that they had received CBT from multiple therapists in the past, which had specifically targeted the participant's clinical perfectionism. They also stated that these previous treatments had been unsuccessful. Participant 211 was the only participant who reported having received treatment for clinical perfectionism prior to this study.

It could be that participant 211 was not a suitable candidate for a short-term CBT intervention, given their history of previous attempts. This could have been assessed using the Suitability for Short-Term Cognitive Therapy Rating Scales (Safran & Segal, 1996, pp. 257–266). They may have had deeply held schema, which could possibly require a more personalised and nuanced treatment than a self-help therapy could provide. They may also have had a broader constellation of difficulties beyond clinical perfectionism that were not detected by the assessment measures used in this study. It might be that these needed to be addressed first before clinical perfectionism. Participant 211 was the only participant to state that they did not appreciate the vignettes and case studies embedded in the ICBT-P, stating that they did not need to relate to other people with perfectionism to make changes in themselves. Possibly, this attitude interfered with engaging in the treatment. Other participants highlighted this material enhanced their engagement and learning. Participant 211 was also the only participant to state that they

did not like the imagery, because it reminded them too much of the self-help genre. Nevertheless, according to their report, it seems that face-to-face treatment had not produced positive outcomes in the past for this person either.

Drawing on perfectionism literature, it could be theorised that participant 211 had attributed their historical lack of success to themselves, and thus viewed themselves as a failure. This would fit with the CBT maintenance model of clinical perfectionism. If this were the case, then the theory of Miller and colleagues (2017) would suggest that participant 211 may have projected their self-criticism onto the guiding therapist, expecting the guiding therapist to also view them as a failure. According to Miller and colleagues (2017), this would result in hostility from participant 211 and difficulty developing a therapeutic alliance, which would ultimately impact treatment outcomes. Notably, participant 211 was recognisably harder to engage in the initial assessment and final interview. If hostility and difficulty with alliance building did impact their outcomes, then it might be that face-to-face therapy with a clinician rated above average in Rogerian attributes, as suggested by Miller and colleagues (2017), could offer the best probability of producing positive outcomes. Alternatively, initial face-to-face sessions with such a therapist to build the alliance, followed by the ICBT-P may be an alternative protocol to explore.

All other participants, including participants 202 and 204 who were not included in the RCSC analysis, made substantial improvements and were below the cut-off score on the CPQ at follow-up. In fact, there was a selection of participants who experienced significant and stressful life events, which could have reasonably been considered to disrupt treatment progress and trigger old perfectionistic thinking styles and behaviours

but did not. For example, participant 210 reported that they ended their marriage and moved out of their home during the treatment. Participant 202 reported that their father died during the treatment, while trying to complete their Master's thesis. They reported that they had to return to their home town to care for their family and were the lead person in organising their father's funeral. Such events do not appear to have impacted treatment outcomes, which could be attributed to the effectiveness of the treatment, although this was not tested directly.

In regards to other measures of perfectionism used, a majority of participants also recovered on the FMPS CM and PS subscales. On the FMPS-CM 67% of participants were recovered by follow-up and on the FMPS-PS 58% had recovered. While not as impressive as the CPQ findings, this is nevertheless a promising result. Both the Sweden-based Rozental et al. (2017) trial and the United Kingdom-based Shafran et al. (2017a) trial of a similar ICBT-P used the FMPS-CM for RCSC analysis. These trials achieved 59% and 43% recovery, respectively (Rozental et al., 2018). Furthermore, the results of the current study are directly comparable with the Egan et al. (2014) results for face-to-face CBT-P, where a matching 67% recovery rate on the FMPS-CM was observed. In comparison to ICBT interventions for other difficulties, the results of this study also performed well. For example, as mentioned in the literature review, Nordgren et al. (2014) reported recovery rates of 46% for mixed anxiety disorders.

It is interesting to note the substantial difference in recovery rates between the CPQ and FMPS subscales. This is likely due to the fact that the same authors and same theory underlie both the ICBT-P treatment and the CPQ scale. Therefore, it could be concluded that the ICBT-P does indeed target what it aimed to target. Another possible

explanation for this observed difference is that at face value, the CPQ items appear more concrete and behavioural than the FMPS items. The FMPS items seem to capture seemingly more stable ideas about the self, the world, and others, possibly reflecting what is referred to as negative assumptions and core beliefs in CBT. This difference in the face value of items would seem to make sense given that the CPQ reflects the CBT definition of clinical perfectionism, which was specifically developed as a construct to be targeted in therapy. Alternatively, the FMPS is rooted in a definition of perfectionism as a personality trait, which would seemingly focus on more stable beliefs and ways of behaving. Therefore, it could be that the ICBT-P treatment can shift the clinical perfectionism behaviours (resulting in a reduction on the CPQ) and develop new adaptive beliefs while also maintaining the individual's original, more stable, negative beliefs to an extent (resulting in a lesser reduction on the FMPS).

The more recent school of thought in CBT theory would argue that one can still hold maladaptive beliefs (albeit weakened) but also develop new, more adaptive ones through therapy. These new beliefs are added to the individual's repertoire to challenge the unhelpful ones as they arise (see Mooney & Padesky, 2000). Therefore, one could still endorse negative beliefs on an instrument such as the FMPS but nevertheless also hold more positive ones. This would result in the individual's clinical perfectionism behaviours reducing as they challenged their unhelpful thinking. Thus ultimately, resulting in a reduction of the performance and experience of clinical perfectionism for the individual.

Hypothesis two: The guided ICBT-P intervention will produce clinically significant reductions in self-criticism, depression, anxiety, and stress, and increases in self-esteem, which will be maintained at follow-up. The intervention had a mixed and less clear impact on the remaining five secondary outcome measures. This may be due to methodological issues rather than a true reflection of the impact of the intervention of the variables, as discussed below.

Firstly however, favorable results were demonstrated for the effectiveness of the guided ICBT-P on self-criticism. On the DAS-SC, 73% of participants had recovered by follow-up. This finding fits with participants' feedback that a reduction in self-criticism was one of the most noticeable changes they recognised within themselves. A gradual decline in scores was observed throughout the treatment (refer to Figure 7 in Chapter Three: Results). This suggests the treatment slowly intervened with the unhelpful thinking process, rather than any one module having a large and observable impact on it. Of the three participants who remained unchanged, participant 211 was included. This participant remained unchanged on all measures delivered.

It is within the DASS21 results that the findings become less clear. With regards to depression, 11% of participants included in the analysis recovered. The same was true of anxiety, and 57% recovered from stress. On both the depression and anxiety subscales, the majority of participants (whether included in the RCSC analysis or not) were in the normal range at baseline and remained there at follow-up. In both cases only two participants were not in the normal range at follow-up. On the stress subscale, a wide range from normal to extremely severe was observed at baseline. At follow-up a majority

of the participants were in the normal range. Only three were not, and these individuals were all in the mild range.

The seemingly low impact of the intervention on depression and anxiety may be due to floor effects. Given most participants were in the normal range at baseline, they had little opportunity for downward movement in scores. Therefore, no change was detected when completing the RCSC analysis. A more sensitive measure for detecting change may have been helpful. Although, if individuals are in the normal range, the utility of this information for clinical purposes seems relatively superfluous. Interestingly, participants reported experiencing a relaxation and unwinding within themselves as an outcome of the treatment. It could be that some reduction in anxiety did occur for a number of participants, which was not captured by the DASS21-A within the RCSC method of analysis.

For the stress subscale, considerable within participant variability was demonstrated throughout the baseline and treatment phases. As a result of this instability, five participants were not included in the RCSC analysis. This left only seven included, and of them, 57% recovered. This finding is encouraging, but in reality only reflects four participants achieving reliable and clinically significant change. Given the considerable observed variability, these findings should be interpreted with caution. It is difficult to identify whether change truly occurred over treatment.

The final secondary outcome variable measured was self-esteem, using the RSES. Of the participants included in the analysis, 27% had recovered by follow-up. Overall, a small upward trend was observed for the participants. This modest result does not reflect

the participants' feedback of experiencing a sizeable positive increase in their self-esteem following treatment. It is possible that the measure did not capture "self-esteem" as understood by the participants. It is true that considerable debate exists within the literature as to what the RSES is actually measuring, and defining self-esteem is a contentious topic (Blascovich & Tomaka, 2013; Morris Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). It may be the case that the RSES was measuring global self-esteem changes, while the participants experienced more specific self-esteem improvements (see Morris Rosenberg et al., 1995).

Exploratory research question: How did the participants experience the guided ICBT-P?

The participants' experience of the website and treatment. An overall positive response to the ICBT-P was described by the twelve participants. They described what they enjoyed and what they found useful, as well as difficulties they experienced with engagement and in reaction to certain treatment tasks. This was discussed within four themes: 1) engagement with treatment, 2) treatment delivery, 3) the website content, and 4) the role of the guiding therapist.

A key finding was the participants' awareness of the impact of their clinical perfectionism on their engagement with the treatment. As discussed in Chapter One (Literature Review) perfectionism is recognised as a treatment interfering issue, and this contributes to its role as a transdiagnostic process (Egan, Wade, & Shafran, 2011). The participants recognised that their clinical perfectionism led to difficulties with procrastinating on completing modules, spending too long on modules. It also reportedly

led to participants being overly self-critical when learning about the causes and maintaining factors of clinical perfectionism or trying to complete treatment tasks.

A number of participants took longer than the advised one week to complete a module. It seems from the participants' reports that procrastination was the lead cause of this frequent delay. Numerous reminder emails were then sent out by the guiding therapist to keep the participants on track. Previous research on a guided ICBT for generalised anxiety disorder suggested that deadline flexibility on the part of the guiding therapist was negatively correlated with treatment outcomes (Paxling et al., 2013). However, in the current study participants highlighted the guiding therapist's patience as a quality they appreciated. Importantly, 90% of the participants in this study recovered from clinical perfectionism in spite of the deadline flexibility provided.

