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Sexual Perfectionism mediates General Perfectionism and Female Sexual Functioning in Women with Anorexia Nervosa

by

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Portfolio for the Professional Doctorate in Counselling Psychology

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COVID-19 Impact Statement

This statement is provided for the aid and benefit of future readers to summarise the impact of the COVID-19 pandemic on the scope, methodology, and research activity associated with this thesis. The academic standards for a research degree awarded by City University of London and for which this thesis is submitted remain the same regardless of this context.

Title of the research project: Sexual Perfectionism Mediates General Perfectionism and Female Sexual Functioning in Women with Anorexia Nervosa

1. **Summary of how the research project, scope or methodology has been revised because of COVID-19 restrictions**

The methodology was revised due to the COVID-19 pandemic. In the original project, it was planned to recruit participants through National Health Service (NHS) services. However, the NHS was no longer able to support the project when the pandemic began. It was therefore decided to recruit participants through private and not-for-profit organisations by disseminating the research survey on these organisations' social media platforms. However, the pace of recruitment was too slow by these means, and amendments had to be sent to the ethics committee requesting that the researcher recruit participants independently on social media, and create a professional account and publish all relevant information and the survey link for potential participants to access. This account was deactivated at the end of the recruitment phase.

2. **Summary of how research activity and/or data collection was impacted because of COVID-19 restrictions, and how any initially planned activity would have fitted within the thesis narrative**

Due to changes in recruitment processes and modifications that had to be submitted to and approved by the ethics committee, this doctoral study was affected in terms of time and sample size. The original plan to recruit participants from within the NHS would have enabled the recruitment of more participants in a shorter period and the analysis phase of the project to begin in accordance with the original research schedule.

3. **Summary of actions or decisions taken to mitigate the impact of data collection or research activity that was prevented by COVID-19**

Due to the limitations mentioned above, decisions also had to be made regarding the analysis. The sample size was considered too small to distinguish between the two subtypes of anorexia nervosa and to perform pathway models for both to compare the results. In addition, the original aim was to study specific components of sexual functioning (such as pain, lubrication, arousal, desire, and satisfaction) in association with sexual perfectionism, but due to the small sample size, this procedure was not carried out in order to ensure that a quality study was produced within its means rather than to produce new data that might be overly affected by its statistical limitations. As a result, female sexual functioning was studied as an overall construct in relation to general and sexual perfectionism.

4. **Summary of how any planned work might have changed the thesis narrative, including new research questions that have arisen from adjusting the scope of the research project**

Fortunately, the COVID-19 pandemic did not impact the thesis narrative, as the study was originally planned as a quantitative piece of work.

Date of statement: 16/01/2022

Acknowledgements

To Jim Glackin

For teaching me at a young age about perseverance and self-compassion in the face of adversity.

To Dr. Angie Cucchi

For her expertise and support in carrying out this work.

Preface to the portfolio

This portfolio is produced as part of my professional development during my training for the Professional Doctorate in Counselling Psychology at City University of London. It is divided into three sections: an empirical research study, an extended case study and the publishable version of the research project, which is intended for submission to the *Journal of Sex Research*.

During my professional development, I have been fascinated by the mind-body relationship and the role it can play in mental health difficulties. This has stemmed from exposure to evidence-based knowledge that highlighted the relevance and importance of the intersection between physiological and psychosocial components in understanding mental health difficulties (Danese & Lewis, 2016, 2017).

I believe that paying attention to the intersection of mind and body and venturing into research that offers a multitude of different perspectives on the same subject, for example, combined with the variety of therapeutic modalities I have been privileged to learn and practise in my training, has led to the development of a therapeutic style that is based on an integrative approach and rooted in the very essence of prioritising clients' needs and responding to those needs with flexibility and curiosity. Indeed, it follows that no one modality or epistemological view of emotional difficulties is right or wrong, but rather all are equally relevant and necessary to respond to the variety of clients' needs. The intention is to adapt to their views of the world, their relationships with it, and, consequently, their relationships with themselves.

I am drawn to consider the mind-body relationship in my clinical work. I have grown into a practitioner who cherishes clinical skills as I attempt to conceptualise emotional problems and the client as multidimensional, and to link biological aspects of difficulties to psychosocial factors rather than defining phenomena from a one-dimensional approach and/or attempting to reduce the understanding of the onset of difficulties to a set of symptoms.

Such learning has not only influenced my therapeutic style in clinical practice but also shaped my approach to designing my research project. Therefore, a central theme of every part of this portfolio is the complex association between the role of the body and emotional well-being. Furthermore, I was inspired to conduct my empirical research project in a way that integrated this perspective: by including biopsychosocial factors in the way we

understand the subject of female sexual functioning and by attempting to address this subject in the context of anorexia nervosa to highlight the potential multitude of components that might play a role here. Additionally, I hoped that by doing so, my project would pave the way for future research to be undertaken through a variety of different approaches. Indeed, for me it is very important not only to contribute to the evidence-based literature by providing new findings, but also to be aware of other work that could build on these findings, and hence to contribute to the development of understanding of the phenomenon of sexual functioning in the context of anorexia nervosa from different research angles or methodologies, and thus to enable the flourishing of much more knowledge.

For instance, the topic of female sexual functioning can be seen as medicalised; the *Diagnostic and Statistical Manual of Mental Disorders* fifth edition (DSM-5) has a section devoted to sexual dysfunction. The research project was not focused on sexual dysfunctions and the author did not intend to diagnose individuals or to promote the medicalisation of the phenomenon; the aim instead was to study the topic from another perspective and to highlight its relevance to the impact on the mental health of individuals, even as it moved away from a medicalised view.

As such, the aim was to consider the physiological aspects of sexual functioning and their relationship with other psychosocial factors that may contribute to the phenomenon of sexual functioning, and thus to promote a biopsychosocial view of the phenomenon without necessarily medicalising it. Published authors have begun to make this shift as well, in response to the recommendations of the DSM-5 and the *International Classification of Diseases*, tenth revision (ICD-10) to conceptualise sexual functioning within the context of sexual distress. In the research that was undertaken for this study, the author went a step further by adding other psychosocial factors that may be associated with the phenomenon, such as sexual perfectionism.

An in-depth description of the multidimensional concept of sexual perfectionism is provided in the literature chapter. For the purposes of this preface, the notion can be briefly described as a multidimensional concept of perfectionism that is focused on the topic of sex and on the identification of whether or not individuals have perfectionist expectations of themselves or others as sexual partners. The focus on women with anorexia nervosa stemmed from my curiosity about the mental health challenges these individuals may face; because, although the body plays a vital role in the presentation of the condition, evidence has also highlighted the crucial roles of psychological factors (such as perfectionism) and their impact on the risk of development of such a disease and in its maintenance.

My interest was piqued by the complexity of gaining a more comprehensive understanding of these difficulties while valuing the role of biopsychosocial components, and this complexity prompted me to construct my research project. By linking the topic of female sexual functioning with sexual perfectionism in anorexic women, it is possible to investigate the chance that sexual perfectionism mediates the relationship between overall perfectionism and female sexual functioning in this client group.

An important component of my interest in this portfolio and its theme of the body and its association with mental health is the desire to expand research on the understanding of sexuality and to emphasise the important association of sexuality with mental health. Women with anorexia nervosa are examples of people who could benefit from such research. Their difficulties in this area have been understood previously in terms of the linkage of weight loss with the production of too few of the hormones that are necessary to engage in sexual intimacy. However, some evidence has shown that many women with anorexia nervosa would like to improve this aspect of their lives as it impacts on their relationships. Many of them have struggled with anorexia for a long time and have been involved in long-term relationships, some even having children or having the desire to have children.

The link between sexual functioning and well-being has been well documented. However, the emergence of research in this field has lagged behind, and some have suggested that the drive finally to better understand the complexities of female sexual functioning is tied into the emergence of Viagra, because the medicalisation of such issues is another way to make profits -- only from females this time. On the other hand, some women may find comfort in the medicalisation of the phenomenon, as it normalises their experiences of difficulties with sexual functioning rather than reinforcing the old stigma that *'it's all in their heads'.* In this sense, the medicalisation of female sexual functioning has given (to some women) the sense that they are being heard and that their difficulties are finally being taken seriously -- and above all, that they have access to support from health professionals.

I position myself as a seeker of understanding of the rationales of both positions and thus I acknowledge the complexities and justifications of both. I emphasise the need for flexible and critical thinking that enables me to engage with clients and to listen to how they understand their own female sexual functioning, their difficulties with it and how it affects them, as my essential role is to meet each client in her world, better to support her.

As such, my journey as a practitioner has highlighted what I call ‘the power of the and'. Rather than focusing on choosing sides, be they epistemological and/or ontological positions, I have moved towards a preference for a pragmatic approach to my work (Cucchi, 2016). I have prioritised awareness of the multiple ways to understand theoretical phenomena in order to meet the needs of clients and to understand their ways of making sense of the phenomena.

I encourage my clients to take care of all the different aspects of their personalities and to understand how they can co-exist. I show them how empowering it can be to connect to different parts of themselves and how this enables them to engage in growth and to connect with different individuals, cultures and life experiences. Additionally, I wish to highlight the importance of practitioners daring to engage with phenomena that may not be commonly associated with their practices and to encourage them to look at these phenomena from a different perspective, even if that means they must sit with the tensions that certain paradigms may bring, in order to meet clients' needs.

It is normalised and common in clinical practice to talk to clients about their emotional and intimate partners, but the clients are not asked systematically about their intimate physical experiences. Perhaps this is because the subject is considered sensitive and taboo, or because practitioners feel uncomfortable venturing into a phenomenon that has been medicalised, or even because they lack awareness of the relevance of exploring such topics in certain clinical populations. This is an important point that future research should address or that practitioners at least should consider, as the broad topic of sexuality may be relevant to a variety of mental health difficulties such as are found in anorexia nervosa.

Some evidence has pointed to clients’ difficulties in the navigation of intimate relationships and recent practice guidelines have attempted to include partners in recovery processes; yet there remains a lack of exploration in psychological treatments of physical aspects such as sexual functioning and sexual distress, and no current guidelines advise practitioners on how to address these themes. Research has highlighted that some of the divide between the exploration of emotional and physical intimacy in this clinical population may stem from the belief that women with anorexia nervosa have no interest in sexual activities, but this does not consider the different stages of recovery of these women, the severity of their symptoms, or the fact that in many women, anorexia nervosa occurs at a crucial stage of development in which sexuality plays a key role, as it is also part of how individuals construct their identities.

Thus, the aim of this doctoral dissertation is to explore the phenomenon of sexual functioning in a clinical population that deserves further attention and to investigate the ways in which counselling psychology and its core values may benefit and support this group. I hope to encourage researchers to conduct studies that are set apart from the medicalisation of this concept but that do not reject it, through incorporation of the physiological and psychosocial aspects of the phenomenon, the highlighting of their intersections and the emphasis on the complexities that exist between them.

These findings are thus important for counselling psychology practitioners, as the combination of core values that are rooted in reflexivity, critical thinking, and the ability to reflect and consider multiple perspectives in the way we meet with our clients, makes them well-equipped to support women with anorexia who have difficulties with sexual functioning.

Furthermore, I recognise that this topic can be approached by acknowledging the importance of the physiological and psychological components of the phenomenon in the context of research. The field of counselling psychology, known for its ability to value objective explanations that may be applicable to many people and the subjective experiences and personal contexts of each individual, can be the appropriate field in which to explore the complexity of such a phenomenon. The need to adapt a biopsychosocial approach to a phenomenon is not exclusive to sexual functioning or the clinical anorexia nervosa population; my experience of working in a clinical health psychology department has made this clear to me.

The case study in the second section of the portfolio tells the moving story of a survivor of childhood sexual abuse. Over time, the client developed a severe case of asthma. Through my work with this client, my learning evolved enormously, as the asthma attacks were always triggered by stimulation associated with past experiences of sexual and emotional abuse, and this observation led me to discover a large body of published evidence on the link between adult asthma and childhood sexual abuse. Although asthma is a medical condition that requires physical care, one cannot ignore the important predisposing factor that is rooted in psychological trauma. The importance of understanding the complexity that links physiological components and psychosocial factors was clearly highlighted to me.

Practitioners must therefore consider the different factors that may affect clients' clinical presentations in order to provide the best possible support. In my case, the discovery of evidence-based research that linked childhood sexual trauma to the onset of asthma in adulthood has not only influenced my understanding but also my support of my client.

This highlighted for me how necessary it was to be mindful of other ways to understand phenomena and not to stick to a one-dimensional way of conceptualising psychological distress with which we may be familiar, and to which therefore we tend to gravitate. This clinical experience taught me how crucial it was to venture into research to determine whether other elements could help me to understand what clients might bring into the clinical room, rather than assuming that the knowledge I had was sufficient. My experience heavily underlined the importance of a continued commitment to research and professional development.

This piece of clinical work introduced me to the field of psychoneuroimmunology, which can be seen as a discipline that is focused on the association between the mind and physical health, and specifically, on how emotional experiences or states can impact such physical states as immunity. I was led to the work of Dr Gabor Mate, who summarises with great clarity key aspects of the complex relationship between mind and body in different contexts, such as addiction, trauma, attention deficit hyperactivity disorder, and certain physical health conditions. Dr Mate argues that the lack of investigation into psychological predispositions, particularly towards psychological trauma, may have impacts on the risk factors for the development of physical illnesses (Mate & Dollin, 2005).

Of course, this does not preclude the need for medical treatment, but one must have the courage to step back and look at the bigger picture to identify the biopsychosocial factors that may be involved in the problems that the client presents, in order to best help them, whether these factors be medical or psychological or both. Thus, I decided to create a portfolio that would highlight the theme of the mind-body relationship, as this was a central topic of my professional development not only as a counselling psychologist, but also as a researcher with a strong curiosity to bring in a multitude of components in the hope of creating a biopsychosocial perspective that could bring new discoveries in the context of sexual functioning and that, I hope, could impact on future clinical practice for women with anorexia nervosa.

PART I: Research – Sexual Perfectionism Mediates General Perfectionism and Female Sexual Functioning in Women with Anorexia Nervosa

A quantitative study

Abstract

Background: Studies have highlighted the importance of determining which psychosocial factors may contribute to difficulties in sexual functioning in women with anorexia nervosa. Sexual functioning is examined in relation to sexual distress in order to avoid labelling a person as having sexual functioning difficulties without considering whether or not they experience them as problematic, as recommended in the literature. As perfectionism can play a crucial role in anorexia nervosa and some studies have linked sexual perfectionism and sexual functioning in women, it was hypothesised that sexual perfectionism may mediate the relationship between overall perfectionism and sexual functioning in this clinical population.

Method: A quasi-experimental research design, based on an online questionnaire, was employed. The research material was shared on social media platforms, with the support of the City Health Care Partnership community interest company, Breathe Therapies, the Eating Disorder Association of Northern Ireland (NI) and NIWE Eating Distress Service (now Eating Distress North East), to recruit participants who were required to be over 18 years of age and either to have been diagnosed with anorexia nervosa by a healthcare professional or to have never been diagnosed with mental health difficulties. The latter would be members of the control group. The data for both groups (N=164 for the clinical group; N=214 for the control group) were analysed through the use of statistical path models to compare results.

Results: Sexual perfectionism was found to mediate the relationship between general perfectionism and sexual functioning in both groups and sexual distress was found also to mediate this indirect relationship. This was also the case regarding self-oriented sexual perfectionism, while partner-prescribed sexual perfectionism mediated only through sexual distress in both groups. Socially prescribed sexual perfectionism only played a mediating role in the context of sexual distress in the clinical group but mediated between perfectionism and sexual functioning alone in the control group. However, partner-oriented sexual perfectionism did not play any mediating role in either group.

Conclusions: The findings regarding partner-prescribed sexual perfectionism and socially prescribed sexual perfectionism, in that they were found to play mediating roles only in the context of sexual distress, suggest that the inability to control the perceptions of others may be distressing for the clinical group, as it may lead to fear of judgement and rejection, which are factors commonly associated with anorexia nervosa. That self-oriented sexual

perfectionism was found also to mediate outside the context of sexual distress may be because some have greater control than others over meeting self-imposed standards as sexual partners. The role of sexual distress in relation to sexual perfectionism is thus highlighted.

Chapter 1: Literature Review

1. General overview

Sexual functioning in the context of women with anorexia nervosa, widely known as anorexia, has been studied mainly in association with experiences of trauma (Gonidakis, Kravvariti & Varsou, 2015; Dunkley, Gorzalka & Brotto, 2016). Little attention has been paid to other psychosocial factors that may play important roles in the theoretical understanding of sexual functioning in women with anorexia (Pinheiro et al., 2010). Price's recent systematic review, published in 2020, reveals that difficulties with sexual functioning in women with anorexia are common, but that understanding of the biological and psychosocial themes that may impact this phenomenon remains limited (Price et al., 2020).

The work of Raboch and Faltus (1991), who looked at sexual development and functioning in women with anorexia nervosa, showed that of their sample of 30 women in their clinical group, 80% had difficulties. Specifically, 53% of them had experienced difficulties in their sex lives before diagnosis, 27% of them experienced deterioration after the onset of anorexia, and 20% of them were avoiding sexual experiences (Raboch & Faltus, 1991). They recommended that topics around sexuality, such as sexual functioning, should be discussed with clients, and they highlighted that some resolution of their sexual problems could positively impact both their general health and their intimate interpersonal relationships, which is another area of difficulty for these women (Arcelus, Yates & Whiteley, 2012). Other studies have determined that women with anorexia nervosa experience greater levels of difficulty in their sexual functioning than do women without any eating disorder (Cassioli et al., 2019).

In many cases, anorexia nervosa is associated with excessive weight loss (Ghizzani & Montomoli, 2000). However, the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) requires that individuals meet the following criteria in order to be diagnosed with the condition:

> *'…having an intense fear of weight gain'*
> or they must experience
> *'…restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, development trajectory and physical health'*
> or they must experience
> '…*a disturbance in the way in which one's bodyweight or shape is experienced'*
> (American Psychiatric Association, 2013).

Two subtypes of anorexia nervosa are identified by the DSM-5: '*anorexia nervosa restricting'* and '*anorexia nervosa binge eating and purging'*. The division of the condition into two types was first introduced in the DSM-IV to distinguish between those with the condition who binge-ate and purged and those who did not. This subcategory also covered behaviours such as self-induced purging, and the misuse of laxatives, enemas, or diuretics (American Psychiatric Association, 2013). However, women with either subtype of anorexia may exhibit perfectionism (Halmi, Sunday, Strober, Kaplan, Woodside & Flichter, 2000; Halmi et al., 2012).

Frost et al. (1990) define perfectionism as a '*tendency to set high standards and employ overly critical self-evaluations'*. It is one of the main risks and maintenance factors of anorexia (Lloyd et al., 2014). Research by Egan (2011) and Shafran (2003) has shown that individuals with anorexia nervosa reported elevated levels of perfectionism, which is also considered a risk factor for relapse post-treatment (Lloyd et al., 2014). The important effect of perfectionism on long-term recovery has been considered (Bastiani et al., 1995; Kaye et al.,), and other studies have examined other components that may play a similar role in the inhibition of recovery. One way to gather such data has been to focus on health-related quality of life in adults with anorexia nervosa. This method has been used because engagement in recovery is difficult due to the *'ego-syntonic'* aspect of anorexia nervosa, which alters the levels of motivation required to undertake treatment (Gregertsen, Mandy & Serpell, 2017; Sy et al., 2013). Therefore, a focus on individuals' perceptions of the quality of their lives during psychological treatments might be associated with greater chances of sustainable recovery (Haracz & Robson, 2017), as many seem to have a low quality of life even after they have regained a healthy weight and finished psychological treatment (Padierna et al., 2002; de la Rie et al., 2007).

Indeed, this clinical population has stated that having interpersonal relationships is one of the most important factors that can improve their quality of life (De Ruysscher et al., 2016). Newton et al. (2006) showed that participants wished to engage in healthy, positive, physically intimate experiences. This finding contradicted previous studies that suggested that women with anorexia nervosa tended to prioritise the desire for emotional closeness over physical intimacy (Newton et al., 2006). This finding is aligned with the current theoretical understanding held in the medical field of the importance of having a healthy and positive sex life and how it is strongly correlated with a person's overall quality of life (Dunkley et al., 2016). Such arguments are also aligned with the work of other researchers, who demonstrated that women with anorexia nervosa showed the same desire for positive emotional and physical intimacy as did healthy controls (Schmidt et al., 1995; Maxwell et al.,

2011). These findings highlight that further research is needed to better understand the difficulties that women with anorexia face in these areas of their lives, and there is a need to address the sexual problems they may encounter (Morgan, Wederman & Pryor, 1995).

The *International Classification of Diseases,* tenth edition (ICD-10), which is published by the World Health Organisation, conceptualises sexual functioning difficulties as '*various ways in which an individual is unable to participate in a sexual relationship as he or she would wish'* (Basson, 2000). The DSM-5 conceptualises this phenomenon as a *'clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure'* (American Psychiatric Association, 2013, p.423). However, the debate regarding what defines a sexual problem and whether or not this can be pathologised is ongoing (Balon, Segraves & Clayton, 2007). This issue is discussed in depth later in this chapter.

There is evidence of some of the difficulties in sexual functioning that some women with anorexia nervosa experience. Work by Pinheiro and colleagues (2010) showed that women with restricting and purging behaviours were more prone to loss of libido than were women with bulimia or eating disorders that had not been specified, and that they changed partners more frequently than women without eating disorders. This behaviour may have reflected the difficulties they experienced in intimate relationships (Pinheiro et al., 2010). In addition, Raboch (1986) showed that less than half of a cohort of women with anorexia achieved orgasm, compared with 78% of women without eating disorders, who reported that they experienced orgasm regularly during penetrative sex.

In one study, women with anorexia were reported to show moderate satisfaction with their sexual experiences (Pryor, Wiederman & McGilley, 1996). Another study reported that many women with anorexia nervosa experienced difficulties in their intimate relationships, both in maintaining emotionally close, intimate relationships and in the sexual aspect of these relationships (Gonidakis et al., 2016).

These findings create a wide range of possibilities for further exploration within a biopsychosocial approach of the components that may be associated with these difficulties (Pinheiro et al., 2010). For example, although low body weight may be associated with reduced libido, it has been determined that nutritional problems alone are not sufficient to create difficulties in the sexual domain (Keys et al., 1950). Researchers have also begun to question the role of personality in the difficulties that may arise for these women in sexual functioning (Eddy, Novotny & Westen, 2004; Gonidakis et al., 2016).

Eddy et al. (2004) performed the only research to have examined the relationship between sexual functioning in anorexia nervosa and personality traits such as perfectionism. The findings highlighted the presence of perfectionism and its potential influence on the sexual functioning experiences of women with anorexia nervosa. The researchers encouraged others to produce further evidence (Eddy et al., 2004). They argued that one of the reasons why the literature produced conflicting results on sexual difficulties in this population was due to the focus on the comparison of DSM diagnoses of eating disorders only, and that perhaps, the performance of studies on this issue that controlled for other factors, such as personality profiles, might yield new data that might be applicable to more than just samples of inpatients.

The study was performed according to a '*practice research network approach'* (Eddy et al., 2004), which is a method whereby a randomly selected sample of experienced health professionals provide data on their patients. In this case, clinicians described each patient according to a set of measures (clinical data form – eating disorder version, axis I eating disorder checklist and the Shedler-Westen-200 assessment procedure) and in a personality letter. This system maximised generalisability as it retained the focus on the clinical presentation of symptoms rather than on the ways in which the patients met DSM-IV diagnostic criteria.

The study looked at three personality styles. The first was described as '*high-functioning'* or '*perfectionist'*, which was characterised by a combination of empathy and high levels of perfectionism, anxiety or guilt. Another was described as *'restricted'* or *'over-controlled';* these individuals were more likely than the others to have limited psychological insight. The third was '*dysregulated'* or *'under-controlled';* these individuals found it difficult to regulate high emotional states. Limitations of the study were the lack of specific measures and the examination of sexual attitudes and behaviours as an outcome of exploring the broader topic of sexuality in association with eating disorders. Yet despite this, the results highlight that '*personality links eating and sexuality, at least in a subset of women with eating disorders'* (Eddy, Novotny & Westen, 2004).

Parallel studies have investigated whether perfectionism, in the context of sex, may be associated with different aspects of sexuality, including female sexual functioning (Stoeber et al., 2013). Wiederman (2001) argued that women were more likely to set particularly high and often unrealistic expectations of themselves as sexual partners, which could lead them to worry about their bodily appearance and/or performance during sexual activity (Wiederman, 2001).

The term ‘sexual perfectionism’ is derived from the work of Snell, who was inspired by work on perfectionism by Hewitt and Flett (Hewitt & Flett, 1991). Specifically, Eidelson and Epstein (1982) defined sexual perfectionism as a ‘*cognitive distortion involving the belief that one must be the perfect sexual partner*’ (Eidelson & Epstein, 1982). Sexual perfectionism should be understood as a multidimensional phenomenon that involves the following four areas: self-oriented sexual perfectionism, which is focused on individuals who set high standards for themselves as sexual partners; partner-oriented sexual perfectionism, which refers to the perfectionist expectations one may have of one’s partner; partner-prescribed sexual perfectionism, which refers to the expectations of one partner that the other will have high expectations of them as a sexual partner; and finally, socially prescribed sexual perfectionism, which refers to the sense a person has that society requires them to meet certain expectations as a sexual partner (Stoeber & Harvey, 2016).

The concept of sexual perfectionism is independent of overall perfectionism. It resulted from the evolution of the field of perfectionism to an examination of perfectionism in specific areas, as researchers became aware that individuals might be perfectionist in some aspects of their lives but not in others (McArdle, 2010). However, this does not mean that general perfectionism is unimportant in the context of eating disorders; Stoeber and Yang (2015) showed that although it was useful and insightful to study, for example, physical appearance perfectionism and its association with eating disorder symptoms, levels of general perfectionism played important roles in their findings (Stoeber & Yang, 2015).

In line with these findings, it has been suggested that a general measure of perfectionism should be included in future research on all forms of sexual perfectionism, particularly in the context of sexual functioning (Stoeber & Harvey, 2016). It has been established that women tend to set unrealistic expectations of themselves as sexual partners (Quadland, 1980), and there is increasing parallel evidence on the multidimensional factors that influence female sexual functioning (Farmer & Meston, 2007; Woertman & van den Brink, 2012; Barbara et al., 2017; Roy et al., 2019); yet only recently has the evidence-based literature begun to explore the relationship between sexual perfectionism and female sexual functioning in the general public (Stoeber et al., 2013). For instance, partner-prescribed sexual perfectionism has been associated with decreased levels of arousal and lubrication over time (Stoeber & Harvey, 2016).

These studies taken together show evidence of a link between sexual perfectionism and sexual functioning in women and the recommendation that a general measure of perfectionism be included in future research on sexual perfectionism (Stoeber & Harvey,

2016); evidence that difficulties in sexual functioning among women with anorexia are linked with their high levels of perfectionism (Bardone-Cone et al., 2009, 2010; Pinheiro et al., 2010); and evidence that anorexia has a negative impact on emotional and physical relationship experiences (Gonidakis et al., 2016). Therefore, it was hypothesised that sexual perfectionism might mediate the relationship between perfectionism and sexual functioning in women with anorexia nervosa.

It is worth explaining why the topic of female sexual functioning in anorexia nervosa should be explored in relation to the field of counselling psychology. This section is crucial as it highlights the importance of paying attention to such topics because of their potential impact on clinical practice and the development of future guidelines.

2. Relevance of the study to counselling psychology

Although the study described in this paper was focused on whether or not sexual perfectionism mediated between perfectionism and female sexual functioning in the context of anorexia nervosa, female sexual functioning is part of the broader phenomenon of sexuality, which is described by the World Health Organisation as follows:

> *'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships … Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors'* (World Health Organisation, 2016, para. 6).

It is important to emphasise that sexuality is not limited to the body and that physiological aspects are influenced by psychosocial factors, the individual's context, and their mental health (Butler, O'Donovan & Shaw, 2010; Murray, Pope & Willis, 2017). It has been recommended that the field of counselling psychology incorporate a sex positivity approach (Burnes, Singh, & Witherspoon, 2017; Cruz, Greenwald, & Sandil, 2017; Mosher, 2017) that draws on a variety of disciplines such as feminist and humanist philosophies, sexology and sociology (McLaren, 1999; Beauvoir, 2015; Mosher, 2017; Dodd, 2020). Sex positivity emphasises the positive aspects of eroticism and intimacy, normalises the fluidity of sexual experiences as long as they are consensual expressions (Moss, 1996), acknowledges that

sexual practices are undertaken for pleasure (Hull, 2008) and considers individual differences and their socio-political contexts and cultural norms (Popovic, 2006; Moir, 2022).

A sex positivity approach involves consideration of a multitude of factors that are not anchored solely in the outcomes of sexual behaviour or gender. Williams, Prior and Wegner (2013) conceptualised the sex positivity approach as *'allowing for a wide range of sexual expression that takes into account sexual identities, orientations, and behaviours; gender presentation; accessible health care and education; and multiple important dimensions of human diversity'* (p.273). Thus, the importance of remaining open-minded, non-judgemental, and respectful of others and their unique expressions of sexuality is crucial in the context of adopting a sex-positive approach (Kimmes et al., 2015), and these are key values that align with the field of counselling psychology (Cooper, 2009).

Stephenson and Meston (2015) highlighted the lack of discussion around the topic of sexuality in counselling psychology training programmes, even though it is an important aspect of well-being. They emphasised the relevance of integrating such topics into the field, as counselling psychologists are known to place a strong foundational value on all aspects of the self in their clinical practices (Stedmon & Dallos, 2009; Stephenson & Meston, 2015).

Although the topic of sexuality may be lacking from the taught aspects of educational programmes, the interest in it among doctorate students within the profession has been demonstrated by the various doctoral research projects that have been conducted on the topic (Bakuri, 2021). This highlights not only the students' interest but also the importance and appropriateness of the topic for incorporation into the field of counselling psychology, and that counselling psychology research that addresses such topics is relevant and necessary (Jager, 2021; Arends, 2022). Lifelong development and sociocultural contexts, for instance, are factors to which counselling psychologists pay attention with their clients (Mollen et al., 2020). Reissing and Di Giulio (2010) argued that counselling psychologists could address sexuality-related difficulties from a systemic perspective, as they would often do with other clinical difficulties that they encountered outside this area of expertise.

Furthermore, it has been suggested that with supervision and by engaging in their own reflexivity about the topic of sexuality, counselling psychologists can develop skills to address these difficulties with clients (Cruz, Greenwald & Sandil, 2017). There are American Psychological Association practice guidelines for working with women and girls (American Psychological Association, 2007), many of these direct clinicians to explore sexuality-related themes that are focused on safe sex, sexuality across the lifespan, pregnancy or

menopause. There is a lack of guidance to prepare clinicians to help clients with other sexuality-related concerns, particularly in areas such as sexual functioning. This may be because sexual functioning has been medicalised and therefore the impression has been given that it is not as relevant as other topics to the field of counselling psychology (Tiefer, 2010; Mollen et al., 2020).

Yet the lack of discussion of sexual functioning with clients may contribute to the medicalisation of these difficulties, as clients seek physiological explanations or pharmacotherapeutic treatments rather than engagement in psychological treatments to discuss whether certain psychosocial factors, such as sexual distress, are causing or at least exacerbating difficulties with sexual functioning (Bradley & Fine, 2009; Zeglin, Van Dam & Hergenrather, 2018). Furthermore, if clients are hesitant to discuss sex-related issues in the therapy room, perhaps for fear of the clinician's judgement (Daines & Perrett, 2000), and if they are not asked directly about this topic by the clinician, they may feel that this is not the place to discuss these issues (Miller & Byers, 2009).

In the literature, researchers have highlighted the fact that in many cases, sex-related topics are not discussed in the context of therapy if clients do not raise these issues themselves (Ng, 2007). It has been suggested that psychologists may be reluctant to discuss sexuality-related topics with their clients because they do not feel competent to address these concerns (Miller & Byers, 2012; Abbott, Vargas & Santiago, 2023).

Thus, it is important that counselling psychologists reflect on what aspects of sexuality they are not comfortable discussing and why, and that they learn how to initiate and lead conversations on these topics (Butler, O'Donovan & Shaw, 2010; Hatcher et al., 2013). It has been suggested that feelings of embarrassment or awkwardness may lead clinicians to avoid discussion of sex-related topics. Therefore, it has been recommended that efforts be made to make clinicians comfortable with the topic by normalising it and encouraging them to engage in discussions with other professionals on the subject (Zeglin, Van Dam & Hergenrather, 2018; Thompson, 2020; Mollen & Abbott, 2022).

The literature stresses the importance of integrating both psychosocial factors and discussion of sexual difficulties into the theoretical understanding of female sexual functioning in order to create a broad clinical formulation that can be applied to other issues, such as mood, relationship difficulties, and even anxiety and depression (Bodenmann, Ledermann & Bradbury, 2007; Vencill, Tebbe & Garos, 2015; Kogure et al., 2019).

Therefore, it could be argued that this is an important area with which counselling psychologists should engage (Thomas & Thurston, 2016). It is important to note that these factors are all known to affect the severity of anorexia nervosa as well (Gauthier et al., 2013, 2014; Godart et al., 2015; Treasure & Cardi, 2017).

The recommendation in the DSM-5 that psychological distress be integrated into the understanding of female sexual functioning highlights the tension that resides in the current conceptualisation of sexual functioning. This tension occurs because, although female sexual functioning has been medicalised, some criticisms of this move have led to the recognition that difficulties with sexual functioning can involve a multitude of complexities that cannot be reduced to a purely physiological component (Thomas & Thurston, 2016; McCool-Myers et al., 2018).

For this reason, it can be argued that psychological sexual distress should be understood as a component of female sexual problems. Of course, the experience, frequency and level of this distress is rooted in personal circumstances and individual differences, which highlights that sexual functioning, one of many factors involved in the broad concept of sexuality, is complex and unique to each individual (Stephenson & Meston, 2012; Pascoal et al., 2018).

The Division of Counselling Psychology of the British Psychological Society (BPS) claims that a strong purpose of counselling psychology practice is to '*engage with subjectivity and intersubjectivity, values and beliefs*' and that this subjectivity *'unfolds with the physical, social, cultural and spiritual dimensions of living' (*BPS, 2015). Therefore, the considerations outlined above regarding sexual functioning align with the values of the counselling psychology profession. In fact, some authors have argued that counselling psychology incorporates a nomothetic approach because, on the one hand, it recognises the uniqueness of everyone, but it also sees the value of objective explanations that may be applicable to multiple individuals (Galbraith, 2018).

Thus, the phenomenon of sexual functioning is relevant in counselling psychology because the theory of the profession encompasses the biopsychosocial model and its values encourage further research into the phenomenon to integrate subjective and objective aspects. This is due to the relationship between physiological and psychosocial factors that influence the experience of sexual functioning.

Moreover, evidence shows that sexual functioning is affected in a clinical population such as those with anorexia, and most research on eating disorders is now generally published in eating disorder journals. Thus, there is a need to increase the number of articles on anorexia nervosa that are published in counselling psychology journals. The latest evidence suggests that people with severe eating disorders have better prognoses if they are treated by multidisciplinary teams (Woodruff et al., 2020). This is likely to be due to the multiple aspects of this condition, which mean that those with it require the support of professionals with different expertise, such as nutritionists medical doctors and psychologists (Culbert, Racine & Klump, 2015).

Furthermore, research has also shown that the involvement of partners of people with anorexia nervosa during treatment may be beneficial (Bulik et al., 2011). An important aspect of anorexia nervosa is its impact on interpersonal relationships (Fischer et al., 2015), which also influences engagement levels in psychological treatments (Tozzi et al., 2003). The quality of an intimate relationship can be altered by the way in which the partner supports the patient in their recovery from anorexia nervosa, and this dynamic can influence emotional intimacy and therefore physical intimacy and its aspects, such as sexual functioning (Cassioli et al., 2019, 2020).

The awareness of difficulties in sexual functioning in the anorexia nervosa population, the link between sexual functioning and mental health, and the recent shift in the theoretical conceptualisation of female sexual functioning towards a biopsychosocial approach, all demonstrate the relevance of the further study of this topic by counselling professionals so that they can provide appropriate psychological care to this population.

3. Literature search process

The design of the study performed for this project was the result of the literature search process described here. First, the search term ‘anorexia nervosa AND sexuality OR female sexual functioning’ was used. All study designs were considered; however, studies that concerned sexual orientation or gender identity were excluded, as this was not the focus of the research. The search term drew out studies that concerned either sexual attitudes and components of sexual functioning (such as difficulties with desire and orgasm) or the use of the female sexual functioning index (Buvat-Herbaut et al., 1983; Raboch & Faltus, 1991; Morgan, Lacey & Reid, 1999; Gonidalis et al., 2016; Ricca et al., 2017).

To ensure that no information had been missed due to the restriction of the search to anorexia nervosa, a second search was conducted using the search term ‘eating disorders AND sexuality OR female sexual functioning’ from which any studies that included a sample of anorexia nervosa patients were examined. Studies that did not mention sexual functioning were excluded, but those that mentioned a multitude of sexuality-related factors, such as sexual behaviour or attitudes, were included if they also incorporated the factor of female sexual functioning, or components associated with it such as desire, arousal, lubrication, orgasm, pain, and satisfaction (Rosen et al., 2000).

The aim of this method was to ensure that findings on female sexual functioning could be considered during the development of the present study by highlighting research recommendations that promoted the understanding of the phenomenon of sexual functioning, for example in the context of personality (Wiederman, 1996; Eddy, Novotny & Westen, 2004; Ricca et al., 2017; Cassioli et al., 2022).

Since perfectionism is considered a common personality trait in people with anorexia nervosa (Dahlenburg, Gleaves & Hutchinson, 2019), another search was carried out to discover whether perfectionism in the context of female sexual functioning had been studied and to investigate whether these studies might suggest that this was a potential concern for women with anorexia nervosa. The search term 'perfectionism AND female sexual functioning' drew out evidence regarding sexual perfectionism and sexual functioning in women in the general population, and evidence that perfectionism should be included in future research that aimed to examine sexual perfectionism and sexual functioning (Kluck, Zhuzha & Hughes, 2016; Stoeber & Harvey, 2016).

