

The Oxford Institute of Clinical Psychology Training & Research

How the Light Gets In: Investigating Perfectionism, Eating Disorders, and Systemic Family Therapy

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Ring the bells that still can ring,
Forget your perfect offering,
There is a crack in everything,
That's how the light gets in.

Leonard Cohen.

Word Counts

Systematic Review of the Literature: 6,522 words.

Service Improvement Project: 5,072 words.

Theoretically Driven Research Project: 4,959 words.

Executive Summaries: 1,406 words.

Connective Narrative: 998 words.

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Table of Contents

[Hyperlinked]

Systematic Review of the Literature 1

Abstract 2

1. Introduction 3

1.1. Background 3

1.1.1. Eating disorders 3

1.1.2. Perfectionism 3

1.1.3. Reviewing the literature 4

1.1.4. Research aims 5

2. Methods 6

2.1. Protocol development 6

2.1.1. Conceptualisation 6

2.1.2. Co-production 6

2.1.3. Registration 6

2.2. Search strategy 7

2.2.1. Inclusion criteria 7

2.2.2. Search terms 8

2.2.3. Databases 8

2.2.4. Hand-searching 8

2.3. Study selection 9

2.3.1. Title/abstract screening 9

2.3.2. Full-text screening 9

2.4. Data extraction 9

2.4.1. Extraction 9

2.4.2. Inter-rating 10

2.5. Quality assessment 10

2.5.1. Assessment 10

2.5.2. Inter-rating 11

2.6. Data synthesis 11

2.6.1. Coding 11

2.6.2. Descriptive themes 12

2.6.3. Analytical themes 12

2.7. Reflexive statement 12

3. Results 14

3.1. Study selection 14

3.2. Study characteristics 14
3.3. Critical appraisal 21
3.4. Synthesis outcomes 21
3.4.1. Translation 21
3.4.2. Themes 23
3.4.2.1. Development 23
3.4.2.2. Maintenance 26
3.4.2.3. Recovery 29
4. Discussion 32
4.1. Wider literature 32
4.1.1. Onset 32
4.1.2. Maintenance 32
4.1.3. Recovery 33
4.2. Implications 34
4.2.1. Multidimensional frameworks 34
4.2.2. Treatment models 35
4.2.2.1. Current treatment 35
4.2.2.2. Emergent models 36
4.3. Limitations 37
4.3.1. Quality caveats 37
4.3.2. Synthesis caveats 37
4.4. Conclusions 38
References 39
Service Improvement Project 51
Abstract 52
1. Introduction 53
1.1. National context 53
1.1.1. Older adults 53
1.1.2. Older-adult provision 53
1.1.3. Family therapy 54
1.2. Service context 55
1.3. Service improvement 56
1.3.1. Aims 56
1.3.2. Questions 57
1.3.3. Theory 57
2. Methods 58
2.1. Ethics 58

2.2. Co-production 58
2.2.1. Staff consultation 58
2.2.2. Service-user consultation 59
2.3. Participants 59
2.3.1. Staff members 59
2.3.2. Service users 59
2.4. Design 60
2.4.1. Qualitative 60
2.4.1.1. Staff-side 60
2.4.1.2. Client-side 60
2.5. Procedure 60
2.5.1. Staff-side 60
2.5.2. Client-side 61
2.6. Data analysis 61
2.7. Reflexive statement 62
3. Results 63
3.1. Staff-side 63
3.1.1. Participation 63
3.1.2. Themes 64
3.1.2.1. Referral 64
3.1.2.2. Accessibility 65
3.1.2.3. Integration 66
3.2. Client-side 67
3.2.1. Participation 67
3.2.2. Themes 68
3.2.2.1. Referral pathway 68
3.2.2.2. In therapy 69
3.2.2.3. Reviewing therapy 70
4. Discussion 71
4.1. Findings 71
4.1.1. Staff-side 71
4.1.2. Client-side 72
4.2. Recommendations 73
4.2.1. Solutions 73
4.2.1.1. Staff-oriented 73
4.2.1.2. Client-oriented 73
4.2.2. Feedback 74

4.3. Relevance 75
4.4. Limitations 75
4.4. Implications 76
References 77
Theoretically Driven Research Project 82
Abstract 83
1. Introduction 84
1.1. Background 84
1.1.1. Eating disorders 84
1.1.2. Negative self-beliefs 84
1.1.3. Measures 85
1.1.4. Perfectionism 86
1.2. Current investigation 87
1.2.1. Objectives 87
1.2.2. Research questions 88
1.2.3. Hypotheses 89
2. Methods 91
2.1. Co-production 91
2.2. Participants 91
2.2.1. Sample 91
2.2.2. Power 92
2.2.3. Recruitment 92
2.3. Design 93
2.3.1. Operationalisation 94
2.3.1.1. Perfectionism 94
2.3.1.2. Disordered eating 94
2.3.1.3. Confounds 94
2.3.2. Hypothesis testing 95
2.3.2.1. Primary sub-design 95
2.3.2.2. Secondary sub-design 95
2.4. Procedure 95
2.5. Data analysis 96
2.5.1. Primary analysis 96
2.5.2. Secondary analysis 96
3. Results 97
3.1. Sample characteristics 97
3.1.1. Selection 96

3.1.2. Demographics 97
3.1.3. Characteristics 97
3.2. Group comparisons 100
3.2.1. Assumptions 100
3.2.2. Analysis 100
3.2.3. Effects 100
3.2.2.1. Overall effects 100
3.2.2.2. Univariate findings 101
3.3. Symptom correlations 102
3.3.1. Analysis 102
3.3.2. Effects 102
4. Discussion 107
4.1. Main questions 107
4.1.1. Addressing hypotheses 107
4.1.2. Interpretations 108
4.1.2.1. Multidimensionality 108
4.1.2.2. Measures 109
4.1.2.3. Diagnoses 109
4.2. Exploratory questions 110
4.2.1. Addressing hypotheses 110
4.2.2. Interpretations 110
4.3. Limitations 111
4.4. Future research 111
References 113
Executive Summaries 123
1. Systematic Review of the Literature 123
2. Service Improvement Project 124
3. Theoretically Driven Research Project 125
Connecting Narrative 126
Acknowledgements 131
Appendices 132
Systematic Review of the Literature 132
Appendix A: Journal instructions 132
Appendix B: Authors' statements 134
Appendix C: Database terms 135
Appendix D: CASP & Data Richness criteria 145

Service Improvement Project 147
Appendix E: Journal instructions 147
Appendix F: Research questions 148
Appendix G: Staff focus-group questions 149
Appendix H: Client interview questions 150
Appendix I: Staff data coding frame 151
Appendix J: Client data coding frame 152
Theoretically Driven Research Project 153
Appendix K: Journal instructions 154
Appendix L: Authors' statements 155
Appendix M: Abbreviation glossary 156
Appendix N: Ethical approval 157
Appendix O: Demographic questionnaire 158
Appendix P: Diagnostic data 160
Appendix Q: Perfectionism data distributions 161
Appendix R: Hierarchical regression results 165

Project Titles

Systematic Review of the Literature: The Lived Experience of Perfectionism in People with Eating Disorders: A Systematic Review and Thematic Synthesis.

Service Improvement Project: Understanding and Improving Staff and Client Experiences of a Systemic Family Therapy Clinic for Older People.

Theoretically Driven Research Project: Investigating Links between Eating Disorders and Perfectionism: A Quantitative Study of Multidimensional Perfectionism Constructs across Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder.

Abstracts

1. Systematic Review of the Literature

Objectives: Cognitive research into eating disorders (EDs) highlights perfectionism as a risk factor and maintenance mechanism. All existing reviews of perfectionism in EDs are quantitative. This review aimed to synthesise all available qualitative studies of perfectionism in people with EDs: seeking to supplement quantitative overviews with greater phenomenological insight.

Methods: A systematic review of seven databases was undertaken in August 2024, alongside reference-list handsearching, using PRISMA guidelines. Criteria targeted qualitative studies of EDs and perfectionism. Screening was performed between two inter-raters and reviewed by a third. Quality was appraised via adapted *CASP* and *Data-Richness Scale* tools. Data were extracted using an adapted *JBI* extraction framework, and analysed using thematic synthesis.

Results: Twenty-two studies were included in the thematic synthesis: spanning 286 participants, aged 15–65, with 284 women. All papers demonstrated at-least-satisfactory quality and good data-richness. The synthesis generated three main themes: ED development; ED maintenance; and ED recovery—each via perfectionism. These comprised 15 subthemes: including family, cultural, academic perfectionism; negative-self relationships; coping through EDs; self-oriented and intersubjective perfectionism; losing control; finding self-compassion; and resisting perfectionism.

Conclusions: This review offers qualitative evidence that perfectionism appears influential both in predisposing and maintaining EDs and in wider life-domains of people with EDs. It supports a multidimensional model of perfectionism – and suggests that treatment protocols may be improved. Specifically, transdiagnostic therapy for perfectionism may require clearer links to EDs if applied to them—and perfectionism modules of ED treatment protocols may benefit from complementing ED-specificity with wider, more multidimensional attention to perfectionism.

2. Service Improvement Project

Service context: With ageing populations, mental health problems in older people are rising. NHS policy advocates that specialised older-adult community mental health teams offer diverse therapeutic support, involving carers and families. Systemic family therapy (SFT) is a highly apt intervention, given relational factors affecting older-adult mental health and carer strain. Yet, few policies mention SFT. The SFT evidence base for efficacy with older adults is lacking. This project was conducted within a newly established SFT Clinic for older people.

Improvement aims: This service improvement project aimed to understand and improve staff knowledge of SFT and referrals, and to better address client needs and experiences of the Clinic. Secondarily, the improvement outcomes were hoped to innovate an evidence base for SFT with older adults.

Project methods: Designs were co-developed in staff and client consultations. Staff and client perspectives on the Clinic were elicited as qualitative data. Staff data were collected via a single focus group; client data were collected through semi-structured interviews, each with clients alongside their partner or adult child. The two data sets were analysed separately using thematic analysis.

Findings: Three main themes were extracted from the staff data: supporting referral, enhancing accessibility, and improving integration. These themes incorporated varied sub-themes, such as multidisciplinary team (MDT) collaboration, increased clarity, and more education on SFT. Three main themes extracted from the client data comprised the referral pathway, therapy itself, and reviewing therapy. Sub-themes included goal setting, supporting loved ones, therapist expertise, and difficult endings.

Conclusions: Data were positive overall, with staff expressing enthusiasm for the Clinic and clients conveying appreciation and benefits. Both data sets also highlighted some areas of discomfort or inefficacy in referral processes and the therapy itself which invite improvement.

Recommendations: Service recommendations emerged. These entailed creating educational resources for staff, including SFT MDT meetings; inviting more staff referrers into SFT sessions; updating introductory resources for clients; clarifying SFT aims and client goal-setting; and reviewing client experiences of SFT more regularly during therapy.

3. Theoretically Driven Research Project

Objectives: Examining negative self-beliefs is key to understanding and treating eating disorders (EDs). There is recognition of the role of perfectionistic self-beliefs in EDs—yet the dimensions, and multidimensionality, of perfectionism are contested. At present there is a lack of validated measures. The perfectionism subscale of the Eating Disorder Core Beliefs Questionnaire (ED-CBQ) recently failed to discriminate between ED- and non-ED groups, albeit with non-clinical samples. This study aimed to investigate how the ED-CBQ's 'high standards' subscale discriminated between diagnosable ED samples and healthy volunteers, alongside measures of other perfectionism dimensions thought to be salient in this population.

Methods: Adults with and without EDs were recruited through social media; 577 participants with anorexia nervosa, bulimia nervosa, binge eating disorder, and no ED diagnosis completed perfectionism, mental health, and ED symptom and diagnostic questionnaires. Relationships between ED diagnoses and measures of perfectionism were explored using MANCOVA. Relationships between ED symptomology and perfectionism were then explored using hierarchical regression.

Results: The MANCOVA indicated a significant overall effect of diagnosis on perfectionism measures, with a medium-to-large effect size. 'High standards perfectionism' showed a significant, near-medium effect size. 'Physical appearance' perfectionism showed the strongest univariate effect size. Pairwise comparisons suggested that 'high standards' was best at distinguishing between ED diagnoses, while 'physical appearance' and 'mistakes reactivity' perfectionism dimensions were best at distinguishing EDs from non-EDs. The subsequent regression found that 'physical appearance' predicted ED symptom severity; 'general perfectionism' subscales were somewhat predictive; and 'high standards' was not at all predictive of symptomology.

Conclusions: Overall, this study showed that a range of perfectionism measures are relevant in EDs, and their differing performance across diagnoses is suggestive of a multidimensional model of perfectionism. Results indicated that the ED-CBQ 'high standards' scale may be the best current operationalism of perfectionism in clinical EDs, while the 'physical appearance' and 'mistakes reactivity' scales exhibited strong ceiling effects. The failure of 'high standards' to predict symptomology invites more research into the relationships between perfectionism dimensions across ED diagnoses and symptom severity – alongside a need for recalibrated measures.

Systematic Review of the Literature

The Lived Experience of Perfectionism in People with Eating Disorders: A Systematic Review and Thematic Synthesis

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This project was approved by the Oxford Institute for Clinical Psychology Research and Training.

It has been submitted to **The International Journal of Eating Disorders**.

Journal instructions and authors' statements are in Appendices A and B.

Abstract

Objectives: Cognitive research into eating disorders (EDs) highlights perfectionism as a risk factor and maintenance mechanism. All existing reviews of perfectionism in EDs are quantitative. This review aimed to synthesise all available qualitative studies of perfectionism in people with EDs: seeking to supplement quantitative overviews with greater phenomenological insight.

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Results: Twenty-two studies were included in the thematic synthesis: spanning 286 participants, aged 15–65, with 284 women. All papers demonstrated at-least-satisfactory quality and good data-richness. The synthesis generated three main themes: ED development; ED maintenance; and ED recovery—each via perfectionism. These comprised 15 subthemes: including family, cultural, academic perfectionism; negative-self relationships; coping through EDs; self-oriented and intersubjective perfectionism; losing control; finding self-compassion; and resisting perfectionism.

Conclusions: This review offers qualitative evidence that perfectionism appears influential both in predisposing and maintaining EDs and in wider life-domains of people with EDs. It supports a multidimensional model of perfectionism – and suggests that treatment protocols may be improved. Specifically, transdiagnostic therapy for perfectionism may require clearer links to EDs if applied to them—and perfectionism modules of ED treatment protocols may benefit from complementing ED-specificity with wider, more multidimensional attention to perfectionism.

Keywords: Eating disorders, perfectionism, qualitative, systematic review.

1. Introduction

1.1. Background

1.1.1. Eating disorders

Eating disorders (EDs) are characterised by disturbed food consumption and related behaviours significantly affecting physical and psychosocial health (Attia et al., 2013). EDs are increasingly prevalent, and associated with high morbidity, physical illness, and psychiatric comorbidity (Kazdin et al., 2017). Treatment efficacy is mixed, and psychological interventions require improvement (Solmi et al., 2024). A recent UK consensus paper on enhancing ED treatment invited more modular interventions (Davey et al., 2023).

1.1.2. Perfectionism

Cognitive research into eating-disorder (ED) psychopathology and treatment has long involved perfectionism (Bardone-Cone et al., 2007; Garner et al., 1984). Perfectionism conceptualisations converge on unrelenting striving for flawlessness and overly critical self-evaluation (Lo et al., 2020). Core ED features (e.g., pursuing 'perfect' weight/shape) are argued as inherently perfectionistic (Goldner et al., 2002). Indeed, ED pioneer Hilde Bruch posited anorexia nervosa (AN) as "every parent's and teacher's idea of perfection" (Bruch, 1978, p.59).

Extensive quantitative research into multidimensional perfectionism constructs has emerged (Stairs et al., 2012). Operationalisation spans numerous measures, including the *Frost Multidimensional Perfectionism Scale* (*FMPS*; Frost et al., 1990) and *Multidimensional Perfectionism Scale* (Hewitt et al., 1991). Over 3 decades, core dimensions may have emerged, including self-oriented perfectionism; socially prescribed perfectionism; other-oriented perfectionism; personal standards; concern over mistakes; and doubts about actions (Smith et al., 2022). Though perfectionism is not exclusive to EDs, meta-analyses reaffirm the roles of multidimensional perfectionism in AN and bulimia nervosa (BN; (Dahlenburg et al., 2019).

Perfectionism has also been operationalised transdiagnostically via a unidimensional measure, the *Clinical Perfectionism Questionnaire* (Shafran et al., 2002). This conceptualisation holds that additional dimensions are shaped by proliferating perfectionism measures which assess (merely) related constructs, such as concern over mistakes (Shafran et al., 2002). Cognitive-behavioural therapy for perfectionism (CBT-P), based on this model, has shown efficacy in reducing ED symptomology across recent meta-analyses (Galloway et al., 2022; Robinson & Wade, 2021). Other reviews invited more modular, person-centred treatment options for varied perfectionism presentations (Smith et al., 2023b).

1.1.3. Reviewing the literature

Throughout perfectionism and ED reviews, notably little attention has been paid to qualitative research. Shafran et al.'s (2023) recent overview cited three qualitative studies and one review, but none ED-specific. Smith et al.'s (2022) review of multidimensional perfectionism cited no qualitative literature. There are relatively few qualitative studies of perfectionism overall, and far fewer of perfectionism in EDs. A recent meta-synthesis of clinical, qualitative perfectionism research spanned 37 studies, but examined anxiety and depression rather than EDs (Egan et al., 2022). A qualitative review of perfectionism and suicidality also omitted EDs (Katzenmajer-Pump & Balázs, 2021). Individual qualitative studies have examined, for instance: experiences of perfectionism in transdiagnostic ED patients (Petersson et al., 2017); perfectionism as social identity in EDs (Bouguettaya et al., 2019); and AN patient perspectives of group therapy for perfectionism (Larsson et al., 2018). Yet, at present, qualitative research on perfectionism in EDs has not been synthesised.

1.1.4. Research aims

This paper therefore aimed to review the qualitative evidence base on perfectionism and EDs. It hoped that synthesising qualitative voices may yield greater phenomenological insight into experiences of perfectionism in EDs and implications for treatment. This is particularly pertinent as original CBT models did not draw on qualitative literature (Shafran et al., 2002). While quantitative work has established statistical associations between multidimensional perfectionism and EDs, qualitative data can bridge semantic gaps left by quantitative operationalisations (Tetnowski & Damico, 2001) and evidence, experientially, how these associations might operate (Johnson, 2008). Simply put, this review asked: What are the experiences of perfectionism in people with EDs?

2. Methods

This systematic review aggregated qualitative evidence on perfectionism in EDs using thematic synthesis.

2.1. Protocol development

2.1.1. Conceptualisation

Review protocol was designed using *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines (Moher et al., 2009). Data extraction, quality appraisal, and data synthesis were informed by thematic-synthesis methodology (Thomas & Harden, 2008). This entailed broadly critical–realist epistemologies (assuming underlying realities, accessed subjectively) – combining principles from meta-ethnography (integrating qualitative data into new theoretical frameworks; Noblit, 1988) and grounded theory (rooting data in their research contexts; Glaser et al., 1968).

2.1.2. Co-production

Seven ED experts-by-experience were consulted on the review's remit and design. They endorsed a qualitative review as valuable for capturing nuanced experiences of perfectionism among ED communities. They also expressed interest in heterogenous perfectionism experiences across both eating and wider-life domains.

2.1.3. Registration

Following consultations, protocols were registered on PROSPERO (CRD42023479069; November 2023).

2.2. Search strategy

Studies were selected for synthesis via preregistered search and screening strategies. These aimed to include all available qualitative literature addressing the research questions. Idealist qualitative epistemologies suggest that theoretical sampling for conceptual saturation may suffice (Thomas & Harden, 2008)—that is, data-gathering until no further concepts emerge. However, this review – shaped by realist healthcare contexts – sought comprehensiveness: spanning all available studies for a holistic, open-ended account.

2.2.1. Inclusion criteria

Papers sought in this review studied people with EDs or disordered eating. ED diagnoses were ideally reflective of *Diagnostic and Statistical Manual of Mental Disorders* (4^{th}–5^{th} editions; DSM-IV–V; APA, 2000, 2013), and either verified by clinicians or by researchers using validated scales. However, self-reported diagnoses were accepted where the study met all other inclusion criteria, and where diagnoses were clearly specified. Disordered eating symptomology was measured by researchers using psychometrically supported scales (e.g., *Eating Disorder Examination Questionnaire*; Fairburn & Beglin, 2008).

Targeted papers also explored experiences of perfectionism – including corollary concepts, such as concerns about mistakes – either as central investigative questions or substantial components of findings. Papers also used qualitative methodology: including mixed methods, if producing substantive qualitative data.

Targeted papers featured participants of any age; used English, Spanish, French, or Russian, given authors' language competencies; and were published in any date. Papers were peer-reviewed journal articles or grey literature: where journal articles excluded systematic reviews and book chapters lacking original research, and where grey literature featured unpublished original research, namely as doctoral theses. Grey literature, initially excluded, was included after several robustly relevant doctoral theses emerged (Section 3.2) – and PROSPERO review protocol updated (August 2024).

2.2.2. Search terms

Search terms were devised between authors (SK, MC; initials used hereon), and calibrated with support from a specialist librarian (July 2024). ED terms spanned all DSM-V diagnoses; acronyms were removed when risking excessive irrelevant results.[1] Perfectionism terms drew on leading quantitative measures and recent systematic reviews. Qualitative terms covered all major methodologies and related software (Appendix C).

2.2.3. Databases

Seven electronic databases were predetermined for relevance to clinical psychology: CINAHL (EBSCO), Embase (Ovid), MEDLINE (Ovid), PubMed (PubMed), PsycINFO (Ovid), Scopus (Elsevier), Web of Science (Clarivate). All searches were conducted on 6th August 2024, and reiterated in April 2025. Search terms remained consistent, while additional index terms varied across databases (Appendix C). Search results were exported into *EndNote*.

2.2.4. Hand-searching

Hand-searching methods were employed. Google Scholar was used for scoping searches before preregistration to ensure sufficient studies existed; papers identified were added to database-search results before duplicate removal. At the full-text screening stage, additional snowball searching was conducted.

[1] Terms relating to body dysmorphia were included erroneously (Appendix 2), and excluded at screening.

2.3. Study selection

Search results were exported to EndNote; duplicates removed; titles/abstracts were screened; and remaining papers screened in full—with inter-rating at each stage.

2.3.1. Title/abstract screening

Records were screened by SK via titles and abstracts. For credibility, randomised 20% were additionally screened by JL (Altman & Doré, 1990). Inter-rater reliability – calculated via Cohen's *kappa statistic* was achieved with 'near-perfect' agreement ($\kappa = .83$; Landis & Koch, 1977). Limited disaccord was discussed between reviewers (Noyes et al., 2019). Disputed papers were retained for full-text screening.

2.3.2. Full-text screening

Remaining papers were screened in full by SK, with 25% screened by JL. Handsearching was reattempted via citations, but no new papers found. Inter-rater reliability was achieved with 'perfect' agreement ($\kappa = 1$; Landis & Koch, 1977). Final study selection was reviewed with MC: confirming inclusion of theses that met inclusion criteria.

2.4. Data extraction

Following final study selection, included papers were scrutinised to consider relevant data. Data were extracted, with further inter-rating.

2.4.1. Extraction

Core study features were captured using the *Joanna Briggs Institute* data extraction tool (Lockwood et al., 2020). It was adapted by SK and MC to incorporate study epistemologies and thematic data (Table 1).

Thematic findings were also extracted for in-depth thematic analysis (Braun & Clarke, 2006, 2022). Defining 'findings' in qualitative syntheses is debated (Thomas & Harden, 2008): from 'key concepts' (Campbell et al., 2003) to participant quotations (Sandelowski & Barroso, 2002). For maximal coverage, findings were extracted both from 'first-order' participant quotations and 'second-order' author interpretations, themes, conclusions (Sandelowski, 2004).

2.4.2. Inter-rating

Additional 50% of data extraction was independently examined by JL: with inter-rater reliability achieved at 'perfect' agreement ($\kappa = 1$; Landis & Koch, 1977). For maximal credibility, both the data extraction tool (Table 1) and coding of findings were double-rated.

2.5. Quality assessment

The quality of included papers was also appraised, with inter-rating.

2.5.1. Assessment

Quality and credibility of included papers were assessed by SK using *Critical Appraisal Skills Programme* (*CASP*) Qualitative Studies Checklist (Long et al., 2020). Three questions were added, regarding researcher positionality, theoretical situatedness, and peer reviewal (Appendix D). Ratings were also adapted to include "Somewhat" (when criteria were half-satisfied; Table 2).

Additionally, the Data Richness Scale was used to appraise data thickness (Ames et al., 2019). Thickness was operationalised primarily as relevance to the review question: ranging from 'very little' to 'large amount and depth' of qualitative data relating to the synthesis object (Appendix D).

2.5.2. Inter-rating

Randomised 30% of quality appraisals were independently undertaken by JL: finding 'near-perfect' agreement ($\kappa = .81$; Landis & Koch, 1977). Discrepancies were discussed: agreeing more stringency for awarding "Yes" over "Somewhat" quality-ratings. Excluding qualitative data based on quality appraisal is also contentious (Spencer et al., 2003). No exclusions were made – aligned with meta-ethnographic epistemologies (France et al., 2019a) – but synthesis interpretations were informed by quality appraisals (Section 4.1.3).

2.6. Data synthesis

Data were coded and synthesised following reflexive discussions (SK, MC). For this, thematic synthesis (Thomas & Harden, 2008) was used to 'translate' findings across included studies (Noblit, 1988), which is central to synthesising any qualitative research (Britten et al., 2002). Thematic synthesis employs thematic analysis as its method of synthesis (Braun & Clarke, 2006; Thomas & Harden, 2008). Though aligned with meta-ethnography, thematic synthesis was chosen to prioritise thematic analysis over more elaborate, self-reflexive analyses (Thomas & Harden, 2008).

2.6.1. Coding

TS stages detailed by Thomas and Harden (2008) were replicated. Data extracted verbatim from included studies were coded line-by-line by SK using thematic analysis (Braun & Clarke, 2006, 2022). Inductive coding captured explicit and latent meanings (Joffe & Elsey, 2014) from participant quotations and researcher interpretations (termed 'first-' and 'second-order' in meta-ethnography; Toye et al., 2014). Finally – drawing on 'axial coding' from grounded theory (Fisher et al., 2006) – similar codes were examined across papers to ensure interpretive consistency. Inter-rating with JL was completed before further synthesis.

2.6.2. Descriptive themes

Translation between papers was facilitated by constructing 'descriptive themes' from inductive codes (Thomas & Harden, 2008)—hereon described as 'subthemes' for readability (Fatt et al., 2024). Codes were organised iteratively into separate hierarchical structures—each comprising distinct, 'second-order' themes. Subthemes remained semantically close to studies' findings – without introducing *a priori* theoretical interpretations – though more interpretive than coding. All coding hierarchies and subthemes were reviewed with MC.

2.6.3. Analytical themes

The review question was addressed by generating 'analytical themes' (Thomas & Harden, 2008)—hereon called '(main) themes'. Via reflexive interpretations (between authors), subthemes were formulated into fewer, superordinate main themes: as in thematic analysis (Braun & Clarke, 2006, 2022). While subthemes acted as descriptors for the original data, main themes were equivalent to 'third-order interpretations' in meta-ethnography (Toye et al., 2014). This facilitated more abstract, deductive interpretation to promote new understandings and theories beyond primary-study findings.

For more granular illustrations of thematic synthesis methodology, analogous worked examples can be consulted (McMahon et al., 2022).

2.7. Reflexive statement

Given inevitable influence of author positionality over analyses (Schwarz, 2007), researchers privileged self-reflexivity throughout this review. Though less centralised in TS, reflexive logs and inter-researcher discussion are integral to meta-ethnography (France et al., 2019b), and utilised here.

The lead author (SK) is a white male in their late-twenties. Clinically, SK feels most inspired by Systemic family therapy and social-constructionist epistemologies. However, SK respected the value of critical realism within pragmatic systematic-review contexts.

Academically, SK recently studied multidimensional perfectionism in EDs, and recognised that purely inductive subthemes – without influence from related literature – was implausible. MC agreed that some theoretical knowledge influenced her thematic-analytic contributions. Biographically, SK did not perceive major connections to EDs, but did identify as perfectionistic, having received CBT-P using Shafran's (2003) model (as client). SK hypothesised being influenced by finding this model personally compelling, and having experienced it transdiagnostically.

EK is a white female in her early thirties. Her interests are in the overlap between neurodiversity and EDs, and, with experience of working in both autism and ED clinical services, has experience in working with perfectionism as overlapping with cognitive rigidity. She had no prior experience with, or preference towards, specific psychological models of perfectionism.

JL is a white male in his early thirties. JL held some experience working with perfectionism (as therapist) in contexts of depression and social anxiety, spurring curiosity for the construct – though was not extensively versed in the literature. JL also felt relatively inexperienced with EDs, facilitating more inductive inter-rating.

MC is a white female in her sixties. She has had a 35-year career in eating-disorder and related research, often using cognitive models. For many years she practiced clinically using CBT. This was her first research specifically on perfectionism. Likely once a perfectionist, she thinks work pressures have made her more pragmatic. Cognitive approaches have always appealed, and the basic Beckian cognitive model likely informed her contributions to the analysis. MC felt the data reflected her experience of the area and ED patients.

3. Results

3.1. Study selection

Figure 1 summarises systematic search and screening results (Page et al., 2021). Database searching produced 1,514 records, while initial handsearching added 22 (N=1,536). Following deduplication, 879 were removed, leaving 657 records. At abstract/title screening, 583 papers were excluded, leaving 74. At full-text screening, 52 studies were excluded. Latter handsearching added 0 papers, leaving 22 included studies.

3.2. Study characteristics

Table 1 summarises included-study characteristics. Papers were published between 1997–2024 (mean=2013, median=2014). Fourteen papers were peer-reviewed journal articles; 8 were unpublished doctoral theses. One paper was published in Spanish; 21 in English. One paper was mixed-method; 21, purely qualitative. Analyses included grounded theory, thematic, interpretative–phenomenological, framework, and constant–comparative. Sample sizes ranged from n=4—n=36 participants (mean=13) – with N=286 across combined studies, aged 15–65 years, and 284 women. Three studies supplied racial demographics, across which 34 participants were white, and one was non-white. Only one study indicated (varied) socioeconomic status. EDs spanned AN (n=150), BN (n=24), binge eating disorder (n=9), and OSFED (n=28)—with five additional studies unspecifying ED ratios (n=39).

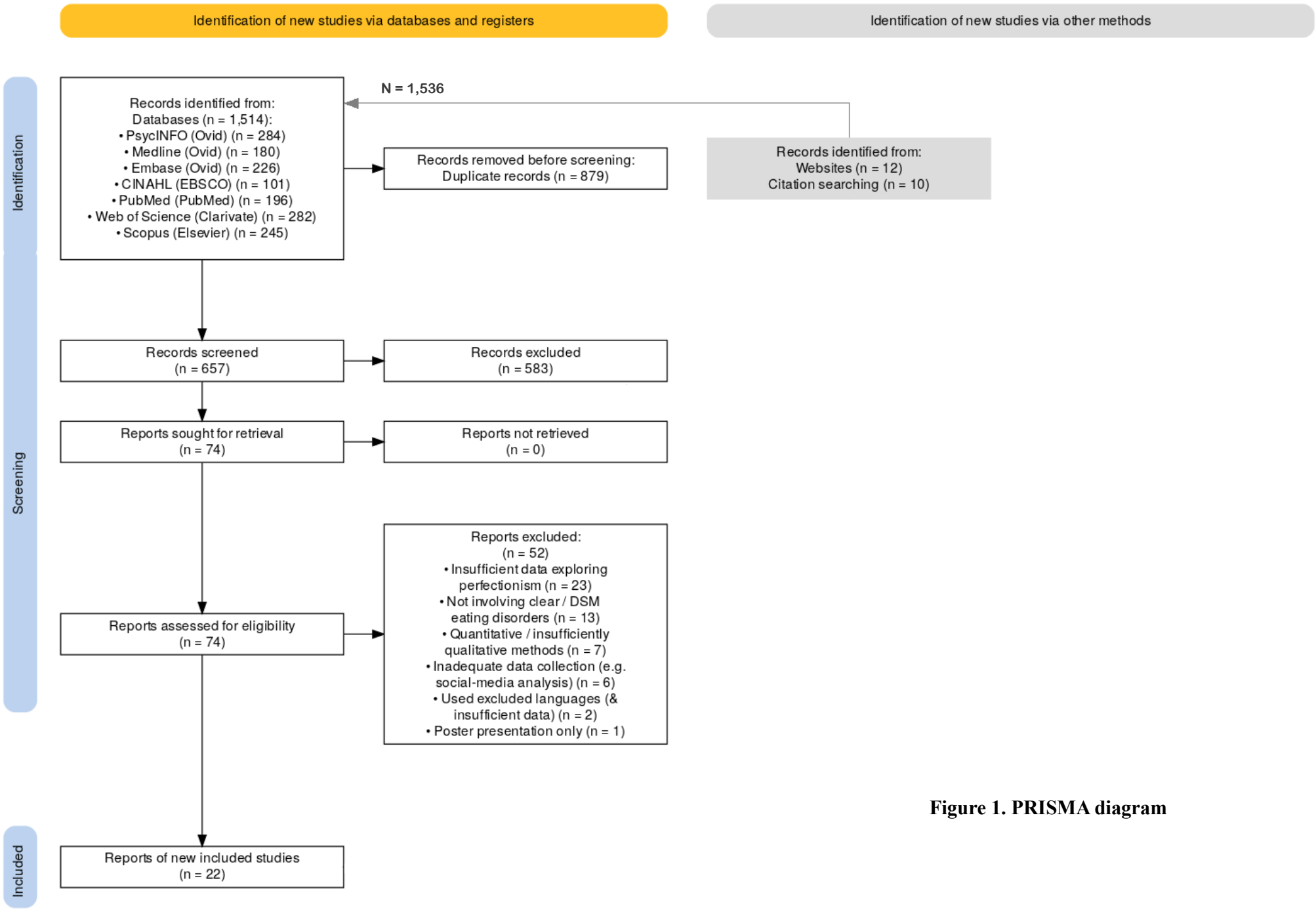


Figure 1. PRISMA diagram

Table 1. Included-study characteristics

No. (Date-order)	**Study** (Authors, date, setting)	**Aims** (Remit, research questions)	**Methodology** (Data collection & analysis; epistemology)	**Participants** (Number, gender, recruitment, age, EDs[a])	**Results** (Main themes)	**Conclusions** (Author interpretations, implications for theory or practice)	**Rigour** (CASP[b], Data Richness[c], publication)
1	Goldswain (1997); British Columbia, Canada	Examine the governing scripts in the dreams, early memories, & lives of women with EDs	•Narrative interviews •Script-theoretic narrative analysis •Script theory; existential-phenomenological framework	•5 Canadian women •Aged 27–36 years •Race & SES unspecified •AN[e] & BN[f] (diagnosed by involved psychiatrist)	•Longing for lost parent/love •No talk about painful feelings •Home perceived as unsafe •Surviving stress via striving to be the 'perfect girl'	•Qualitative links between attachment scripts & EDs •Value of fostering 'good enough' mindset in therapy	•CASP: 18/26 •Richness: 3/5 •Thesis (unpublished)
2	Collins (1999); Texas, USA	Close examination of detailed, daily lived experiences of women with EDs	•Multiple-case study email correspondence with author •Constant comparative content analysis & axial coding •Interpretive phenomenology	•4 U.S. women •Aged 22–35 years •Race & SES unspecified •AN & BN (psychiatric diagnoses self-reported)	•Family perfectionism, abuse, rigidity, poor communication •Guilt, shame, low self-esteem perpetuating EDs •Strategies for 'getting better'	•Family-based approaches can target key schemas •Nuanced trade-offs in freedom vs hospitalisation	•CASP: 13/26 •Richness: 2/5 •Thesis (unpublished)
3	Wade (2002); California, USA	Explore inner voices, attitudes conflicts, feelings of people with AN during self-criticism	•Semi-structured interviews •Voice-centred analysis •Phenomenological method	•6 U.S. women •Ages unspecified •Race & SES unspecified •AN, 2-years-recovered (diagnosis self-reported)	•Voices of self-criticism, self-loathing, & self-monitoring •Voice of perfection managing shame, guilt, & control •Born from patriarchal culture	•Centrality of seeking worth via body perfection •Distancing perfectionist voices can reduce self-hatred & support recovery	•CASP: 16/26 •Richness: 3/5 •Thesis (unpublished)
4	Jacobs (2003); Pennsylv-ania, USA	Examined in-depth daily lived experiences of people with EDs	•Extensive written submission •Constant comparative method •Interpretive paradigm	•4 U.S. women •All aged 18 years •White; middle-class •AN (diagnosis self-reported)	•Early family trauma, abuse & perfectionism influencing ED onset & perfectionism •EDs maintained by guilt, shame, & low self-esteem	•ED treatment may benefit from family approach •Individual therapy can target self-esteem, shame, & perfectionism	•CASP: 16/26 •Richness: 3/5 •Thesis (unpublished)
5	Dignon et al. (2006); UK	Explored narratives of AN patients on causes of their ED	•Open-ended interviews •Grounded theory analysis •Positivism described	•13 women, 2 men (UK) •Race & SES unspecified •Ages unspecified •AN (diagnosed at ED clinic)	•Coping with unhappiness via perfectionism & eating control •Pride in restriction forming perfectionist spirals	•Importance of social input (family, school, media) in predisposing to EDs •Therapy can address body shame & perfectionism	•CASP: 21/26 •Richness: 3/5 •Journal article (peer-reviewed)
6	Edgington et al. (2008); Utah, USA	Examined how Latter-day Saints with EDs & perfectionism perceive Christ's Atonement	•Semi-structured interviews •Phenomenological thematic analysis •Phenomenology, hermeneutics	•20 U.S. women •Race & SES unspecified •Ages unspecified •AN, BN, EDNOS[g] (diagnosed at ED clinic)	•Disinterested in forgiveness if entrenched in perfectionism •Embracing God's forgiveness if confronting perfectionistic beliefs & guilt	•Addressing perfectionism via spiritual concepts may benefit ED treatments •Reducing perfectionism may promote ED recovery	•CASP: 19/26 •Richness: 4/5 •Journal article (peer-reviewed)

No.	Study	Aims	Methodology	Participants	Results	Conclusions	Rigour
7	Tierney & Fox (2010); UK	Investigated experiences of living with an anorexic voice	•Extensive written submission •Thematic analysis •Epistemology undescribed	•21 UK women •Mean age: 22.1 years •Race & SES unspecified •AN, past or present (diagnosis self-reported)	•Experiencing anorexic voice as positive in ED onset & negative during maintenance •Harsh, forceful character, demanding perfection	•Felt bonds between patients & AN voices may inhibit ED recovery •Treatment can recognise & work with AN voices	•CASP: 17/26 •Richness: 2/5 •Journal article (peer-reviewed)
8	Gustafsson et al. (2011); Sweden	Explored how adolescents with EDs perceive dealing with sociocultural pressures	•Semi-structured interviews •Phenomenographic research approach •Context-related phenomenography	•18 Swedish girls •Aged 15–19 years •Race & SES unspecified •AN (5), BN (1); EDNOS (12); diagnosed by ED service	•EDs stemming from struggles with social norms & pressures •Balancing meeting social expectations with self-acceptance & assertiveness	•ED treatment can promote interpersonal assertiveness •Therapies should not neglect relevance of social perfectionism to EDs	•CASP: 17/26 •Richness: 3/5 •Journal article (peer-reviewed)
9	Tierney et al. (2011); UK	Examined views of women with ED history on pregnancy & motherhood	•Semi-structured interviews •Framework analysis •Epistemology undescribed	•8 UK women •Aged 17–37 years •Race & SES unspecified •AN & BN (diagnosed by involved psychiatrist)	•Feeling torn between prioritising ED or motherhood •Experiencing fear of failure, ED relapse, & worry over children's shape & weight	•Control, identity & perfectionism themes may moderate ED relapse •Treatments in pregnancy can target these issues	•CASP: 19/26 •Richness: 3/5 •Journal article (peer-reviewed)
10	Murach (2013); UK	Explored the meaning of perfectionism for patients with EDs	•Semi-structured interviews •Interpretative phenomenological analysis •Subjective phenomenology	•6 UK women •Aged 20–26 years •Race & SES unspecified •AN (5), BN (1); screened by researchers	•Torn between pursuing high standards & fearing failure •Experiencing perfectionism & EDs as intertwined coping strategies for each other	•Perfectionism may play parallel ego-syntonic role to EDs themselves •Unclear how ED recovery modulates perfectionism	•CASP: 21/26 •Richness: 5/5 •Thesis (unpublished)
11	Mandich et al. (2014); Chile (Spanish language)	Compared perspectives of AN & BN patients on illness, food & self-image concepts	•Semi-structured interviews •Grounded theory methods •Descriptive-analytic approach	•15 Chilean women •Aged 18–30 years •Race & SES unspecified •AN (8), BN (7); diagnosed by associated psychiatrist	•Centring on illness, receiving diagnosis, meanings ascribed to food, eating, & body image •Associating self-image with perfectionism & body ideals	•Treatment should attend to range of dimensions of ED experiences •Conceptual differences may occur in AN vs BN	•CASP: 16/26 •Richness: 2/5 •Journal article (peer-reviewed)
12	Caoili (2015); Utah, USA	Explored role of spirituality in ED treatment & recovery	•In-depth interviews •Grounded theory methods •Epistemology undescribed	•12 U.S. women •Mean age: 28 years •Race & SES unspecified •AN, BN, BED[h], EDNOS (diagnosed by ED clinic)	•Spiritual perfectionism entwining with ED aetiology •Spiritual practices & counselling sometimes supporting ED recovery	•ED interventions can harness spiritual meaning-making & practices •But must address spiritual influences on ED onset	•CASP: 17/26 •Richness: 2/5 •Journal article (peer-reviewed)