Notably, the participants appeared to interpret the flexibility as the guiding therapist being understanding and compassionate. Maintaining a rigid structure and moving onto the next module even if the last one was not completed, as was done in the Rozental et al. (2017) study, could potentially trigger beliefs about failure to meet an expected standard and therefore failure as a person in someone who struggles with clinical perfectionism. Having the guiding therapist model understanding and compassion may have helped the participants to learn to become more self-compassionate as they internalized the positive experience. Furthermore, deadline flexibility may be important in a treatment for clinical perfectionism in a way that it is not for another issue such as generalised anxiety disorder because it models flexibility rather than emphasising rigid rules and standards (which was a key target of treatment). Yet again the participants could internalise this experience and learn from it. Allowing time (to a reasonable degree) whilst

also encouraging the participants to complete the module places value on the importance of completing the treatment for the purpose of helping the participant grow, rather than simply achieving the module within the specified time frame.

The second way in which the participants recognised their clinical perfectionism interfering with engagement was how it led to them taking too long to complete a module. A number of participants took longer than the recommended one hour. This was linked to being too thorough and overly inclusive in responses, writing responses to impress the guiding therapist rather than for their own learning experience (i.e., needing to “achieve” therapy rather than experience it), and being inflexible in how they completed modules, for example not being able to move on to the next task if they were having difficulty with a particular module segment.

To overcome this difficulty and the aforementioned procrastination, the guiding therapy appeared to play an essential role. It was important to highlight and challenge the treatment interfering behaviours and use them as a teaching opportunity. Doing so provided real life, real time examples of how their clinical perfectionism was playing out and interfering with something they wanted to achieve. The guiding therapy was able to illustrate how making small changes in the way the participant was thinking and behaving within the treatment (essentially letting go of clinical perfectionism) had positive and rewarding effects. For example, encouraging participant 213 to reduce their responses to bullet points led to them completing the modules within the hour, recognising that they were completing this treatment for themselves and not the guiding therapist, and enjoying the treatment more.

Another element that appeared to help with procrastination and engagement more widely was the embedded vignettes and case studies within the ICBT-P. These were reported to have enhanced the participants' ability to engage by 1) helping them to better understand the clinical perfectionism issue being targeted, 2) normalise and validate the participants' experiences because they could relate to the examples, and 3) provide a stepping stone from which the participants could come up with a new similar example of their own to use within a task. This last function was highlighted as a useful means for overcoming procrastination, because it made the task seem easier and less daunting. Such elements may be particularly useful when working with individuals with clinical perfectionism because tasks that seem hard might otherwise be avoided due to fear of failure.

The final way in which participants described their perfectionism interfering with treatment was through experiences of being overly self-critical when completing modules. Again, the guiding therapy appeared to play a significant role in overcoming this threat to engagement. The guiding therapy was used to normalise experiences of maintenance factors (e.g. the guiding therapist made statements such as "we all make thinking errors from time to time") and thus, reduce self-blame. It was also used to provide psychoeducation, for example about the effects of black and white thinking or "should" statements being used by the participant, and to model compassion and a "good enough is good enough" attitude towards task completion.

An adverse effect of treatment described by some participants was a negative emotional response to recognising the clinical perfectionism cycle within themselves and thinking about the causes of it. This is in line with adverse effects described by Rozental

et al. (2015) for ICBT's targeting social anxiety disorder, panic disorder, major depressive disorder, or chronic and severe procrastination. Much like this previous study, some participants reported wanting to seek reassurance and comfort from the guiding therapist. In the case of this study participant 204, for example, reported using the end of module reflection text boxes to communicate their distress with the guiding therapist and to receive support, which was given through the normalisation and validation of experiences in the guiding therapist's personalised module feedback. In agreement with the argument made by Rozental et al. (2015), it would appear that these adverse emotional experiences did not impact the treatment outcomes and may be an unavoidable, but short-lived, part of engaging with psychological treatment.

Another adverse experience was some participants experiencing the treatment pace as stressful. This again, supported the findings of Rozental et al. (2015). Some of the participants in the current study reported wanting more time to complete homework tasks and to assimilate and consolidate new information gained in a module. While some participants found the one module a week schedule sufficient, others reported they would have preferred modules being delivered once a fortnight. A schedule specialised to the individual person would more closely reflect face-to-face treatment in clinics. Nevertheless, tailored treatment schedules would need to be considered in terms of the individual's case formulation, as the reason for some participants' desire for extended time was due to clinical perfectionism-related therapy-interfering behaviours. In such cases it was better to recognise this and challenge these behaviours (as described above) through the guiding therapy, and then to encourage the continued weekly schedule. Alternative reasons for slowing down the pace would be to accommodate external life

events. For example, many participants in this study were completing the treatment over Christmas and New Year's (which is the main summer vacation period in NZ). Over this time an increase in reminder emails was required to encourage module completion. In face-to-face therapy there would usually be a treatment break over this time.

An element of the treatment that was described by the participants as useful towards assimilation and consolidation of information was the treatment reflection tasks. Participants were required to complete these at the end of each module and before the beginning of the next. Participants reported that this prompted them to review previous sessions and in doing so enhanced their learning. The reflection process was highlighted as a task that increased procrastination in some participants. However, it could also be an element of treatment that might combat the need for more processing time between modules, if used properly.

An interesting element of the treatment that was widely discussed by the participants was the images used to create the website aesthetic. These images were chosen by the author to relate to the written content on each page, to entice a sense of calm and comfort, and to be encouraging and motivating. They were also chosen to be appreciated by both genders, as well as a wide range of ages, and to relate to a New Zealand sample. The participants reported that the images were experienced as soothing, encouraged them to engage in self-care activities, and conveyed a sense of empathy from the author. The possibility of images a) communicating a sense of caring for the participant, and b) promoting participant treatment goals such becoming more relaxed and having a more balanced life that includes self-care is worthy of note. If this is achieved, then it could be that images within ICBT websites play an important role in

developing the client-programme alliance proposed by previous researchers (see K Cavanagh, 2010; Kate Cavanagh & Millings, 2013; Pihlaja et al., 2018). As mentioned in the Chapter One, the therapeutic alliance is defined as “the positive emotional bond between therapist and client, and their mutual agreement on the goals and tasks of the treatment” (Pihlaja et al., 2018, p. 2). It seems that the website images may have helped promote a similar phenomenon with the ICBT-P in the current study.

Although not directly tested with an instrument such as the WAI in this study, participants’ reports suggested that the guiding therapy also played a significant role in the development of therapeutic alliance. This may have been enhanced by the inclusion of an initial face-to-face assessment, where the participant was able to meet the therapist and put a face to the name. The guiding therapy was described as adding a personalised element, conveying compassion, empathy, and encouragement, and as important to the sense of accountability that was developed within the participants. The participants’ feedback highlighted that they perceived the client-therapist relationship as important to them and their adherence. Therefore, the current study supports arguments put forward by Pihlaja and colleagues (2018) that the bond is important to guided ICBT treatments, and this is further bolstered by the low attrition rate and promising results on outcome measures observed.

Researchers such as Miller, Hilsenroth, and Hewitt (2017) have demonstrated that when working with individuals with perfectionism, the therapeutic alliance and the strength of the therapist’s Rogerian attributes (as perceived by the client) predicts treatment outcomes. It is argued that therapists high in Rogerian attributes are more able to challenge the client’s self-criticism and directly contradict the projected criticism the

client perceives in others (Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). Based on the participants' feedback in this study, it seems that the guiding therapist was perceived as being high in these attributes, and this improved that participants' experience and treatment outcomes. Miller, Hilsenroth, and Hewitt (2017) also highlight that developing self-compassion in an individual high in self-criticism requires a therapeutic environment of acceptance and compassion. According to the participants of this study, such an environment was created within the ICBT-P currently under investigation through the guiding therapy and choice of images in the website. While this research can make no substantiated claims about the impact of these qualities on the outcomes measured, at the very least it seems important to the participants. This is worth noting because regardless of a treatment's impact on outcome measures, meeting the client's needs is crucial to achieving buy-in and maintaining adherence in therapy.

The participants' perceived outcomes of treatment. The participants discussed their perceived outcomes of completing the ICBT-P in terms of six themes. Following the treatment, they reported experiencing more flexible thinking, greater insight into their difficulties, an increase in self-love, improved interpersonal dynamics, and an increase in productivity, as well as an understanding that overcoming perfectionism was an ongoing process. Within these, a further fourteen subthemes were described (see Chapter Three: Results).

Overall the participants' reports were congruent with the quantitative results discussed above, with the one exception of self-esteem. As previously argued, this incongruence may be an instrumentation issue. A review of the treatment targets, which were presented within the agenda provided at the beginning of each module (see Chapter

Two: Methods, page 90), revealed that all of the targets had been discussed by the participants as areas they had experienced positive change in. As a collective, the treatment successfully met every treatment target. This is reflected in the 90% recovery rate on the CPQ.

One further positive outcome experienced by the participants that was not intentionally directly targeted by the ICBT-P was the reported interpersonal improvements. The participants stated that following treatment they felt they had become closer to friends as a result of allowing themselves to share their vulnerabilities more and be more open. They also reported being less critical of others and engaging in less micromanagement of others, which had improved their relationships. This is a positive secondary outcome of targeting clinical perfectionism. It fits with the wider concept of perfectionism described by Hewitt and Flett (1991) of interpersonal dynamics within their model. It also lends support to the argument that the parsimonious unidimensional definition of clinical perfectionism is sufficient to address the intrinsic, essential mechanisms needed to maintain the psychopathology and also have an impact on allied concerns and secondary consequences.

The Author's/Guiding Therapist's Reflection

To further future research in guided ICBTs, Pihlaja and colleagues (2018) challenged authors to include a description of the guiding therapist and the ICBT programme. Doing so could provide probable predictors of alliance and of treatment outcome that can then be scientifically scrutinised. Therefore, the first part of this section provides a brief reflection of the guiding therapist's characteristics and the guidance

provided. Given the author held the dual role of author and guiding therapist, the section will be written in first person. The second part of this section is the author's reflection of their role in the design, implementation, and analysis of this study.