The key phrase 'sexual perfectionism' was then used in a search to highlight any evidence that may have established links between it and areas of sexual functioning, such as sexual satisfaction (Habke, Hewitt & Flett, 1999). Finally, as the literature has shown that some women with anorexia nervosa report healthy and positive sex lives (Buvat-Herbaut et al., 1983) but they may experience difficulties in sexual functioning, another search was conducted using the term 'anorexia nervosa AND female sexual functioning'.

4. Female sexual functioning

4.1 Definition

A 'simple' way to define and understand female sexual functioning is as a construct of the following factors: desire, arousal, lubrication, orgasm, satisfaction, and pain/discomfort (Fielder, 2013). One way to ascertain whether or not someone is having difficulty with sexual functioning would be to refer to specific problems with one of those factors, or with moving from one factor to another, as they can be related to each other during sexual experiences (Fielder, 2013).

However, measurement of the degree of satisfaction of the individual regarding the problem is required, which is why this factor is present in the definition. This might include dissatisfaction with the frequency of what they are experiencing; for example, some people may say that they are having difficulties if they are not achieving orgasm as often as they would like, or if they find that they often have difficulty with lubrication or arousal levels.

It is essential that this concept is understood in association with the ways in which individuals relate to themselves. It could be argued, therefore, that there is ambiguity in referring to sexual difficulty as dysfunction, as this can suggest a reductionist perception of the phenomenon of sexual functioning to physiological components only. Psychological and sociocultural factors have impacts on elements, such as orgasm, of female sexual functioning (Mah & Binik, 2005; Cuntim & Nobre, 2011; Kontula & Miettinen, 2016). For instance, researchers have investigated the factors that may influence the function and frequency of orgasm in the context of heterosexual relationships, and have highlighted the inequalities between male and female sexual pleasure (Lentz & Zaikman, 2021). A factor that may play a role in the frequency of orgasm is traditional gender roles (Kiefer & Sanchez, 2007; Sanchez, Fetterolf & Rudman, 2012).

For example, the traditional ideology that men are more entitled to sexual pleasure than women (Klein & Conley, 2022), and the view that women are submissive (Kiefer et al., 2006) are associated with a reduced capacity for female orgasm due to a lack of sexual agency and therefore satisfaction (Simon & Gagnon, 1998). There is evidence that passivity during sex can reduce the chance of orgasm in heterosexual women (Wongsomboon, Webster & Burleson, 2022). These are just a few examples of factors that may be related to the difficulty of achieving orgasm.

To demonstrate the complexity of this phenomenon, researchers have examined other psychological, social, and contextual factors that impact orgasm in terms of individuals and their intimate relationships (Nekoolaltak et al., 2017; Ribeiro et al., 2022). It has been found that women are more judgemental of their bodies than men and many consider their genitals to be unattractive, which can impact their levels of sexual satisfaction, another component of female sexual functioning (Reinholtz & Muehlenhard, 1995). Nobre and Pinto-Gouveia (2008) discovered that women with strongly negative perceptions of their bodies were more likely to have lower sexual responses than were women with less negative perceptions (Nobre & Pinto-Gouveia, 2008; Ramseyer Winter et al., 2020). This could be because they felt emotions such as shame or guilt regarding their body (Schooler et al., 2005).

Body image is also associated with other components of female sexual functioning (Woertman & van den Brink, 2012; Dakanalis et al., 2013). This link has been explored through the lens of objectification theory (Fredrickson & Roberts, 1997), which highlights how, in Western culture, many people view women's bodies as objects to be evaluated and commented upon constantly by others. Thus, women are exposed daily to either the *'sexualised male gaze*' (Gervais, Vescio & Allen, 2011; Tiggeman & Williams, 2012) or to media that promote unrealistic body ideals (Szymanski, Moffitt & Carr, 2011). As a result, women may internalise this perception of themselves as objects, which increases the risk of development by some women of a variety of negative issues such as eating disorders (Noll & Frederickson, 1998; Calogero, Davis & Thompson, 2005; August-Horvath & Tylka, 2009; Calogero & Thompson, 2009; Katznelson et al., 2021), or of anxiety about their physical appearance that can lead women to 'scan' or 'police' their bodies (Fredrickson & Roberts, 1997).

One can argue that women undertake a type of surveillance of their bodies as they have learnt to associate their looks with societal rewards. For example, if women associate their self-esteem with a committed relationship, which they perceive to be conditional on their continued perseverance to achieve society's unrealistic standards of beauty, they may engage in behaviours that may impact their mental and physical health negatively in order to maintain the relationship (Tylka & Augustus-Horvath, 2011). Some women who are preoccupied with their physical attractiveness report lower levels of desire and arousal than those without such a preoccupation and have lower levels of sexual satisfaction (Seal, Bradford & Meston, 2009; Quinn-Nilas et al., 2016). Conversely, research has shown that a woman’s perception that her partner values her body has a positive impact on her sexual functioning (Walters, Lykins & Graham, 2019).

In the study conducted for this project, there was no time to consider all the variables related to female sexual functioning. However, it is important to highlight and acknowledge the multitude of factors that may affect sexual functioning in order to avoid the promotion of a reductionist approach to the phenomenon. For example, such an approach might ascribe sexual functioning problems to demographics, social norms, relationship quality, body image, gender norms and sexual orientation, history of sexual experiences, culture, genetics, or physical health conditions (Viljanen et al., 2007; Kingsberg & Knudson, 2011; Assalian, 2013; Khajehei, Doherty & Tilley, 2015; Boquiren et al., 2016; Pascoal et al., 2018; Scappini & Fioravanti, 2022). Readers are therefore encouraged to pursue further research to better understand the various biopsychosocial factors that may be related to or intertwined with the components of female sexual functioning.

One issue that arises in relation to the definition and conceptualisation of female sexual functioning is the way in which the terminology of sexual functioning may be associated with various factors in the literature and can therefore easily lead to confusion about how we define it and what it involves. Researchers sometimes do not define carefully what they are referring to when they talk about sexual functioning, even if they use measurement tools that assess the phenomenon clearly. For example, whereas van der Vaart et al. (2022) give the reader relevant information about what they are referring to when they talk about sexual functioning, but in some studies the terminology 'sexual functioning' and 'sexual dysfunction' seem to be intertwined, with use of the terminology 'sexual functioning' in the title but the use of phrases such as 'sexual dysfunction' in the results (Dèttore, Pucciarelli & Santarnecchi, 2013).

One way to understand this is to observe that the study of difficulties with sexual functioning through a medicalised approach usually involves referral to them as sexual dysfunctions or disorders; however, use of such language can give the impression that a medicalised approach to the phenomenon has been adopted, which leads to the question of whether the phenomenon can be studied from another angle, and to consider the possibility of studying sexual functioning without referring to it as 'dysfunction' or 'disorder'. This conundrum is illustrated in the review conducted by Price et al. (2020), where it is clearly stated in the methodology section that the authors searched the databases for studies that referred to 'sexual function' and 'sexual dysfunction'. Both terms were searched for because it is of course possible to determine whether individuals are experiencing difficulties related to factors such as low arousal, difficulty reaching orgasm or pain during sexual activity without resorting to clinical terms such as 'dysfunction' or 'disorder' (Stephenson & Meston, 2012; Price et al., 2020).

It is worth noting this in order to clear up any confusion with regard to the topic explored in this study, and to point out that there are discrepancies in the literature with regard to wording, but that examination of the phenomenon of sexual functioning does involve the above-mentioned factors, and that it is only a matter of terminology and approach to this topic that may differ depending on how studies are conducted and the vocabulary that researchers choose to use. This review addresses the complexity of the phenomenon of sexual functioning, but the purpose of this study was to look at the concept of sexual functioning without opting for a medical approach, so there was no intention to identify disorders or dysfunctions, but rather to explore the phenomenon of sexual functioning by taking into account its components: desire, arousal, lubrication, orgasm, satisfaction, and pain/discomfort.

Most importantly, this study conceptualised sexual functioning in the context of sexual distress in order to recognise the psychological aspects and contexts of the individual rather than to promote a purely physical understanding of female sexual functioning. On the face of it, if one looks at the conceptualisation of sexual functioning in the DSM-5, the name can be seen as an 'umbrella term' that implies a variety of diagnoses such as female orgasm disorder, female sexual interest/arousal disorder, genital-pelvic pain/penetration disorder, and substance/medication-induced sexual dysfunction.

Although such diagnoses can be useful and even crucial for research into how best to assess and develop treatments for sexual problems (Carvalho, Vieira & Nobre, 2011, 2012), it could be argued that this listing of difficulties that may arise and associating them with the concept of 'dysfunction' does not provide a clear definition of the phenomenon of sexual functioning or an understanding of the depth of what is involved in female sexual functioning.

Jones' (2002) review highlighted how knowledge of female sexual functioning had changed over the previous ten to 15 years, due to the multitude of domains that were involved in the phenomenon. This increased level of knowledge also impacted how researchers gathered evidence on the subject, as measurement instruments, for example, had become more sophisticated in terms of the number of factors they could track (Jones, 2002).

Researchers have cautioned against relying on one measurement tool to understand or even to diagnose or treat sexual functioning difficulties. This point calls into question literature statements and clinical practice in terms of how to care for clients with sexual functioning difficulties and ensure that assessment is comprehensive (Jones, 2002).

These complexities and the referral in many studies to DSM criteria for sexual dysfunction make it difficult to understand what sexual functioning is and what it entails as a phenomenon. Many researchers opt for a medicalised approach to the phenomenon and then seek comprehensive aspects of what they call 'disorders', which compartmentalises its specific domains into categories of 'dysfunction'. Fagan's (2004) work showed how difficult it could be for researchers and/or clinicians to understand the range of different perspectives on sexual functioning that were shown in the literature while they used as a baseline the DSM classification of difficulties into established categories. This study also showed the extent to which professionals had to be able to integrate different perspectives on the issue during clinical practice and to consider carefully their approach to the phenomenon during the conduct of evidence-based research on the issue so that others could clearly understand on which perspective the research had been built (Fagan, 2004).

To understand better the historical tensions and complexities that are associated with this concept, it is necessary to step back and examine some of its aspects. Therefore, the next section contains a brief overview of the thinking about the origins of the concept of 'functioning' in the social sciences. It is followed by an overview of the early theories of female sexual functioning, the theories on which the DSM and ICD classifications of problems are based and the tensions that arose from this approach.

4.2 The notion of 'functioning' in social sciences

Aristotle and Galen were the first authors to focus on the concept of 'function', claiming that, as Freemon (1994) put it, '*every structure in the human and animal body was perfectly situated to perform its function'*. The focus on function became a fundamental element in the development of science in the modern period. The term 'dysfunction', on the other hand, emerged in the early 20th century, when researchers began to focus on brain function. As a result, the definition and conceptualisation of function began to be applied in the life sciences (Katz & Marshall, 2004).

For instance, authors started to define anxiety, depression and apathy as mental dysfunctions. Mackenzie, for example, claimed that *'the mind like any other organ is in arrhythmia, and either overworks or underworks'* (Mackenzie, 1941, p.181). As the biomedical perspective gained support, this meant that sexual functioning became measurable, standardisable, and subject to medical treatments.

There has been a major shift in the 20th and 21st centuries regarding emotional and psychological factors and their influence on sexual difficulties. The biomedical perspective was strongly rooted in the belief that sexual desire, for instance, was consistent and women experienced it in similar ways at different times in their lives (Wood, Koch & Mansfield, 2006). This is because of the context of the time, when researchers considered that there was little difference between the sexes in terms of how they responded to the process of sexual functioning. This attitude is highlighted in the section below and shows the importance of gaining a brief understanding of the theory and its societal and political contexts.

4.3 Early theory of female sexual functioning

Both the ICD and DSM were initially based on the model of the human sexual response cycle that had been developed by Masters and Johnson (1970) and was later revised by Kaplan (1979) (Carvalho, Vieira & Bobre, 2012). Masters and Johnson observed the physiological aspects of sexual behaviour in men and women and created a model, which emphasised that sexual responses could be understood as several coordinated phases: the excitement, plateau, orgasmic and resolution phases. The excitement phase referred to being aroused by physical or psychic stimuli. They claimed that if the response felt pleasant to the individual, its intensity would lead to sexual tensions that would lead to orgasm. They referred to this period as the plateau phase. They posited that the duration of these phases was dependent on the effectiveness of the stimulus.

The orgasmic phase was defined as *the 'few seconds during which the veinous constriction and myotonia developed from sexual stimuli are released'.* It represented the highest level of sexual tension (Pines, 1968). There was an acknowledgement within their model that the duration and intensity of orgasm differed between females and males; however, they stressed that both went through a similar process as they passed from the orgasmic to the resolution phase, which was the stage at which the individual returned to an unstimulated state. Masters and Johnson stressed that there were more similarities between the sexes than there were differences, in terms of how they both reacted to sexual stimulation, which increased muscle tension and that the stage of orgasm represented the release of such tensions (Pines, 1968). In this sense, one can argue that Masters and Johnson's initial understanding of sexual functioning placed a strong emphasis on physical responses and therefore promoted the notion that sexual responses were linear and predictable (Masters & Johnson, 1970).

Masters and Johnson’s work was initially considered iconic, particularly given that it was conducted in a laboratory setting and no other study had managed to replicate the results. However, researchers have reflected critically on this work over time and now emphasise that the model's greatest weakness is its lack of a psychological component (Levin, 2008).

Tiefer (1991) went further and criticised the design of the laboratory experiment because it involved a selection of a small, selective sample of individuals who were willing to expose their sexuality in a laboratory environment. The sample was therefore not random, which raised problems regarding the generalisation of sexual physiology from not necessarily 'normal' physiological responses.

No other researcher has been able to obtain a random sample of participants to replicate the results and thus determine whether or not the physiological responses described in the model can be described as normal or abnormal (Tiefer, 1991). However, Kaplan revised the model and proposed a three-phase version that comprised desire, arousal and orgasm (Thomas & Thurston, 2016) after gathering evidence that individuals had difficulties with desire (Dodd, 1980). This issue was further explored various authors.

4.4 Basson’s circular theory

Basson developed a new understanding of female sexual functioning through her proposal of a circular model of female sexual response that emphasised the role of both physical and emotional satisfaction (Basson, 2000). A survey conducted in 1999 found that the sexual functioning-related difficulty that was identified the most among females aged 18-59 years was the experience of a lack of desire (Laumann, Paik & Rosen, 1999).

Bancroft, Loftus and Long (2003) found that the Laumann et al. (1999) study was used subsequently as evidence to support the need to develop effective medical treatments for female sexual difficulties. They pointed out that the results were widely cited in this way in the media and medical literature despite the findings showing a strong association between mental health, relationship difficulties and other aspects of quality of life with female sexual functioning (Bancroft, Loftus & Long, 2003). This raised concerns about how the results might be understood and the impact they might have on further investigations. This episode highlighted the current ambiguity in labelling sexual difficulty as ‘dysfunction’ and how easy it could be to reduce the phenomena of female sexual functioning to physiological components only.

Other data have confirmed that many women report low levels of sexual desire; however, a critical approach to understanding these findings is necessary due to methodological limitations, such as uncertainty about whether women report a lack of spontaneous sexual desire but experience desire that is triggered by stimulation (Basson, 2005).

Further evidence has highlighted that most women do not differentiate between desire and arousal (Carvalho, Vieira & Nobre, 2012). This finding may influence study results if researchers do not ensure that all their participants share the same understanding of the terms. This ambiguity may be why it has proved difficult to develop effective and appropriate pharmacotherapy treatments (Nappi et al., 2016). Critical reflections such as these have enabled the emergence of new evidence and highlighted the importance of acknowledging the complexity of sexual desire in women (Bancroft et al., 2003).

Women initiate sexual experiences for a variety of reasons that are not necessarily rooted in the presence or absence of sexual desire. Researchers have found that many women experience a lack of sexual desire at the beginning of sexual experiences. They report that people engage in sexual activity for various reasons, such as to experience intimacy and commitment with a partner, to try to reduce their stress levels, or because they wish to feel physically attractive (Meston & Buss, 2007; Kelberga & Martinsone, 2021).

Reports in the literature have classified motivations for sex as either positive or negative; positive motivations are related to a sense of intimacy and increased sexual and relationship satisfaction (Muise, Boudreau & Rosen, 2017), while negative motivations are associated with factors such as a way to cope with negative emotions such as loneliness or low self-esteem, or to handle relationship conflict, which can lead to difficulties with sexual functioning (Impett et al., 2008; Watson et al., 2017).

Indeed, it has been shown that individuals who engage in sexual activities for negative reasons experience lower levels of sexual satisfaction and desire than those who engage in it with positive motivation. Both of these emotions are important factors in sexual functioning (Muise, Impett & Desmarais, 2013; Opperman, Benson & Milhausen, 2013). It has also been shown that women who engage in casual sex, for example for physical pleasure, and prioritise their pleasure, they have better orgasmic function, which is another component of sexual functioning. In contrast, women who choose to engage in such activities for reasons of insecurity, which involves factors such as feeling pressured to have sex, trying to maintain self-esteem, or perhaps worrying about a partner's judgement, have more difficulty reaching orgasm.

The experience of fewer orgasms is also associated with an increase in levels of negative emotions after casual sex, such as regret (Wongsomboon, Webster & Burleson, 2022), or even feeling pressured to fake an orgasm to please their male partner, which may lead them to experience feelings of disappointment or resentment (Piemonte, Conley & Gusakova, 2019).

It is important to bear in mind that the context of casual sex may be associated with lower orgasmic function compared with women in relationships, because the partner's responsiveness to the woman's sexual needs is greater in the context of a relationship than it is with a casual partner. Women may find it more difficult to assert themselves during sex with casual partners, which may be the result of social power dynamics (Armstrong, England & Fogarty, 2012). Sexual assertiveness is also associated with sexual functioning (Woerner & Abbey, 2017).

However, if a woman’s purpose is to experience physical pleasure and to be assertive in communicating their needs, they can experience positive casual sex experiences (Wongsomboon, Webster & Burleson, 2022). Basson's (2005) study pointed out that a woman who was willing to engage sexually with her partner could do so by focusing on the sexual stimulation provided by both parties. As a result, if the stimulation was satisfactory, her sexual desire and arousal might increase over time and lead her to become more engaged in sexual activity (Basson, 2005). However, it is imperative to note that studies have shown that women's personal beliefs about female sexual functioning can both trigger and maintain sexual difficulties.

Women's relationships with their sexual functioning and how they define what is 'normal' or ’abnormal’, or satisfying or not, can influence their overall experience of their sexual well-being. This statement highlights the importance of considering psychosocial factors and the context of the individual regarding sexual functioning, and how much more there is for evidence-based research to discover when it comes to further understanding what psychosocial factors influence the phenomenon of female sexual functioning.

Women's beliefs have been shown to play an important role in their quality of life and sexual functioning. Researchers have examined how women’s beliefs reflect certain tensions; for instance, many women have been shown to hold beliefs such as ‘*love ensures naturally perfect sex’* or that ‘*passive submission to love will ensure my sexual satisfaction’* (Chang, Klein, & Gorzalka, 2013). Such beliefs can significantly impact how women relate to their sexual functioning.

Arguably, these beliefs promote passivity rather than communication between partners. Thus, women may be reluctant to communicate their preferred sexual practices, and this reluctance reduces the likelihood that they will receive sufficient stimulation or arousal to satisfy them or to achieve orgasm.

In this sense, one could argue that Masters and Johnson's (1970) model supports conservative beliefs that can have negative impacts on women's sexual learning, because it promotes the idea that sexual responses are rooted in biological factors alone and that therefore women have no agency or autonomy over their sexual functioning (Masters & Johnson, 1970). This notion may prevent women from exploring their sexual preferences, including modes of stimulation and capacity for orgasm. Furthermore, such beliefs may contribute to the assumption that women 'prefer' to adopt submissive sexual roles. This has been documented in some studies (Kiefer et al., 2006). However, it is unclear whether such behaviour and belief systems are the result of beliefs that are internalised due to imposed societal 'gender norms' rather than a genuine desire to be submissive.

In either case, if women wish to play submissive roles, then sexual autonomy would place them at risk of experiencing low levels of arousal and sexual difficulties (Sanchez, Kiefer & Ybarra, 2006). Such evidence demonstrates the personal and sensitive nature of the issue and the necessity to examine the belief systems that clients hold when they present with concerns about their sexual functioning. This is necessary in order for the psychologist to understand fully their relationship with the client, and to understand where that belief system comes from and whether or not clients may feel the desire to reflect on their beliefs and to adopt new ways of relating to themselves as women and to their sexual experiences. This should be explored in further evidence-based study to see whether such reflection might have an impact on their sexual functioning, but more importantly on their level of satisfaction with themselves and their sex lives.

Although women may focus on sexual stimulation to engage further in sexual responses if they do not feel spontaneous sexual desire, it is imperative to note that some women may have difficulty knowing their preferred levels of stimulation, particularly if they have never explored these preferences or if they do not feel confident to share theirs with their partners. Research has confirmed that the difficulties that some women encounter if they wish to communicate their sexual needs negatively impact their sexual functioning (Brassard et al., 2015).

This evidence suggests that it is crucial not to underestimate other psychosocial factors that may contribute to the development of difficulties in sexual functioning. Therefore, it would be reductive to generalise our current understanding of female sexual responses by assuming that sexual desire is the primary factor in the sexual process. More importantly, it suggests the need to think critically about whether women experience ‘abnormal’ sexual difficulties as well.

4.5 A sexual problem or a sexual dysfunction?

The definition of female sexual functioning remains controversial, as no evidence-based studies have been performed that have integrated biological and psychological factors, both of which play important roles. The circular model, described above, suggests that sexual desire may arise from intimacy rather than from biological factors alone (Basson, 2000). For instance, low levels of sexual desire are associated with higher levels of distress in married women than in single women. This finding suggests that the degree of distress caused by low levels of desire may be influenced by the nature and status of interpersonal relationships, or act as a reflection of worries about how their low level of desire may impact their relationship (Basson, 2000).

More data are needed to determine how different sexual responses, such as desire, arousal, orgasm, and satisfaction, relate to each other, but studies have shown that evidence must be understood and interpreted within its societal context (Nappi et al., 2016). In addition, authors such as Balon have highlighted the need to address critically the nuance between a 'sexual problem' and ‘sexual dysfunction’ when a person reports difficulties with sexual functioning in the context of consensual sex (Balon, Segraves & Clayton, 2007). Such consideration is necessary because some women may internalise the medicalisation of the phenomenon by thinking that they have a defective body or by blaming their 'genes' for their difficulties. Thus, they feel responsible for their difficulties rather than considering other factors that may affect them due to everyday circumstances, such as fatigue that may be due to work and/or family obligations, or to attempts to balance these (Tiefer, 2010).

Therefore, Aslan and Fynes (2008) and other researchers have strongly recommended that healthcare professionals be trained in how best to support women with such difficulties through adaptation of a multidisciplinary team approach, because sexual functioning is a multifactorial phenomenon that requires input from a variety of experts (Aslan & Fynes, 2008). Evidence collected within the gynaecology profession has shown that patients are not routinely screened for difficulties related to sexual functioning, even though 80% of the female participants who took part in the study said they would like to be given the chance to

discuss such matters when they attended consultations (Briedite et al., 2013). This shows how recent the emergence of an awareness of the phenomenon in the different health fields is, and how important it is for counselling psychologists to liaise with other professionals so that the topic of female sexual functioning can receive more attention in all health services to provide better treatment and support to clients, be that through pharmacotherapeutic and/or psychological interventions.

It would be sensible to ask women what they think and feel in relation to trends in research and the medicalisation of female sexual functioning, as their responses could shed light on factors that may have been missed in studies in order to inspire further exploration. The answers might also highlight views and perspectives that could surface within clinical practice. Through the conduct of such inquiry, practitioners would become aware of the perspectives that clients might bring to the consulting room and thus reflect on how to navigate these beliefs with them. Indeed, there were some interesting contradictory findings when asking this question.

4.6 Do women prefer the medicalisation of female sexual functioning?

Authors have argued that female sexual difficulties should not be categorised as psychiatric disorders alone but should be considered as medical problems as well. As Berman, Berman and Goldstein (1999) stated: *'Not all female sexual complaints are psychological.'.* On the other hand, some feminist critics consider that the categorisation of female sexual functioning as medical has occurred because of the success of Viagra (Angel, 2012) and that this could lead to the ignoring of psychosocial factors in relation to female sexual functioning; to take such a narrow view would be to misunderstand the complexity of the phenomenon and would reduce the appropriateness of the support that women should receive according to their needs. A working group that comprised 12 feminist scholars, therapists and researchers published articles that highlighted the inadequacy of the medicalisation of female sexual functioning. The group stated:

> *'All women are not the same, and their sexual needs, satisfactions, and problems do not fit neatly into categories of desire, arousal, orgasm, or pain. Women differ in their values, approaches to sexuality, social and cultural backgrounds, and current situations, and these differences cannot be smoothed over into an identical notion of 'dysfunction' or an identical, one-size-fits-all treatment '* (Wood, Koch & Mansfield, 2006).

Individuals differ in how they perceive and conceptualise female sexual functioning and there are multiple ways of understanding it. Those ways depend on the relationship that individuals have with the condition and in the societal context and those people's personal positions. Some may find relief in the medicalisation of the phenomenon as they feel that it is finally being taken seriously and that medical support is becoming more accessible for these issues, instead of the issues being regarded as the result of individual problems or as 'all in their mind'. Others may regard the medicalised view of the phenomenon as reductive and not taking into account individual differences in the way that women relate to their own sexual functioning; such a view risks the generalisation of people's problems and the reduction of the subject into 'normal' and 'abnormal' functioning (Sugrue & Whipple, 2001; Wood, Koch & Mansfield, 2006; Tiefer, 2010; Bellamy, Gott & Hinchliff, 2013).

In addition, some may be sceptical of pharmacotherapeutic treatments (Tiefer, 2001, 2002; Moynihan, 2003). Some are concerned that medicalising the subject may suggest that a woman who experiences lower levels of desire than expected is suffering from a medical problem that requires medical attention, rather than a condition that requires nuanced understanding of lack of desire and the multitude of factors that may cause these levels of desire (Brotto, 2010; Bell, Giil & Træen, 2022). Indeed, it has been argued that the situation might be improved if future studies are focused on the effects of the integration of psychological therapies with pharmacotherapy rather than solely on pharmaceutical trials to treat difficulties with female sexual functioning, and how factors such as ethnicity, culture, sexual orientation, and age should be incorporated into such future research (Graham, Boynton & Gould, 2017).

Bellamy, Gott and Hinchliff (2013) suggest that health professionals should take a holistic approach to difficulties in sexual functioning and recognise that, although a wide range of pharmacological treatments may be effective, there are also psychological ways in which to address these difficulties (Lee et al., 2022).

It is important that practitioners are aware not only of the multitude of ways in which the phenomenon can be conceptualised and approached, but also of their need to pay close attention to their clients' views on this topic when they explore it in a therapeutic setting and of the need for them to reflect critically on the position with which they align. This underscores the need for research.

Because of the shift from a linear to a circular model of the conceptualisation of sexual functioning, research has been conducted in which women were asked how they experienced and related to this shift. Sand and Fisher's (2007) study showed that for women with no difficulties in sexual functioning, their sexual functioning scores were correlated with the Masters-Johnson-Kaplan model and they were more likely to align with this model. Similarly, Giles and McCabe (2009) showed that women who reported no sexual functioning-related difficulties showed a preference for the linear model, whereas women who presented with such difficulties endorsed the Basson model.

Furthermore, Hayes' (2011) study showed that most women seemed to prefer the linear model of sexual response or Basson's (2005) composite circular model, which includes the nuance that the motivations behind the desire to engage in sex could come from either psychosocial elements or spontaneous physiological desire. The latter could change, for example over the course of a woman's menstrual cycle (Basson, 2002, 2005). This finding showed that both genital and non-genital elements could play a role in a woman's engagement in sexual encounters and that this should be understood in the context of the individual or her relationship (Hayes, 2011).

A study by Nowosielski, Wróbel & Kowelczyk (2016) produced mixed results, which overall showed that women with sexual functioning-related difficulties endorsed a mixed model and that factors such as relationship difficulties had an impact on the preferred model. The authors suggested that the evidence collected at the time of their study indicated that partner factors were the most important predictor of female sexual functioning (Nowosielski, Wróbel & Kowelczyk, 2016). Therefore, due to a variety of factors, women might relate to one model or another. This highlights the importance of incorporating into the choice of therapy women's particular contexts and individual factors, which may shape their views and experiences of their sexual functioning.

These contradictory findings may reflect the historical and political tensions in how female sexual functioning has been defined and therefore influences how women are supported in their sexual experiences. Gilligan's work, which highlights the differences between male and female development and the lack of inclusion of women's voices and experiences in science, particularly in psychology, strengthens this argument (Gilligan, 1993, 2003, 2009; Torres & Garcia, 2019). She argues that girls are pressured to suppress and regulate their sexuality, desires, opinions, and relationships to fit into the patriarchal framework of society, particularly as they move from adolescence to adulthood. She claimed that:

> *'Women are giving up relationship for the sake of having relationships, and then missing themselves and missing relationship or feeling stranded in a confusing isolation which is often filled with self-condemnation'* (Gilligan, 1995).

Women were confronted with consequences that could harm their relationships if they stood up for their desire to have their own relationships and to have their needs met. Gilligan linked wanting to speak out with potential harm. She stated that when women had fought to have their voices heard on various issues, such as education, healthcare, domestic violence and interpersonal issues, for example in the 1970s, many were confronted with the painful truth that they were ignorant about their bodies, their identity and those of other women, which Gilligan recognised as a form of dissociation (Gilligan, 1993, 2003, 2009).

This can also be applied to the context of sexuality, as there is evidence that some women apply traditional sexual scripts to gender roles, in which male pleasures are privileged and the man's role is to seek sex while women regulate their sexuality and suppress their sexual desires in order to maintain the relationship. This situation has been associated with difficulties in sexual functioning that may stem from the feeling of sexual pressure (Scappini & Fioravanti, 2022).

Women now have more freedom than previous generations did to choose whether or not to endorse a 'traditional' heterosexual script in their sexual encounters, and this cultivates higher levels of sexual subjectivity, which relate to women's sense of entitlement to pleasure and consensual, safe sex (Horne & Zimmer-Gembeck, 2006). Yet some young women now feel that they are receiving conflicting messages about female sexuality and miss the opportunity to develop a positive representation of themselves as sexual beings because of this confusion (Scappini & Fioravanti, 2022).

This problem may prevent girls from exploring themselves as positive sexual beings (Hogarth & Ingham, 2009) and automatically push them into passivity, which can lead to difficulties in knowing their sexual preferences and not knowing how to communicate them in the context of sex (Scappini & Fioravanti, 2022). These issues impact sexual satisfaction and functioning (Merwin, O'Sullivan & Rosen, 2017; Jones, Robinson & Seedall, 2018). The feminist literature on sexuality stresses the importance for females of cultivating sexual subjectivity. It states that the first step is to acknowledge and recognise their internalised voices and structures of oppression and importantly, to unlearn internalised norms of how sexuality should be for a female (Hooks, 2015; Bannerman, 2017).

In this sense, it could be argued that the suggestion that women adhere to their chosen model of sexual functioning according to whether or not they experience difficulties in sexual functioning (Nowosielski, Wróbel & Kowelczyk, 2016) may represent the changes that women are making to unlearn the traditional biological, one-dimensional view of sexual functioning Tiefer, 1991; Tiefer, Hall & Tavris, 2002). It may occur as they begin to explore their own feelings (Brown & Gilligan, 2013) and make their voices heard by pointing out other psychosocial factors that compromise their sexual experiences (Byers, 2005; Fitz & Zucker, 2014; Pascoal, Narciso, Santa Bárbara & Pereira, 2014; Gianotten, Alley & Diamond, 2021; Peixoto & Lopes, 2023).

One clear, common theme has emerged throughout the literature: the critical importance of examining whether women feel satisfied or dissatisfied with their experiences of sexual functioning. This has led to the emergence of a new wave of evidence that has highlighted the importance of examining whether or not women explore their sexual distress in relation to their experiences.

4.7 Sexual distress in the understanding of female sexual functioning

The changes that were made in the definition of female sexual functioning between the DSM-IV and the DSM-5 shifted the understanding of sexual functioning from a linear to a circular model, in which sexual desire was no longer considered the starting point of the process of sexual responses or the primary reason for engaging in sexual activities (Ferenidou, Kirana & Athanasiadis, 2017). It can be argued that this shift was an attempt to acknowledge the complexity of and bridge the tensions in understanding the phenomenon and has highlighted how sexual functioning must be understood in the context of psychological distress as well.

The World Health Organisation stressed the importance of incorporating psychosocial factors into the understanding of sexual functioning. It stated that individuals should not be reduced to their physical symptoms but rather considered in terms of context, so as to investigate whether or not individuals felt satisfied with and fulfilled in their physical, emotional, and social experiences of their sex lives (World Health Organisation, 2006, p.35). Öberg and Fugl-Meyer (2004) illustrated this; they showed that 45% of participants in their study experienced no distress despite reporting low levels of interest in sex and frequency of orgasm (Öberg & Fugl-Meyer, 2004). Some women may report that they feel dissatisfied with their inability to achieve orgasm but that this does not necessarily cause significant psychological distress and does not negatively impact their overall level of satisfaction with their sex lives (Basson et al., 2001).

These examples show that sexual functioning cannot be understood outside the individual context. Therefore, it could be argued that it is imperative to improve understanding of this phenomenon by studying it within a biopsychosocial framework rather than through a psychological model alone or by dividing it into medical and psychological strands. In line with this, the female sexual functioning index (Rosen et al, 2000), which is based on the linear model that measures desire, arousal, lubrication, orgasm, pain and satisfaction, is widely used in the evidence-based literature. However, due to the change in the DSM criteria for sexual functioning and the importance of determining whether or not women experience psychological distress due to sexual difficulties, the female sexual distress scale has been developed and is used in addition to the female sexual functioning index in the literature (Ter Kuile, Brauer & Laan, 2006).

The main difference between the two constructs is that female sexual distress is focused on whether women's sexual experiences are a cause of psychological distress to them, whereas female sexual functioning is focused primarily on the different aspects that occur when a woman engages in certain sexual activities and the degree of satisfaction that individuals feel as sexual partners. Therefore, the use of both can create a more complete understanding of a person's experiences by balancing the assessment of the physiological and psychological components of their experiences (Derogatis et al., 2002).

Clinicians must understand the results of both scales together, since if individuals report concerns in their sexual functioning scores but do not experience psychological distress, one should refrain from interpreting these results as problematic (Ter Kuile, Brauer, & Laan, 2006). The concept of sexual satisfaction is integrated into the concept of sexual functioning, with a subscale of satisfaction included in the female sexual functioning index (Opperman, Benson and Milhausen, 2013). This is because previous data have linked women's reports of higher than-average levels of sexual satisfaction with reports of fewer than-average difficulties in their female sexual functioning (Peixoto et al., 2018).

This association between sexual functioning and sexual satisfaction and the latest focus on understanding sexual functioning in the context of sexual distress have led to changes in the sexual satisfaction scale for women (Meston & Trapnell, 2005). It has been revisited to create an overlap between sexual distress and sexual satisfaction in order to align it with recommendations from the literature as a fuller understanding and conceptualisation of the phenomenon of sexual functioning is developed (Meston, 2005). In this sense, the addition of sexual distress to the understanding of sexual functioning and other related variables

such as sexual satisfaction demonstrates the importance of refraining from adoption of a reductionist view of sexual functioning.

One could argue that such modifications and considerations show that there is some scepticism about the temptation to medicalise female sexual functioning, which might reduce treatment to just the physiological through the use of pharmacotherapy. Indeed, changes in sexual functioning may be responses to everyday stressors (Bodenmann, Ledermann & Bradbury, 2007; Bodenmann, Atkins, Schär & Poffet, 2010) or stressful circumstances, such as a pandemic (Yazici, 2022). Chronic stress has been associated with arousal difficulties in women (Hamilton & Julian, 2014), and there is evidence that female sexual functioning worsened during the Covid-19 pandemic (De Rose et al., 2021; Hessami et al., 2022).

The reduction of sexual functioning to a biological phenomenon may lead health practitioners to offer inadequate support by failing to explore other factors (Moynihan, 2003). Therefore, although the DSM-5 emphasises that a diagnosis of sexual functioning difficulties can only be made if these difficulties cause significant distress to the individual, the fact that sexual functioning can be considered a disorder prompts a thoughtful, ongoing debate about whether or not this phenomenon should be medicalised (Bellamy, Gott & Hinchliff, 2013).

4.7 Understanding female sexual functioning within a biopsychosocial approach

Many authors, mainly feminists, have disagreed with the treatment of female sexual functioning as purely physiological. Some have stated that such treatment can be seen to suggest an idealistic way in which women's bodies should respond to sexual experiences, with a fundamental focus on the association of sex primarily with penetrative sex (Bellamy, Gott & Hinchliff, 2013). This approach can be seen to label a person's body as 'abnormal' through assessment of their physiological responses alone without consideration of psychosocial, cultural and relational factors that may be at play. Whether or not a person expresses distress in relation to sexual functioning difficulties does not mean that these experiences and distress are due to or related to something 'abnormal' or a 'disorder'.

This approach may imply that the person is 'defective'. Rosenberg (2006) found that the women in the study highlighted the need for health professionals to broaden their knowledge of the complexity of sexual functioning and the factors that might be associated with it rather than trying to categorise their difficulties as purely physical, social or psychological. They wanted health practitioners to take everything into account at once, and to integrate this perspective into clinical practice (Rosenberg, 2006; Bellamy, Gott & Hinchliff, 2013).