No.	Study	Aims	Methodology	Participants	Results	Conclusions	Rigour
13	Miller (2016); California USA	Investigated roles of personality traits such as perfectionism in AN recovery	•Semi-structured interviews •Constant comparative method •Grounded theory approach	•7 U.S. women •Aged 29–50 years •'Caucasian'; varied SES •AN (diagnosis self-reported; treatment received)	•Recognising perfectionist value & tendencies in relation to life & eating •Using self-knowledge of personality for ED recovery	Treatment can harness perfectionism towards recovery, rather than aim to reverse personality traits & use strengths focus	•CASP: 18/26 •Richness: 4/5 •Thesis (unpublished)
14	Gulliksen et al. (2016); Norway	Identified structural components in common narratives of emergence of AN	•Semi-open, strategic 'Experience Interviews' •Grounded theory methods •Communication theory	•36 Norwegian women •Aged 18–51 years •Race & SES unspecified •AN (diagnosed in last 2 years by psychiatrist or clinical psychologist)	'Avoidant' (restrictive eating), 'Transformer' (idealized thinness), 'Achiever' (perfectionism), 'Punisher' (self-hate) pathways	•Common denominator of AN emergence in trying to master life challenges •Yet treatment can account for varied pathways	•CASP: 18/26 •Richness: 3/5 •Journal article (peer-reviewed)
15	Petersson et al. (2017); Sweden	Explored perspectives & experiences of perfectionism in ED patients	•In-depth, semi-structured interviews •Thematic analysis •Epistemology undescribed	•15 Swedish women •Aged 18–44 years •Race & SES unspecified •AN (4), BN (4), OSFED[i] (7); diagnosed by ED clinic	•Main perfectionism themes featuring origins, control, performance, perfect body •Recognising perfection as unattainable	•Psychometric measures may not capture qualitative range of perfectionisms •Perfect weight & shape not central to all patients	•CASP: 20/26 •Richness: 5/5 •Journal article (peer-reviewed)
16	Bouguetta-ya et al. (2019); Australia	Clarified how social group membership relates to perfectionism in EDs	•Semi-structured interviews •Interpretive phenomenological analysis •Epistemology undescribed	•10 Australian women •Aged 19–34 years •Race & SES unspecified •AN (5), BN (2), EDNOS (3); diagnosed by psychiatrist	•Personal perfectionism (self-control) emerging from family standards •Social perfectionism defined by social groups/norms	•ED treatments can use Social Identity Approach •Treatment can reduce perfectionism by redefining social norms	•CASP: 23/26 •Richness: 5/5 •Journal article (peer-reviewed)
17	Eiring et al. (2021); Norway	Investigated experiences of people with past AN diagnoses perceived as 'not sick enough'	•Semi-structured interviews •Interpretive phenomenological analysis •Phenomenology, hermeneutics, idiography	•7 Norwegian women •Aged 21–47 years •Race & SES unspecified •Past (only) diagnoses of AN or atypical AN (diagnosed self-reported)	•Feeling pressure to prove oneself as perfect •Focus on perfect physical appearance alongside ED •Wanting to feel understood	•Treatment benefitted by helping patients feel seen •Emphasis on weight as severity indicator can be challenged	•CASP: 18/26 •Richness: 2/5 •Journal article (peer-reviewed)
18	Sommer-feldt et al. (2022); Norway	Examined how women priorly in ED treatment experience pregnancy	•In-depth interviews •Ideal type analyses •Interpretive social research	•24 Norwegian women •Aged 26–42 years •Race & SES unspecified •BN (3), OSFED (18), UFED[j] (2); diagnosed by researchers (EDE-Q[k])	•ED worsening or relapse in pregnancy •Relapse relating to rigidity, perfectionism, loss of control •Wanting 'perfect pregnancy'	•Vulnerability to EDs in pregnancy •Relapse mediated by personality factors, including perfectionism	•CASP: 19/26 •Richness: 3/5 •Journal article (peer-reviewed)

No.	Study	Aims	Methodology	Participants	Results	Conclusions	Rigour
19	Howard et al. (2023); UK	Explored potential relationships between shame, perfectionism, & AN	•Semi-structured interviews •Grounded theory methodology •Constructivist approach	•11 UK females •Aged 25–41 years •Race & SES unspecified •AN (diagnosed confirmed by clinician)	•Vicious cycle of alleviating shame with perfectionism •Wanting perfect body, perfect life; self-punishment via AN •Wishing to perfect AN, too	•Shame & perfectionism are important to address together in therapy •Challenging perfectionist coping may evoke shame	•CASP: 18/26 •Richness: 4/5 •Journal article (peer-reviewed)
20	Watterson et al. (2023); New Zealand	Explored life events experienced as relevant to ED onset and recovery by women with ED histories	•Semi-structured interviews •Structural narrative analysis •Critical realism, narrative approach	•18 New Zealand women •Aged 16–51 years •'New Zealand European'; SES unspecified •Via charities & internet •AN (7), BN (7), BED (4): diagnosis self-reported	•Childhood loss & fear of abandonment •Belief in acceptance predicated on perfection •Struggle to seek emotional support	•Therapy can target coping with emotions and feels of being a burden •Prioritising therapist rapport may be key for epistemic trust	•CASP: 18/26 •Richness: 3/5 •Journal article (peer-reviewed)
21	Declercq et al. (2024); UK	Evaluated feasibility of comedy course to support ED recovery	•Semi-structured interviews •Framework analysis, via CHIME framework of personal recovery •Epistemology undescribed	•10 British people with EDs (8 female, 2 male; 1 of whom transgender) •Aged 25–46 (Mn: 29) •9 White, 1 British Asian; SES unspecified •AN, BN, BED, ARFID[l]: diagnoses self-reported •Via ED-support charity	•Comedy giving levity & hope for life & recovery •Resisting perfectionism via playfulness & self-acceptance •Great sense of meaning in life	•Innovative interventions such as comedy can support ED recovery •Levity can reduce impact of perfectionist cognitions	•CASP: 18/26 •Richness: 2/5 •Journal article (peer-reviewed)
22	Marney et al. (2024); UK	Explored ED-experiencers' schema modes	•Mixed methods: *Schema Mode Inventory for EDs*, and semi-structured interviews •Thematic analysis •Epistemology undescribed	•16 British women in UK •Aged 22–65 years •Race & SES unspecified •AN (9), BN (2), BED (5); 14 diagnosed, 2 self-reported •Via ED-support charity	•Trauma & vulnerability from unrealistic family standards •Demanding Mode schema affecting daily life & EDs •People-pleasing as self-protection; barrier to recovery	•Demanding & Vulnerable schemas resonated with ED-experiencers •Schema therapy may target key schemas maintaining enduring EDs	•CASP: 17/26 •Richness: 3/5 •Journal article (peer-reviewed)

[a]**ED**: Eating disorder (DSM-IV–V)
[b]**CASP**: Critical Appraisal Skills Programme Qualitative Studies Checklist (CASP, 2018), adapted
[c]**Richness**: Data Richness Scale (Ames et al., 2019)
[d]**SES**: Socioeconomic status
[e]**AN**: Anorexia nervosa (DSM-V)
[f]**BN**: Bulimia nervosa (DSM-V)
[g]**EDNOS**: Eating disorder not otherwise specified (DSM-IV)
[h]**BED**: Binge eating disorder (DSM-V)
[i]**OSFED**: Other specified feeding or eating disorders (DSM-V)
[j]**UFED**: Unspecified eating disorder (DSM-IV)
[k]**EDE-Q**: Eating disorder examination questionnaire
[l]**ARFID**: Avoidant restrictive food intake disorder (DSM-V)

Table 2. Quality appraisal ratings

Study (number, authors, date)	**Q1**[*]	**Q2**[**]	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**[**]	**Q9**	**Q10**	**Q11**	**Q12**	**Q13**[**]	**Total** (/26)	**Data Richness Score** (/5)[***]
1. Goldswain (1998)	Y[a]	Y	Y	Y	N[b]	S[c]	Y	N	Y	S[c]	Y	S	N	**18**	**3**
2. Collins (1999)	Y	Y	S	S	S	S	N	S	S	S	S	S	N	**13**	**2**
3. Wade (2002)	Y	Y	S	S	S	S	S	Y	Y	S	S	S	N	**16**	**3**
4. Jacobs (2003)	Y	Y	S	S	S	S	S	Y	Y	S	S	S	N	**16**	**3**
5. Dignon et al. (2006)	Y	Y	Y	Y	Y	S	Y	N	S	Y	Y	S	Y	**21**	**3**
6. Edgington (2008)	Y	Y	S	Y	Y	Y	S	N	N	S	Y	Y	Y	**19**	**4**
7. Tierney & Fox (2010)	Y	S	S	S	S	S	N	Y	N	Y	Y	Y	Y	**17**	**2**
8. Gustafsson et al. (2011)	Y	S	S	S	S	Y	S	N	S	Y	Y	S	Y	**17**	**3**
9. Tierney et al. (2011)	Y	Y	Y	S	Y	Y	N	N	S	S	Y	Y	Y	**19**	**3**
10. Murach (2013)	Y	Y	Y	Y	S	Y	S	Y	S	Y	Y	Y	N	**21**	**5**
11. Mandich et al. (2014)	S	Y	Y	Y	Y	S	N	N	S	S	S	S	Y	**16**	**2**
12. Caoili (2015)	S	S	Y	Y	Y	Y	N	S	S	S	Y	Y	N	**17**	**2**
13. Miller (2016)	Y	S	S	S	Y	S	Y	S	Y	Y	Y	S	N	**18**	**4**
14. Gulliksen et al. (2017)	Y	Y	S	S	Y	Y	S	N	S	Y	Y	S	Y	**18**	**3**
15. Petersson et al. (2017)	S	Y	Y	Y	Y	Y	S	N	S	Y	Y	Y	Y	**20**	**5**
16. Bouguettaya et al. (2019)	Y	Y	Y	Y	Y	Y	S	S	S	Y	Y	Y	Y	**23**	**5**
17. Eiring et al. (2021)	Y	S	Y	Y	Y	Y	N	N	N	Y	Y	S	Y	**18**	**2**
18. Sommerfeldt et al. (2022)	Y	Y	Y	Y	Y	Y	S	N	S	S	S	Y	Y	**19**	**3**
19. Howard et al. (2023)	Y	Y	S	Y	Y	S	N	S	S	S	Y	Y	Y	**18**	**4**
20. Watterson et al. (2023)	Y	S	Y	Y	S	S	N	S	S	Y	Y	Y	Y	**18**	**3**
21. Declercq et al. (2024)	Y	Y	S	Y	Y	Y	N	N	S	S	Y	Y	Y	**18**	**2**
22. Marney et al. (2024)	Y	Y	Y	Y	S	S	N	N	S	S	Y	Y	Y	**17**	**3**

[*] Questions 1–13, adapted from *Critical Appraisal Skills Programme* Qualitative Studies Checklist (Long et al., 2020; Appendix D)

[**] Questions 2, 8 & 13 inserted by researchers [***] Data Richness Scale (Ames et al., 2019; Appendix D)

[a] Y: "Yes" (criteria mainly/fully met) [b] N: "No" (criteria minimally/not met) [c] S: "Somewhat" (criteria partly/ambiguously met)

3.3. Critical appraisal

Table 2 summarises quality-assessment ratings. While CASP lacks clear-cut scoring thresholds (Long et al., 2020), and scoring is contentious (Noyes et al., 2018), researchers interpreted scores above 13/26 as 'reasonable quality' (Vanderspank-Wright et al., 2018). All studies rated reasonably, ranging from 13–23/26 (mean/median=18/26). Theses scored modestly lower (mean=17/26) than published articles (18.5/26). All studies achieved at-least-somewhat clear research aims; theoretical situatedness; appropriate design; rigorous analysis; and valuable contribution. 'Reasonable-quality' ratings were not achieved in some studies for interview reflexivity (n=10), researcher positionality (n=12), and ethical consideration (n=4).

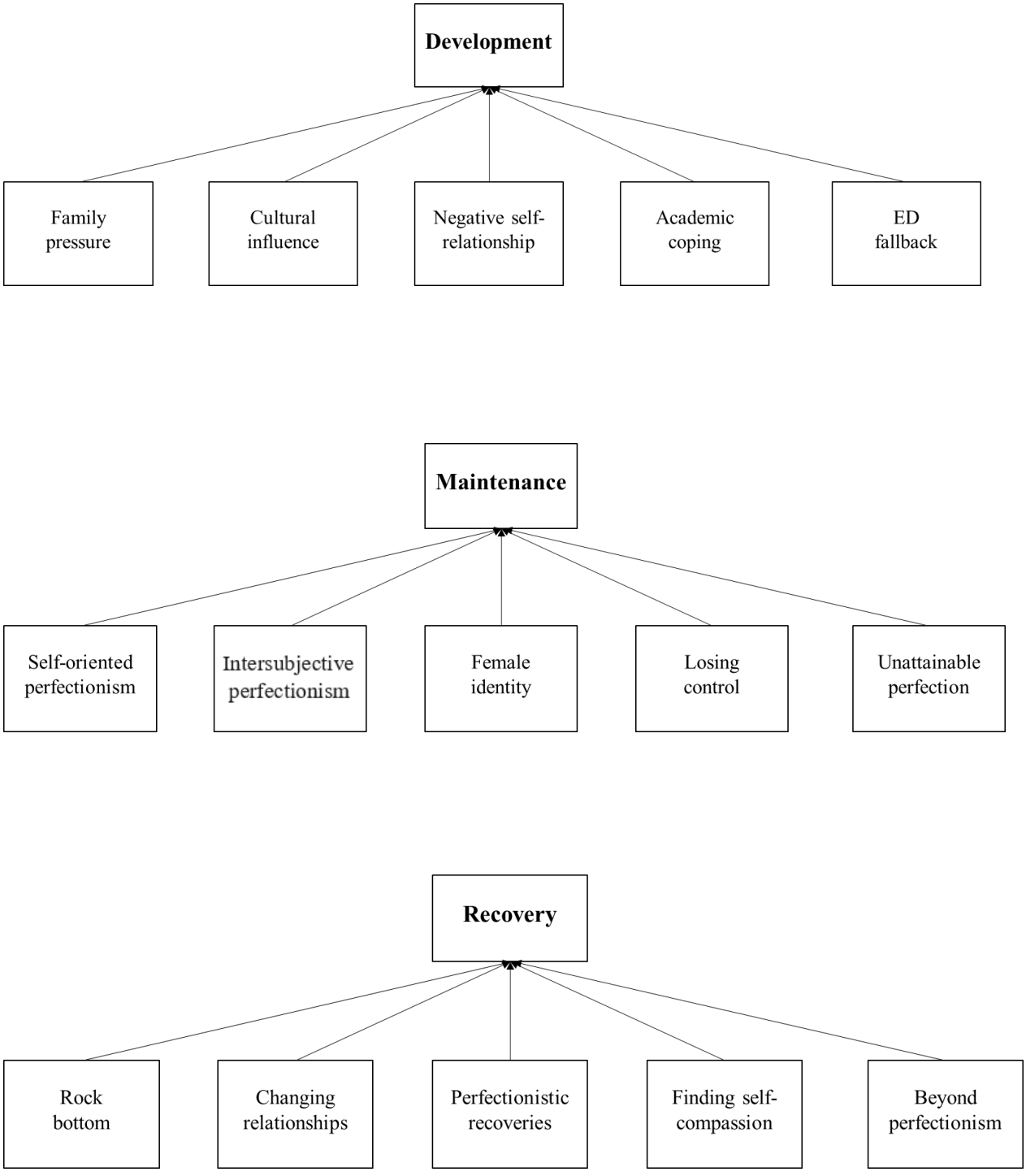
Data richness ranged from 2–5/5 (mean/median=3/5): all studies containing at-least 'some' data with at-least 'good' conceptual relevance to the review aims (Appendix D).

3.4. Synthesis outcomes

3.4.1. Translation

Included studies were translated into 15 subthemes. Subthemes spanned multifaceted experiences of perfectionism, self-criticism, and self-compassion in ED contexts. Three main themes were constructed, based on perceived shared meaningfulness to the codes. These themes captured chronological trajectories shaped by the subthemes. They narrated how perfectionism arose in people; predisposed and precipitated EDs; maintained EDs multifacetedly; and both beleaguered and empowered recovery. They are delineated below (with coding frames in Figure 2).

Figure 2. Thematic synthesis coding frame



3.4.2. Themes

3.4.2.1. Development

Chronologies began with early onsets of perfectionism and EDs. Family pressures predisposed participants via distant/demanding parenting; abandonment; or abuse—where striving and achievement engendered felt-safeness. Cultural messaging compounded perfectionisms: with perfect bodies in media, and flawlessness at Church. Punitive ideals embedded deep-seated shame and felt-defectiveness. Excelling academically alleviated self-loathing – but generated increasing stress. As excelling grew harder, becoming the 'best at EDs' (particularly restriction) offered relief—and monomaniacal mastery over peers and felt-turmoil.

3.4.2.1.1. Family pressure

Perfectionism was conceptualised as stemming from "demanding or high-achieving parents" [Paper 15, author(s) (P15a), p.5] exerting expectations yet withholding praise:

"*very high standards, but were less practised at congratulating*" [P5a, p.952]

Failure was associated with risk of abandonment, while achievement earned affection:

"*I have to be perfect so that Dad cares*" [P20, respondent (P20r), p.275]

"Physical and emotional abuse" [P19a, p.45] were also described – where becoming "perfect daughter[s]" [P4r, p.64] and restricting food offered perceived security:

"*excessive dieting and restricting [for…] the feeling of control*" [P2a, p.94].

3.4.2.1.2. Cultural influences

Perfectionism was also conceived as instilled by cultural messaging. "[A]dvertisements, media and social media" [P15a, p.5] implanted ideals of thinness:

"*they're all perfect […] the same image is constantly reinforced*" [P5r, p.952]

Cultural influence included religious institutions, where "teachings [were…] interpreted as telling a woman that she needed to be perfect" [P12a, p.26]. Participants substituted failed spiritual perfection with thinness:

"*do anything to get skinny [to…] at least seem perfect on the outside*" [P12r, p.27]

Restricting food intake via "religious fasting" was reinterpreted to "give meaning to their self-starvation" [P12a, p.38].

3.4.2.1.3. Negative self-relationship

Whether from family or cultural pains, intensely negative self-relationships were elaborated (entailing shame and self-criticism):

"*feelings of inadequacy, sadness, and despair became those of self-loathing"* [P3a, p.342]

Self-loathing extended to feeling spiritually flawed, undeserving of forgiveness :

"*I was sent to earth bad… not worthy of the atonement*" [P6r, p.28]

Physical-appearance perfectionism and EDs was conceived as mitigating self-disgust:

"*AN became a source of pride […] to suppress shame*" [P19r, p.49].

3.4.2.1.4. Academic coping

Esteem-boosting perfectionism was focalised in academics, particularly by parental expectation:

> "*dad had massively high standards […] quiz[zing] me on the 10% I got wrong"* [P22r, p.7]

Standards progressively rose—from personal achievement to out-competing peers:

> "*'beat[ing]' the other girls academically […] provoked even a stronger drive*" [P2r, p.109]

Perfectionism begat rising pressure, internalised as emotionally, somatically destabilising:

> "*then came exams […] my body was restless all the time. Felt like chaos around me and within me*" [P14r, p.852].

3.4.2.1.5. ED fallback

As academic supremacy grew unattainable, EDs were conceptualised as the substitutive focus for striving:

> "*definition of perfection changed to one of restriction, instead of academia"* [P16a, p.353]

Imperfection across all life-domains found "multi-mastery […] substituted by mono-mastery" [P14a, p.852]:

> "*too much for me to be best at everything. Then I found my thing (AN)*" [P14r, p.852]

EDs lent senses of "expertise" and being "the best" [P17a, p.5]— containing felt chaos:

> "*couldn't control anything in my life […] only thing I could control was [restriction…] thought life would be perfect if I lost weight*" [P19r, p.48].

3.4.2.2. *Maintenance*

Narratives continued with perfectionism perpetuating and intensifying EDs. 'Self-oriented' standards demanded perfect achievement, bodies, and EDs—or ED-behaviours were analgesic for wider failures. 'Interpersonal perfectionism' compelled perfect performances as friends, partners, relatives, often concerning appearance. This intertwined with 'female identity': conceptualising 'ideal women' as self-controlled and thin— including in pregnancy, where less-than-perfect mothering provoked restrictions. ED- and perfectionism-severity escalated codependently: promising perceived-control – including over healthcare – but becoming shrinking comfort zones, ceding actual control to EDs. Recognition emerged towards perfection's unattainability and EDs' diminishing returns in reducing self-loathing.

3.4.2.2.1. Self-oriented perfectionism

Self-imposed "insane" "standards" [P22r, p.7] were described – particularly appearance-related:

> "*I always have to have the perfect body*" [P19r, p.47]

EDs were framed as analgesic responses to failing these standards:

> "*might fall back on the eating disorder, to make me feel better*" [P10r, p.93]

Yet, as self-imposed standards extended to EDs themselves – embodying "the 'perfect anorexic'" [P19a, p.50] – the analgesic brought its own pain:

> "*do this to your body, to strive for what you think is perfect […] you're hurting*" [P3r, p.222].

3.4.2.2.2. Intersubjective perfectionism

EDs were also conceived as maintained by social perfectionism. Participants felt compelled to be perfect in others' perceptions:

> "*I have to be the perfect friend […] perfect girlfriend […] perfect student […] perfect daughter*" [P22r, p.7]

Self-abnegation in EDs was mirrored by participants' prioritising others' needs – particularly to prevent abandonment:

> "*must please everybody […] so they don't leave you*" [P20r, p.274]

Intersubjective perfectionism amplified ED cycles of restriction and imagined social reward:

> "*when I dieted […] other people would suddenly turn around and like me*" [P19r, p.46].

3.4.2.2.3. Female identity

Some studies used implicitly feminist lens – noting societal imperatives to be a "perfect woman" [P16r, p.351]. This entailed managing thinness, even when pregnant:

> "*perfect pregnant woman […] have a caesarean section, and be the thin mother*" [P18r, p.8]

Participants described perfectionism as enforced intersubjectively by "other women" [P16r, p.353]. Fear of failure loomed over motherhood:

> "*concerned about being judged negatively […] on external markers of their mothering*" [P9a, p.1,227]

Struggling with mothering reinforced EDs as more familiar domains of perceived success:

> "*return to a familiar role in which they have succeeded previously, namely as someone with an eating disorder*" [P9a, p. 1,228].

3.4.2.2.4. Losing control

ED maintenance was also construed as perfectionist over-controlling backfiring. Controlling social environments – including care received – pulled participants into severer EDs:

> "*I would be f******* sick enough for her to tell me that 'now you need help'*" [P17r, p.5]

This produced paradoxes, whereby increased "degree[s] of perfectionism […and] ED severity" [P15a, p.7] meant more control lost:

> "*I was too self-demanding […] I poured all control into my eating*" [P11r, p.75; translated (SK)]

Participants felt increasingly trapped by perfectionism: comfort zones shrunken by fear of failure:

> "*if I don't try, I can't get it wrong […] but then that's maladaptive because nothing happens*" [P22r, p.7].

3.4.2.2.5. Unattainable perfection

Entrapment in EDs was elaborated via recognition of perfection being unattainable. Achievement, even interpersonal, diminishingly alleviated self-loathing:

> "*did not seem to change participants' internal experience of never being good enough*" [10a, p.85]

Ever-climbing standards produced relentless "push[es] to do things better" [P6a, p.29], leaving successes short-lived:

> "*As soon as you reach one level it isn't long before you strive to go farther*" [P15r, p.7]

Structural flaws of embedding self-worth in perfectionism were acknowledged across all life-tasks:

> "*Everything is about climbing higher and higher: be prettier, be thinner, be better […] I get some new demand and the whole thing crumbles*" [P8r, p.107].

3.4.2.3. *Recovery*

Narratives concluded with (mixed) recovery. Hitting 'rock bottom', desire strengthened for releasing Sisyphus' impossible burden. Overthrowing EDs resembled losing friends – grieving promised perfection – facilitated confiding in friends, family, and God. Perfectionism obstructed ED recoveries, engendering fear of failed attempts – or, worse, being 'nothing' without domain-mastery. Self-compassion bolstered recovery efforts: playfulness and forgiveness softening shame and self-criticism. This empowered redirecting perfectionism from eating, appearance, and excelling to being 'perfectly healthy'—or to life 'beyond perfectionism', and nascent faith in being 'good enough' already.

3.4.2.3.1. Rock bottom

Recovery was conceived as starting when participants deemed perfection an ideal they were "[un]sure even exists" [P15a, p.7]:

> "*it's impossible to have the perfect levels of everything*" [P10r, p.95]

Multiple papers cited participants' allegory of Sisyphus: realising there would be "no end" [P15r, p.6] to pursuing perfection:

> "*pushing a massive boulder uphill and at the end of every day it falls down again*" [P22r, p.7]

Echoing this metaphor, other studies found participants "report[ing] 'hitting rock bottom'" – exhausting their "energy to keep" up [6a, p.29] with perfectionism and EDs. This precipitated participants' redirecting efforts overcoming EDs:

> "*turned that determination toward recovery [and other…] healthy avenues*" [P13r, p.40].

3.4.2.3.2. Changing relationships

Recovery also involved altered relationships with voices experienced dissociatively as ventriloquising EDs and perfectionism. Distance from these voices resembled grief, "like killing your best friend" [P7r, p.249]. Resisting entrapment, participants retorted:

> "*The perfection you promised had seemed so right […] but the longer I engaged in your project, the further away that ideal became*" [P7a, p.248]

Recovery fostered shifted perceptions of God's voice – from "critical and harsh" [P6a, p.28] to supportive:

> "*feeling that God was behind them and cheering them on, whether they made mistakes or not*" [P6a, p.30]

Dynamics also shifted with loved ones, when participants finally confided their EDs—sacrificing façades "that everything was going very well" [P14a, p.852]. Unexpected relief arose from not being rejected for revealing imperfection:

> "*surprised to receive love and support when they opened up […] about their eating disorders*" [P12a, p.32].

3.4.2.3.3. Perfectionistic recoveries

Perfectionism was deemed a "large barrier" to ED recoveries – as participants waited for "perfect recovery" [P19a, p.51]. Trying and failing risked self-flagellating shame:

> "*obsessed with perfectly getting better, and if you don't succeed, then you can beat yourself*" [P19r, p.52]

Competitiveness flared: wanting to "be the best" at recovery [P21a, p.9] if not at EDs. Participants feared dangerous plunges in life-meaning without EDs:

> "*what if I am left with nothing? It's like jumping off a cliff*" [P19r, p.51]

Fear was assuaged by redirecting attention from EDs onto wider life-values:

> "*not what my body looks like or what I'm eating […] who do I want to be in the world*" [P13r, p.39].

3.4.2.3.4. Finding self-compassion

Recovery was empowered by self-compassion. ED interventions involving patients in performing comedy compassionately distanced participants from perfectionist self-bullying:

> "*let go of the idea that everything has to be perfect and planned*" [P21r, p.14]

Self-compassion included "being gentle" with pains of feeling "less than perfect" [P13r, p.39] – instead of self-numbing with EDs:

> "*learning to experience the feelings and move on, rather than be tortured*" [13r, p.39]

Anti-perfectionist techniques facilitated "more relaxed […] kinder" [P21r, p.9] emotional postures when facing mistakes—aided by felt-connection to humanity:

> "*not perfect, but when I got to the club everybody else was there to welcome me in*" [P13r, p.41].

3.4.2.3.5. Beyond perfectionism

Alongside ED recovery, recovery from perfectionism was explored. For some, shedding perfectionism felt unviable, but helped them conquer EDs—striving to be "perfectly healthy" [P10a, p.100]:

> "*tendencies towards achievement […but] I don't think my body is one of them anymore*" [P13r, p.41]

Others extended recovery beyond EDs – rejecting self-worth's affiliation with achievement:

> "*like my eating disorder wasn't healthy for me, it's not healthy […] to be all success-focused*" [P13r, p.39]

Surpassing both empowered participants towards wider self-acceptance – supporting cognitive-behavioural peace:

> "*striving to accept themselves […] and to think and act according to the premise that they were good enough*" [P8a, p.106].

4. Discussion

This novel systematic review identified 22 qualitative studies of reasonable quality involving perfectionism in people with EDs. Thematic synthesis was used inductively to generate 15 subthemes, from which three main themes were derived: which charted ED trajectories from onset to maintenance to recovery, via perfectionism. Findings of this meta-synthesis suggest multifaceted resonance with wider, mixed-method ED literature.

4.1. Wider literature

4.1.1. Onset

Taken chronologically: early-life emotional abuse is comorbid with ED development (Caslini et al., 2016). Demanding parenting styles are associated with adolescent EDs (Hampshire et al., 2022)—indeed, '*Parental Expectations and Criticism*' constitutes an *FMPS* subscale (Stöber, 1998). Epidemiological influences of 'perfect' media on EDs are documented (Dane & Bhatia, 2023) – though research on religiocultural messaging is more emergent (Richards et al., 2018). EDs are robustly associated with self-disgust and self-criticism (Bektas et al., 2022; Paranjothy & Wade, 2024). Some research has shown shame to mediate perfectionism and community-identity (Piotrowski et al., 2023), with no existing meta-analysis. Despite limited research examining academic perfectionism and EDs, with no meta-analyses, associations have been established (Claydon & Zullig, 2020; Schilder et al., 2021). Themes of finding self-efficacy in mastering EDs are reflected in reviews of competitiveness and EDs (Osborn, 2023). Overall, 'ED development' themes suggested perfectionism may be underrepresented in preventative ED research (Koreshe et al., 2023).

4.1.2. Maintenance

Subthemes of self-oriented and intersubjective perfectionism explicitly reflect dimensions of the *Multidimensional Perfectionism Scale* ('*Self-Oriented'* and '*Socially Prescribed'* subscales; Hewitt & Flett, 1991). Despite themes from the current synthesis of self-

oriented and social perfectionism's maintaining EDs, quantitative investigations have found no significant effects on ED and psychiatric symptomatology (Petersson et al., 2018). Systematic reviews of ED-relapse in pregnancy identified appearance-related perfectionism as relevant (Janas-Kozik et al., 2021) – though wider associations with motherhood and female identity are underreported. Themes of tightening control echo cognitive-behavioural models: where control-seeking maintains EDs, particularly AN (Fairburn et al., 1999)—although recent reconceptualisations argue control-seeking is overemphasised (Branley-Bell et al., 2023). While control-seeking in perfectionism appears under-studied, high standards are found to grow ever-higher in perfectionist cycles (Kobori et al., 2009; Shafran et al., 2023). Yet, though higher perfectionist traits predict greater ED symptomology (Barbarich-Marsteller et al., 2011), specific links between escalating standards and EDs appear under-researched.

4.1.3. Recovery

Recovery-oriented subthemes from the current synthesis offer modest theoretical links. Emergent research into 'ED-voice experiences' suggests addressing patients' internal monologues can promote ED recovery (Aya et al., 2019). Meta-ethnography of ED-recovery emphasised 'letting go'—though more related to releasing EDs than perfectionistic standards (Eaton, 2020). While some literature found perfectionism levels persisting after ED recovery (Bardone-Cone et al., 2007), updated findings suggest perfectionism reduces in longer-term recovery (Bardone-Cone et al., 2010). Self-compassion mediates perfectionism and wellbeing in adults (Benedetto et al., 2024), and predicts reduced eating pathology (Braun et al., 2016), but limited research has studied all three. One study saw self-compassion moderating disordered eating and physical-appearance-perfectionism, but not general perfectionism (Bergunde & Dritschel, 2020)—reflecting subthemes here of lingering perfectionism. This invites further, quantitative research, elucidating relationships between perfectionism types and ED improvement.

4.2. Implications

These findings offer translational relevance to clinical ED literature—nuancing mainstream and emergent treatment models with suggested multidimensionality of perfectionism.

4.2.1. Multidimensional frameworks

Synthesised themes provide multifaceted qualitative representations of multidimensional perfectionism in EDs. Unidimensional-clinical-perfectionism proponents have argued that multidimensional perfectionism conflates distinct, non-perfectionist concepts (Shafran et al., 2003); however, data in this synthesis drew conceptual equivalency between multiple and apparently heterogeneous perfectionism constructs. Related themes of perfectionist motivations – including fearing failure, avoiding trying, anticipating judgment, mitigating shame – were delineated by participants (and researchers). Moreover, themes of varied perfectionist contexts were also intertwined—as multidimensional perfectionism proponents have postulated (Smith et al., 2022; Stöber, 1998). These included both ED-specific themes (e.g., appearance, restrictive-eating, recovery-concerned perfectionism) and non-ED-specific themes: such as self-oriented (e.g., academic, athletic) and socially prescribed (e.g., status, parenting) perfectionism. This thematic nuance endorses the value of multidimensional perfectionism, above being homogenised by clinical perfectionism.

Further quantitative research might explore statistical associations between the perfectionism phenomena captured by subthemes in this review to further inform if these are best understood in terms of multidimensional perfectionism or unidimensional models. This includes self-compassion, alongside under-researched areas, including religious perfectionism, atonement, and forgiveness.

4.2.2. Treatment models

4.2.2.1. Current treatment

On the one hand, the synthesis resembles core CBT formulations of predisposing/precipitating factors; maintenance cycles; and cognitive-behavioural cycle-disruptions (Fairburn, 2008). Limited differentiation between ED types resembles Fairburn et al.'s (2003) transdiagnostic model. Transdiagnostic ED models reflect arguments for prevalent diagnostic migration and shared core-pathologies across ED profiles (Bardone-Cone et al., 2010; Tozzi et al., 2005). 'Core low-self-esteem' and 'perfectionism' represent key transdiagnostic ED perpetuators (Fairburn et al., 2003; Figure 3). Fairburn's (2008) original CBT-E highlights how overvaluation of shape, weight, and their control drives ED behaviours – including dieting and binge eating – with these cycles exacerbated by external events and mood. Treatment modules therefore focus on body image, addressing dietary restraint, and coping with events and their impact on mood. In addition to these core modules, Fairburn's (2008) CBT-E appends optional core low-self-esteem and perfectionism modules – adapting generalised self-esteem (Fennell, 1997) and CBT-P (Shafran et al., 2003) models – in case perfectionism and/or core low-self-esteem impede primary ED treatment. Subthemes here suggest both modules may benefit perfectionistic CBT patients. Moreover, specific perfectionism facets found in this synthesis cohere also with Shafran et al.'s (2003) transdiagnostic perfectionism model (CBT-P). CBT-P depicts interrelation between self-worth and achievement, alongside ever-increasing standards (Figure 3) – prevalent in these subthemes.

However, many ED-related perfectionism nuances identified in this synthesis are unspecified in CBT-P. Moreover, the above endorsement of multidimensional perfectionism may further warrant modular adaptations to CBT-P. It remains unclear whether CBT-P (Shafran et al., 2003) sufficiently targets ED-focused experiences – both within and beyond perfectionism. Thus, it is perhaps unsurprising that recent CBT-P meta-analyses found large effect sizes for perfectionism but only medium for disordered eating (Galloway et al., 2022; Robinson & Wade, 2021). Further research might investigate whether CBT-P is successful in

producing holistic ED recovery as well as reducing symptomology (Shafran et al., 2023). More modular iterations of CBT-P might, informed by this review's main themes, adapt core modules for different stages of ED and life journeys (such as onset and recovery).

Conversely, it also appears unclear whether CBT-E perfectionism modules (Fairburn, 2008) sufficiently address wider forms of perfectionism that appear to drive EDs. Additional research could test whether CBT-E perfectionism and self-esteem modules reduce wider perfectionism dimensions, and whether these dimensions are influential in ED recovery.

4.2.2.2. Emergent models

Findings may also inform nascent ED-treatment models. They indicate interrelation between increased self-compassion and reduced perfectionism in ED recovery – despite ambiguous associations identified in quantitative research (Bergunde & Dritschel, 2020). It endorses further development of emergent compassion-focussed therapy for eating disorders (Goss & Allan, 2014)—which may support superior long-term ED recovery than CBT-E in trauma contexts (Vrabel et al., 2024).

Moreover, themes of ED-recoverees' embracing wider, valued life-aspects implies acceptance-and-commitment therapy (ACT) may also be valuable. Though fledgling – and showing herein mixed efficacy (Onnink et al., 2022) – ACT-for-EDs' emphases on values over goals and life-balance over monomania may potently target perfectionism (Ong et al., 2019). ACT favours metaphors, and ACT for perfectionism in EDs might harness imagery of releasing Sisyphus' boulder—reminiscent of Hayes' dropping the rope (Stoddard & Afari, 2014).

Finally, the synthesis offers robust qualitative evidence for involvement of perfectionism in ED onset. So, more speculatively, future research may investigate whether current ED prevention and early-intervention programmes might benefit from augmenting perfectionism-related components (Koreshe et al., 2023; Stice et al., 2021).

4.3. Limitations

4.3.1. Quality caveats

Findings were caveated by research-quality appraisal (Section 3.3). Yet, all 22 studies demonstrated satisfactory-or-higher quality. Although eight studies were unpublished theses, they demonstrated robust quality. Moreover, no themes were derived solely from theses. Similarly, all subthemes were found in peer-reviewed papers rated 18+/26 (Section 3.3). Themes from studies with notably small sample-sizes (papers 1, 2 & 4) were cross-referenced with larger studies. Finally, all themes were corroborated by direct participant quotations – further buffering them from epistemological threats to credibility (Hannes et al., 2017).

4.3.2. Synthesis caveats

Synthesised findings lacked specificity discerning ED diagnoses – stemming from limited distinguishment between diagnoses in included studies across themes. Additionally, not all included studies confirmed psychiatric proof of diagnosis, as nine studies were included that relied on self-reporting. Moreover, male participants were strikingly underrepresented across the synthesised studies, and thus in this review. Given the predominantly female sample, and emergence of a 'female identity' subtheme, findings may hold uncertain relevance to other genders. Furthermore, it is ambiguous what proportion of women were cisgendered, though only one transgender participant was mentioned. This reflects a gender imbalance in the literature that merits redressing. The review also encountered stark underrepresentation of non-white participants, reflective of wider ED literature (Halbeisen et al., 2022), while 19 synthesised studies neglected to supply racial demographics. Relevance to non-white populations is therefore unclear. Finally, it was not possible to draw age-related conclusions from the synthesis. Future research into this topic would benefit from prioritising exploring these complex intersectionalities.

Methodologically, generating immaculately inductive subthemes was untenable: as authors were influenced by their recent research into multidimensional perfectionism. While authors sought to limit bias through the use of inter-rating and reflexive conversations, they acknowledge that findings will reflect their subjective positionalities (Schwartz, 2007). Additionally, authors of the included studies were not contacted regarding germane unpublished work. Finally, qualitative methods are not designed to be representative, and causal links between these themes should be hypothesised with caution.

4.4. Conclusions

This systematic review presents a novel synthesis of the qualitative evidence base for experiences of perfectionism in people with EDs. It sought to fill striking gaps in the literature and contribute phenomenological insight into lived experiences of hitherto highly nomothetic constructs.

Findings endorsed a multidimensional picture of perfectionism in EDs. Perfectionism expressions and domains appeared conceptually coherent yet heterogeneous—challenging both transdiagnostic and ED-specific clinical frameworks conceptualising perfectionism as unidimensional. Therefore, current treatment models may warrant modular adaptation to address this multidimensionality and adopt more idiographic nuance. Third-wave CBTs, including CFT and ACT, also hold emergent promise for improved, holistic outcomes.