At the time of acting as guiding therapist, I was a clinical psychology intern, completing my final year of post-graduate clinical training in a doctoral programme. This involved previously completing two years of CBT training in assessment and treatment theory and practical skills, along with three placements in clinical settings totaling 600 hours. In my role as a clinician, I have frequently been described as highly empathetic by my clients, supervisors, and teachers. This has been reported to be one of my strongest attributes. I am an attentive therapist, who is skilled at reflecting and summarizing the client's experiences, and I make good use of minimal encouragers (e.g. empathetic utterances, body language, and tone) to communicate understanding, empathy, and genuine positive regard. This was likely experienced by the participants in the initial face-to-face assessment. It could be that the participants then incorporated these qualities into how they perceived the ongoing text communication.

As the guiding therapist, I used a script in the sense that I cut and pasted previous responses to participants and then adapted them to reflect the current participant's responses in module tasks. The original set of guiding therapy responses were developed in the pilot study. These were based on examples obtained from the lead author of the Shafran et al. (2017a) trial and reviewed by Doctor Angela McNaught, the original first supervisor for the current research. Maintaining this script was deemed important to prevent therapist drift.

In my role as guiding therapist, I personalised module feedback by using the participants' names and adding short participant-specific comments about their lives. For example, "Hello Jane, I hope your study is going well". Throughout the feedback I included examples the participants had given in their module work and end-of-module feedback, and ensured I used the participants' own words to demonstrate that I was attentive to their experiences. I also added comments relevant to current events, such as "Merry Christmas", to give the impression I was writing the email freshly in response to the participants' module input.

As the guiding therapist, I used the CBT technique of Socratic questioning to challenge unhelpful thinking and behaviours, for example "What might be another way of making sense of this?" or "Is it always the case that the more someone puts into something, the more they get out of it?". Questions were intended as rhetorical, in order to be thought-provoking, rather than to encourage email replies from the participants. Most participants understood this intuitively. However, one participant did not, so they asked and it was explained.

Finally, to prevent procrastination of completing the upcoming module, I included a comment at the end of feedback that alluded to what was exciting or useful about the following module and invited the participant to start working on it. When needed, I used patient and encouraging language to entice participants to complete overdue module work. I used tactics such as reminding the participants of why it was beneficial for them to do the treatment and quoted research demonstrating that maintaining a certain pace was important to treatment outcomes.

My training as a clinical psychologist impacted my decision-making throughout this study in many ways beyond the implementation of the guiding therapy. This was true in regards to the model of perfectionism I adopted, study design decisions, the development of the website, the analysis of data, and write-up of the thesis. I was well aware of my position as researcher, therapist, and author. I knew this would impact my interpretation of data, as well as the feedback the participants provided me (discussed next, in the limitations section).

I chose the CBT model of clinical perfectionism and its therapy as a focus for investigation. Furthermore, as a clinician, I appreciated this model as a useful one. Therefore, I had a certain level of allegiance to the model. The study was designed to provide evidence for the clinical utility of the model and its treatment in website form. One can therefore assume a risk of allegiance effects. This is true of all research, however the risk may have been heightened due to my coinciding roles as researcher, therapist, and author. Nevertheless, these concerns were considered and addressed through frequent consultations with my supervisors. The data analysis I completed was not completed solely by myself in isolation. Rather, my supervisors played an active role in reviewing the analysis to increase the reliability of the interpretations.

I believe my dual role as therapist and researcher enriched my analysis and final discussion. When a participant discussed a particular experience they had in their interview, I could remember the incident they were talking about. I could remember how they behaved and how I responded as the therapist. This provided me with a fuller understanding of how the guiding therapy was helpful or not, which I could then include in the write-up of the analysis. My training as a clinical psychologist provided me with a

scientific, evidence based foundation from which to make my interpretations. Using this training, I could make sense of the psychological processes the participants experienced during the intervention, as well as what they reported in the final interview. This guided by analysis of the data and allowed me to make informed interpretations. These were then discussed with my supervisors, who were also registered clinical psychologists.

Study Limitations

The current study has several limitations that must be considered. Firstly, while the results have potential generalisability to the general population, they do not necessarily generalise to a clinic setting, which is argued to be a defining feature of an effectiveness study (Andersson & Hedman, 2013). This is because the participants were self-referred, rather than being referred by clinicians from a clinic setting. However, it has been argued by some that participants recruited from the general public are more representative of potential ICBT users than those recruited from clinical setting (Titov, Andrews, Kemp, & Robinson, 2010). Therefore, such participants may be appropriate for the demonstration of effectiveness in ICBTs.

The self-referred nature of the participants does however suggest that they may have had prior motivation to complete the ICBT as their treatment of choice. This may have resulted in greater likelihood of treatment adherence and success, and positively biased responses in the qualitative feedback. Furthermore, only those who completed the treatment were interviewed for their experiences of the ICBT-P. This may have biased the results towards those who appreciated it. However, of those who did not complete the treatment, two pulled out before completing any modules and one left due to extenuating

circumstances. This third person did complete the treatment once they had resolved their family issues and anecdotally reported that they enjoyed the ICBT-P and found it beneficial towards overcoming their clinical perfectionism difficulties.

Another limitation related to the study sample was the overall high level of education amongst the participants. Most of the participants had completed or were engaged in post-graduate level studies. This is a common issue of recruitment for ICBT trials. Whether the treatment is effective for a wider range of education levels in New Zealand remains unknown. Reading levels, for example, have been demonstrated to affect the efficacy of self-help treatments (Andersson, 2018). Furthermore, those with less education are more likely to be of lower socio-economic status and thus have more difficulty attending face-to-face treatment as a result of cost and transport hurdles. Therefore, it is important to investigate whether the more easily accessible and low-cost ICBTs are effective with such individuals. However, whether or not clinical perfectionism is evenly distributed throughout individuals of higher and lower socio-economic status and education levels, particularly the New Zealand population, is unknown. This is an issue that requires further investigation.

The outcomes of this study reflect the effectiveness of the ICBT-P using one guiding therapist. Differentiating between what changes were due to the ICBT and what were due to the specific therapist is not possible in this study. Also, it remains unknown whether these results would be achieved if there were different guiding therapists involved. An investigation of these issues requires further research. Furthermore, within this research, the author, interviewer, and guiding therapist were all the same person. Firstly, this may have led to unrecognised biased questioning in the interviewing of

participants and interpretation of data towards achieving more favourable responses. However, efforts were made to maintain open-ended questioning and a balance between asking what was useful, not useful, liked and disliked by the participants, and to include the participants' adverse experiences in the coding and analysis of themes. Secondly, the participants were aware that the same individual held all three roles, which may have influenced their responses. For example, it may have increased the sense of accountability participants described, as they might have been aware that completing the treatment was important to the author's/guiding therapist's research, not just important for their own benefit. Furthermore, it may have contributed to social desirability effects, whereby participants favoured giving the interviewer positive feedback about the treatment and their experiences.

A number of factors were discussed above that appear to have positively enhanced adherence. However, the weekly monitoring of participants may have also increased this, as suggested by Andersson and Headman (2013). It might be that the participant felt more closely observed as a result of the monitoring, and thus felt a greater sense of obligation to completing the treatment. However, the guiding therapy in this study meant the participants were already being closely observed, and this was described as a useful element towards increasing the participants' sense of accountability. Therefore, the added monitoring may not have had a further impact. In fact, a number of the participants described the weekly measures as bothersome and attributed it to some of their procrastination in completing the modules.

The best practice for establishing stable baselines in case series research is to allow the baseline phase to continue for as long as needed until stability is achieved

(Barlow & Hersen, 1984). However, it was determined that this may take a considerable length of time and may result in greater attrition rates as participants become frustrated waiting to begin treatment. Therefore, a baseline of four time-points was used for all measures but the secondary perfectionism measure (i.e., the FMPS CM and PS subscales). This meant that some participants did not achieve stability during the time constraints and were then unable to be included in the ongoing analysis. As a result of this, the number of participants included in the RCSC analysis of each measure administered varied, which can make comparison of recovery rates between constructs difficult and confusing. Within the write up of results, the author endeavoured to be as clear and transparent as possible to minimise such confusion. Also, given that only one baseline point was collected for the FMPS CM and PS subscales, these results, in particular, should be interpreted with caution.

Critically, validated cut-offs for differentiating dysfunctional from functional distributions do not exist for most of the measures used in this study. Therefore, norms from previous studies were carefully selected to develop such cut-offs for the RCSC analysis, based on recommendations of Jacobson and Truax (1991). This means that it is unclear (for all measures used but the DASS21) whether the cut-offs used for determining clinically significant change are indeed sensitive enough to accurately differentiate between clinical and nonclinical populations and truly represent recovery in terms of meeting clinically determined criteria. However, the cut-offs derived were compared to previous studies that have used this method but not necessarily the same norms (e.g., Rozental et al., 2017) and were found to be comparable. Likewise, the derived cut-offs for the DASS21 were compared to the existing validated cut-offs provided by Lovibond

and Lovibond (1995b). Another limitation within the analysis is that the RCI assumes normally distributed measurement error, however it is not possible to directly test for this because measurement error is not directly observable. Therefore, there is the potential for some unrecognised error within the reported outcomes.

As previously mentioned, there were also some issues with the scales used. It seems that the DASS21 was not sensitive enough to capture changes in mood, anxiety, and stress amongst individuals in the “normal” range. Secondly, interpretation of the stress subscale data is limited in this study, as there was excessive variation within participants’ self-reported measures from week to week. There is little research available demonstrating the test retest reliability of the DASS21. It might be that the stress subscale is a state measure that is easily influenced by environmental factors, and therefore establishing a stable baseline for the purpose of conducting a RCSC analysis is difficult. In any case, it is difficult to state whether the treatment had a clinically significant impact on stress in this study.