This feedback is consistent with the literature when considering the association between sexual functioning and quality of life, which integrates many components concerning environmental, physical and mental health (Vahedi, 2010; Agustus, Munivenkatappa & Prasad, 2017).

4.8 Association of female sexual functioning with mental health

Healthy sexual functioning is a key factor in quality of life (Panahi et al., 2021), which can be compromised by mental health disorders (Laurent & Simons, 2009; McMillan et al., 2017). For instance, difficulties regarding components of sexual functioning such as desire, arousal and orgasmic functions have been associated with anxiety and depression in women (Kalmbach et al., 2015). Moreover, many mental health disorders have an early onset, usually during adolescence or the young adult stage, and this can influence the development of sexual identity and healthy sexual functioning (Impett, Schooler & Tolman, 2006).

Eating disorders such as anorexia nervosa have traditionally been considered to start during puberty, coinciding with the biological, physiological, and social changes that occur during this developmental stage (Connan et al., 2003; Mangweth-Matzek et al., Rupp, Hausmann, Kemmler & Biebl, 2007; Herpetz-Dahlmann, Seitz & Konrad, 2011; Watson & Bulik, 2013; Olivo, Gaudio & Schiöth, 2019). This is despite evidence that late onset of anorexia is possible (Matsumoto et al., 2001; Kimura et al., 2007).

The literature has explored the many factors that can contribute to the development of anorexia nervosa and highlights the conceptualisation of the condition through the use of a biopsychosocial framework (Rikani et al., 2013). This issue is discussed in detail later in this chapter. An important factor to highlight here is that difficulties in navigating the developmental phase of adolescence, which is embedded in identity formation (Erikson, 1968; Ferrer-Wreder & Kröger, 2019) are linked to the risk of developing eating disorders (Bruch, 1981; Stein & Corte, 2007; Conti et al., 2020; Achermann et al., 2022).

Hsu (1989) points out that a woman's societal ideal can contain conflicting aspects that trigger difficulties regarding identity formation during this period. Eating disorder behaviours may begin as protective behaviours against the emotional distress related to identity confusion (Stein & Corte, 2007; Verschueren et al., 2017). Therefore, the eating disorder becomes an identity and a new way of defining oneself (Lamoureux & Bottorff, 2005; Polivy & Herman, 2007).

Psychological treatment providers are recommended to take this into account and to address the topic of identity with individuals in recovery (Koskina & Schmidt, 2019; Stockford et al., 2019). This finding explains why anorexia nervosa occurs predominantly in adolescence or early adulthood (American Psychiatric Association, 2013). This suggests that it is likely that adolescent girls who struggle to overcome anorexia during puberty or their early 20s also face negative impacts on their sexual functioning, which may exacerbate mental ill-health, as during this period the theme of sexuality, which entails sexual functioning, flourishes (Gonidakis et al., 2016).

Adolescence is considered a difficult developmental stage for any individual (Breen, Lewis & Sutherland, 2013), and many girls with anorexia report also suffering from depression or anxiety (Salbach-Andrae et al., 2008; Xu et al., 2016, 2017; Monteleone et al., 2019). This is understandable, especially if they are struggling to navigate the identity formation process (Luyckx et al., 2013; Claes et al., 2015; Verschueren et al., 2017) and these factors are both associated with difficulties in female sexual functioning (Kogure et al., 2019). Anxiety and depression have also been shown to be linked to perfectionism (Schuler, 2000; Hill et al., 2015; Limburg et al., 2017; Egan et al., 2022). In the following section, data are brought together on how anorexia nervosa may be associated with difficulties with perfectionism and sexual functioning.

5. Anorexia nervosa and perfectionism

5.1 Key perspectives on anorexia: a brief overview of early theories leading to modern science

The understanding of anorexia nervosa has evolved, which means that there are different ways of understanding it. This section provides an overview of some key perspectives on anorexia nervosa, particularly the early theories, to enable readers to understand the history associated with the condition and the key factors that led to the development of the latest evidence.

In the 13th century, there were motivations in Europe to starve oneself for religious reasons. This form of starvation was known as *'holy anorexia'* (Sipilä et al., 2017). As religious starvation seems to resemble anorexia nervosa in terms of symptoms, the link between religion and starvation was studied (Thomas et al., 2017, 2018). This continued until in the 1870s Lasègue and Gull described the syndrome of anorexia nervosa as a form of '*hysteria'* (Simonovic, Gross & Ernst, 2015; Dell'Osso et al., 2016).

Gull identified subsequently that anorexia nervosa could occur in men or women, and thus described it as a form of *'neurosis'* (Simonovic, Gross & Ernst, 2015; Moncrieff-Boyd, 2016). Authors such as Charcot and Janet, emphasised the role of family dynamics in the emergence of anorexia nervosa. They understood starvation as a way to deny the process of one's own development and becoming a woman (Simonovic, Gross & Ernst, 2015).

In the late 1930s, psychoanalytical theories played a key role in the understanding of anorexia nervosa with the contribution of Sigmund Freud, who argued that anorexia nervosa could be understood to be the result of unresolved and repressed conflicts with primary caregivers (Caparrotta & Ghaffari, 2006).

This conceptualisation became important for the psychoanalytical movement (Dahl, 2016); Anna Freud built on this by arguing that the shift from binge eating to restricting behaviours could be associated with children's ambivalent feelings towards their mothers (Joyce, 2016). Early psychoanalytical theories placed a strong emphasis on unconscious ways to resolve conflicts, which were considered a risk factor for the development of eating disorders (Caparotta & Ghaffari, 2006).

These ideas have led authors associated with the object relations theory movement to expand on them. This movement is based on the idea that children develop a sense of self through their relationships with others (whether caregivers or the environment) (Piper & Duncan, 1999). Klein suggested that children may have had difficulty eating due to unconscious repression of their impulses, which were rooted in difficulties related to separation from their mothers (Spillius, 1988).

Winnicott suggested that the mother's role was to enable her child to develop and to provide a safe environment for development to flourish, through formation of a *'mother-baby relational unit'* (Caparotta & Ghaffari, 2006). Although Winnicott's work did not focus on eating disorders, these observations led to further research regarding family dynamics in anorexia nervosa (Humphrey & Stern, 1988; Vlahaki, 2012).

The link between early development and the caregiver has been studied by the school of self-psychology, which has shown that developmental problems are consistent in anorexia nervosa: anorexics tend to have a poor sense of self (Bruch, 1965; Sours, 1974; Bachar, 2018). Kohut (1971) and Goodsitt (1974) claimed that the main failure within the development was due to a deficit in idealisation in the way that the maternal response was received, and thus resulted in children being unable to regulate their emotions.

They did not have the capacity to have a sense of control over their psychological identity or their bodies, which explained why children might feel '*completely out of control'* and become sensitive to stimuli in their environment (Kohut, 1971; Goodsitt, 1974).

These arguments have helped to explain why eating disorders often begin in puberty, as this is a time when significant emotional and physical changes occur. These changes can be perceived as threatening, because they amplify the reality of separation between caregiver and child (Herpertz-Dahlmann, Seitz & Konrad, 2011). It is understandable therefore that anorexia becomes a means to maintain a sense of identity (Bers, Blatt & Dolinsky, 2004; Williams, King & Fox, 2016).

Over time, it has been established that some individuals with anorexia do not have the same developmental difficulties. However, the themes of sense of self, identity and personality have resurfaced over the years in different theories (Ciccolo & Johnsson, 2002; Williams & Reid, 2012; Williams, King & Fox, 2016; Oldershaw, Startup & Lavender, 2019). The origins of the understanding of anorexia nervosa by cognitive behavioural approaches go back to the work of Bruch, who had a psychoanalytical orientation. It was proposed that the thinking style associated with anorexia reflected a *'paralysing sense of ineffectiveness, which pervades all thinking and activities'* (Bruch, 1973, p.254).

Bruch's work led to that of Gardner and Bemis (1982), who incorporated the principles of Beck's cognitive theory concerning anorexia nervosa (Turner, 2014). Subsequently, further evidence on personality in relation to anorexia nervosa emerged (Segal & Blatt, 1993; Vitousek & Manke, 1994). The literature is replete with theoretical reflections on eating disorders and the factors that may contribute to them, whether rooted in psychoanalytical, psychodynamic, attachment or cognitive approaches (Schmidt & Treasure, 2006; Kjaersdam Telléus et al., 2014, 2015 Balottin et al., 2017; De la Red Gallego et al., 2017) and thus emphasise the need for the adoption of a multidimensional model in order to understand anorexia nervosa.

Clinicians now attend to more than the early parental relationship (Munro, Randell & Lawrie, 2017); they also consider biological determinants and body distortions, which may be related to the context of society and links with cultural and gender expectations. This thinking has led to evidence of the usefulness of bridging theories to facilitate integrated clinical care for this population (Munro, Randell & Lawrie, 2017; Castellini et al., 2022). Anorexia nervosa has been described as a need for control that is linked to cognitive distortions associated

with a poor sense of identity that can become characteristic of perfectionism (Fairburn, Shafran & Cooper, 1999).

5.2 Perfectionism

Just as female sexual functioning and anorexia nervosa can be understood from different perspectives, authors have defined and conceptualised perfectionism in different ways as well. For instance, early theories, such as those of Freud, Beck and Missildine, all conceptualised perfectionism as a unitary construct. This meant that individuals with perfectionist traits sought high standards in order to avoid a feeling of failure. Horney illustrated this clearly:

> *'He holds before his soul his image of perfection and unconsciously tells himself about the disgraceful creature you actually are; this is how you should be; and to be this idealized self is all that matters. You should be able to endure everything, to understand everything, to like everybody, to always be productive'* (cited in Sirois & Molnar, 2016, p.65,).

Early theory claimed that perfectionists did not experience satisfaction when they achieved their self-set standards. It was through the work of Hamacheck (1978) that the phenomenon of perfectionism began to be understood as a multidimensional construct. Hamacheck (1978) stated that distinctions could be made between *normal* and *neurotic* perfectionism. Individuals were normally perfectionists if they set achievable goals and standards for themselves that resulted in an increased sense of self-satisfaction and self-esteem. Neurotic perfectionists, on the other hand, were individuals who set high standards for themselves that stemmed from a significant fear of failure and the judgement of others (Flett & Hewitt, 2002).

As a result, individuals defined their self-worth in terms of whether they believed they could meet their excessively high standards. Specifically, a distinction has been proposed between individuals who find a genuine sense of pleasure in the challenges associated with achieving the high standards they have set to reach a goal but find the freedom to be less tedious or precise when they can; versus others (i.e., neurotics) who never achieve a sense of satisfaction in any circumstances (Sirois & Molnar, 2016). This theory enables a better understanding of the phenomenon and creates the distinction between interpersonal and intrapersonal constructs in relation to perfectionism (Franco-Paredes et al., 2005).

Perfectionism is now commonly understood as a multidimensional concept. However, researchers have recognised the importance of differentiating '*general perfectionism'* from other types of perfectionism that are domain-specific. Romantic perfectionism, for example, refers to perfectionism in the context of romantic relationships (Matte & LaFontaine, 2012).

Perfectionism became studied predominantly through the use of trait models; the multidimensional perfectionism scale (Frost et al., 1990) was developed to conceptualise perfectionism in terms of the following six dimensions: high standards, organisation, concern about mistakes, doubts about actions, parental criticism, and parental expectations.

Although the scale is widely used to assess perfectionism (DiBartolo & Rendón, 2012), there are some criticisms of the measure, particularly regarding the subscale dimension of '*doubts about actions'* and its potential to assess symptoms related to obsessive-compulsive disorder instead of perfectionism. In contrast, Hewitt and Flett (1991) suggested that perfectionism should instead be conceptualised according to the following three constructs: self-oriented perfectionism (which they applied to individuals who set high personal standards and frequently monitored behaviours); other-oriented perfectionism (the tendency to set high standards for other people); and socially prescribed perfectionism (the need to achieve certain standards imposed by significant others) (Hewitt & Flett, 1991; Flett & Hewitt, 2002).

This framework enabled the identification of people who were attributed with perfectionist behaviour rather than focusing solely on behavioural patterns (Franco-Paredes et al., 2005). This led to the development of another multidimensional perfectionism scale (Hewitt & Flett, 1991) to assess these components. Under this model, the personal and social aspects of perfectionism were considered equally rather than through a focus on self-centred constructs as proposed in the trait model (Sirois & Molnar, 2016). The main reason for the development of this approach was that the socially prescribed and other-oriented dimensions of perfectionism could have significant clinical implications, such as maintenance of a therapeutic alliance (Shafran, Cooper & Fairburn, 2003).

It is imperative to acknowledge the discrepancies in the different definitions and conceptualisations of perfectionism, as this debate has caused disagreement over its exact definition and dimensions. The choice of conceptualisation may influence the results of evidence-based studies. A sound theoretical understanding of perfectionism and the approach chosen by authors enables readers to understand results in the appropriate context.

The conceptualisation of perfectionism as a multidimensional phenomenon has led researchers to investigate which aspects of perfectionism might be associated with positive characteristics. This work links back to the work of Hamacheck, who suggested the difference between 'normal' and 'neurotic' perfectionism (Hamacheck, 1978). Arguably, the desire for further research into the components potentially associated with 'healthy' or 'unhealthy' perfectionism stems primarily from the work of those who compared the multidimensional perfectionism scale developed by Frost, Marten, Lahart and Rosenblate (1990) with the scale similarly named by Hewitt and Flett (1991).

Frost, Heimberg, Holt, Matt, and Neubauer (1993) identified an overlap between the two scales and created two main dimensions: maladaptive evaluation concerns, which covered socially prescribed perfectionism, concern over mistakes, parental criticism, parental expectations, and doubts about actions; and positive achievement strivings, which referred to personal standards, organisation, and self-oriented and other-oriented perfectionism. Disagreement remains about whether 'healthy' perfectionism should be conceptualised as perfectionism (Greenspon, 2000; Flett & Hewitt, 2006; Gaudreau, 2019) because setting high standards for oneself and striving for excellence are not central to perfectionism (Frost, Marten, Lahart & Rosenblate, 1990).

Despite this, many researchers have built on this new concept and explored the components of perfectionism that may be associated with healthy or unhealthy perfectionism and their complexity (Lynd-Stevenson & Hearne, 1999; Blankstein & Dunkley, 2002; Flett & Hewitt, 2002; Bieling, Israeli & Antony, 2004; Hong et al., 2017; Bender et al., 2022). Some authors have used different combinations of dimensions to conduct their studies (Stoeber & Otto, 2006), or different language to label the dimensions; for example, some refer to 'normal' or 'neurotic' perfectionism (Ashby & Kottman, 1996), 'adaptive' or 'maladaptive' perfectionism (Di Schiena et al., 2012), 'healthy' or 'unhealthy' perfectionism (Slof-Op't Landt, Claes & van Furth, 2016), or 'functional' or 'dysfunctional' perfectionism (Khawaja & Armstrong, 2005).

Despite these differences, evidence has begun to point to the fact that positive perfectionist strivings may be associated with factors such as high levels of self-esteem and low levels of anxiety and depression, (Ashby & Rice, 2002; Mobley, Slaney & Rice, 2005). While individuals who fit the characteristics of positive perfectionist strivings may set high standards for themselves, an important difference between them and individuals who are in the maladaptive group is that they are not consumed with meeting such expectations and do not exhibit the cognitive distortions that are typically associated with depression, which is a cause for concern for individuals in the maladaptive group (Rice et al., 2003).

It is important to recognise that some aspects of perfectionism are not considered to be related to psychopathology and that this aspect of the literature is still expanding (Stoeber, Madigan & Gonidis, 2020); however, the negative impacts of perfectionism and its association with anorexia nervosa have been widely documented (Riley et al., 2007).

5.3 Perfectionism in anorexia nervosa

Perfectionism is regarded as one of the key factors in theoretical models of anorexia nervosa (Dahlenburg, Gleaves & Hutchinson, 2019). For instance, it has been shown that some individuals with anorexia engage in hypervigilant monitoring of outcomes and are extremely attentive to signs of failure. Therefore, the concept of '*concern over mistakes'* has been associated particularly with anorexia nervosa (Bulik et al., 2003; Pieters et al., 2007).

Perfectionism is considered not only a risk factor for the development of anorexia, but also an important maintenance mechanism that contributes to the severity of the disorder (Fairburn, Cooper, & Shafran, 2003). Evidence has shown that the two forms of perfectionism defined by Hewitt and Flett (1991) (self-oriented and socially prescribed perfectionism) apply to anorexia nervosa (Bardone-Cone, 2007).

In addition, Hewitt and colleagues (2003) emphasised the importance of understanding the role in perfectionism of self-presentation and its two components, which were: either proving and reinforcing the impression of being perfect or preventing others from believing they were not (Hewitt et al., 2003). Furthermore, the perfectionist self-presentation provided a broader understanding of psychological maladjustment. Such evidence, although preliminary, remains crucial because of the important role that perfectionist self-presentation plays within perfectionism.

Empirical studies have consistently found elevated levels of perfectionism and self-presentation perfectionism in women with anorexia nervosa (Cockell et al., 2002; Hewitt et al., 2003; Stoeber et al., 2016). As the association between perfectionism and anorexia nervosa is well-established, levels of perfectionism are also identified to provide prognostic outcomes (Welch et al., 2020).

Higher levels of perfectionism are correlated with poorer outcomes in psychological treatment and have been associated with high rates of treatment dropout (Franco et al., 2005; Bardone-Cone, 2007; Hurst & Zimmer-Gembeck, 2015; Vall & Wade, 2017). For this reason, researchers have begun to study psychological treatments that target perfectionism

(Tchanturia, Larsson & Adamson, 2016). Some studies have shown the effectiveness of administering cognitive behavioural therapies as a group intervention to reduce perfectionism in individuals with anorexia nervosa. Although these studies show promising results, the degree of perfectionism in individuals must be considered when such treatment is administered (Lloyd, 2004; Larsson et al., 2018).

The potential efficacy of group treatments to reduce perfectionism-related symptoms effectively has been studied (Levinson et al., 2017). Other findings suggest that in order to generalise findings on the effectiveness of psychological treatments that target perfectionism, further studies are required, particularly to consider whether outcomes differ if long-term therapy is provided (Goldstein et al., 2014).

There remains a need for further research to determine the most effective psychological treatments to decrease levels of perfectionism in anorexia nervosa (Robinson & Wade, 2021). One way to understand the persistence of symptoms related to perfectionism, even after recovery, is related to the inconsistent and current conceptualisation of recovery and what characterises it (Ackard et al., 2013, 2014). Recovery is frequently associated with weight restoration and eating habits within this clinical population, but there is a lack of evaluation regarding cognitions.

For instance, maladaptive perfectionism constructs such as ‘concerns about mistakes’ and ‘doubts about actions’ have been associated with levels of cognitive symptom severity in anorexia nervosa (Haynos et al., 2018). Thus, the maladaptive means that are used to achieve goals and fuel overall perfectionism remain strong after treatments. Furthermore, it is important to consider the potential transdiagnostic role that perfectionism may play across anxiety and depression in this clinical population (Limburg et al., 2017; Galloway et al., 2022). A transdiagnostic approach involves the argument that comorbidity across disorders occurs due to shared vulnerabilities or coping mechanisms (Egan, Wade & Shafran, 2012). This is especially important as anxiety and depression are common comorbid disorders in anorexia nervosa (Junne et al., 2016).

Thus, this indirect link between perfectionism, eating disorder symptoms, anxiety and depression requires greater attention in the context of treatment and recovery (Drieberg et al., 2018, 2019; Castro et al., 2021). It has been highlighted that individuals who are regarded as fully recovered from eating disorder symptoms are indistinguishable from healthy controls, yet they show higher levels of anxiety symptoms (Ackard et al., 2013, 2014).

Individuals with anorexia nervosa may experience higher levels of anxiety and depression after remission due to difficulties in regulating their emotions (Haynos et al., 2014; Castro et al., 2021). This finding suggests that a possible goal of disordered eating is to cope with difficult emotions, such as shame (Brockmeyer et al., 2012; Racine & Wildes, 2014, 2015 Rowsell, MacDonald & Carter, 2016).

Perfectionism in this clinical population has become so prominent that research has turned to find the best ways to incorporate perfectionism into psychological treatments, whether with adults or adolescents (Lloyd et al., 2014; Hurst & Zimmer-Gembeck, 2015). This can be seen as equally relevant to schema therapy, particularly in the context of eating disorders (Macik & Sas, 2015; Pugh, 2015; Joshua et al., 2023). Schema therapy was developed by Young (1990, 1999). It is an integrated therapy that includes concepts from cognitive behavioural therapy and other theories, such as attachment, interpersonal and object-relations theories (Young, 1990, 1999; Young, Klosko & Weishaar, 2003). The aim of schema therapy is to help individuals to identify their unmet emotional needs and thinking and behaviour patterns, and thus to develop healthier alternatives. These patterns are called schemas, or life traps, which influence the ways in which individuals perceive themselves, others and the world (Young, Klosko & Weishaar, 2003).

They are thought to develop throughout childhood and can negatively influence the way in which a person perceives their environment, thereby promoting maladaptive coping strategies that can contribute to mental health difficulties (Young, Klosko & Weishaar, 2003; Damiano et al., 2015; Kilbert et al., 2015). Researchers have explored cognitive schemas that may be present in perfectionism and associated with anxiety symptoms that have also been investigated in the context of eating disorders (Deas et al., 2011; Boone et al., 2013). Indeed, it has been found that perfectionists, particularly those who are susceptible to socially prescribed perfectionism, are more likely to perceive their environment as threatening and to experience a greater sense of lack of control than do non-perfectionists, and this is also relevant to generalised anxiety disorder (Frost & DiBartolo, 2002; Brown & Naragon-Gainey, 2012, 2013; Kilbert et al., 2015).

The study by Boone et al. (2013) showed that both components of perfectionism were correlated with body image difficulties in the context of eating disorders. Many individuals prove resistant to change as they maintain their schemas by continuing to distort their perceptions of themselves and others, and many maintain a low sense of self-esteem (Rafaeli, Bernstein & Young, 2011). Poor self-esteem has been linked to anorexia (Brockmeyer et al., 2012, 2013) and perfectionism (Glover et al., 2007).

These findings explain why schema therapy may have great potential for these individuals due to their tendency to resist treatment (Young, 1999; Waller, Kennerley & Ohanian, 2007). Additionally, schema therapy has been shown to be an effective treatment for personality disorders (Bach et al., 2016), which is another comorbidity for some individuals with eating disorders (Kröger et al., 2010; Kordynska et al., 2018). Researchers must continue to explore the specifics of schema therapy, its benefits and its application to eating disorders, study results already support the use of schema therapy as an appropriate tool for this clinical population (Waller, Kennerley & Ohanian, 2007).

Based on the evidence stated above, it can be argued that the literature shows promising results in the use of schema therapy as a means to target perfectionism and anxiety in the context of eating disorders, due to their overlap in terms of the cognitive factors involved (Maloney et al., 2014). The evidence that perfectionism is involved in cognitive distortions and is linked to the severity of anorexia nervosa pathology is so strong (Duffy et al., 2019) that researchers have begun to examine whether perfectionism also impacts little-studied but relevant factors in relation to anorexia nervosa, such as sexuality.

6.1 Anorexia, perfectionism and sexuality: An overview

Eddy et al.'s (2004) study was the first to establish a link between sexuality, perfectionism and anorexia nervosa. Some studies have suggested that sexual difficulties may be a by-product of anorexia, as there is some evidence that dietary restrictions, particularly starvation and hormone depletion, can have an impact on libido (Eddy et al., 2004). However, biological factors such as low body weight and hormonal factors were the focus of early explorations of the sexuality-anorexia nervosa phenomenon, and sexual difficulties were observed even after weight restoration, suggesting that the difficulties were more complex than simply the result of biological factors.

The explanation for inconsistencies in the literature could be that women have a diagnosis of anorexia nervosa but experience different sexual difficulties because they have different personality styles. In line with this, the Eddy et al. (2004) study was built on the work of Westen and Harnden-Fischer (2001), who proposed three personality characteristics in eating disorders. Eddy et al. (2004) examined the relationship of these characteristics to sexual difficulties. One personality style suggested was the *'high-functioning'* style, which was rooted in self-criticism and perfectionism; another was defined as the *'over-controlled'* style, which led to significant personality disturbances among individuals who were particularly prone to feelings of shame and inadequacy; and the third was the *'emotionally*

dysregulated' style, also known as *'under-controlled'*, which involved difficulty with regulation of emotions and therefore adoption by individuals of self-destructive methods to calm themselves when they felt intense emotions (Westen & Hardnen-Fischer, 2001).

The study examined the relationship between pathology and sexuality by considering broad personality traits. The results showed that individuals with restrictive anorexia nervosa seemed to exhibit *'childlike behaviour'*, which was referred to as individuals showing more 'proper' or prudish behaviour. This was particularly apparent in those with restricted or over-controlled personalities. The study also suggested that sexual difficulties within this group should be understood within a developmental context. This led to the suggestion that a personality trait such as perfectionism, which is such a crucial component of the condition, might be a relevant factor for study in relation to sexuality in women with anorexia nervosa, although the authors cautioned that this phenomenon should be studied in the context of the individual's development.

One interpretation of these findings is that careful consideration should be given to whether sexual difficulties developed during adolescence or young adulthood, given that most onset of anorexia nervosa also occurs during this period, or to investigate further whether there is indeed an association between the onset of anorexia nervosa and sexual difficulties. This interpretation underscores the relevance of studying sexual difficulties in the clinical population with eating disorders such as anorexia nervosa, as it is likely that this condition appears at a time in development when the topic of sexuality, such as sexual functioning, is a sensitive issue that could affect quality of life. However, a very important limitation of Eddy et al.'s (2004) study was the lack of a comprehensive measure and definition of sexuality, as the study dealt with sexual attitudes and behaviours, which may have led to confusion and made it difficult to generalise the data (Eddy et al., 2004).

The methodology relied on asking clinicians to describe their clients, which is of concern as we have previously established that clinicians do not currently use guidelines to discuss topics such as sex and are not routinely trained to discuss these topics unless they work in sexual or psychosexual health services. Reliance on clinicians' knowledge and views of their clients about a topic that has not been sufficiently researched and emphasised in clinical training courses highlights the need to treat the results as preliminary in studies of the topic of sexuality, personality traits and anorexia nervosa. As stated earlier, since the 2000s, the topic of sexual functioning has begun to be studied in relation to women with anorexia nervosa, due to evidence, that has challenged the general belief that anorexic women are not interested in physical intimacy (Pinheiro, 2010).

6.2 Anorexia nervosa and female sexual functioning

A few studies have examined sexual functioning through the application of the female sexual functioning index (Mazzei et al., 2011; Gonidakis, Kravvariti & Varsou, 2015) and have indicated that women with anorexia nervosa are particularly prone to sexual functioning problems. However, it could be argued that the consistency of the results is because the studies used the same measurement tool. This indicates either that researchers have a tendency to use quantitative methods to obtain generalisable data and that other methodologies such as mixed or qualitative methods have not yet been used to study this phenomenon, or that researchers struggle to use clear definitions and ways of collecting clear and consistent data on the many factors that may be involved in female sexual functioning. The study by Pinheiro and colleagues (2010) reviewed studies on sexual behaviour and showed that sexuality could cover various dimensions and that terms were used interchangeably (Pinheiro et al., 2010).

Furthermore, as noted in the previous section, sexual functioning must be understood alongside psychological distress (Derogatis et al., 2002; Ter Kuile, Brauer & Laan, 2006). Yet few studies have examined difficulties with sexual functioning in the context of sexual distress in people with eating disorders (Dunkley, Gorzalka & Brotto, 2020). However, studies have indicated that women with anorexia nervosa are generally more likely to experience difficulties with decreased levels of arousal or libido and may have difficulties with lubrication and orgasm (Pinheiro et al., 2010). A study by Castellini et al (2012) was specific; it showed that women with anorexia nervosa were almost eight times more likely to experience difficulties with sexual functioning than were women without anorexia nervosa.

Specifically, the Castellini study was designed to examine potential predictors of sexual functioning in samples of women with anorexia or bulimia (44 women in the anorexia group; 44 in the bulimia group). The women were recruited in an outpatient clinical setting (Castellini et al., 2012). Participants completed a series of questionnaires such as the DSM-IV structured clinical interview, the eating disorders examination questionnaire (EDEQ), the emotional eating scale, the Beck depression inventory, the Spielberg treatment state inventory, the Barratt impulsivity scale, the symptom checklist and the female sexual functioning index. Univariate statistical analyses were conducted to determine which clinical variable could be associated with female sexual functioning scores in each group.

The results showed that those in the restrictive anorexia nervosa category were associated with higher levels of restraint on the EDEQ and lower levels of desire. They also reported higher scores on the shape subscale of the EDEQ, which was significantly associated with a lower total score on the female sexual functioning index. In contrast, the anorexia nervosa purging subtype group had higher scores on the eating concern subscale of the EDEQ and was significantly associated with lower total sexual functioning scores (Castellini et al., 2012).

The results also showed that there were no significant differences between anorexia nervosa and bulimia nervosa in terms of female sexual functioning scores, but that the results for both groups were different from those from healthy controls. Indeed, except for the pain and desire subscales, the women with eating disorders had lower sexual functioning scores than the healthy controls.

The same study also revealed crucial information about sexual desire in women with anorexia nervosa. It reported that these women had very similar levels of sexual desire to women who did not suffer from eating disorders (Castellini et al., 2012). On the other hand, the study by Cassioli and colleagues (2020) showed a link between food restriction and low sexual desire in women with anorexia nervosa. However, this link was mediated by attachment issues (Cassioli et al., 2020).

There have been studies on the broader topic of sexuality in women with anorexia nervosa in the context of factors such as a history of trauma, for example, sexual abuse (Caslini et al., 2016; Calugi et al., 2018). However, most studies that have considered sexual functioning specifically in this clinical group have been conducted in relation to weight (Gonidakis et al., 2016). This could be seen as a reflection of the tendency of researchers to focus on investigations from a biomedical perspective.

Of course, anorexia nervosa has physiological aspects that should not be underestimated in relation to sexual functioning, such as how starvation can affect hormone levels, which has an impact on libido (Tuiten et al., 1993; Morgan, Lacey & Reid, 1999; Pinheiro et al., 2010). However, there is some evidence that contradicts these findings, and this highlights that the link may not be important for all women. This consideration prompts critical reflection on the role of body mass index (BMI) in sexual functioning in this clinical population (Beaumont, Abraham & Simpson, 1981).

There is some evidence that there is no significant relationship between weight and sexual difficulties in women with anorexia nervosa, particularly if they feel satisfied with their relationship (Price et al., 2020). The literature is unclear about the direct role of BMI on female sexual functioning. Researchers point out that how individuals relate to their own bodies and how they accept and are satisfied with their physical appearance are more likely to affect sexual functioning than BMI alone (Afshari et al., 2016; Di Nardo et al., 2020, 2021).

Factors such as self-esteem, anxiety, depression or body image are all associated with anorexia nervosa and with female sexual functioning (Tiggemann & Williams, 2012; Woertman & van den Brink, 2012; Dèttore, Pucciarelli & Santarnecchi, 2013; Mattheisen, Mortensen & Petersen, 2015; Fuss, Trottier & Carter, 2015; Spivak-Lavi et al., 2019; Reddy et al., 2020; Mayano & Sánchez-Fuentes, 2021). Furthermore, sexual functioning can be linked to social anxiety or aggravation of a distorted body image and thus effects on self-esteem (Pascoal, Narciso & Pereira, 2012, 2013; Hucker & McCabe, 2014; Brassard et al., 2015; Hummel et al., 2015; Haghi et al., 2018; Ribeiro et al., 2022).

These findings are of great concern regarding women with anorexia nervosa, as they are sensitive to how they perceive themselves internally (Jappe et al., 2011; Williams & Reid, 2012; Zucker et al., 2014, 2015). Again, such arguments highlight the importance of other factors, such as levels of relationship satisfaction, which are linked to themes such as levels of intimacy, and that exclusion of these factors in considerations of sexual functioning is reductive (Laumann et al., 2006; Coffelt & Hess, 2014; Burri, Radwan & Bodenmann, 2015; Witherow et al., 2016; Merwin, O'Sullivan & Rosen, 2017; Ribeiro et al., 2022).

A study by Bulik et al. (2011) highlighted the importance of addressing difficulties in sexual functioning for women with anorexia nervosa, because such problems might be linked to factors in anorexia nervosa. For example, increased sexual desire might be associated with weight restoration, while sexual satisfaction might be related to caloric intake (Beaumont, Abraham & Simpson, 1981; Wiederman, Pryor & Morgan, 1996; Morgan, Lacey & Reid, 1999; Bulik et al., 2011).

Researchers have also begun to examine whether the involvement of intimate partners in the therapeutic process can have a positive impact on the recovery of women with anorexia, in response to increasing amounts of evidence that poor relationship experiences are correlated with higher rates of relapse (Bulik, Baucom & Kirby, 2012). Specifically, Bulik et al. (2011) recommended that clinicians examine whether a couple experienced difficulties in the intimate and physical aspects of their relationship and whether these difficulties might be

related to body image issues. Body image is a factor commonly associated with anorexia nervosa and with difficulties in sexual functioning in some women (Weaver & Byers, 2006; Espeset et al., 2012; Dakanalis et al., 2013; Ciwoniuk, Wayda-Zalewska & Kucharska, 2022).

Therefore, the involvement of partners in the therapeutic space might be beneficial (Fischer et al., 2015). Researchers have shown that the integration of sexual difficulties into the therapeutic process showed long-term improvements in the clients' sexual functioning and that small to moderate improvements that almost reached the level of 'normative' sexual functioning could be observed after six years (Fichter, Quadflieg & Hedlund, 2006).

However, an important criticism of Pinheiro's study is that the topic of sexuality in this clinical population remains primarily studied in the context of trauma (Pinheiro, 2010). This highlights the need for researchers to gather a broader understanding of sexual functioning in women with anorexia nervosa outside the context of abuse or trauma history (Goldfarb, 1987; Waller, Halek & Crisp, 1993; Carter et al., 2006; Kindges, Macedo & Habigzang, 2016; Calugi et al., 2018; Malecki, Rhodes, Ussher & Boydell, 2022).

This is not to say that trauma history should no longer be studied in the context of sexual functioning in this population. However, the focus on this issue may minimise the exploration of other factors that may also impact this phenomenon and encourage researchers and practitioners to remain aware that issues of sexual functioning, whether in this population or others, must also be considered in the absence of any historical trauma or sexual abuse.
In addition, researchers have begun to consider whether sexuality, including sexual functioning, can be understood in the context of sexual perfectionism (Hosseini, Hadizadeh-Talasaz & Bahri, 2023), taking into account the importance of not generalising perfectionism to an individual as a whole and that it is best to study the topic of perfectionism in association with specific domains (Yang, 2017; Levine & Milyavskaya, 2018).

7. Female sexual functioning and sexual perfectionism

7.1 Definition of sexual perfectionism

Building on the work of Hewitt and Flett's multidimensional model of perfectionism, Snell (2001) developed a multidimensional model of sexual perfectionism. The model aimed to assess the impact on sexuality of perfectionist tendencies and beliefs about oneself as a sexual partner. This occurred because evidence showed that perfectionism could have a significant impact on many areas of a person's life, and therefore researchers focused on

whether perfectionism might also be a multidimensional component that could impact sexual well-being (Snell, 2001). As stated earlier, this model was made up of four components: self-oriented, partner-oriented, partner-prescribed and socially prescribed sexual perfectionism (Stoeber & Harvey, 2016).

An important notion to consider is that, of course, each woman may have a different view of what must be perfect for them as a sexual partner. Some women may be perfectionists in terms of their ability to achieve orgasm, whereas others may set unrealistic expectations in terms of sexual competence or helping their partner to achieve orgasm. Researchers have not explored these components; this area of research is recent and must flourish to create a comprehensive understanding of sexual perfectionism in women (Kluck, Hughes & Zhuzha, 2018). Although the study of sexual perfectionism in women is in its infancy, it has begun to focus on the relationship between sexual perfectionism and women's sexual behaviour, and has shown some promising preliminary results.

7.2 A review of the current evidence of the link between sexuality and sexual perfectionism

It is important to keep in mind that there is a multitude of components associated with the phenomenon of sexuality. Some of the current evidence-based research can be considered quite inconsistent, as it has explored different aspects of sexuality in relation to sexual perfectionism rather than gathered consistent data about the same theme. Therefore, the current evidence can be considered an initial approach to identify what aspects of sexuality seem to have significant associations with multidimensional aspects of sexual perfectionism. The findings can then be considered an indication to guide research in areas that should be explored and developed further (Stoeber et al., 2013; Kluck, Zhuzha & Hughes, 2016; Stoeber & Harvey, 2016; Kluck, Hughes & Zhuzha, 2018; Vangeel et al., 2020).

The first of these research studies, by Stoeber et al. (2013), explored the issue of sexual perfectionism to determine whether different forms of the condition could be linked to sexuality negatively or positively. This could be thought to have stemmed from the literature on perfectionism, and this suggestion highlights that during the exploration of such concepts, it is important to identify which components are considered adaptive or maladaptive and which are not. It is possible to consider that some components of sexual perfectionism may have different impacts, and the identification of those that may be maladaptive could direct future research toward a much closer examination of these components.

To establish this, Stoeber et al. (2013) used a sample of university students, male (52) and female (220), who ascribed measures to the four types of sexual perfectionism and measures of sexual esteem, sexual self-efficacy, sexual satisfaction, sexual anxiety, sexual depression, self-blame for sexual problems, and negative cognitions of sexual perfectionism during sexual activity. The researchers used regression statistical analyses to determine the relationships among sexual perfectionism and its various components with other variables.

The study showed that self-oriented and partner-oriented sexual perfectionisms were positively associated with sexual esteem and self-efficacy. Moreover, self-oriented sexual perfectionism was shown to have a positive impact on sexual satisfaction and to reduce feelings of depression about sex, but it also harmed individuals in terms of anxiety and fear of making mistakes during sexual activity. This indicated that factors did not always play either an adaptive or maladaptive role and that they might impact a person's life in different ways depending on other psychosocial factors or individual differences. Such outcomes point to the need to continue to pay attention to the dual role that self-oriented sexual perfectionism can play in individuals and to investigate this issue further.