References

Altman, D. G., & Doré, C. J. (1990). Randomisation and baseline comparisons in clinical trials. *Lancet*, *335*(8682), 149–153. https://doi.org/10.1016/0140-6736(90)90014-v

Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: A worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, *19*(1), 26. https://doi.org/10.1186/s12874-019-0665-4

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™, 5th ed*. American Psychiatric Publishing, Inc. https://doi.org/10.1176/appi.books.9780890425596

Attia, E., Becker, A. E., Bryant-Waugh, R., Hoek, H. W., Kreipe, R. E., Marcus, M. D., Mitchell, J. E., Striegel, R. H., Walsh, B. T., Wilson, G. T., Wolfe, B. E., & Wonderlich, S. (2013). Feeding and eating disorders in DSM-5. *The American Journal of Psychiatry*, *170*(11), 1237–1239. https://doi.org/10.1176/appi.ajp.2013.13030326

Aya, V., Ulusoy, K., & Cardi, V. (2019). A systematic review of the 'eating disorder voice' experience. *International Review of Psychiatry*, *31*(4), 347–366. https://doi.org/10.1080/09540261.2019.1593112

Barbarich-Marsteller, N. C., Foltin, R. W., & Walsh, B. T. (2011). Does Anorexia Nervosa Resemble an Addiction? *Current Drug Abuse Reviews*, *4*(3), 197–200.

Bardone-Cone, A. M., Sturm, K., Lawson, M. A., Robinson, D. P., & Smith, R. (2010). Perfectionism across stages of recovery from eating disorders. *International Journal of Eating Disorders*, *43*(2), 139–148. https://doi.org/10.1002/eat.20674

Bardone-Cone, A. M., Wonderlich, S. A., Frost, R. O., Bulik, C. M., Mitchell, J. E., Uppala, S., & Simonich, H. (2007). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review*, *27*(3), 384–405. https://doi.org/10.1016/j.cpr.2006.12.005

Bektas, S., Keeler, J. L., Anderson, L. M., Mutwalli, H., Himmerich, H., & Treasure, J. (2022). Disgust and Self-Disgust in Eating Disorders: A Systematic Review and Meta-Analysis. *Nutrients*, *14*(9). https://doi.org/10.3390/nu14091728

Benedetto, L., Macidonio, S., & Ingrassia, M. (2024). Well-Being and Perfectionism: Assessing the Mediational Role of Self-Compassion in Emerging Adults. *European Journal of Investigation in Health, Psychology and Education*, *14*(5). https://doi.org/10.3390/ejihpe14050091

Bergunde, L., & Dritschel, B. (2020). The shield of self-compassion: A buffer against disordered eating risk from physical appearance perfectionism. *PLOS ONE*, *15*(1), e0227564. https://doi.org/10.1371/journal.pone.0227564

Bouguettaya, A., Klas, A., Moulding, R., King, R., & Knight, T. (2019). Perfectionism as a social identity in eating disorders: A qualitative investigation of identity navigation. *Australian Psychologist*, *54*(4), 347–357. https://doi.org/10.1111/ap.12379

Branley-Bell, D., Talbot, C. V., Downs, J., Figueras, C., Green, J., McGilley, B., & Murphy-Morgan, C. (2023). It's not all about control: Challenging mainstream framing of eating disorders. *Journal of Eating Disorders*, *11*(1), 25. https://doi.org/10.1186/s40337-023-00752-9

Braun, T., Park, C., & Gorin, A. (2016). Self-compassion, body image, and disordered eating: A review of the literature. *Body Image*, *17*, 117–131. https://doi.org/10.1016/j.bodyim.2016.03.003

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health, 24(1)*, 1–6.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, *7*(4), 209–215. https://doi.org/10.1258/135581902320432732

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. Harvard University Press.

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine (1982)*, *56*(4), 671–684. https://doi.org/10.1016/s0277-9536(02)00064-3

Caoili, C. (2015). *The Role of Spirituality in Treatment and Recovery from Eating Disorders* [Unpublished doctoral dissertation]. https://scholarsarchive.byu.edu/etd/5484

Caslini, M., Bartoli, F., Crocamo, C., Dakanalis, A., Clerici, M., & Carrà, G. (2016). Disentangling the Association Between Child Abuse and Eating Disorders: A Systematic Review and Meta-Analysis. *Psychosomatic Medicine*, *78*(1), 79. https://doi.org/10.1097/PSY.0000000000000233

CASP. (2018). *Critical Appraisal Skills Programme. CASP qualitative checklist*. https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Claydon, E., & Zullig, K. J. (2020). Eating disorders and academic performance among college students. *Journal of American College Health: J of ACH*, *68*(3), 320–325. https://doi.org/10.1080/07448481.2018.1549556

Collins, P. L. (1999). *Eating disorders: A multiple-case investigation of the Internet e-mail correspondence of women's lived experience* [Unpublished doctoral dissertation: Texas Tech University]. http://hdl.handle.net/2346/16077

Cruzat Mandich, C., Díaz Castrillón, F., Aylwin Navarro, J., García Troncoso, A., Behar Astudillo, R., & Arancibia Meza, M. (2014). Speeches in anorexia and bulimia nervosa: A qualitative study about the disorder experiencing. *Revista Mexicana de Trastornos Alimentarios - Mexican Journal of Eating Disorders*, *5*(2), 70–79. https://doi.org/10.1016/S2007-1523(14)72002-6

Dahlenburg, S. C., Gleaves, D. H., & Hutchinson, A. D. (2019). Anorexia nervosa and perfectionism: A meta-analysis. *International Journal of Eating Disorders*, *52*(3), 219–229. https://doi.org/10.1002/eat.23009

Dane, A., & Bhatia, K. (2023). The social media diet: A scoping review to investigate the association between social media, body image and eating disorders amongst young people. *PLOS Global Public Health*, *3*(3), e0001091. https://doi.org/10.1371/journal.pgph.0001091

Davey, E., Allen, K., Bennett, S. D., Bryant-Waugh, R., Clarke, T., Cooper, Z., Dixon-Ward, K., Dudley, J., Eisler, I., Griffiths, J., Hill, A. J., Micali, N., Murphy, R., Picek, I., Rea, R., Schmidt, U., Simic, M., Tchanturia, K., Traviss-Turner, G., … Shafran, R. (2023). Improving programme-led and focused interventions for eating disorders: An experts' consensus statement-A UK perspective. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, *31*(5), 577–595. https://doi.org/10.1002/erv.2981

Declercq, D., Kafle, E., Peters, J., Raby, S., Chawner, D., Blease, J., & Foye, U. (2024). "Finding light in the darkness": Exploring comedy as an intervention for eating disorder recovery. *Mental Health Review Journal*, *29*(1), 110–126. https://doi.org/10.1108/MHRJ-08-2023-0045

Dickie, L., Surgenor, L. J., Wilson, M., & McDowall, J. (2012). The structure and reliability of the Clinical Perfectionism Questionnaire. *Personality and Individual Differences*, *52*(8), 865–869. https://doi.org/10.1016/j.paid.2012.02.003

Dignon, A., Beardsmore, A., Spain, S., & Kuan, A. (2006). 'Why I Won't Eat': Patient Testimony from 15 Anorexics Concerning the Causes of Their Disorder. *Journal of Health Psychology*, *11*(6), 942–956. https://doi.org/10.1177/1359105306069097

Eaton, C. M. (2020). Eating Disorder Recovery: A Metaethnography. *Journal of the American Psychiatric Nurses Association*, *26*(4), 373–388. https://doi.org/10.1177/1078390319849106

Edgington, S., Richards, P., Erickson, M., & Jackson, A. (2008). Perceptions of Jesus Christ's Atonement Among Latter-day Saint Women with Eating Disorders and

Perfectionism. *Issues in Religion and Psychotherapy*, *32*(1). https://scholarsarchive.byu.edu/irp/vol32/iss1/4

Egan, S. J., Wade, T. D., Fitzallen, G., O'Brien, A., & Shafran, R. (2022). A meta-synthesis of qualitative studies of the link between anxiety, depression and perfectionism: Implications for treatment. *Behavioural and Cognitive Psychotherapy*, *50*(1), 89–105. https://doi.org/10.1017/S1352465821000357

Egan, S. J., Wade, T. D., Watson, H. J., Öst, L.-G., Cuijpers, P., & Shafran, R. (2023). Towards high standards of evidence for cognitive behaviour therapy for perfectionism: A critique of Smith et al. (2023). *Canadian Psychology / Psychologie Canadienne*, *64*(4), 377–381. https://doi.org/10.1037/cap0000369

Eiring, K., Wiig Hage, T., & Reas, D. L. (2021). Exploring the experience of being viewed as "not sick enough": A qualitative study of women recovered from anorexia nervosa or atypical anorexia nervosa. *Journal of Eating Disorders*, *9*(1), 142. https://doi.org/10.1186/s40337-021-00495-5

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. Guilford Press.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/S0005-7967(02)00088-8

Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy*, *37*(1), 1–13. https://doi.org/10.1016/s0005-7967(98)00102-8

Fairburn, C. G., & Beglin, S. J. (2008). Eating Disorder Examination Questionnaire (6.0). In Fairburn, C. G. (Ed.), *Cognitive Behavior Therapy and Eating Disorders.* New York: Guilford Press.

Fatt, S. J., George, E., Hay, P., Jeacocke, N., Day, S., & Mitchison, D. (2024). A systematic review and meta-synthesis of qualitative research investigating disordered eating and help-seeking in elite athletes. *The International Journal of Eating Disorders*, *57*(8), 1621–1641. https://doi.org/10.1002/eat.24205

Fennell, M. J. V. (1997). Low self esteem: A cognitive perspective. *Behavioural and Cognitive Psychotherapy*, *25(1)*, 1–25. https://doi.org/10.1017/S1352465800015368

Fisher, M., Qureshi, H., Hardyman, W., & Homewood, J. (2006). *Using Qualitative Research in Systematic Reviews: Older People's Views of Hospital Discharge*.

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., … Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Psycho-Oncology*, *28*(3), 447–458. https://doi.org/10.1002/pon.4915

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology*, *19*(1), 35. https://doi.org/10.1186/s12874-019-0670-7

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

Galloway, R., Watson, H., Greene, D., Shafran, R., & Egan, S. J. (2022). The efficacy of randomised controlled trials of cognitive behaviour therapy for perfectionism: A systematic review and meta-analysis. *Cognitive Behaviour Therapy*, *51*(2), 170–184. https://doi.org/10.1080/16506073.2021.1952302

Garner, D. M., Olmsted, M. P., Polivy, J., & Garfinkel, P. E. (1984). Comparison between weight-preoccupied women and anorexia nervosa. *Psychosomatic Medicine*, *46*(3), 255–266. https://doi.org/10.1097/00006842-198405000-00007

Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The Discovery of Grounded Theory; Strategies for Qualitative Research. *Nursing Research (New York)*, *17*(4), 364–364. https://doi.org/10.1097/00006199-196807000-00014

Goldner, E. M., Cockell, S. J., & Srikameswaran, S. (2002). Perfectionism and eating disorders. In *Perfectionism: Theory, research, and treatment* (pp. 319–340). American Psychological Association. https://doi.org/10.1037/10458-013

Goldswain, S. M. (1998). *A narrative examination of the governing scripts in the dreams and early recollections of women with eating disorders* [Unpublished doctoral dissertation; Vol. 59, Issues 2-B, p. 0903]. ProQuest Information & Learning.

Goss, K., & Allan, S. (2014). The development and application of compassion-focused therapy for eating disorders (CFT-E). *The British Journal of Clinical Psychology*, *53*(1), 62–77. https://doi.org/10.1111/bjc.12039

Gulliksen, K. S., Nordbø, R. H. S., Espeset, E. M. S., Skårderud, F., & Holte, A. (2017). Four Pathways to Anorexia Nervosa: Patients' Perspective on the Emergence of AN. *Clinical Psychology & Psychotherapy*, *24*(4), 846–858. https://doi.org/10.1002/cpp.2050

Gustafsson, S. A., Edlund, B., Davén, J., Kjellin, L., & Norring, C. (2011). How to deal with sociocultural pressures in daily life: Reflections of adolescent girls suffering from eating disorders. *Journal of Multidisciplinary Healthcare*, *4*, 103–110. https://doi.org/10.2147/JMDH.S17319

Halbeisen, G., Brandt, G., & Paslakis, G. (2022). A Plea for Diversity in Eating Disorders Research. F*rontiers in Psychiatry, 13,* 820043. https://doi.org/10.3389/fpsyt.2022.820043

Hampshire, C., Mahoney, B., & Davis, S. K. (2022). Parenting Styles and Disordered Eating Among Youths: A Rapid Scoping Review. *Frontiers in Psychology*, *12*, 802567. https://doi.org/10.3389/fpsyg.2021.802567

Hannes, K., Petry, K., & Heyvaert, M. (2017). The meta-aggregative approach to qualitative evidence synthesis: A worked example on experiences of pupils with special educational needs in inclusive education. *International Journal of Research & Method in Education*, *41*, 1–15. https://doi.org/10.1080/1743727X.2017.1299124

Hewitt, P. L., Flett, G. L., Besser, A., Sherry, S. B., & McGee, B. (2003). Perfectionism Is Multidimensional: A reply to Shafran, Cooper and Fairburn (2002). *Behaviour Research and Therapy*, *41*(10), 1221–1236. https://doi.org/10.1016/S0005-7967(03)00021-4

Hewitt, P. L., Flett, G. L., Turnbull-Donovan, W., & Mikail, S. F. (1991). The Multidimensional Perfectionism Scale: Reliability, validity, and psychometric properties in psychiatric samples. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *3*, 464–468. https://doi.org/10.1037/1040-3590.3.3.464

Howard, T. L. M., Williams, M. O., Woodward, D., & Fox, J. R. E. (2023). The relationship between shame, perfectionism and Anorexia Nervosa: A grounded theory study. *Psychology and Psychotherapy*, *96*(1), 40–55. https://doi.org/10.1111/papt.12425

Jacobs, M. J. (2003). *The anorectic poverty of self: Eating disorders and young women* [Unpublished doctoral dissertation]. ProQuest Dissertations & Theses. https://www.proquest.com/docview/305221721?pq-origsite=primo&accountid=13042

Janas-Kozik, M., Żmijowska, A., Zasada, I., Jelonek, I., Cichoń, L., Siwiec, A., & Wilczyński, K. M. (2021). Systematic Review of Literature on Eating Disorders During Pregnancy-Risk and Consequences for Mother and Child. *Frontiers in Psychiatry*, *12*, 777529. https://doi.org/10.3389/fpsyt.2021.777529

Joffe, H. (2012). Thematic analysis. In D. Harper & A. Thompson (Eds.), *Qualitative methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209–223). Wiley

Joffe, H., & Elsey, J. W. B. (2014). Free Association in Psychology and the Grid Elaboration Method. *Review of General Psychology*, *18*(3), 173–185. https://doi.org/10.1037/gpr0000014

Johnson, B. & Christensen, L. B. (2008). *Educational research: Quantitative, qualitative, and mixed approaches* (3rd ed.). SAGE.

Katzenmajer-Pump, L., & Balázs, J. (2021). Perfectionism and Suicide: A systematic review of qualitative studies. *Psychiatria Hungarica: A Magyar Pszichiatriai Tarsasag Tudomanyos Folyoirata*, *36*(1), 4–11.

Kazdin, A. E., Fitzsimmons-Craft, E. E., & Wilfley, D. E. (2017). Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders*, *50*(3), 170–189. https://doi.org/10.1002/eat.22670

Kobori, O., Hayakawa, M., & Tanno, Y. (2009). Do perfectionists raise their standards after success? An experimental examination of the revaluation of standard setting in perfectionism. *Journal of Behavior Therapy and Experimental Psychiatry*, *40*(4), 515–521. https://doi.org/10.1016/j.jbtep.2009.07.003

Koreshe, E., Paxton, S., Miskovic-Wheatley, J., Bryant, E., Le, A., Maloney, D., Aouad, P., Barakat, S., Boakes, R., Brennan, L., Bryant, E., Byrne, S., Caldwell, B., Calvert, S., Carroll, B., Castle, D., Caterson, I., Chelius, B., Chiem, L., … National Eating Disorder Research Consortium. (2023). Prevention and early intervention in eating disorders: Findings from a rapid review. *Journal of Eating Disorders*, *11*(1), 38. https://doi.org/10.1186/s40337-023-00758-3

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, *33*(1), 159–174.

Larsson, E., Lloyd, S., Westwood, H., & Tchanturia, K. (2018). Patients' perspective of a group intervention for perfectionism in anorexia nervosa: A qualitative study. *Journal of Health Psychology*, *23*(12), 1521–1532. https://doi.org/10.1177/1359105316660183

Lo, A., Hunt, C., & Abbott, M. J. (2020). A Systematic Review of the Psychometric Properties of Multidimensional Trait Perfectionism Self-Report Measures. *Behaviour Change*, *37*(2), 45–58. https://doi.org/10.1017/bec.2020.2

Lockwood, C., Porritt, K., Munn, Z., Rittenmeyer, L., Salmond, S., Bjerrum, M., Loveday, H., Carrier, J., & Stannard, D. (2020). Chapter 2: Systematic reviews of qualitative evidence. In *JBI Manual for Evidence Synthesis*. JBI. https://doi.org/10.46658/JBIMES-20-03

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Marney, C., Reid, M., & Wright, B. (2024). A mixed methods study of schema modes amongst people living with eating disorders. *Journal of Eating Disorders*, *12*(1), 78. https://doi.org/10.1186/s40337-024-01031-x

McMahon, K., Clark, I. N., Stensæth, K., Odell-Miller, H., Wosch, T., Bukowska, A., & Baker, F. A. (2022). Exploring Shared Musical Experiences in Dementia Care: A Worked Example of a Qualitative Systematic Review and Thematic Synthesis. *International Journal of Qualitative Methods, 21*.

Miller, J. M. (2016). *Grounded theory analysis: Role of personality traits after recovery from anorexia nervosa*. [Unpublished doctoral dissertation; Alliant International University].

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Murach, K. (2013). *How can control in anorexia nervosa be understood in the framework of perceptual control theory? A theoretical systematic review AND What is the meaning of perfectionism for clients with eating disorders? A qualitative study* [Unpublished doctoral dissertation; University of Birmingham]. https://etheses.bham.ac.uk/id/eprint/4729/

Noblit, G. W. & Hare, R. D. (1988). *Meta-ethnography synthesizing qualitative studies*. SAGE.

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series-paper 3: Methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology*, *97*, 49–58. https://doi.org/10.1016/j.jclinepi.2017.06.020

Noyes, J., Booth, A., Moore, G., Flemming, K., Tunçalp, Ö., & Shakibazadeh, E. (2019). Synthesising quantitative and qualitative evidence to inform guidelines on complex interventions: Clarifying the purposes, designs and outlining some methods. *BMJ Global Health*, *4*(Suppl 1), e000893. https://doi.org/10.1136/bmjgh-2018-000893

Ong, C. W., Lee, E. B., Krafft, J., Terry, C. L., Barrett, T. S., Levin, M. E., & Twohig, M. P. (2019). A randomized controlled trial of acceptance and commitment therapy for clinical perfectionism. *Journal of Obsessive-Compulsive and Related Disorders*, *22*, 100444. https://doi.org/10.1016/j.jocrd.2019.100444

Osborn, K. D. (2023). Competing for perfection: A scoping review evaluating relationships between competitiveness and eating disorders or disordered eating behaviours. *European Eating Disorders Review: The Journal of the Eating Disorders Association*, *31*(5), 549–576. https://doi.org/10.1002/erv.2978

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ (Clinical Research Ed.)*, *372*, n71. https://doi.org/10.1136/bmj.n71

Paranjothy, S. M., & Wade, T. D. (2024). A meta-analysis of disordered eating and its association with self-criticism and self-compassion. *International Journal of Eating Disorders*, *57*(3), 473–536. https://doi.org/10.1002/eat.24166

Petersson, S., Clinton, D., Brundin, L., Perseius, K.-I., & Norring, C. (2018). Perfectionism in eating disorders: Are long-term outcomes influenced by extent and changeability in initial perfectionism? *Journal for Person-Oriented Research*, *4*(1). https://doi.org/10.17505/jpor.2018.01

Petersson, S., Johnsson, P., & Perseius, K.-I. (2017). A Sisyphean task: Experiences of perfectionism in patients with eating disorders. *Journal of Eating Disorders*, *5*(1), 3. https://doi.org/10.1186/s40337-017-0136-4

Piotrowski, K., Bojanowska, A., Nowicka, A., & Janasek, B. (2023). Perfectionism and community-identity integration: The mediating role of shame, guilt and self-esteem. *Current Psychology*, *42*(2), 1308–1316. https://doi.org/10.1007/s12144-021-01499-9

Richards, P. S., Caoili, C. L., Crowton, S. A., Berrett, M. E., Hardman, R. K., Jackson, R. N., & Sanders, P. W. (2018). An exploration of the role of religion and spirituality in the treatment and recovery of patients with eating disorders. *Spirituality in Clinical Practice*, *5*(2), 88–103. https://doi.org/10.1037/scp0000159

Robinson, K., & Wade, T. D. (2021). Perfectionism interventions targeting disordered eating: A systematic review and meta-analysis. *International Journal of Eating Disorders*, *54*(4), 473–487. https://doi.org/10.1002/eat.23483

Sandelowski, M. (2004). Using qualitative research. *Qualitative Health Research*, *14*(10), 1366–1386. https://doi.org/10.1177/1049732304269672

Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society of Nursing*, *34*(3), 213–219. https://doi.org/10.1111/j.1547-5069.2002.00213.x

Schilder, C. M. T., Sternheim, L. C., Aarts, E., van Elburg, A. A., & Danner, U. N. (2021). Relationships between educational achievement, intelligence, and perfectionism in adolescents with eating disorders. *The International Journal of Eating Disorders*, *54*(5), 794–801. https://doi.org/10.1002/eat.23482

Schwarz, N. (2007). Cognitive aspects of survey methodology. *Applied Cognitive Psychology*, *21*(2), 277–287. https://doi.org/10.1002/acp.1340

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

Shafran, R., Cooper, Z., & Fairburn, C. G. (2003). 'Clinical perfectionism' is not 'multidimensional perfectionism': A reply to Hewitt, Flett, Besser, Sherry & McGee. *Behaviour Research and Therapy*, *41*, 1217–1220. https://doi.org/10.1016/S0005-7967(03)00020-2

Shafran, R., Egan, S. J., & Wade, T. D. (2023). Coming of age: A reflection of the first 21 years of cognitive behaviour therapy for perfectionism. *Behaviour Research and Therapy*, *161*, 104258. https://doi.org/10.1016/j.brat.2023.104258

Smith, M. M., Hewitt, P. L., Sherry, S. B., Flett, G. L., Kealy, D., Tasca, G. A., Ge, S., & Kristen, A. (2023). Towards higher standards and improved treatments for perfectionism: A reply to Egan et al. (2023). *Canadian Psychology / Psychologie Canadienne*, *64*(4), 382–385. https://doi.org/10.1037/cap0000373

Smith, M. M., Hewitt, P. L., Sherry, S. B., Flett, G. L., Kealy, D., Tasca, G. A., Ge, S., Ying, F., & Bakken, K. (2023). A meta-analytic test of the efficacy of cognitive behavioural therapy for perfectionism: A replication and extension. *Canadian Psychology / Psychologie Canadienne*, *64*(4), 355–376. https://doi.org/10.1037/cap0000360

Smith, M. M., Sherry, S. B., Ge, S. Y. J., Hewitt, P. L., Flett, G. L., & Baggley, D. L. (2022). Multidimensional perfectionism turns 30: A review of known knowns and known unknowns. *Canadian Psychology / Psychologie Canadienne*, *63*, 16–31. https://doi.org/10.1037/cap0000288

Solmi, M., Monaco, F., Højlund, M., Monteleone, A. M., Trott, M., Firth, J., Carfagno, M., Eaton, M., De Toffol, M., Vergine, M., Meneguzzo, P., Collantoni, E., Gallicchio, D., Stubbs, B., Girardi, A., Busetto, P., Favaro, A., Carvalho, A. F., Steinhausen, H.-C., & Correll, C. U. (2024). Outcomes in people with eating disorders: A transdiagnostic and disorder-specific systematic review, meta-analysis and multivariable meta-regression analysis. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *23*(1), 124–138. https://doi.org/10.1002/wps.21182

Sommerfeldt, B., Skårderud, F., Kvalem, I. L., Gulliksen, K. S., & Holte, A. (2022). Bodies out of control: Relapse and worsening of eating disorders in pregnancy. *Frontiers in Psychology*, *13*, 986217. https://doi.org/10.3389/fpsyg.2022.986217

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). Quality in Qualitative Evaluation: A Framework For Assessing Research Evidence. *Government Chief Social Researcher's Office Occasional Papers Series No.2*.

Stairs, A. M., Smith, G. T., Zapolski, T. C. B., Combs, J. L., & Settles, R. E. (2012). Clarifying the Construct of Perfectionism. *Assessment*, *19*(2), 146–166. https://doi.org/10.1177/1073191111411663

Stice, E., Onipede, Z. A., & Marti, C. N. (2021). A meta-analytic review of trials that tested whether eating disorder prevention programs prevent eating disorder onset. *Clinical Psychology Review*, *87*, 102046. https://doi.org/10.1016/j.cpr.2021.102046

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

Stoddard, J. A., & Afari, N. (2014). *The big book of ACT metaphors: A practitioner's guide to experiential exercises and metaphors in acceptance and commitment therapy*. New Harbinger Publications.

Stoeber, J., & Damian, L. E. (2014). The Clinical Perfectionism Questionnaire: Further evidence for two factors capturing perfectionistic strivings and concerns. *Personality and Individual Differences*, *61–62*, 38–42. https://doi.org/10.1016/j.paid.2014.01.003

Tetnowski, J., & Damico, J. (2001). A demonstration of the advantages of qualitative methodologies in stuttering research. *Journal of Fluency Disorders*, *26*. https://doi.org/10.1016/S0094-730X(01)00094-8

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 45. https://doi.org/10.1186/1471-2288-8-45

Tierney, S., & Fox, J. R. E. (2010). Living with the anorexic voice: A thematic analysis. *Psychology and Psychotherapy*, *83*(3), 243–254. https://doi.org/10.1348/147608309X480172

Tierney, S., Fox, J. R. E., Butterfield, C., Stringer, E., & Furber, C. (2011). Treading the tightrope between motherhood and an eating disorder: A qualitative study. *International Journal of Nursing Studies*, *48*(10), 1223–1233. https://doi.org/10.1016/j.ijnurstu.2010.11.007

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: Challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology*, *14*, 80. https://doi.org/10.1186/1471-2288-14-80

Tozzi, F., Thornton, L. M., Klump, K. L., Fichter, M. M., Halmi, K. A., Kaplan, A. S., Strober, M., Woodside, D. B., Crow, S., Mitchell, J., Rotondo, A., Mauri, M., Cassano, G., Keel, P., Plotnicov, K. H., Pollice, C., Lilenfeld, L. R., Berrettini, W. H., Bulik, C. M., & Kaye, W. H. (2005). Symptom fluctuation in eating disorders: Correlates of diagnostic crossover. *The American Journal of Psychiatry*, *162*(4), 732–740. https://doi.org/10.1176/appi.ajp.162.4.732

Vanderspank-Wright, B., Efstathiou, N., & Vandyk, A. D. (2018). Critical care nurses' experiences of withdrawal of treatment: A systematic review of qualitative evidence. *International Journal of Nursing Studies*, *77*, 15–26. https://doi.org/10.1016/j.ijnurstu.2017.09.012

Vrabel, K. R., Waller, G., Goss, K., Wampold, B., Kopland, M., & Hoffart, A. (2024). Cognitive behavioral therapy versus compassion focused therapy for adult patients with eating disorders with and without childhood trauma: A randomized controlled trial in an intensive treatment setting. *Behaviour Research and Therapy*, *174*, 104480. https://doi.org/10.1016/j.brat.2024.104480

Wade, J. B. (2002). *The voices within the anorexic* [Unpublished doctoral dissertation; ProQuest Dissertations & Theses].

Watterson, R. L., Crowe, M., Jordan, J., Lovell, S., & Carter, J. D. (2023). A Tale of Childhood Loss, Conditional Acceptance and a Fear of Abandonment: A Qualitative Study Taking a Narrative Approach to Eating Disorders. *Qualitative Health Research*, *33*(4), 270–283. https://doi.org/10.1177/10497323231152142

Service Improvement Project

Understanding and Improving Staff and Client Experiences of a Systemic Family Therapy Clinic for Older People

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It will be submitted to **The Journal of Family Therapy**.

Journal instructions are in Appendix E.

Abstract

Service context: With ageing populations, mental health problems in older people are rising. NHS policy advocates that specialised older-adult community mental health teams offer diverse therapeutic support, involving carers and families. Systemic family therapy (SFT) is a highly apt intervention, given relational factors affecting older-adult mental health and carer strain. Yet, few policies mention SFT. The SFT evidence base for efficacy with older adults is lacking. This project was conducted within a newly established SFT Clinic for older people.

Improvement aims: This service improvement project aimed to understand and improve staff knowledge of SFT and referrals, and to better address client needs and experiences of the Clinic. Secondarily, the improvement outcomes were hoped to innovate an evidence base for SFT with older adults.

Project methods: Designs were co-developed in staff and client consultations. Staff and client perspectives on the Clinic were elicited as qualitative data. Staff data were collected via a single focus group; client data were collected through semi-structured interviews, each with clients alongside their partner or adult child. The two data sets were analysed separately using thematic analysis.

Findings: Three main themes were extracted from the staff data: supporting referral, enhancing accessibility, and improving integration. These themes incorporated varied sub-themes, such as multidisciplinary team (MDT) collaboration, increased clarity, and more education on SFT. Three main themes extracted from the client data comprised the referral pathway, therapy itself, and reviewing therapy. Sub-themes included goal setting, supporting loved ones, therapist expertise, and difficult endings.

Conclusions: Data were positive overall, with staff expressing enthusiasm for the Clinic and clients conveying appreciation and benefits. Both data sets also highlighted some areas of discomfort or inefficacy in referral processes and the therapy itself which invite improvement.

Recommendations: Service recommendations emerged. These entailed creating educational resources for staff, including SFT MDT meetings; inviting more staff referrers into SFT sessions; updating introductory resources for clients; clarifying SFT aims and client goal-setting; and reviewing client experiences of SFT more regularly during therapy.

Keywords: Systemic family therapy, older adults, community mental health.

1. Introduction

1.1. National context

1.1.1. Older adults

Over 18% of UK inhabitants are older people: aged 65+ years (Office for National Statistics, 2023; ONS). This proportion is projected to climb to 24.7% by 2046, while those aged 75+ may double (ONS, 2023). Around 10% of older adults live with frailty (Age UK, 2017), and over 10% of older adults are unpaid carers, with nearly half giving 50+ hours of weekly care (ONS, 2023).

Mental health difficulties in older people are prevalent. Around 40% of older adults using GP services may have a mental health problem, rising to 50% in hospitals, and 60% in care homes (Royal College of Psychiatrists, 2018; RCPsych). Depression, for example, affects circa 22% of older men and 28% of older women (Age UK, 2016) – and may rise by 49% by 2035 (RCPsych, 2018). Ageing is predicted to become the leading driver of increased population-wide UK and global mental health problems (McCrone et al, 2008; Reynolds et al., 2022).

1.1.2. Older-adult provision

Nonetheless, 85% of older people experiencing depression may not receive NHS support, and are 80% less likely to access talking therapy—yet 600% more likely to receive psychiatric medication (Burns, 2015). The *Five Year Forward View for Mental Health* (NHSE, 2016) attends little to specific older-adult needs, and there is no *National Institute for Health and Care Excellence* guideline on treating mental health problems in older people (NICE, 2013). Growth of 'ageless' services since the 2000s may lead to reduced person-centred care and service-user satisfaction (RCPsych, 2017) – while growing single-tariff service-commissioning based on mental-health-problem 'clusters' cannot account for the complexity and costs of older-adult work (Nilforooshan et al, 2016).

Specialist, age-appropriate services have shown superior results in supporting older-adult mental health (Licht-Strunk et al., 2009; Ryan et al., 2008; Tops et al., 2024) – often halving unmet need among older people with enduring mental health problems (Abdul-Hamid et al., 2015). The longstanding *National Service Framework for Older People* (NHSE, 2001) called for specialised, age-appropriate, integrated mental health care for older people alongside their carers—recently echoed by the *NHS Long Term Workforce Plan* (NHSE, 2023). Indeed, specialist older-adult community mental health teams (CMHTs) have resumed growth since their development in the 1980s–'90s (Hilton, 2015; RCPsych, 2018).

1.1.3. Family therapy

A South-England NHS Trust's *Family, Friends, and Carers Strategy 2021–2024* (2021) advocated multidisciplinary working in older-adult CMHTs with both older people and their families. The *Community Mental Health Framework for Adults and Older Adults* (NHSE, 2019) also emphasised that therapeutic provision should not be limited to cognitive behavioural therapy (CBT). Systemic family therapy (SFT) bridges these imperatives. Shifting social identity in later life and cultural changes in Western family structures can exacerbate mental health problems and family relations (Ball, 2024; Curtis and Dixon, 2005). SFT involves and strengthens family systems as resources to effective therapy (Stratton, 2016). There is robust, increasing evidence for SFT's efficacy across many mental health problems and wider relational problems (Carr, 2014, 2018; Wittenborn & Holtrop, 2022). NICE guidelines both on treating bipolar disorder and schizophrenia (2014a, 2014b) incorporate family interventions. Moreover, seminal SFT theory and practice have long attended specifically to working with older people: across themes including ageing, attachment, reminiscence, and intergenerational narratives (Coleman, 1999; Curtis & Dixon, 2005; Fredman et al., 2010; Richardson et al., 1994; Roper-Hall, 1998). Indeed, recent research explored SFT for supporting families affected by dementia—engendering a new, UK-wide *Older-Adult Systemic Community of Practice* (Ball, 2024).

However, older-adult Systemic literature has not extended substantially in the last two decades beyond Curtis and Dixon's review (2005) review. The *Faculty of the Psychology of Older People* newsletter, for instance, has featured no articles on SFT more recently. Furthermore, SFT for older adults lacks the empirical, outcome-oriented evidence bases that exist for Systemic work with children (Carr, 2019a) and 'adults' (Carr, 2019b). Outcome studies have either excluded older people in their age cut-offs or included them without scrutinising older-adult themes (Carr, 2019b). Moreover, the *Older People's Mental Health Practice Primer* (NHSE, 2017) advocates CBT, counselling, problem-solving, and psychodynamic psychotherapies within CMHTs, but omits SFT.

As Systemic teams expand across UK older-adult CMHTs, greater evidence is needed both on team experiences of supporting SFT, and on SFT's efficacy in supporting older adults and their families.

1.2. Service context

One part-time SFT Clinic was established in 2021, resourced by existing senior Psychology staff in the Older Adult Mental Health Team of a South-England NHS Foundation Trust, including a Systemic psychotherapist. By 2023, the Clinic had seen approximately 14 older-adult clients and their partners or adult children for SFT. Almost all SFT clients were White British, and evenly split across gender — representative of client demographics across the wider service.

The addition of this Clinic engendered systemic shifts in the organisation of Psychology resources and referral pathways to offer an additional evidence-based intervention meeting family needs. Moreover, the CMHT saw high recent staff turnover, including multiple new team members and a new Manager, with few staff currently referring to the Clinic. At this key time of organisational change, better understanding of team and service-user experiences of the Clinic could empower service improvement. While unclear what proportion of the 149 clients on the service's waiting list between 2021–23 may have been eligible for SFT, it was speculated

that enhanced staff knowledge might enable more frequent and appropriate referrals to the Clinic (by proposing clients ad hoc to the Systemic psychotherapist for consideration). With capacity for eight SFT sessions per month, optimal referral rates could maximise Clinic utility.

1.3. Service improvement

1.3.1. Aims

Collecting qualitative data on staff and client experiences and recommendations for the Clinic could appraise effectiveness and support improvements with greater idiographic detail. These could inform which dimensions of SFT should be elevated, relegated, honed, or removed—such as whether and how to retain use of reflecting teams. Moreover, inviting staff to reflect on their decisions to refer, and increasing team understanding of SFT overall, may promote greater engagement with the Clinic.

Secondarily, this project could contribute innovatively towards a nascent, process-oriented, and outcome-centred evidence base for Systemic work with older people. Similar NHS Systemic Clinics are expanding across Birmingham, Bristol, Lancaster, London, Northampton – currently being surveyed anecdotally by the *Older-Adult Systemic Community of Practice* – but are, as yet, under-reported. This important, under-researched intervention requires further investigation to foster access for older people.

This SIP therefore aimed to:

- Improve the referral pathway for SFT to enhance clinical outcomes,
    - by understanding team members' knowledge of SFT and experiences of referring that shaped their decision-making.
- Improve SFT provision to better address clients' needs,
    - by building staff understanding of client experiences of being referred and of receiving therapy.
- Contribute to a new evidence base for Systemic work with older people within CMHTs.

1.3.2. Questions

In order to realise these aims, specific research questions were developed (with supplementary granularity in Appendix F):

- How can intra-service referrals be improved (e.g., made more timely and appropriate)?
    - How can staff knowledge of SFT be enhanced to support this?
- How can SFT delivery be improved (e.g., enhancing client satisfaction and benefit)?

1.3.3. Theory

Client-side service improvement was conceptualised within Systemic theories of 'relationship to help' (Reder & Fredman, 1996). Here, idiosyncratic client beliefs about receiving support were conceived as similarly important as any overarching emphases on service accessibility and throughput of cases. Staff-side service improvement was additionally conceptualised within Systemic, post-Milan concepts of 'curiosity' (Cecchin, 1987). Here, from a second-order cybernetic position (Krause, 2012), the clinician/researcher was theorised as involved in the staff system: 'neutral' but not separate from co-constructed ideas about the Clinic. Through this lens, the methods of data collection might already begin to realise the project's relational aims of communicating and building knowledge across the team via a reflexive and participatory process.

2. Methods

This SIP used semi-structured interviews of service users (in pairs) and a separate focus group with staff members to explore experiences of and recommendations for the Clinic. Both sets of interview data were analysed using thematic analysis (Braun & Clarke, 2006, 2022).

2.1. Ethics

Approval for this SIP was received from the relevant NHS Foundation Trust Audit and Improvement team in June 2023 (ref: SE/2023-24/02). NHS ethical approval was not required because client interviews focused on use of services, and the overall project aimed to improve a single Clinic, rather than prioritising generalisable findings (thus constituting audit and evaluation, not research; Health Research Authority, 2020).

2.2. Co-production

2.2.1. Staff consultation

A one-hour group consultation was held in May 2023 to invite perspectives from key senior-staff stakeholders on useful aims, structure, and content for staff the focus group and service-user interviews. This included the older-adult CMHT Psychology Lead and Principal (both SIP supervisors), and Team Manager. The first author held dual stakeholder status as a CMHT team member and Systemic-Clinic trainee. Key outcomes included reformulating interview questions to optimise clarity and accessibility, and co-designing a presentation for recruiting heterogeneous staff to the focus group.

2.2.2. Service-user consultation

A half-hour consultation was held in August 2023 with a service-user stakeholder who had previously attended the Clinic. Key outcomes included agreement with the project's scope, and incorporation of an additional line of enquiry, concerning clients' understanding of the Clinic.

2.3. Participants

2.3.1. Staff members

Staff participants were all NHS employees within the older-adult CMHT. Up to eight focus-group participants were sought. Participants had a range of exposure to the Clinic: from complete unfamiliarity, to experience of referring clients to the Clinic, or even joining therapy sessions as care coordinator (Table 1).

2.3.2. Service users

Service-user participants were all UK-based adults aged 65+ who had completed therapy in the Clinic. A sample size of 6–10 participants was chosen, fitting the 6–15-participant range recommended for small-to-medium samples (Braun & Clarke, 2013; Guest et al., 2006). Each interview aimed to include the identified older-adult client, and their partner or adult child co-attending therapy (Table 2).

2.4. Design

2.4.1. Qualitative

2.4.1.1. Staff-side

A semi-structured focus group was conducted to elicit relatively free, unconstrained responses from staff participants with limited interviewer contamination (Joffe & Elsey, 2014). The focus group aimed to last one hour in order to facilitate sufficient elaboration from all participants. Thematic analysis was chosen as the method of analysis to locate explicit and latent patterns of meaning in participants' experiences, ideas, and associations (Joffe, 2012).

2.4.1.2. Client-side

Semi-structured interviewing and thematic analysis were also chosen for eliciting service-user data. Each interview aimed to last 30 minutes, in order to accommodate potential fatigue or health needs of some clients.

2.5. Procedure

2.5.1. Staff-side

Following departmental and NHS Audit approval and stakeholder consultation, staff participants were recruited via presentations in CMHT meetings (June 2023). Following sufficient expressions of interest and consent from staff participants, a single focus group was conducted and recorded remotely via video-call on *Microsoft Teams* (July 2023). Staff participants were reminded that they could leave at any time and all questions were optional – though all perspectives welcome – regardless of experience. Participants were then asked predetermined interview questions (listed in Appendix G). Finally, participants were informed that the focus group was concluded, thanked for their involvement, and given opportunity to voice queries or concerns.