With regards to the RSES, it is unknown whether this scale was measuring self-esteem as interpreted by the participants and intended by the researcher. The RSES captures a global construct of self-esteem, whereas a scale that captures specific self-esteem within pre-determined domains may have been more useful. Lastly, the VAS were unsuccessfully administered in this study. Again, excessive variability was observed in the within participant data. This was determined to be because the scales were not anchored appropriately in terms of stable comparisons. The VAS, which provides a measure of subjective change, would have provided useful data to complement the

qualitative analysis. Therefore, future research should attempt to include VAS again with appropriate anchors.

A further and final limitation is that the study only included a two-month follow-up. A longer time-lapse between treatment end and follow-up, such as six months or one year, would have been preferable to demonstrate sustained changes. This study has demonstrated that in the short-term that the treatment effects are maintained or even improved. Nevertheless, future research should endeavour to include a longer delay before the collection of follow-up data.

Contributions to the Literature

Although the study has some limitations, the current research has successfully provided evidence for the effectiveness of a guided ICBT-P for *clinical* perfectionism specifically. This was achieved by being the first study to conduct an RCSC analysis on the measure that was purposefully developed to capture the construct, namely the CPQ. Furthermore, the study has provided more robust evidence for treatment effectiveness by demonstrating baseline stability over four time points when conducting said analysis. The study is also the first study to investigate an ICBT-P with a New Zealand sample, providing evidence for its effectiveness and acceptability through the combined quantitative and qualitative exploration. Moreover, the case series design provided evidence of this for both genders, a wide range of ages, and multiple ethnicities, within this New Zealand sample.

The FMPS CM and PS subscales were also included in the current research as secondary perfectionism outcome measures to allow for ease of comparison with existing

studies of ICBT-Ps, and CBT-Ps more generally. When targeting a New Zealand sample, the guided ICBT-P performed comparably to past research, including both Internet-based and face-to-face trials. Notable is the reduction in scores on the FMPS-PS, along with participant reports that their standards had become more reasonable rather than dropped following treatment. This lends support for the growing base of literature that refutes claims that the PS subscale is categorically an adaptive form of perfectionism (see Smith et al., 2018).

Importantly, this study reported deterioration rates and reasons for participant dropout, not just the desirable recovery rates. Such data is largely missing from published ICBT research, according to a recent meta-analysis by Karyotaki et al. (2018). Furthermore, adverse experiences of the participants were also reported, which is also a frequently neglected area, as highlighted by Rozental et al. (2015). Outstandingly, in this study none of the participants had deteriorated on any of the measures used at follow-up.

An important contribution to the literature is the newly gained knowledge about the processes of change within ICBT-P's, which was requested by Andersson and Titov (2014). This was achieved through the inclusion of a thematic analysis of participants' experiences of the intervention. Participants reported finding the guiding therapy, website images, case studies and vignettes, treatment reflections, and experiential learning, especially behavioural experiments, particularly useful towards overcoming their clinical perfectionism. The qualitative results highlighted that individuals with clinical perfectionism can develop a bond with their guiding therapist through an ICBT. In the case of this study, participants responded well to guiding therapy that consisted of an initial face-to-face assessment and weekly module feedback sent via email.

Communication that was particularly important to them was that which conveyed a personalised response and included compassion and encouragement. They reported that this type of guiding therapy increased their sense of accountability to complete the treatment.

Barazzone and colleagues (2012) found that relational features within an ICBT included the website text, which could convey a sense of understanding, warmth, and empathy. The current study extended this research by demonstrating that the images too could create this experience for the website users. The other element that increased the sense of a growing relationship bond for the participants in this study was the guiding therapy. The participants reported that having someone there who attended to their module responses and provided personalised feedback gave them the sense that someone understood them, cared, and was on the journey with them. In line with the suggestion of Rozental and colleagues (2015), this was further enhanced by the flexibility that was provided for module completion deadlines, which was perceived as the guiding therapist conveying compassion and patience by the participants.

This study was the first known study to report the participants' perceived effects of their clinical perfectionism on their ability to engage with an ICBT. It highlighted that their greatest struggles, as they perceived them, included difficulties with procrastination, spending too long on modules, and being overly self-critical when trying to complete modules. The study highlighted that in response to this, the guiding therapy played an important role in overcoming such difficulties. Finally, the current research was also the first known study to report the participants' perceived outcomes of completing a guided ICBT-P. Their reports supported the quantitative findings and provided greater detail into

specific cognitive and behavioural processes that were adapted as a result of the intervention.

Future Research

Despite the early promise of this intervention a number of areas still require further exploration. As previously mentioned, the current study should be replicated to include a longer follow-up phase. Ideally, at least 12 months to provide evidence for maintained effectiveness. It has been claimed that approximately 53% of those who complete a guided self-help relapse within the first year of completing the treatment (Delgadillo, 2018). This was not true for the 12-month follow-up of the Rozental et al. (2017) ICBT-P trial (see Rozental et al., 2018). However, it needs to be demonstrated again, and specifically for the current ICBT-P in a New Zealand sample.

Replication studies would also benefit from using different mood and anxiety scales, such as the Beck Depression Inventory – II (A. T. Beck & Steer, 1987) and the Beck Anxiety Inventory (A. T. Beck & Steer, 1990). Using such scales might potentially capture more subtle changes in mood and anxiety amongst those in the “mild” and “normal” populations. Given that the ICBT-P targets self-compassion, it would also be useful to include a measure of this, such as the Self-Compassion Scale – Short Form (Raes, Pommier, Neff, & Gucht, 2011). This could provide statistical evidence to support the participants’ reports of positive outcomes within the current study. Other changes that could be made could include completing the study again but maintaining a strict weekly schedule for module completion or using multiple guiding therapists to observe if either of these factors influence treatment outcomes.

A much larger RCT to demonstrate efficacy of the ICBT-P within a New Zealand sample would also be an excellent next step. Such research might also begin to explore participant characteristics or guiding therapist characteristics that predict treatment outcomes. Engaging with clinic settings as a place of referral for participation in efficacy and effectiveness studies would be useful. It would be beneficial to learn if such referrals could produce similar results to the current study. Clinical referrals would also likely lead to more participants with more severe mental health disorders taking part in studies, which again would be useful future research to explore. Within the guided self-help research, evidence suggests that certain combinations of client features, such as having severe depression along with personality disorder traits and socioeconomic disadvantages, predict increased drop-out rates and poorer treatment outcomes (Delgadillo, 2018). Therefore, future research might also explore the combining of face-to-face treatments for the likes of severe depression or personality disorders along with the ICBT-P of interest in this study.

Additionally, longitudinal studies of three or five years could investigate the long term impacts of recovery from the transdiagnostic issue of clinical perfectionism on the rates of comorbid difficulties such as mood, anxiety, and eating disorders. Investigating whether the intervention prevents the future development of such disorders would be interesting. Similarly, the impact of said recovery on subsequent treatment for comorbid disorders could be tested. Alternatively, longitudinal studies could investigate the rates of positive outcomes following an ICBT-P, such as improved productivity and impact on significant relationships.

Finally, the importance of therapeutic alliance for individuals with clinical perfectionism engaging with a guided ICBT-P is potentially a fruitful area of future research. Given that client contribution has been found to be important to alliance (Miller et al., 2017), future research might target questions regarding what clients can do to contribute to the development of this, particularly in the early stages of therapy. For example, how clients can contribute to the development of the treatment goals and tasks within an ICBT-P. Further to this, the development of a client-programme alliance rating scale would aid further research into understanding if such a bond is possible. If so, using this scale to help decipher which features of an ICBT-P promote the perceived bond would be illuminating.

Clinical Implications

In December 2018 the New Zealand Minister of Health released the Mental Health and Addiction Inquiry's report, "*He Ara Oranga*" (New Zealand Ministry of Health, 2018). One of the primary ten recommendations described in the report was to give people more access to services and more choice in the services available. It was acknowledged that currently the government aims to help the top 3% of people who need mental health support, but 20% of New Zealanders are struggling with mental health difficulties. Therefore, it was recommended that the target percentage should be increased to help more people sooner. Another primary recommendation was to take action to prevent problems and promote wellbeing before serious mental health difficulties have developed.

The guided ICBT-P investigated in this research could be one means of contributing towards achieving these goals. The ICBT-P provides a choice for an alternative form of therapy to traditional face-to-face therapy. This study demonstrated it to be effective for those who would choose it as their preferred treatment delivery format. The ICBT-P would provide an option for a treatment that could be completed in the client's own home and at a time that suits them. Furthermore, the client could choose to complete a module all in one sitting or over the course of multiple sittings during the week, as some of the participants did in this study. Completing the treatment at home would reduce transport costs for the client, thus making it a more accessible option. Moreover, it would be a less resource-heavy form of treatment, as it would only require approximately seventeen minutes of a therapist's time per client each week.

According to participants' reports in this study, the ICBT format was preferred to a self-help book, which might be another treatment option. Contributing to this preference was the interactive elements available to the website format. This was linked to subjectively perceived improved engagement because the expectation placed on the participant to complete text boxes meant they could not just do the task in their head and potentially avoid completing it. It would also seem that the interactive element would make it easier to implement the guiding therapy because the therapist could see clients' input. Furthermore, compared to a self-help book, the guided ICBT-P format allowed participants to feel like they were not completing the treatment alone; that someone was attending to their responses and they were on the journey with them.

With regards to preventing future mental health problems, the ICBT-P was demonstrated to effectively reduce self-criticism and stress. These issues have the

potential to be precursors to the development of more serious mental health problems. Participants also reported that the ICBT-P reduced their procrastination, improved productivity, and increased their self-care, self-compassion, and self-esteem, which could all act as protective factors from developing future difficulties. Unfortunately, this study cannot make comments on the potential impact of the ICBT-P on depression and anxiety because most participants scored low on these difficulties at the beginning of treatment and floor effects prevented the demonstration of any changes. Nevertheless, it did appear to target problematic treatment-interfering behaviours, thus improving the odds of recovery should these or other psychiatric disorders be addressed with subsequent therapy.