Partner-oriented sexual perfectionism, however, was found to be associated only with positive outcomes, in which individuals showed decreased levels of concern about making mistakes and low levels of anxiety. Partner-prescribed sexual perfectionism was associated with a greater tendency to blame oneself for sexual problems, and socially prescribed sexual perfectionism was associated with increased levels of anxiety and feelings of depression about sex, and higher levels of cognitive distortions in relation to sex (Stoeber et al., 2013).

These results demonstrated that the mental health of individuals who were more concerned about meeting standards they perceived in others about their abilities as sexual partners, whether from their sexual partners directly or due to broader societal pressures, could be significantly affected. The study must be understood in light of its limitations, such as the use of a sample of participants under the age of 50 years who were attending university.

Further research would be required to replicate the results, for example with a focus on specific age groups and incorporating the developmental stages of these age groups, to establish the specifics of that stage or life-cycle change (such as menopause) that may impact such associations. Such studies could also explore whether the results suggested different associations that might lead to interesting factors on which to reflect.

In addition, the data could not be used to determine causality between variables, but to determine only if there were associations between a variety of components that fell under the category of sexuality in relation to sexual perfectionism. This is another crucial factor to consider when interpreting such preliminary results.

These preliminary results highlighted that each dimension of sexual perfectionism may have a unique relationship with a multitude of sexuality-related variables. Furthermore, it was observed that the two most maladaptive forms (partner-prescribed and socially prescribed sexual perfectionism) are characterised by their orientation towards others, while the other constructs are found to be ambivalent in terms of adaptive or maladaptive influences. These initial data suggest that individuals may feel they have greater control over their own expectations, which can be understood as a coping strategy for psychological distress.

In contrast, individuals have little control over the expectations of others regarding their sexual performance. Currently, research suggests that this may be the most important contributing factor to why partner-prescribed sexual perfectionism and socially prescribed sexual perfectionism act as maladaptive forms of sexual perfectionism that evoke higher levels of sexual difficulties in women (Stoeber et al., 2013).

Kluck, Zhuzha and Hughes (2016) investigated the associations between sexual perfectionism, its domains and sexual functioning, communication and self-consciousness regarding appearance during sex in a sample of 208 sexually active women who were between the ages of 19 and 50 years. The women completed measurement scales online: the multidimensional sexual perfectionism questionnaire (Stoeber et al., 2013); the dyadic sexual communication scale (Alizadeh et al., 2020); the female sexual functioning index (Rosen et al., 2000); and the body image self-consciousness scale (Wiederman, 2000).

The researchers used the same statistical strategy as Stoeber et al. (2013). They also set out to identify potential predictors of sexual perfectionism on the desire subscale of female sexual functioning in order to add to the literature that had already demonstrated a link between sexual perfectionism and desire. The results showed that the shared variance of sexual perfectionism was positively related to desire, but that the specific components of sexual perfectionism did not reach statistical significance for single variances. However, other results showed that self-directed and partner-directed sexual perfectionism were less problematic than partner-prescribed and socially prescribed sexual perfectionism regarding the setting of high expectations of oneself as a sexual partner, which is associated with increased levels of cognitive distortion about sex.

Indeed, the results showed that partner-prescribed sexual perfectionism was a significant predictor of unique variance on the scale of self-consciousness regarding appearance during sex. Furthermore, the statistical results also showed that there was an indirect effect between the appearance of self-consciousness during sex, all domains of sexual perfectionism and sexual functioning. Self-oriented sexual perfectionism was related to improved levels of sexual functioning through the means of increased communication, whereas the indirect effect between socially and partner-prescribed components of sexual perfectionism on sexual functioning through poor communication skills about sex could be assumed to be related to higher levels of self-awareness about performance. This finding aligned with the theory of Wiederman regarding spectatoring, and how distractions and concerns about oneself as a sexual partner during sex might result in greater levels of difficulties during sex (Wiederman, 2001; Kluck, Zhuzha and Hughes, 2016).

The researchers also found that female sexual functioning might be positively associated with desire, but the study was clear in the need for further research to focus specifically on the relationship between sexual perfectionism and female sexual functioning to create a more accurate and adequate evidence-based understanding of the matter. Stoeber et al. (2013) acknowledged that sexual functioning was not an area of investigation in their study, despite the significant research attention it had received in the ongoing exploration of understanding sexual functioning in women.

Therefore, Stoeber et al. conducted another study (2016) that was specifically on sexual functioning and sexual perfectionism in women. They measured sexual functioning through the application of the female sexual functioning index, but the study did not use any measurement tool to determine whether participants suffered psychological distress because of their sexual difficulties. This highlights the need to understand the results very carefully, as current guidelines set in the ICD-10 and DSM-5 emphasise the importance of understanding female sexual functioning in the context of psychological distress (World Health Organisation, 2006; American Psychiatric Association, 2013).

This issue reflects the current tension in research regarding the topic of female sexual functioning. The female sexual functioning index is used in many research studies to identify sexual dysfunctions but without adherence to the medicalisation of the phenomenon or having a specific interest in diagnosing participants with them. It is crucial to take this into account when interpreting the results and relating them to current data in the literature on female’s sexual functioning, because the objective of the study was not to determine whether or not sexual perfectionism was related to sexual dysfunctions, but rather whether it

could be associated with difficulties in sexual functioning that incorporated elements that could be but did not need to be medicalised. In this study, the component of sexual psychological distress was not included, and this should be noted because it suggests that this context was missing and would be worth adding to future research.

This is another way to alleviate any pressure regarding statements that women's experiences of sexual functioning are or are not likely to be considered problematic and to give women the autonomy and opportunity to define and conceptualise for themselves whether or not they feel they are experiencing difficulties and how they relate to them. The most important finding of the study was the role of partner-prescribed sexual perfectionism in impacting sexual functioning, particularly regarding arousal and lubrication (Stoeber & Harvey, 2016). Difficulties with arousal and lubrication were found to impact the ability to reach orgasm, as manual maintenance of lubrication could prevent the person from completing sexual activity and increase the risk of pain during intercourse.

Thus, partner-prescribed sexual perfectionism can have a significant impact on arousal due to reduced levels of lubrication. On the other hand, self-oriented sexual perfectionism was associated with desire and arousal, and it was found that women without a partner experienced higher levels of arousal than women with a partner. However, self-oriented sexual perfectionism was also associated with the tendency to blame oneself for sexual problems.

A key finding was the importance of sexual satisfaction in women's sexual functioning (Rosen et al., 2000), as it is common for women to experience low levels of sexual satisfaction even if they have no concerns about their levels of desire, arousal, or orgasm (Dundon & Rellini, 2010). The data highlighted that partner-oriented sexual perfectionism could influence sexual satisfaction and sexual functioning in very clear ways (Stoeber et al., 2016). However, as with the others, this study should be considered exploratory.

8. Aims of the present study

The development of the multidimensional concept of sexual perfectionism (Snell, 2001) and the strong association between perfectionism and anorexia nervosa (Hewitt et al., 2003) provided an opportunity to expand the research base by examining the role of sexual perfectionism in the potential indirect relationship between perfectionism and sexual functioning in women with anorexia nervosa. It was hypothesised that sexual perfectionism mediated the relationship between perfectionism and sexual functioning in women with

anorexia nervosa. The literature has highlighted how perfectionism can impact different areas of a person's life; however, perfectionism has not been sufficiently studied in relation to sexuality, despite evidence that confirmed the importance of sexually directed perfectionism over 30 years ago. As women with anorexia nervosa generally have high levels of perfectionism, it seemed important to determine whether their perfectionism might also be directed towards their sexuality and whether it had a specific impact on sexual functioning, as women with anorexia have been shown to have difficulties in this area (Quadland, 1980; Pinheiro et al., 2010; Stoeber et al., 2013).

Through this doctoral study, the author aimed first to replicate previous findings in terms of the relationship between problems with sexual functioning in women and anorexia nervosa. The study also filled a gap in the literature by using the female sexual distress scale, as female sexual functioning must be understood in the context of psychological distress (Derogatis et al., 2002; World Health Organisation, 2006; American Psychiatric Association, 2013). Moreover, the primary aim of this study was to explore the association between perfectionism and sexual perfectionism in the first instance. Such results would support the hypothesis that individuals who have high levels of perfectionism in general are likely to experience higher levels of sexual perfectionism; or conversely, demonstrate that there is no such association, as sexual perfectionism may vary according to each woman's beliefs and context, with some women being perfectionists in some areas of their lives and not in others, such as sex.

The study also explored which components of sexual perfectionism might be associated with female sexual functioning. Such findings would create data about whether self-oriented, partner-oriented, partner-prescribed, or socially prescribed sexual perfectionism mediated the relationship between perfectionism and sexual functioning. This would enable researchers to determine whether some components played bigger roles than others in this mediating relationship or whether some did not act as mediating factors at all.

The study was important as its results may guide further research in determining what components of sexual perfectionism can be understood as having greater clinical implications than others for this clinical population. Furthermore, as research on female sexual functioning in women with anorexia nervosa and on sexual perfectionism in the general population are in their early days, the aim was for this doctoral study to collect data from a clinical group and a healthy control group to determine whether women with anorexia nervosa experience more difficulties with perfectionism, sexual perfectionism, and sexual functioning than women without any kind of eating disorders or any other mental health

problem. The aim was to explore the results to discover whether certain findings were more specific to the anorexia population and to discuss any unusual findings in terms of the current evidence-based literature.

Chapter 2: Methodology

1. Epistemological framework

Although the present study uses a quantitative methodology to answer the research question and thus relies on a positivist and deductive approach, it is positioned in an overall pragmatic paradigm. The focus is therefore on action, i.e., on questions about the purpose of conducting research in a certain way and the value of generating new knowledge and its potential impact, rather than on the nature of reality or the research methodologies themselves (Morgan, 2014). Thus, a pragmatic approach requires neither epistemology nor ontology (Cucchi, 2016), as it promotes the idea that the research process starts with questions that need to be answered and is more concerned with their purpose, their usefulness, and the tools that can be used to answer these questions.

Moreover, it considers the results of evidence-based research as a way to contribute to the literature by providing an opening for future research to build on the results in the most useful and appropriate way according to the research questions that arise from the results. It encourages the perception of research as a process that promotes the union of different tools in response to objectives and emphasises the choice of methodological designs that are most appropriate to the research question being asked (Morgan, 2014).

This explanation relates to the process that took place and that led to the construction of the present study. The research question that was chosen for the present study stemmed from a gap that was found in the literature. The gap involved the exploration of whether or not there was an indirect relationship between perfectionism, sexual perfectionism, and sexual functioning in the context of anorexia nervosa. The most appropriate methodology to use to answer such a question was a quantitative methodology to determine the existence of this phenomenon. However, this author recognised the complexity of the subject matter and was aware that the potential relationship between these concepts might be experienced differently by individuals due to their uniqueness and/or personal context.

Therefore, in the discussion chapter, the results are presented in the context of the limitations that were due to the adoption of a quantitative approach, which could not control for confounding variables that could have been better identified through the use of other methodologies. In addition, recommendations are provided regarding building on the results in future research in a way that would require the use of other methodological tools to

explore them.

Kasket (2012) defines a counselling psychologist researcher as '*being open to exploring all the paradoxes, divergences, and different perspectives we may encounter in the literature reviewing process and beyond*' (Kasket, 2012, p.8). This definition ties in with Milton (2010), who reflected on the importance of the skills required by counselling psychologists so that they could conduct research from different perspectives rather than taking a one-sided approach (Milton, 2010).

Milton argued that counselling psychologists should not be afraid to vary their approaches and methodologies within the profession in order to gain new knowledge, as they were trained to work with a range of different perspectives and to recognise the benefits of this flexibility in clinical practice or research (Milton, 2010). Application of this perspective could prevent bias and support counselling psychologists in adhering to the profession's practice guidelines (2006) and the code of ethics and conduct of the British Psychological Society (BPS, 2006; Cucchi, 2016; BPS, 2018).

2. Reflexivity

Ryan and Golden (2006) highlighted that reflexivity, while predominant in qualitative and mixed-methods research, is also an asset in quantitative studies. Although quantitative studies emphasise the importance of minimising the factors that may interfere with the research project by controlling the environment as much as possible, the researcher makes many choices in the design of the study (Ryan & Golden, 2006). McLeod argued that reflexivity was crucial to the production of high-quality empirical research, as the methodologies chosen by researchers were rooted in the philosophical beliefs and views that they held (McLeod, 2003). For this reason, this section examines the key points that have been reflected upon and discussed throughout this study at various stages of the work.

2.1 Motivations

2.1.1 Why this topic?

Cooper has raised concerns about researchers engaging in research only when it resonates with their values and beliefs, and how this could pose a risk to the development of coherent evidence-based knowledge (Etherington, 2017). I share Cooper's concern. For example, since I am a woman, my interest in the topic of sexual functioning could be said to stem from a desire to support female empowerment, to destigmatise the topic of sexual functioning and

to raise awareness of its contribution to quality of life, due to its significant impact on mental and physical health (Dunkley et al., 2016).

My interest in the clinical population of anorexia nervosa came from listening to the stories shared by my clients throughout my clinical training. Their stories highlighted their interest in discussing issues related to sexual functioning in the therapeutic setting, but their hesitation to bring such difficulties forward. They wondered whether these issues would be better discussed in other services, such as psychosexual services, or not at all in a therapeutic space, since they were unsure whether their difficulties should be resolved by drug therapy and therefore discussed with another health professional.

These experiences with my clients have highlighted that some women with anorexia are interested in sex, contrary to the popular belief that they are not. Therefore, to generalise the idea that female sexual functioning is irrelevant to women with anorexia nervosa could be seen as a misrepresentation that may stem from a lack of theoretical knowledge about the association of female sexual functioning with anorexia. After observing clinically that this topic sometimes emerged in client conversations, I found that sexual functioning was a recent topic of study in this population; it came to the fore in the evidence-based literature only in recent decades (Pinheiro et al., 2010; Price et al., 2020). I thought therefore that researching this topic would help to meet the needs of the research community by trying to take these women's suggestions into account to advance the field.

2.1.2 Where does the desire to refrain from medicalising the phenomenon of sexual functioning in this study come from?

The above arguments have led me to reflect on how anorexia nervosa and female sexual functioning are understood, and on the tendency to medicalise these phenomena, or to try to find explanations that are rooted in the medical model. For example, researchers have looked first at whether weight loss correlates with difficulties in sexual functioning in this population, rather than trying to establish a more complex and broader view that would incorporate a biopsychosocial model (Masters & Johnson, 1970; Gonidakis et al., 2016).

The literature emphasises that anorexia nervosa and female sexual functioning are two phenomena that require the integration of multidimensional physical and psychosocial factors into our theoretical understanding of these phenomena and their mutual interactions. My tendency to question or perceive phenomena from different perspectives and to prefer to acknowledge the multiple factors that might contribute to the understanding of the

constructs, rather than to adopt a reductionist approach and conceptualise the constructs from a single point of view, stems from my multicultural background, which enables me always to consider multiple ways in which to approach subjects.

2.1.3 Who is the study for?

Although this study was conducted as part of a professional doctorate in counselling psychology, the importance of the impact of the research within the profession took precedence over the requirements of the doctoral training. Hence, I put dedication and hard work into this study with the aim of producing quality results that would contribute to the profession, even if this meant stepping out of comfort zones and working on a large-scale project. For a lone doctoral researcher, this was a significant undertaking, particularly within the timeframe imposed by the duration of the training and due to the challenges imposed within the context of the Covid-19 pandemic. These challenges were faced happily because I considered it important to undertake this study. The study was conducted to improve the understanding of these phenomena and to contribute to the evidence-based literature so that researchers can continue to explore this topic in this clinical population to reach a point at which clinical guidelines can be created to impact clinical practice and support clients.

2.1.4 Why was the research hypothesis prioritised over others, and what were the potential biases?

The study was the result of recommendations from previous findings that emphasised the importance of studying this topic in relation to psychosocial factors that were not rooted in the history of trauma or in relation to trauma. A bias stemmed from the strong association between anorexia nervosa and perfectionism, which led to a literature search regarding the association between sexual functioning and perfectionism and uncovered the exploration of sexual perfectionism among women in the general public. This finding led to the hypothesis that sexual perfectionism might be a cause for concern among women with anorexia nervosa, and this hypothesis shaped the study.

While this was of course an important topic to explore and the study was rooted in evidence-based knowledge, it remained imperative that the study was driven by the tendency to link anorexia nervosa primarily to perfectionism. This was in accordance with the teaching during my training of the importance of these themes within this clinical population. It may have obscured other important factors that are involved in anorexia nervosa.

In this sense, the theme of sexual functioning in this population could have been explored in relation to other psychosocial factors rather than through the prism of perfectionism and specifically sexual perfectionism. This also means that the results were expected to reflect high levels of perfectionism and difficulties with sexual perfectionism and sexual functioning in this group compared with the healthy control group. The data challenged this expectation, and this finding is discussed in the discussion chapter.

2.2 Methodological choices

2.2.1 Why a quantitative piece of work?

The decision to conduct quantitative research was not only because it was decided that this was a superior method by which to investigate the hypothesis, but also because I desired as much separation as possible between the researcher and the participants, due to the sensitive nature of the subject matter and the ambiguity of previous findings in terms of whether or not this clinical population was interested in and highly sensitive regarding the subject matter. This made it difficult to predict how participants would engage in this study.

This desire for separation, and my wish to protect participants from discomfort, may have been influenced by my own projection and an assumption that participants would be more comfortable taking part in an online survey rather than having to discuss these issues in a research interview, which is different from discussing these topics in a therapeutic setting. Furthermore, the lack of qualitative studies concerning this phenomenon in the context of anorexia nervosa led to the conclusion that it was more ethical to ask participants to complete a survey using measurement tools already used in the literature to ensure the quality of the work and the emotional safety of the participants.

However, these reflections have led me to identify aspects of female sexual functioning that I am not comfortable discussing, whether in a clinical or research setting and the belief system I hold that may cause this discomfort. I aim to continue to do the internal work of challenging these beliefs, as recommended in the literature, which has now turned to the cultivation of evidence that could support the struggle against the lack of competence of professionals on the subject (Zeglin, Van Dam & Hergenrather, 2018; Mollen & Abbott, 2022; Abbott, Vargas & Santiago, 2022, 2023).

Nevertheless, the decision to put distance between myself and the participants reflects an understanding of quantitative methodology, which was chosen as the most appropriate way to answer the research question.

It also highlights that I prioritise the safety and emotional well-being of participants, reflect critically on the literature, and do not engage in research practices if I feel that there is a lack of foundation in the literature on which to construct appropriate methodological tools, such as the creation of interview questionnaires in the context of a specific clinical population. I agree with the BPS's recommendation not to engage in practices that clinicians do not feel able to manage appropriately and to commit to improvement to be able to engage in this way in the future through participation in professional development (BPS, 2018).

2.2.2 How have the risks of data being affected by the data collection process been minimised?

In this study, data were collected by asking participants to complete an online questionnaire, which presented measurement tools that had been used previously in the literature and displayed appropriate reliability scores. The participants were informed of this and thus understood that the questions were asked for a specific purpose and that the set of questions asked had not been invented by the researcher. The measures were Likert scales, which enabled consistent measurement of responses, which would not have been the case if the questions had been open-ended. The participants were not asked to complete the survey within a certain time frame so that the pressure of limited time would not influence how they answered the questions.

Steps were taken to minimise the problem that participants might score their answers based on what they knew regarding what was being studied. For example, they were informed that the researcher recognised that levels of perfectionism had been linked to anorexia nervosa. All participants were asked to complete the perfectionism questionnaire and it was emphasised that the aim was not to diagnose people with perfectionism at a clinical level. Before they answered the questions, the participants were reminded that certain levels of perfectionism were associated with adaptive factors. The aim was to normalise certain levels of perfectionism for all participants and therefore to help them to answer as honestly and neutrally as possible.

2.3 Reflections on the end of the study

2.3.1 Did any factors influence the way in which data were interpreted and presented?

One of the main lessons I learned from conducting this study was the importance of remaining open to the idea that the data collected might reveal things that I may not have considered, and how I should integrate these findings ethically.

Although it was suspected that the role of sexual distress would be an important component of sexual functioning because of the recommendations in the literature, its role in the indirect relationship between perfectionism, sexual perfectionism and sexual functioning showed a new facet of this phenomenon that had not been sufficiently considered at the outset, and it was therefore crucial to ensure that this was highlighted in the study.

In addition, it was important to report the results in context. Hence the strengths and limitations of the study were reported to recognise many factors that may have had an impact on the results but could not be controlled. These considerations led to suggestions of factors that future researchers could incorporate into their research designs and methodological choices. It was crucial to be transparent regarding some of the assumptions made when interpreting the results; for example, I explained how linking the data to evidence-based literature led to certain interpretations and I highlighted the nature of those interpretations: for instance, if the data led to a new 'hypothesis', which would be suggested for further exploration. It could be argued that for me it was so important to reflect critically and to acknowledge systematically what might be missing in the understanding of the results because I was resistant to the adoption of a reductionist approach to such a complex phenomenon.

2.3.2 What tools were used to ensure reflexivity throughout the process of conducting this study?

Reflective practice over the course of conducting this research was ensured by regularly engaging with writing in a journal, which would allow me later to return to what I had written in order to reflect further on the matter. However, supervision played a central role in my development as a doctoral researcher and provided the foundation that helped me to navigate such important and complex work. This helped me to sharpen my critical thinking skills, as well as to learn how to make certain decisions about the research design and writing of the study. For instance, I faced an important challenge and discussion during supervision, which involved reflection on whether the literature review should be written from a broad sexuality perspective and then focus progressively on the specifics of female sexual functioning, or whether this would be seen as losing sight of the main research objective. In addition, the reflective space has increased my awareness of my needs as a supervisee and how to meet them myself by becoming more resourceful while learning when to ask for support, especially during the difficult period of the Covid-19 lockdowns. I can say confidently that the supervisory space has contributed enormously to my professional development.

3. Research design

A quasi-experimental research design was used to establish whether sexual perfectionism (endogenous variable) mediated the relationship between perfectionism and sexual functioning (exogenous variable). We set up an online survey to be completed by two groups: the clinical group (women diagnosed with anorexia by a licensed health professional) and the healthy control group (women with no prior mental health diagnoses).

4. Research hypotheses

The main hypothesis was that sexual perfectionism would mediate the relationship between perfectionism and sexual functioning in women with anorexia nervosa. The expectation was that it would be a greater cause for concern among members of the clinical group than among those in the control group, due to the tendency for women with anorexia to show higher levels of perfectionism than those without. It was also hypothesised that the clinical group would have more difficulties with sexual functioning.

5. Participants

a. Inclusion criteria

In line with ethical research practices as defined by the British Psychological Society Code of Ethics for Human Research (2021), participants were required to be over 18 years of age to ensure consent and capacity. To participate in this study as a member of the clinical group, participants were required to have been diagnosed with anorexia nervosa by a registered health professional. In contrast, participants who wished to take part in the study as members of the healthy control group had to declare that they had never had any difficulties with their eating behaviour and had therefore never consulted a registered health professional for such concerns. Furthermore, the information form stated that the study did not take relationship status into account, as it recognised that female sexual functioning could be an important factor for single women, those dating, or those in a more serious long-term relationship. As the study was focused on a female population, only women were included.

The study was open to people who were fluent in English and who felt they could understand the content of all the research materials (such as the information and consent forms) and the online survey. The researcher did not seek a specific nationality.

b. Exclusion criteria

As this study only involved adults, anyone under the age of 18 could not participate. It was also made clear that participants could not take part in the study if they had mental health difficulties other than anorexia (such as comorbidities) that had been diagnosed by a registered health professional, regardless of whether they wished to participate in the clinical or healthy control group.

6. Recruitment strategy

6.1 Pilot phase

Given the inconsistencies reported in the literature regarding the lack of interest of women with anorexia nervosa in the topic of sex (Raboch & Faltus, 1991; Price et al., 2020), it was decided to conduct a pilot phase in which individuals would be invited to review the online survey and to provide feedback. The aim was to determine whether it was possible to continue the study based on the feedback received and to gain insight into possible dropout rates. A sample of five women, all over the age of 18, agreed to review the online survey.

No data were collected at this stage and the participants were peers of the researcher with no previous mental health diagnoses. Two had histories of anorexia nervosa but were in remission at the time of the pilot phase. The feedback received confirmed that completion of the survey took about 15 minutes and that they did not experience any psychological distress. One person indicated that the eating disorder review questionnaire (sixth version) might cause some discomfort as it reminded them of their experiences of discussing their symptoms with clinicians in the past. However, they confirmed that they were not experiencing any form of distress. In addition, the general feedback showed that taking time to reflect on their sex lives had been a positive experience and that this was an area of their lives about which they felt they were not thinking enough. This pilot phase determined that potential participants were likely to be interested in sexual functioning and sexual perfectionism.

6.2 Recruitment process

This study was conducted in the context of the Covid-19 pandemic. As a result, the recruitment strategy had to be changed twice. Initially, participants were to be recruited from within NHS services. However, the occurrence of the Covid-19 pandemic led to the withdrawal of commitment by NHS services that had initially expressed an interest in

supporting the project. Therefore, the recruitment process shifted to non-profit and/or independent organisations such as the City Health Care Partnership CIC, Breathe Therapies, the Eating Disorder Association of NI and NIWE Eating Distress Service (now Eating Distress North East), which supported the study. These organisations disseminated the research material on their social media platforms.

The study also obtained ethical approval from the research ethics committee of the Department of Psychology, City University of London, in October 2020 to advertise the research study independently on social media platforms. To maintain professional boundaries, a professional account was created for the research on the Twitter and Instagram platforms.

If participants wished to participate and met the inclusion criteria, they were invited to complete the online questionnaire, which took approximately 15-30 minutes. Participants were asked to complete the survey consent form before they accessed the questionnaire. Their participation was voluntary and anonymous, which was clearly indicated on all research materials, and they were informed in the information and consent forms that they could withdraw from the study by closing the web browser page at any time during the survey. Once the recruitment process had been completed and data analysis began, the social media accounts were deactivated. This was done to ensure that individuals would not be disappointed if they wanted to participate in the study once the recruitment process was complete.

7. Procedure

The study consisted of a healthy control group (women without a prior mental health diagnosis) and a clinical group (women diagnosed with anorexia nervosa by a registered health professional). Participants were asked to indicate in the survey whether or not they had been diagnosed with anorexia nervosa. To differentiate between the two groups, the eating disorders review questionnaire (sixth edition) was used. Research posters were published on social media platforms such as Instagram and Twitter, and the posters provided a link to the Qualtrics survey. Once participants opened the survey, they were informed that they would first find the information form, which they were strongly encouraged to read and take their time to consider before they decided whether or not they wished to participate in the study.

Once the decision was made, a consent form was available on the second page, and all participants were asked to complete this form. Only once the participant had given consent could they access the questions relating to perfectionism, sexual perfectionism, sexual functioning, and sexual psychological distress. They were informed that they could withdraw from the study at any time by closing the web browser, and a process bar was available throughout the survey to inform participants of the time remaining to complete the survey. A debriefing form was provided at the end of the survey, where participants could find contact information and counselling resources if they had questions or required support after completing the survey.

8. Ethical issues

This study was compliant with the BPS's code of human research ethics and the requirements of the ethics board of the City University of London. This study obtained ethical approval from the Department of Psychology research ethics committee in June 2020 (Reference: ETH1920-0944). Due to the sensitive nature of the phenomena being explored and the clinical population involved, certain measures were put in place to protect participants and to minimise the risk of them feeling vulnerable because of their participation in the study. It is important to note that no participants were in hospital when they took part in this study, which reduced the level of vulnerability that participants may have felt when they participated in the online survey.

The study faced the risk of stigmatising women with the term 'sexual functioning'. Although it is not possible to determine with certainty whether all participants may have viewed this terminology as a label that suggested a mental health disorder or a physical health 'problem', this possibility was considered. To minimise this risk, it was clearly stated in the information form and online survey that the aim of this research was not to encourage the medicalisation of this phenomenon and that there was no objective to diagnose participants with any sexual dysfunction. A second risk was the possibility of evoking emotional distress in participants, depending on their relationship with the subjects studied, which were sensitive in nature.

Although it was not possible to identify specific factors that might determine who was more likely to experience emotional distress, the following steps were put in place to support participants in their well-being if they needed it.

- Participants were given all relevant information about the purpose of the study and what it entailed in the research material to ensure that they could make an informed decision about participating.

- It was emphasised that their participation was anonymous (i.e., no identifiable data were collected) and that their confidentiality and anonymity would be preserved even if a report was published in a journal, that it was voluntary and that they could withdraw from the study by closing the webpage at any time.

- It was clarified that once consent had been given on the survey, it would be assumed for the duration of the survey.

- Participants did not have limited time to complete the survey; for example, they could choose to return to the survey later if they wished to take a break, and a progress bar was available throughout the survey to inform them of the amount of survey that was left to complete.

- Participants were provided with resources that they could access if they felt the need to seek psychological support (i.e., the Samaritans, Beat Adult Helpline, a leading eating disorder charity) and Rethink Mental Illness.

  Contact details for these organisations were available on all research materials and were present at the beginning and end of the survey, as well as on the debriefing form.

- Participants were given the opportunity to skip questions if they were uncomfortable with them. This was intended to promote a sense of autonomy among participants. They were also invited to contact the researcher or research supervisor if they had any questions about the study, by using the contact details available on the research material and the online survey.

If participants wished to make a complaint about the research project, they had access to the contact details and details of the ethics committee complaint procedure were provided on the research material and information form in case they did not wish to have contact with the researcher or research supervisor.

9. Measures

9.1 Eating Disorder Examination Questionnaire, sixth edition

The eating disorders questionnaire involves self-reporting on eating psychopathology. It consists of 28 questions within the following subscales: shape concern, weight concern, eating concern and restraint, and is scored on a seven-point scale. Empirical evidence indicates that the validity and internal consistency of the scale have been tested numerous times, ensuring that the measure meets appropriate standards for use in research (Luce & Crowther, 1999). Data from a study by Kelly and Karter (2014) show Cronbach's alpha values such as 0.89 for shape concern, 0.81 for weight concern, 0.88 for eating concern, 0.83 for restraint, and 0.96 for overall scores (Kelly & Carter, 2014). For ethical reasons, it is important to emphasise that this measurement tool was not used to diagnose participants, but rather as a screening tool to identify participants who belonged to the control or clinical groups (Kelly & Carter, 2014).

9.2 Frost multidimensional perfectionism scale

As discussed in the literature chapter, there are multiple ways to conceptualise and measure perfectionism. Unlike previous studies that were rooted in the conceptualisation of perfectionism as a unidimensional construct (Hamacheck, 1978; Garner, Olmstead & Polivy, 1983), this doctoral study was based on a multidimensional approach to understanding perfectionism and therefore used Frost's multidimensional perfectionism scale to measure perfectionism in participants (Frost et al., 1990). The scores make up a Likert scale that ranges from 1 (strongly disagree) to 5 (strongly agree), comprising four subscales, namely organisation, worry about mistakes, parental expectations, and personal standards. This measure is a well-known self-report instrument to reveal perfectionist traits and was developed when the conceptualisation of perfectionism shifted to a multidimensional approach (Bardone-Cone et al., 2009, 2010). This scale has been used in many studies that concern perfectionism in the eating disorder population (Sassaroli et al., 2008; Slof-Op't Landt et al., 2016).

Studies have assessed the internal consistency of the scale and have found Cronbach's alpha coefficients that ranged from 0.85 to 0.93 (Franco et al., 2014). To calculate the scores for Frost's multidimensional perfectionism scale, the sums of the scores for all subscales except the organisation subscale were calculated (Stoeber, 1998; Frost & Marten, 1990). Scores were presented in percentiles; percentiles above the 90th percentile indicated dysfunctional perfectionism and high percentiles suggested problematic levels of perfectionism.

Although high scores on the organisation subscale were excluded from the overall total score, if the scores were high in combination with the total score, they were considered an indication of problematic levels of perfectionism (Bastiani et al., 2006).

9.3 Multidimensional sexual perfectionism questionnaire

Sexual perfectionism was measured according to the only measure that has been created to assess sexual perfectionism. It is the multidimensional sexual perfectionism questionnaire, which was developed by Snell (1997). It is a Likert scale that ranges in scores from 1 (not at all characteristic of me) to 5 (very characteristic of me), and it is composed of four domains: self-oriented sexual perfectionism and partner-oriented sexual perfectionism, which are aimed to determine whether individuals might direct their sexual perfectionism towards themselves or their partner; and partner-prescribed sexual perfectionism and socially prescribed sexual perfectionism, which are designed to determine whether or not individuals perceive that others have perfectionist expectations of them as sexual partners, either directly from their partner (partner-prescribed) or on a broader societal scale (socially prescribed) (Kluck, Zhuzha & Hughes, 2016).

The multidimensional sexual perfectionism questionnaire shows good reliability, with an alpha coefficient for all subscales of >0.84 (Stoeber et al., 2013; Kluck et al., 2018). To obtain the scores, it was recommended that responses to all items should be summed, with higher scores suggesting higher levels of sexual perfectionism. To date, there is no specific cut-off score for this scale (Stoeber & Harvey, 2016).

9.4 Female sexual function index

This index is a self-reported measure that was developed to assess various aspects of female sexual functioning. The scale comprises various items such as desire and subjective arousal, lubrication, orgasm, satisfaction, and pain. The measure has shown appropriate standards of reliability, with high scores for each item ($r = 0.79$ to 0.86) and Cronbach's alpha values of 0.82 and above (Rosen et al., 2000.) The scale has been used widely in previous studies of sexual functioning in eating disorder pathology, including studies of anorexia nervosa (Dunkley, Gorzalka, & Brotto, 2020). However, in this study, this measure was not intended for use as a tool to diagnose sexual dysfunctions. The guidelines of Rosen et al. (2000) were used to calculate scores for the index; subscale scores were calculated by summing the items and multiplying the results by 0.6 for the desire subscale, 0.3 for the arousal and lubrication subscales, and 0.4 for the orgasm, satisfaction, and pain subscales.

A cut-off score of 26.5 was used to interpret the total scores, with higher scores indicating better sexual functioning (Rosen et al., 2000; Wiegel, Meston & Rosen, 2005).
The female sexual functioning scale included responses for 'no sexual activity', which were included in the calculation of the sum of all subscale scores. This compromised the results by giving lower scores for women who had not been sexually active in the past four weeks compared with women who had. Previous studies have suggested that these ‘no sexual activity’ scores should be considered missing values (Meyer-Bahlburg & Dolezal, 2007; Stoeber & Harvey, 2016).

For this reason, we replaced ‘no sexual activity’ with the mean scores calculated in the female sexual index scale, on the following subscales: arousal, lubrication, orgasm and pain. Moreover, as described in the literature chapter, the phenomenon of sexual functioning is complex and involves biopsychosocial components, with the DSM-5 recommending that distress be considered as part of the theoretical understanding of female sexual functioning (American Psychological Association, 2013). Thus, the female sexual distress scale - revisited was also used to gain a more comprehensive understanding of sexual functioning.

9.5 Female sexual distress scale – revisited

Female sexual distress is now considered a crucial element in the assessment of sexual functioning in women. Therefore, Derogatis and colleagues developed this self-reported instrument to assess personal sexual distress appropriately. The scale was revisited in 2008, adding a 13th item, which increased sensitivity (Aydin et al., 2016). As sexual functioning played a key role in this study, it was crucial to adhere to the recent literature and its new conceptualisations of sexual functioning. Thus, the inclusion of this measure ensured that the results of the study would be relevant to the existing literature.

The scale met the necessary reliability and validity criteria and was therefore considered an appropriate measurement tool for research purposes. The literature reported scores such as 92.2% for sensitivity and 76.6% for specificity regarding the ability of the scale to detect the presence or absence of sexual functioning difficulties (Ter Kuile et al., 2006). To interpret the results, higher scores (sum) indicated greater distress (Ghassami et al., 2014).

10. Analytical strategy

10.1 Sample size

An a priori sample size calculation for the analysis of the structural equation model was performed to estimate the sample size that was required for the study. Online calculation software was used to perform a priori calculations in the context of structural equation models (Soper, 2023). The calculations showed that the study required a sample of 308 clinical participants and a minimum of 200 participants in the healthy control group. Please refer to Soper (2023) for the specific mathematical formulae used. The observable variables were age, ethnicity, gender, eating disorder diagnosis, BMI, education level, employment status, relationship status, menopause, medication and the score for the Eating Disorder Examination Questionnaire, sixth version. The latent variables were perfectionism, sexual perfectionism, female sexual distress, female sexual functioning and satisfaction.

The anticipated effect size was 0.6, which suggested a medium range. This anticipated effect size was derived from studies that had been focused on the relationship between sexual perfectionism and sexual functioning within the general population and the link between perfectionism and anorexia nervosa. This led to the hypothesis that the strength among such variables had sufficient strength to aim for this potential effect size for the study.

10.2 Cleaning data

The first step in the data analysis was to identify missing values, which were only replaced by calculated averages if 95% of the data was intact, otherwise they were removed (Field, 2018). A total sample of 426 participants was collected, and 43 cases with less than 95% of the data were identified, to produce a total of 383 participants. Additionally, as mentioned above, the ‘no sexual activity’ responses on the sexual functioning index scale were also treated as missing values, by calculating the mean scores (Stoeber & Harvey, 2016).

The second step was to reverse code. Some items had to be reversed on the female sexual functioning scale: item 2, ‘how difficult was it to lubricate yourself during sexual activity?’ and item 4, ‘how difficult was it to maintain your lubrication?’ on the lubrication subscale; and item 2, ‘when you had sexual stimulation or intercourse, how difficult was it to reach orgasm?’ on the orgasm subscale. On the Frost multidimensional perfectionism scale, there was no need to reverse the items (Boyle, Saklofske & Matthews, 2015). This also applied to the sexual perfectionism scale (Snell, 1996) and the female sexual distress scale (Ter Kuile, Brauer & Laan, 2006).