2.5.2. Client-side

Following service-user consultation, clients were also invited by phone and post to participate (August 2023). No financial incentive was offered. Interviews were held in person at the NHS Clinic site or on *Teams*. At the start of interviews, participants were reminded of the interview context; that all questions were optional; and that they could pause or end the interview at any time. Participants were then asked lead-in and some follow-up questions (Appendix H). Finally, participants were debriefed and offered avenues for support if subsequently needed.

2.6. Data analysis

All interviews were transcribed by the author using confidential recordings and the *Teams* transcription function. Transcripts were edited in accordance with Barker et al. (2002): producing speech content verbatim, but without intonational information. Notes were taken informally during transcription on common themes raised by participants. The staff focus-group and client-interview transcripts were treated as two separate data sets.

Both data sets were analysed by the author using thematic analysis (Campbell et al., 2021). The software package *Atlas.ti.8* enabled systematic coding and organisation of interrelated themes. For each data set, themes were identified inductively from the data (Braun and Clarke, 2022) and a coding frame was developed. Quantifying inter-rater reliability would undermine the qualitative epistemology (O'Connor & Joffe, 2020); however, coding frames were discussed reflexively with the third author: considering the researchers' identities, positionality, and biases, and checking for notably idiosyncratic coding.

2.7. Reflexive statement

Inadvertent researcher influence over interviews and thematic analysis is unavoidable (Schwartz, 2007). The first author is a white, neurodivergent male in their late-twenties. The author noted their own enthusiastic interest and faith in SFT as potential biases, as well as admiration for the third author's therapeutic skill in Clinic.

As both supervisor and lead therapist for the Clinic, the third author held the dual role of supervising the first author researching her practice, situated within the culture of her MDT. She acknowledged her investment in wanting the family Clinic to be more accessible to clients and a useful resource to the team to balance some of the overmedicalisation and individualisation of difficulties for their older-adult client group. Throughout the project, authors aimed to be reflexive and open to learning from the staff and client responses to be able to integrate the Clinic further.

3. Results

3.1. Staff-side

3.1.1. Participation

Nine team members consented to participate. Given logistical obstacles and unexpected clinical duties, three participants withdrew prior to the focus group. Six participants attended the focus group; however, one participant exited before they had shared any responses due to technological difficulties. So, data were collected from five participants, during 65 minutes. Demographic data are displayed in Table 1.

Table 1. Staff participant demographics

Participant	**Role**	**Experience of Clinic**
Withdrew before group	Clinical psychologist	—
Withdrew before group	CPN*, Deputy Team Manager	—
Withdrew before group	Psychiatrist	—
Withdrew during group	CPN	Had not heard of the Clinic.
Participant 1	CPN, Team Manager	Had referred clients to the Clinic.
Participant 2	Occupational therapist	Had referred clients to the Clinic.
Participant 3	Occupational therapist	Had not heard of the Clinic.
Participant 4	CPN, Deputy Team Manager	Had referred clients to the Clinic and had joined a session.
Participant 5	CPN	Had not heard of the Clinic.

***CPN**: Community psychiatric nurse

3.1.2. Themes

In thematic analysis of staff participants' elaborations, three main themes emerged: supporting referral; enhancing accessibility; and improving integration. The most salient sub-themes comprising these themes are delineated below (with a coding frame in Appendix I).

3.1.2.1. Referral

All participants elaborated on the referral process: via current unfamiliarity, referrers' hesitancy, and team discussion.

3.1.2.1.1. Unfamiliarity

Participants conceptualised the referral process as unfamiliar, given limited exposure to the Clinic. This unfamiliarity related to uncertainty towards referral criteria on "who to refer" and the Clinic's function and remit:

"*is there somewhere to go where it states what's available?*" [Participant (P) 5].

3.1.2.1.2. Hesitancy

Referral was also conceived via hesitancy to broach relational issues with clients. Through recurrent imagery of opening a "cans of worms", participants expressed reluctance to risk ruptures with "intrusive" or "sensitive" questions. Preference was expressed for restricting relational topics to the Clinic:

"*it's more boundaried and contained for some of those discussions*" [P3].

3.1.2.1.3. MDTs

Participants equated referral with multidisciplinary team (MDT) discussion ("the same thing really"). MDT conversations were framed as a supportive "triage" process, with Psychology elevated as holding wisdom to elucidate and approve potential referrals:

"*a psychologist will [give] the sort of go-ahead, and enlighten me to think more [Systemically]"* [P4].

3.1.2.2. *Accessibility*

All participants elaborated on the Clinic's accessibility: via limited resources, language use, and education.

3.1.2.2.1. Resource

Participants conceived the Clinic as a potent resource that "cured" the "cause" of clients' problems. This resource was considered scarce, and concern recurred that sub-optimal referrals might squander resources:

> "*the resource is so limited that we have to […] be really certain that it's completely the right sort of patient being referred*" [P1].

3.1.2.2.2. Language

Accessibility was conceptualised saliently in terms of obscurity, with the language of SFT framed as "unnecessarily complicated". Concern was expressed that clients might not feel "educated enough to engage" with the "big words" – or even be daunted by the therapy's name:

> "*What on Earth does 'Systemic' mean?*" [P4].

3.1.2.2.3. Education

Education featured strongly as a solution to inaccessibility. Explanatory resources with "basic language" were suggested, spanning "patient information leaflets" for clients and "education sessions" for staff:

> "*a presentation on what it is, how you refer […] would be really good, to have that space*" [P2].

3.1.2.3. *Integration*

All participants elaborated on integrating the Clinic within the CMHT: via collaboration, endings, and collegial support.

3.1.2.3.1. Collaboration

Disappointment was expressed at perceived disconnection from the Clinic and limited "communication between CMHT and family therapy". This frustration was connected with hope for integration – including joining therapy sessions or progress meetings:

> "*really useful to collaborate […] so that people remember we're all the same team […] working towards one goal*" [P4].

3.1.2.3.2. Endings

The theme of cohesive endings was also prevalent. Participants felt excluded from SFT discharge processes and Psychology's "briefer notes". Frustration was compounded by a sense of SFT's "delaying discharge" after "intensive care coordination". A solution was conceived as multidisciplinary "discharge reviews" at the end of therapy:

> "*it would be great to really kind of tie things together*" [P2].

3.1.2.3.3. Support

Despite potential frustrations, participants positioned the Clinic as integrally supportive, and clients' receiving "robust, collaborative" SFT as reassuring. More integrated channels of support from the Clinic were sought. In particular, a forum for advice-seeking and "troubleshooting" was envisioned:

> "*could we have like a Systemic [Q&A] where we bring families and patients we're really struggling with?*" [P1].

3.2. Client-side

3.2.1. Participation

Twelve service users were eligible for interview (from the Clinic's so-far limited pool). One client died, however, and another became unwell. A further family extended their therapy, which superseded their research involvement. This left three client pairs, comprising six participant voices. Two interviews were held on *Teams*, given participant preference (instead of travelling or hosting), while the third was held in person. Pseudonymised demographic data are displayed in Table 2, which were broadly reflective of the Clinic's wider caseload. For maximal anonymity, quotations below are not linked to participant numbers.

Table 2. Client participant demographics

Participant pseudonym	**Interview**	**Relation**	**Gender**	**Age (years)**	**Ethnicity**	**Use of Clinic**
Participant 1	Interview 1	Client	Woman (cis)	65–69	White British	Sept 2021 – May 2022
Participant 2	Interview 1	Husband	Man (cis)	65–69	White British	Sept 2021 – May 2022
Participant 3	Interview 2	Client	Woman (cis)	70–79	White British	May 2022 – July 2022
Participant 4	Interview 2	Daughter	Woman (cis)	40–49	White British	May 2022 – July 2022
Participant 5	Interview 3	Client	Woman (cis)	70–79	White British	Sept 2022 – Feb 2023
Participant 6	Interview 3	Husband	Man (cis)	70–79	Asian British	Sept 2022 – Feb 2023

3.2.2. Themes

In thematic analysis of service-user participants' elaborations, three main themes emerged: the referral pathway; therapy itself; and reviewing therapy. Multiple sub-themes comprised these themes, with the most salient presented below (and visually in Appendix J).

3.2.2.1. *Referral pathway*

All participants elaborated on the referral pathway: via being referred, family support, and goal setting.

3.2.2.1.1. Being referred

Participants conceptualised SFT referrals as being "suggested" by care coordinators or individual therapists when other help was faltering. The Clinic was conveyed as initially mysterious until participants were "actually in the room", despite referrers' prior explanations:

> "*probably did give us a bit of grounding, but not until we got there did we realise […] what was involved*".

3.2.2.1.2. Family support

While some 'carer' participants framed therapy aetiologically, as "finding the cure" for their loved one's problems, most clients located the support more relationally—in shifted perspectives and patterns of interaction:

> "*sold it as something that would help me [… as he] couldn't see that my depression was anything to do with him*".

3.2.2.1.3. Goal setting

Some participants emphasised initial goal-setting as "really helpful", while others described limited recollection. The process was often framed as empowered by "specific questions" from the therapist. While most participants articulated relational goals, such as "carrying on with this marriage", some aims remained more individualised:

> "*to find out what was happening with me*".

3.2.2.2. *In therapy*

All participants elaborated on the therapy process: via broad appreciation, therapist expertise, and the reflecting team.

3.2.2.2.1. Appreciation

Participants expressed broad, meta-level appreciation for the therapy itself, declining specific critiques. This connected with general gratitude for having been referred, and specific thankfulness towards the collaborative nature of the therapy:

"*attention to what was going on […] not just a doctor pushing pills at the problem*".

3.2.2.2.2. Expertise

Therapy was conceptualised particularly in terms of the lead therapist's "expertise". Participants expressed admiration for the therapist's "clever" techniques for supporting them to "open up" together. Though more comfortably positioning themselves as "patients", participants described co-constructing their therapy:

"*there was a definite framework that we all shared*".

3.2.2.2.3. Reflecting team

Some participants did not recall any reflecting team, while others described finding it daunting to have professionals listening but "not actually participating". Most participants considered it a valuable aspect of the therapy to have "other people's viewpoints", especially referrers':

"*having extra people looking into it […] gave us hope*".

3.2.2.3. *Reviewing therapy*

All participants elaborated on reviewing the therapy retrospectively: via its fruitfulness, partial discomfort, and potential relapse.

3.2.2.3.1. Fruitfulness

Participants described noticing their post-therapeutic progress: including refreshed relational dynamics, such as "working together now". Participants attributed their progress particularly to "open discussions" that promoted new insight into one another:

> "*I'd mentioned [things] to him, but he'd never noticed until [the therapist] noticed, and then he really became aware*".

3.2.2.3.2. Discomfort

Participants also reflected on "painful" aspects of the therapy. This included finding it "hard to hear" their loved one's pain and to talk about their own feelings. Some participants found the end of therapy "really tough", particularly from experiencing the discharge process as abrupt:

> "*they'd discharged me, and that was it. I didn't hear anymore and haven't heard anything*".

3.2.2.3.3. Relapse

Some participants described their progress as having "reverted back a bit" over time, including some pessimism towards their capacity for "lasting change". This led to desire being expressed to be checked on after discharge:

> "*I just wonder [about…] more resources or time allocated to […] seeing how things are in the future*".

4. Discussion

4.1. Findings

4.1.1. Staff-side

This SIP aimed to understand and improve staff knowledge and experiences of referral to and therapy within the Clinic. Focus-group data were encouraging, finding team members reflectively invested in the Clinic. The salience of referring – both as a main theme and across other subthemes – reflected the team's primary interface with the referral pathway (rather than therapy itself). Respect expressed for Psychology highlighted longstanding team acculturation to psychological input and formulation. The emphasis on multidisciplinary collaboration was promising, highlighting fertile ground for increased training and engagement—fostering staff motivation to engage with the Clinic. The frustrations shared were equally important, enabling scope for redressing any senses of obscurity or exclusion. It is particularly illuminating that language clarification was advocated, highlighting care coordinators' insight into client confusion or frustration (when clients' politeness might mask doubts during SFT).

Explicit staff recommendations were also salient—potentially stemming from team members' awareness of the service-improvement context of their participation. Some recommendations are readily implementable. Information leaflets concerning the Clinic's remit can be updated and recirculated (including clarified differentiation between SFT and 'Relate'). Omission or careful clarification of the word 'Systemic' can also be considered—supporting staff opportunity to access the Clinic. Team members can also be re-welcomed to join Clinic sessions. Other recommendations are likely feasible, pending service capacity. These include both multidisciplinary discharge meetings, and periodic training or formulation sessions facilitated by Systemic clinicians—promoting staff capability around Systemic referring and reflecting.

4.1.2. Client-side

The SIP additionally aimed to understand and improve client experiences. Semi-structured-interview data were also encouraging, finding clients appreciative of the Clinic and their therapeutic progress. Clients' broad positivity may have stemmed partly from politeness (whereas staff were likely more conscious of critiques' being invited). Yet, clients' meta-level admiration was nuanced by specific caveats. Conceptions of therapeutic achievement ranged from complete change, to change then relapse, to limited initial change.

Notable contradictions emerged between a few clients' self-description as patient-recipients of therapist expertise, versus a majority emphasis on dual client–therapist expertise—explicitly prioritised in the Clinic. Similarly, a subset of conceptualisations of SFT as biomedicalised (e.g. investigating aetiology) diverged from most clients' more relational focus (e.g., understanding arguments). These findings resonated with themes of some interpersonal progress' reversing post-therapy: suggesting that the relational nature and aims of SFT might become obfuscated over time for some service-users. Interview dynamics – such as all clients' disregarding questions about referral processes until explicitly prompted – similarly implied that pathways to the Clinic might be less salient for clients. Clarifying these processes, remits, and objectives appeared requisite.

Clear points for improvement included reinforcing the goal-setting phase to encourage agreed understandings of relational aims and focuses—improving clients' opportunity to maximise therapeutic benefits. Inviting more referrers to join reflecting teams, which participants particularly valued, might augment client capability to welcome this idiosyncratic feature of SFT. Checking clients' comfort with reflecting-team practices and therapeutic content (especially in earlier sessions) – might sustain their motivation for therapy. These adaptations align with existing Systemic theory of accommodating each client's unique relationship to help (Reder & Fredman, 1996). Explicit, but less feasible recommendations emerged for long-term follow-ups with clients after therapy, which might be limited by service capacity. More feasibly, abrupt discharges can be avoided—consonant with staff recommendations for joint end-of-therapy meetings.

4.2. Recommendations

4.2.1. Solutions

Specific service-improvement recommendations were generated by the authors: by noting challenges most salient in the data and identifying solutions, either extracted from the data or conceived subsequently by the authors. These recommendations harnessed ideas drawn from client and staff data, divided pragmatically for clarity:

4.2.1.1. *Staff-oriented:*

- Create clear, readily accessible resources for staff that:
    - Explain referral criteria;
    - Elucidate any jargon relating to SFT terminology;
    - Suggest ways of framing the Clinic to clients.

- Implement Systemic MDT meetings that:
    - Answer any queries about referring to the Clinic;
    - Provide space for Systemic reflection and formulation;
    - Offer brief education in Systemic ways of working.

- Reinforce more inter-team collaboration that:
    - Invites care coordinators or other referrers to join Clinic sessions;
    - Aims to organise discharge meetings joined by clients, care coordinators, and Systemic clinicians;
    - Shares regular updates and learning from the Clinic in MDT meetings.

4.2.1.2. Client-oriented:

- Update clear resources for clients that:
    - Care coordinators can share when suggesting referral;
    - Explain without jargon what the Clinic offers;
    - Emphasise that no 'aptitude' is needed, nor is any fault being implied.

- Clarify the Clinic and SFT to clients by:
    - Reiterating the reasons for being referred;
    - Reinforcing the objectives and remits of therapy goal-setting;
    - Preparing clients for end-of-therapy processes, including possible discharge.

- Enhance existing SFT approaches by:
    - Inviting referrers and/or care coordinators more often to join reflecting teams;
    - Checking more frequently how clients feel about reflecting team practices;
    - Monitoring explicitly whether clients feel criticised by any therapy content.

4.2.2. Feedback

Findings were presented in June 2024 to 17 team members, including service managers. Staff endorsed all recommendations. Care coordinators particularly welcomed materials providing clear language for explaining SFT to clients, and older-adult-specific leaflets to share directly. Introductory videos were also suggested for illustrating how SFT might look and, for instance, 'differ from marriage counselling'. Managers additionally supported recommendations for building staff familiarity with SFT: particularly encouraging referrers to join more Clinic sessions and potentially joint discharge meetings. All staff embraced developing Systemic MDT spaces for formulating relational difficulties; triaging SFT referrals; offering SFT-skills training; and for increasing interface between SFT clinicians and the wider MDT. It was acknowledged that, via the focus group and this feedback session, the SIP began to enact its relational aims of increasing team engagement and interactivity with the Clinic.

4.3. Relevance

These findings are situated within wider Systemic literature. However, sparse recent discussion, and sparser empirical evidence, exists for Systemic practice with older people (Ball, 2024). This dearth renders the SIP isolated, yet innovative: providing novel outcome-oriented insights into an older-adult Systemic Clinic. Its findings therefore cannot be contextualised directly—but, instead, compared with wider adult Systemic evidence bases. Findings that clients have appreciated and benefitted from the therapy reflect accumulating evidence that SFT can yield recovery both from mental health problems and relational strain that compounds them (Carr, 2014, 2019b; Wittenborn & Holtrop, 2022). Harmonious feedback from clients and their relatives resonates with evidence that family systems can serve as resources to therapy beyond individual work (Stratton, 2016). This project extends preliminary literature on Systemic work with older people (Curtis & Dixon, 2005): especially, demonstrating the importance of SFT in later-life contexts where ageing, illness, carers, and adult children are closely involved.

4.4. Limitations

Several limitations are noteworthy. Concerning staff data, all participants were care coordinators (four CPNs, one occupational therapist). Though care coordinators are highly relevant to referral pathways, the data might have better reflected wider team experiences if other disciplines had been represented (such as the psychiatrist and clinical psychologist who withdrew). Moreover, respect expressed by staff towards psychologists should be caveated by the interviewer's professional identity and known affiliation with the Clinic.

Concerning client data, only six participants were interviewed. Though adequate (Braun & Clarke, 2013), the intended sample size would have been more robust. Additionally, the demographics of service users available for interview did not reflect the wider cultural and ethnic diversities seen by the Clinic. Finally, participant barriers such as frailty and pain made

(30-minute) interviews briefer than potentially ideal for richer elaborations (Dicicco-Bloom & Crabtree, 2006).

Overall, the qualitative methodology and small sample-sizes mean that recommendations are not generalisable to other Clinics—nor directly predictive of altered outcomes in this Clinic. Moreover, this SIP has generated speculative recommendations without appraising their implementation: precluding evaluation of whether the proposed organisational developments might indeed produce long-term behavioural change.

4.5. Implications

This SIP generated immediate, translational improvements to the nascent SFT service under investigation. It also hopes to empower kindred Systemic services for older people to pursue analogous projects. Where SFT must keep pace with other evidence-based interventions in order to survive and proliferate, further inquiry of this kind is vital.

References

Abdul-Hamid, W.K., Lewis-Cole, K., Holloway, F., Silverman, A.M. (2015). Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey. *British Journal of Psychiatry, 207*, 440-3.

Age UK. (2016) *Hidden in Plain Sight: The Unmet Mental Health Needs of Older People. Age UK.* Available at: www.ageuk.org.uk/brandpartnerglobal/wiganboroughvpp/hidden_in_plain_sight_older_peoples_mental_health.pdf.

Age UK. (2017). *Briefing: Human Rights of Older Persons and their Comprehensive Care.* Age UK. Available at: https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/care--support/the_health_and_care_of_older_people_in_england_2017.pdf

Ball, P. L. (2024). Systemic family therapists and dementia: A constructivist grounded theory study. *Journal of Family Therapy, 46(2)*, 179–195. https://doi.org/10.1111/1467-6427.12453

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2),* 77–101. http://doi.org/10.1191/1478088706qp063oa

Braun, V. and Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. SAGE Publication, London.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11(4),* 589- 597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health, 24(1)*, 1–6.

Burns, A. (2015). *Better Access to Mental Health Services for Older People*. Available at: https://www.england.nhs.uk/blog/mh-better-access.

Campbell, K. A., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive thematic analysis for applied qualitative health research. *The Qualitative Report, 26(6),* 2011-2028. https://doi.org/10.46743/2160-3715/2021.5010.

Carr, A. (2014). The evidence-base for family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy. 36(2)*, 107-157.

Carr, A. (2019a). Family therapy and systemic interventions for child-focused problems: The current evidence base. *Journal of Family Therapy, 41(2)*, 153–213. https://doi.org/10.1111/1467-6427.12226

Carr, A. (2019b). Couple therapy, family therapy and systemic interventions for adult-focused problems: The current evidence base. *Journal of Family Therapy, 41(4)*, 492–536. https://doi.org/10.1111/1467-6427.12225

Cecchin G. (1987). Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. *Family Process, 26(4)*, 405–413. https://doi.org/10.1111/j.1545-5300.1987.00405.x

Coleman, P. (1999). Identity management in later life. In R. T. Woods (ed*.), Psychological Problems of Ageing. Assessment, Treatment and Care*. Wiley.

Curtis, E., & Dixon, M. (2005). Family therapy and systemic practice with older people: where are we now? *Journal of Family Therapy, 27*, 43-64.

Dicicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40(4)*, 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Fredman, L., Cauley, J. A., Hochberg, M., Ensrud, K. E., & Doros, G. (2010). Mortality associated with caregiving, general stress, and caregiving-related stress in elderly women: results of caregiver-study of osteoporotic fractures. *Journal of the American Geriatrics Society, 58(5)*, 937–943. https://doi.org/10.1111/j.1532-5415.2010.02808.x

Health Research Authority. (2020). *Is my study research?* Medical Research Council. Available at: http://www.hradecisiontools.org.uk/research/about.html.

Hilton, C. (2015). Age inclusive services or separate old age and working age services? A historical analysis from the formative years of old age psychiatry c.1940–1989. *BJPsych Bulletin, 39(2)*: 90–95.

I Care, You Care. (2021). *[Trust] Family, Friends and Carers Strategy 2021-24*. NHS [Redacted] Foundation Trust. Available at: [Redacted]

Jenkins, H.J., Moloney, N.A., French, S.D. … Hancock, M. J. (2018). Using behaviour change theory and preliminary testing to develop an implementation intervention to reduce imaging for low back pain. *BMC Health Services Research, 18,* 734 (2018). https://doi.org/10.1186/s12913-018-3526-7

Joffe, H. (2012). Thematic analysis. In D. Harper & A. Thompson (Eds.), *Qualitative methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209–223). Wiley.

Joffe, H., & Elsey, J. W. B. (2014). Free Association in Psychology and the Grid Elaboration Method. *Review of General Psychology*, *18*(3), 173–185. https://doi.org/10.1037/gpr0000014

Krause, I.-B. (2012). Culture and the reflexive subject in systemic psychotherapy. In: I.-B. Krause (ed.). *Culture and Reflexivity in Systemic Psychotherapy* (pp. 1–36). London: Karnac.

Laidlaw, K., & Kishita, N. (2015). Age-appropriate augmented cognitive behavior therapy to enhance treatment outcome for late-life depression and anxiety disorders. *The Journal*

of Gerontopsychology and Geriatric Psychiatry, 28(2), 57-66. https//doi:10.1024/1662-9647/a000128.

Licht-Strunk, E., Van Marwijk, H., Twisk, J., De Haan, M. (2009). Outcome of depression in later life in primary care: longitudinal cohort study with three years follow up. *BMJ, 3079:* 338.

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith, S. (2008). *Paying the Price: The Cost of Mental Health Care in England to 2026.* King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/paying-price-mental-health-cost

Michie, S., Atkins, L., & West, R. (2014). *The Behaviour Change Wheel: A Guide to Designing Intervention*. Silverback.

National Institute for Health and Care Excellence. (2011). *Common mental health problems: identification and pathways to care Clinical guideline* [NICE Guideline No. 123]. Available at: https://www.nice.org.uk/guidance/ng123

National Institute for Health and Care Excellence. (2014a). *Bipolar disorder: assessment and management* [NICE Guideline No. 185]. Available at: https://www.nice.org.uk/guidance/ng123.

National Institute for Health and Care Excellence. (2014b). *Psychosis and schizophrenia in adults: prevention and management* [NICE Guideline No. 178]. Available at: https://www.nice.org.uk/guidance/ng123

NHS England. (2016). *The Five Year Forward View for Mental Health.* Department of Health and Social Care. Available at: www.england.nhs.uk/wp-content/uploads/2016/02/Mental-HealthTaskforce-FYFV-final.pdf

NHS England. (2001). *National Service Framework for Older People*. Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people

NHS England. (2017). *Older People's Mental Health: The Practice Primer*. Older People's Mental Health and Dementia. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/09/practice-primer.pdf

NHS England. (2023). *NHS Long Term Workforce Plan*. Department of Health and Social Care. Available at: https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Nilforooshan R, Benson L, Gage H, Williams P, Zoha M, & Warner J. (2016). Comparison of service utilisation and costs of working age adults and older adults receiving treatment for psychosis and severe non-psychotic conditions in England: implications for commissioning. *International Journal of Geriatric Psychiatry, 32*: 110–15.

O'Connor, C., & Joffe, H. (2020). Intercoder Reliability in Qualitative Research: Debates and Practical Guidelines. *International Journal of Qualitative Methods, 19*. https://doi.org/10.1177/1609406919899220

Office for National Statistics. (2023). *Profile of the older population living in England and Wales in 2021 and changes since 2011.* Available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03

Reder, P., Fredman, G. (1996). The Relationship to Help: Interacting Beliefs about the Treatment Process. *Clinical Child Psychology and Psychiatry. 1(3):* 457-467.

Reynolds, C. F., Jeste, D. V., Sachdev, P. S., & Blazer, D. G. (2022). Mental health care for older adults: recent advances and new directions in clinical practice and research. *World Psychiatry, 21(3)*, 336–363. https://doi.org/10.1002/wps.20996

Richardson, C. A., Gilleard, C. J., Lieberman, S. & Peeler, R. (1994). Working with older adults and their families – a review. *Journal of Family Therapy, 16*, 225–240.

Roper-Hall, A. (1998). Working Systemically with Older People and their Families who have 'Come to Grief'. In: Sutcliffe, P., Tufnell, G., Cornish, U. (eds). *Working with the Dying and Bereaved*. Palgrave. https://doi.org/10.1007/978-1-349-26222-9_7

Royal College of Psychiatrists. (2017). *Survey of Services Based on Information from Faculty Members. Royal College of Psychiatrists*. Faculty of Old Age Psychiatry. Available at: www.rcpsych.ac.uk/workinpsychiatry/faculties/oldagepsychiatry/newsreportsresources.aspx.

Royal College of Psychiatrists. (2018). *Suffering in silence: age inequality in older people's mental health care (CR211).* Faculty of Old Age Psychiatry. Available at https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221

Ryan J., Carriere, I., Ritchie, K., Stewart, R., Toulemonde, G., Dartigues, J.F. (2008). Late life depression and mortality: influence of gender and antidepressants. *British Journal of Psychiatry, 192*, 12–8.

Stratton, P. (2016). *The Evidence Base of Family Therapy and Systemic Practice*. Association for Family Therapy, UK.

Tops, L., Beerten, S. G., Vandenbulcke, M., Vermandere, M., & Deschodt, M. (2024). Integrated Care Models for Older Adults with Depression and Physical Comorbidity: A Scoping Review. *International Journal of Integrated Care, 24(1)*, 1. https://doi.org/10.5334/ijic.7576

The Community Mental Health Framework for Adults and Older Adults. (2019). *NHS England and NHS Improvement and the National Collaborating Central for Mental Health*. NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

Wittenborn, A. K., & Holtrop, K. (2022). Introduction to the special issue on the efficacy and effectiveness of couple and family interventions: Evidence base update 2010-2019.

Journal of Marital and Family Therapy, 48(1), 5–22.
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Theoretically Driven Research Project

Investigating Links between Eating Disorders and Perfectionism: A Quantitative Study of Multidimensional Perfectionism Constructs across Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder

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This project was approved by the Oxford Central University Research Ethics Committee (ref: #R88910/RE001).

It has been submitted to **The International Journal of Eating Disorders**.

Journal instructions and authors' statements are in Appendices K and L.

Abstract

Objectives: Examining negative self-beliefs is key to understanding and treating eating disorders (EDs). There is recognition of the role of perfectionistic self-beliefs in EDs—yet the dimensions, and multidimensionality, of perfectionism are contested. At present there is a lack of validated measures. The perfectionism subscale of the Eating Disorder Core Beliefs Questionnaire (ED-CBQ) recently failed to discriminate between ED- and non-ED groups, albeit with non-clinical samples. This study aimed to investigate how the ED-CBQ's 'high standards' subscale discriminated between diagnosable ED samples and healthy volunteers, alongside measures of other perfectionism dimensions thought to be salient in this population.

Methods: Adults with and without EDs were recruited through social media; 577 participants with anorexia nervosa, bulimia nervosa, binge eating disorder, and no ED diagnosis completed perfectionism, mental health, and ED symptom and diagnostic questionnaires. Relationships between ED diagnoses and measures of perfectionism were explored using MANCOVA. Relationships between ED symptomology and perfectionism were then explored using hierarchical regression.

Results: The MANCOVA indicated a significant overall effect of diagnosis on perfectionism measures, with a medium-to-large effect size. 'High standards perfectionism' showed a significant, near-medium effect size. 'Physical appearance' perfectionism showed the strongest univariate effect size. Pairwise comparisons suggested that 'high standards' was best at distinguishing between ED diagnoses, while 'physical appearance' and 'mistakes reactivity' perfectionism dimensions were best at distinguishing EDs from non-EDs. The subsequent regression found that 'physical appearance' predicted ED symptom severity; 'general perfectionism' subscales were somewhat predictive; and 'high standards' was not at all predictive of symptomology.

Conclusions: Overall, this study showed that a range of perfectionism measures are relevant in EDs, and their differing performance across diagnoses is suggestive of a multidimensional model of perfectionism. Results indicated that the ED-CBQ 'high standards' scale may be the best current operationalism of perfectionism in clinical EDs, while the 'physical appearance' and 'mistakes reactivity' scales exhibited strong ceiling effects. The failure of 'high standards' to predict symptomology invites more research into the relationships between perfectionism dimensions across ED diagnoses and symptom severity – alongside a need for recalibrated measures.

Keywords: Eating disorders, multidimensional perfectionism, negative self-beliefs.

1. Introduction

1.1. Background

1.1.1. Eating disorders

Eating disorders (EDs) constitute a leading public health concern (Coffino et al., 2019; Mitchison et al., 2017), with global prevalence rising from 3.5% to 7.8% between 2000–2018 (Galmiche et al., 2019). Anorexia nervosa (AN) is associated with higher fatality rates than most psychiatric diagnoses (Chesney et al., 2014).[2] EDs also predict physical health conditions – including malnutrition, heart problems, and neural atrophy (Arcelus et al., 2011; Hudson et al., 2007) – and psychological suffering, including depression, lower quality of life, and suicide (Smith et al., 2019; Winkler et al., 2014). Treatment outcomes remain sub-optimal (Bergh et al., 2013). It is therefore vital to better understand the risk factors and maintaining mechanisms of EDs (Waller et al., 2007).

1.1.2. Negative self-beliefs

Recent research investigating the development and maintenance of EDs has focussed on the role of negative core beliefs about the self (Cooper et al., 2004; Fairburn et al., 2003; Jones et al., 2007). Core beliefs are conceptualised as entrenched, unconditional, global content of cognitive schemata about others, the world, or oneself (Beck & Freeman, 1990; Young et al., 2003). Negative self-beliefs have been demonstrated as underlying factors in cognitive, affective, and behavioural dimensions of EDs (Waller, 2003). Cognitive models of AN, bulimia nervosa (BN), and binge eating disorder (BED) all highlight pervasive negative self-beliefs as major predisposing factors (Burton & Abbott, 2019; Cooper, 2012; Cooper et al., 2004). Transdiagnostically, negative self-beliefs may increase vulnerability to developing disordered-eating behaviours (Jones et al., 2007; Pugh, 2015; Vervaet et al., 2021). It is therefore key to investigate and treat EDs at the schematic level of negative self-beliefs (Waller et al., 2007).

[2] See Appendix M for all abbreviations.

1.1.3. Measures

Limited measures have been developed to investigate these negative self-beliefs. The Eating Disorder Core Beliefs Questionnaire (ED-CBQ) draws on theoretical and empirical literature (Somerville & Cooper, 2007; Woolrich et al., 2006) to incorporate ED-specific themes: including defectiveness, extremely high standards, weakness, self-loathing, and self-disgust (Fairchild & Cooper, 2010). It was developed using exploratory factor analysis with 40 items across five negative-self-beliefs domains (Self-loathing, Unassertive/Inhibited, Demanding/Needy, Abandoned/Deprived, High Standards for Self). The High Standards for Self subscale (hereon, '*High Standards*') was a positive predictor of ED symptoms in regression analyses and successfully supported significant discrimination of ED diagnostic groups.

The ED-CBQ promises greater insight into the role of negative self-beliefs in ED aetiology and psychopathology (Fairchild & Cooper, 2010). However, it is little used in empirical research (Young & Cooper, 2013), and *High Standards* requires further scrutiny. A recent validation study appraised the factor-structure and psychometric efficacy of the ED-CBQ via confirmatory factor analysis (CFA) and specificity-testing across high and low ED-symptomatic samples (Hatoum et al., 2022). Fairchild and Cooper's (2010) five-factor structure was not fully supported by the CFA; instead, Hatoum et al. (2022) suggested a four-factor structure, omitting *High Standards*, due to negative correlations between *High Standards* and all other subscales.

1.1.4. Perfectionism

It is striking that *High Standards* did not emerge as a distinct construct in Hatoum et al.'s (2022) CFA, as perfectionistic standards are well demonstrated in EDs (Hatoum et al., 2022), particularly in AN (Dahlenburg et al., 2019). Perfectionism is defined as personality disposition towards unrelenting striving and overly critical self-evaluation (Stöber & Damian, 2014). High standards have often been found the most prominent feature of perfectionism (Dickie et al., 2012); thus this subscale offered a unique perfectionism measure developed specifically for EDs.

One limitation of Hatoum et al.'s (2022) study was its using non-ED-diagnosed samples: which may explain why *High Standards* did not emerge as a distinct construct. Hatoum et al. (2022) also proposed operationalising not just high standards (with neutral and positive valences), but also failure to meet them (negatively valenced). This aligns with wider literature emphasising (negative) 'perfectionistic concerns' alongside (positive) 'personal standards' (Frost et al., 1993; Stöber & Otto, 2006). Indeed, factor analyses of constructs underlying perfectionism differentiated 'High Standards' (strivings) from 'Reactivity to Mistakes' (concerns; Stairs et al., 2012)—endorsing their multidimensionality.

Yet, perfectionism models are debated. 'Clinical perfectionism' forms a key part of CBT for EDs in Fairburn and colleagues' CBT-E model (Fairburn, 2008). However, clinical perfectionism has long been critiqued (Hewitt et al., 2003), and prevailing theory and evidence indicate perfectionism constructs may be multidimensional (Smith et al., 2022). Alternative, multidimensional perfectionism models have proliferated. Early operationalisations of multidimensional perfectionism – against which clinical perfectionism was developed (Shafran et al., 2002) – are robustly associated with ED symptomatology and diagnoses (Dahlenburg et al., 2019; Jones et al., 2007). This includes the Frost Multidimensional Perfectionism Scale (hereon, *FMPS*; Frost et al., 1990): a leading operationalisation of multidimensional perfectionism (Gavino et al., 2019). Although *FMPS* is not adapted to EDs, its *Parent Expectations and Criticism* (*PEC*) subscale holds particular thematic relevance to AN (Philipp

et al., 2020). Moreover, Barber et al. (2025) recently scrutinised two further *FMPS* subscales in ED groups, finding the *Personal Standards* subscale particularly relevant to AN.[3]

More explicitly ED-specific perfectionism dimensions have emerged. Physical-appearance perfectionism is a domain-specific construct with notable theoretical relevance to EDs: particularly AN and BN (Kiani-Sheikhabadi et al., 2019), where shape and appearance are key (Yang & Stoeber, 2012). Moreover, its operationalised measure, the Physical-Appearance Perfectionism Scale (hereon, '*Appearance Perfectionism*') explains 9–17% of unique variance in ED symptoms beyond 11–20% variance explained by general perfectionism measures (Stöber & Yang, 2015).

1.2. Current investigation

1.2.1. Objectives

The present study therefore sought to redress several gaps in the literature. Addressing Hatoum et al.'s (2022) findings, it aimed to assess *High Standards* in people with ED diagnoses. Where Hatoum et al. (2022) used non-clinical samples, whose ED-symptomatic groupings lacked formal diagnosis or clinical cut-offs, this study aimed to test *High Standards* in clinically defined EDs.

This validation also undertook a broader exploration of perfectionism dimensions theorised to be particularly relevant in EDs, to better understand the presentation and measurement of perfectionism across different ED diagnoses. Drawing on Hatoum et al.'s concluding suggestions (2022), this study sought to appraise *High Standards* alongside a negatively valenced measure—the Reactivity to Mistakes subscale (hereon, '*Mistakes Reactivity*'; Stairs et al., 2012). It also included a measure of physical appearance perfectionism (*Appearance Perfectionism*) and general perfectionism (*FMPS*).

[3] This study was designed before Barber et al. (2025), so hypotheses did not account for this subsequent ED-focused application of *FMPS*.

Examining multiple perfectionism measures together speaks to debates concerning unidimensional clinical perfectionism versus multidimensional perfectionism. Highly similar results found across measures may indicate unidimensionality, and limited value of using separate scales. Findings of specific effects in each measure may endorse multidimensionality, and the utility of employing focused scales—including, potentially, *High Standards*.

Fulfilling these research objectives could support enhancing the ED-CBQ by elucidating its *High Standards* subscale; corroborate the case for multidimensional perfectionism, particularly in examining EDs; and inform future clinical research investigating negative self-beliefs in development and maintenance of EDs. It could also supplement insight into relevant perfectionism dimensions across different ED diagnoses, and hone perfectionism-oriented components of current treatment models.

1.2.2. Research questions

The primary research questions of this study were therefore:

- How do different perfectionism measures discriminate between different ED populations?
    - And what are their implications for multidimensionality of perfectionism?
- What is the role in EDs of having high standards versus being reactive to failure?
- What is the role of physical-appearance perfectionism versus general perfectionism measures?

Secondary, exploratory research questions included:

- Are *High Standards* and *Appearance Perfectionism* significant unique predictors of ED symptomology beyond general multidimensional perfectionism?

1.2.3. Hypotheses

Specific hypotheses followed from these research questions—primarily predicting that:

- *High Standards* scores would be higher in ED-diagnosed subgroups than in healthy volunteers (HVs), given clinical samples rather than non-clinical samples were used in this study.
    - *High Standards* scores would be particularly high in AN, as perfectionistic strivings are especially well demonstrated in AN and to a lesser extent in BN and BED (Dahlenburg et al., 2019).
- *Mistakes Reactivity* scores would be significantly higher in ED groups than in HVs, since Hatoum et al. (2022) hypothesised that a negatively valenced perfectionism measure would be particularly relevant to EDs.
    - *Mistakes Reactivity* scores would be significantly different between ED groups, as above.
- *Appearance Perfectionism* scores would be higher in ED groups than in HVs, given its thematic relevance to EDs.
    - *Appearance Perfectionism* scores would be particularly high in AN and potentially BN, as appearance concern is especially germane to AN and BN phenomenology.
- General multidimensional perfectionism scores (operationalised as the *FMPS*) would not be significantly higher in ED groups than in HVs, given that the *FMPS* was not validated in ED samples.
    - Except the *Parental Expectations & Criticism* subscale would be higher in AN, given particular relevance to AN experiences (Philipp et al., 2020).

And secondary, follow-up hypotheses predicted that:

- *High Standards* and *Appearance Perfectionism* would both predict unique variance above and beyond confounders such as anxiety and depression.
    - *High Standards* and *Appearance Perfectionism* would also predict unique variance in ED symptoms above and beyond general multidimensional perfectionism (*FMPS*).

2. Methods

This study investigated relationships between EDs and multidimensional perfectionism using online questionnaires and quantitative analyses. Ethical approval was received from the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (ID: R88910/RE001; Appendix N).

2.1. Co-production

Seven experts by experience of EDs were involved in honing design aspects. Consultations covered the advertisement and information sheet, and selection and presentation of questionnaires. Experts endorsed perfectionism-focussed ED research, and suggested online recruitment avenues. Recommendations included reducing perfectionism-related stress via reminders that questionnaires had 'no right answers', and increasing attentional accessibility via questionnaire colour-coding and pausing options.