The results of this research would suggest that the ICBT-P can remain effective even in the face of serious and potentially triggering life events, as was the case for some participants in this study. It appeared that the progression of change when completing the treatment involved a gradual learning process. Further to this, it seemed that the treatment as a whole slowly intervened with self-criticism; therefore it is not recommended that therapists isolate the specific modules that target this and only give clients those modules. The treatment was described as an accumulative process and therefore should be delivered in the order recommended and as an entire protocol. Therapists could also expect continued improvement in clients after treatment end.

Treatment-interfering behaviours to be aware of in potential clients include procrastination, taking too long to complete module tasks due to being overly thorough, and self-criticism in response to completing modules. Guiding therapists should remain alert for this so they can intervene. This can include using the unhelpful behaviours as

examples for guiding therapy material or modeling compassion and a “good enough is good enough” attitude. Aversive emotional responses in clients to recognising their clinical perfectionism maintenance model and the historical causes are another treatment response issue to be aware of. When recognised, the guiding therapist could intervene by normalizing and validating these experiences and demonstrating empathy.

Encouraging clients to listen to the vignettes and read case studies is also recommended, as it was reported that this element of the ICBT-P enhanced engagement and prevented procrastination. Similarly, it would seem that encouraging clients to make use of the reflection boxes could be beneficial towards improving information assimilation and treatment understanding. It was suggested that these reflection tasks could help the treatment become a coherent whole for the clients. For some clients it might be an option to space the treatment out to one module a fortnight, as those who took longer in this study still had positive outcomes. However, a good understanding of the client’s case formulation and why they wish to slow down the pace is necessary. If it is due to perfectionism-related treatment-interfering behaviours then those behaviours should be addressed and the original treatment pace maintained.

Following best practice recommendations, a face-to-face initial assessment should be used. A potential red flag for whom this ICBT-P may not be appropriate for might be those individuals who have already seen multiple therapists for their clinical perfectionism and received treatment that appears to have been unsuccessful. The face-to-face assessment is an opportunity to start building a therapeutic alliance with the client. It allows them to put a face to a name and develop a sense of the guiding therapist’s tone in subsequent text communication. Within this communication it is recommended that

the guiding therapist demonstrates compassion and empathy, personalises responses, and is encouraging. This type of guiding therapy can give the client a sense that there is someone on the journey with them, that they are being heard and understood. According to participants of this study, incorporating these features into the guiding therapy will improve the client's experience, help develop the sense of a bond between therapist and client, and increase client accountability. It seems that these experiences can be further enhanced if relevant, compassionate, and encouraging images are used throughout the website and if the guiding therapist demonstrates patience and reasonable deadline flexibility.

Conclusion

In conclusion, the guided ICBT-P, (*I'm*)*perfectly Me*, has been demonstrated to be effective at treating clinical perfectionism. It also performed comparably to previous trials of similar ICBT-P protocols on measures of alternative forms of perfectionism, and performed en pas with a trial of a face-to-face treatment of clinical perfectionism. Promising results were also observed for the impact of the treatment on self-criticism and stress. Furthermore, some participants recovered from depression and anxiety and demonstrated clinically significant change in their levels of self-esteem. The participants described both positive and aversive experiences related to their engagement with the treatment, the delivery of the treatment, specific website content, and their interaction with the guiding therapist. The descriptions of the participants' subjectively experienced outcomes of the guided ICBT-P were overwhelmingly positive. In particular, they highlighted developing more flexible thinking, gaining greater insight into their difficulties, enhancing their self-love, experiencing improved interpersonal dynamics,

and increasing their productivity, as well as having an understanding that overcoming perfectionism was an ongoing process. This study has provided initial evidence to support the use of a guided ICBT-P within New Zealand and has paved the way for further exploration of a promising intervention.

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Appendix A:

Example Webpages from *(I'm)perfectly Me*

(i'm)perfectly Me

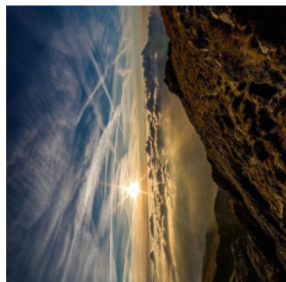


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TE HĀUNGA KI PŌHĀROA
UNIVERSITY OF NEW ZEALAND

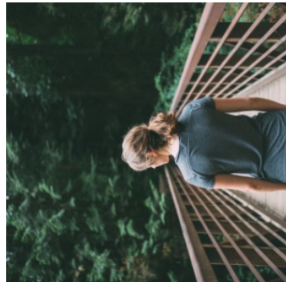
Your Subject ID = ?
Please ensure your 3-digit ID is showing above.
Please assign your 3-digit Subject ID if it is not showing above and click on the submit button.
Subject ID:

[Information sheet](#)

Overcoming Perfectionism



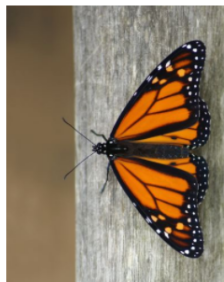
1. Your perfectionism cycle



2. Preparing for change



3. Myth busting

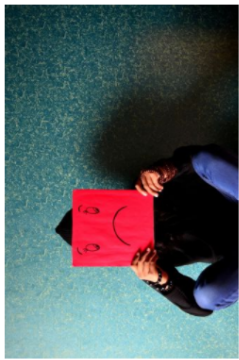




Your Subject ID = ?
Please ensure your 3-digit ID is showing above.
Please add/change your 3-digit Subject ID if it is not showing above and click on the submit button:
Subject ID:

Session 1

Introduction



Is it common for people to tell you "You're such a perfectionist" or "You have to do things perfectly"?

While it is good to seek high standards, it can also be upsetting when perfectionism becomes unhelpful. For example, do you attend to details so thoroughly, that you find yourself spending extended periods of time completing tasks without adding a great deal of value to the final outcome?

This can be stressful and a lot of time is spent worrying about one's ability to do well, be it in studies, sports, leisure, appearance or social situations. This type of unhelpful perfectionism can result in self-criticism, low self-esteem, poor performance, stress, anxiety and low mood.

"Overcoming perfectionism" is an online guided self-help treatment that helps you defeat unhelpful perfectionism. You can learn skills to be more flexible and free, to like yourself, to be kind to yourself and to enjoy your life without lowering your performance.

We recommend you do 1 session a week over the next 8 weeks to best learn and use the skills in this program.

Have a look at these two examples and then have a go at it yourself.

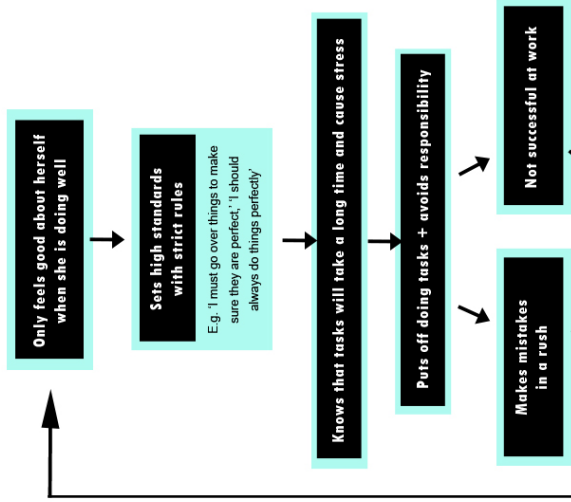
Some examples

JENNY'S EXAMPLE




Doing things at the last minute was her way to cope with her perfectionism because she believed that if she started the task earlier, she would repeatedly check through her work right until the deadline anyway, and feel extremely anxious the entire time.

Here's a diagram that shows how Jenny's perfectionism is maintained.



Massey - Albany - Dash... X Massey - emmasjohnston... X Screenshots - Dropbox X (i'm)perfectly Me X
www.massey.ac.nz/~pspyres/perfectionism/Mod1/Mod1_P10.html
Outlook X Dropbox X Massey Library X Rataora X Massey Scholar X CCI X Age Calculator X Evernote X Facebook X YouTube X Google Maps X Wikipedia X Overcoming Perfectionism

(i'm)perfectly Me



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TE KUNINGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Take home message

Perfectionism can be difficult to change because there are rewards associated with it, and it can be maintained by ways of thinking, feeling and behaving.

Still, decreasing unhelpful perfection can improve other problem areas in your life, such as low self-esteem, depression, anxiety and disordered eating.

Drawing your own perfectionism cycle is the first step in knowing what changes need to be made. Remember there is no "right" or "wrong" answer to your perfectionism cycle. All that matters is that it makes sense to you!

Next session, we will look at ways to prepare you for change and to overcome perfectionism.

We would like you to do one small activity each week between modules to really help you make changes in your daily life. This week, it's simple, keep an ear out so you can start recognising your perfectionism voice and when it is telling you that you need to be perfect and when it is telling you that you have not done well enough.

Please answer the following 2 questions:

BETWEEN SESSION WORK:

BEFORE YOU GO!

Approximately how much time did you spend completing this week's session? (in minutes)

Please comment on this week's session.
(E.g. what you found useful/interesting, your engagement with the readings and exercises, any emotional responses to specific parts of the module you noticed, if you felt rushed, if you found it confusing, or anything else of interest worth noting)

Appendix B:

Recruitment Poster



Do people call you a perfectionist?

Do you often think that what you have done is not good enough?

Do you feel like you have to work harder & longer than everyone else to achieve similar results?

Do your friends often tell you that you're too self-critical?



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If this sounds like you, you might be struggling with the unhelpful form of perfectionism.