Management of outliers was a crucial aspect of the cleaning of the data, which was done by following Field's guidelines through use of the recommended equation Z = (z x s) + X to replace scores (Field, 2018). Some outliers were identified in the following scales: items 1 ('organisation is very important to me'), 3 ('I try to be an organised person'), 4 ('I try to be a neat person') and 6 ('I am an organised person') on the organisation subscale; item 2 ('It is important to me that I be thoroughly competent in what I do') of the personal standards subscale; items 5 ('I expect nothing less than perfectionism from my sexual partner') and 6 ('I will appreciate my partner only if she/he is a perfect sexual lover') from the partner-oriented sexual perfectionism subscale; items 1 ('how often did you feel sexually aroused during sexual activity or intercourse?), 2 ('how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?'), 3 ('how confident were you about becoming sexually aroused during sexual activity or intercourse?') and 4 ('how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?') from the arousal subscale; item 2 ('how would you rate your level (degree) of sexual desire or interest?') of the desire subscale; item 2 of the lubrication subscale ('how difficult was it to become lubricated ("wet") during sexual activity or intercourse?'); item 2 of the distress scale ('how often did you feel unhappy about your sexual relationship?'); and items 1 (how often did you experience discomfort or pain during vaginal penetration?)', 2 ('how often did you experience discomfort or pain following vaginal penetration?') and 3 ('how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?') of the pain subscale.

In addition, outliers were identified by examining the demographic variable of age. Five cases of outliers, namely three participants who were over 55 years of age and two participants who were over 60 years of age, were found. It was assumed that the lack of participants in these age groups may be because participants were recruited through social media platforms. The decision was made to exclude these participants from the data as it would be inappropriate to generate further results. The limited data for this age range meant that the analysis would not produce a good understanding of participants in this age range and could have a negative impact on the overall results of the study (Delice, 2010). Five participants were therefore excluded, giving a total of 378 participants.

Pearson correlations were calculated in order to get an idea of whether significant associations could be established between the different variables. Although the present study focused on the potential mediating role of sexual perfectionism between perfectionism and sexual functioning in women with anorexia nervosa, the results of the Pearson correlations allowed for the presentation of results that highlighted any interrelationships

among all the variables involved, which might be useful for further clinical investigations. It is important to note that correlations can indicate either significantly positive or negative associations between variables, and the score can also suggest the strength of these relationships, bringing important evidence to light.

A principal component analysis, which involved the Frost multidimensional perfectionism scale, the multidimensional sexual perfectionism questionnaire, the female sexual functioning index and the female sexual distress scale (revisited version) was conducted. This was an attempt to identify whether it was possible to exclude certain variables that were less relevant to the primary hypothesis under investigation. The results are presented in the results chapter. They show why variable extraction would not be possible in this case, as it would reduce the complexity of the constructs so that they would no longer be representative of the phenomenon and this would risk the study no longer contributing accurately to the current evidence-based literature if we extracted some variables.

Therefore, the next step entailed computing the variables to check for normality. To test whether the data were normally distributed, the sample size (N=378) and the objective of performing a structural equation model, more specifically a forward path regression analysis, were taken into consideration. Kim (2013) recommends referral to histograms and boxplots rather than sole reliance on Kolmogorov-Smirnov or Shapiro-Wilk tests when the sample size is greater than 300. It was important to consider the sample size for the interpretation of skewness and kurtosis. Kim (2013) recommends that the cut-off score for a sample size above 300 for skewness should be between -2 and +2 and -7 and +7 for kurtosis.

Brown (2006) suggests that skewness scores between -3 and +3 and kurtosis scores between -10 and +10 are considered acceptable values in the context of using structural equation models. According to such recommendations, normality was assumed, and the relevant results are presented in the results section.

Reliability tests that used Cronbach's alpha statistical test were performed to check the reliability of all measurement tools. The results showed appropriate levels of reliability, confirming that it was appropriate to continue the data analysis with the measurement tools provided. Independent t-tests were then calculated to determine whether there was a statistically significant difference between the healthy control group and the clinical group on the following variables: the EDEQ, the Frost multidimensional perfectionism scale, the

multidimensional sexual perfectionism scale, the female sexual functioning index, and the sexual distress scale.

An independent t-test was performed to confirm whether the scores on the Eating Disorder Examination Questionnaire subscales (restraint, shape concern, weight concern and eating concern) differed between the clinical and control groups. Independent t-tests were also conducted to identify whether the groups differed from one another on the following measurement tools: the female sexual functioning index, the multidimensional sexual perfectionism questionnaire, the female sexual distress scale – revisited version and the Frost multidimensional perfectionism scale. As the model involved various independent variables and the Pearson correlation scores indicated strong significant correlations among them, a multicollinearity test was performed to ensure that there were no issues with multicollinearity before the path analysis models were run. The results indicated that there were no problems, as all variance inflation factor scores were below the threshold of 2.5 (Johnston, Jones & Manley, 2018;2017).

10.3 Path analysis

Structural equation models were used to test relationships between constructs. Structural equation modelling can be compared with other quantitative methods, such as correlation, multiple regression, and analysis of variance, as their techniques are similar. The main advantage of using structural equation models is the ability to test the relationships and strengths among variables. In addition, structural equation models can be used to deal with measurement-specific error issues (Weston, 2006, 2016).

Structural equation models were chosen for the data analysis as this study involved many variables. Specifically, path analysis models were performed for each group to compare the results. Path analysis is considered an extension of multiple regression analysis; it is regarded as effective to examine multiple variables and their influences on each other. Although previously referred to as *'causal modelling'*, it is essential to stress that path analysis does not assume causality or determine whether a model is correct. Its purpose is to determine whether the data can be considered consistent with the model.

Furthermore, path analysis takes a *'model testing'* rather than a *'model building'* approach, which means that path analysis is a type of structural equation model that is only a structural model and does not involve a measurement model (Streiner, 2005). This is because, in path analysis, the model works with measured variables.

Other structural equation models work with factor analysis. For this reason, only the structural models are presented in the results section. Table 9 presents significant results in the Appendix.

10.4 Model specification

Path models were calculated using AMOS statistical software (version 26). They represented a theoretical model that sexual perfectionism may mediate the relationship between perfectionism and sexual functioning in women with anorexia nervosa. This hypothesis stemmed from evidence that linked sexual perfectionism and sexual functioning in women in the general population (Stoeber, 2013, 2016). As this was a new area of research, and as women with anorexia nervosa experience high levels of perfectionism (Lloyd, 2014), and difficulties in sexual functioning have been documented (Bulik, 2013), it was important to contribute to the literature by investigating whether sexual perfectionism (and its subcomponents) might mediate the association between perfectionism and sexual functioning in this clinical group.

Due to the complexity of the phenomenon of sexual functioning and the DSM-5 recommendation that difficulties with sexual functioning should be understood in relation to whether or not the individual was experiencing psychological distress, the path model included the variable of sexual distress, to be understood adjacent to sexual functioning. However, the literature suggests that exploration of alternative theoretical models is good practice when structural equation models are used (Morrison, Morrison & McCutcheon, 2017); as this method recognises the existence of alternative models that may be able to better test the theoretical underpinnings of the phenomenon.

For this reason, the variable of sexual distress was also investigated in terms of whether it played a role in the potential mediating relationship among perfectionism, sexual perfectionism, and sexual functioning. No evidence-based research so far has included the concept of sexual distress in relation to sexual functioning in women with anorexia nervosa, even though it is an important factor in the current understanding of what constitutes sexual functioning in women (American Psychiatric Association, 2013). One could argue that it is imperative to detect whether or not sexual distress plays a role in the mediating relationship among perfectionism, sexual perfectionism, and sexual functioning.

10.5 Parameter estimation

As the data were normally distributed, maximum likelihood parameter estimation was preferred over other estimation methods (Kline, 2005). All cases of missing values and outliers were handled throughout the data cleaning process, so that no missing values or outliers were present at the path analysis stage. This is relevant for all models presented in the results chapter.

Chapter 3: Results

1. Introduction

This chapter presents separately the statistical results of the data cleaning process and the regression path analyses that were conducted for both groups. It is crucial to consider how the results may be interpreted and therefore to pay close attention to how the data were analysed and to be transparent about the results, the context in which they were obtained and their limitations (BPS, 2021). It is imperative that readers bear in mind that the data were collected to complete a professional doctoral course in counselling psychology and that, as mentioned in the Covid-19 impact statement above, this doctoral study was heavily impacted by the pandemic, which reduced the sample size significantly.

This analysis section is focused on the investigation of the following research question: does sexual perfectionism mediate the relationship between perfectionism and sexual functioning in women with anorexia nervosa? This hypothesis stemmed from the literature that linked perfectionism with anorexia nervosa (Lloyd et al., 2014); reported difficulties in sexual functioning in anorexia nervosa (Pinheiro et al., 2010); and considered sexual perfectionism and sexual functioning in women from the general public (Stoeber & Harvey, 2016). Such parallel links suggested that there was a gap in the literature that necessitated the investigation of the research question.

2. Description of participants

A total of 426 participants completed the online survey. After completion of the data cleaning process, which is described in more detail in the data cleaning section below, the dataset comprised 378 participants: 164 women in the clinical group (43.4%) and 214 women in the healthy control group (56.6%). Participants were recruited through social media platforms, and all volunteered to participate anonymously. Further details on the recruitment process are available in the methodology chapter. Table 1 presents the descriptive statistics for all participants, whereas demographic percentile scores can be found in Table 2 in the Appendix.

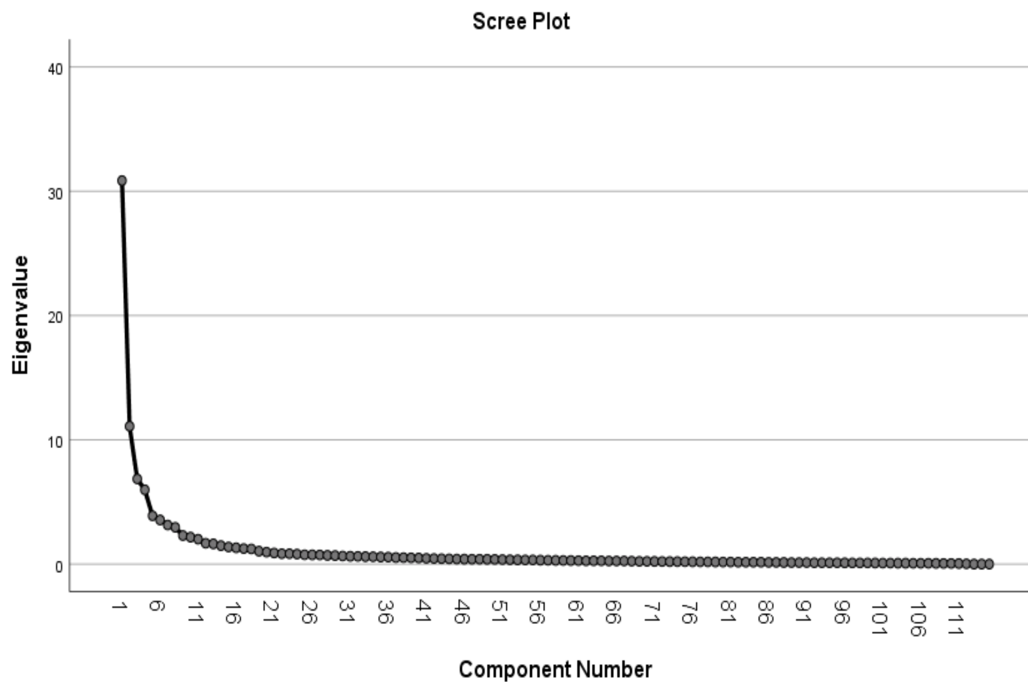
Table 1. Descriptive statistics

	Clinical group			Healthy control group		
	N	Mean	Std. deviation	N	Mean	Std. deviation
Age	164	3.2	1.43	214	2.8	1.24
Education	164	2.9	1.04	214	3.6	.99
Employment status	164	2.9	2.13	214	3.5	2.31
Relationship status	164	2.6	1.57	214	2.4	1.43
Diagnosis	164	1.0	.00	214	2.0	.00
BMI	164	2.3	1.37	214	2.3	.88

3. Principal component analysis

A scree plot is presented in Figure 1, whereas the eigenvalues (Table 3) are reported in the Appendix. The results indicated that it would not be appropriate to extract components in this case, as this could distort the results and would not be an appropriate representation of the phenomena studied.

Figure 1. Principal component analysis scree plot



A promax rotation was conducted. The results showed that the combined cumulative eigenvalue scores for the first two components was 36% and that other results up to the 19th component scored above 1. Therefore, extraction was not feasible.

4. Participant scores: a comparison between clinical and healthy control groups

The results showed that 8.5% of the clinical group reported sexual functioning-related difficulties, whereas 12.6% of the healthy control group reported such difficulties. However, 56% of the control group and 81.7% of the clinical group reported high levels of sexual distress. Furthermore, the results showed that 75.6% of the clinical group scored clinically significant scores on the Eating Disorder Examination Questionnaire. More specifically, 61% of the clinical group showed significant clinical scores on the restrain subscale, 79% significant clinical scores on the shape subscale, 84.8% significant clinical scores on the weight concern subscale and 67.7% clinically significant scores on the eating concern subscale.

In comparison, 72.9% of the women in the control group had no clinically significant scores on the total scores; 80.8% did not report clinically significant results on the restrain subscale; 55.1% did not report clinically significant scores on the shape subscale; 57.5% did not report clinically significant scores on the weight concern subscale; and 86% showed no clinically significant results on the eating concern subscale. Furthermore, the results showed that 10% of the women with anorexia nervosa had clinically dysfunctional perfectionism, and 50% had problematic levels of perfectionism. In the healthy control group, 10% were found to have clinically dysfunctional levels of perfectionism.

The healthy control group scored higher than the clinical group on sexual perfectionism, with 25% having overall scores above 24.75, whereas in the clinical group, 25% scored above 20 only. However, the clinical group had higher scores on partner-oriented sexual perfectionism, with 50% scoring above 24, while 50% of the healthy control group scored 23. Although there is no specific cut-off score for sexual perfectionism, higher scores should be taken to show higher levels of sexual perfectionism.

5. Normality

Kolmogorov-Smirnov and Shapiro-Wilk scores (Tables 4 and 5 in the Appendix) showed that normality could be assumed (Brown, 2006; Kim, 2013).

6. Reliability

Table 6. Cronbach's reliability statistics

	Cronbach's alpha	No of items
Female sexual functioning index	0.858	19
Female sexual distress scale	0.954	13
Multidimensional sexual perfectionism questionnaire	0.938	24
Frost multidimensional perfectionism scale	0.945	35
Eating Disorder Examination Questionnaire	0.959	20

7. Independent t-tests

Table 7. T-test results

	Group	N	Mean	Std. deviation	Significance	t	df
Restraint	Clinical	164	4.65	1.83	<0.001	11.38	376
	Healthy control	214	2.63	1.59			
Shape concern	Clinical	164	5.48	1.60	<0.001	9.74	376
	Healthy control	214	3.75	1.79			
Weight concern	Clinical	164	5.47	1.46	<0.001	10.28	376
	Healthy control	214	3.71	1.77			
Eating concern	Clinical	164	4.46	1.54	<0.001	13.69	318.754
	Healthy control	214	2.39	1.31			
Perfectionism	Clinical	164	2.09	0.65	<0.001	8.01	376
	Healthy control	214	2.69	0.77			
Parental expectations	Clinical	164	2.57	1.01	<0.001	-5.194	376
	Healthy control	214	3.15	1.10			
Organisation	Clinical	164	1.77	0.72	<0.051	-1.96	376
	Healthy control	214	1.91	0.69			

Personal standards	Clinical	164	1.81	0.77	<0.001	-4.76	376
	Healthy control	214	2.20	0.78			
Concern over mistakes	Clinical	164	1.89	0.69	<0.001	-0.942	376
	Healthy control	214	2.73	0.97			
Sexual functioning	Clinical	164	35.98	6.43	<0.001	4.34	376
	Healthy control	214	33.27	5.69			
Desire	Clinical	164	12.89	4.42	<.001	2.12	376
	Healthy control	214	12	3.32			
Arousal	Clinical	164	4.57	0.99	<0.001	4.49	376
	Healthy control	214	4.12	0.92			
Lubrication	Clinical	164	3.98	1.08	<0.001	3.225	376
	Healthy control	214	3.63	1.02			
Orgasm	Clinical	164	4.96	1.48	<0.001	5.054	376
	Healthy control	214	4.19	1.43			
Satisfaction	Clinical	164	3.70	1.41	<0.001	4.753	376
	Healthy control	214	3.07	1.17			
Pain	Clinical	164	5.87	0.82	<0.001	-4.305	376
	Healthy control	214	6.23	0.79			
Sexual distress	Clinical	164	2.99	0.98	<0.001	7.926	376
	Healthy control	214	2.21	0.90			
Sexual perfectionism	Clinical	164	17.71	4.33	<0.001	-6.78	376
	Healthy control	214	21	4.90			
Self-oriented sexual perfectionism	Clinical	164	10.82	5.766	<0.001	-9.77	376
	Healthy control	214	17.29	6.80			
Partner-oriented sexual perfectionism	Clinical	164	23.12	5.69	0.248	1.157	376
	Healthy control	214	22.48	5.04			
Partner-prescribed sexual perfectionism	Clinical	164	20.75	6.94	<0.001	-3.493	376
	Healthy control	214	23.08	6.04			

Socially prescribed sexual perfectionism	Clinical	164	16.15	6.55	<0.001	-7.078	376
	Healthy control	214	21.14	6.95			

8. Pearson correlations

Table 8. Pearson correlations across both groups

		Perfectionism	**Sexual functioning**	**Sexual perfectionism**	**Sexual distress**
Eating disorder examination	Pearson correlation	-0.473**	0.354**	-0.393**	0.483**
Perfectionism	Pearson correlation		-0.168**	0.553**	-0.352**
Sexual functioning	Pearson correlation			-0.102*	0.525**
Sexual perfectionism	Pearson correlation				-0.459**

** Correlation is significant at the 0.01 level (two-tailed)

* Correlation is significant at the 0.05 level (two-tailed)

9. PART 1. Path models that investigate whether sexual perfectionism mediates the relationship between perfectionism and sexual functioning

Figure 2: Path regression model for clinical group

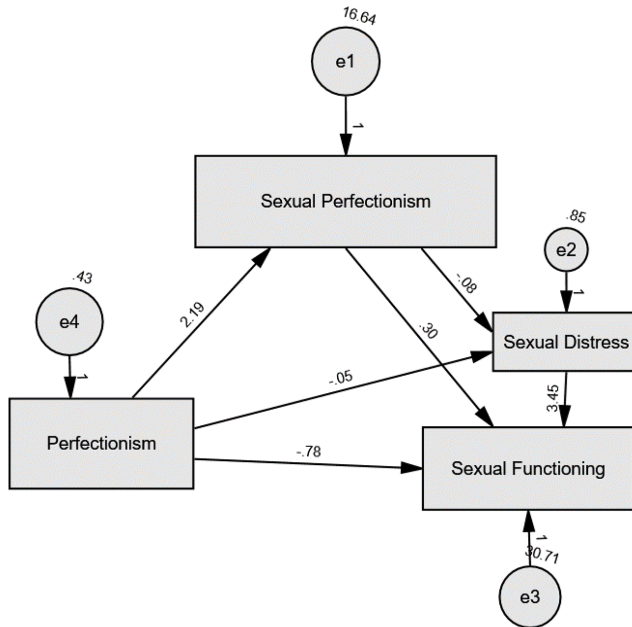
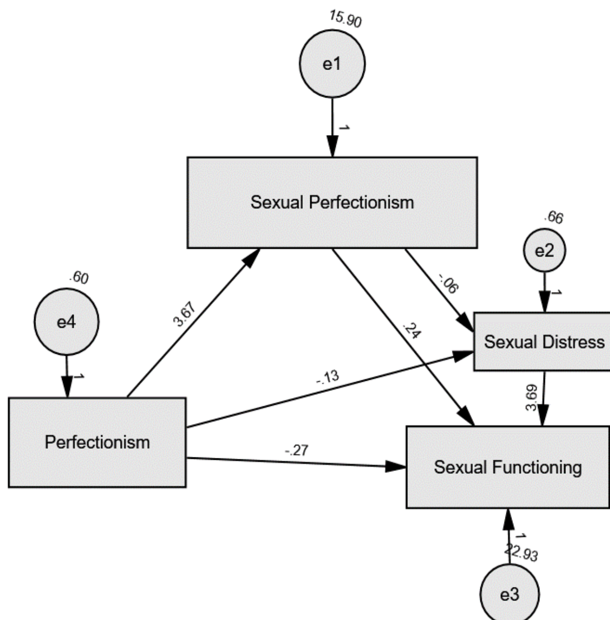


Figure 3: Path regression model for the healthy control group



10. PART 2. Path models that investigate the domains of sexual perfectionism and whether they mediate the relationship between perfectionism and sexual functioning

Figure 4. Path model: self-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the clinical group

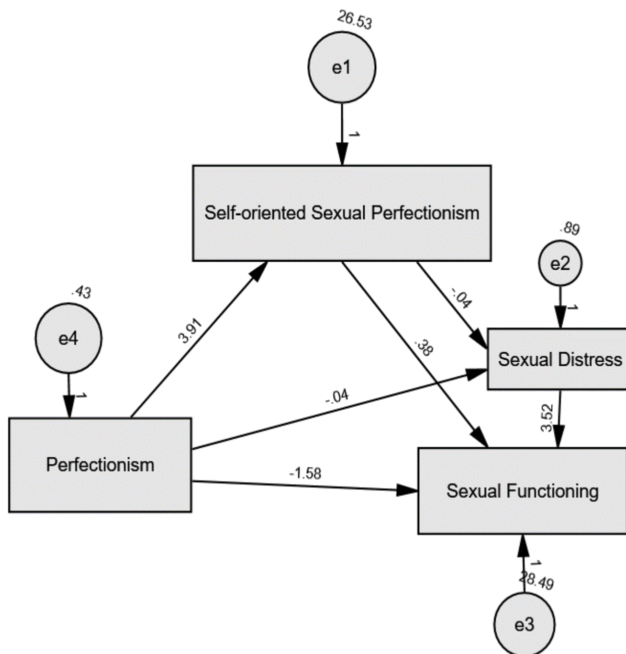


Figure 5. Path model: self-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group

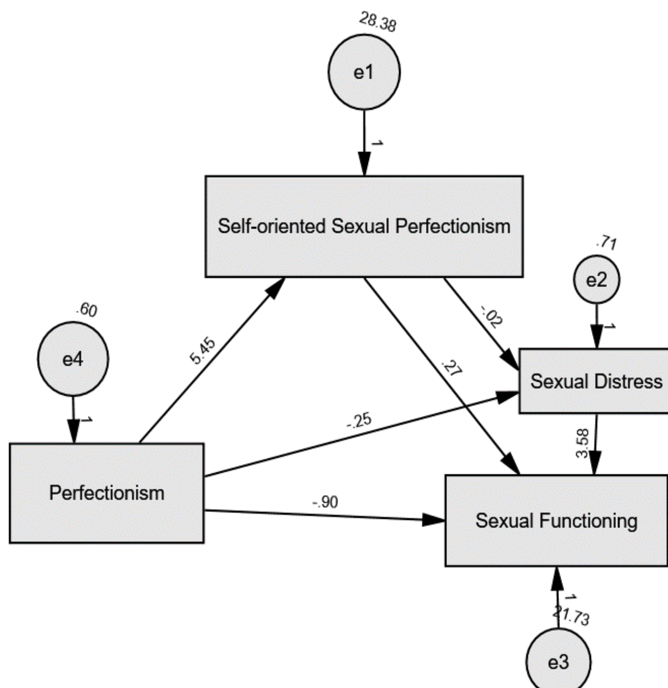


Figure 6. Path model: partner-oriented sexual perfectionism does not mediate between perfectionism and sexual functioning in the clinical group

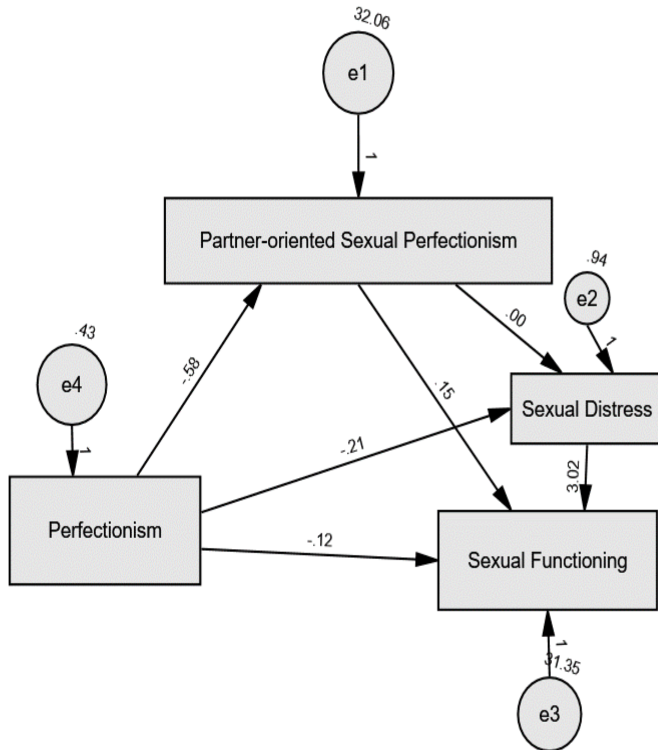


Figure 7. Path model: partner-oriented sexual perfectionism does not mediate between perfectionism and sexual functioning in the healthy control group

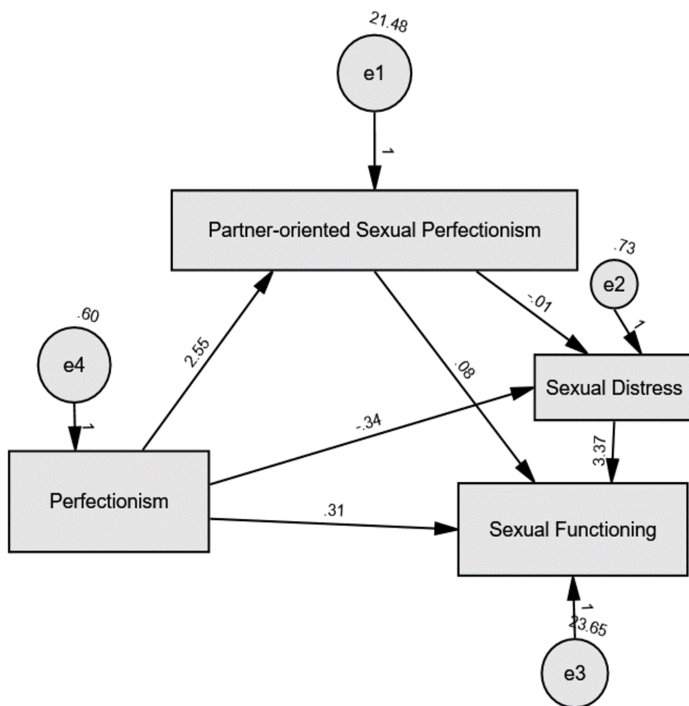


Figure 8. Path model: partner-prescribed sexual perfectionism mediates between perfectionism and sexual functioning through sexual distress in the clinical group

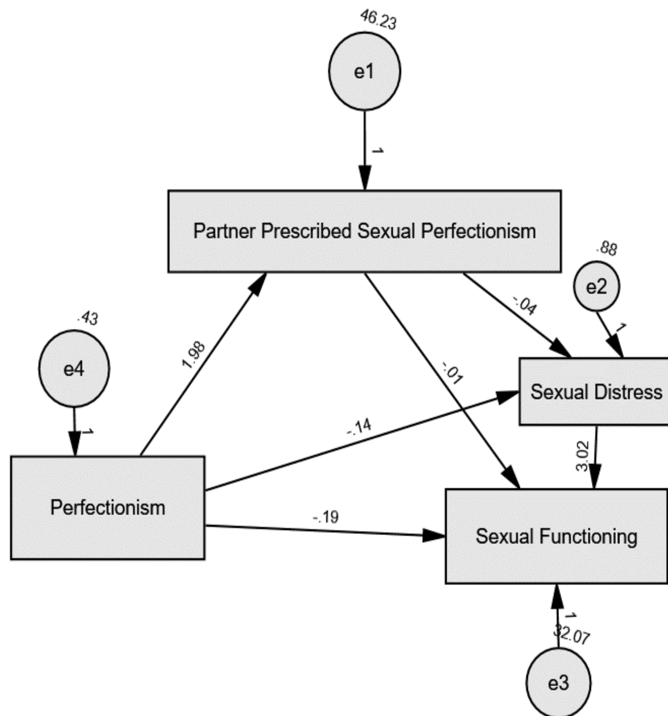


Figure 9. Path model: partner-prescribed sexual perfectionism mediates between perfectionism and sexual functioning through sexual distress in a healthy control group

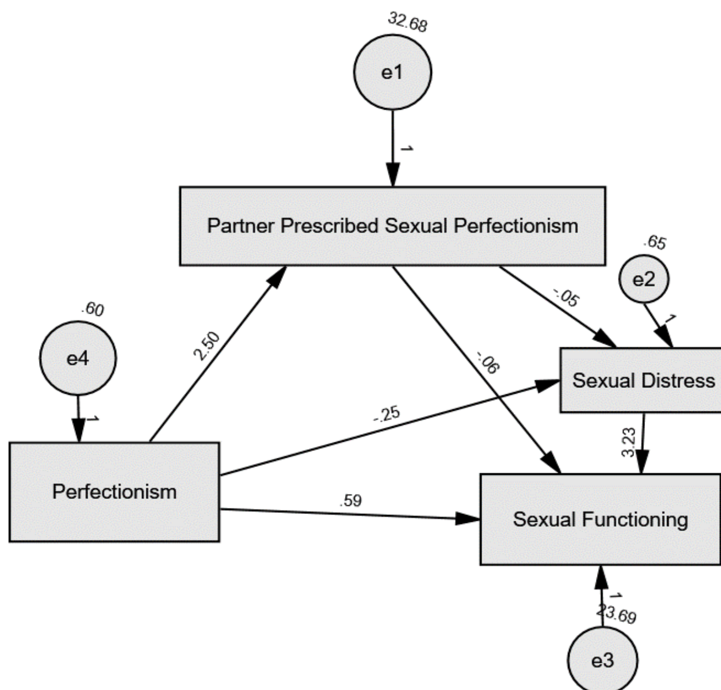


Figure 10. Path model: socially prescribed sexual perfectionism mediates between perfectionism and sexual functioning through sexual distress in the clinical group

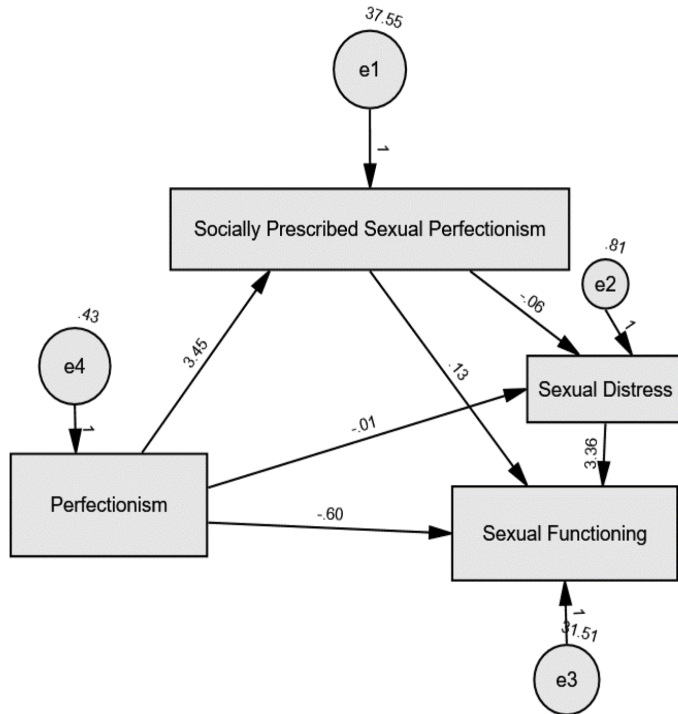
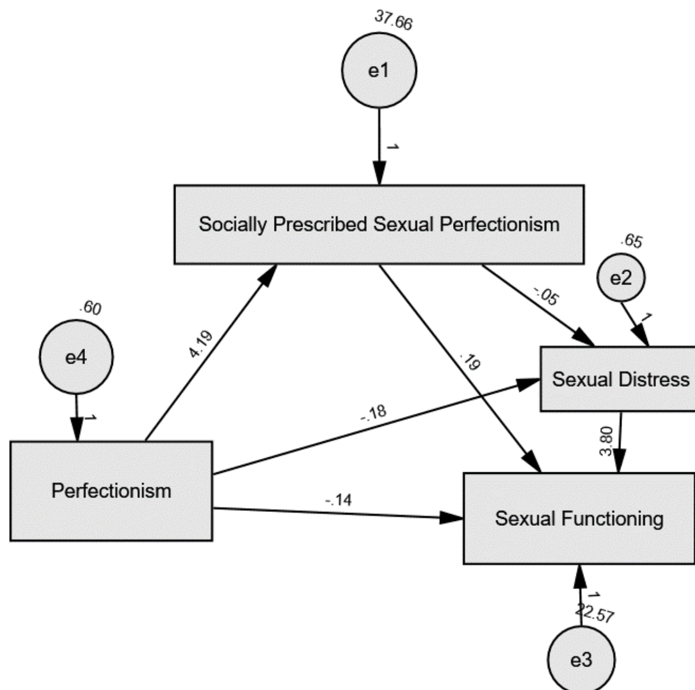


Figure 11. Path model: socially prescribed sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group



Chapter 4: Discussion

1. Brief overview of results

Sexual perfectionism was found through this study to mediate the relationship between perfectionism and sexual functioning in women with anorexia nervosa. Moreover, there was an indirect association with sexual distress as well. Hence, there was a relationship arising between perfectionism, sexual perfectionism, sexual distress and sexual functioning. For the healthy control group in this study, sexual perfectionism was found also to mediate the relationship between perfectionism and sexual functioning, and sexual distress also played a role in this relationship. Furthermore, the results showed that self-oriented sexual perfectionism mediated between perfectionism and sexual functioning in women with anorexia, and sexual distress also indirectly played a significant role. This also applied in this study to the healthy control group. Moreover, partner-oriented sexual perfectionism did not play a mediating role between perfectionism and sexual functioning, even through the means of the variable of sexual distress. This was applicable to both groups.

Regarding partner-prescribed sexual perfectionism, there was an association between perfectionism, partner-prescribed sexual perfectionism, sexual distress, and sexual functioning. However, without sexual distress, there was no association between perfectionism, partner-prescribed sexual perfectionism and sexual functioning. This applied to both groups. Finally, when looking at socially prescribed sexual perfectionism, differences between the clinical and control groups emerged. There was no relationship among perfectionism, socially prescribed sexual perfectionism, and sexual functioning in women with anorexia nervosa. However, an indirect relationship was significant when sexual distress was taken into account. Moreover, in the control group, the results showed that socially prescribed sexual perfectionism mediated between perfectionism and sexual functioning, and this was also the case when the role of sexual distress was examined within that indirect relationship.

2. Introduction

The clinical group comprised a sample of 164 women who had volunteered to participate in the study and reported that they had been diagnosed with anorexia nervosa by a registered health professional. The healthy control group was a sample of 214 women who had also volunteered to participate and reported that they had never been diagnosed with anorexia nervosa or any other type of mental disorder by a registered health professional.

Participants in both groups were at least 18 years old. The results indicated that 8.5% of the women with anorexia nervosa reported difficulties in their sexual functioning, and 91% of them showed scores above the cut-off point of 26.5, indicating that they felt they had no problems with their sexual functioning. However, 81.7% of them did report high levels of sexual distress. For the healthy control group, 12.6% showed difficulties with sexual functioning, and the other 87.4% scored above the level that would indicate that they had any such difficulties. Yet 51.6% reported high levels of sexual distress. Such statistics stress the importance of conceptualising female sexual functioning by incorporating the sexual distress factor within the phenomenon.

Indeed, if one were to consider only scores on the female sexual functioning index, one could interpret the findings to mean that sexual functioning difficulties are not of concern for women with anorexia nervosa. Moreover, when compared with the healthy control group, one might even conclude that sexual functioning is more of a concern for the controls than for the members of the clinical group, which might feed the ideology that sex-related topics are not relevant to women with anorexia nervosa. However, previous research has highlighted the importance of distinguishing between reports of high levels of negative experiences and showing a lack of interest (Wiederman, Pryor & Morgan, 1996).

Furthermore, it is important to study the sexual functioning of women with anorexia nervosa in the context of the individual (Pinheiro et al., 2010). The findings of this study confirmed that if the female sexual functioning index scores were interpreted alongside the female sexual distress scores (World Health Organisation, 2006; American Psychiatric Association, 2013), the results highlighted that sexual functioning was an important consideration in women with anorexia nervosa, as 81.7% experienced sexual distress.

The results also showed that 51.6% of women in the healthy control group reported high levels of sexual distress. These figures highlight the importance of this aspect, regardless of whether a woman has or has not received a mental health diagnosis from a registered health professional. However, the results showed that women with anorexia nervosa reported higher levels of sexual distress than did the healthy control group. The findings were explored further to discover what elements may cause a higher degree of sexual distress in the clinical group.

In this chapter, the findings regarding levels of perfectionism are discussed, and then the mediating role of sexual perfectionism (and its subcomponents) is explored between perfectionism and sexual functioning. The two groups are compared to explore what the

findings might indicate. In addition, sexual distress, its association with sexual functioning, and its role in the indirect relationship among perfectionism, sexual perfectionism and sexual functioning are discussed.