2.2. Participants

2.2.1. Sample

The study aimed to recruit a minimum of 180 participants: including 45 participants not meeting clinical thresholds for ED diagnosis; 45 meeting diagnostic thresholds for AN; 45 for BN; and 45 for BED. Participants' EDDS responses were used to establish likely diagnoses. Non-clinical sampling was chosen to capture broader samples, as access to treatment is influenced by factors including race and socioeconomic status (Sonneville & Lipson, 2018). Inclusion criteria stipulated English-speaking adults (aged 16+); with or without disordered eating (to include healthy volunteers; HVs); and based in the UK, USA, Ireland, Canada, Australia, or New Zealand (for similar healthcare systems and ED treatments).

2.2.2. Power

Sample-size was determined statistically using *G*Power* 3.1.9.7: indicating that one-way MANOVA with four groups and seven dependent variables required a minimum sample size of 148 participants to detect a medium effect size (f^2=.0625, p=.05) with 90% power (Stackpole et al., 2023). To ensure sufficient data was collected for all groups, a minimum-group-size of 45 was determined. This size also adequately powered the planned hierarchical regression with seven independent variables, given conventions for 10+ participants per independent variable (Van Voorhis & Morgan, 2007).

2.2.3. Recruitment

Following ethical approval and consultation with experts, recruitment materials were disseminated digitally. Participants were recruited primarily via social media (Instagram, Reddit) – particularly by inviting social-media 'influencers' to share the study posters. National ED-relevant third-sector organisations were also contacted, alongside Oxford University student groups. No inducements were offered. Posters contained weblinks to an online information sheet and consent form, and approximately 20-minute *Qualtrics* survey. No identifying information was collected.

2.3. Design

A cross-sectional design was used – with one main between-participant factor of group (HV, AN, BN, and BED). Multiple dependent-variable measures were used for analyses.

2.3.1. Operationalisation

2.3.1.1. *Perfectionism*

Measures were chosen to operationalise salient perfectionism dimensions:

- ED-specific perfectionism was operationalised via the *High Standards* subscale of the ED-CBQ (Fairchild & Cooper, 2010). ED-CBQ subscales have previously demonstrated adequate internal consistency and construct validity (Fairchild & Cooper, 2010).

- Perfectionistic concerns were operationalised via the Reactivity to Mistakes subscale of the Measure of Constructs Underlying Perfectionism (M-CUP); *Mistakes Reactivity* aggregated three separate subscales capturing perfectionistic concerns (Stairs et al., 2012). All M-CUP subscales have previously shown good internal consistency, temporal stability, and discriminant validity (Stairs et al., 2012).

- Physical-appearance perfectionism was captured using the Physical Appearance Perfectionism Scale (*Appearance Perfectionism*; Yang & Stoeber, 2012). *Appearance Perfectionism* has demonstrated good construct validity and differential validity to differentiate physical-appearance perfectionism (Yang & Stoeber, 2012).

- General multidimensional perfectionism was captured using four core subscales of the *FMPS*: factorially distilled from six, and displaying stronger differential and convergent validity (Stoeber, 1998). These subscales are *Parental Expectations & Criticism*, *Concern over Mistakes & Doubts about Actions*, *Personal Standards*, and *Precision & Organisation*.

2.3.1.2. Disordered eating

Disordered eating was captured varyingly:

- Participants were allocated to categorical diagnostic ED groups via the Eating Disorder Diagnostic Scale (*EDDS*), adapted for DSM-V criteria (PhenX, 2023). It had demonstrated good test–retest reliability and internal consistency (Stice et al., 2000).
- Continuous ED symptomatology was captured via the Eating Disorder Examination Questionnaire 6.0 (*EDE-Q*; Fairburn & Beglin, 2008). With good convergent validity and acceptable criterion validity, the EDE-Q appears well-suited in community samples (Mond et al., 2004).

2.3.1.3. Confounds

Demographic data were collected (Appendix O), and two most-relevant confounding mental-health correlates were measured:

- Depressive symptomology was captured via the Patient Health Questionnaire 8-item (*PHQ-8*) – similarly validated as the PHQ-9, but avoiding ethical risk issues of asking about suicidality online (Wu et al., 2020).
- Anxious symptomology was captured via the well validated General Anxiety Disorder p7-item (*GAD-7*; Spitzer et al., 2006).

All measures demonstrated high reliability in this sample, ranging from Cronbach's α=.716–.957.

2.3.2. Hypothesis testing

2.3.2.1. Primary sub-design

Hypothesised differences in perfectionistic striving (*High Standards*) and concerns (*Mistakes Reactivity*) between HVs and diagnosed ED groups were assessed using MANCOVA. As ED-related core-belief measures are often confounded by depression and anxiety in the literature (Fairchild & Cooper, 2010), *PHQ-8* and *GAD-7* were controlled for.

Hypothesised differences in physical-appearance perfectionism (*Appearance Perfectionism*) and general multidimensional perfectionism (*FMPS*) between HVs and diagnosed ED groups were also assessed using MANCOVA.

2.3.2.2. Secondary sub-design

Variance in ED symptomatology explained by different perfectionism measures was assessed using hierarchical regression (Section 2.5.3).

2.4. Procedure

Following consent, participants were invited to complete eight online perfectionism and EDs questionnaires. Following completion, respondents were thanked for participation and signposted to nationally relevant ED-related resources.

2.5. Data analysis

Following recruitment, analyses were performed in *SPSS.v29*. Unusual patterns of responding were checked for in the data.

2.5.1. Primary analysis

Primary and secondary questions were addressed in one MANCOVA to minimise statistical power lost from multiple tests (Huberty & Morris, 1989). Diagnostic grouping – assigned by *EDDS* – comprised the independent variable; perfectionism measures were dependent variables; and depression and anxiety (*PHQ-8*, *GAD-7*) were covariates.

2.5.2. Secondary analysis

Tertiary hypotheses were addressed separately using hierarchical regression. Here, ED symptomatology (via *EDE-Q* scores) was the dependent variable, and perfectionism measures were independent variables. The regressions entered covariates first; then, the *FMPS* subscales; then, *Appearance Perfectionism*; then *High Standards*. Additional, exploratory regression sequences were anticipated, such as entering *High Standards* before *Appearance Perfectionism*.

3. Results

3.1. Sample characteristics

3.1.1. Selection

Of 941 recorded responses, 50 missed diagnostic data; 341 cases were removed as diagnoses less relevant to this study (e.g., atypical AN; Appendix P): leaving 577 cases. The largest group was BN (*n*=233), with similar HV (*n*=137) and AN groups (*n=139*), and smaller BED group (*n*=68). To address the issue of unbalanced groups, BED-targeted recruitment increased BED by seven participants, yet augmented BN by 57. As the minimum of 45 participants per group had been reached, recruitment was ceased.

3.1.2. Demographics

Participants were aged 16–60, predominantly white and female (Table 1). Categories within some demographic variables were amalgamated to preclude small cells from distorting Pearson's *chi-square* (Howell, 2010) or later analyses. All except *Ethnicity* and *CBT Support* differed significantly between diagnostic groups ($p<.05$).

3.1.3. Characteristics

HVs were less ED-symptomatic than ED-diagnosed groups, though more ED-symptomatic than community norms (Aardoom et al., 2012; Table 2). HVs also appeared less depressed and anxious than ED groups – and below clinical thresholds (Kroenke et al., 2009; Spitzer et al., 2006). *Appearance Perfectionism* was expectedly higher in ED groups (with no HV norms available). However, *High Standards*, *Mistakes Reactivity*, and *FMPS* subscales were similar between HVs and EDs groups – with HVs higher than norms (Hatoum et al., 2022; Stairs et al., 2012; Stöber, 1998).

Table 1: Demographic Characteristics

Characteristic	HV group	AN group	BN group	BED group	Total
Sex (birth assigned)					$\chi^2[6]=12.1, p=.061$*
Female	128 (94.1%)	138 (99.3%)	229 (98.7%)	67 (95.7%)	562 (97.7%)
Male	8 (5.90%)	1 (0.72%)	3 (1.30%)	1 (4.30%)	13 (2.25%)
Gender**					$\chi^2[3]=9.11, p=.013$ *
Female	118 (86.8%)	132 (95.7%)	216 (92.7%)	64 (95.5%)	530 (91.9%)
Other	18 (13.2%)	6 (3.35%)	17 (7.30%)	3 (4.48%)	44 (7.63%)
Ethnicity**					$\chi^2[3]=7.03, p<.071$*
White	112 (81.8%)	120 (86.3%)	187 (80.3%)	63 (92.6%)	482 (83.5%)
Non-white	25 (18.2%)	19 (13.7%)	46 (19.7%)	5 (7.35%)	95 (16.5%)
Education**					$\chi^2[3]=24.8, p<.001$*
Up to tertiary ed.	39 (28.5%)	74 (53.2%)	77 (33.0%)	18 (26.5%)	208 (36.1%)
Tertiary complete	98 (71.5%)	65 (46.8%)	156 (67.0%)	50 (73.5%)	369 (64.0%)
Occupation**					$\chi^2[3]=12.5, p=.006$*
Employed	83 (60.6%)	68 (48.9%)	148 (63.5%)	49 (72.1%)	348 (60.3%)
Unemployed/other	54 (39.4%)	71 (51.1%)	85 (36.5%)	19 (27.9%)	229 (39.7%)
Civil status**					$\chi^2[6]=18.1, p=.006$*
Single/separated	84 (61.8%)	104 (74.8%)	137 (58.8%)	34 (50.0%)	359 (62.2%)
Partnered/other	52 (38.2%)	35 (25.2%)	96 (41.2%)	34 (50.0%)	217 (37.6%)
Parent?					$\chi^2[3]=22.7, p<.001$*
No	122 (89.1%)	129 (92.8%)	198 (85.0%)	47 (69.1%)	496 (86.0%)
Yes	15 (10.9%)	10 (7.19%)	35 (15.0%)	21 (30.9%)	81 (14.0%)
Current support?					$\chi^2[3]=18.5, p<.001$*
No[a]	74 (54.0%)	41 (29.5%)	104 (44.6%)	34 (50.0%)	253 (43.9%)
Yes	63 (46.0%)	98 (70.5%)	129 (55.4%)	34 (50.0%)	324 (56.2%)
Therapy?					$\chi^2[6]=16.7, p=.011$*
No current support	65 (47.4%)	35 (25.2%)	91 (15.8%)	29 (42.6%)	220 (38.1%)
No	18 (13.1%)	26 (18.7%)	29 (5.03%)	10 (14.7%)	83 (14.4%)
Yes	54 (39.4%)	78 (56.1%)	113 (19.6%)	29 (42.6%)	274 (47.5%)
CBT?					$\chi^2[6]=10.8, p=.094$*
No current support	82 (59.9%)	61 (43.9%)	119 (39.1%)	39 (57.4%)	301 (52.2%)
No, other therapy	38 (27.7%)	45 (32.4%)	75 (32.2%)	16 (23.5%)	174 (30.2%)
Yes, CBT	17 (12.4%)	33 (23.7%)	39 (16.7%)	13 (19.1%)	102 (24.8%)
Past support?					$\chi^2[6]=20.5, p=.002$*
Past and current	59 (43.1%)	95 (68.3%)	120 (51.5%)	35 (51.5%)	309 (53.6%)
Past, not current	57 (41.6%)	36 (25.9%)	87 (37.3%)	27 (39.7%)	207 (35.9%)
Never received	21 (15.3%)	8 (5.76%)	26 (11.2%)	6 (8.82%)	61 (10.6%)
Medication?					$\chi^2[3]=12.7, p=.005$*
No	91 (66.4%)	64 (46.0%)	138 (59.2%)	36 (52.9%)	329 (57.0%)
Yes	46 (33.6%)	75 (54.0%)	95 (40.8%)	32 (47.1%)	248 (43.0%)
Age					$F[3]=12.5, p<.001$*
Mean (*SD*)[1]	28.1 (9.35)	25.5 (7.86)	28.4 (9.00)	33.7 (10.2)	28.2 (9.25)
Body mass index					$F[3]=63.4, p<.001$*
Mean (*SD*)	25.1 (8.92)	16.5 (2.72)	29.6 (12.0)	32.5 (12.1)	25.7 (11.3)

[1]Standard deviation * $\alpha=.05$. ** Recoded categories. [a]Full questionnaire items in Appendix O

Table 2: Variable Characteristics

Scale / group	HV[l] group	AN[m] group	BN[n] group	BED[o] group	ED[p] groups	All groups
PHQ-8[a]						
Data: mean (*SD*[b])	6.72 (4.87)	14.8 (5.25)	12.3 (5.49)	10.6 (5.40)	12.8 (5.58)	11.4 (6.01)
Norms: cutoff[1]	≤10.0	≤10.0	≤10.0	≤10.0	≤10.0	≤10.0
GAD-7[c]						
Data: mean (*SD*)	7.15 (5.54)	13.5 (5.31)	10.9 (5.56)	8.56 (5.21)	11.4 (5.67)	10.4 (5.91)
Norms: cutoff[2]	≤9.0	≤9.0	≤9.0	≤9.0	≤9.0	≤9.0
HSS[d]						
Data: mean (*SD*)	4.47 (0.94)	4.79 (0.90)	4.42 (0.91)	4.03 (1.12)	4.48 (0.97)	4.47 (0.96)
Norms: mean (*SD*)[3]	4.41 (1.05)	4.32 (1.04)[a]	4.32 (1.04)	4.32 (1.04)	4.32 (1.04)	4.39 (1.05)
RtMS[e]						
Data: mean (SD)	26.6 (6.87)	31.3 (4.08)	30.3 (4.85)	29.5 (6.24)	30.5 (4.90)	29.6 (5.67)
Norms: mean (*SD*)[4]	17.0 (5.53)	17.0 (5.53)	17.0 (5.53)	17.0 (5.53)	17.0 (5.53)	17.0 (5.53)
PAPS[f]						
Data: mean (*SD*)	3.66 (0.75)	4.41 (0.51)	4.55 (0.49)	4.29 (0.71)	4.46 (0.54)	4.27 (0.69)
Norms: mean (*SD*)[5]	N/A	N/A	N/A	N/A	N/A	N/A
FMPS: PS[g]						
Data: mean (*SD*)	27.7 (5.12)	29.5 (4.17)	28.5 (4.77)	27.2 (5.25)	28.6 (4.71)	28.4 (3.83)
Norms: mean (*SD*)[6]	21.3 (5.25)	21.3 (5.25)	21.3 (5.25)	21.3 (5.25)	21.3 (5.25)	21.3 (5.25)
FMPS: CMD[h]						
Data: mean (*SD*)	45.3 (10.4)	29.5 (4.17)	51.5 (8.25)	49.6 (9.39)	51.9 (8.01)	50.3 (9.11)
Norms: mean (*SD*)[7]	30.6 (9.31)	30.6 (9.31)	30.6 (9.31)	30.6 (9.31)	30.6 (9.31)	30.6 (9.31)
FMPS: PEC[i]						
Data: mean (*SD*)	24.8 (8.71)	26.8 (9.24)	30.1 (8.26)	27.7 (8.95)	28.7 (8.80)	27.8 (8.93)
Norms: mean (*SD*)[8]	20.1 (7.93)	20.1 (7.93)	20.1 (7.93)	20.1 (7.93)	20.1 (7.93)	20.1 (7.93)
FMPS: PO[j]						
Data: mean (*SD*)	23.7 (5.14)	25.2 (4.09)	24.2 (4.66)	23.8 (4.71)	24.4 (4.52)	24.3 (4.68)
Norms: mean (*SD*)[9]	20.9 (4.85)	20.9 (4.85)	20.9 (4.85)	20.9 (4.85)	20.9 (4.85)	20.9 (4.85)
EDE-Q[k]						
Data: mean (*SD*)	1.74 (1.20)	4.64 (0.92)	4.54 (0.90)	3.67 (1.23)	4.43 (1.00)	3.80 (1.56)
Norms: mean (*SD*)[10]	0.93 (0.86)	4.17 (1.30)	4.34 (1.04)	3.46 (0.98)	N/A	N/A

[a]Patient Health Questionnaire 8-Item [b]Standard deviation [c]Generalised Anxiety Disorder 7-Item [d]High Standards for Self scale [e]Reactivity to Mistakes Scale [f]Physical Appearance Perfectionism Scale [g]Frost Multidimensional Perfectionism Scale: Personal Standards [h]Concerns over Mistakes & Doubts about Actions [i]Parental Expectations & Criticism [j]Precision & Organisation [k]Eating Disorder Examination Questionnaire [l]Healthy volunteer [m]Anorexia nervosa [n]Bulimia nervosa [o]Binge eating disorder [p]Eating disorder

[1]Taken from Kroenke et al. (2009) [2]From Spitzer et al. (2006) [3]From Hatoum et al. (2022) [4]From Stairs et al. (2012) [5]Unavailable in Yang & Stöber (2012) [6–9]From Stöber (1998) [10]From Aardoom et al. (2012)

3.2. Group comparisons

3.2.1. Assumptions

Statistical assumptions of MANCOVA were mostly met. Some assumptions of multivariate normality, univariate variances, and homogeneity of variance–covariance were violated (Appendix Q). However, Mahalanobis-distance calculations indicated few problematic outliers (Barnett, 1994), and in large samples statistics are rarely biased by normality violations (Pallant, 2007). Moreover, given Levene's *F* and Box's *M* are over-sensitised by large samples, Pillai's trace was utilised. As Pillai's statistics are robust to violations with equal group sizes (Field, 2004), and to ensure confidence in effects, bootstrapping was conducted with five randomised datasets of equalised groups, and consistent Pillai's traces confirmed in each.

3.2.2. Analysis

All dependent variables were included in a single MANCOVA. Beyond *GAD-7* and *PHQ-8*, only demographic variables *Age* and *Medication* were made additional covariates, to limit statistical strain on assumptions. Medications can affect cognitive processes influencing perfectionism (Gül et al., 2009); age tends to differ across onsets of different ED diagnoses (Galmiche et al., 2019), while its influence on perfectionism is mixed (Sand et al., 2021).

3.2.3. Effects

3.2.2.1. Overall effects

Pillai's trace indicated a significant multivariate effect of diagnosis on perfectionism measures, indicating an overall difference: V=0.29, $F(21, 1695)$=8.64, p<.001. Via Cohen's (1988) benchmarks (throughout), *partial eta-squared* suggested a medium-to-large effect size (η_p^2=.097). Pillai's trace is most robust to unequal variance–covariance matrices (Olson,

1976)—though mainly with even sample-sizes. Given fewer BEDs, robustness was not presumed. Instead, five additional datasets containing randomly equalised groups were analysed and supported confidence in this main effect, as Pillai's remained significant (p<.001).

3.2.2.2. *Univariate findings*

Univariate tests were conducted to examine high standards (*High Standards*) and reactivity to mistakes (*Mistakes Reactivity*). Univariate ANCOVAs indicated significant effects – near-medium and small respectively – of diagnosis on ***High Standards***, $F(3,573)=10.3$, p<.001, η_p^2=.052 and ***Mistakes Reactivity***, $F(3,573)=5.81$, p<.001, η_p^2=.030.

Post hoc Bonferroni-corrected pairwise comparisons were conducted. Figure 1 displays graphs with between-group significance-levels across all dependent variables. *High Standards* scores were significantly higher in AN than all other groups, and significantly lower in BED than other EDs. *Mistakes Reactivity* scores were significantly higher in all EDs than HVs, though not significantly different between any EDs.

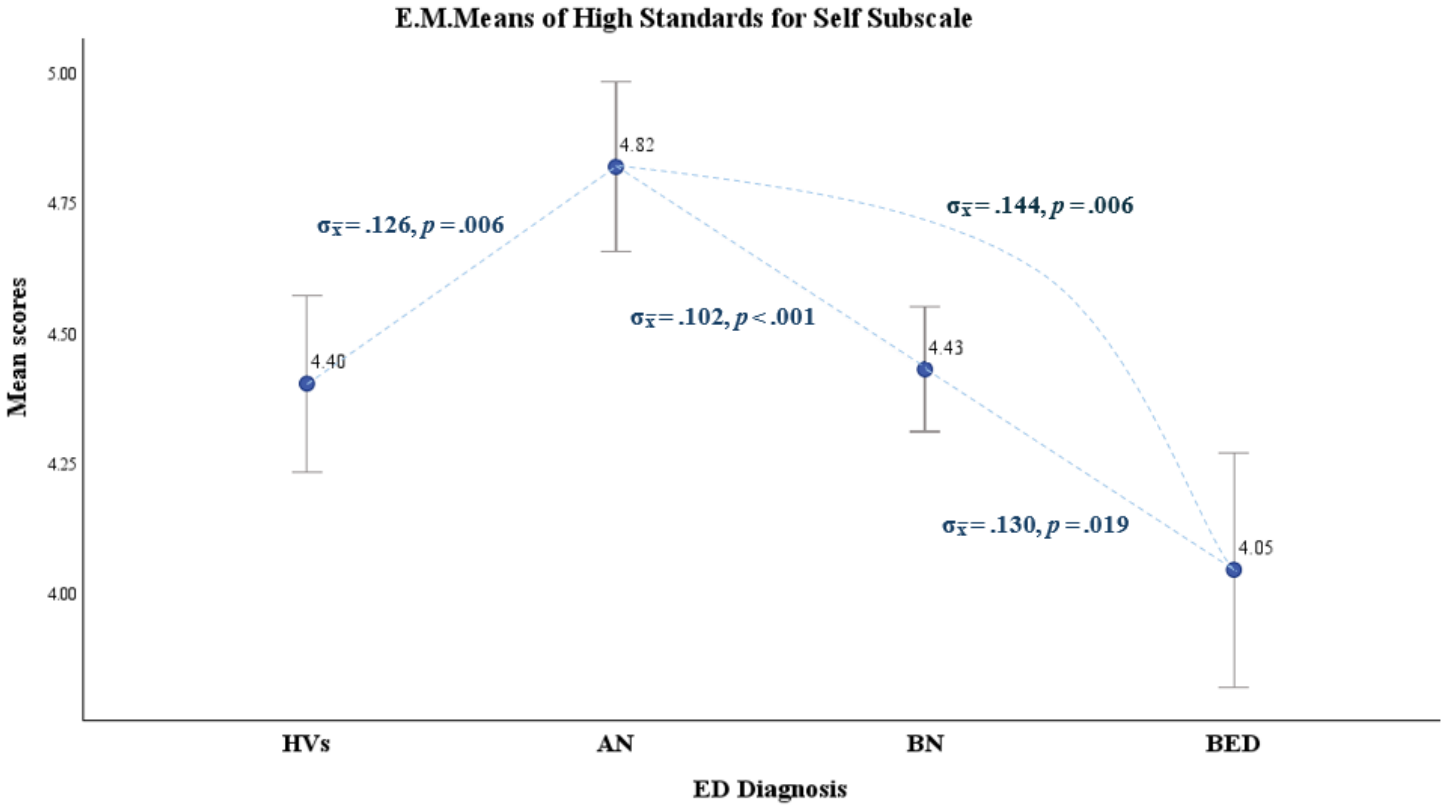
Further analyses tested physical-appearance perfectionism (*Appearance Perfectionism*) and general multidimensional perfectionism (*FMPS*). ANCOVAs indicated a significant, large effect of diagnosis on ***Appearance Perfectionism****,* $F(3,573)=42.1$, p<.001, η_p^2=.14. There were significant, small effects on all *FMPS* subscales: ***Parental Expectations***, $F(3,573)=8.20$, p<.001, η_p^2=.041; ***Concerns over Mistakes***, $F(3,573)=4.67$, p=.003, η_p^2=.024; ***Precision & Organisation***, $F(3,573)=3.11$, p=.026, η_p^2=.016; ***Personal Standards***, $F(3,573)=2.99$, p=.031, η_p^2=.041.

Post hoc pairwise comparisons were again consulted (Figure 1). *Appearance Perfectionism* scores were significantly higher in all EDs than HVs, and in BN than AN. *FMPS*-subscale patterns were less clear-cut. *Parental Expectations* was significantly higher in BN than HVs and AN, and *Concern over Mistakes* higher than HVs in BN and AN. In *Personal Standards* and *Precision & Organisation*, differences were significant only between HVs and AN.

Figure 1. Mean group scores across all dependent variables

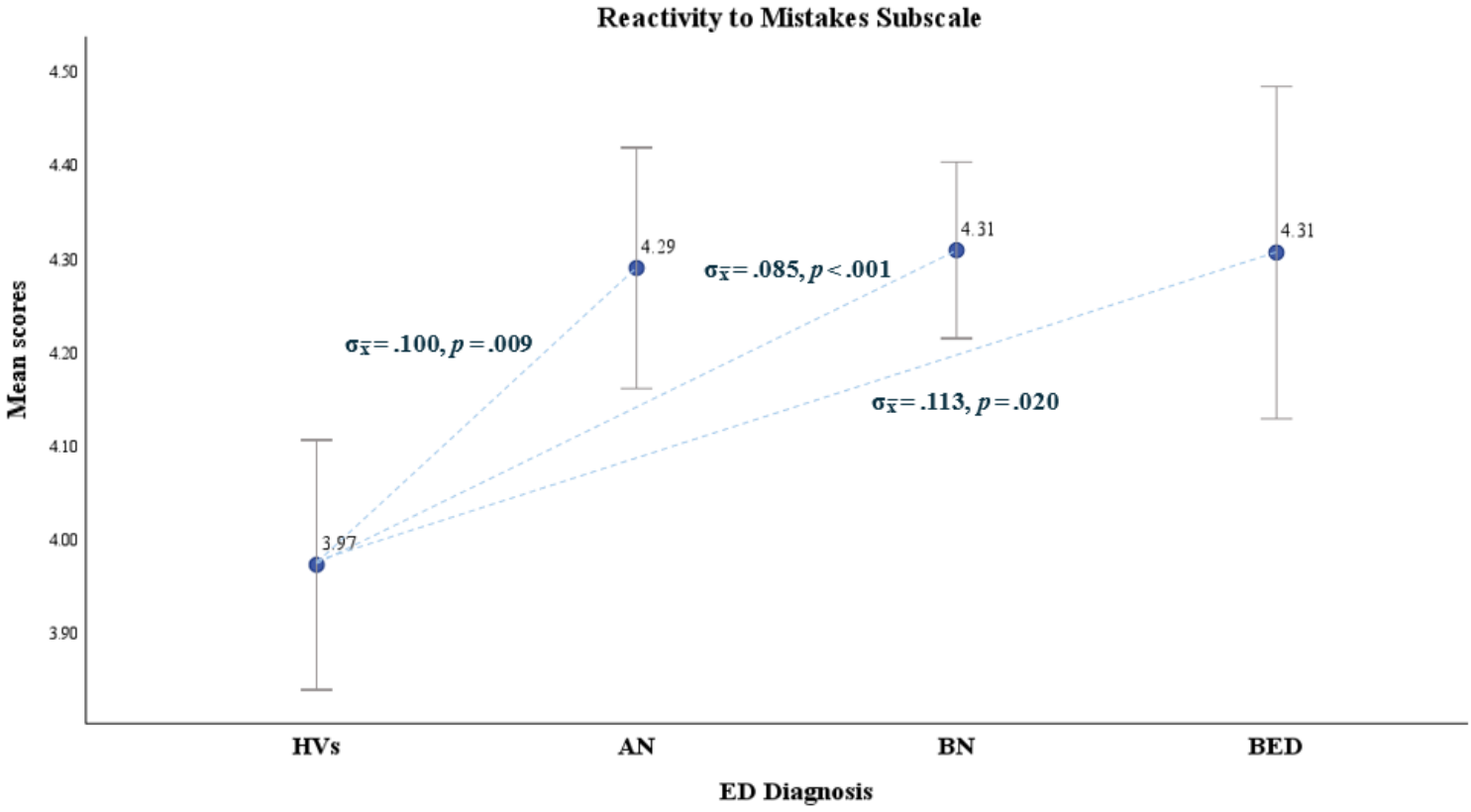
Covariates appearing in all models (below) evaluated at: PHQ-8 = 11.4; GAD-7 = 10.4; Age = 28.3; Medication = .430.

All error bars: 95% confidence intervals.

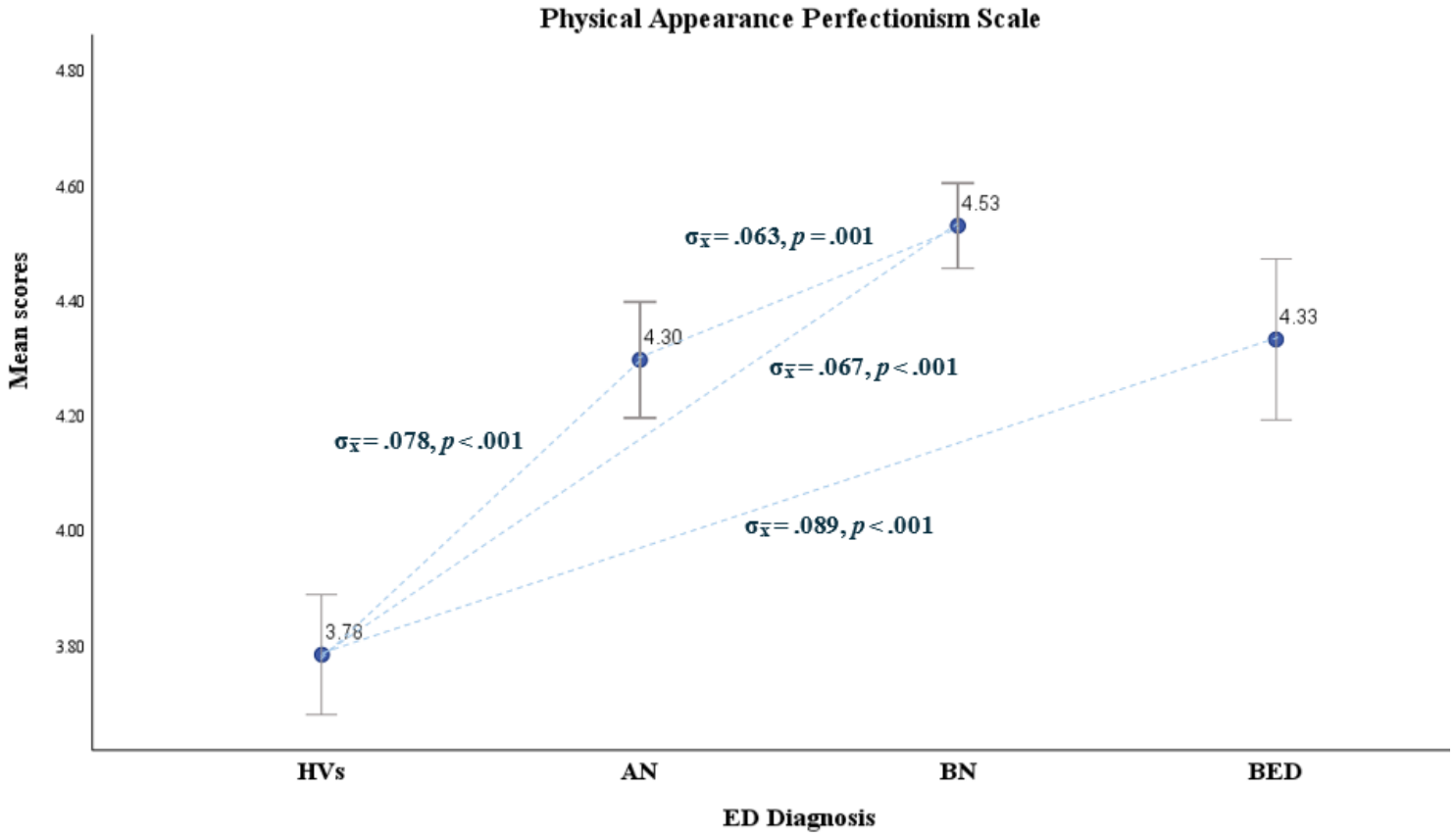


Significant: HV < AN; BED < BN; BED < AN; BN < AN. **Non-significant**: BED < HV; HV < BN.

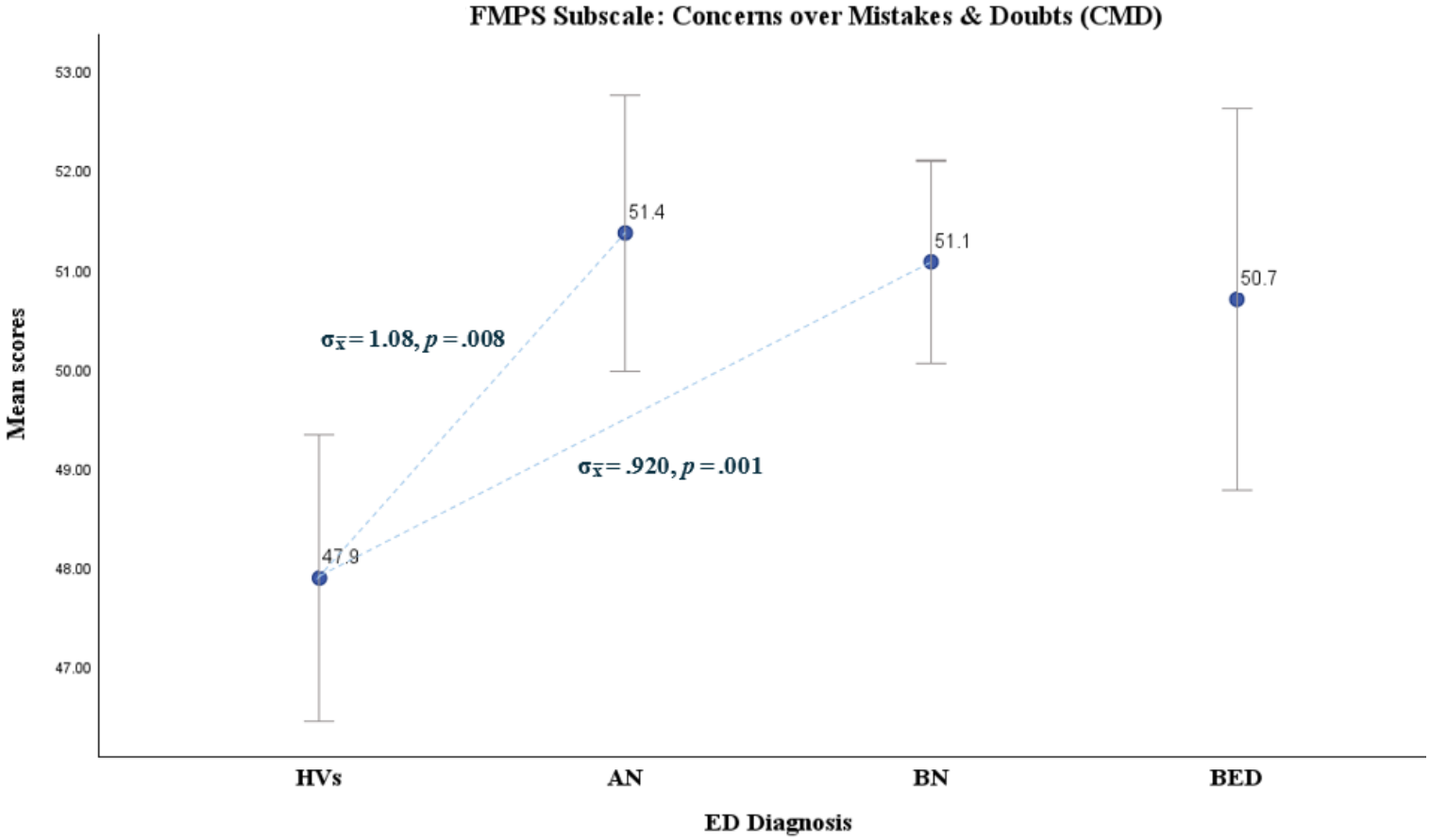
HVs: Healthy volunteers **AN**: Anorexia nervosa **BN**: Bulimia nervosa **BED**: Binge eating disorder



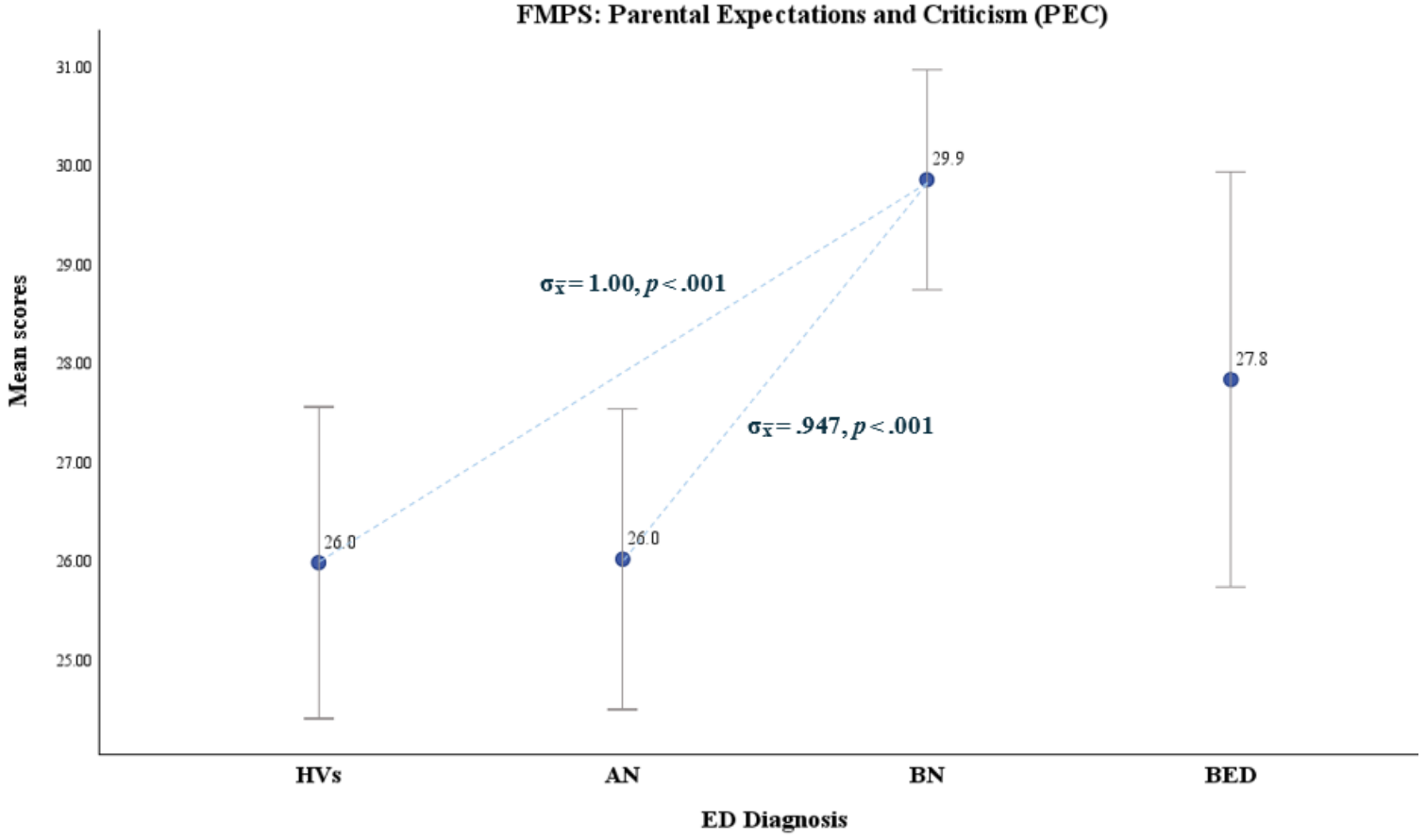
Significant: HV < AN; HV < BN; HV < BED. **Non-significant**: AN < BN; AN < BED; BN = BED.