My name is Emma and I would love you to take part in my doctoral study. This is your opportunity to use a new free online self-help programme for unhelpful perfectionism to reduce the stress in your life without lowering your performance. If you are interested please visit

(website name)



A free eight-week online programme for unhelpful perfectionism based on the acclaimed self help book 'Overcoming Perfectionism' by Shafran, Egan & Wade (2010). Along with the added bonus of personalised weekly online feedback from a guiding therapist

Appendix C:

Facebook Post for Recruitment

facebook.com

Rataora My HR Massey Email Clinical Interventions (CCI) Mental Health Jobs My Print Center Toggl (I'm)perfectly Me Pinterest Facebook Pin It YouTube Amaz

Gmail

OVERCOMING PERFECTIONISM

Do people call you a perfectionist?
Do you often think that what you have done is not good enough?
Do you feel like you have to work harder & longer than everyone else to achieve similar results?
Do your friends often tell you that you're too self-critical?

If this sounds like you, you might be struggling with the **unhelpful** form of **perfectionism**.

My name is Emma and I would love you to take part in my doctoral study. This is your opportunity to use a **new free online self-help programme** for unhelpful perfectionism to reduce the stress in your life without lowering your performance. If you are interested please visit <http://tinyurl.com/imperfectlyme>

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A free eight-week online programme for unhelpful perfectionism based on the acclaimed self-help book "Overcoming Perfectionism" by Shafran, Egger & Wade (2010). Along with the added bonus of personalised weekly online feedback from a guiding therapist.

October 8, 2016 · 🌐

Calling all perfectionists or concerned friends of perfectionists! If you know anyone who may be experiencing stress or other difficulties because they put too much pressure on themselves to achieve excessively high (and sometimes unreasonable) standards please pass this on to them or take a look for yourself at my doctoral research information page. I am seeking participants to take part in a **FREE** online treatment programme to help reduce unhelpful perfectionism and the stresses that come with it, all without reducing the high performance that perfectionists are so well known for. <http://tinyurl.com/imperfectlyme>
See comment section for further information...

Tag Photo Add Location Edit

👍❤️👏 51 6 Comments 11 Shares

Like Comment Share

Please note: participants must be able to attend an interview at the Centre for Psychology in Albany, Auckland. Also, please share this privately with friends that you think might be interested in order to maintain their confidentiality. Close friends and family of mine cannot participate because I will be acting as the guiding therapist. Thanks 😊

Like · Reply · 2y · Edited

Write a comment...

Appendix D:

Recruitment Email to Friends and Colleagues

mail.google.com

sey.ac.nz Rataora My HR Massey Email Clinical Interventions (CCI) Mental Health Jobs My Print Center Toggl (!'m)perfectly Me Pinterest Facebook Pin It

opbox Gmail Gmail - Recruiting for my research Mail - [redacted]

participation perfectionism

143 of many

Recruiting for my research

Inbox x

Emma Miller <[redacted]> to [redacted]

19 Sep 2016, 15:55

Hey guys :-)

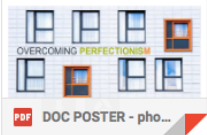
I am on the recruiting mission at the moment and am hoping some of you might know people who could benefit from the programme I have to offer.

If any of you know any perfectionists out there who might be a little happier or a little less stressed if they completed an online 8-week CBT for perfectionism programme please pass this poster on to them.

They need to be between 18 to 65 years, be able to meet me at the clinic for an interview, and not currently be receiving any other psychological treatment.

Thank you!

...



DOC POSTER - pho...

Appendix E:

Brief Reports to Eligible and Ineligible Participants

Response to Eligible Participants:

Thank you for taking the time to complete our questionnaire.

Your results suggest that you may be struggling with clinical perfectionism.
You are, therefore, eligible to take part in our study.

Through this study you will receive a *free* 8-week treatment designed to help reduce your clinical perfectionism along with other difficulties such as stress, anxiety, low mood, and low self-esteem, without reducing your performance.

Please enter your details below and hit submit.

Name:

Email address:

Submit

(Next pop up page)

Thank you

You will receive an email from us in the next 24 hours.

Response to Ineligible Participants:

Thank you for taking the time to complete our questionnaire.

Your results:

Subscale:	Your Score	Threshold
Depression		11
Posttraumatic Stress		10
Bulimia/Binge-Eating		4
Obsessive-Compulsive		2
Panic		5
Psychosis		1
Agoraphobia		5
Social Phobia		7
Alcohol Abuse		1
Drug Abuse		1
Generalised Anxiety		10
Somatisation		3
Hypochondriasis		3
Concern Over Mistakes		22
Personal Standards		24
Perfectionism		29

Regretfully, for one of the following reasons you are not eligible to take part in our study.

Either

You did not meet the threshold for clinical perfectionism. It seems that you are doing well and do not need the 8-week treatment programme.

If you meet the threshold for the Personal Standards subscale then it may be that you have what we consider to be healthy perfectionism (AKA positive striving). This is referred to as the “functional pursuit of excellence” and suggests you strive for high standards in a positive way that does not negatively affect your mental wellbeing. Well done you!

Or

You scored on or above the threshold for at least one subscale of the screening measure other than clinical perfectionism (i.e. the first 13 subscales). These results suggest that you *may* be struggling with difficulties beyond that which our study can provide help for. Below we have compiled a list of services that may be able to provide more specialized help.

If you have any immediate concerns about your mental wellbeing please contact your GP.

If you wish to seek further help for difficulties you are experiencing, we can recommend the following services:

General:

Centre for Psychology

Level 3, North Shore Library Building
229 Dairy Flat Highway
Albany Village
09 441 8175

Youthline

0800 37 66 33
Free txt 234
talk@youthline.co.nz
www.youthline.co.nz

Lifeline

0800 543 354
09 522 2999
www.lifeline.org.nz

Depression:

Depression Helpline

0800 376 633
www.depression.org.nz

The Lowdown

Free txt 5626
www.thelowdown.co.nz

Alcohol and drug use:

CADS Auckland – North

44 Taharoto Rd
Takapuna
North Shore City 0622
09 845 1818
www.cads.org.nz

Acute mental health:

Mental Health Crisis Team (CATT team)

North Shore 09 487 1414
After hours 09 486 1491

Suicide Prevention Helpline

0508 828 865 (0508 TAUTOKO)

Search for other services in your area:

www.familyservices.govt.nz/directory/

Appendix F:

Information Sheet



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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

A Web-Based Cognitive Behaviour Therapy for Clinical Perfectionism

INFORMATION SHEET

Nau mai haere mai! Welcome! My name is Emma Johnston and I am a Doctor of Clinical Psychology student at Massey University. I would like you to take part in my doctoral research project about clinical perfectionism. Lots of people view perfectionism as a positive attribute, however many people struggle with difficulties related to an unhelpful form of perfectionism that tends to be more self-critical. The aim of my research is to see if a self-help treatment delivered in a website format and accompanied by emails from a guiding therapist can reduce these difficulties.

Overcoming Perfectionism

The programme is an eight-week guided self-help treatment, meaning, each week you will complete a module, which will include information to read and small tasks and worksheets to complete. After completing each module the guiding therapist will contact you via email to discuss it and give you feedback on your input and progress. The potential benefits of taking part in this research include reducing unhelpful perfectionism and its associated difficulties and experiencing an increase in self-esteem and general wellbeing.

Am I eligible?

If you agree to take part, you will be directed to an online questionnaire to complete (approximately 30 minutes), which will assess your eligibility to participate. Eligible individuals will be between 18 and 65 years old, score high in clinical perfectionism, will not be suffering from another serious mental disorder, not receiving another form of psychotherapy, and will be available to take part in each step of the treatment and data collection process. If you complete the questionnaire and it turns out that you are not eligible, we will send you a brief report explaining why. We will also give you a few helpful suggestions of where to seek information and support if you scored high in another mental health area that may be causing you difficulties.

What's involved:

If selected, you will meet with me, the guiding therapist, at the Centre for Psychology in Albany for an initial 50-minute interview and then complete a short online questionnaire (approximately 15 minutes) once a week for four weeks, before starting the online programme. You will then receive the 8-week treatment programme! Finally, eight weeks after the treatment has ended you will be required to attend a completion interview at the Centre for Psychology in Albany, and complete a short questionnaire. Each interview will be audio recorded.

For this you will need:

- a. A PC/laptop with an internet connection and
- b. A time and place that suits you to complete each weekly module

The weekly requirements will be:

1. Completing the week's therapy module (about 30 minutes to 1 hour each),
2. Interacting with the guiding therapist, and
3. Completing the short online questionnaire

Interacting with the guiding therapist simply means reading any emails you are sent and responding if you have any questions or feedback.

What else do I need to know?

I will be acting as both the guiding therapist and the lead researcher in this study. The data will be anonymised and your name will be kept confidential to my supervisor and myself. The information you provide us will be kept securely in a password-protected database. To cover travel costs you will be given a \$40 petrol voucher at the end of the completion interview.

At the conclusion of the study you will be emailed a summary of the findings if you are interested. As per university protocol, the data will be securely filed by my supervisor for 5 years and then destroyed.

Whilst we don't expect this to be the case, some people may find the treatment challenging because it involves experiencing new situations. If your mood drops below a meaningful level for two consecutive weeks or you disclose that you may have concerns about your own safety, then we would need to discuss appropriate actions with you, such as informing your GP and providing you with referral information for further support.

Your participation is entirely voluntary. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any point before data analysis commences;
- ask any questions about the study at any time during participation;
- ask for the recorder to be turned off at any time during the interviews.

Project Contacts

You are invited to contact me, Emma Johnston, at overcomingperfectionism.massey@gmail.com, or my supervisor, Dr Angela McNaught, at a.mcnaught@massey.ac.nz or 09 414 0800 ext: 43106, if you have any questions about the project.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 15/054. If you have any concerns about the conduct of this research, please contact Dr Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317, email humanethicsnorth@massey.ac.nz.