3. Perfectionism: reflection on outcomes

There is much-published literature that highlights the importance of perfectionism in anorexia nervosa. Therefore, one would have assumed that the clinical group would report higher levels of perfectionism than would the healthy control group. However, the findings showed that in this instance, women in the healthy control group reported higher rates of perfectionism than those in the clinical group. These findings were inconsistent with the literature regarding the different levels of perfectionism between the groups (Dahlenburg, Gleaves & Hutchinson, 2019). The factors that may have led to such results were explored.

It is important to note that this study did not collect data regarding whether or not the participants were undergoing psychological treatment at the time of the study, nor did it assess the severity of the symptomatology, nor did it indicate whether the participants were in remission and, if so, for how long had they been so. It is essential to consider these limitations, particularly the small sample size of the clinical group (N=164) compared with the size of the healthy control group (N=214), and how these data may have influenced the overall results.

Furthermore, although it has been shown that individuals who have recovered from anorexia nervosa retain high levels of perfectionism (Bastiani et al., 1995), there is some inconsistency in the literature in this regard; one possible reason for this is that studies have used different scales of perfectionism. Many have assessed perfectionism through the use of measurement tools that are rooted in the conceptualisation of perfectionism as a unidimensional construct (Hamacheck, 1978; Garner, Olmstead & Polivy, 1983) rather than as a multidimensional construct.

Thus, one of the assumptions that might be made about the reason for the differences in the scores compared with other outcomes is that the use of a multidimensional approach to the assessment of perfectionism caused the discrepancy. Some studies have not considered the different stages of the recovery process during the exploration of rates of perfectionism in this clinical population (Bardone-Cone et al., 2009, 2010). It has been shown that levels of perfectionism can significantly decrease to the level of healthy controls when individuals are in cognitive and behavioural recovery (Bachner-Melman, Zohar & Ebstein, 2006).

This illustrates the reflection in the literature chapter on the current conflict over how we conceptualise recovery and how this may impact how research is conducted, or how findings are interpreted, and as a result how this may influence clinical practice (Bardone-Cone, 2007; Bardone-Cone et al., 2009, 2010).

It can be argued also that these reasons may have impacts on the results obtained through the use of the EDEQ and on the reason why only 75.6% of the participants in the clinical group reported clinically significant levels on this scale. Levels of perfectionism are generally correlated with levels of eating disorder symptomatology (Dahlenburg, Gleaves & Hutchinson, 2019). Therefore, it is important not to conclude that participants who scored low on this scale did not exhibit the characteristics of anorexia, but rather that the limitations described above prevented capture in the study of their symptomatology, or at least their level of severity, in the context in which they found themselves. It is important that future research takes this into consideration and perhaps is focused on screening or controlling for these variables.

This does not mean that the clinical group did not show a significant amount of perfectionism in their outcomes. A potential explanation for the level of perfectionism in the control group could be that there has been a general increase in levels of perfectionism in young individuals due to changes in cultural values from previous generations. Markus and Kitayama (2010) have stressed that cultural norms and changes can impact individual belief systems and even personalities. Recent work by Curran and Hill (2019) has shown that individuals seem to be more exposed to the pressures of striving and competing with others than their peers were in previous generations, whether it be for academic success, the achievement of social status or the pursuit of the 'perfect body type'. In addition, social media is seen to provide the necessary platform for continuous exposure to the representations of others and to perpetuate a false sense of the 'perfect lifestyle', which can lead to increased concerns about body image or even to social isolation (Grabe, Ward & Hyde, 2008).

The societal ideals of Western culture, which emphasise individualism, social comparison, and the idea of *'becoming a perfect individual'* (Eckersley, 2006; Curran & Hill, 2019) may be behind this rise in perfectionism. It has been suggested that university students show greater tendencies to try to demonstrate perfection as a means of gaining feelings of belonging, and thus seem to experience the world as harsh and demanding of them (Curran & Hill, 2019).

There seems to be an increase in socially prescribed perfectionism, which the research suggests is worrying as this component of perfectionism is often associated with social isolation and factors such as anxiety or increased levels of control (Limburg et al., 2017). This is consistent with the suggestion of Flett and Hewitt (2002) that perfectionism can be seen as a predisposing factor for various mental health disorders, as perfectionists are more likely to be socially isolated because they feel that they will never belong in a group, as their perception of belonging is dependent on the achievement of unrealistic standards (Flett & Hewitt, 2002).

Such arguments align with the findings of Hamacheck (1978), who argued that the main problem with perfectionists was that they overvalued performance compared with their sense of self. Hamacheck stated that *"he learns only through performance that he has a self"* (Hamacheck, 1978, p.29). This statement resonates with the work of Hewitt, Flett and Mikail (2017), who stated that young generations are now taught to strive for high achievement and perfection and that this is rewarded, which leads young people to set unrealistic goals and to define themselves by their performance alone.

Literature reports show that young individuals are less engaged in group activities than in previous generations and prefer to focus on individual activities that they associate with achievement (Twenge, 2014). Moreover, perfectionism and psychopathology are known to be associated, and an increase in perfectionism may be linked to World Health Organisation data that shows an increase in the occurrence of mental ill-health in the form of higher levels of depression, suicide ideation, anxiety, body dysmorphia and eating disorders compared with its occurrence in previous generations (Bor et al., 2014; World Health Organisation, 2017).

As a considerable proportion (51.9%) of the participants in this study were aged 18-25 and 25-30 (22.5%), it can be assumed that the high levels of perfectionism in the healthy control group may be due to the increased levels of perfectionism in this generation. Furthermore, perfectionism may play a role as a coping and maladaptive factor, which is of particular importance regarding presentations of anorexia nervosa (Haynos et al., 2018). Thus, it is impossible to conclude that the high levels of perfectionism discovered in both clinical and healthy control groups are related to adaptive or maladaptive behaviour per se. This is another factor to consider when interpreting the results and should be considered in future research that involves an investigation of the interrelationships among perfectionism, sexual perfectionism, and female sexual functioning.

There is little evidence that has identified which types of sexual perfectionism can be considered adaptive or maladaptive. Current evidence suggests that self-oriented sexual perfectionism may play both roles (Kluck, 2016), whereas partner-oriented sexual perfectionism has been associated with maladaptive effects and negative impacts on sexual functioning (Stoeber & Harvey, 2016). However, these findings should be viewed with an awareness of the limitations of the studies. The literature on the subject is sparse, so readers should remain critical of such findings and avoid sweeping generalisations until there is a wealth of further evidence to investigate the issue.

Indeed, there is no evidence yet to link sexual perfectionism to specific areas of the multidimensional factors of perfectionism. This means that there is currently no certainty about whether certain areas of perfectionism are more likely to be associated with different types of sexual perfectionism. The findings showed that the healthy control group in this study reported higher levels of sexual perfectionism than women with anorexia nervosa. Nevertheless, levels of perfectionism and sexual perfectionism remained significant in both groups, highlighting the relevance of such multidimensional constructs in both groups. Thus, investigation of whether sexual perfectionism mediates the relationship between perfectionism and sexual functioning is important for both groups, although the implications may be different for each.

4. Sexual perfectionism: a mediating factor between perfectionism and sexual functioning?

The findings of this study showed that sexual perfectionism mediated the relationship between perfectionism and sexual functioning in both groups. Nevertheless, the results highlighted the role of sexual distress in the relationship between sexual perfectionism and sexual functioning in women with anorexia nervosa, and the existence of an indirect relationship among perfectionism, sexual perfectionism, sexual distress, and sexual functioning. This finding highlights the role of sexual distress in the theoretical conceptualisation and understanding of female sexual functioning in both groups. These findings add to the recent wave of evidence-based research regarding sexual perfectionism in women, confirming that sexual perfectionism is a phenomenon that affects women and must be studied further (Stoeber & Harvey, 2016).

The present study is the first to have included a general measure of perfectionism in association with sexual perfectionism, which stemmed from the recommendation of Stoeber and Harvey's (2016) study.

They argued that, although more specific forms of perfectionism were associated with a better ability to identify processes and construct-specific outcomes than were general measures, there was a need to include general measures of perfectionism to study sexual perfectionism in the context of sexual functioning in order to create a broader theoretical understanding of the phenomena (Stoeber & Harvey, 2016).

The results of this study showed a significant, positive association between perfectionism and sexual perfectionism, and between sexual perfectionism and sexual functioning. However, without the mediating role of sexual perfectionism there was no association between perfectionism and sexual functioning. These preliminary results are important for both groups, because although they cannot reveal causality, they do provide hypotheses for future research on the subject.

It may be argued that these results are consistent with the findings in the current literature, which emphasise the importance of considering difficulties in sexual functioning in the context of anorexia nervosa. The results also meet the needs established in the literature, which suggest that other psychosocial factors, such as perfectionism and other multidimensional constructs such as sexual perfectionism, should be studied in relation to female sexual functioning in this clinical population (Pinheiro et al., 2010).

Such findings may raise awareness of the possibility that such themes could be integrated into clinical practice, with a particular focus on the association between perfectionism and sexual perfectionism, and the potential mediating role of sexual perfectionism between perfectionism and sexual functioning in the context of anorexia nervosa. The next section contains reflections on findings regarding subcomponents of sexual perfectionism, such as self-oriented, partner-oriented, partner-prescribed and socially prescribed sexual perfectionism, and their potential mediating roles between perfectionism and sexual functioning.

Self-oriented sexual perfectionism concerns individuals who are perfectionist about themselves as sexual partners, while partner-oriented sexual perfectionism concerns the high standards that a person may have about their sexual partner. Partner-prescribed sexual perfectionism reflects people's beliefs that their partner may have perfectionist expectations of them as a sexual partner. Socially prescribed sexual perfectionism, finally, refers to individuals' beliefs that society has high expectations of their prowess as sexual partners (Stoeber & Harvey, 2016).

Therefore, the results presented below consider whether all constructs that involve sexual perfectionism also mediate the relationship between perfectionism and female sexual functioning, or whether some of its components are relevant only to the clinical group or to the healthy control group, or to neither.

5. **Self-oriented sexual perfectionism: a mediating factor between perfectionism and sexual functioning?**

Given that the literature has focused on the different dimensions of perfectionism and whether certain aspects of perfectionism are more likely to be linked to clinical presentations of or to be considered predispositions in individuals to maladaptive traits, published studies have examined the role of self-oriented perfectionism in anorexia nervosa and has found significant evidence that the two are linked. Studies by Cockell and colleagues (2002) and Bastiani et al. (1995) have established that levels of self-oriented perfectionism are elevated in this clinical population and are particularly high compared with those of healthy control groups (Bastiani et al., 1995; Cockell et al., 2002). The findings of the study described in this paper are in line with the argument of Dunkley et al. (2006) that self-critical aspects of perfectionism have a significant negative impact on clinical presentations such as anorexia nervosa. In fact, the tendency of setting unrealistically high standards towards oneself and fearing negative social consequences is a key maintenance factor of anorexia nervosa (Dingemans, Spinhoven & van Furth, 2006; Hinrichsen, Garry & Waller, 2006).

One could argue that the finding that self-oriented sexual perfectionism mediates the relationship between perfectionism and sexual functioning in women with anorexia aligns with the expectations set by the literature that this is a cause of concern, as self-oriented sexual perfectionism is rooted in the high expectations that a person sets for themselves as a sexual partner. The findings of the study under discussion demonstrated that self-oriented sexual perfectionism mediated the relationship between perfectionism and sexual functioning in the healthy control group also, and this highlights the crucial role of self-oriented sexual perfectionism in both groups. Given that one of the main factors of perfectionism is that it is internally rather than externally motivated (Stoeber & Stoeber, 2009), the fact that self-oriented sexual perfectionism mediated perfectionism and sexual functioning in the control group is not surprising. Previous evidence has established that women tend to experience significant cultural pressure to please their partners and that this pressure might be internalised (Kluck, Hughes & Zhuzha, 2018).

However, it is not possible to state with certainty why participants exhibited high levels of self-oriented sexual perfectionism, as this may have arisen due to individual differences. Thus, although it can be suggested that participants have internal beliefs that they must be 'perfect sexual partners', it is not possible to identify the specific external sources that enabled such perceived pressure to be internalised. It is also crucial to highlight that for both groups, it is not possible to identify which specific component of self-oriented sexual perfectionism causes the greatest concern, as some women may be perfectionists about their sexual skills, whilst others might be perfectionists about their arousal, or their ability to help their partners to achieve pleasure or orgasm (Kluck, Hughes & Zhuzha, 2018).

The present findings suggest only that self-oriented sexual perfectionism is associated with female sexual functioning and, more specifically, that it mediates the relationship between perfectionism and female sexual functioning in both groups. Thus it provides preliminary evidence that future research can be designed to investigate in terms of the specifics of these interrelations. Moreover, the findings show that there is also an indirect relationship between perfectionism, self-oriented sexual perfectionism, sexual distress, and sexual functioning in both groups, with a stronger negative association between self-oriented sexual perfectionism and sexual distress in the clinical group than in the healthy control group. This is an important distinction, as it highlights that women with anorexia nervosa may experience higher levels of sexual distress than do women without the condition, and that this may be associated with sexual functioning but also with their experiences of self-oriented sexual perfectionism.

It is not possible from the results of this study to determine whether the women's sexual distress fuels their self-oriented sexual perfectionism, or whether they try to use sexual perfectionism as a form of coping with their sexual distress, or, conversely, whether their sexual distress is a result of their self-oriented sexual perfectionism. The findings support the need to investigate further the association between self-oriented sexual perfectionism and sexual distress to highlight the specifics of this relationship.

6. Partner-oriented sexual perfectionism: a mediating factor between perfectionism and sexual functioning?

The results showed that partner-oriented sexual perfectionism did not mediate the relationship between perfectionism and sexual functioning in either group. Partner-oriented sexual perfectionism may be related to what has been called in the literature *other-oriented perfectionism* but is applied within the context of sexual perfectionism (Stoeber & Harvey,

2016). Other-oriented perfectionism has been associated with *'narcissistic perfectionism'*, which involves narcissistic grandiosity and entitlement (Ayearst, Flett & Hewitt, 2012). Individuals with high levels of other-oriented perfectionism have a lack of interest in other people and their feelings; indeed, they show behaviours and feelings that are the opposite of what is positively associated with self-oriented perfectionism (Stoeber, 2013, 2014, 2015).

Therefore, it is understandable that the results showed no association among perfectionism, partner-oriented sexual perfectionism and sexual functioning, since the results showed a significant association among perfectionism, self-oriented sexual perfectionism and sexual functioning, which can be considered to be opposites.

Not surprisingly, there was also no relationship between perfectionism, sexual perfectionism, sexual distress and sexual functioning. It could therefore be argued that partner-oriented sexual perfectionists focus solely on the expectations they have set for their partner and how this disposition serves them (Stoeber, 2015). For these reasons, one would expect that the concept of sexual distress would not be associated with partner-oriented sexual perfectionism. Although there was no statistically significant association among perfectionism, partner-oriented sexual perfectionism and sexual functioning, these findings are important considerations for future researchers who seek to investigate sexual perfectionism further, as they highlight the need to study this phenomenon by looking more specifically at its components and how they relate to other constructs.

Additionally, further research should seek to replicate these findings, but if wider evidence indicates that partner-oriented sexual perfectionism is less relevant to this clinical population than other forms of sexual perfectionism, this may support the omission of this aspect as researchers focus on those areas of sexual perfectionism that seem to be of clinical relevance.

7. Partner-prescribed sexual perfectionism: a mediating factor between perfectionism and sexual functioning?

Partner-prescribed sexual perfectionism has been associated in the literature with feelings of self-blame as individuals feel that they are not a '*good enough'* sexual partner (Kluck, Hughes & Zhuzha, 2018). It can be assumed that women who perceive that their partners have certain expectations of them as sexual partners may experience psychological discomfort and even sexual distress because of their preoccupation with meeting these standards.

Such a preoccupation may lead individuals to be less present in their own sexual experience and to self-monitor in terms of physiological responses (for example, checking whether they are sufficiently lubricated); this focus on the self to please the partner has been termed *'spectatoring',* which can be considered as the essence of sexual perfectionism. It has been shown to be associated with negative cognitive and emotional impacts (van Lankveld & Bergh, 2008; de Jong, 2009).

This distress can be compounded over time; if a person feels that they have not achieved the standards that they believe their partner holds them to, they may become anxious about the next sexual encounter and worry about their future 'sexual performance'. As a result, sexual experiences may become a source of sexual distress that can impact levels of intimacy with the partner. Some individuals may resort to avoidant behaviours (Rowland & Kolba, 2018). Therefore, the demonstration from the results that partner-prescribed sexual perfectionism mediates the relationship between perfectionism and sexual functioning only through the concept of sexual distress in both groups makes sense and aligns with literature reports that link sexual distress to its impact on sexual functioning and its potential impact on the relational dynamics between individuals. In this study, no association among perfectionism, partner-prescribed sexual perfectionism and sexual functioning, without the inclusion of the phenomenon of sexual distress, was demonstrated.

This suggests that both groups are affected by partner-prescribed sexual perfectionism and its association with sexual distress and sexual functioning. However, since the results suggested that the clinical group reported higher levels of sexual distress than did the control group, it can be argued that women in the clinical group were more concerned than those in the control group regarding the expectations they believed their partner had about who they should be or how they should act as a sexual partner.

Women with anorexia nervosa are more sensitive to feelings of rejection than are women free of the condition. Their tendencies in trying to achieve unrealistic expectations of who they should be for others, in order to feel a sense of acceptance and belonging, may also affect their sexual experiences. Individuals may feel anxiety about meeting stereotypical ideas of what they should be like in their sexuality according to their gender norms, and some may act out to meet these expectations. This is an important factor to consider, in order to determine whether concerns about partners' beliefs may impact behaviour during sexual experiences and therefore negatively impact sexual functioning.

It can be argued that the physical experience is associated with the relationship with the partner and potentially linked to other factors such as levels of intimacy and communication, which are important aspects that can impact female sexual functioning. Moreover, the fact that this indirect relationship between perfectionism, partner-prescribed sexual perfectionism and sexual functioning is only relevant through the concept of sexual distress may be an indicator that women with anorexia nervosa are more likely to worry about their partner's perception and therefore experience partner-prescribed sexual perfectionism, either because of their concerns or, conversely, in response to their concerns regarding their ability to achieve the standards they believe their partner holds.

Finally, it is important to specify that the survey questions relevant to a partner-prescribed component of sexual perfectionism did not ask about body shape or weight. This is an important aspect in relation to women with anorexia nervosa, as one might assume that the expectations lay in the fear of not being physically attractive or of not having the weight desired by the partner.

There is evidence that women feel pressure from their partners regarding their weight (Roberts, Cunningham & Dreher, 2012). Since body shape and weight control are well-known aspects of anorexia nervosa - studies have linked body image issues with difficulties in sexual functioning in this clinical group - (Pinheiro et al., 2010), one might assume that the sexual distress of women in this group and the expectations they think their partner has of them may also be based on these factors. However, the elements of partner-prescribed sexual perfectionism focus on the feeling of being pushed to be a '*perfect sexual partner'*, or the feeling of always having to please the partner who '*demands nothing less than perfection from me as a sexual partner'* and, above all, the feeling that '*in order for my partner to appreciate me, I have to be a perfect sexual lover'*. Therefore, it can be said that the results of this study highlight the fact that other issues are present here and that these are important in relation to sexual functioning and should also be considered for further research.

8. Socially prescribed sexual perfectionism: a mediating factor between perfectionism and sexual functioning?

Socially prescribed sexual perfectionism is socially prescribed perfectionism that is applied to the context of sex (Stoeber, 2013, 2014). Socially prescribed perfectionism, which is the belief that others expect them to be 'perfect', has been identified as a risk factor in the development of eating disorders, particularly anorexia nervosa (Bouguettaya et al., 2019). Cultural trends that value women according to their ability to please others sexually can

have an impact on women who feel pressured to pursue unrealistic standards of themselves as sexual partners. Thus, internalising unrealistic beliefs about how a female's sexual experiences should be lived increase the likelihood of being sexually perfectionist and prone to experiencing higher levels of socially prescribed sexual perfectionism (Kluck, Hughes & Zhuzha, 2018).

Therefore, the results of this study were consistent with assumptions in the literature that both the clinical and healthy control groups might be affected by socially prescribed sexual perfectionism. Although the results demonstrated this, a key difference emerged between the two groups. For the healthy control group, socially prescribed sexual perfectionism was found to mediate the relationship between perfectionism and sexual functioning, and this indirect relationship was also mediated by sexual distress. It could be argued that this is due to external societal pressures and the way in which, for example, each individual internalises their beliefs about gender roles and/or their identity as a woman. Although it is impossible to identify the specifics of each participant in this study and to determine to which 'other' they relate, the pressures on women and the link to sexual performance and their role in the satisfaction of self and others is undeniable (Cacchioni, 2007; Jackson & Scott, 2007; Frith, 2013).

For these reasons, it could be argued that the role of sexual distress in relation to socially prescribed sexual perfectionism in women was predictable but even more important in the case of women with anorexia nervosa, as they are a population known to be highly susceptible to negative judgements and rejection (Turton et al., 2017, 2018). These women are much more likely to anticipate judgement from others in social situations than are people without eating disorders (Cardi et al., 2017). Therefore, if one combines the fact that women generally feel external pressure to 'perform' and achieve certain standards as sexual partners with the heightened sensitivity to rejection in women with anorexia nervosa, one might assume that women with anorexia would be subject to socially prescribed sexual perfectionism.

In fact, they may be preoccupied with embarrassment or guilt about their experiences, which may stem from a variety of external pressures, whether they are connected to their specific partner or feel that they do not meet the expectations of societal or cultural norms, for example. As we do not know to whom the participants were referring as 'the other' when they responded to the survey, it is difficult to determine what influences their socially prescribed sexual perfectionism.

However, sexual distress plays a crucial role in the indirect relationship among perfectionism, socially prescribed sexual perfectionism and sexual functioning, as the association does not exist without the component of sexual distress.

Thus, the importance of sexual distress could be considered to be higher in this clinical population than in the general population when it comes to socially prescribed sexual perfectionism, due to their level of sensitivity to their attempts to belong and conform to the idea of the 'perfect woman'. This highlights that sexual distress is a key component of how women with anorexia nervosa experience socially prescribed sexual perfectionism and its relationship between perfectionism and sexual functioning. This issue should be explored further.

It could be argued that a key difference between the healthy control group and the clinical group in this respect was that, although women are generally more likely to internalise beliefs about how they should be as sexual partners, this does not guarantee or imply that women experience psychological distress as a result. It should be recognised that some women may adhere to societal norms and not necessarily experience distress as a result of their internalised beliefs or the implications of them regarding the need to be a 'perfect sexual partner'. The present study could not account for these individual differences, but it is important to note this to avoid making generalisations.

Socially prescribed sexual perfectionism places so much emphasis on the other that it can be associated with a lack of control, as one cannot control how others perceive you as a sexual partner, whereas self-oriented sexual perfectionism, for example, is centred on the individual, which can give individuals a greater sense of agency and thus reduce levels of distress. This lack of control may also be a component in the clinical group, as lack of control is also considered a key aspect of anorexia nervosa. Anorexics find it difficult to cope with uncertainty; hence the tendency to control food intake and assert as much control as possible over their bodies (Frank et al., 2012).

Therefore, the sexual distress component was crucial in the case of women with anorexia nervosa. Although the theoretical underpinnings of the findings of this study were based on hypotheses that were derived from the current knowledge of women and sexual functioning and the particularities of anorexia nervosa, further research is required to investigate these results further in order not only to replicate them, but also to try to discover what other factors are involved in this indirect relationship and to investigate further this difference between the healthy control and clinical groups.

9. Clinical implications for women with anorexia nervosa

The findings demonstrated that the multidimensional construct of sexual perfectionism should be considered in association with female sexual functioning and sexual distress in this clinical population. The findings aligned with the evidence of Price (2020) and Pinheiro et al. (2010), who stressed the need to investigate psychosocial factors that might be associated with sexual functioning for women with anorexia nervosa (Pinheiro et al., 2010; Price, 2020).

Furthermore, because women with anorexia nervosa are known to have difficulties in their interpersonal relationships (Arcelus, Yates & Whiteley, 2012), it could be argued that the provision of support for individuals is not only crucial in the difficulties they may encounter in the context of their interpersonal relationships, but that it is possible to support them regarding the topic of sexual functioning as well.

Some evidence has linked relationship quality to sexual functioning. This area of research could be fruitful for women with anorexia nervosa (Burri, Radwan & Bodenmann, 2015; Walters, Lykins & Graham, 2019). The results of this study highlight that sexual functioning in women with anorexia is important, regardless of relationship status, but they suggest that further research should be performed to explore whether controlling for this variable would yield other results with important clinical implications. Such research might highlight the need to assess relationship satisfaction and to determine whether this is another variable that impacts on sexual functioning or vice versa, and whether this can be implemented in psychological treatments.

Moreover, the findings highlighted that women with anorexia nervosa seemed to have greater difficulties with self-oriented, partner-prescribed, and socially prescribed sexual perfectionism than healthy women. This finding aligned with evidence that aspects of sexual perfectionism could be considered adaptive or maladaptive among the general public. As discussed in the literature chapter, the perception of others regarding being a perfect sexual partner is a source of concern (Kluck, Zhuzha & Hughes, 2016). Therefore, this may be even more important in women with anorexia nervosa, as they may experience distress due to their inability to control how others perceive them as sexual partners. Control seeking is a widely known aspect of anorexia nervosa (Lawrence, 1979) that is associated with hypersensitivity to criticism and thus, fear of rejection by others (Cardi et al., 2017). Therefore it can be argued that targeting partner-prescribed and socially prescribed sexual perfectionism in treatment could be of significant clinical relevance.

Although self-oriented sexual perfectionism alone mediates the relationship between perfectionism and sexual functioning, partner-prescribed sexual perfectionism and socially prescribed sexual perfectionism mediate this association when sexual distress is taken into account and hence this factor is also part of this indirect relationship. Thus, the findings encourage the performance of further research that should be focused on those aspects of perfectionism that are directly associated with sexual perfectionism, to consider the potential role of sexual perfectionism in this clinical population and to investigate further how it relates to sexual distress, sexual functioning and other psychosocial factors that may also influence this indirect relationship.

10. Strengths and limitations of the study: further recommendations

10.1 Strengths

The study performed for this project was the first to investigate sexual functioning in parallel with the sexual distress factor without the intention of diagnosing participants with sexual dysfunctions. This highlights the ability to study phenomena that might be considered medicalised without intending to medicalise them but recognising their importance to individual well-being and continuing to study issues of sexual functioning without adopting a medicalised position.

The results of this study highlighted the importance of exploring how other multidimensional factors may be at play regarding sexual functioning, and how they affect women with anorexia nervosa and women without mental health difficulties. Sexual perfectionism, for example, has not been studied in parallel with a measure of general perfectionism, which is a recommended suggestion in the published literature. Given the evolving conceptualisation of perfectionism as a multidimensional construct, with sexual perfectionism also being a multidimensional construct, the choice to use a multidimensional perfectionism scale was motivated by the attempt to create some coherence and consistency within the measurement tools that were used to consider the quality of the study.

Therefore, one of the strengths of the study was its reflexivity in the study design regarding measurement choices. The aim was to remain as close as possible to the needs of the current evidence-based literature to make a fruitful contribution to the field of research. This was also reflected in the choices of statistical analyses that were made, as the statistical analyses did not generate complete truth data, but rather provided an initial exploration of the potential interactions among the different constructs present in this study, grounded in an awareness of the limitations that surrounded them.

For example, as this study employed a saturated model of regression path analysis, model fitting did not have to be considered as there was no intention to build a new model. This is because well-established measurement tools were used, which meant that there was no possibility to establish statistics that could generate model-fitting results. Furthermore, the decision-making processes that were aimed at moving away from a medicalised approach to the phenomenon of sexual functioning and trying to create a comprehensive set of measures that each served a related purpose, took into consideration the core values of counselling psychology by incorporating a critical approach to the way in which statistics

were conducted and understood.

10.2 Limitations and further research recommendations

Although this study focused on perfectionism, in particular sexual perfectionism, it did not exclude the reality that other factors play a role in this phenomenon and that these factors should be explored in further research. The control group that was used imposed a limitation, as the only way to screen potential participants was to ask if they had ever been diagnosed with a mental health condition by a registered health professional. This method did not rule out the possibility that some individuals may have had mental health difficulties that the study did not capture, and which may have had an impact on the results.

As mentioned in the literature chapter, the DSM-5 highlights the complexity of the phenomenon and how physiological, behavioural, psychosocial, political, and cultural factors all influence female sexual functioning (Dziegielewski, 2015). For this reason, it is necessary to assess other factors, such as life events, physical and mental health, substance use and medication, when determining whether or not there may be difficulties in female sexual functioning. Unfortunately, the author of this doctoral study had to exclude such criteria due to methodological limitations. Hence the study results cannot account for all potential confounding variables that may have interfered with the exploration of the research question. Thus, the results must be understood in the context of these limitations.

Another limitation was the sample of participants. There was no specific age target, for example, which may have impacted the results in several ways: it could be argued that, depending on the age of the participants, some might be more likely to experience difficulties with sexual functioning that may be the result of menopause or early onset of menopause (Mishra & Kuh, 2006). This aligns with the recommendation by Stoeber and Harvey (2016) that further studies should be focused on women in their 40s or 50s (Stoeber & Harvey, 2016).

Stoeber et al. (2016) used the female sexual functioning index measure in their study of sexual perfectionism and sexual functioning. This influenced the decision to use the same measurement tool in this study to bring consistency and coherence to the literature (Stoeber et al., 2016). Other researchers could explore the topic of sexual functioning with the use of other measurement tools or through the use of other methodological designs, such as qualitative research, for instance, to compare the results.

The evidence-based literature presents conflicting findings regarding whether or not the incidence of anorexia peaks at the developmental age of adolescence and young adulthood. Later onset of anorexia nervosa in some individuals cannot be ignored, but this study was unable to consider this concern. It would be useful to consider these factors in future, to identify whether there are any differences between late and early onset of anorexia during important life development stages and whether such differences are reflected in the indirect relationship among perfectionism, sexual perfectionism, sexual distress, and sexual functioning. Research has shown that some women experience anorexia onset at or after the date of their marriages (Dally, 1984), whilst other women experience late onset of anorexia as a response to the fear of ageing (Gupta, 1990).

These data highlight not only the fact that later life stages may present the possibility of developing anorexia nervosa, but also the psychosocial aspects of anorexia nervosa that incorporate interpersonal relationships. Therefore, it would be interesting in future research to target the age of participants, as this could provide insight into how age (i.e., the context of the lifespan stages in which the participants find themselves) may impact the relationship between sexual functioning and anorexia symptomatology. It would progress the literature as it could be determined whether outcomes differ across age groups with respect to sexual perfectionism and its role in mediating the relationship between perfectionism and sexual functioning, and the effect of sexual distress in this indirect relationship and other psychosocial aspects, such as relationship status and/or levels of intimacy.

Sexual distress was a component of this indirect relationship that proved crucial in this study and has previously been associated with difficulties in sexual functioning (Stephenson & Meston, 2012). However, evidence has highlighted that this association is not statistically positive when controlled with emotional intimacy within the relationship (Bancroft, Loftus & Long, 2003).

Women with anorexia nervosa are known to have interpersonal difficulties, which involve the factor of intimacy (van Zutphen et al., 2018, 2019), and studies have linked partner support to symptomatology (Zak-Hunter & Johnson, 2015; Kirby et al., 2016). Therefore, future studies could control for relational intimacy during investigations of the indirect relationship among perfectionism, sexual perfectionism, sexual distress and sexual functioning in this clinical group. This would clarify the needs of women with anorexia in a therapeutic context and might encourage the production of clinical guidelines that would discuss themes related to sexual functioning, sexual distress and/or sexual perfectionism to provide more comprehensive support.

One could argue that further evidence is crucial to determine whether levels of intimacy may play a role in decreasing levels of sexual distress or in minimising levels of sexual perfectionism in relation to sexual functioning in this clinical population. Such information could shape clinical work.

A crucial limitation of the clinical population sample in this study was the lack of tracking of symptom severity and the inability to identify the onset of anorexia nervosa, or whether individuals were actively engaged in psychological treatment at the time of participation. As levels of perfectionism may fluctuate according to the stage of the individual's recovery process, it would be imperative for future studies to screen for symptom severity and to incorporate the recovery process into the study design (Bardone-Cone et al., 2009, 2010). This would enable future researchers to replicate the results of this study by incorporating specific factors that would shed light on whether or not outcomes would differ, and if so, whether this was due to symptom severity or to subtypes of anorexia nervosa, for instance (Pinheiro et al., 2010).

Future studies should screen for the subtypes of anorexia nervosa in relation to sexual functioning in order to identify whether or not there are any key differences between groups in this regard and if there are, to investigate further to what they are due and how such differences might shape the way in which clinicians would work with them. In the initial research design process, the present study was intended to consider both types of anorexia nervosa, but due to the impact of the Covid-19 pandemic on the recruitment process and therefore the gathering of a smaller sample size than anticipated, it was felt that the final sample size was not sufficient to conduct path models for each group and to compare results. Therefore, this highlights the need not to generalise the current findings, and to be aware that knowledge is missing regarding the subtypes.

It is recommended that future studies include the specific factors that involve the sexual functioning construct to be investigated in order to establish whether or not the indirect relationship among perfectionism, sexual perfectionism, sexual distress, and sexual functioning has a more specific impact on the different factors of sexual functioning. This will enable a better understanding of which specific factors of sexual functioning are more affected than others, and whether the clinical group has more difficulty in certain areas than women in a healthy control group. This is an important limitation to note, as is the inability of this study design to identify causality between the constructs, as this knowledge may help other researchers to explore this issue further.

This is also applicable to the concept of sexual perfectionism. Although self-oriented sexual perfectionism, partner-oriented sexual perfectionism, partner-prescribed sexual perfectionism and socially prescribed sexual perfectionism have been studied for their potential to mediate perfectionism and sexual functioning, there are limitations in knowing what external pressures made individuals more likely to experience socially and/or partner-prescribed sexual perfectionism. Therefore, it is also recommended that further research is undertaken to investigate the external pressures that may lead to this phenomenon, with consideration of, for example, individual differences and the cultural context.

It is important to be aware of the cultural context in which the results are understood. This study was rooted in Western culture, not only in the way it conceptualised notions of perfectionism, female sexual functioning, sexual distress, and sexual perfectionism, but also in the way in which the measurement tools were used in the design of this study. The study was focused on topics that are sensitive in terms of investigating the components of people's sex lives, and the evidence regarding the attitudes of the clinical group to this issue is ambiguous; therefore, it was considered best practice not to add the factor of ethnicity to the data collection process in order to minimise the level of sensitivity that could arise from participation in the study.

There is evidence that some individuals are offended by questions about ethnicity and question the value of being asked ethnicity-related questions. Some groups state that they are reluctant to engage with ethnicity data collection practices (Farkas, 2017). Research has emphasised the risk of associating ethnicity with interpretations of outcomes, and has stressed that the focus should be placed on finding *'causal factors'* rather than simply describing outcomes, which incorporates the risk of speculation (Salway et al., 2009).

The study performed for this project could not address the ethnicity factor, as it did not seek causal intersections between variables, but rather focused on the existence of relationships among them and the interpretation of these results in relation to existing data on the constructs. Such a focus was considered risky in relation to ethnicity, as there is not enough evidence that ethnicity is linked to female sexual functioning at this stage. Evidence is required from studies of specific groups in different cultural contexts to generate appropriate results (Attaky et al., 2021).

Researchers must focus on how data is presented and described in discussions of ethnicity and its interrelationship with subjects, to ensure ethical practice and to avoid stigmatisation of certain groups. This is another reason why the present study did not include data on

ethnicity, as this would not enable meaningful and appropriate generalisations of the results due to methodological limitations.

It is also crucial that counselling psychologists, whether in their clinical or research practice, be aware of their limitations and refrain from engaging in practices with which they may not be best equipped to engage in this way, to protect others from harm, and to re-engage when they feel they have appropriate resources to address certain issues (BPS, 2017). This is not to say that ethnicity is not a key factor to emphasise here. Indeed, investigating the topic of female sexual functioning without consideration of political, economic, psychosocial, and cultural factors can be problematic (Attaky et al., 2021).

The latter researchers highlighted this by exploring the sexual functioning difficulties of Arab couples who lived in Saudi Arabia. Their findings that sexual distress did not correlate with sexual functioning, for instance, were contrary to much evidence in the West. They argued that this may be due to the context of life in Saudi Arabia, where residents may not have the same awareness of sexual issues that Western residents do and/or do not think of them as a cause for concern (Attaky et al., 2021).

Such reflections on sexual functioning in a different cultural context underline how important it is that research continues to explore the ways in which cultural differences may shape these experiences. It is crucial to highlight such issues, and to show how the topic of sexual functioning, also in relation to other factors such as sexual perfectionism, sexual distress, and perfectionism, is a phenomenon that counselling psychologists can look at through a cultural lens and draw on their skills to consider the context of their clients and apply them to this topic (Altmaier & Hansen, 2011, 2012).

11. Implications for counselling psychology

Female sexual functioning can be misunderstood as irrelevant to the field of counselling psychology, as it is known to be highly medicalised (Lewis, 2004). However, the work of Mosher (2017), who reflected on the study of sexuality-related topics within the counselling psychology profession, emphasised the importance of researching these topics as they relate to well-being. Mosher (2017) rejected the idea of engaging solely in research that was focused on the risk-related components of the topic of sexuality. The author highlighted that the ways in which everyone related to their sexuality, which incorporates the topic of sexual functioning, was not only unique, but also multidimensional. It could change throughout life and differ according to individual differences.

This highlighted the importance of cultural differences and socio-political context. These themes are all strongly correlated with the type of work that counselling psychologists do (Mosher, 2017).