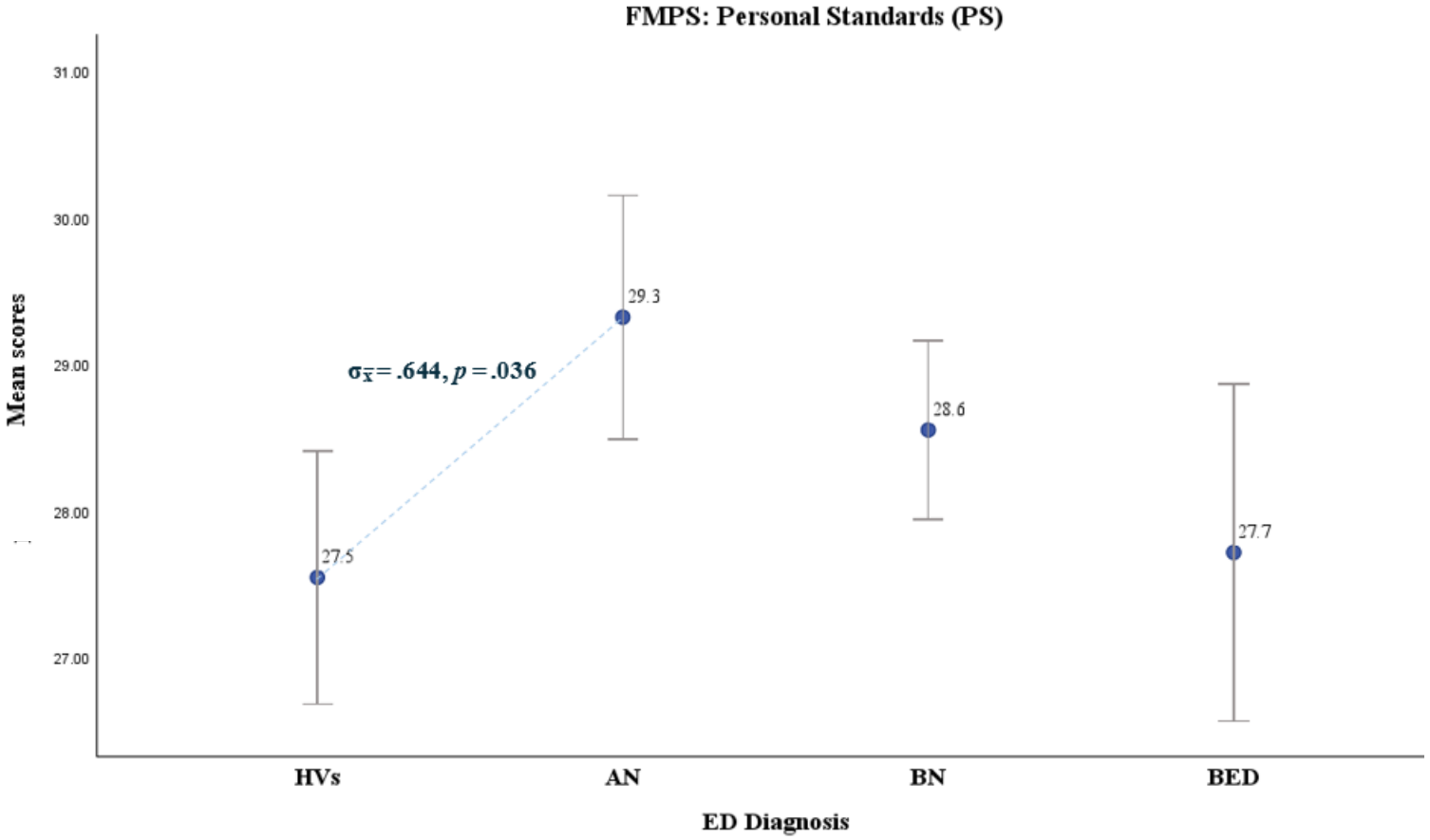
Significant: HV < AN; HV < BED; HV < BN; AN < BN. **Non-significant**: AN < BED; BED < BN.



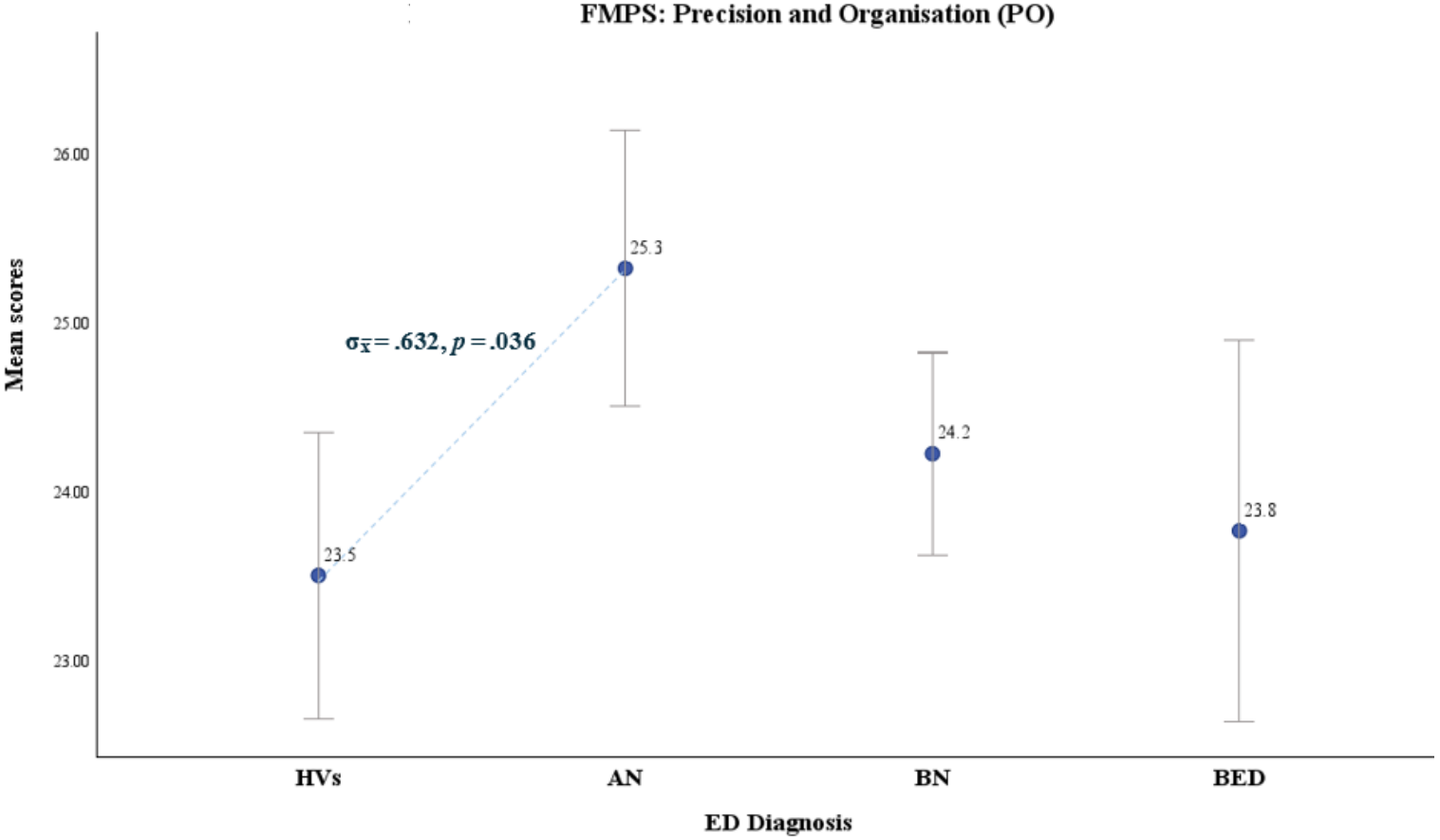
Significant: HV < BN; HV < AN. **Non-significant**: HV < BED; BED < BN; BED < AN; BED < AN.



Significant: HV < BN; AN < BN. **Non-significant**: HV = AN; HV < BED; AN < BED; BED < BN.



Significant: HV < AN. **Non-significant**: HV < BED; HV < BN; BED < BN; BED < AN; BN < AN.



Significant: HV < AN. **Non-significant**: HV < BED; HV < BN; BED < BN; BED < AN; BN < AN.

3.3. Symptom correlations

3.3.1. Analysis

All assumptions of regression were met. Six independent variables (*High Standards*, *Appearance Perfectionism*, *FMPS*) subscales were regressed, with four covariates (*PHQ-8*, *GAD-7*, *Age*, *Medication*), and *EDE-Q* total scores as dependent variable. Covariates were entered first, as most known predictors; then *FMPS*, as the general measure; then *Appearance Perfectionism*; then, *High Standards*. Further regressions were run exploratorily. All regressions were bootstrapped, using 1,500 samples (Davidson & MacKinnon, 2000).

3.3.2. Effects

FMPS significantly explained 6.3% of variance in ED symptoms beyond covariates (Appendix R). *Appearance Perfectionism* explained 17.6% beyond covariates and *FMPS*. *High Standards*, however, contributed no significant unique prediction. In further, speculative regressions, *High Standards* did not significantly predict ED symptoms when entered before *Appearance Perfectionism*: R^2_{adj}=.592, F(1, 567)<.001, p=.998 — nor when run for isolated diagnostic groups.

4. Discussion

4.1. Main questions

Core questions regarding patterns of perfectionism across EDs were addressed by MANCOVA. Results corroborated the case for multidimensional perfectionism, as different perfectionism measures performed differently across ED groups.

4.1.1. Addressing hypotheses

Developed for ED populations, *High Standards* was expected to differentiate ED groups. It was the second-strongest measure for distinguishing between groups overall. As hypothesised, *High Standards* was highest in AN; however, contrary to predictions, neither BN nor BED scores significantly differed from HVs. In addition, *High Standards* was significantly lower in BED than AN and BN contradicting literature that perfectionistic striving may feature highly in BED (Vicent et al., 2023). This is partially consistent with Hatoum et al.'s (2022) finding no difference between participants with high versus low ED symptomology – but also highlighting the importance of using clinically diagnosable samples.

As hypothesised, *Mistakes Reactivity* – unvalidated in ED populations – failed to distinguish any ED diagnoses, with a small effect size in distinguishing groups overall. However, *Mistakes Reactivity* was significantly higher in all ED diagnoses than HVs. This supports Hatoum et al.'s (2022) speculative suggestion of including negatively valenced perfectionism – and suggests wider perfectionism dimensions are elevated in ED-diagnosed groups. However, *Mistakes Reactivity*'s ceiling effects in ED groups – with most participants showing highest-possible scores – may mean some diagnostic differences were not detected.

Appearance Perfectionism was expected to distinguish groups well, given pertinence to EDs. *Appearance Perfectionism* emerged with the largest effect size on groups overall – and, as predicted, was significantly higher in all ED groups than HVs. *Appearance Perfectionism* was highest in BN – though, unexpectedly, BN levels were significantly higher than AN, and not BED. AN participants had significantly lower BMIs, and so may have currently been less

concerned by their appearance. Alternatively, this may be attributable to ceiling effects in *Appearance Perfectionism* ED-group scores.

FMPS – developed with general populations – was not predicted to be higher in ED groups. *FMPS*-subscale effect sizes were modest. The largest effect size (small-to-medium) was in *Parent Expectations*; however, scores were not significantly higher in AN—contradicting parent-related literature (Carpinelli & Watzlawik, 2023). Other *FMPS* subscale effect sizes were smaller, so significance levels should be interpreted cautiously. *FMPS*' insensitivity to ED diagnoses could not be ascribed to ceiling effects.

4.1.2. Interpretations

4.1.2.1. Multidimensionality

There are proliferating perspectives on perfectionism as multidimensional (Hewitt et al., 2003; Smith et al., 2022). This study theorised that, if relevant multidimensional perfectionism measures performed differently, this might endorse multidimensionality of perfectionism in EDs. Ostensibly corroborating unidimensional perfectionism as transdiagnostic in EDs (Shafran et al., 2003), all multidimensional perfectionism measures discriminated some ED diagnoses from HVs. Yet, the measures demonstrated differing discriminative abilities between specific diagnoses. *FMPS* was notably limited in differentiating between EDs and HVs, while *Mistakes Reactivity* distinguished all EDs from HVs. Moreover, *High Standards* and *Appearance Perfectionism* were notably more powerful in discriminating between ED diagnoses. These differences affirm the relevance of multiple, thematically contrasting perfectionism dimensions in EDs.

4.1.2.2. Measures

Most measures failed to discriminate ED diagnoses from each other. Weaker results seemed to stem from limitations in measures. Perfectionism measures developed with non-clinical populations appeared disadvantaged with EDs. Even *Appearance Perfectionism*, with greatest thematic relevance, failed to distinguish BED from AN or BN. Ceiling effects invite recalibration of these measures with greater sensitivity at their higher ends. Additional items or Likert-points could accommodate extreme perfectionist experiences. *High Standards* – with items distilled through ED-research and calibrated with correlates including depression (Fairchild & Cooper, 2010) – demonstrated this advantage. Moreover, despite ostensible similarities between *High Standards* and *FMPS Personal Standards*, their differing success suggests semantic nuances differ and matter in multidimensional perfectionism.

4.1.2.3. Diagnoses

Enhancing multidimensional perfectionism measures will refine insights into differential roles of perfectionism dimensions across EDs—as demonstrated in recent research (Barber et al., 2025). As predicted, *High Standards* was higher in AN than other EDs, suggesting this type of perfectionism may be most relevant to AN (Dahlenburg et al., 2019). However, *Parental Expectations* appeared significantly highest in BN: suggesting a different type of perfectionism may be associated with BN. Finally, it was noteworthy that several measures had significantly higher scores in BED than HVs – given perfectionism has been less strongly associated with BED (Vicent et al., 2023). Overall, identifying diagnostic groups facilitated nuanced understanding: whereby some perfectionism measures differentiated ED groups (including *High Standards*), while other measures (including *FMPS*) could not.

4.2. Exploratory questions

Positive primary findings from categorical hypotheses supported more speculative, dimensional explorations—focussing on *High Standards* and *Appearance Perfectionism*.

4.2.1. Addressing hypotheses

As hypothesised, *Appearance Perfectionism* added significant predictive power beyond *FMPS* subscales and covariates—despite depression and anxiety often correlating with perfectionism (Suh et al., 2024). That said, *FMPS* subscales added relatively little unique explanation of symptoms beyond covariates. Moreover, *Personal Standards* did not emerge a unique predictor – and only *Organisation* retained significance once *Appearance Perfectionism* was added. Finally, contrary to hypotheses, *High Standards* failed to contribute beyond covariates and *FMPS*.

4.2.2. Interpretations

While Hatoum et al. (2022) found *High Standards* unsuccessful in predicting ED symptomology, this study hypothesised their finding stemmed from non-clinical samples. Given support for this was found – with *High Standards* discriminating well between ED groups – it was surprising that it still failed to predict ED symptoms in the regression. This is, however, consistent with Fairchild and Cooper (2010), who found *High Standards* the only *ED-CBQ* subscale without convergent validity with ED symptoms. Notably, they used the *Eating Attitudes Test-26* (Garner et al., 1982) rather than *EDE-Q* as a symptom measure; yet, akin to this study, *High Standards* did significantly predict ED diagnosis within discriminant function analyses (2010). *High Standards* therefore seems to be meaningful in establishing differences between ED types, but not their severity. In contrast, *FMPS* appears less effective in differentiating ED diagnoses, but more significantly correlated with the severity of those disorders.

4.3. Limitations

Several data limitations are referenced above, including with perfectionism measures. Results were not necessarily representative of wider populations, given likely overrepresentation of young, white, and female participants. HV samples also appeared more perfectionistic and ED-symptomatic than general populations. Sample biases may be explained by recruiting predominantly from social media. Recruitment materials emphasising 'perfectionism research' may have attracted particularly perfectionistic respondents. Indeed, the sudden, sizeable influx of participants beyond anticipated parameters suggested perfectionism might have exerted notable interest. Similarly, dissemination of these materials predominantly via ED and 'health' influencers may have reached HVs with recovered EDs as well as those with supernormal (albeit subclinical) symptomology. Historically, there have been concerns with compromised diagnostic validity of online samples compared to recruiting from clinical settings with confirmed diagnoses (Quagan et al., 2021). Moreover, assigning diagnoses from EDDS scores can be less robust than clinical interviews (Maguen et al., 2024). However, acceptability of virtual recruitment is growing (Iflaifel et al., 2023) – and the *EDDS* has demonstrated clinical accuracy in diagnosing EDs (Krabbenborg et al., 2012). Finally, being correlational, exploratory findings should be interpreted cautiously. Vulnerability–stress models of EDs (Cooper et al., 2005) suggest complex, non-linear relationships between individual symptom profiles and diagnostic thresholds – which require better understanding.

4.4. Future research

This study highlights several promising measures for understanding multidimensional perfectionism in EDs that might benefit from further investigation: including how perfectionism dimensions differ across EDs diagnoses, and how different measures relate to severity of ED symptoms. Moreover, while limited research has discerned general characteristic differences between ED groups, significant between-group differences in

perfectionism suggest this paucity may stem from limitations in measures. Future investigations might benefit from adaptations to existing perfectionism measures, as current ceiling effects may limit their usefulness in ED treatment and research – such as refining item difficulty or increasing scale sensitivity at higher trait levels. Improved sensitivity could enhance their translational utility for EDs—and other MHPs associated with perfectionism, including depression (Suh et al., 2024).

Finally, this study contributes evidence for perfectionism operating multidimensionally in EDs. Different perfectionism types were observed to perform differently across EDs, including with varying discriminative power. It therefore seems fruitful for ED research and treatment to continue assessing perfectionism as multidimensional. This could include scrutinising perfectionism in subclinical and recovered samples – as well as in other clinical ED groups, such as atypical AN, which were highly represented in excluded diagnoses for this study (Appendix P). Altogether, a unidimensional measure may not suffice to yield robust, evolving insights into nuanced perfectionism profiles across distinct ED diagnoses, and may limit treatment development.

References

Aardoom, J. J., Dingemans, A. E., Slof Op't Landt, M. C. T., & Van Furth, E. F. (2012). Norms and discriminative validity of the Eating Disorder Examination Questionnaire (EDE-Q). *Eating Behaviors*, *13*(4), 305–309. https://doi.org/10.1016/j.eatbeh.2012.09.002

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies. *Archives of General Psychiatry*, *68*(7), 724–731. https://doi.org/10.1001/archgenpsychiatry.2011.74

Barber, K. E., Ralph-Nearman, C., Hooper, M. A., Glatt, S., Han, Y., & Levinson, C. A. (2025). Dimensions of perfectionism in subtypes of anorexia nervosa, atypical anorexia nervosa, and bulimia nervosa. E*ating Behaviors, 48*, 101986. https://doi.org/10.1016/j.eatbeh.2025.101986

Barnett, V. & Lewis, T. (1994). *Outliers in statistical data* (3rd ed). Wiley.

Beck, A. T., & Freeman, A. M. (1990). *Cognitive therapy of personality disorders*. Guilford Press.

Bergh, C., Callmar, M., Danemar, S., Hölcke, M., Isberg, S., Leon, M., Lindgren, J., Lundqvist, Å., Niinimaa, M., Olofsson, B., Palmberg, K., Pettersson, A., Zandian, M., Åsberg, K., Brodin, U., Maletz, L., Court, J., Iafeta, I., Björnström, M., … Södersten, P. (2013). Effective treatment of eating disorders: Results at multiple sites. *Behavioral Neuroscience*, *127*, 878–889. https://doi.org/10.1037/a0034921

Burton, A. L., & Abbott, M. J. (2019). Processes and pathways to binge eating: Development of an integrated cognitive and behavioural model of binge eating. *Journal of Eating Disorders*, *7*(1), 18. https://doi.org/10.1186/s40337-019-0248-0

Carpinelli, L., & Watzlawik, M. (2023). Anorexia Nervosa in Adolescence: Parental Narratives Explore Causes and Responsibilities. *International Journal of Environmental Research and Public Health*, *20*(5), 4075. https://doi.org/10.3390/ijerph20054075

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, *13*(2), 153–160. https://doi.org/10.1002/wps.20128

Coffino, J. A., Udo, T., & Grilo, C. M. (2019). Rates of Help-Seeking in US Adults With Lifetime DSM-5 Eating Disorders: Prevalence Across Diagnoses and Differences by

Sex and Ethnicity/Race. *Mayo Clinic Proceedings*, *94*(8), 1415–1426. https://doi.org/10.1016/j.mayocp.2019.02.030

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Erlbaum Associates. https://doi.org/10.4324/9780203771587

Cooper, M. (2012). Cognitive Behavioural Models in Eating Disorders. In *Eating and its Disorders*. https://doi.org/10.1002/9781118328910.ch15

Cooper, M. J., Rose, K. S., & Turner, H. (2005). Core beliefs and the presence or absence of eating disorder symptoms and depressive symptoms in adolescent girls. *International Journal of Eating Disorders*, *38*(1), 60–64. https://doi.org/10.1002/eat.20157

Cooper, M. J., Wells, A., & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology*, *43*(1), 1–16. https://doi.org/10.1348/014466504772812931

Dahlenburg, S. C., Gleaves, D. H., & Hutchinson, A. D. (2019). Anorexia nervosa and perfectionism: A meta-analysis. *International Journal of Eating Disorders*, *52*(3), 219–229. https://doi.org/10.1002/eat.23009

Davidson, R., & MacKinnon, J. (2000). Bootstrap tests: How many bootstraps? *Econometric Reviews*, *19*(1), 55–68.

Dickie, L., Surgenor, L. J., Wilson, M., & McDowall, J. (2012). The structure and reliability of the Clinical Perfectionism Questionnaire. *Personality and Individual Differences*, *52*(8), 865–869. https://doi.org/10.1016/j.paid.2012.02.003

Egan, S. J., Shafran, R., Lee, M., Fairburn, C. G., Cooper, Z., Doll, H. A., Palmer, R. L., & Watson, H. J. (2016). The Reliability and Validity of the Clinical Perfectionism Questionnaire in Eating Disorder and Community Samples. *Behavioural and Cognitive Psychotherapy*, *44*(1), 79–91. https://doi.org/10.1017/S1352465814000629

Fairburn, C., & Beglin, S. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders*, *16*(4). https://ora.ox.ac.uk/objects/uuid:1e0d1278-a487-4198-a6c6-fd351d36dbc7

Fairburn, C. G., & Beglin, S. J. (2008). Eating Disorder Examination Questionnaire (6.0). In Fairburn, C. G. (Ed.), *Cognitive Behavior Therapy and Eating Disorders.* New York: Guilford Press.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. Guilford Press.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/S0005-7967(02)00088-8

Fairchild, H., & Cooper, M. (2010). A multidimensional measure of core beliefs relevant to eating disorders: Preliminary development and validation. *Eating Behaviors*, *11*(4), 239–246. https://doi.org/10.1016/j.eatbeh.2010.05.004

Field, A. P. (2004). *Discovering statistics using SPSS for Windows* (2nd ed.). SAGE Publications.

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

Frost, R. O., & Marten, P. A. (1990). Perfectionism and evaluative threat. *Cognitive Therapy and Research*, *14*, 559–572. https://doi.org/10.1007/BF01173364

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

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000–2018 period: A systematic literature review. *The American Journal of Clinical Nutrition*, *109*(5), 1402–1413. https://doi.org/10.1093/ajcn/nqy342

Gavino, A., Nogueira, R., Pérez-Costillas, L., & Godoy, A. (2019). Psychometric Properties of the Frost Multidimensional Perfectionism Scale in Spanish Children and Adolescents. *Assessment*, *26*(3), 445–464. https://doi.org/10.1177/1073191117740204

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: Psychometric features and clinical correlates. *Psychological Medicine, 12*(4), 871–878. https://doi.org/10.1017/S0033291700049163.

Gül, E. S., Yılmaz, A., & Berksun, O. (2009). Mükemmeliyetçiliğin depresyon, antidepresana yanit ve intihar düşüncesi ile ilişkisi [The association of perfectionism with depression, antidepressant medication response and suicidal ideation]. *Klinik Psikofarmakoloji Bülteni / Bulletin of Clinical Psychopharmacology, 19*(1), 48–54.

Hahs-Vaughn, D. (2016). Applied Multivariate Statistical Concepts. In *Applied Multivariate Statistical Concepts*. https://doi.org/10.4324/9781315816685

Hatoum, A. H., Burton, A. L., & Abbott, M. J. (2022). Assessing negative core beliefs in eating disorders: Revision of the Eating Disorder Core Beliefs Questionnaire. *Journal of Eating Disorders*, *10*(1), 18. https://doi.org/10.1186/s40337-022-00542-9

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of*

Personality and Social Psychology, *60*, 456–470. https://doi.org/10.1037/0022-3514.60.3.456

Hewitt, P. L., Flett, G. L., Besser, A., Sherry, S. B., & McGee, B. (2003). Perfectionism Is Multidimensional: A reply to Shafran, Cooper and Fairburn (2002). *Behaviour Research and Therapy*, *41*(10), 1221–1236. https://doi.org/10.1016/S0005-7967(03)00021-4

Hewitt, P. L., Flett, G. L., Turnbull-Donovan, W., & Mikail, S. F. (1991). The Multidimensional Perfectionism Scale: Reliability, validity, and psychometric properties in psychiatric samples. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *3*, 464–468. https://doi.org/10.1037/1040-3590.3.3.464

Howell, D. C. (2010). *Statistical methods for psychology* (7th ed.). Wadsworth.

Huberty, C. J., & Morris, J. D. (1989). Multivariate analysis versus multiple univariate analyses. *Psychological Bulletin*, *105*(2), 302–308. https://doi.org/10.1037/0033-2909.105.2.302

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Iflaifel, M., Hall, C. L., Green, H. R., Willis, A., Rennick-Egglestone, S., Juszczak, E., Townsend, M., Martin, J., & Sprange, K. (2023). Widening participation – recruitment methods in mental health randomised controlled trials: A qualitative study. *BMC Medical Research Methodology*, *23*(1), 211. https://doi.org/10.1186/s12874-023-02032-1

Jones, C., Leung, N., & Harris, G. (2007). Dysfunctional Core Beliefs in Eating Disorders: A Review. *Journal of Cognitive Psychotherapy*, *21*(2), 156–171. https://doi.org/10.1891/088983907780851531

Kehayes, I.-L. L., Smith, M. M., Sherry, S. B., Vidovic, V., & Saklofske, D. H. (2019). Are perfectionism dimensions risk factors for bulimic symptoms? A meta-analysis of longitudinal studies. *Personality and Individual Differences*, *138*, 117–125. https://doi.org/10.1016/j.paid.2018.09.022

Kiani-Sheikhabadi, M., Beigi, M., & Mohebbi-Dehnavi, Z. (2019). The relationship between perfectionism and body image with eating disorder in pregnancy. *Journal of Education and Health Promotion*, *8*, 242. https://doi.org/10.4103/jehp.jehp_58_19

Krabbenborg, M. A., Danner, U. N., Larsen, J. K., van der Veer, N., van Elburg, A. A., de Ridder, D. T., Evers, C., Stice, E., & Engels, R. C. (2012). The Eating Disorder Diagnostic Scale: psychometric features within a clinical population and a cut-off point

to differentiate clinical patients from healthy controls. *European Eating Disorders Review: The journal of the Eating Disorders Association, 20(4)*, 315–320. https://doi.org/10.1002/erv.1144

Kroenke, K., Strine, T. W., Spitzer, R. L., Williams, J. B. W., Berry, J. T., & Mokdad, A. H. (2009). The PHQ-8 as a measure of current depression in the general population. *Journal of Affective Disorders*, *114*(1–3), 163–173. https://doi.org/10.1016/j.jad.2008.06.026

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

Maguen, S., Batten, A., Siegel, S. E., Huggins, J., Snow, J. L., Fenn, L. M., Dick, A. M., Zenteno, C., West, A. C., & Masheb, R. M. (2024). Validation of the EDDS-5 self-report survey against the SCID-5 diagnostic interview in US veterans. *Eating Behaviors, 52,* 101846. https://doi.org/10.1016/j.eatbeh.2024.101846

Mitchison, D., Touyz, S., González-Chica, D. A., Stocks, N., & Hay, P. (2017). How abnormal is binge eating? 18-Year time trends in population prevalence and burden. *Acta Psychiatrica Scandinavica*, *136*(2), 147–155. https://doi.org/10.1111/acps.12735

Mond, J. M., Hay, P. J., Rodgers, B., Owen, C., & Beumont, P. J. V. (2004). Validity of the Eating Disorder Examination Questionnaire (EDE-Q) in screening for eating disorders in community samples. *Behaviour Research and Therapy*, *42*(5), 551–567. https://doi.org/10.1016/S0005-7967(03)00161-X

Olson, C. L. (1976). On choosing a test statistic in multivariate analysis of variance. *Psychological Bulletin*, *83*(4), 579–586. https://doi.org/10.1037/0033-2909.83.4.579

Pacht, A. R. (1984). Reflections on perfection. *American Psychologist*, *39*(4), 386–390. https://doi.org/10.1037/0003-066X.39.4.386

Pallant, J. (2007). *SPSS survival manual: A step by step guide to data analysis using SPSS for Windows* (3rd ed.). Open University Press.

PhenX Toolkit. *The Eating Disorder Diagnostic Scale (EDDS-5) for the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5).* Retrieved November 4, 2023 from: https://phenxtoolkit.org/protocols/view/120602

Philipp, J., Truttmann, S., Zeiler, M., Franta, C., Wittek, T., Schöfbeck, G., Mitterer, M., Mairhofer, D., Zanko, A., Imgart, H., Auer-Welsbach, E., Treasure, J., Wagner, G., & Karwautz, A. F. K. (2020). Reduction of High Expressed Emotion and Treatment

Outcomes in Anorexia Nervosa—Caregivers' and Adolescents' Perspective. *Journal of Clinical Medicine*, *9*(7), 2021. https://doi.org/10.3390/jcm9072021

Pugh, M. (2015). A narrative review of schemas and schema therapy outcomes in the eating disorders. *Clinical Psychology Review*, *39*, 30–41. https://doi.org/10.1016/j.cpr.2015.04.003

Quagan, B., Woods, S. W., & Powers, A. R. (2021). Navigating the Benefits and Pitfalls of Online Psychiatric Data Collection. *JAMA Psychiatry, 78(11)*, 1185–1186. https://doi.org/10.1001/jamapsychiatry.2021.2315

Sand, L., Bøe, T., Shafran, R., Stormark, K. M., & Hysing, M. (2021). Perfectionism in Adolescence: Associations With Gender, Age, and Socioeconomic Status in a Norwegian Sample. *Frontiers in Public Health, 9*, 688811. https://doi.org/10.3389/fpubh.2021.688811

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

Shafran, R., Cooper, Z., & Fairburn, C. G. (2003). 'Clinical perfectionism' is not 'multidimensional perfectionism': A reply to Hewitt, Flett, Besser, Sherry & McGee. *Behaviour Research and Therapy*, *41*, 1217–1220. https://doi.org/10.1016/S0005-7967(03)00020-2

Smith, A. R., Velkoff, E. A., Ribeiro, J. D., & Franklin, J. (2019). Are Eating Disorders and Related Symptoms Risk Factors for Suicidal Thoughts and Behaviors? A Meta-analysis. *Suicide and Life-Threatening Behavior*, *49*(1), 221–239. https://doi.org/10.1111/sltb.12427

Smith, M. M., Sherry, S. B., Gautreau, C. M., Stewart, S. H., Saklofske, D. H., & Mushquash, A. R. (2017). Are perfectionistic concerns an antecedent of or a consequence of binge eating, or both? A short-term four-wave longitudinal study of undergraduate women. *Eating Behaviors*, *26*, 23–26. https://doi.org/10.1016/j.eatbeh.2017.01.001

Smith, M. M., Sherry, S. B., Ge, S. Y. J., Hewitt, P. L., Flett, G. L., & Baggley, D. L. (2022). Multidimensional perfectionism turns 30: A review of known knowns and known unknowns. *Canadian Psychology / Psychologie Canadienne*, *63*, 16–31. https://doi.org/10.1037/cap0000288

Somerville, K., & Cooper, M. (2007). Using imagery to identify and characterise core beliefs in women with bulimia nervosa, dieting and non-dieting women. *Eating Behaviors*, *8*(4), 450–456. https://doi.org/10.1016/j.eatbeh.2006.12.004

Sonneville, K. R., & Lipson, S.K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders, 51(6)*, 518–26. https://doi.org/10.1002/eat.22846

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Stackpole, R., Greene, D., Bills, E., & Egan, S. J. (2023). The association between eating disorders and perfectionism in adults: A systematic review and meta-analysis. *Eating Behaviors, 50*, 101769. https://doi.org/10.1016/j.eatbeh.2023.101769

Stairs, A. M., Smith, G. T., Zapolski, T. C. B., Combs, J. L., & Settles, R. E. (2012). Clarifying the Construct of Perfectionism. *Assessment*, *19*(2), 146–166. https://doi.org/10.1177/1073191111411663

Steele, A. L., O'Shea, A., Murdock, A., & Wade, T. D. (2011). Perfectionism and its relation to overevaluation of weight and shape and depression in an eating disorder sample. *International Journal of Eating Disorders*, *44*(5), 459–464. https://doi.org/10.1002/eat.20817

Stice, E., Telch, C. F., & Rizvi, S. L. (2000). Development and validation of the Eating Disorder Diagnostic Scale: A brief self-report measure of anorexia, bulimia, and binge-eating disorder. *Psychological Assessment*, *12*, 123–131. https://doi.org/10.1037/1040-3590.12.2.123

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

Stöber, J., & Damian, L. E. (2014). The Clinical Perfectionism Questionnaire: Further evidence for two factors capturing perfectionistic strivings and concerns. *Personality and Individual Differences*, *61–62*, 38–42. https://doi.org/10.1016/j.paid.2014.01.003

Stöber, J., & Otto, K. (2006). Positive Conceptions of Perfectionism: Approaches, Evidence, Challenges. *Personality and Social Psychology Review*, *10*, 295–319. https://doi.org/10.1207/s15327957pspr1004_2

Stöber, J., & Yang, H. (2015). Physical appearance perfectionism explains variance in eating disorder symptoms above general perfectionism. *Personality and Individual Differences*, *86*, 303–307. https://doi.org/10.1016/j.paid.2015.06.032

Suh, H., Liou, P.-Y., Jeong, J., & Kim, S. Y. (2024). Perfectionism, Prolonged Stress Reactivity, and Depression: A Two-Wave Cross-Lagged Analysis. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *42*(1), 54–68. https://doi.org/10.1007/s10942-022-00483-x

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53–55.

Terry-Short, L. A., Owens, R. G., Slade, P. D., & Dewey, M. E. (1995). Positive and negative perfectionism. *Personality and Individual Differences*, *18*(5), 663–668. https://doi.org/10.1016/0191-8869(94)00192-U

Udo, T., & Grilo, C. M. (2018). Prevalence and Correlates of DSM-5-Defined Eating Disorders in a Nationally Representative Sample of U.S. Adults. *Biological Psychiatry*, *84*(5), 345–354. https://doi.org/10.1016/j.biopsych.2018.03.014

Van Voorhis, C. R. W., & Morgan, B. L. (2007). Understanding Power and Rules of Thumb for Determining Sample Sizes. *Tutorials in Quantitative Methods for Psychology*, *3*(2), 43–50. https://doi.org/10.20982/tqmp.03.2.p043

Vervaet, M., Puttevils, L., Hoekstra, R. H. A., Fried, E., & Vanderhasselt, M.-A. (2021). Transdiagnostic vulnerability factors in eating disorders: A network analysis. *European Eating Disorders Review*, *29*(1), 86–100. https://doi.org/10.1002/erv.2805

Vicent, M., Gonzálvez, C., Quiles, M. J., & Sánchez-Meca, J. (2023). Perfectionism and binge eating association: A systematic review and meta-analysis. *Journal of Eating Disorders*, *11*(1), 101. https://doi.org/10.1186/s40337-023-00817-9

Wade, T. D., O'Shea, A., & Shafran, R. (2016). Perfectionism and Eating Disorders. In F. M. Sirois & D. S. Molnar (Eds.), *Perfectionism, Health, and Well-Being* (pp. 205–222). Springer International Publishing. https://doi.org/10.1007/978-3-319-18582-8_9

Waller, G. (2003). Schema-level cognitions in patients with binge eating disorder: A case control study. *International Journal of Eating Disorders*, *33*(4), 458–464. https://doi.org/10.1002/eat.10161

Waller, G., Kennerley, H., & Ohanian, V. (2007). Schema-Focused Cognitive-Behavioral Therapy for Eating Disorders. In *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide* (pp. 139–175). American Psychological Association. https://doi.org/10.1037/11561-007

Winkler, L. A.-D., Christiansen, E., Lichtenstein, M. B., Hansen, N. B., Bilenberg, N., & Støving, R. K. (2014). Quality of life in eating disorders: A meta-analysis. *Psychiatry Research*, *219*(1), 1–9. https://doi.org/10.1016/j.psychres.2014.05.002

Woodfin, V., Binder, P.-E., & Molde, H. (2020). The Psychometric Properties of the Frost Multidimensional Perfectionism Scale—Brief. *Frontiers in Psychology*, *11*, 1860. https://doi.org/10.3389/fpsyg.2020.01860

Woolrich, R. A., Cooper, M. J., & Turner, H. M. (2006). A Preliminary Study of Negative Self-Beliefs in Anorexia Nervosa: A Detailed Exploration of Their Content, Origins and Functional Links to "Not Eating Enough" and Other Characteristic Behaviors. *Cognitive Therapy and Research*, *30*(6), 735–748. https://doi.org/10.1007/s10608-006-9024-y

Wu, Y., Levis, B., Riehm, K. E., Saadat, N., Levis, A. W., Azar, M., Rice, D. B., Boruff, J., Cuijpers, P., Gilbody, S., Ioannidis, J. P. A., Kloda, L. A., McMillan, D., Patten, S. B., Shrier, I., Ziegelstein, R. C., Akena, D. H., Arroll, B., Ayalon, L., … Thombs, B. D. (2020). Equivalency of the diagnostic accuracy of the PHQ-8 and PHQ-9: A systematic review and individual participant data meta-analysis. *Psychological Medicine*, *50*(8), 1368–1380. https://doi.org/10.1017/S0033291719001314

Yang, H., & Stöber, J. (2012). The Physical Appearance Perfectionism Scale: Development and preliminary validation. *Journal of Psychopathology and Behavioral Assessment*, *34*, 69–83. https://doi.org/10.1007/s10862-011-9260-7

Young, E., & Cooper, M. (2013). Applying a cognitive model to binge eating in a female community sample. *Eating Behaviors*, *14*(3), 295–298. https://doi.org/10.1016/j.eatbeh.2013.05.012

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.

Executive Summaries

Systematic Review of the Literature

Eating disorders impact heavily on many people's lives. Treatments for eating disorders still need improving. Research into this issue often looks at perfectionist personality traits in people with eating disorders. Recent reviews of this research have only focused on quantitative (statistical) studies. There is no review of all the qualitative studies on perfectionism in eating disorders (studies using interviews and verbal material from participants). This paper aimed to address this gap by using a review of the qualitative studies to address uncertainties left by quantitative research: including whether, and how, perfectionism might have multiple, distinct (multidimensional) manifestations.

As a systematic review, the project devised search terms to capture all studies that were about eating disorders, about perfectionism, and (at least partly) qualitative. These terms were inputted into seven databases. This produced 657 studies (once duplicates were removed). One researcher (SK) read all titles and abstracts (summaries) of these papers, keeping relevant studies and deleting the others. A second researcher (JL) screened a proportion of these, to check there was enough agreement. With 74 studies remaining, the first researcher read all full texts to retain relevant papers and remove the rest. Again, a second researcher screened a proportion to check agreement. With the final selection of 22 studies, the researcher rated the quality of these papers based on established criteria (and the other researcher rated a proportion). Then, the researcher captured the relevant parts of the results and discussions of these studies and reproduced them separately. The researcher annotated these findings with 'codes' (labels describing different ideas or metaphors), and the second researcher reviewed a proportion of these too. Finally, the researcher organised these codes into different 'themes' (recurring patterns of codes) – and discussed and tweaked these with the third researcher (MC).

This process produced 15 themes, which described different ways that perfectionism and eating disorders affected people's lives, and each other. These themes all grouped into three main themes: which told a story of how people became perfectionistic in the first place; how being perfectionists eventually led people to develop eating disorders; how different forms of perfectionism in people's lives kept their eating disorders going; how people sometimes began to realise that being perfect was a never-ending quest; how perfectionism got in the way of some people trying to shake off their eating disorders; how perfectionism helped other people to perfect their recovery; and how, eventually, some tried to leave perfectionism itself behind.

These themes are in line with what much of the quantitative research shows. This includes models of therapy that think about how eating disorders can develop, carry on, be disrupted. It also supports researchers who argue that perfectionism has many dimensions in eating disorders. This raises questions about therapies for eating disorders, which may use an overly general idea of perfectionism. Future research could test whether therapy for eating disorders and for perfectionism get better results if these nuances are accounted for.

Service Improvement Project

There are more and more older people in the world facing mental health difficulties. NHS services should use a variety of ways of helping older people and their families. Supporting older people alongside their partners or adult children is particularly recommended. Systemic family therapy is well suited to this end because it supports mental health by working with family relationships. There is not much concrete evidence yet for how well family therapy works with older people, so more attention is needed. This NHS community mental health service for older people launched a Clinic that gives family therapy. It needs to be assessed on how well it is working for clients using it and for NHS colleagues who interact with it.

A group interview with multiple staff members was held to ask about their experiences of referring clients to the Clinic so far and any ideas for improving the Clinic. Individual interviews were also held separately with clients who had already had therapy in the Clinic. These interviews included each client and their partner or adult child who had attended the therapy with them. The group staff interview and the client interviews were analysed as two separate data sets, looking for common themes (of experiences and ideas) in each group.

The interviews showed that staff and older people who had received family therapy both felt positively towards the Clinic. Staff members who had recommended clients to the Clinic felt that it had benefitted the lives of these older people. All staff members also expressed a lot of interest in learning more about family therapy, and about how to get better at judging who they should recommend to the Clinic. Clients, meanwhile, expressed deep appreciation for the therapy they had done and for the therapist they had done it with. They also shared some ideas for improving the Clinic, such as making the goals of the therapy clearer and making the end of therapy easier to go through.