Appendix G:

Examples of Guiding Therapy

Case Conceptualisation Following Initial Assessment Interview:

“Jane” presented with clinical perfectionism predominantly in her work and in her roles as a mother and wife. Jane reported that in the past month she experienced a panic attack and depression related to health difficulties. She reported that her mood has improved but she still experiences some difficulties related to low mood. Jane also presented with what appears to be generalised anxiety disorder.

Jane reported that she believes she has had clinical perfectionism her entire life. Some of the rigid rules she holds in regards to maintaining high standards include “I must be error free”, “I must meet others’ standards of me”, and “I must check over everything I do”. She recognises these rules to be her own and if she cannot keep them she reported that she feels like a failure and becomes anxious and her mood drops. While she believes the pressure to maintain her standards comes from within herself, she reported that her colleagues also maintain very high standards and there is a workplace environmental pressure to meet excessively high expectations.

Jane reported that she is afraid of failing and will avoid doing tasks if she thinks she may fail at them. Jane consistently pushes herself very hard to meet her goals. This has been the case in her work and in her home life. She gave the example of pushing herself to go to work even when she was very unwell. Jane recognised that the standards she expects to maintain can be dysfunctional and are often only achievable with great personal sacrifice. Problems she reported related to her dysfunctional standards include: being continually overloaded, unable to complete things, and always feeling like she has not done a good enough job for her patients. Adverse consequences of these dysfunctional standards include that she does not complete tasks as quickly as she would like, she experiences interpersonal difficulties, and she misses out on self-care time. According to Jane, all of these problems can cause her marked distress.

Jane reported that it is much easier to recognise her “failures” than her successes. When asked if she recognises her successes she reported that she did not tend to notice them or celebrate them. It seems that Jane has a tendency towards black and white thinking when evaluating whether something is a success or failure. Furthermore, she often discounts her successes and does not give herself credit for them because she perceives it as simply being what was expected of her and what she “should” have done. Jane reported that she has a tendency to be very self-critical, and this impacts on her work and leaves her feeling unhappy.

Jane has a number of daily safety behaviours, which appear to be helping maintain her clinical perfectionism. These include: frequently checking and rechecking her’s and other’s work, micromanaging her staff, saying yes to too many things, and always trying to please others. Finally, Jane’s fear of failure is a strong motivating force helping to maintain her perfectionism. Jane stated that she also believes she strives for perfection because it is the right way to be. Jane reported these two issues equally influence her drive for perfection.

Jane has a number of protective factors which will help her through the treatment programme. Firstly, she is intelligent and has insight into her problems. She has also sort help of her own accord. Jane has a positive attitude towards psychological therapy and stated that she intends to complete the programme.

Module Two Feedback:

Hello Jane,

You're doing a great job at recognising your perfectionism and considering how it's impacting many different areas of your life. When we have been doing something one way for so long it becomes normal and we can become somewhat blind to the negative consequences of it. It can be useful to take the time to consider how our actions are affecting us now and in the long run. It is great to see you engaging with the material and putting thought into your responses.

It sounds as though you are worried that your standards might drop, and that you might not put in the extra effort when it is needed if you let go of some of your perfectionism. This is a very common thought that people with perfectionism have and can sometimes struggle with. The treatment is not designed to reduce your standards, because we know that no-one wants to do that. However, it can be helpful to start to look at things in some slightly different ways so that you can think about your standards differently. Sometimes, what we have found is that people find the costs of trying to meet their standards is extremely high too, and might even lead to them being unable to achieve their goals. It seems to me that it will be near impossible for you to do your best for your patients if you are approaching burnout. Perhaps it's time to try another way? The goal of this treatment is not to lower your standards. It is to help you base your self-evaluation on other areas of life, not just achievement, and to help you recognise what is a healthy balance for you between doing your best and overdoing it. In that way, you will have a choice whether to pursue your standards or not, depending on the cost of doing so.

I hope you are enjoying the programme. Change can be hard but hopefully some of the cons on your list can help you feel like the hard work is worth it.

You can now complete Session Three this week. Lucky for you it's a super quick one!

Warm wishes,

Emma

Module Four Feedback:

Hello Jane,

Well done on completing Session Four. You are now halfway through the treatment programme!

The gains you have shown so far are wonderful and I am so pleased to hear you have noticed them too. I am excited by some of the new ideas you came up with in the behavioural experiments, i.e.:

1. I can rely on my judgment because I have XX years of experience

2. I can still practice safely and “cut corners”
3. “Cutting corners” is not so anxiety provoking

You are doing a good job at challenging some of your old, well-ingrained ways. It’s great that we can start to recognise these ideas/habits now and begin to implement some healthy alternatives. Of course, this will take time. No-one is going to become the perfect non-perfectionist overnight.

You should be feeling good about yourself for all the effort you are putting into this programme, so make sure to acknowledge your successes.

I look forward to hearing how your recent self-discoveries help in your new role.

Please complete Session Five this week.

Best wishes,

Emma

Module Six Feedback:

Hello Jane,

Well done on completing Session Six. You have shown good insight into how your procrastination can get in the way of things.

Procrastination is a difficulty that interferes with a lot of people’s progress, especially the perfectionistic kind. So you are not alone with these struggles. Now that you are aware of what underlies your procrastination and the type of thought patterns that lead to it you can keep a sharp eye out for it. Remember you don’t have to suddenly become the “perfect” non-procrastinator, you just need to take small steps when you see yourself engaging in it.

I’m really pleased to hear you found it helpful and I look forward to hearing how you integrate the strategies into your everyday life. I hope you took an opportunity to reflect on your experiment with completing referrals at work. That was a great experiment to set up.

You can now complete Session Seven.

Warm wishes,

Emma

Module Six Feedback:

Hello Jane,

Well done on completing the Overcoming Perfectionism programme! It seems you have been on quite a journey. You have developed a whole new set of knowledge about your perfectionism, what maintains it, and what you can do to change it. Now that you are at the end of the sessions, it is worth you taking the time to reflect on your journey through the programme so you can continue to put the energy in where needed to integrate your new found knowledge and skills into your everyday life.

As you are no doubt well aware, the work doesn't finish here. For you, I think continuing to practice using a kind, caring voice towards yourself on a daily basis is important.

Thank you for all the effort you have put into the programme. I have witnessed you take strides towards developing a more adaptive pursuit of excellence. I strongly believe that the effort you put in will be reflected in the benefits you experience long term.

Thanks again for all your effort and well done!

Warm regards,

Emma

Appendix H:

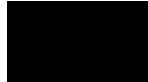
Ethics Approval Letter



MASSEY UNIVERSITY
ALBANY

15 December 2015

Emma Johnston



Dear Emma

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 15/054
A Web-Based Cognitive Behaviour Therapy for Clinical Perfectionism

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a re-approval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Andrew Chrystall
Acting Chair
Human Ethics Committee: Northern

cc Dr Angela McNaught, Dr Bev Haarhoff, Professor Paul Merrick
School of Psychology
Albany Campus

Professor James Liu
Head of School of Psychology
Palmerston North campus

Appendix I:

Research Case Study

Note: This research case study was completed to fulfill the requirements of the Massey University clinical psychology programme internship year (3rd Year DClinPsych Thesis Part C: 175.993). The case study has already been graded by the examiners of that year and achieved a pass grade. It is a requirement of the programme that it is included in the candidates doctoral thesis as an appendix.

**An Internet-Delivered Cognitive Behavioural Therapy
for Clinical Perfectionism: A Case Study**

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And

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Abstract

Background: Clinical perfectionism is a transdiagnostic process that can cause considerable distress. Few studies have examined the acceptability and usefulness of a guided web-based cognitive behavioural therapy for clinical perfectionism (CBT-CP). **Aim:** To investigate whether a guided web-based CBT-CP was an effective treatment for an outpatient adult with clinical perfectionism (CP). **Method:** Weekly self-report measures were completed during baseline (A) and intervention phase (B). **Results:** The case demonstrated reductions in CP, self-criticism, and stress, and an increase in self-esteem. **Conclusion:** A guided web-based CBT-CP may be an acceptable and useful intervention for outpatient adults with CP.

Key words: Cognitive Behaviour Therapy, Perfectionism, Clinical Perfectionism, Web-therapy, Self-help, Guided Self-help

Introduction

Whilst there is various understandings of perfectionism, some of which are considered to be adaptive, “clinical perfectionism” is the form of perfectionism that is deemed detrimental to an individual’s wellbeing and is observed and treated in mental health settings. Shafran, Cooper, and Fairburn (2002) defined clinical perfectionism (CP) as “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” (p. 778). This definition was developed to capture the maintaining factors of maladaptive perfectionism so it could be targeted with Cognitive Behavioural Therapy (CBT). According to Shafran et al. (2002), CP is distinguishable from the “functional pursuit of excellence” by the continued pursuit of rigid standards despite experiencing harmful consequences. At the crux of clinical perfectionism is the over-dependence of self-worth on achievement (Shafran et al., 2002).

CP is associated with a number of difficulties including low self-esteem, stress, work strain, procrastination, burnout, sleep disturbance, and problems with rumination, intimacy, emotional expressiveness, and assertiveness (Egan, Wade, Shafran, & Antony, 2014). Along with causing its own distress, CP has been demonstrated to be a vulnerability factor for the development and maintenance of a number of disorders, including eating disorders, Obsessive–Compulsive Disorder, Social Anxiety Disorder, and Major Depression Disorder, and is linked to the high rates of co-occurrence between such disorders (Egan, Wade, & Shafran, 2011). It is therefore considered to be a transdiagnostic process and if targeted with psychotherapy can reduce the symptoms of multiple other mental health difficulties. A recent meta-analysis by Lloyd, Schmidt, Khondoker & Tchanturia (2014), which included all available empirical studies investigating treatments for maladaptive forms of perfectionism, reported that at present this is best achieved using CBT for CP (CBT-CP).