Sexual functioning can be influenced by important developmental milestones in life (Clayton & Harsh, 2016), which can impact how individuals relate to themselves and others as sexual partners for example. This statement further highlights the importance of this topic for women with anorexia. Anorexia nervosa is strongly associated with these developmental milestones and has an impact on interpersonal relationships and therefore on levels of isolation (Hempel, Vanderbleek & Lynch, 2018). This also applies to the late onset of these difficulties, as there is evidence that the onset of these problems is often associated with a significant change in the lives of individuals, such as the break-up of a relationship or the entry into a new phase of life (Dally, 1984).

Although the present study is limited in its reporting of an indirect relationship among perfectionism, sexual perfectionism, and sexual functioning in women with anorexia nervosa, the results should be understood as a first step in highlighting the relevance of this topic to women with anorexia. The findings highlight the place of this topic within the field of counselling psychology and how the core values of the profession can support the emergence of new research that is focused on the investigation of the multidimensional aspects that may play a role in the phenomenon and considers the different factors that may be involved.

12. Final conclusions

This study has revealed findings that suggest that sexual perfectionism may be considered a mediating factor between perfectionism and sexual functioning among women with anorexia, and it has highlighted the role of sexual distress in this indirect relationship. The findings suggest that there may be scope for further research to establish the role of sexual perfectionism in anorexia nervosa and how it may impact specific aspects of female sexual functioning as well as the quality of women’s interpersonal relationships.

This study investigated the issue of sexual perfectionism in relation to sexual functioning in anorexia nervosa in a quantitative manner. It would be interesting to use other methodologies to investigate the issue in order to gather further data on the indirect relationship among perfectionism, sexual perfectionism and sexual functioning to highlight

other factors that may shape this association and to continue to identify its clinical implications in order to improve the mental health of these individuals.

The author of this doctoral study hopes to have demonstrated that sexual functioning can be explored without its medicalisation or denial of its physiological aspects. She recognises the important supportive roles that psychosexual services and pharmacotherapy already play, but rather adds to current research in the hope of improving how we treat these difficulties.

Evidence-based research is underway to determine which psychological interventions best help women overcome difficulties with sexual functioning (Lin et al., 2019). However, this study offers counselling psychologists an opportunity to begin to incorporate the topic of sexual functioning in the context of anorexia into their practice in the following ways: through normalisation of the discussion of these topics in a therapeutic setting and emphasising the role of a positive sex life on overall quality of life (Chow et al., 2016); through assessment of sexual functioning in the context of sexual distress (Hucker & McCabe, 2014); through determination of whether clients have perfectionist beliefs about their role as sexual partners (Stoeber & Harvey, 2016), where these beliefs stem from (Scappini & Fioravanti, 2022) and how they affect the belief holders' sexual experiences; and finally, through assessment of how these women experience their emotional relationships with their partners (Kelly, Strassberg & Turner, 2006). Counselling psychologists are encouraged to consider the context of the individual and their culture when they explore these themes (Hidalgo & Dewitte, 2021; Shenoi & Prabhu, 2022).

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Appendices

Appendix 1: Questionnaire package

EDE-Q, 6th

The following questions are concerned with the past four weeks (28 days) only.

Questions 1 to 12. Please circle the appropriate number on the right. Remember that the questions refer to the past four weeks (28 days) only.

ON HOW MANY OF THE PAST 28 DAYS …….		No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1	Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?	0	1	2	3	4	5	6
2.	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
3.	Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4.	Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5.	Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6.	Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7.	Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8.	Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9.	Have you had a definite fear of losing control overeating?	0	1	2	3	4	5	6
10.	Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11.	Have you felt fat?	0	1	2	3	4	5	6
12.	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days) ……

13.	Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)? …………………
14.	……On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)? …………………
15.	Over the past 28 days, on how many **DAYS** have such episodes of overeating occurred (i.e., you have eaten an unusually large amount of food and have had a sense of loss of control at the time)? …………………
16.	Over the past 28 days, how many times have you made yourself sick (vomit) as a means of controlling your shape or weight? …………………
17.	Over the past 28 days, how many times have you taken laxatives as a means of controlling your shape or weight? …………………
18.	Over the past 28 days, how many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat, or to burn off calories? …………………

Questions 19-21: Please circle the appropriate number. Please note that for these questions the term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control overeating.

19.	Over the past 28 days, on how many days have you eaten in secret (i.e., furtively)? ……Do not count episodes of binge eating	No days 0	1-5 days 1	6- 12 days 2	13-15 days 3	16-22 days 4	23-27 days 5	Everyday 6
20.	On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight? ……Do not count episodes of binge eating	None of the times 0	A few of the times 1	Less then half 2	Half of the times 3	More than half 4	Most of the time 5	Every time 6
21.	Over the past 28 days, how concerned have you been about other people seeing you eat? ...... Do not count episodes of binge eating	Not at all 0	1	Slightly 2	3	Moderately 4	5	Markedly 6

Questions 22 to 28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks 28 days)

Over the past 28 days ……		NOT AT ALL		SLIGHTLTY		MODERATELY		MARKEDLY
22.	Has your <u>weight</u> influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23.	Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24.	How much would it upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25.	How dissatisfied have you felt about your <u>weight</u>?	0	1	2	3	4	5	6
26.	How dissatisfied have you felt about your <u>shape</u>?	0	1	2	3	4	5	6
27.	How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28.	How uncomfortable have you felt about <u>others</u> seeing your shape or figure (for example. In communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

If female: Over the past three-to-four months, have you missed any menstrual periods? ……………

If so, how many? ……………

Have you been taking the "pill"? …………

Frost multidimensional perfectionism scale (FMPS)

This section of the survey determines whether you might have some perfectionistic tendencies. It is important for you to understand that having some levels of perfectionism is not necessarily a negative trait and that this study is not aiming at diagnosing our participants with perfectionism. Some aspects of perfectionism can positively influence levels of motivation and achievements (Hawkins, Watt & Sinclair, 2006). Some questions in this section refer t' 'high goa's', this refers to whether you have tendencies to set very high goals for yourself. This section is included to identify whether there is some presence of perfectionistic tendencies and whether they can have an impact on sexual well-being.

For each statement:

1 = Strongly agree with statement
2 = Moderately agree with the statement
3 = Neutra– - neither agree nor disagree
4 = Moderately disagree with the statement
5 = Strongly disagree with the statement

1. My parents set very high standards for me.
2. Organisation is very important to me.
3. As a child, I was punished for doing things less than perfectly.
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person.
5. My parents never tried to understand my mistakes.
6. It is important to me that I be thoroughly competent in what I do.
7. I am a neat person.
8. I try to be an organised person.
9. If I fail at work/school, I am a failure as a person.
10. I should be upset if I make a mistake.
11. My parents wanted me to be the best at everything.
12. I set higher goals than most people.
13. If someone does a task at work/school better than I do, then I feel as if I failed the whole task.
14. If I fail partly, it is as bad as being a complete failure.
15. Only outstanding performance is good enough in my family.
16. I am very good at focusing my efforts on attaining a goal.
17. Even when I do something very carefully, I often feel that it is not quite right.
18. I hate being less than the best at things.
19. I have extremely high goals.
20. My parents expect excellence from me.
21. People will probably think less of me if I make a mistake.
22. I never feel that I can meet my parents' expectations.
23. If I do not do as well as other people, it means I am an inferior being.
24. Other people seem to accept lower standards from themselves than I do.
25. If I do not do well all the time, people will not respect me.
26. My parents have always had higher expectations for my future than I have.
27. I try to be a neat person.
28. I usually have doubts about the simple everyday things that I do.
29. Neatness is very important to me.
30. I expect higher performance in my daily tasks than most people.
31. I am an organised person.
32. I tend to get behind in my work because I repeat things over and over.
33. It takes me a long time to do something 'right
34. The fewer mistakes I make, the more people will like me.
35. I never feel that I can meet my parents' standards.

Multidimensional sexual perfectionism questionnaire

INSTRUCTIONS: Listed below are several statements that concern the topic of sexual relationships. Please read each item carefully and decide to what extent it is characteristic of you. Some of the items refer to a specific sexual relationship.

Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be. Then, for each statement fill in the response on the answer sheet that indicates how much it applies to you by using the following scale

1- Not at all characteristic of me
2- Slightly characteristic of me
3- Somewhat characteristic of me
4- Moderately Characteristic of me
5- Very characteristic of me

Self-Oriented Sexual Perfectionism (the desire to be the perfect sexual partner)

- I have very high perfectionistic goals for myself as a sexual partner.
- I set very high standards for myself as a sexual partner.
- I must always be successful as a sexual partner.
- One of my goals is to be a “perfect” sexual partner.
- I always feel the need to be a “perfect” sexual partner.
- I always pressure myself to be the best sexual partner in the world.

Partner-Oriented Sexual Perfectionism (the desire for your partner to be perfect)

- I expect my sexual partner to try to be perfectionistic when it comes to sex.
- I expect my partner to always be a top-notch and competent sexual partner.
- My partner should never let me down when it comes to my sexual needs.
- I cannot stand for my partner to be less than a satisfying sexual partner.
- I expect nothing less than perfectionism from my sexual partner.
- I will appreciate my partner only if she/he is a perfect sexual lover.

Partner-Prescribed Sexual Perfectionism (is the feeling that your partner expects you to be perfect)

- My partner demands nothing less than perfection of me as a sexual partner.
- My partner expects me to be a perfect sexual partner.
- My partner always wants me to sexually please him/her.
- My partner pressures me to be a perfect sexual partner.
- My sexual partner has very high perfectionistic goals for me as a sexual partner.
- In order for my partner to appreciate me, I have to be a perfect sexual lover.

Socially Prescribed Sexual Perfectionism (relates to the feeling that society expects you to be a perfect sexual partner)

- Most people in society expect me to always be a perfect sexual partner.
- If I am “perfect” as a sexual partner, then society will consider me to be a good partner.
- Most people expect me to always be an excellent sexual partner.
- I have to be a perfect sexual partner in order for most people to regard me as okay.
- In order for people to accept me, I have to be the greatest sex partner in the world.
- Most people expect me to be perfectionistic when it comes to sex.

Female sexual functioning index

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions, the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse. Sexual intercourse is defined as penile penetration (entry) of the vagina. Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

2. Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partn'r's sexual initiation, and thinking or fantasising about having sex.. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
3. Almost always or always
   Most times (more than half the time)
   Sometimes (about half the time)
   A few times (less than half the time)
   Almost never or never. Over the past 4 weeks, how would you rate your **level**(degree)of sexual desire or interest?

Very high
High
Moderate Low
Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

Over the past 4 weeks, how **often** did you feel sexually arouse“("turned ”n") during sexual activity or intercourse?

No sexual activity
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

3. Over the past 4 weeks, how would you rate your **level** of sexual arousal“("turn ”n") during sexual activity or intercourse?

   No sexual activity
   Very high
   High
   Moderate
   Low
   Very low or none at all

4. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

   No sexual activity
   Very high confidence
   High confidence

Moderate confidence
Low confidence
Very low or no confidence

5. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

   No sexual activity
   Almost always or always
   Most times (more than half the time)
   Sometimes (about half the time)
   A few times (less than half the time)
   Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricate“("wet”) during sexual activity or intercourse?

   No sexual activity
   Almost always or always
   Most times (more than half the time)
   Sometimes (about half the time)
   A few times (less than half the time)
   Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricate“("wet”) during sexual activity or intercourse?

   No sexual activity
   Extremely difficult or impossible Very difficult
   Difficult
   Slightly difficult
   Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubricatio“("wetne”s") until completion of sexual activity or intercourse?

   No sexual activity
   Almost always or always
   Most times (more than half the time)
   Sometimes (about half the time)
   A few times (less than half the time)
   Almost never or never

10.Over the past 4 weeks, how **difficult** was it to maintain your lubrication“("wetne”s") until completion of sexual activity or intercourse?

No sexual activity
Extremely difficult or impossible
Very difficult
Difficult
Slightly difficult
Not difficult

11.Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

No sexual activity
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

12.Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

No sexual activity
Extremely difficult or impossible Very difficult
Difficult
Slightly difficult
Not difficult

13.Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

No sexual activity
Very satisfied
Moderately satisfied
About equally satisfied and dissatisfied
Moderately dissatisfied
Very dissatisfied

14.Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

No sexual activity
Very satisfied
Moderately satisfied
About equally satisfied and dissatisfied
Moderately dissatisfied
Very dissatisfied

15.Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

Very satisfied
Moderately satisfied
About equally satisfied and dissatisfied
Moderately dissatisfied
Very dissatisfied

16.Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

Very satisfied
Moderately satisfied
About equally satisfied and dissatisfied
Moderately dissatisfied
Very dissatisfied

17.Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

Did not attempt intercourse
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

18.Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

Did not attempt intercourse
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

19.Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

Did not attempt intercourse
Very high
High
Moderate
Low
Very low or none

Female Sexual Distress Scale – Revisited.

Below is a list of feelings and problems that men and women sometimes have concerning their sexuality. Please read each item carefully and check the box that best describes how often that problem has bothered you or caused distress **over the last 4 weeks**. Please check only one box for each item and take care not to skip ANY items. If you change your mind, erase your markings carefully.

---

4. **Please check one box per question..** How often did you feel **distressed about your sex life**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
5. 4 Always. How often did you feel **unhappy about your sexual relationship**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
6. 4 Always. How often did you feel **guilty about your sexual difficulties**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
7. 4 Always. How often did you feel **frustrated by your sexual problems**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
8. 4 Always. How often did you feel **stressed about sex**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
9. 4 Always. How often did you feel **inferior because of sexual problems**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
10. 4 Always. How often did you feel **worried about sex**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
11. 4 Always. How often did you feel **sexually inadequate**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
12. 4 Always. How often did you feel **regrets about your sexuality**?
   0 Never
   1 Rarely
   2 Occasionally
   3 Frequently
13. 4 Always. How often did you feel **embarrassed about sexual problems**?
   0 Never
   1 Rarely

2 Occasionally
3 Frequently
14. 4 Always. How often did you feel **dissatisfied with your sex life**?
0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always
15. . How often did you feel **angry about your sex**?
0 Never
1 Rarely
2 Occasionally
3 Frequently
16. 4 Always. How often did you feel **bothered by low desire**?
0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

Appendix 2: Participant's information form

Dear participant,

You are being invited to take part in a doctoral research project being conducted as part of a Professional Doctorate in Counselling Psychology at City, University of London. This study invites women over 18 years old with anorexia nervosa to complete an online questionnaire about sexual perfectionism, functioning and sexual well-being. Before you decide to participate, please read the following information carefully. Should anything be unclear, or you require additional information do not hesitate to contact us using the details provided. After you have read the information, please take the necessary time to consider your participation as it is crucial that you understand what the research is about and why it is being conducted.

Your participation will be anonymous. Your participation is entirely voluntary.

What is the purpose of the study?

This study seeks to determine whether the sexual functioning of women can be impacted by their beliefs about themselves and their sexual partners. It is crucial for you to understand that sexual perfectionism is not a diagnosis, but rather a conceptualisation of how perfectionism can translate into sexuality. We want to establish whether holding perfectionistic beliefs about sex can influence sexual functioning and as a result, sexual well-being. We hope to expand this area of research to improve the sexual well-being of women with anorexia nervosa.

Why have I been chosen to take part in this study?

Perfectionistic tendencies are commonly present in anorexia nervosa. Sexual functioning and sexual satisfaction can be affected by perfectionistic tendencies in women. I want to determine whether this also concerns women with anorexia nervosa so we can develop psychological therapies to support their sexual well-being.

I'm looking for women with anorexia nervosa that are over 18 years old, who have received a diagnosis by a healthcare professional. You do not need to be currently sexually active or in a relationship to partake in this study. Please do not participate if you never received a diagnosis from a licensed medical professional. Should you have concerns about your eating and well-being, please refer to the psychological support helpline at the bottom of the form or contact your primary physician.

Who is organising the study?

My name is Pauline Chiarizia. I'm a trainee counselling psychologist conducting my doctorate in Counselling Psychology at City, University of London. This project is supervised by Dr Angie Cucchi. You can use our email addresses if you have any further questions: Pauline.Chiarizia@city.ac.uk or Angie.Cucchi.2@city.ac.uk

What am I expected to do if I take part?

If you decide to partake in this study, you will be asked to complete an online survey. This should not take longer than 30 minutes to complete. You will be asked for your consent through the survey link before you can access the questionnaire. You will be asked questions about eating disorder diagnosis, perfectionism, sexual perfectionism, sexual distress and functioning. All your answers will remain anonymous. You may withdraw from the study before data analysis starts by the end of November 2020. If you wish to withdraw, simply close the web browser of the survey.

What are the possible benefits and risks of taking part?

Certain questions might evoke discomfort as they ask about sexual functioning. You are presented with 'I do not wish to disclose' options to some questions. The data remains anonymous throughout the entire survey and remains so in the event of a Journal Publication. It is important for you to understand that the study is in no way trying to label normal or abnormal sexual functioning. It is also not looking to diagnose women with perfectionism or sexual perfectionism. Sexual perfectionism is a multidimensional concept, and the focus of the study is to establish the role of each factor of this concept on sexual functioning and well-being in women with anorexia nervosa. Your participation could contribute to the current literature on sexual functioning in women with anorexia nervosa and influence the development of future psychological therapies.

What will happen to the results?

The data is stored securely by encrypted files and will be destroyed after ten years. The data will be used towards the completion of the doctorate and could result in a Journal Publication. The data will remain anonymous in the event of any publication. Should you wish to hear about the results of the study, please feel free to contact me on my email address provided above.

Who has reviewed this study?

This study has been approved by City, University of London Psychology Department Research Ethics Committee.

Data privacy statement

City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task. Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible. For further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/). You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

What if there is a problem?

If you have any problems or questions about this study, you can contact myself or my supervisor. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To issue a complain regarding the study, you may call 020 7040 3040 and then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is 'The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa.''

You can also write to the Secretary at:

Anna Ramberg

Research Integrity Manager

City, University of London, Northampton Square

London, EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

Insurance

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

If you need psychological support, you can contact The Adult Helpline from Beat (leading charity for eating disorders) on 0808 8010677, the Samaritans on 116 123 or Rethink Mental Illness on 0300 5000 927.

Thank you for taking the time to read this information sheet.

Further information and contact details
Researcher: Pauline Chiarizia; Pauline.Chiarizia@city.ac.uk
Supervisor: Dr Angie Cucchi; Angie.Cucchi.2@city.ac.uk

Appendix 3: Consent form

Title of the study: The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa

Ethics approval code: ETH1920-1209

I agree to take part in the above City, University of London research project. I have had the project explained to me, and I have read the participant information sheet.

<u>I understand this will involve:</u>

1. Completing a survey asking me about eating disorder symptoms, BMI, perfectionism, sexual perfectionism, sexual functioning, and sexual distress.

This information will be held and processed for the following purpose(s):

2. To determine whether sexual perfectionism mediates the relationship between perfectionism and sexual functioning in women with anorexia nervosa.

3. I understand that any information I provide is confidential, and that no information that could lead to the identification will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published, and data will not be shared with any other organisation.

4. I understand that my participation is voluntary, that I can choose not to participate in part or all the project, and that I can withdraw without being penalised or disadvantaged in any way. I understand that I can withdraw from the study by closing the web browser.

5. I agree to City, University of London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the General Data Protection Regulation (GDPR).

6. I understand that if I wish to be informed of the results of the study once it has been completed, I can use the contact details on the information sheet to stay in touch with the

researcher and will only be contacted for the purpose of the results.

7. I agree to take part in the above study.

Appendix 4: Online advertisement flyer

a) Clinical group poster

b) Healthy control group poster

Sexual Perfectionism & Functioning in women with Anorexia Nervosa

? Who is organizing the study?

My name is Pauline Chiarizia. I'm a trainee Counselling Psychologist conducting my doctorate in counselling psychology at City, University of London. This project is supervised by Dr. Angie Cucchi. This project has received approval by City, University of London Psychology Department Research Ethics Committee.

Participation

While perfectionistic tendencies are commonly present in anorexia nervosa, sexual functioning and satisfaction can be affected by perfectionistic tendencies in women in the general public too. For such reason, I am looking for women with no mental health diagnosis over 18 years old to complete an online survey. You do not need to be currently sexually active nor in a relationship to partake in this study.

Purpose of this study

The study wants to determine whether women that hold certain beliefs about themselves and/or others as sexual partners can have an impact on their social functioning. Perfectionistic tendencies are commonly present in anorexia nervosa. Sexual functioning and satisfaction can be affected by perfectionistic tendencies in women. For this reason, I want to determine whether this also concerns women with anorexia nervosa so we can develop psychological therapies to support them.

Participate below:

https://cityunilondon.eu.qualtrics.com/jfe/form/SV_9yPIGeKsChlcFIV

Participation is entirely voluntary.

Contact details

Researcher: Pauline Chiarizia
Contact: Pauline.Chiarizia@city.ac.uk

Supervisor: Dr. Angie Cucchi
Contact: Angie.Cucchi.2@city.ac.uk

If you have any problems or questions about this study, you can contact myself or my supervisor. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To issue a complaint regarding the study, you may call 020 7040 3040 and then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is Sexual Perfectionism: a mediating factor between perfectionism and sexual functioning in women

You can also write to the Secretary at: Anna Ramberg, Research Integrity Manager City, University of London, Northampton Square, London, EC1V 0HB.

For psychological support: contact The Adult Helpline Beat on 0808 8010677, Samaritans on 116 123 or Rethink Mental Illness on 0300 5000 927.

Appendix 5: Ethics form approval by City, University of London.

Pauline Chiarizia

Psychology

School of Arts and Social Sciences

City, University of London

London

EC1V 0HB

21st of February 2020

FULL INDEMNITY

Dear Pauline,

Reference: ETH1920-0944

Project Title: Sexual Perfectionism: Mediator factor between perfectionism and sexual functioning in women with anorexia nervosa

Start Date: 2nd of March 2020 **End Date:** 30th of September 2021

This letter confirms that City, University of London agrees to act as Sponsor for this project. Please, upload the relevant approval letter for an externally approved project once this is available and before commencing the project.

The Principal Investigator must ensure that any relevant local governance policies and procedures are adhered to. You are now free to start recruitment.

Please ensure that you are familiar with Ci'y's Framework for Good Practice in Research and any appropriate Departmental/School guidelines.

Project amendments/extensions

Note that you must complete an amendment/extension form if one of the following occurs:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration.
- Add a new or change a territory for international projects.
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants.
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument.
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers.
- Change to the insurance or indemnity arrangements for the project.
- Change the end date of the project.

Adverse events or untoward incidents

- Adverse events.
- Breaches of confidentiality and/or inappropriate disclosure of personal data under

GDPR.

- Safeguarding issues relating to children or adults at risk.
- Incidents that affect the personal safety of a participant or researcher.

Adverse events and breaches of confidentiality and/or inappropriate disclosure of personal data under GDPR should be reported as soon as possible and no later than five days after the event. Incidents that affect the personal safety of a participant or researcher and safeguarding issues relating to children or adults at risk should be reported immediately. You should also report adverse events to the relevant institutions, including police or social services.

Kind regards,
Prof Tina Forster
Psychology committee: medium risk City, University of London

Ethics ETH1920-1209: Miss Pauline Chiarizia (Medium risk)

Date Created 16 Mar 2020
Date Submitted 18 Mar 2020
Date of last resubmission 15 Jun 2020
Date forwarded to committee 16 Jun 2020
Date of committee meeting 06 May 2020
Academic Staff Miss Pauline Chiarizia, Dr Angie Cucchi
Student ID 170053965
Category Doctoral Researcher
Academic Staff Supervisor Dr Angie Cucchi
Project The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa
School of Arts and Social Sciences Department Psychology
Current status Approved after amendments made

Ethics application

Risks
R1) Does the project have funding? No

R2) Does the project involve human participants? Yes

R3) Will the researcher be located outside of the UK during the conduct of the research? No

R4) Will any part of the project be carried out under the auspices of an external organisation, involve collaboration between institutions, or involve data collection at an external organisation? Yes

R5) Does your project involve access to, or use of, material that could be classified as security sensitive? No

R6) Does the project involve the use of live animals? No
R7) Does the project involve the use of animal tissue? No
R8) Does the project involve accessing obscene materials? No
R9) Does the project involve access to confidential business data (e.g., commercially sensitive data, trade secrets, minutes of internal meetings)? No

R10) Does the project involve access to personal data (e.g., personnel or student records) not in the public domain? No

R11) Does the project involve deviation from standard or routine clinical practice, outside of current guidelines? No

R12) Will the project involve the potential for adverse impact on employment, social or financial standing? No

R13) Will the project involve the potential for psychological distress, anxiety, humiliation, or pain greater than that of normal life for the participant? Yes

R15) Will the project involve research into illegal or criminal activity where there is a risk that the researcher will be placed in physical danger or in legal jeopardy? No

R16) Will the project specifically recruit individuals who may be involved in illegal or criminal activity? No

R17) Will the project involve engaging individuals who may be involved in terrorism, radicalisation, extremism or violent activity and other activity that falls within the Counterterrorism and Security Act (2015)? No

<u>**Applicant & research team**</u>
T1) Principal Applicant
Name Miss Pauline Chiarizia

Provide a summary of the research’r's training and experience that is relevant to this research project. Trainee Counselling Psychologist

T2) Co-Applicant(s) at City
Name Dr Angie Cucchi

Provide a summary of the research'r's training and experience that is relevant to this research project.

Dr. Angie Cucchi, MSc, PgDip, DPsych, CPsychol, FHEA
Charted Counselling Psychologist Lecturer in Psychology and Counselling

https://www.researchgate.net/profile/Angie_Cucchi
https://www.harleytherapy.com/therapists/angie-cucchi

T3) External Co-Applicant(s)
T4) Supervisor(s) Dr Angie Cucchi

T5) Do any of the investigators have direct personal involvement in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest? No

T6) Will any of the investigators receive any personal benefits or incentives, including payment above normal salary, from undertaking the research or from the results of the research above those normally associated with scholarly activity? No

T7) List anyone else involved in the project. Not Applicable

Project details

P1) Project title

The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa

P1.1) Short project title

Sexual Perfectionism & Functioning in Anorexia Nervosa

P2) Provide a lay summary of the background and aims of the research, including the research questions (max 400 words).

The study investigates whether sexual perfectionism mediates the relationship between perfectionism and sexual functioning in women with anorexia nervosa. This study emerged

from evidence that links sexual perfectionism and sexual functioning in the general population (Stoeber, 2013, 2016) Given the little amount of information on this topic and the fact that women with anorexia nervosa experience high levels of perfectionism (Lloyd, 2014) and difficulties in sexual functioning (Bulik, 2013), it seems crucial to add to the literature and explore whether sexual perfectionism might mediate the two factors in this client group. Participants (+18) will be required to fill in an online survey (max 30 minutes time). The study recruits for women with and without anorexia nervosa. We ask for women with no mental health diagnosis to partake in this study to compare the two groups and replicate previous results from Stoeber's studies. We use the EDQ[-6]th edition to screen for eating disorder diagnosis and ask all women to complete it. This will help us identify who is part of the clinical and control group, along with the question 'how did you hear from this study'. The outcome of this study will increase theoretical knowledge in the field and create treatment pathways.

P4) Provide a summary and brief explanation of the research design, method, and data analysis.

The study is cross-sectional due to the hypothesis of the research, which focuses on determining the relationships between the concerned variables in one moment at the time. The lack of literature around this topic suggests that a quantitative study with a cross-sectional design is needed to determine the significance of the relationships between the variables and the mediating role of sexual perfectionism prior to further investigate this matter with other methodologies such as mixed-methods and qualitative approaches. We will conduct structural equation models for both, the clinical and control group by using SPSS and AMOS statistical programmes to facilitate the determination of our hypothesis. To recruit the appropriate participants, the researcher takes the following steps:

- The inclusion of the EDE-Q ([6]th edition) to screen for a diagnosis of anorexia nervosa. All participants are requested to complete this as it will allow us to identify whether the participant is part of the clinical or control group

- The question 'where did you hear about this study', will also help us identify whether the participant belongs to the clinical or control group. If a participant informs us that they heard about this study through an organisation affiliated with the study, this will shed light on whether they are part of the clinical group.

- Recruit only women over 18 years old to facilitate consent and capacity concerns. There is no age limit to participate. We are looking for women that received a mental health diagnosis of anorexia by a licensed medical professional or no mental health diagnosis of any kind. As mentioned above, the EDE-Q questionnaire will help us ensure the presence/lack of diagnosis of our participants and recognise in what group they are in.

- If participants want to participate (voluntary), they are asked to complete an online questionnaire, which does not take more than 30minutes to fill out. An extra 10 minutes was added for potential participants. This was tested by myself and peers (data was not recorded) to determine the length of the survey. A progress bar is included in the study, so participants have a sense of how much there is left to complete.

- The survey will include a demographic questionnaire, which involves age, gender, employment status (Mulders-Jones, Mitchison, Girosi & Hay, 2017), educational level (Goodman et al., 2014.), BMI (Pinheiro et al., 2010), menopause (Johnson et al., 2019), medications such as antipsychotic or antidepressants (McMillan et al., 2017; Croft et al., 1999). Should participants take other medication or believe they have another physical health condition that can have an impact on their sexual well-being they are given the option to complete th‘ 'other secti’n' of the item. We also ask for marital status (Bussolotti et al., 2002). More rationale about the inclusion criteria of the demographic items can be found on the participants information section of the ethics application. The study then asks questions about perfectionism, sexual functioning, sexual perfectionism, and sexual distress measures. Participants are informed of this in the consent form and are asked to take this under consideration before taking the decision to participate– - Participants can withdraw from the survey by closing the webpage prior data analysis begins at the end of November 2020.

- The researcher will create a Facebook, Instagram, and Twitter page for the research (business account). The page will include the same details of the information sheets, the link to the survey. Should participants send private messages on the account, they will be redirected to send me an email on my City university email account: Pauline.Chiarizia@city.ac.uk

P4.1) If relevant, please upload your research protocol.

P5) What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?

As mentioned previously, participants (18years +) are informed that their participation is voluntary, and that confidentiality is kept through anonymous data. Participants can find information about data storage, confidentiality and what happens to the results in the information and debrief sheet. They may also withdraw from the study by the time data analysis starts by the end of November 2020. Participants can withdraw the study by closing the web browser. Importantly, the researcher has no means to monitor capacity so once consent is given, it will be assumed throughout the rest of the study. Consent is asked and recorded on the Qualtrics platform of the survey. The study is only recruiting women as it fills out the gap in the literature. However, it does recognise the presence of eating disorders in men and encourages further research to develop for men. Language sensitivity was considered in the information and consent sheets and will be further considered on the social media accounts when posting about the study. Participants are informed that participation is entirely voluntary and their right to withdraw from the study prior to data analysis, commencing by the end of November 2020. Participants are presented with 'do not wish to disclose' options in the demographic questionnaire.

After careful consideration, the study will not be asking about previous experiences of sexual abuse nor assault any longer. This decision was based on the current literature regarding sexual abuse and sexual functioning in women. Despite the findings outlining positive correlations between such factors (DiLillo, 2001) and how childhood experiences can influence sexual functioning in adulthood (Leonard, Iversion & Folette, 2008) the amount of literature around this topic remains too limited for us to include sexual abuse as a control variable. Additionally, the studies of Stoeber investigating sexual perfectionism in sexual functioning in women does not control for sexual assault either (Stoeber & Harvey, 2016). Although sexual assault remains an important component in conceptualising the onset of the disorder (Afifi et al., 2017; Matt Lacoste, 2017) and is an important risk factor (Rayworth et al., 2004), the scare literature regarding sexual functioning and sexual abuse and its need for further investigations led us to exclude sexual abuse as a control variable for our study. Although important, this lack of foundation was reconsidered for the study. As the study wants to primarily focus on perfectionism and the mediating role of sexual perfectionism on sexual functioning in this clinical group, we will not be including sexual abuse history in our study. However, this could be of consideration in future studies should research continue to show robust outcomes regarding sexual abuse and sexual functioning in women and its key

role in the pathology of anorexia nervosa. A small sample of women (5 women over 18 years old, without and with past anorexia diagnosis) have reviewed the survey, without completing it and providing any data. They all confirmed that it took no longer than 15 minutes to reach the end of the survey and reported that the only slightly uncomfortable questionnaire was the EDE-Q(6th edition) as this can remind the participant of times of diagnosis. This was followed-up and expanded, showing that the questions of the EDE-Q questionnaires did not act as a profound psychological trigger but that it reminded one person of the time when they were asked similar questions for the very first time by their doctor. However, they claimed they had a positive experience completing the study. They described being pleased with taking the time to reflect on their own sexuality and functioning as this is not something they are often asked about and felt as this allowed them to explore another part of their sexuality. Some highlighted it felt empowering and would enjoy to part-take in the research. It is important to note however, that the women concerned are individuals that I personally know. As everyone completes surveys at different paces, depending on how comfortable one might be to answer questions regarding sexual functioning and satisfaction, we decided to inform participants that it shouldn't take any longer than 30 minutes to complete on the information sheet.

Importantly, this study has no intentions in labelling participants with sexual dysfunction diagnoses. It does not aim at encouraging the medicalisation of such phenomena (Taylor, 2015). It is highlighted in the information sheet that the study does not aim to diagnose for sexual dysfunctions and despite the terminology of 'sexual perfectionism' suggesting for a normal or abnormal sexual well-being, we inform the participants that this is a recent new developed multifactorial concept and is not an official classified diagnosis. In fact, studies have been carried out to highlight this conflict, showing how sexual perfectionism cannot be simply understood as a maladaptive trait due to the multiple dimensions it entails (Kluck et al., 2016). The study wants to highlight whether certain perfectionistic tendencies of thinking about oneself or another as a sexual partner can have an impact on sexual functioning and satisfaction. This will be outlined on the information sheet and risk will be monitored by encouraging women with concerns about labelling to contact myself or my supervisor.

P6) Project start date

The start date will be the date of approval.

P7) Anticipated project end date

24 Sept 2021

P8) Where will the research take place?

17. The following organisations are involved in the project and confirmed their participation. . Eating Disorders N.I. confirmed their participation in allowing the researcher to recruit through their social media platform. Once ethical approval is obtained it was agreed that I will initiate contact again and provide proof of ethical clearance. The information sheet and research flyer will be given for them to uploaded on their social media platform. They will be informed of our social media platform (account) should they wish to include us in their post. . Receptio– - Breathe Therapies is a non-profit organisation that confirmed their participation in the project by allowing the researcher to use their social media platform to recruit the required data. Again, once ethical approval is obtained, I will send the necessary proof and information and research flyer for them to upload on their social media platform. . CITY HEALTH CARE PARTNERSHIP CIC confirmed their participation in the project; however, this is to be revisited once the project receives ethical approval of the University board and open discussion under what capacity they can support the study then as they currently postponed research projects due to covid-19 situation. It was agreed that we would re-visit their engagement with the project once ethical approval has been obtained, including discussing specific steps regarding recruitment. . NIWE eating distress service is willing for us to recruit through their social media platforms by posting about the study. Please find all communications between the researcher and the above organisations in th' 'extern'l' section of the ethics application. No participants for the clinical group will be recruited through other means but the organisations listed above. For participants that want to part-take in the control group, they will be recruited through our social media platform such as Instagram, Facebook, Twitter. All the information included on the consent, information and debriefs forms will be found on the pages, including the link to the survey, and showing proof of ethical approval and association with City, University of London with the appropriate logos.

P10) Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee? No
External organisations

E1) Provide details of the external organisation/institution involved with this project.
Eating Disorder NI is a non-profit organisation situated in Belfast. Breathe Therapies is a non-profit organisation situated in Preston. CIC City Health Care Partnership CIC is an

independen‘ 'for better prof't' and co-owned Community Interest. Company responsible for providing local health and care services. NIWE eating distress service is a non-profit organisation situated in Newcastle upon Tyne.

E2) If applicable, has permission to conduct research in, at or through another institution or organisation been obtained? Yes

18. **E2.1) Provide details and attach the correspondence. Please find below email correspondence that confirms the involvement of research sites and under what capacity:** . Eating Disorders N.I. Mon 4/6/2020 4:14 PM

    Hi Pauline, Thank you for the update. I can confirm that EDA is willing to support Pauline Chiarizia in the recruitment process through sharing of the study poster online through E'A's social media platforms. We will be happy to do this once the study is cleared and signed off by the ethics committee. I hope this is suffice Pauline. Kindest regards Aileen . Receptio– - Breathe Therapies Wed 4/8/2020 3:23 PM

19. Dear Pauline Thank you for your email. We would be willing to put a post asking if anybody would like to volunteer to participate in your study on our Facebook page. You would need to send us a link and the wording and a photo to engage people (not of someone with anorexia!) for the post. Kind Regards, Ruth Asch Lead Receptionist Breathe Therapies and S.E.E.D. Lancashire Reception Breathe Therapies & S.E.E.D Lancashire Quayside House Navigation Way Preston Lancashire PR2 2YP 01772 915 735 . Research (CITY HEALTH CARE PARTNERSHIP CI– - NNF) Fri 4/3/2020 3:39 PM CAUTION: This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and believe the content to be safe.

Hello Pauline, my name is Lucy Riggs and I work with Sue Pender, who has asked me to respond to all research queries as she has been temporarily redeployed as part of COVID-19 response. As you will appreciate, in these unprecedented times, any new research activity is on pause within our services, as many are having to operate very differently. However, after reading the email trail below, I can see that Sue did respond to your initial query on November [11]th with the response you are seeking and information regarding the required documentation that we would require to proceed (see email trail below with ‘CHCP's permission to list as a potential research site'). When you have received the appropriate ethics approval, please follow the guidance within Sue's email below and submit

the required documents to the CHCP research in box: chcp.research@nhs.net. Please note that at present although we would be able to consider the documents for approval (subject to service manager agreement), we would be unable to identify a potential start date until services resume to usual operational status. We will be able to discuss this further once your documents have been received and service manager agreement sought. Please do not hesitate to contact me at the email address above if you have any further questions.

Kind regards, Lucy

Lucy Riggs Quality Improvement Practitioner Quality Improvement Team City Health Care Partnership CIC M: 07816 645229| E: lucy.riggs@nhs.net | www.chcpcic.org.uk | Think before you print Due to covid-19 circumstances, the researcher will not approach participants directly through support groups or on research sites.