This report therefore suggested some recommendations for improving the Clinic. These recommendations included sharing some educational materials for staff to read about the Clinic and referring clients to it, and inviting staff to some meetings where they could learn more about family therapy. It was also recommended that staff who had referred an older client to the Clinic could join a therapy session to support that client. Recommendations for the therapy itself included having more clarity around the nature of family therapy and what its goals could be, and checking in more often with how clients are finding the therapy – especially its ending. These recommendations were welcomed by the service, and plans were made for implementing them.

Theoretically Driven Research Project

Understanding how people's eating disorders start and carry on is crucial for helping people recover. Research has shown that understanding people's deeply held beliefs about themselves can be relevant and important for treatment. One such set of beliefs relates to perfectionism: that is, holding extremely high standards and berating oneself for not achieving them. It is not fully clear yet how exactly perfectionistic beliefs relate to eating disorders, as studies so far have diverged in how this is measured, and what they have found. One recent study tested a questionnaire that was created for finding out the core beliefs of people with eating disorders, and it found that the questions about having high standards were not showing clear relationships with eating disorders. In this study, we wanted to find out more about how these 'high standards' questions and other questionnaires about perfectionism relate to eating disorders. We are especially interested in whether people with certain eating disorder diagnoses seem to be more perfectionistic or have different types of perfectionism. For this, we wanted to look at anorexia, bulimia, and binge eating. We are also interested in whether any of the questionnaires do better than others in explaining people's eating disorder symptoms. For this, we gave people questionnaires related to eating disorders and to perfectionism, and looked at how their questionnaire scores related perfectionism to different eating disorder diagnoses and to their levels of symptoms.

We expected high standards to feature more in all eating disorders than in people with no eating disorder, but we found that this was only the case in anorexia. High standards were still a good way of telling between different types of eating disorders. Meanwhile, a questionnaire on how much people worry about making mistakes was not so good at telling between eating disorder types, but it was higher in all eating disorders than in people without eating disorders. Moreover, a questionnaire on perfectionism about one's appearance was much higher in people with eating disorders, and surprisingly highest in bulimia. Lastly, general measures of perfectionism were only able to tell between people with no eating disorders and people with anorexia. When we related the perfectionism questionnaires to eating disorder symptoms, we found that appearance perfectionism was good at predicting who had more disordered eating, and general perfectionism questionnaires were quite good too. We were surprised to see that our high standards questionnaire could not predict levels of disordered eating at all. This made us wonder whether the relationship between disordered eating and qualifying for different eating disorder diagnoses is not straightforward. We concluded that looking at high standards is a useful way of telling if someone would have an eating disorder, and that other perfectionism questionnaires were important too, but needed to be adapted to work better for people with eating disorders.

Connecting Narrative

1. Common threads

The projects in this portfolio are tied by common threads. More conspicuous threads include the domains of perfectionism and eating disorders (EDs) that connect the theoretically driven research project (TDRP) and systematic review of the literature (SRL). Other threads are subtler. All three papers reflect clinical knowledge and research skills that I had wished to hone ahead of pursuing this doctorate: including Systemic family therapy; perfectionism models; qualitative syntheses; and statistical methods. Adopting first-person language (for the first time in this thesis) invites an emotional posture of reflexivity (Fredman, 2007), exemplified by Systemic reflective-writing practices (White, 1997). I will trace, self-reflexively, the common thematic threads interweaving these projects – and my identity within clinical psychology.

2. Exploring perfectionism

On reflection, I see that the roots of this thesis run deep. Wanting to be a clinical psychologist since receiving cognitive-behavioural therapy (CBT) from an extraordinary therapist, Mohammed M., I became particularly fascinated with Roz Shafran's formulation of perfectionism, on which our CBT drew. While converting to psychological sciences at University College London (UCL), I was intrigued to hear Roz lecture on perfectionism and, later, to join her on a CBT podcast on perfectionism. I felt motivated to transition from 'expertise by experience' to expertise through research.

Undertaking this thesis at Oxford (not UCL), I brought to Myra Cooper a naïvely undefined, atheoretical interest in perfectionism. Conversations with Myra oriented me in scrutinising and operationalising specific aspects of CBT models as the mode of innovating them. That is, Myra encouraged me to clarify which components, and models, of perfectionism we wished to explore. We became alive to the theoretical and empirical debates proliferating since the outset of Roz's clinical perfectionism (Hewitt et al., 2003; Shafran et al., 2003)

between proponents of multidimensional versus unidimensional perfectionism (Dickie et al., 2012; Stoeber & Damian, 2014). Roz and colleagues emphasise translational utility and clinical treatment evidence (Shafran et al., 2023), with few therapies based on multidimensional perfectionism, and fewer reporting much clinical impact (Smith, 2022). Yet, I learned to conceptualise CBT models such as Roz's within their theoretical contexts. We noted that a recent meta-analysis found Roz and colleagues' CBT for perfectionism (CBT-P) limited in efficacy (Smith et al., 2023a), which advocated further research and adaptation of CBT-P to seemingly treatment-resistant dimensions.

Reading Roz and colleagues' questioning the quality of this meta-analysis (Egan et al., 2023), and the multidimensional proponents then replicating their findings (Smith et al., 2023b), I learned how nuanced, and charged, such debates can be. Smith et al. (2022, 2023b) invited more modular, person-centred treatment options for varied perfectionism presentations—inspiring our phenomenological focus on Myra's domain of expertise: EDs.

3. Theoretically driven research project

This TDRP felt formative in my training. Having specialised in qualitative methodology as a research assistant (e.g., Keen et al., 2022), quantitative methods felt abstract and daunting. The objective of testing prevailing interventions was familiar; yet, where I had previously probed pain neuroscience education using qualitative interviewing (Keen et al., 2021), this TDRP grounded me in operationalising more granular, quantitative approaches. Studying nuances of statistical method choices and assumptions-testing showed me how, akin to qualitative debates (e.g., O'Connor & Joffe, 2020), quantitative analyses carry their own subjectivities and uncertainties. This helped me to question positivist epistemologies as potentially more constructivist and inflected by researcher biases than often purported (Harding, 1994).

4. Systematic literature review

The SRL was differently rewarding: allowing us to approach perfectionism-dimensionality questions from another angle. Quantitative questions became qualitative, granular methods became overarching. This allowed me to consolidate and extend my thematic analysis skills: in practising thematic synthesis. These methodologies felt aligned with my preferred epistemology, harnessing social constructionist reflexivity on researcher positionality. That said, although I respected Oxford doctoral requirements, accommodating expectations such as intercoder rating felt uncomfortably incongruent with most epistemological premises of thematic analysis (Braun & Clarke, 2022).

Publication processes for this SRL were particularly instructive. Inviting critical scrutiny from seven academics (three peer-reviewers, a journal editor, and now, my two viva examiners) oriented me to the scientific value of ensuring every research decision was intentional and defensible. That said, accommodating some reviewer comments created further epistemological complications. Requests, for instance, to quantify the thematic analyses through demographic trend-seeking prompted me to reflect further on the dominance of positivist postures across clinical and research contexts.

5. Service improvement project

The service improvement project was distinct from my other projects with respect to populations and phenomena under investigation. Yet, it still encapsulated the core learning I sought from this doctoral training: a valuable nexus between research skills and clinical practice. Systemic family therapy is my primary clinical passion, and I was privileged to undertake the Systemic Intermediate training as part of my doctorate. EDs are foundational to early Systemic family theory (Minuchin et al., 1978), so I am surprised never to have managed to work with EDs clinically. Yet, being able to harness research techniques to improve a clinic in which I was working, and which I admired, reinforced the privilege of clinical psychologists' dual roles. Indeed, being supervised on the project by Kathryn Evans – the clinic lead and my course tutor – showed me how heterogeneous and rewarding professional relationships within

this vocation can be. Kathryn embodied to me how being a skilful therapist and researcher can intersect – in the spirit of scientist-practitioner models – in service of our clients.

Moreover, as the older-adult Systemic evidence base is notably slimmer than the expansive literature to which my perfectionism research was speaking, it felt translationally valuable to contribute new insights. Most rewarding was disseminating these insights to our service – witnessing how research findings might take hold in practice.

6. Final reflections

Finally, as I value deconstructing false boundaries between 'the sick and well' (Foucault, 1963), I have been reflecting on how this thesis might reflect on me. Noticing how perfectionistic I became, cognitively and behaviourally, in preparing this manuscript – visualising the viva, anticipating revisions – I recalled that I am ever a co-clinician and co-client, co-researcher and co-participant (McGinn et al., 2008).

References

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health, 24(1)*, 1–6.

Dickie, L., Surgenor, L. J., Wilson, M., & McDowall, J. (2012). The structure and reliability of the Clinical Perfectionism Questionnaire. *Personality and Individual Differences*, *52*(8), 865–869.

Egan, S. J., Wade, T. D., Watson, H. J., Öst, L.-G., Cuijpers, P., & Shafran, R. (2023). Towards high standards of evidence for cognitive behaviour therapy for perfectionism: A critique of Smith et al. (2023). *Canadian Psychology / Psychologie canadienne, 64*(4), 377–381.

Foucault, M. (1963). *The Birth of the Clinic: An Archaeology of Medical Perception*. Routledge.

Fredman, G. (2007). Preparing Our Selves for the Therapeutic Relationship Revisiting 'Hypothesizing Revisited'. *Human Systems: The Journal of Systemic Consultation & Management, 18*, 44–59.

Harding, S. (1994). Is science multicultural? Challenges, resources, opportunities, uncertainties. *Configurations, 2(2)*.

Hewitt, P. L., Flett, G. L., Besser, A., Sherry, S. B., & McGee, B. (2003). Perfectionism Is Multidimensional: A reply to Shafran, Cooper and Fairburn (2002). *Behaviour Research and Therapy, 41(10)*, 1221–1236.

Keen, S., Lomeli-Rodriguez, M., & Joffe, H. (2022). From Challenge to Opportunity: Virtual Qualitative Research During COVID-19 and Beyond. *International Journal of Qualitative Methods, 21*, 16094069221105075.

Keen, S., Lomeli-Rodriguez, M., & Williams, A. C. C. (2021). Exploring how people with chronic pain understand their pain: a qualitative study. *Scandinavian Journal of Pain, 21(4)*, 743–753.

McGinn, M., Brodsky, A., Colligan, S., Gordon, D., Pitts, M., Miller-Day, M., Ritchie, S., Rigano, D., & Russell, L. (2008). Researcher–participant relationships. In: *The SAGE Encyclopedia of Qualitative Research Methods*. SAGE Publications.

Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context.* Harvard University Press.

O'Connor, C., & Joffe, H. (2020). Intercoder Reliability in Qualitative Research: Debates and Practical Guidelines. *International Journal of Qualitative Methods, 19*.

Shafran, R., Cooper, Z., & Fairburn, C. G. (2003). 'Clinical perfectionism' is not 'multidimensional perfectionism': A reply to Hewitt, Flett, Besser, Sherry & McGee. *Behaviour Research and Therapy, 41*, 1217–1220.

Shafran, R., Egan, S. J., & Wade, T. D. (2023). Coming of age: A reflection of the first 21 years of cognitive behaviour therapy for perfectionism. *Behaviour Research and Therapy*, *161*, 104258.

Smith, M. M., Hewitt, P. L., Sherry, S. B., Flett, G. L., Kealy, D., Tasca, G. A., Ge, S., & Kristen, A. (2023b). Towards higher standards and improved treatments for perfectionism: A reply to Egan et al. (2023). *Canadian Psychology / Psychologie Canadienne*, *64*(4), 382–385.

Smith, M. M., Hewitt, P. L., Sherry, S. B., Flett, G. L., Kealy, D., Tasca, G. A., Ge, S., Ying, F., & Bakken, K. (2023a). A meta-analytic test of the efficacy of cognitive behavioural therapy for perfectionism: A replication and extension. *Canadian Psychology / Psychologie Canadienne*, *64*(4), 355–376.

Smith, M. M., Sherry, S. B., Ge, S. Y. J., Hewitt, P. L., Flett, G. L., & Baggley, D. L. (2022). Multidimensional perfectionism turns 30: A review of known knowns and known unknowns. *Canadian Psychology / Psychologie Canadienne*, *63*, 16–31.

Stoeber, J., & Damian, L. E. (2014). The Clinical Perfectionism Questionnaire: Further evidence for two factors capturing perfectionistic strivings and concerns. *Personality and Individual Differences*, *61–62*, 38–42.

White, M. (1997). *Narratives of Therapists' Lives*. Adelaide: Dulwich Centre.

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My participants; each and every one of them, generous and brave.

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My friends and my family; I hope I thank you every day.

Appendices

Systematic Review of the Literature

Appendix A. Journal instructions

The authors have submitted to submit to ***The International Journal of Eating Disorders*** *for publication. The Instructions for Authors of this journal include:*

Systematic reviews *(up to 7,500 words)*
These articles critically review the status of a given research area and propose new directions for research and/or practice. Both systematic and meta-analytic review papers are welcomed if they review a literature that is advanced and/or developed to the point of warranting a review and synthesis of existing studies. Reviews of topics with a limited number of studies are unlikely to be deemed as substantive enough for this IJED review paper type. The journal does not accept papers that merely describe or compile a list of previous studies without a critical synthesis of the literature that moves the field forward.

All systematic reviews and meta-analyses must follow the PRISMA Guidelines, summarized in the Page et al. (2021) article entitled "The PRISMA 2020 statement: an updated guideline for reporting systematic reviews" (J. Clin. Epidemiol.). Authors who choose this contribution type must include the 2020 PRISMA Flow Diagram and complete the PRISMA Checklist upon submission of the manuscript.

Pre-registration
Authors are encouraged to pre-register their systematic reviews, meta-analyses, and scoping reviews to detail their review strategy/protocol with regard to their research questions, inclusion/exclusion criteria, databases searched, search terms used, synthesis/analytic methods, etc. Examples of pre-registration systems that could be used include Prospero (https://www.crd.york.ac.uk/prospero/) for systematic reviews and meta-analyses.

Dates
All IJED review papers must include the month/year that the last literature search was conducted. This date must be within 6 months of the manuscript submission date.

Language
In the interest of representing the global literature, authors are strongly encouraged to include non-English language articles where practically possible. While not required, to the extent possible, we encourage authors to pursue opportunities for accessing non-English language papers such as inviting collaborators with the requisite language skills; employing translation software; or seeking expert assistance in translating articles.

Submission checklist
Adapted from PRISMA 2020 checklist:

- *Introduction:* Describe the rationale for the review in the context of existing knowledge.
- Provide an explicit statement of the objective(s) or question(s) the review addresses.

- *Methods:* Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.
- Please include a search of the unpublished ("grey") literature. Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. The search date must be within 6 months of the submission date.
- Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.
- Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.
- Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.
- Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis.

- *Results:* Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.
- Cite each included study and present its characteristics.
- Present assessments of risk of bias for each included study.

- *Discussion:* Provide a general interpretation of the results in the context of other evidence.
- Discuss any limitations of the evidence included in the review.
- Discuss any limitations of the review processes used.
- Discuss implications of the results for practice, policy, and future research.

- *Other:* Provide registration information for the review, including register name and registration number, or state that the review was not registered.
- Indicate where the review protocol can be accessed, or state that a protocol was not prepared.
- Describe and explain any amendments to information provided at registration or in the protocol.

Appendix B. Authors' statements

Author contributions: Research was completed by the first author, supervised by the last author. The first and last authors contributed to research design and data analysis; the third author to screening and inter-rating; and the second author (Joel Lewin) to refining data interpretation and manuscript presentation. All authors accept responsibility for the entire content of this manuscript and have approved its submission.

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Competing interests: Authors state no conflict of interest.

Research funding: Authors state no funding involved.

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Project approval: This project was approved by the Oxford Institute for Clinical Psychology Research and Training. Ethical approval was not required, as data collection did not involve new human participants.

Key Points Summary:

- Research into ED aetiology and treatment often highlights perfectionism. Yet, reviews mainly cover quantitative (statistical) studies. This paper was the first review of all qualitative studies on perfectionism in EDs.
- It used thematic synthesis to integrate qualitative data into new findings.
- It showed perfectionism can affect many life areas: including how EDs may develop, continue, and be overcome. It shed light on updating ED and perfectionism therapies.

Appendix C. Database search strategy and results

PsycINFO (Ovid)

Number	Search Terms	Results
1	(anorectic or anorexia or "anorexia nervosa" or "anorexia nervosa of low frequency" or anorexic or "anorexic patient" or ARFID or "avoidant restrictive food intake disorder" or "avoidant/restrictive food intake disorder" or "body dysmorphia" or "body dysmorphic disorder" or "binge eating" or "binge eating disorder" or "binge-eating disorder" or "binge eating syndrome" or "binge-eating syndrome" or bulimia or "bulimia nervosa" or "bulimia nervosa of low frequency" or bulimic or "bulimic patient" or "compulsive exercise" or "compulsive overeating" or "compulsive over-eating" or "disordered eating" or "eating disorder" or "eating disordered" or "eating disorders" or EDNOS or "low frequency AN" or "low frequency anorexia nervosa" or "low frequency BN" or "low frequency bulimia nervosa" or "night eating syndrome" or OSFED or "pica" or purging or "purging disorder" or "recovered anorexic patient" or "recovered bulimic patient" or "rumination disorder" or "unspecified feeding or eating disorder").ab,ti.	49,063
2	anorexia nervosa/ or avoidant restrictive food intake disorder/ or binge eating disorder/ or bulimia/ or night eating syndrome/ or pica/ or purging disorder/ or sleep eating/	38,673
3	(ashamed or "appearance perfectionism" or "concern over mistakes" or "doubts about actions" or entitlement or "fear of failure" or flawless or flawlessness or flaws or harsh or "high performance" or "high performing" or "high standards" or hypercriticism or imperfection or "mistake concern" or "mistakes concern" or musterbation or musting or "must-ing" or "narcissistic perfectionism" or "other-oriented perfectionism" or "perfect performance" or perfection or perfectionism or perfectionist or "perfectionist concerns" or "perfectionistic concerns" or "perfectionistic standards" or perfectionistic or perfect or perfectly or performance anxiety or planfulness or "reactivity to failure" or "reactivity to mistakes" or "relentless goals" or "relentless standards" or "rigid goals" or "rigid perfectionism" or "rigid standards" or "self-critical perfectionism" or "self-oriented perfectionism" or "self-worth contingencies" or "self-worth contingency" or shoulding or "should-ing" or "socially prescribed perfectionism" or "socially oriented perfectionism" or striving or "striving for achievement" or "striving for excellence" or "unrelenting standards").ab,ti.	49,046
4	perfectionism/	3,444
5	("action research" or "Atlas.ti" or "critical discourse analysis" or "qualitative content analysis" or Dedoose or "discourse analysis" or "ethnographic" or "ethnography" or "fantasy theme analysis" or "framework analysis" or "focus group" or "focus groups" or "grounded theory" or idiographic or "interpretative phenomenological analysis" or interview or interviewing or interviews or IPA or "narrative analysis" or NVivo or "pattern analysis" or "pattern based analysis" or "pattern-based analysis" or perspective or perspectives or phenomenological or phenomenology or qualitative or "qualitative content analysis" or "qualitative data analysis" or "semi-structured interview" or "thematic analysis" or themes or Transana).ab,ti.	871,266
6	qualitative analysis/ or qualitative research/	66,659
7	1 or 2	51,440
8	3 or 4	49,125
9	5 or 6	885,919
10	7 and 8 and 9	**284**

Medline (Ovid)

Number	Search Terms	Results
1	(anorectic or anorexia or "anorexia nervosa" or "anorexia nervosa of low frequency" or anorexic or "anorexic patient" or ARFID or "avoidant restrictive food intake disorder" or "avoidant/restrictive food intake disorder" or "body dysmorphia" or "body dysmorphic disorder" or "binge eating" or "binge eating disorder" or "binge-eating disorder" or "binge eating syndrome" or "binge-eating syndrome" or bulimia or "bulimia nervosa" or "bulimia nervosa of low frequency" or bulimic or "bulimic patient" or "compulsive exercise" or "compulsive overeating" or "compulsive over-eating" or "disordered eating" or "eating disorder" or "eating disordered" or "eating disorders" or EDNOS or "low frequency AN" or "low frequency anorexia nervosa" or "low frequency BN" or "low frequency bulimia nervosa" or "night eating syndrome" or OSFED or "pica" or purging or "purging disorder" or "recovered anorexic patient" or "recovered bulimic patient" or "rumination disorder" or "unspecified feeding or eating disorder").ab,ti.	72,139
2	anorexia nervosa/ or avoidant restrictive food intake disorder/ or binge eating disorder/ or bulimia/ or night eating syndrome/ or pica/ or purging disorder/ or sleep eating/	20,792
3	(ashamed or "appearance perfectionism" or "concern over mistakes" or "doubts about actions" or entitlement or "fear of failure" or flawless or flawlessness or flaws or harsh or "high performance" or "high performing" or "high standards" or hypercriticism or imperfection or "mistake concern" or "mistakes concern" or musterbation or musting or "must-ing" or "narcissistic perfectionism" or "other-oriented perfectionism" or "perfect performance" or perfection or perfectionism or perfectionist or "perfectionist concerns" or "perfectionistic concerns" or "perfectionistic standards" or perfectionistic or perfect or perfectly or performance anxiety or planfulness or "reactivity to failure" or "reactivity to mistakes" or "relentless goals" or "relentless standards" or "rigid goals" or "rigid perfectionism" or "rigid standards" or "self-critical perfectionism" or "self-oriented perfectionism" or "self-worth contingencies" or "self-worth contingency" or shoulding or "should-ing" or "socially prescribed perfectionism" or "socially oriented perfectionism" or striving or "striving for achievement" or "striving for excellence" or "unrelenting standards").ab,ti.	294,523
4	perfectionism/	627
5	("action research" or "Atlas.ti" or "critical discourse analysis" or "qualitative content analysis" or Dedoose or "discourse analysis" or "ethnographic" or "ethnography" or "fantasy theme analysis" or "framework analysis" or "focus group" or "focus groups" or "grounded theory" or idiographic or "interpretative phenomenological analysis" or interview or interviewing or interviews or IPA or "narrative analysis" or NVivo or "pattern analysis" or "pattern based analysis" or "pattern-based analysis" or perspective or perspectives or phenomenological or phenomenology or qualitative or "qualitative content analysis" or "qualitative data analysis" or "semi-structured interview" or "thematic analysis" or themes or Transana).ab,ti.	1,176,427
6	qualitative analysis/ or qualitative research/	90,978
7	1 or 2	75,105
8	3 or 4	294,539
9	5 or 6	1,182,925
10	7 and 8 and 9	**180**

Embase (Ovid)

Number	Search Terms	Results
1	(anorectic or anorexia or "anorexia nervosa" or "anorexia nervosa of low frequency" or anorexic or "anorexic patient" or ARFID or "avoidant restrictive food intake disorder" or "avoidant/restrictive food intake disorder" or "body dysmorphia" or "body dysmorphic disorder" or "binge eating" or "binge eating disorder" or "binge-eating disorder" or "binge eating syndrome" or "binge-eating syndrome" or bulimia or "bulimia nervosa" or "bulimia nervosa of low frequency" or bulimic or "bulimic patient" or "compulsive exercise" or "compulsive overeating" or "compulsive over-eating" or "disordered eating" or "eating disorder" or "eating disordered" or "eating disorders" or EDNOS or "low frequency AN" or "low frequency anorexia nervosa" or "low frequency BN" or "low frequency bulimia nervosa" or "night eating syndrome" or OSFED or "pica" or purging or "purging disorder" or "recovered anorexic patient" or "recovered bulimic patient" or "rumination disorder" or "unspecified feeding or eating disorder").ab,ti.	97,703
2	anorexia nervosa/ or avoidant restrictive food intake disorder/ or binge eating disorder/ or bulimia/ or night eating syndrome/ or pica/ or purging disorder/ or sleep eating/	41,504
3	(ashamed or "appearance perfectionism" or "concern over mistakes" or "doubts about actions" or entitlement or "fear of failure" or flawless or flawlessness or flaws or harsh or "high performance" or "high performing" or "high standards" or hypercriticism or imperfection or "mistake concern" or "mistakes concern" or musterbation or musting or "must-ing" or "narcissistic perfectionism" or "other-oriented perfectionism" or "perfect performance" or perfection or perfectionism or perfectionist or "perfectionist concerns" or "perfectionistic concerns" or "perfectionistic standards" or perfectionistic or perfect or perfectly or performance anxiety or planfulness or "reactivity to failure" or "reactivity to mistakes" or "relentless goals" or "relentless standards" or "rigid goals" or "rigid perfectionism" or "rigid standards" or "self-critical perfectionism" or "self-oriented perfectionism" or "self-worth contingencies" or "self-worth contingency" or shoulding or "should-ing" or "socially prescribed perfectionism" or "socially oriented perfectionism" or striving or "striving for achievement" or "striving for excellence" or "unrelenting standards").ab,ti.	333,911
4	perfectionism/	3,444
5	("action research" or "Atlas.ti" or "critical discourse analysis" or "qualitative content analysis" or Dedoose or "discourse analysis" or "ethnographic" or "ethnography" or "fantasy theme analysis" or "framework analysis" or "focus group" or "focus groups" or "grounded theory" or idiographic or "interpretative phenomenological analysis" or interview or interviewing or interviews or IPA or "narrative analysis" or NVivo or "pattern analysis" or "pattern based analysis" or "pattern-based analysis" or perspective or perspectives or phenomenological or phenomenology or qualitative or "qualitative content analysis" or "qualitative data analysis" or "semi-structured interview" or "thematic analysis" or themes or Transana).ab,ti.	1,435,753
6	qualitative analysis/ or qualitative research/	220,451
7	1 or 2	104,581
8	3 or 4	334,272
9	5 or 6	1,473,779
10	7 and 8 and 9	**226**

CINAHL (EBSCO)

Number	Search Terms	Results
1	TI ((ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards")) OR AB ((ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards"))	25,227
2	(MH "Eating Disorders") OR (MH "Anorexia Nervosa") OR (MH "Binge Eating Disorder") OR (MH "Avoidant Restrictive Food Intake Disorder") OR (MH "Bulimia Nervosa") OR (MH "Bulimia") OR (MH "Night Eating Syndrome") OR (MH "Anorexia") OR (MH "Pica")	21,886
3	TI ((ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards")) OR AB ((ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR	33,772

	"perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards"))	
4	(MH "Perfectionism")	556
5	TI (("action research" OR "Atlas.ti" OR "critical discourse analysis" OR "qualitative content analysis" OR Dedoose OR "discourse analysis" OR "ethnographic" OR "ethnography" OR "fantasy theme analysis" OR "framework analysis" OR "focus group" OR "focus groups" OR "grounded theory" OR idiographic OR "interpretative phenomenological analysis" OR interview OR interviewing OR interviews OR IPA OR "narrative analysis" OR NVivo OR "pattern analysis" OR "pattern based analysis" OR "pattern-based analysis" OR perspective OR perspectives OR phenomenological OR phenomenology OR qualitative OR "qualitative content analysis" OR "qualitative data analysis" OR "semi-structured interview" OR "thematic analysis" OR themes OR Transana)) OR AB (("action research" OR "Atlas.ti" OR "critical discourse analysis" OR "qualitative content analysis" OR Dedoose OR "discourse analysis" OR "ethnographic" OR "ethnography" OR "fantasy theme analysis" OR "framework analysis" OR "focus group" OR "focus groups" OR "grounded theory" OR idiographic OR "interpretative phenomenological analysis" OR interview OR interviewing OR interviews OR IPA OR "narrative analysis" OR NVivo OR "pattern analysis" OR "pattern based analysis" OR "pattern-based analysis" OR perspective OR perspectives OR phenomenological OR phenomenology OR qualitative OR "qualitative content analysis" OR "qualitative data analysis" OR "semi-structured interview" OR "thematic analysis" OR themes OR Transana))	519,267
6	(MH "Qualitative Studies+")	196,845
7	1 or 2	30,388
8	3 or 4	30,348
9	5 or 6	562,740
10	7 and 8 and 9	**101**

PubMed (PubMed)

Number	Search Terms	Results
1	anorectic[Title/Abstract] OR anorexia[Title/Abstract] OR "anorexia nervosa"[Title/Abstract] OR "anorexia nervosa of low frequency"[Title/Abstract] OR anorexic[Title/Abstract] OR "anorexic patient"[Title/Abstract] OR ARFID[Title/Abstract] OR "avoidant restrictive food intake disorder"[Title/Abstract] OR "avoidant/restrictive food intake disorder"[Title/Abstract] OR "body dysmorphia"[Title/Abstract] OR "body dysmorphic disorder"[Title/Abstract] OR "binge eating"[Title/Abstract] OR "binge eating disorder"[Title/Abstract] OR "binge-eating disorder"[Title/Abstract] OR "binge eating syndrome"[Title/Abstract] OR "binge-eating syndrome"[Title/Abstract] OR bulimia[Title/Abstract] OR "bulimia nervosa"[Title/Abstract] OR "bulimia nervosa of low frequency"[Title/Abstract] OR bulimic[Title/Abstract] OR "bulimic patient"[Title/Abstract] OR "compulsive exercise"[Title/Abstract] OR "compulsive overeating"[Title/Abstract] OR "compulsive over-eating"[Title/Abstract] OR "disordered eating"[Title/Abstract] OR "eating disorder"[Title/Abstract] OR "eating disordered"[Title/Abstract] OR "eating disorders"[Title/Abstract] OR EDNOS[Title/Abstract] OR "low frequency AN"[Title/Abstract] OR "low frequency anorexia nervosa"[Title/Abstract] OR "low frequency BN"[Title/Abstract] OR "low frequency bulimia nervosa"[Title/Abstract] OR "night eating syndrome"[Title/Abstract] OR OSFED[Title/Abstract] OR "pica"[Title/Abstract] OR purging[Title/Abstract] OR "purging disorder"[Title/Abstract] OR "recovered anorexic patient"[Title/Abstract] OR "recovered bulimic patient"[Title/Abstract] OR "rumination disorder"[Title/Abstract]	32,193
2	(((((("feeding and eating disorders"[MeSH Terms]) OR ("anorexia nervosa"[MeSH Terms])) OR ("avoidant restrictive food intake disorder"[MeSH Terms])) OR ("binge eating disorder"[MeSH Terms])) OR ("bulimia nervosa"[MeSH Terms])) OR ("pica"[MeSH Terms])) OR ("rumination syndrome"[MeSH Terms])) OR ("compulsive exercise"[MeSH Terms])	37,787
3	ashamed[Title/Abstract] OR "appearance perfectionism"[Title/Abstract] OR "concern over mistakes"[Title/Abstract] OR "doubts about actions"[Title/Abstract] OR entitlement[Title/Abstract] OR "fear of failure"[Title/Abstract] OR flawless[Title/Abstract] OR flawlessness[Title/Abstract] OR flaws[Title/Abstract] OR harsh[Title/Abstract] OR "high performance"[Title/Abstract] OR "high performing"[Title/Abstract] OR "high standards"[Title/Abstract] OR hypercriticism[Title/Abstract] OR imperfection[Title/Abstract] OR "mistake concern"[Title/Abstract] OR "mistakes concern"[Title/Abstract] OR musterbation[Title/Abstract] OR musting[Title/Abstract] OR "must-ing"[Title/Abstract] OR "narcissistic perfectionism"[Title/Abstract] OR "other-oriented perfectionism"[Title/Abstract] OR perfect[Title/Abstract] OR "perfect performance"[Title/Abstract] OR perfection[Title/Abstract] OR perfectionism[Title/Abstract] OR perfectionist[Title/Abstract] OR "perfectionist concerns"[Title/Abstract] OR "perfectionistic concerns"[Title/Abstract] OR perfectly[Title/Abstract] OR "perfectionistic standards"[Title/Abstract] OR perfectionistic[Title/Abstract] OR performance anxiety[Title/Abstract] OR planfulness[Title/Abstract] OR "reactivity to failure"[Title/Abstract] OR "reactivity to mistakes"[Title/Abstract] OR "relentless goals"[Title/Abstract] OR "relentless standards"[Title/Abstract] OR "rigid goals"[Title/Abstract] OR "rigid perfectionism"[Title/Abstract] OR "rigid standards"[Title/Abstract] OR "self-critical perfectionism"[Title/Abstract] OR "self-oriented perfectionism"[Title/Abstract] OR "self-worth contingencies"[Title/Abstract] OR "self-worth contingency"[Title/Abstract] OR shoulding[Title/Abstract] OR "should-ing"[Title/Abstract] OR "socially prescribed perfectionism"[Title/Abstract] OR "socially oriented perfectionism"[Title/Abstract] OR striving[Title/Abstract] OR "striving for achievement"[Title/Abstract] OR "striving for excellence"[Title/Abstract] OR "unrelenting standards"[Title/Abstract]	296,562

4	"perfectionism"[MeSH Terms]	623
5	"action research"[Title/Abstract] OR "ATLAS.ti"[Title/Abstract] OR "critical discourse analysis"[Title/Abstract] OR "qualitative content analysis"[Title/Abstract] OR Dedoose[Title/Abstract] OR "discourse analysis"[Title/Abstract] OR "ethnographic"[Title/Abstract] OR "ethnography"[Title/Abstract] OR "fantasy theme analysis"[Title/Abstract] OR "framework analysis"[Title/Abstract] OR "focus group"[Title/Abstract] OR "focus groups"[Title/Abstract] OR "grounded theory"[Title/Abstract] OR idiographic[Title/Abstract] OR "interpretative phenomenological analysis"[Title/Abstract] OR interview[Title/Abstract] OR interviewing[Title/Abstract] OR interviews[Title/Abstract] OR IPA[Title/Abstract] OR "narrative analysis"[Title/Abstract] OR NVivo[Title/Abstract] OR "pattern analysis"[Title/Abstract] OR "pattern based analysis"[Title/Abstract] OR "pattern-based analysis"[Title/Abstract] OR perspective[Title/Abstract] OR perspectives[Title/Abstract] OR phenomenological[Title/Abstract] OR phenomenology[Title/Abstract] OR qualitative[Title/Abstract] OR "qualitative content analysis"[Title/Abstract] OR "qualitative data analysis"[Title/Abstract] OR "semi structured interview"[Title/Abstract] OR "semi-structured interview"[Title/Abstract] OR "thematic analysis"[Title/Abstract] OR themes[Title/Abstract] OR Transana[Title/Abstract]	1,180,711
6	(((((("qualitative research"[MeSH Terms]) OR ("focus groups"[MeSH Terms])) OR ("grounded theory"[MeSH Terms])) OR ("interview, psychological"[MeSH Terms])) OR ("interviews as topic"[MeSH Terms]))	181,197
7	1 or 2	81,256
8	3 or 4	296,577
9	5 or 6	1,211,598
10	7 and 8 and 9	**196**

Web of Science (Clarivate)

Number	Search Terms	Results
1	TI=(anorectic OR anorexia OR "anorexia nervosa" OR "anorexia nervosa of low frequency" OR anorexic OR "anorexic patient" OR ARFID OR "avoidant restrictive food intake disorder" OR "avoidant/restrictive food intake disorder" OR "body dysmorphia" OR "body dysmorphic disorder" OR "binge eating" OR "binge eating disorder" OR "binge-eating disorder" OR "binge eating syndrome" OR "binge-eating syndrome" OR bulimia OR "bulimia nervosa" OR "bulimia nervosa of low frequency" OR bulimic OR "bulimic patient" OR "compulsive exercise" OR "compulsive overeating" OR "compulsive over-eating" OR "disordered eating" OR "eating disorder" OR "eating disordered" OR "eating disorders" OR EDNOS OR "low frequency AN" OR "low frequency anorexia nervosa" OR "low frequency BN" OR "low frequency bulimia nervosa" OR "night eating syndrome" OR OSFED OR "pica" OR purging OR "purging disorder" OR "recovered anorexic patient" OR "recovered bulimic patient" OR "rumination disorder" OR "unspecified feeding or eating disorder")	49,179
2	AB=(anorectic OR anorexia OR "anorexia nervosa" OR "anorexia nervosa of low frequency" OR anorexic OR "anorexic patient" OR ARFID OR "avoidant restrictive food intake disorder" OR "avoidant/restrictive food intake disorder" OR "body dysmorphia" OR "body dysmorphic disorder" OR "binge eating" OR "binge eating disorder" OR "binge-eating disorder" OR "binge eating syndrome" OR "binge-eating syndrome" OR bulimia OR "bulimia nervosa" OR "bulimia nervosa of low frequency" OR bulimic OR "bulimic patient" OR "compulsive exercise" OR "compulsive overeating" OR "compulsive over-eating" OR "disordered eating" OR "eating disorder" OR "eating disordered" OR "eating disorders" OR EDNOS OR "low frequency AN" OR "low frequency anorexia nervosa" OR "low frequency BN" OR "low frequency bulimia nervosa" OR "night eating syndrome" OR OSFED OR "pica" OR purging OR "purging disorder" OR "recovered anorexic patient" OR "recovered bulimic patient" OR "rumination disorder" OR "unspecified feeding or eating disorder")	78,693
3	TI=(ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards")	219,811
4	AB=(ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth	890,461

	contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards")	
5	TI=("action research" OR "Atlas.ti" OR "critical discourse analysis" OR "qualitative content analysis" OR Dedoose OR "discourse analysis" OR "ethnographic" OR "ethnography" OR "fantasy theme analysis" OR "framework analysis" OR "focus group" OR "focus groups" OR "grounded theory" OR idiographic OR "interpretative phenomenological analysis" OR interview OR interviewing OR interviews OR IPA OR "narrative analysis" OR NVivo OR "pattern analysis" OR "pattern based analysis" OR "pattern-based analysis" OR perspective OR perspectives OR phenomenological OR phenomenology OR qualitative OR "qualitative content analysis" OR "qualitative data analysis" OR "semi structured interview" OR "semi-structured interview" OR "thematic analysis" OR themes OR Transana)	796,286
6	AB=("action research" OR "Atlas.ti" OR "critical discourse analysis" OR "qualitative content analysis" OR Dedoose OR "discourse analysis" OR "ethnographic" OR "ethnography" OR "fantasy theme analysis" OR "framework analysis" OR "focus group" OR "focus groups" OR "grounded theory" OR idiographic OR "interpretative phenomenological analysis" OR interview OR interviewing OR interviews OR IPA OR "narrative analysis" OR NVivo OR "pattern analysis" OR "pattern based analysis" OR "pattern-based analysis" OR perspective OR perspectives OR phenomenological OR phenomenology OR qualitative OR "qualitative content analysis" OR "qualitative data analysis" OR "semi structured interview" OR "semi-structured interview" OR "thematic analysis" OR themes OR Transana)	2,451,904
7	1 or 2	97,371
8	3 or 4	1,012,803
9	5 or 6	2,970,630
10	7 and 8 and 9	**282**

Scopus (Elsevier)

Number	Search Terms	Results
1	(TITLE-ABS-KEY (anorectic OR anorexia OR "anorexia nervosa" OR "anorexia nervosa of low frequency" OR anorexic OR "anorexic patient" OR arfid OR "avoidant restrictive food intake disorder" OR "avoidant/restrictive food intake disorder" OR "body dysmorphia" OR "body dysmorphic disorder" OR "binge eating" OR "binge eating disorder" OR "binge-eating disorder" OR "binge eating syndrome" OR "binge-eating syndrome" OR bulimia OR "bulimia nervosa" OR "bulimia nervosa of low frequency" OR bulimic OR "bulimic patient" OR "compulsive exercise" OR "compulsive overeating" OR "compulsive over-eating" OR "disordered eating" OR "eating disorder" OR "eating disordered" OR "eating disorders" OR ednos OR "low frequency AN" OR "low frequency anorexia nervosa" OR "low frequency BN" OR "low frequency bulimia nervosa" OR "night eating syndrome" OR osfed OR "pica" OR purging OR "purging disorder" OR "recovered anorexic patient" OR "recovered bulimic patient" OR "rumination disorder" OR "unspecified feeding or eating disorder") AND TITLE-ABS-KEY (ashamed OR "appearance perfectionism" OR "concern over mistakes" OR "doubts about actions" OR entitlement OR "fear of failure" OR flawless OR flawlessness OR flaws OR harsh OR "high performance" OR "high performing" OR "high standards" OR hypercriticism OR imperfection OR "mistake concern" OR "mistakes concern" OR musterbation OR musting OR "must-ing" OR "narcissistic perfectionism" OR "other-oriented perfectionism" OR perfect OR "perfect performance" OR perfection OR perfectionism OR perfectionist OR "perfectionist concerns" OR "perfectionistic concerns" OR perfectly OR "perfectionistic standards" OR perfectionistic OR performance AND anxiety OR planfulness OR "reactivity to failure" OR "reactivity to mistakes" OR "relentless goals" OR "relentless standards" OR "rigid goals" OR "rigid perfectionism" OR "rigid standards" OR "self-critical perfectionism" OR "self-oriented perfectionism" OR "self-worth contingencies" OR "self-worth contingency" OR shoulding OR "should-ing" OR "socially prescribed perfectionism" OR "socially oriented perfectionism" OR striving OR "striving for achievement" OR "striving for excellence" OR "unrelenting standards") AND TITLE-ABS-KEY ("action research" OR "Atlas.ti" OR "critical discourse analysis" OR "qualitative content analysis" OR dedoose OR "discourse analysis" OR "ethnographic" OR "ethnography" OR "fantasy theme analysis" OR "framework analysis" OR "focus group" OR "focus groups" OR "grounded theory" OR idiographic OR "interpretative phenomenological analysis" OR interview OR interviewing OR interviews OR ipa OR "narrative analysis" OR nvivo OR "pattern analysis" OR "pattern based analysis" OR "pattern-based analysis" OR perspective OR perspectives OR phenomenological OR phenomenology OR qualitative OR "qualitative content analysis" OR "qualitative data analysis" OR "semi-structured interview" OR "thematic analysis" OR themes OR transana)	**245**

All results were derived from database searches conducted on 6th August 2024.