In recent years there has been growing interest in research demonstrating that guided self-help web-based therapies are an effective form of treatment that is both cost- and time-efficient (Andersson & Titov, 2014). Treatments targeting transdiagnostic issues such as

perfectionism have also been a focus of research for the same reason. Therefore, it seems worth investigating if a guided web-based CBT-CP might be clinically useful. Minimal research is currently available on such a therapy.

Case Introduction and Aims

Abby, a 31-year-old Caucasian female, presented with clinical perfectionism predominantly in her work, appearance, home cleanliness and order, and social interactions. Abby reported that she recently ended her relationship with her boyfriend of seven years and she believed her perfectionism had played a role.

Abby reported that she believed she had had clinical perfectionism her entire life. She described how she was very afraid of failing, avoided doing tasks if she thought she might fail at them, and consistently pushed herself to meet her goals. Some of the rigid rules Abby held included “I must be thorough”, “I must meet and go beyond what is expected of me”, “I must be one step ahead”, and “I must do things by the book”. She recognised these rules to be her own and if she could not keep them she reported that she felt very anxious. Problems she reported related to her dysfunctional rules included: becoming overly focused on one area of her life at the expense of others; spending too much time on tasks; procrastination; self-criticism; getting caught up in details and forgetting the overall purpose of an activity; giving up on things; and interpersonal difficulties. According to Abby, all of these problems caused her marked distress and led her to be “highly strung” on a daily basis. Abby recognised that the standards she expected to maintain could be dysfunctional, were often only achievable with great personal sacrifice and were unsustainable.

The aim of this case study was to investigate whether a guided web-based self-help CBT-CP could help Abby obtain her goals of:

- Reducing her CP
- Reduce her self-criticism
- Increase her self-esteem
- Reduce her symptoms related to stress

Method

Design

This study employed an A-B single case experimental design, where “A” referred to the baseline and “B” to the intervention phase. The baseline, demonstrating stability in CP, consisted of four weeks between the initial face-to-face assessment and beginning the web-based CBT-CP treatment. Measures were taken via a self-report online questionnaire that was emailed to the client weekly. Included within the questionnaire was the Clinical Perfectionism Questionnaire (CPQ), Dysfunctional Attitude Scale – Self-Criticism (DAS-SC), the stress subscale of the Depression Anxiety and Stress Scale (DASS-21), and the Rosenberg Self-Esteem Scale (RSES). All of these measures have been empirically validated and demonstrated to be reliable.

Intervention

The CBT-CP website, called *(I'm)perfectly Me*, was developed by the lead author. It was based on a similar website for teenage girls, created by Sarah Egan and Chloe Yu Shu at Curtin University, and the self-help book "Overcoming Perfectionism: A Self-Help Guide Using Cognitive Behavioural Techniques" by Shafran, Egan, and Wade (2010). *(I'm)perfectly Me* was developed for an adult, New Zealand population of both genders. The treatment included eight modules delivered over eight weeks. Each module included an agenda, interactive tasks, reflection, and a homework task. The client completed one module a week and then received a brief email (i.e. two or three paragraphs) of therapeutic feedback from the guiding therapist (i.e., the lead author) within three days of completion. The modules consisted of the following:

Module One: Intro to CP and its maintaining factors

- Quiz
- Psychoeducation: Negative effects and rewards
- Personalized formulation diagram

Module Two: Motivation to change

- Pros and Cons of keeping/changing CP
- Goals development
- Recognising domains impacted by CP
- Identify negative effects of CP

Module Three: Facts/myths of CP

- Fact or fiction quiz
- Survey to challenge beliefs

Module Four: Changing all-or-nothing thinking

- Behavioural experiment
- All-or-nothing thinking checklist
- Continuum experiment
- Changing musts/shoulds to guidelines

Module Five: Noticing the positive & changing thinking styles

- Negative thoughts and broadening attention
- Noticing the positive
- Unhelpful thinking styles
- Thought diary

Module Six: Procrastination, problem solving, & pleasant activities

- Monitoring procrastination
- Pros & cons of procrastination
- Procrastination behavioural experiment
- Breaking down the task
- Problem solving
- Pleasant activities checklist

Module Seven: Self-criticism & self-compassion

- Self-Criticism checklist
- Thought diary
- Values charts

- Self-critical thoughts/self-compassion diary
- Module Eight: redefining self-worth and preparing for setbacks*
- Developing flexible markers of self-worth not based on achievement
 - Goals and planning
 - Reflection
 - Continued difficulties and action planning

Results

Figure 1 depicts scores on measures of CP (CPQ), self-esteem (RSES), self-criticism (DASS-SC), and stress (DASS-21). Abby's CP and self-esteem scores were stable during the baseline phase (A). There was some variation in her scores of self-criticism and stress during this time, most notably in Week 4. During the intervention phase (B) Abby experienced a steep decline in CP, self-criticism, and stress scores, and a steep incline in self-esteem. Abby's CP score declined from an average of 32 during baseline to 17 at treatment end, with her scores dropping below the cut-off score for CP (29) at Week 7 (after the third module). Her self-esteem score increased from 16 (average at baseline) to 26, and whilst there is no cut-off score for the RSES, a higher score is considered indicative of higher self-esteem. The highest score possible is 30. Abby's self-criticism scores decreased from 66 (average at baseline) to 27. Again, there is no cut-off score for the DAS-SC but a higher score indicates higher levels of self-criticism and scores can range from 7 to 105. Finally, Abby's scores of stress decreased from 20 (average at baseline) to 4 by the end of treatment. This indicates a shift from "moderate" to "normal" levels of stress.

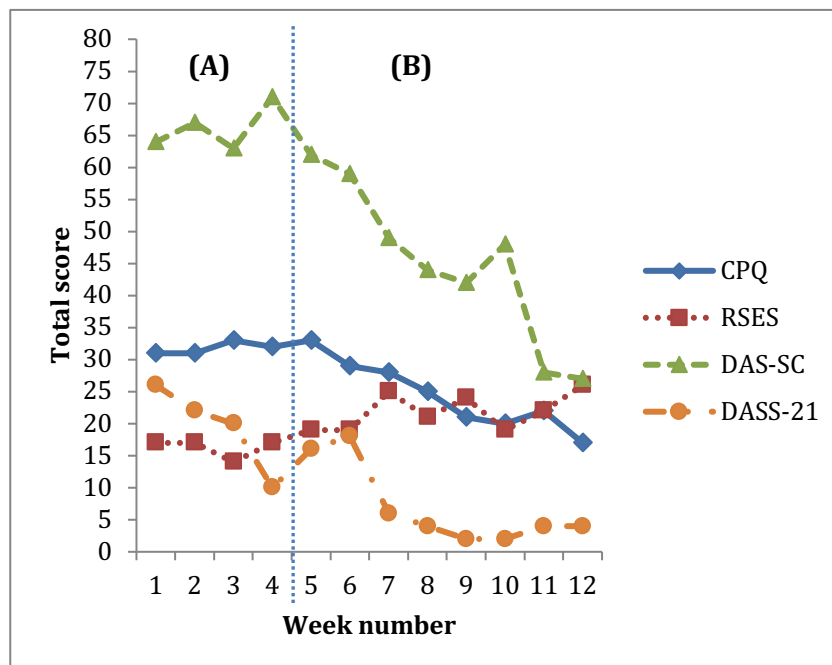


Figure 1. Total scores of CP (CPQ), self-esteem (RSES), self-criticism (DASS-SC), and stress (DASS-21).

Discussion

This case provides initial evidence to suggest that a guided web-based CBT-CP can lead to a rapid reduction in CP, self-criticism, and stress and increase in self-esteem. Overall, the change in scores seems to provide a promising outlook for the utility of a guided self-help treatment that is both cost- and time-efficient.

In closely reviewing the data, it seemed that Module Three (week 7) appeared to have been a catalyst of change for Abby, as her scores demonstrated a sharper slope in self-criticism, self-esteem, and stress after this module. Module Three involved challenging the myths and faulty beliefs related to CP and surveying peers to help challenge such beliefs. The rapid decrease in self-criticism after Module Seven (week 11) is also worth noting. Module Seven specifically targeted self-criticism and focused on replacing negative self-talk with a more self-compassionate voice. This was achieved by using strategies such as monitoring self-criticisms and challenging these by considering what a friend might say of the client in that same situation. It seems that these modules were particularly pertinent to Abby in the development of more adaptive beliefs.

In this case study, Abby was able to maintain the motivation and self-discipline needed to complete each weekly module in a timely manner, and did not report any difficulties in doing so. Thus, she was able to effectively engage with the intervention and experience a range of positive outcomes. A number of factors, however, may have contributed to her approach. It could be that the treatment content was ideally paced and targeted to Abby's needs, and therefore her outcomes were entirely the effect of the intervention. Or it could have been the guiding therapy element of the treatment, which included weekly emailed reminders to complete the next module, that was integral to maintaining adherence. However, it could also be that Abby was suitably psychologically-minded, reliable, and motivated, and/or the adaptive elements of Abby's perfectionism (i.e. pursuit of excellence) helped maintain her adherence. Unfortunately, case study design is limited in its ability to tease apart the various effective treatment versus client elements, so this was unable to be determined.

Although this case has provided some promising results, further research investigating the use of a guided web-based CBT-CP on a larger sample is needed. Research using both quantitative and qualitative methods is required to demonstrate the effectiveness of the treatment and to also gain an understanding of clients' experiences of using such a treatment. The latter knowledge would be helpful to further enhance the treatment and to encourage adherence as well as enjoyment of the intervention.

Whilst caution should be taken, given the limitations of a single-case design, this study illustrates that a web-based CBT-CP may indeed be an acceptable and useful intervention for adults with CP.

Acknowledgements

We are grateful to Dr Sarah Egan and Chloe Yu Shu for allowing us to base our website on their original website.

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Ethical standards: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helenski Declaration of 1975, as revised in 2008.

Conflict of interest: The authors have no conflicts of interest with respect to this publication.

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