Appendix D. CASP and Data Richness criteria

Adapted CASP Questions (CASP, 2018)

1. Was there a clear statement of the aims of the research?
- *What was the goal of the research? Why was it thought important? What was its relevance?*

2. Was there an attempt to situate the paper within some theoretical context?
- *Did the researcher(s) link their study aims, research questions, design, and/or interpretations to an existing theory or related evidence base?*

3. Is the qualitative methodology appropriate?
- *Did the research seek to interpret or illuminate the actions and/or subjective experiences of research participants? Was qualitative research the right methodology for addressing the research goal?*

4. Was the research design appropriate to address the aims of the research?
- *Did the researcher(s) justify the research design and/or discuss how they decided which method to use?*

5. Was the recruitment strategy appropriate to the aims of the research?
- *Did the researcher(s) explain how the participants were selected, and/or explain why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study? Were there any discussions around recruitment (including why some people chose not to take part)?*

6. Was the data collected in a way that addressed the research issue?
- *Was the setting for the data collection justified? Was it clear how data were collected (such as focus groups, semi-structured interviews)? Did the researcher(s) justify the methods chosen? Did they make the methods explicit (such as, for interview methods, an indication of how interviews were conducted)? Were any modifications to methods during the study explained and justified? Was the form of data clear (including tape recordings, video material, notes)? Did the researcher(s) discuss saturation of data?*

7. Has the relationship between researcher and participants been adequately considered?
- *Did the researcher(s) critically examine their own role, potential biases and influences during formulation of the research questions and data collection (including sample recruitment and choice of location)? How did the researcher(s) respond to events during the study, and did they consider the implications of any changes in the research design?*

8. Was reflexivity on researcher positionality integrated throughout the paper?
- *Did the researcher(s) critically examine their own role(s), potential biases and influences during design, interviews, analysis, and selection of data for presentation?*

9. Have ethical issues been taken into consideration?
- *Were there sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained? Did the researcher(s) discuss issues raised by the study (including issues around informed consent or confidentiality, or how they handled*

the effects of the study on the participants during and after the study)? Was approval sought from an ethics committee?

10. Was the data analysis sufficiently rigorous?

- *Was there an in-depth description of the analysis process? If thematic analysis was used, is it clear how the categories/themes were derived from the data? Did the researcher(s) explain how the data presented were selected from the original sample to demonstrate the analysis process? Were sufficient data presented to support the findings? To what extent were contradictory data considered?*

11. Is there a clear statement of findings?

- *Are the findings explicit? Is there adequate discussion of the evidence both for and against the researcher's arguments? Did the researcher(s) discuss the credibility of their findings (including triangulation, respondent validation, more than one analyst)? Are the findings discussed in relation to the original research question?*

12. Is the research uniquely valuable in its contribution to the literature?

- *Did the researcher(s) discuss the contribution the study makes to existing knowledge or understanding (including considering the findings in relation to current practice or policy, or relevant research-based literature)? Did they identify new areas where research was necessary? Did they discuss whether or how the findings can be transferred to other populations, or consider other ways the research may be used?*

13. Is the research published via peer review?

- *Was the research published as a journal article, or submitted, unpublished, as a doctoral thesis?*

Data Richness Scale (Ames et al., 2019)

Assessment guidance	Examples of data of different richness	Data richness score
Very little qualitative data presented that relate to the synthesis objective. Those findings that are presented are fairly descriptive.	A mixed methods study using open ended survey questions or a more detailed qualitative study where only part of the data relates to the synthesis objective	1
Some qualitative data presented that relate to the synthesis objective	A limited number of qualitative findings from a mixed methods or qualitative study	2
A **reasonable** amount of qualitative data that relate to the synthesis objective	A typical qualitative research article in a journal with a smaller word limit and often using simple thematic analysis	3
A **good amount and depth** of qualitative data that relate to the synthesis objective	A qualitative research article in a journal with a larger word count that includes more context and setting descriptions and a more in-depth presentation of the findings	4
A **large amount and depth** of qualitative data that relate in depth to the synthesis objective.	A detailed ethnography or a published qualitative article with the same objectives as the synthesis	5

Appendix E. Journal instructions

*The authors intend to submit to **The Journal of Family Therapy** for publication. The Instructions for Authors of this journal include:*

Advice to Authors
Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors, and The *Journal of Family Therapy* wants to hear from you.

***Research Article** (3,000-6,000 words)*
It is considered good practice (as recommended for example by the UK National Institute For Health Research) for researchers to include participants throughout the process of studies, from design to interpretation to dissemination. A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study.
- Previous work.
- Description of methodology including participants.
- Results/Findings.
- Discussion of results, including implications for future research and practice.

References
References in published papers are formatted according to the Publication Manual of the American Psychological Association (7th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Style
Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Power, Difference & Inequality
Authors' own position and intersecting identities may influence how they respond to data, and be influential in how they are received and responded to, by their research subjects, clients, consultees or trainees, as well as how they are making sense of their findings.

Appendix F. Research questions

Supplementary research questions for staff feedback included:

- What is their knowledge of Systemic family therapy (SFT)?
- What is their understanding of referring for SFT?
- What works well and less well about the referral pathway?
- What differences do they perceive these referrals making to clients' lives?
- What is their experience of joining SFT sessions?
- What do they find innovative, novel, or surprising about this organisational change – and what is disappointing or frustrating?

Supplementary research questions for client feedback included:

- What were their experiences of being referred for SFT?
- Which aspects of the pathway were positive for them, and which more negative?
- What were their experiences of receiving SFT?
- Which aspects of SFT were positive for them, and which more negative?
- How far and in what ways did therapy meet their goals?

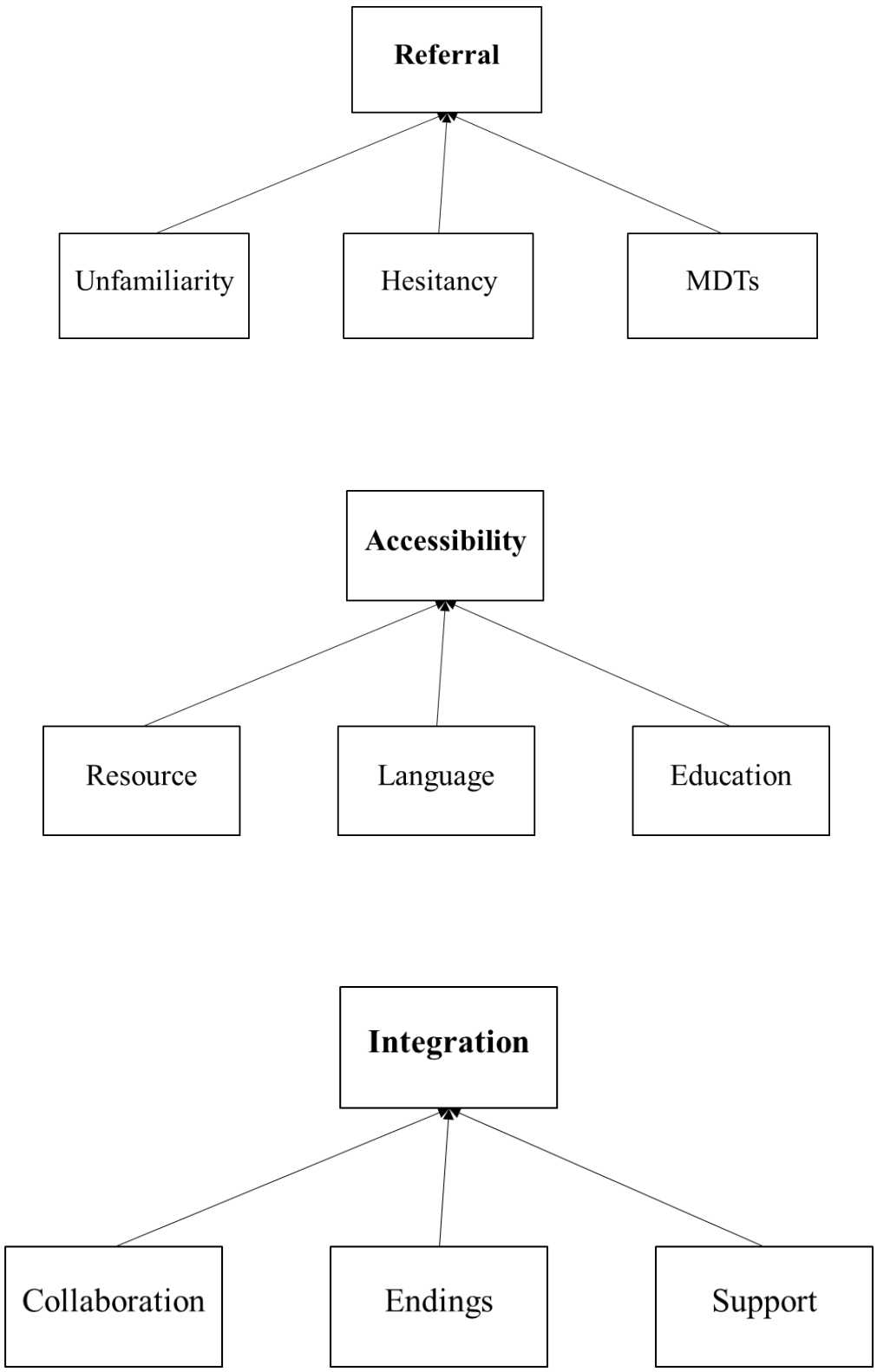
Appendix G. Staff focus-group interview questions

- What are your experiences and/or understanding of referring clients for Systemic therapy?
  - How do you decide whom to refer and whom not to? What would help you to make appropriate referrals?
- How helpful have you found this development of the Clinic / its addition to the team?
  - What do you feel works well, and less well?
- What do you want from the Clinic?
  - What should be different, or more developed, in the future?
- What (if any) has been your experience of joining Systemic therapy sessions, or discussing cases from a Systemic perspective?
  - How (if at all) have you found thinking about family relationships and/or what you might bring to this?
- What feedback (if any) have you heard from clients or referrals you've made?
- What differences do you perceive that Systemic therapy can make to clients' lives?

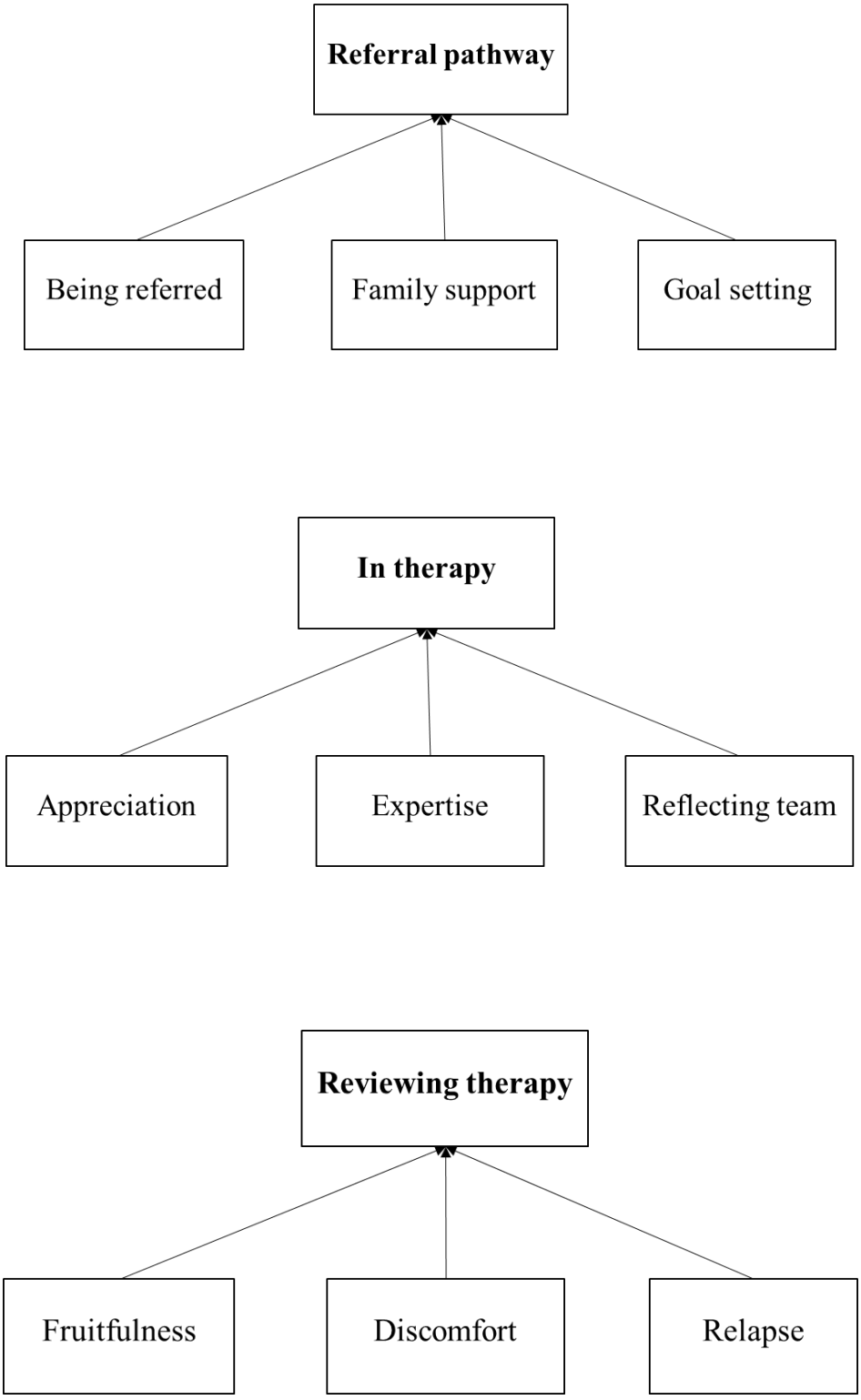
Appendix H. Client semi-structured interview questions

- What were both your experiences of being referred for family therapy?
- How did you find the process of referral?
  - Were there any positives or negatives? Any suggestions for improvement?
- What goals did you bring to family therapy?
  - How did you find the process of setting those goals?
- What were both your experiences of receiving family therapy?
- Which aspects of the family therapy were positive for you, and which were more negative?
- How did you find the reflecting team?
  - Were there any positives or negatives?
- How far, and in what ways, did the family therapy meet your goals?

Appendix I. Staff focus-group data coding frame



Appendix J. Client interview data coding frame



Appendices

Theoretically Driven Research Project

Appendix K. Journal instructions

The authors have submitted to submit to ***The International Journal of Eating Disorders*** *for publication. The Instructions for Authors of this journal include:*

Original articles *(up to 4,500 words)*
These contributions report substantive research that is novel, definitive, or complex enough to require a longer communication.

- Keywords are provided that capture relevant core concepts. Keywords may be single words (“health”) or short multi-word terms (“health services utilization”). The Editor recommends at least five keywords.
- The Title is short and includes one or two keywords to optimize search engine discoverability of the article.
- The Abstract is structured and is a recommended maximum of 250 words. Using the headers “Objective,” “Method,” “Results,” and “Discussion,” the Abstract concisely summarizes the article.
- The Introduction describes how the study builds upon prior research, addresses specific knowledge gaps, and promises to advance the field. The introduction specifies whether the study is hypothesis-generating or hypothesis-testing (if the latter, testable hypotheses are stated).
- If applicable, the Method section states where the study was preregistered.
- The Method section describes how participants were recruited, over what time; and what inclusion/exclusion criteria were applied.
- The Method section supports the choice of study measures with relevant reliability and validity information.
- The Method section attests that ethical approval was obtained and names the entity providing the approval; else, if applicable, it explains why the research was exempt from ethical review and approval.
- The sample description conforms to the IJED Demographic Variables Reporting Guidelines and includes age (required) and sex or gender (required), and where possible, socioeconomic status and race. (Depending on the study design, the sample should be described in Method or Results.)
- The Discussion offers a balanced interpretation of study findings; includes a section on strengths and limitations; recommends future studies; and describes clinical or policy implications (if applicable).

Style
Authors should refrain from using terms that are stigmatizing, discriminatory, or ambiguous. The journal rejects stand-alone nouns that refer to individuals by their diagnosis or condition (e.g., “anorexics," “obese,” “diabetics," etc.), race and ethnicity identification (e.g., “Whites,” “Hispanics,” etc.), or presumed disadvantaged status (“minorities”). “Participants” should be used in place of “subjects.”

Only abbreviate terms if they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter, use the abbreviation only.

Numbers under 10 should be spelt out, except for: measurements with a unit (8 mmol/L); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

References
This journal offers Free Format submission and authors may submit using their preferred referencing style, as long as consistency is applied throughout the manuscript. The typesetter will apply the American Psychological Association reference style on manuscripts accepted for publication. If authors wish, they may review reference style guidelines prior to submission.

Appendix L. Authors' statements

Author contributions: Research was completed as part of the first author's DClinPsy thesis, supervised by the last author. The first, third, and last authors contributed to research design and data analysis, and the second author to refining data interpretation and manuscript presentation. All authors accept responsibility for the entire content of this manuscript and have approved its submission.

Acknowledgements: Authors would like to thank Dr Joanna Adams for sharing her thoughts on perfectionism, EDs, and study design at the outset of this project.

Competing interests: Authors state no conflict of interest.

Research funding: Authors state no funding involved.

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Informed consent: Informed consent was obtained from all participants included in this study.

Ethical approval: Data collection involving human participants complied with all relevant national regulations and institutional policies, and was approved by the authors' research ethical committee (Oxford CUREC #R88910/RE001).

Key Points Summary:

- Understanding how eating disorders (EDs) start and continue is crucial for helping people recover. Research shows people's deeply held beliefs – often perfectionist – are important in treatment.
- It remains unclear how perfectionistic beliefs relate to different EDs.
- This study shows high standards appear differently in different ED diagnoses—a useful trait to measure.
- It also highlights that perfectionism consists of multiple traits, including fear of failure, with differing relevance to ED diagnoses.

Appendix M. Abbreviation glossary

Type	**Acronym**	**Expanded phrase**
Eating disorders*:*	ED	Eating disorder
	AN	Anorexia nervosa
	BN	Bulimia nervosa
	BED	Binge eating disorder
	ED-CBQ	Eating Disorder Core Beliefs Questionnaire
Perfectionism*:*	*High Standards*	High Standards for Self subscale
	Mistakes Reactivity	Reactivity to Mistakes subscale
	M-CUP	Measure of Constructs Underlying Perfectionism
	Appearance Perfectionism	Physical-Appearance Perfectionism Scale
	FMPS	Frost Multidimensional Perfectionism Scale
Other*:*	GAD-7	General Anxiety Disorder 7-item
	PHQ-8	Patient Health Questionnaire 8-item
	IV	Independent variable

Appendix N. Ethical approval

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Myra Cooper & Sam Keen
Oxford Institute for Clinical Psychology Training
(OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

2 November 2023

Dear Dr Cooper and Sam,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R88910/RE001

Study title: Investigating Links between Eating Disorders and Perfectionism: A Quantitative Study of Multidimensional Perfectionism Constructs across Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **2nd November 2023** until **23rd May 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix O. Demographic questionnaire

What sex were you assigned at birth?	Male/Female/Intersex/Prefer not to say
Do you still identify as this? If not, please state your gender (if wished)	Male/Female/Non-binary or other/Prefer not to say
How old are you? *(years)*	Free text
Height (m / feet, please specify)	Free text
Weight (kg / pounds / stone)	Free text
How would you describe your ethnicity?	White 1. English/Welsh/Scottish/Northern Irish/British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe Mixed/Multiple ethnic groups 5. White and Black Caribbean 6. White and Black African 7. White and Asian 8. Any other Mixed/Multiple ethnic background, please describe Asian/Asian British 9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese 13. Any other Asian background, please describe Black/ African/Caribbean/Black British 14. African 15. Caribbean 16. Any other Black/African/Caribbean background, please describe Other ethnic group 17. Arab 18. Any other ethnic group, please describe
What is the highest level of education you have completed?	No formal schooling/less than primary school/primary school completed/secondary or high school completed/sixth form completed/university degree completed/post graduate degree completed
Which of the following best describes your main work status over the past 12 months?	Unemployed/employed/retired/homemaker/student/non-paid or voluntary work/carer/other
What is your civil status?	Married/living as couple/divorced or separated/single/widowed/other/prefer not to say
Are you a parent?	Yes / No

Have you, in the past, received professional support for your mental health?	Yes/No
Do you currently receive professional support for mental health?	Yes/No
If yes, does this include talking therapy?	Yes / No
If so, was this CBT or another type of therapy?	Free text
If any, what would you consider your primary mental health problem?	Free text
Are you currently taking medication for your mental health?	Yes/No
How old were you when your particular mental health difficulties started? (Please write N/A if this does not apply to you)	Free text

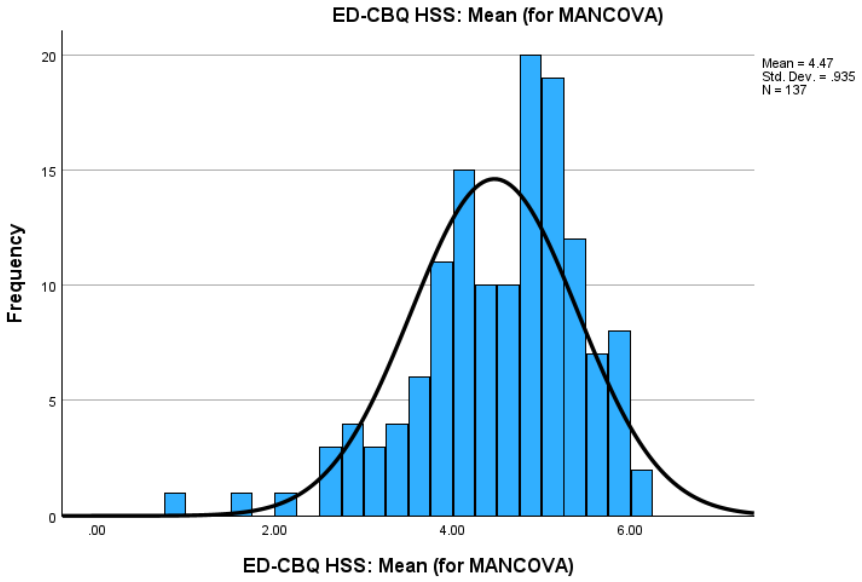
Appendix P. Diagnostic data

Diagnosis	**Number of participants**
Healthy volunteers	137
Anorexia nervosa (AN)	139
Bulimia nervosa (BN)	233
Binge eating disorder (BED)	68
Subtotal (used)	*577*
Atypical AN	230
Low frequency BN	27
Low frequency BED	8
Purging disorder	18
Night eating syndrome	31
Full total (diagnosed)	*891*
(Missing data – unused)	50
Full total (collected)	*941*

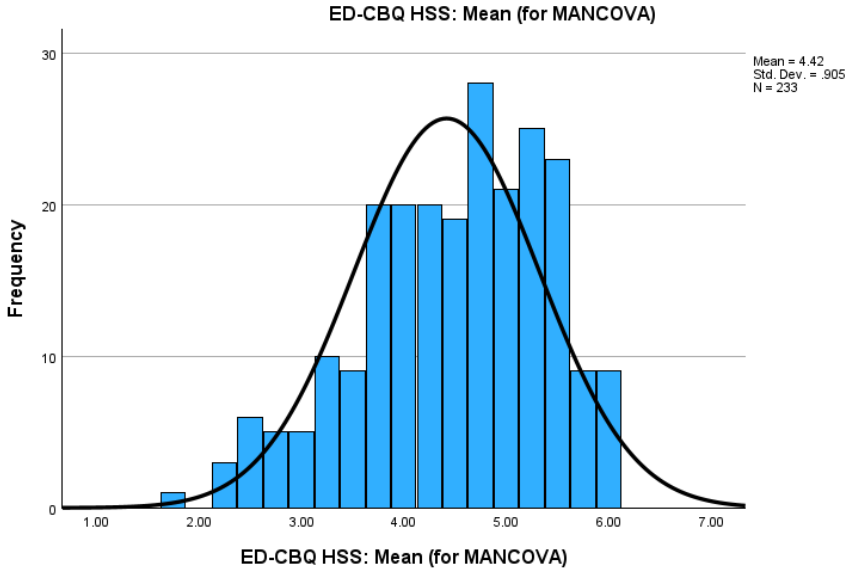
Appendix Q. Perfectionism-measure data distributions

High Standards for Self scale

Healthy volunteers (HVs) – normally distributed:

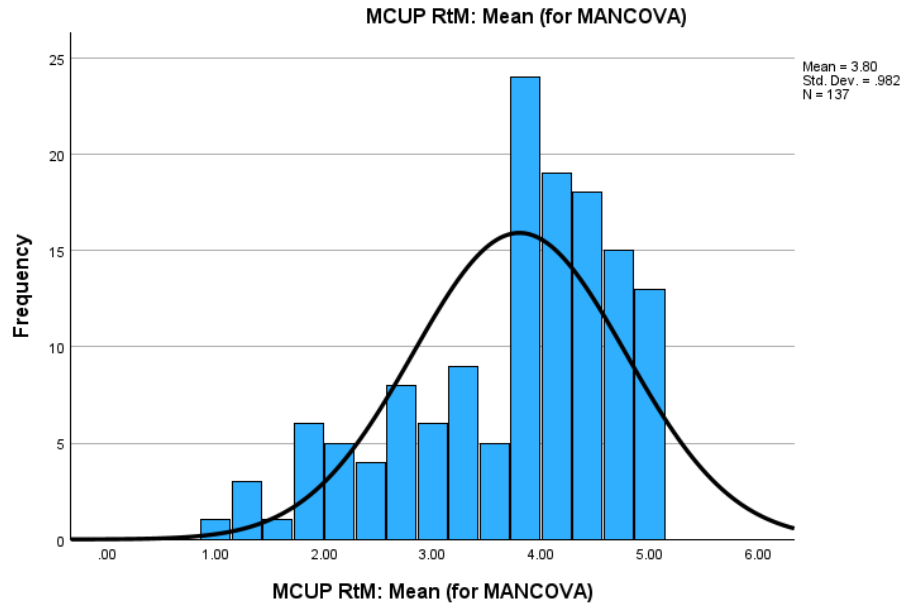


Bulimia nervosa (BN), exemplary of all eating disorder (ED) groups – leptokurtic and negatively skewed:

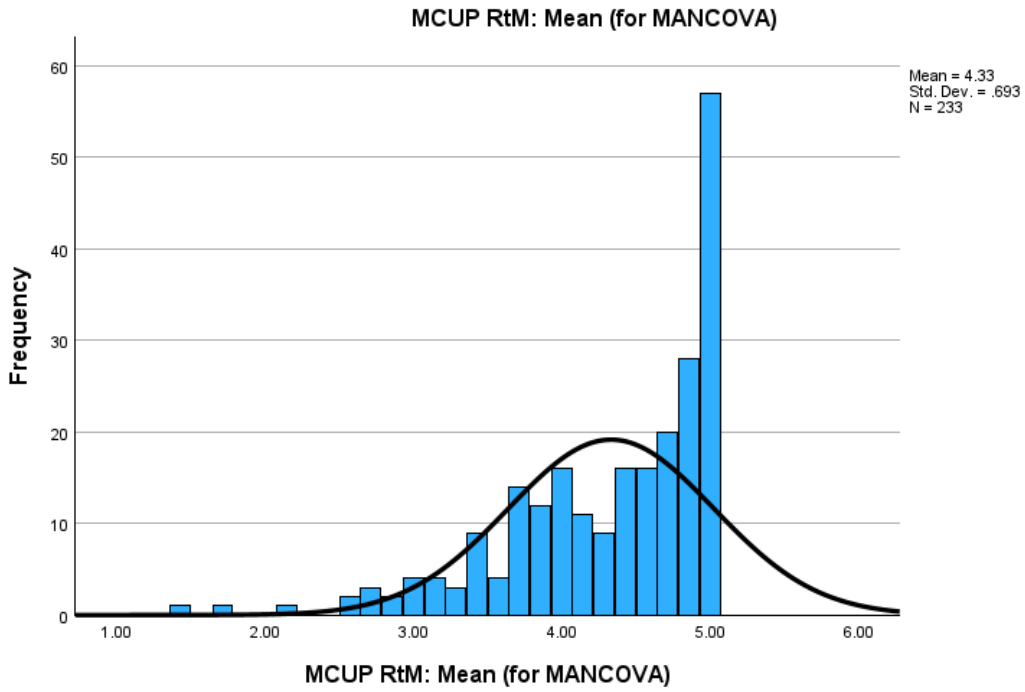


***Reactivity to Mistakes* Scale**

HVs – normally distributed:

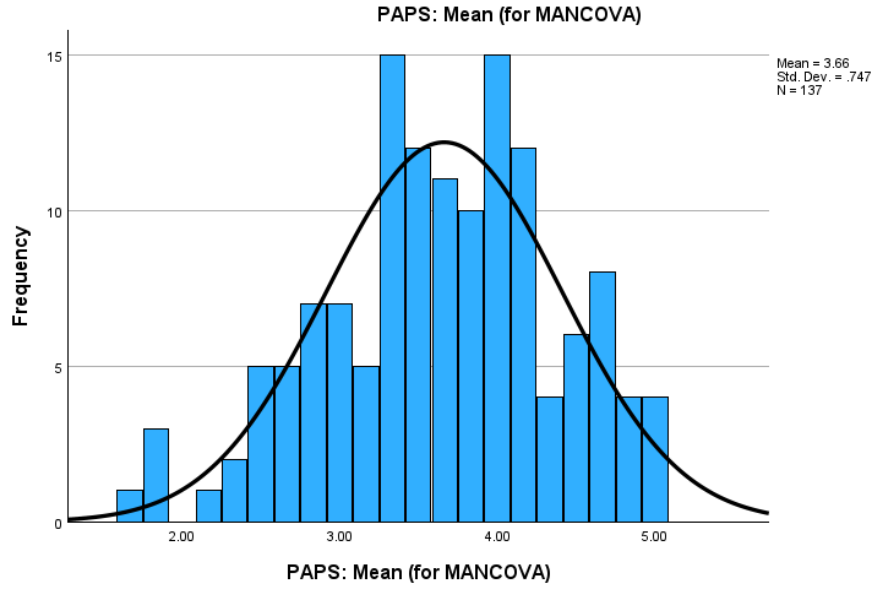


BN (and all ED groups) – leptokurtic and negatively skewed:

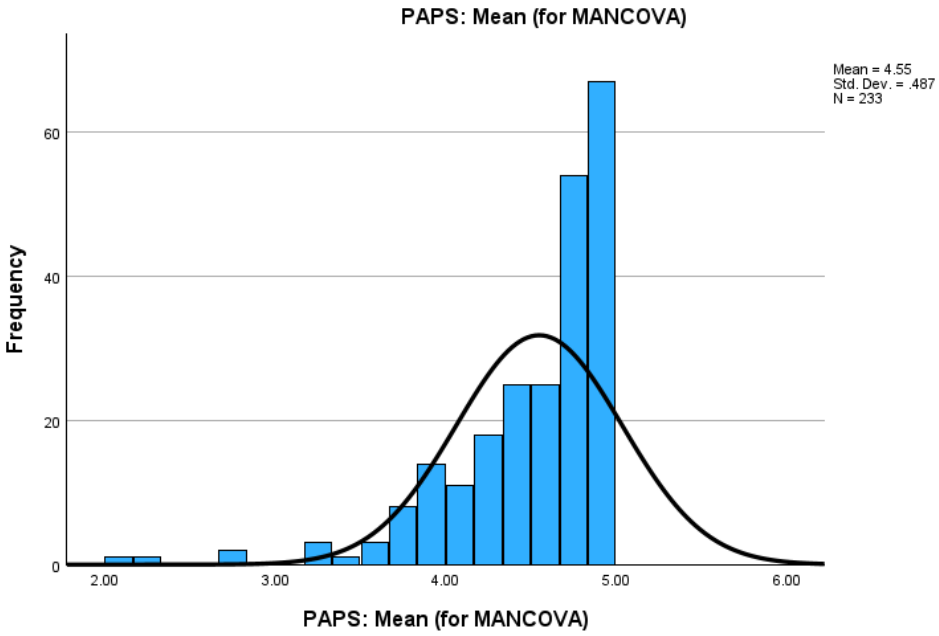


***Physical Appearance Perfectionism* Scale**

HVs – normally distributed:

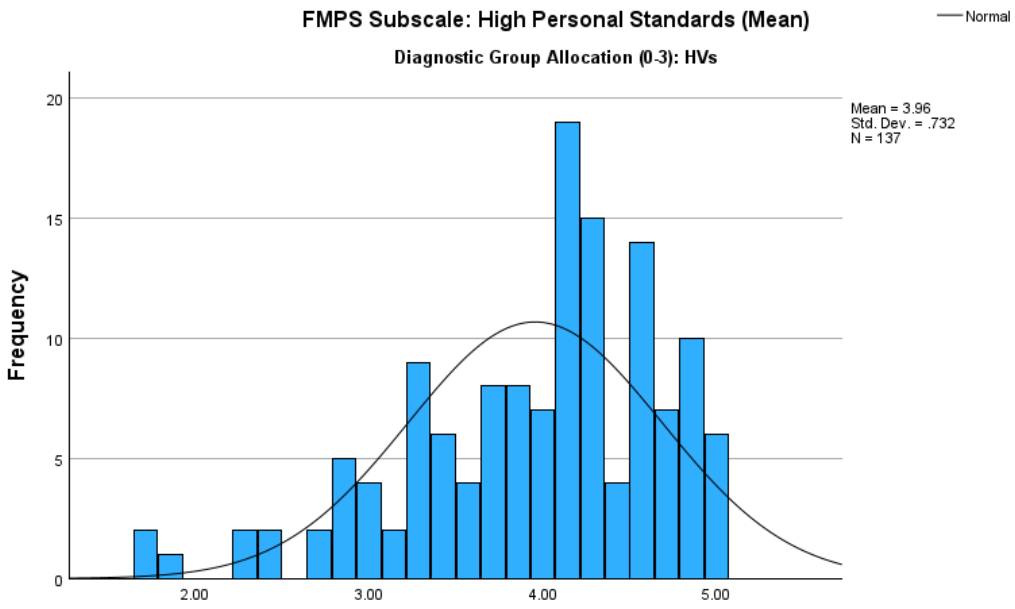


BN (and all ED groups) – leptokurtic and negatively skewed:

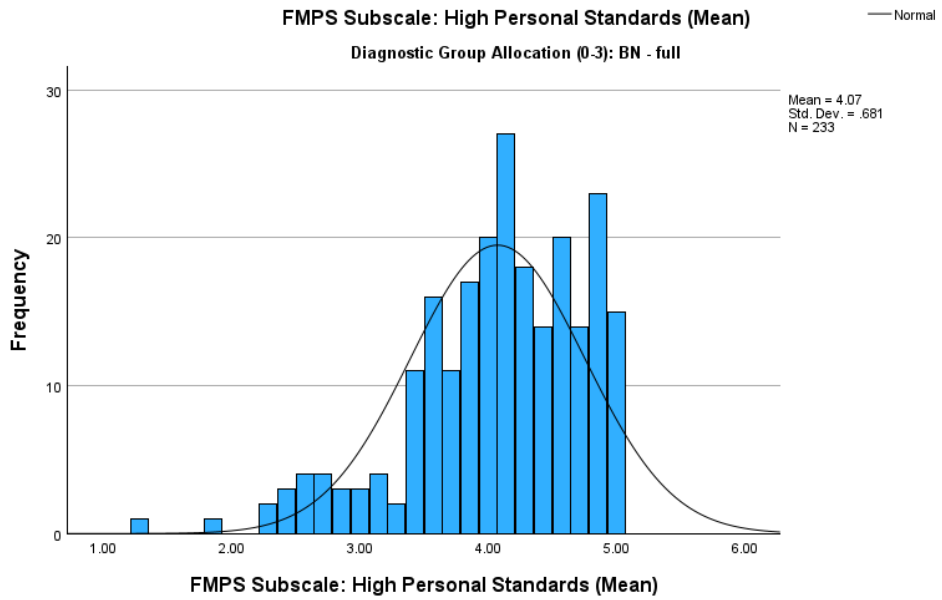


***Frost Multidimensional Perfectionism* Scale (*FMPS*)**

*Example of FMPS **HV** (using* Personal Standards*) – normally distributed:*



*Example of FMPS **BN** (using* Personal Standards*) – also normally distributed:*



Appendix R. Hierarchical multiple regression results

Variable	B	S.E.[i] of B	95% Conf. Int. for B[j]		Sig.[m]	β	R^2	ΔR^2
			L.L.[k]	U.L.[l]				
							.360	.360
Step 1								
(Constant)	9.69	1.38	7.00	12.4	<.001*			
PHQ-8[a]	0.73	0.07	0.60	0.86	<.001	0.49		
GAD-7[b]	0.22	0.07	0.07	0.34	.003	0.14		
Age	0.06	0.04	-0.01	0.13	.072	0.07		
Medication	0.89	0.62	-2.67	2.12	.152	0.05		
Step 2							.423	.063
(Constant)	-5.31	2.36	-9.98	-0.54	.024			
PHQ-8	0.66	0.07	0.51	0.80	<.001	0.44		
GAD-7	0.09	0.07	-0.05	0.22	.169	0.06		
Age	0.06	0.03	-0.01	0.13	.065	0.06		
Medication	0.52	0.60	-0.65	1.65	.402	0.03		
FMPS: CMD[c]	0.20	0.05	-0.12	0.30	<.001	0.21		
FMPS: PEC[d]	0.08	0.3	0.01	0.14	.027	0.08		
FMPS: PS[e]	0.01	0.07	-0.14	0.15	.938	0.01		
FMPS: PO[f]	0.20	0.07	0.07	0.33	.003	0.12		
Step 3							.599	.176
(Constant)	-19.0	2.34	-23.7	-14.3	<.001			
PHQ-8	0.50	0.07	0.37	0.63	<.001	0.34		
GAD-7	0.13	0.06	0.01	0.23	.027	0.09		
Age	0.06	0.03	0.04	0.12	.037	0.06		
Medication	0.10	0.50	-0.92	1.07	.844	0.01		
FMPS: CMD	-0.03	0.04	-0.10	0.05	.489	-0.03		
FMPS: PEC	0.05	0.03	-0.01	0.10	.089	0.05		
FMPS: PS	-0.02	0.06	-0.14	0.10	.784	-0.01		
FMPS: PO	0.18	0.06	0.06	0.29	.003	0.09		
PAPS[g]	6.72	0.46	5.88	7.68	<.001	0.52		
Step 4							.000	.000
(Constant)	-19.0	2.34	-23.7	-14.2	<.001			
PHQ-8	0.50	0.06	0.37	0.63	<.001	0.34		
GAD-7	0.13	0.06	0.09	0.23	.031	0.09		
Age	0.06	0.03	0.04	0.12	.038	0.06		
Medication	0.10	0.50	-0.92	1.07	.844	0.01		
FMPS: CMD	-0.03	0.04	-0.11	0.06	.489	-0.03		
FMPS: PEC	0.05	0.03	-0.01	0.10	.094	0.05		
FMPS: PS	-0.02	0.07	-0.17	0.14	.815	-0.01		
FMPS: PO	0.18	0.06	0.06	0.40	.007	0.09		
PAPS	6.72	0.46	5.88	7.70	<.001	0.52		
HSS[h]	-.001	0.37	-23.7	0.78	.998	0.00		

[a]Patient Health Questionnaire 8-Item [b]Generalised Anxiety Disorder 7-Item [c]Frost Multidimensional Perfectionism Scale: Concerns over Mistakes & Doubts about Actions [c]Parental Expectations & Criticism [e]Personal standards [f]Precision & Organisation [g]Physical Appearance Perfectionism Scale [h]High Standards for Self scale [i]Standard error [j]Confidence interval [k]Lower limit [l]Upper limit [m]Significance *α=.05

End