Participants will be recruited through the social platforms of the organisations. This may be reviewed in the future and the ethics committee will be informed of any changes. In addition to this, the researcher will recruit control and clinical participants on social media platform. For control group participants, the researcher would like to use Instagram, Facebook platforms to obtain the necessary data. As there are support groups for eating disorders on Facebook platform for instance, the researcher would ask for permission to the admin of the group whether they accept that I can diffuse the survey link within their groups.

4. NIWE Eating Distress Service
Holly Lynn Mon 4/20/2020 2:57 PM
Dear Pauline,

To confirm NIWE Eating Distress Service is happy to engage with this project. We will use our social media platforms to help recruitment into your study. Best Wishes, Holly Lynn MBACP and UKCP Counselling Manager NIWE Eating Distress Service The Old Post Office 5 Pink Lane Newcastle upon Tyne NE1 5DW Telephone: 0191 221 0233

Human participants: information and participation
The options for the following question are one or more of: 'Under 18'; 'Adults at risk'; 'Individuals aged 16 and over potentially without the capacity to consent'; 'None of the above'.

H1) Will persons from any of the following groups be participating in the project?

None of the above

H2) How many participants will be recruited? 508

H3) Explain how the sample size has been determined.

A priori power analysis for structural equation model was performed, which stated that the study requires a sample of 308 clinical participants and a minimum of 200 participants for the healthy control group. The observable variables are the following: age, BMI, education level, employment status, marital status, menopause, medication and the Eating Disorder Examination Questionnaire, 6th version. The latent variables are perfectionism, sexual perfectionism, personal sexual distress, and sexual functioning. The anticipated effect size was of 0.6, which suggests a medium range. This derives from previous studies that focused on the relationship between sexual perfectionism and sexual functioning within the general population and the link between perfectionism within the clinical population of anorexia nervosa. This led to the hypothesising that the strength between the relationships between such variables have sufficient strength to aim for this potential effect size for the study.

Please find below the rationale for the inclusion of the demographic questionnaire:
- Educational level: There is an important relationship between family education and risk to develop eating disorders (Goodman et al., 2014). More studies found a significant correlation between the maternal education level and increased risks at developing and hospitalisation of eating disorders (Ahren et al., 2012). Other studies highlight the importance of school in the development of eating disorders, re-affirming that students in schools with highly educated parents have greater risks of developing an eating disorder regardless of individual risks factors (Bould et al., 2016). The significant relationship between educational level and eating disorders lead us to include a question about our participant's educational level.

- BMI: We ask participants to calculate their BMI by accessing the NHS website and inform of their BMI level due to the impact weight loss can have on sexual functioning (Pinheiro et al., 2010).

- Menopause: We ask participants whether they have gone through menopause or not due to the association between menopause and sexual dysfunction (Johnson et al., 2019). However, this is not an excluding criterion. Women that are going through or have gone through menopause are still welcome to participate.

-We ask participants whether they are taking any medications such as antipsychotic or antidepressants medication as they can significantly influence sexual functioning and sexual well-being (McMillan et al., 2017; Croft et al., 1999). Other medications such as painkillers do not need to be listed. If the participant feels they have a physical health condition or medication that they feel has impacted their sexual well-being they are encouraged to complete the 'other' option of the question.

-Marital status: We ask participants to share their marital status as finding suggests that individuals with high eating symptomatology are those engaged with partners and show higher motivation for change. The interpersonal relationships of individuals with eating disorders should be considered in the maintenance of eating disorders. This factor led us to include this question in our demographic questionnaire (Bussolotti et al., 2002).

-Employment status & Ethnicity: Data shows how unemployed individuals are more prone to the onset of eating disorders. It highlights how unemployment is associated with purging, engage in home tasks with an increased focus on weight/shape. We also ask for participants ethnicity as eating disorder can affect all ethnicities equally (Mulders-Jones, Mitchison, Girosi & Hay, 2017).

H4) What is the age group of the participants?
Lower Upper 18

H5) Please specify inclusion and exclusion criteria.
We are recruiting women with a diagnosis of anorexia nervosa only to partake in the study for our clinical group. Such participants will be recruited through the named organisations. To ensure an eating disorder diagnosis of anorexia, participants will require to complete the EDE-Q (6th version) in the survey. Women need to be over 18 years old to ensure capacity and consent. There is no age limit to partake in the study. For our control group, we recruit women with no mental health diagnosis of any kind. Such participants will also complete the EDE-Q (6th version) to ensure the absence of a diagnosis. Women from the control group will be recruited on social media platforms such as Instagram, Facebook, and twitter. We will create a business account about the study. The researcher will not use their personal social media accounts to recruit participants. Important note: Participants are not required to be currently engaged in an intimate relationship or to be sexually active with one or multiple partners. Participants are welcome to complete the study based on previous life experiences. The study will not enquire about the number of sexual partners in the

demographic questionnaire due to the potential risk of being too intrusive, especially for a clinical population where attitudes towards sex is unclear (Carter et al., 2007; Gonidakis, Kravvariti, Fabello & Varsou, 2016). The study excludes women with other eating disorder diagnosis such as bulimia nervosa or any other mental health disorders.

H6) What are the potential risks and burdens for research participants and how will you minimise them?

Participants might experience uncomfortable feelings when responding the survey. This depends on their perspective on the topic of sex and openness to discuss it. To manage such risks, the following steps are put in place for the well-being of the participants:

- Participant's confidentiality is ensured by keeping the responses anonymous.

- Participants are informed that they can withdraw from the study by closing the webpage and that they can withdraw prior data analysis by the end of November 2020. Participation is voluntary only. - A progress bar is also included on the survey so participants can have a sense of how much they have left to complete.

- Psychological support resources can be accessed on the information and debrief sheet. This will give the opportunity to participants to access resources should they feel the need for psychological support prior the beginning of the study and after completion. Participants can also find the psychological support resources on the posters. We hope this will help minimising risks and ensure the well-being of participants.

- Participants are informed that this study was reviewed by the Ethics board, with a suitable reference at the beginning of the information, consent and debrief sheets. Contact information to speak to the board and complaint procedure is highlighted in the information sheet should they wish to speak to other members of staff regarding the study.

- As the study focused on sexual perfectionism and sexual functioning, which are both terminologies that can suggest labelling to participants, we take the following steps to reduce the risk for participants to diagnose themselves with sexual dysfunctions or with sexual perfectionism as diagnoses.

- In the information sheet we address the potential risk for labelling. We express that the interest of the study is not to advocate for a normality regarding sexual well-being and

functioning. We highlight that sexual perfectionism is not a diagnosis but rather a multifactorial recent developed concept that does necessarily qualify as a maladaptive trait. (Kluck et al., 2016). This study explores whether this recent developed concept of sexual perfectionism can be of relevance in its influence on sexual functioning in women with and without anorexia nervosa. However, this does not automatically suggest a diagnosis or a negative relationship between variables. For instance, perfectionism can be used as a negative terminology in everyday life, but research showed not all traits of perfectionism are maladaptive and automatically negatively impact on psychological functioning (Chang et al., 2004). The researcher wants to stress that this study aims to gather a better understanding of the sexual well-being of women with anorexia nervosa and women without any other diagnosis. We hope to contribute to the recent literature on the matter in the hope to influence the development of psychological therapies in the future.

- Should there be any questions about labelling in-regards to sexual functioning or sexual perfectionism, participants are informed that they can contact myself or my supervisor to raise any concerns about the study.

H7) Will you specifically recruit pregnant women, women in labour, or women who have had a recent stillbirth or miscarriage (within the last 12 months)? No

H8) Will you directly recruit any staff and/or students at City? None of the above

H8.1) If you intend to contact staff/students directly for recruitment purpose, please upload a letter of approval from the respective School(s)/Department(s).

H9) How are participants to be identified, approached, and recruited, and by whom?

All participants will be recruited online due to Covid-19 circumstances. This means that the link to the survey will be shared on social media platforms of the organisations to recruit the clinical group. We will recruit women for the control group through social media by creating a business account on Twitter, Facebook, and Instagram. The researcher will not use their private account. To recruit, we will post the same information that can be found on the information, consent and debrief sheets. Participants can find the link to the survey on the posts of the business accounts of the social media platforms. H10) Please upload your participant information sheets and consent form, or if they are online (e.g., on Qualtrics) paste the link below.

H11) If appropriate, please upload a copy of the advertisement, including recruitment emails, flyers or letter.

H12) Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained.

Consent is obtained on the survey software. The survey is Qualtrics and before participants start the survey, they are presented with the information and consent sheet. Participants are required to provide consent on the consent page or else the survey will terminate automatically. Consent is recorded through Qualtrics anonymously. Participants can withdraw from the study by closing the web browser. Consent and capacity will be assumed if a participant completes the entire study. However, the researcher does not have the means to monitor capacity or consent changes. In this sense, once consent is given, it is assumed throughout the whole study. The data used in our analysis will derive from questionnaires that were completed until the end of the survey. Participants that close the web browser prior the end of the survey will be considered as they withdrew from the study and their data will not be recorded. If more than 5% of data is missing in the completed questionnaires, the data will not be used in our analysis. Should there be only 5% or less data missing, we will include it in our analysis and follow the relevant guidelines by substituting the missing value with the average mean for the score (Field, 2013).

H13) Are there any pressures that may make it difficult for participants to refuse to take part in the project? No

H14) Is any part of the research being conducted with participants outside the UK? No

Human participants: method

The options for the following question are one or more of: 'Invasive procedures (for example medical or surgical)'; 'Intrusive procedures (for example psychological or social)'; 'Potentially harmful procedures of any kind'; 'Drugs, placebos, or other substances administered to participants'; 'None of the above'.

M1) Will any of the following methods be involved in the project: None of the above

M2) Does the project involve any deceptive research practices? No

M3) Is there a possibility for over-research of participants? No

M4) Please upload copies of any questionnaires, topic guides for interviews or focus groups, or equivalent research materials.

M5) Will participants be provided with the findings or outcomes of the project? Yes

M5.1) Explain how this information will be provided.

Participants are told in the information sheet, should they want to access the results of the study they are welcome to send an email to the researcher. They will only keep in touch regarding the results of the study and the participants will not be contacted for any other purposes. This is highlighted in the information sheet.

M6) If the research is intended to benefit the participants, third parties or the local community, please give details.

The study aims at increasing theoretical knowledge on sexual functioning in women, including women with anorexia nervosa. It stresses the importance of sexual functioning in one's well-being and for the field of counselling psychology to further explore appropriate psychological treatments to support women with anorexia nervosa.

M7) Are you offering any incentives for participating? No

M8) Does the research involve clinical trial or clinical intervention testing that does not require Health Research Authority or MHRA approval? No

M9) Will the project involve the collection of human tissue or other biological samples that does not fall under the Human Tissue Act (2004) that does not require Health Research Authority Research Ethics Service approval? No

M10) Will the project involve potentially sensitive topics, such as participants' sexual behaviour, their legal or political behaviour, their experience of violence? Yes

M11) Will the project involve activities that may lead to 'labelling' either by the researcher (e.g., categorisation) or by the participant (e.g., 'I'm stupid', 'I'm not normal')? No Data

D1) Indicate which of the following you will be using to collect your data.
Questionnaire

D2) How will the privacy of the participants be protected?
Anonymised sample or data

D3) Will the research involve use of direct quotes? No

D5) Where/how do you intend to store your data?
Password protected computer files Storage on encrypted device (e.g., laptop, hard drive, USB

D6) Will personal data collected be shared with other organisations? No

D7) Will the data be accessed by people other than the named researcher, supervisors, or examiners? No

D8) Is the data intended or required (e.g., by funding body) to be published for reuse or to be shared as part of longitudinal research or a different/wider research project now or in the future? No

D10) How long are you intending to keep the research data generated by the study?
The study will keep data for a minimum of ten years and will follow destruction of data policies as recommended by the institutional guidelines of City, University of London.

D11) How long will personal data be stored or accessed after the study has ended?
The study is aligned with the code of conduct of the BPS and by City, University of London guidelines. The data will be stored and destroyed in seven years as recommended. It will then be only accessible through the doctorate version in the library or if published in Journals, data remains anonymised. Participants are informed that the study is contributing to a doctoral thesis and possibility of publishing the data is highlighted in the information sheet.

D12) How are you intending to destroy the personal data after this period? All material in relation to the study such as the survey, data on statistical software's used for analysis will be deleted. As the data is anonymous there should be no personal data. Health & safety

HS1) Are there any health and safety risks to the researchers over and above that of their normal working life? No

HS3) Are there hazards associated with undertaking this project where a formal risk assessment would be required? No

Ethics ETH2021-0440: Miss Pauline Chiarizia (Medium risk)

Date Created 20 Oct 2020
Date Submitted 20 Oct 2020
Date of last resubmission 20 Oct 2020
Date forwarded to committee 20 Oct 2020
Academic Staff Miss Pauline Chiarizia Dr Angie Cucchi
Student ID 170053965
Category Doctoral Researcher
Academic Staff Supervisor Dr Angie Cucchi

Project
The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa
School - School of Arts and Social Sciences Department Psychology
Current status Approved
Ethics application Amendments

SA1) Types of modification/s

Change the design and/or methodology of the project, including changing or adding a new research method and/or research instrument

SA2) Details of modification

In the previous ethics application, it was agreed that the clinical group would only be advertised through non-profit organisations. Due to the limited engagements of the organisations and the little sample size we currently have, I would like to request the permission to advertise to the clinical group directly on social media (Facebook, Instagram, Twitter) by creating a specific account. I would not advertise from my personal accounts. The selection criteria for the clinical group would not change. The study is still looking for women, over 18 years old that have already received a diagnosis of anorexia nervosa by a licensed healthcare professional. The research poster specifically stresses this and the EDE-Q measure in our study helps us to identify subtypes of anorexia (whether they are part of the bingeing or restricting group) rather than having the purpose of diagnosing. Participants are informed that they cannot participate if they suspect a diagnosis of eating disorders but have never discussed this with a licensed medical professional in the information form. Importantly, participants do not need to fit within a diagnostic criterion of anorexia at the time of completion of the study. The study emphasises on perfectionism within anorexia nervosa, which is a factor that often remains even after remission of anorexia treatments and is frequently considered as a risk factor to relapse rates (Lloyd, 2014).

If participants had a diagnosis in the past, but no longer feel that their well-being is negatively impacted by the disorder, or are in remission, they are still able to participate. In alignment with the Declaration of Helsinki (World Medical Association, 2001) and with the BPS research code of conduct (The British Psychological Society, 2018), the study guarantees confidentiality to our participants. Their data is anonymous, and the study does not ask for personal details' information such as name or email address. For this reason, it is not possible for the researcher to contact a participant should they score high on the EDE-Q measure. However, psychological support services are provided on the information and debrief sheets (such as the Beats helpline phone number) if participants feel the need to engage with psychological support services or if they have concerns about their eating disorder. The information form also clearly informs participants that should they have concerns about their eating and their well-being that they can also contact their primary physician.

SA3) Justify why the amendment is needed

This amendment is needed to be more proactive about the data collection process. Due to Covid-19 circumstances in March, we could not proceed with recruiting via the NHS, so we proceeded with recruiting within non-profit organisations. However, the organisations that are involved with the projects recently disengaged. I have not been able to contact them.

Due to the current extenuating circumstances and limited resources, they have, they have not been able to be proactive about disseminating research posters on their social media platforms. I would be greatly appreciative if I could be granted the opportunity to advertise to the clinical group on social media myself, through a separate professional account. This would allow me to be more proactive about data collection and hopefully gain the required sample size for my study. I'm aware that the ethics board gave me the permission to collect data until the end of November 2020, and I'm requesting an additional 3-6months to collect data. This rationale is based on the sample size of 308 clinical participants that are needed and that I currently have 35.

SA4) Other information

SA5) Please upload all relevant documentation with highlighted changes

Project amendments

P1) Project title

The influence of sexual perfectionism on sexual functioning in women with anorexia nervosa

P2) Principal Applicant

Name Miss Pauline Chiarizia

Provide a summary of the researcher's training and experience that is relevant to this research project. Trainee Counselling Psychologist

P3) Co-Applicant(s) at City

Name Dr Angie Cucchi

Provide a summary of the researcher's training and experience that is relevant to this research project. Charted Counselling Psychologist

P4) External Co-Applicant(s)

P5) Supervisor(s) Dr Angie Cucchi

Appendix: Statistics

Table 2. Demographic Percentiles

		Clinical Group		Healthy Control Group	
Category	**Subcategory**				
		N	**Valid Percent**	**N**	**Valid Percent**
Age	18-25	69	42.1%	127	59.3%
	25-30	41	25%	44	20.6%
	30-35	24	14.6%	19	8.9%
	35-40	15	9.1%	13	6.1%
	40-45	5	3%	5	2.3%
	45-50	9	5.5%	6	2.8%
Menopause	Yes	9	5.5%	3	1.4%
	No	154	93.9%	210	98.1%
	No disclosure	1	0.6%	1	0.5%
Relationship status	Single	66	40.2%	87	40.7%
	Dating	7	4.3%	5	2.3%
	Relationship	51	31.1%	84	39.3%
	Engaged	7	4.3%	6	2.8%
	Married	31	18.9%	31	14.5%
	Divorced	1	0.6%	1	0.5%
	Widowed	1	0.6%		

Medication	Yes	90	54.9%	12	5.6%
	No	60	36.6%	183	85.5%
	No disclosure	3	1.8%	2	0.9%
	Other	11	6.7%	17	7.9%
Employment	Full time	63	38.4%	77	36%
	Part time	27	16.5%	23	10.7%
	Looking for work	17	10.4%	16	7.5%
	Not looking for work	14	8.5%	2	0.9%
	Student	32	19.5%	96	44.9%
	Disabled	10	6.1%		
Education	Less than high school	6	3.7%	2	0.9%
	High school graduate	49	29.9%	20	9.3%
	Bachelor's degree	68	41.5%	76	35.5%
	Master's degree	25	15.2%	93	43.5%
	Professional degree	11	6.7%	5	2.3%
	Doctorate	4	2.4%	16	7.5%
BMI	Underweight	48	29.3%	16	7.5%
	Healthy weight	72	43.9%	141	65.9%
	Overweight	11	6.7%	30	14%
	Obese	6	3.7%	19	8.9%
	No disclosure	27	16.5%	8	3.7%

Table 3. Eigenvalues of the 19 components extracted

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	30.853	26.828	26.828	30.853	26.828	26.828	11.651
2	11.090	9.644	36.472	11.090	9.644	36.472	6.793
3	6.854	5.960	42.432	6.854	5.960	42.432	7.987
4	5.978	5.198	47.630	5.978	5.198	47.630	6.565
5	3.891	3.383	51.013	3.891	3.383	51.013	9.791
6	3.554	3.091	54.104	3.554	3.091	54.104	11.279
7	3.143	2.733	56.836	3.143	2.733	56.836	11.851
8	2.958	2.572	59.408	2.958	2.572	59.408	5.298
9	2.300	2.000	61.408	2.300	2.000	61.408	11.356
10	2.169	1.886	63.294	2.169	1.886	63.294	6.772
11	2.011	1.748	65.042	2.011	1.748	65.042	10.010
12	1.677	1.458	66.500	1.677	1.458	66.500	13.352
13	1.626	1.414	67.914	1.626	1.414	67.914	10.014
14	1.484	1.290	69.204	1.484	1.290	69.204	14.732
15	1.376	1.197	70.401	1.376	1.197	70.401	1.955
16	1.312	1.141	71.542	1.312	1.141	71.542	6.466
17	1.252	1.088	72.631	1.252	1.088	72.631	14.589
18	1.221	1.062	73.693	1.221	1.062	73.693	6.109
19	1.044	.908	74.601	1.044	.908	74.601	6.949

Table 4. Kolmogorov-Smirnov and Shapiro-Wilk Statistics

	Kolmogorov-Smirnov		**Shapiro-Wilk**	
	Statistic	Sig	Statistic	Sig
Eating Disorder Examination Questionnaire	.080	.000	.952	.000
Frost Multidimensional Perfectionism	.049	.027	.977	.000
Female Sexual Functioning Index	.058	.003	.984	.000
Multidimensional Sexual Perfectionism	.048	.037	.990	.009
Sexual Distress	.064	.001	.967	.000

Table 5. Skewness and Kurtosis

		Skewness	**Kurtosis**
Scale	Std Deviation	Statistic	Statistic
Female Sexual Functioning Index	6.16557	.056	-.818
Sexual Distress	1.01157	.266	-.793
Frost Multidimensional Perfectionism	.78395	.242	-.781
Multidimensional Sexual Perfectionism	4.93868	.077	-.393
Eating Disorder Examination Questionnaire	1.70921	-.038	-1.206

Table 9. Path models: Significance results

Sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Sexual Perfectionism	.001	.001
Sexual Perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.679	.139
Perfectionism	→	Sexual Functioning	.267	.611
Sexual Perfectionism	→	Sexual Functioning	.007	.005
Sexual Distress	→	Sexual Functioning	.001	.001

Self-oriented sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Self-oriented sexual perfectionism	.001	.001
Self-oriented sexual perfectionism	→	Sexual Distress	.002	.043
Perfectionism	→	Sexual Distress	.762	.009
Perfectionism	→	Sexual Functioning	.027	.094
Self-oriented sexual perfectionism	→	Sexual Functioning	.001	.001
Sexual Distress	→	Sexual Functioning	.001	.001

Partner-oriented sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Partner-oriented sexual perfectionism	.392	.001
Partner-oriented sexual perfectionism	→	Sexual Distress	.718	.468
Perfectionism	→	Sexual Distress	.071	.001
Perfectionism	→	Sexual Functioning	.857	.531
Partner-oriented sexual perfectionism	→	Sexual Functioning	.051	.284
Sexual Distress	→	Sexual Functioning	.001	.001

Partner-prescribed sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Partner-prescribed sexual perfectionism	.015	.001
Partner-prescribed sexual perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.225	.001
Perfectionism	→	Sexual Functioning	.788	.207
Partner-prescribed sexual perfectionism	→	Sexual Functioning	.861	.369
Sexual Distress	→	Sexual Functioning	.001	.001

Socially prescribed sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Socially prescribed sexual perfectionism	.001	.001
Socially prescribed sexual perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.947	.028
Perfectionism	→	Sexual Functioning	.405	.778
Socially prescribed sexual perfectionism	→	Sexual Functioning	.086	.001
Sexual Distress	→	Sexual Functioning	.001	.001

Part II - The healing journey of a survivor of childhood sexual abuse: **A case study**

Case study

Disclaimer: To protect the confidentiality, the pseudonym 'Lucie' is used for the purpose of this academic work. The specific name of the service is not mentioned, and all identifiable factors have been removed.

Introduction

The Client

I see Lucie as part of an outpatient clinical psychology service. The therapy takes place online due to Covid-19 regulations. Lucie has been diagnosed with a severe asthma condition since 2019. She was referred by her GP when she moved to London in September to access specialist care for her condition. Her asthma led to an admission to intensive care for a few months in 2019, which re-triggered previous psychological trauma. She underwent long-term therapy several years ago. Lucie is able to articulate that her current triggers are related to sexual abuse as a child and traumatic experiences when she was admitted to a mental health ward when she was younger. Her psychiatrist in Ireland diagnosed her with post-traumatic stress disorder.

Initially, the therapy is aimed at increasing coping strategies. Although there is a history of risky behaviours, such as self-harm, substance abuse and a suicide attempt, Lucie did not have these behaviours at the time of our therapy. A risk assessment was carried out and Lucie was not at risk of suicide or self-harm. However, she sometimes engages in binge eating and is ashamed of her weight gain. She initially understands that her historical excessive alcohol consumption is the cause of her weight, which then becomes responsible for her asthma. This affects her self-esteem and interpersonal relationships.

Post-traumatic stress disorder and health

Post-traumatic stress disorder (PTSD) is defined as a chronic state where the individual attempts to regain feelings of safety, control, and predictability, responding to stimuli to survive even when they are not under threat. Individuals with PTSD experience a continuous state of extremely high levels of stress where their responses are rooted in survival reactions (American Psychiatric Association, 2013). Schelling (1998) and Stoll (1999) show that individuals who have a multitude of traumatic memories from ICU admissions show greater risk of developing PTSD (Schelling et al., 1998). The relationship between chronic health conditions and PTSD has been established in the literature, showing that individuals with PTSD access healthcare services at a higher frequency (Stein, McQuaid, Pedrelli, Lenox &

McCahill, 2000). This is due to the nature of PTSD, which implicates a longer-term activation of the sympathetic nervous system. This over-stimulation for a long period impacts significantly on immune activity. This mechanism increases the likelihood of developing medical conditions. Asthma is one of the chronic physical conditions that individuals may be at risk to develop if they experience PTSD. Additionally, the severity of asthma can also be understood in relation to PTSD (Hung, Cheng, Bai, Tsai, Pan, Chen & Chen, 2019). As a result, one should understand the link between PTSD and physical health as a multifactorial concept that brings complexity.

PTSD, Asthma & Childhood Sexual Abuse

Childhood sexual abuse survivors are considered a vulnerable group at risk of developing physical health consequences (Golding, 1999). The link between PTSD, childhood sexual abuse and health conditions such as asthma has been widely established in the literature (Romans, Belaise, Martin, Morris & Raffi, 2002). Importantly, the link between childhood sexual abuse and the onset of asthma in adulthood has been documented too. Arguments have been made that the stress from the abuse can persist in adulthood, affecting the immune system and the airways. Exposure to stress levels impacts developmental processes in children, leading to an increased risk of developing asthma in adulthood (Coogan, Wise, O'Connor, Brown, Palmer & Rosenberg, 2012;2013).

PTSD and Compassion-Focused Therapy (CFT)

CFT is an integrated model developed by Dr. Gilbert. It was developed to support individuals with complex mental health difficulties who did not respond to cognitive behavioural therapy (Gilbert, 2010). Indeed, individuals with high levels of self-criticism and shame did not respond well to CBT (Lawrence & Lee, 2014). CFT suggests that our emotions, cognitions, and motivational behaviours derive from three interacting systems. The threat system is responsible to monitor possible threats. The soothing system promotes attachment and helps the individual to manage stress. This system is commonly associated with feelings of safety. The drive system is related to behaviours concerning achievements. The core concept is that there needs to be a balance between the three systems to experience positive mental health. One common issue is the overactivation of the threat system over others, which is a phenomenon that is often present in PTSD (McLean, Steindl & Bambling, 2018). There is a strong relationship between low levels of compassion and childhood sexual abuse. This includes the tendency of resisting or fearing self-compassion (Miron, Seligowski, Boykin & Orcutt, 2016). Gilbert suggests that this is the result of conditioning self-compassion with abusive environments.

Therefore, individuals who experienced abuse in their childhood can struggle to self-soothe. This inability to self-soothe appropriately maintains the initial symptoms of PTSD (Gilbert, 2012). This resistance towards self-compassion has been documented in individuals with PTSD or who show high levels of shame and self-critical thinking styles (Harman & Lee, 2010;2009). Another difficulty is that engaging in self-compassion activates the threat response, which can make self-compassion overwhelming (Pauley & McPherson, 2010; Lawrence & Lee, 2014). For this reason, normalising resistance to self-compassion and conceptualising this resistance during the formulation stage is important. Gilbert stresses the importance to discuss resistance with curiosity rather than judgement (Miron et al., 2016). In the context of Lucie, understanding the evidence that supports the links between PTSD, asthma and CFT are crucial to guide the therapy with the most appropriate framework. Additionally, it allows the creation of an appropriate formulation of the presenting problem. This client study and process report are rooted in CFT theory and the rationale for this will be further explored in the sections below. This piece of work integrates health and trauma by using CFT to support Lucie.

The therapeutic process

1. Referral

Lucie was referred by the Crisis Team in 2019 after being discharged from the ICU for her severe asthma. Her hospital stay brought back intense symptoms of PTSD. She was referred to the health psychology service and she did not show risk concerns. I was not part of the referral process as I joined the service in January 2020. The referral provided showed limited understanding of her difficulties, except how her new health condition seemed to re-triggered previous traumatic experiences and how her stay in the ICU was extremely difficult for her. The referral shows no risks for suicide or self-harm. Lucie had psychological therapy before, which is when her self-harming behaviour stopped. However, no further details were given in the referral except that the request would be to support Lucie with her PTSD symptoms and recent asthma diagnosis.

2. Assessment

The assessment was conducted by my supervisor and discussed in supervision prior to allocation. Lucie said she felt ‘overwhelming feelings of anxiety and distress and has difficulties in coping with traumatic memories and intrusive thoughts’. Such difficulties surfaced in the context of the Covid-19 pandemic. Lucie told my supervisor that she has a

diagnosis of severe asthma, which led to admissions between February 2019 and August 2020 including being on a ventilator in ICU.

She said she had thoughts that she would die alone in the hospital. Lucie explained that being physically vulnerable and feeling out of control triggered difficult memories from the past, particularly memories of feeling powerless and afraid in the context of childhood sexual abuse. Her father abused her as a child. She had no contact with her parents since she left the house at 18 years old. Lucie has a good relationship with her four siblings, but they do not speak of their parents.

Since the start of lockdown, Lucie noticed an increase in flashbacks and intrusive thoughts. The lockdown had a big impact on Lucie's coping strategies as she is no longer attending a weekly social gathering. This means there are fewer distractions from overwhelming memories. Lucie said that she often blames herself for her difficulties and believes her asthma is due to her weight. Lucie explained that she has been coping by using alcohol, overeating, and finding distractions. However, she stopped drinking alcohol in the summer of 2020. They spoke about how such coping strategies can feel as if they bring relief in the short-term, but that they can impact negatively on her health.

They explicitly discussed Lucie's tendencies in trying to avoid difficult emotions and thoughts as they become too frightening. Lucie talked about her previous therapy experience and how it helped her stop engaging in self-harming behaviours. My supervisor and Lucie agreed that psychological therapy would be beneficial and to use the time to look at how the memories of hospital admissions and past traumas can be intertwined, meaning they become even more overwhelming.

No immediate risk issues were identified during the assessment stage. However, there is a history of one suicide attempt when Lucie was 17 years old. This was in the context of seeking support from the police about the abuse and the lack of support she received from her mother in this process. Lucie did not discuss this more. Lucie was hospitalised and sectioned for her mental health. Lucie explained that she was abused by a psychiatrist. She has no contact with this person now. Lucie was made aware of the resources she can access if she ever feels immediate risk. However, Lucie is no longer self-harming and has no intentions to kill herself.

3. Formulation and treatment plan

Lucie's recent admissions in hospitals and the context of the pandemic of Covid-19 brought back traumatic experiences of childhood sexual abuse and abusive behaviour from when she was on a psychiatric ward by a psychiatrist. The lack of social interactions and inability to access social events that used to be a distraction to cope made Lucie feel out of control. Her distress surfaces as low mood, anxiety, rumination, self-criticism, binge eating.
She blames herself for her asthma as she believes it is her weight that caused it. Lucie felt vulnerable considering the new context of the pandemic, suddenly having to adapt to living with her asthma, which often triggers her traumatic childhood experiences due to the shared feeling of being out of control.

We contracted 12 sessions as per service policy. We acknowledged that Lucie would not go into much depth about certain experiences as the sessions took place over Zoom. Lucie did not always feel comfortable with the idea of being left alone at home after unpacking painful memories. We established a structure for the sessions to ensure Lucie felt grounded. We used the last ten minutes of sessions to review and to engage in grounding exercises and we used the first ten minutes of the sessions with short mindfulness check-in to ease into the session (Kolts, Bell, Bennett-Levey & Irons, 2018). We explored what strategies Lucie could engage with prior and after her sessions to help her be in the therapeutic mindset and process her sessions safely. We also agreed that we could always extend a session by another 10 minutes if she ever feels too distressed towards the end of a session. Discussing the structure of therapy and establishing how we would work together was important for our therapeutic alliance and to ensure safety.

We first explored historical influences. Lucie shared her father sexually abused her throughout her childhood and her mother did not protect her. She attempted to involve authorities, but the mother refused to support her in this process, which resulted in Lucie's attempt to kill herself when she was 17 years old. She was admitted and sectioned on a psychiatric ward for a couple of months. For Lucie, others are dangerous and untrustworthy and has internalised shame as she always blames herself and takes responsibility for others. Lucie did not have a lot of friends in school. She felt alone and anxious. She self-harmed from a young age on her arms and legs by cutting herself. Lucie feels unworthy, inadequate, and feels responsible for the well-being of others. Lucie never displays emotions of anger and has the key fear of conflict, as she associates anger with abuse. A key external fear is rejection or being harmed, particularly if Lucie raises her disagreements with others. Lucie has a strategy to avoid sharing about herself to others but is considered as the 'listening' friend instead.

Lucie feels overwhelmed by her intrusive memories and/or flashbacks and will resume to avoid them. She often blames herself for being unable to cope when she struggles to suppress her emotions or feels overwhelmed. She will also engage in binge eating when she struggles to avoid her emotions. This results in unintended consequences of affecting her self-esteem, making her feel like a failure and worthless, blames herself for being overweight and as a result, blames her weight for her asthma.

We took the necessary time to do some psychoeducation about PTSD, asthma, and the link with childhood sexual abuse to help Lucie sit with this new information and process it safely. It also supported Lucie’s understanding of why her asthma has triggered such profound traumatic pain. Her protective barriers towards others took away opportunities to develop intimate relationships and made Lucie decide she could never have children as she cannot have close connections with others, nor enjoy sexual experiences. Lucie shared she does not feel any partner would be sexually attracted to her. The attempt to suppress feeling and the inability to sit with emotions also led Lucie to engage in binge eating. Lucie relates to herself as weak, exploitable, and unworthy of compassion. We used the Threat-Focused Formulation template in sessions for visual aid and updated it as the sessions unfolded. A version of this is provided in the Appendix section (Gilbert, 2010).

Throughout our exploration of the formulation, I assessed whether the work would need to focus on reprocessing traumatic memories, or whether to work towards building compassion to de-shame Lucie and empower her by providing her more coping strategies. Although Lucie experiences PTSD symptoms, she has very effective coping strategies in place, and she has a strong awareness and understanding of her symptoms. It became clear that Lucie experiences high levels of shame that require therapeutic attention. We decided to explore the difficulty of cultivating compassion towards herself as it acts as a barrier to use soothing strategies. We related her difficulties to her historical influences and her key external and internal fears and provided a whole understanding of Lucie’s narrative. The goals of therapy were the following: to first explore her fear of compassion, distinguish from shame-based and self-attacking self with compassionate self-correction and engage in interventions that will not only provide useful coping soothing tools, but also indirectly increase her self-esteem, trust in her abilities to cope and decrease levels of shame. We agreed to this collaboratively. We also took the time to explore why cultivating compassion can be an emotional process. We explored potential resistance to this process and prompted to adopt a curious approach rather than a judging critical voice towards obstacles. We normalised this process to avoid for her to despair or feel as a failure should some challenge arise over the course of future sessions.

4. Interventions

I provided psychoeducation regarding the difficulty for some abuse survivors to develop self-compassion. We explored why engaging in soothing exercises can feel threatening and bring relief at the same time, and how this can be understood as a result of her experiences of receiving abuse from the caregiver that would also display caring behaviours inconsistently (Harman & Lee, 2010;2009.) Normalising Lucie's difficulties in engaging in some soothing behaviours was an important step to take. It allowed Lucie to continue to engage with therapy rather than confirm her belief that compassion is not accessible to her and that therapy could not be effective. Psychoeducation decreased the likelihood for Lucie to feel ashamed or guilty for still engaging in some of her current behaviours. Additionally, it helped Lucie understand why she is prone to self-criticism and fearful imagining, which allowed her to make a shift from shaming herself excessively for her difficulties and her ways of currently managing them.

We discussed the differences between internal and external shame, particularly when discussing shameful childhood memories. Other interventions were used to activate the soothing-affiliative processing system (Gilbert & Choden, 2015). This included interventions such as soothing rhythm breathing, progressive muscle relaxation, safe place imagery and developing the image of compassionate other (Rose, McIntyre & Rimes, 2018; Matos & Steindl, 2020). We introduced the interventions when the context was appropriate. For instance, in the process report section, I will discuss a session where we went over the safe place imagery exercise as a response to Lucie feeling distressed due to a particular event that took place over the weekend prior to the session.

5. Outcome and ending

At this moment in time, I have not ended with Lucie yet. However, we do discuss the ending of therapy frequently to give the space to Lucie to raise any concerns. We will complete the GAD7 & PHQ9 scores on the last session. My clinical judgement would be to refer Lucie to a trauma service once we end our sessions. Despite the asthma being connected to her childhood abuse, Lucie's distress is mainly rooted in her traumatic experiences rather than her adjusting to a new chronic health condition. Although we took some time to process how asthma in an adult can be a result of childhood sexual abuse, I believe Lucie would benefit from processing her traumatic experiences with other types of therapies such as EMDR or NET. My judgement is that she has now acquired enough stability and soothing techniques and decreased levels of shame that would allow her to engage in traumatic reprocessing safely.

Process report

Overview

The transcript below is a ten-minute extract of a session where Lucie felt distressed because she received an unexpected phone call from her father after years of having no contact with him. As her father sexually abused her as a child and teenager, this triggered the threat response significantly. In the context of the therapy, this was the 7th session out of 12. This means at the time of this session; we had created a strong therapeutic alliance and developed a collaborative understanding of the formulation already.

At the beginning stage of the therapy, Lucie and I agreed that we would expand sessions for 10 extra minutes if she ever felt too distressed by the end of a session. This was agreed upon as Lucie lives alone and often feared to be left alone after her session if she is feeling too triggered. We also agreed to use the first ten minutes of sessions to check-in and do some grounding interventions before discussing anything too painful. This agreement was a result of Lucie often feeling apprehensive about the things that might come up during her sessions. This caused anxiety prior to sessions, which would make attending sessions difficult at times. As we formulated her tendency for avoidance and the role of avoidance in being a barrier to emotional processing of traumatic experiences but also its impact on physical health, introducing this structure to our sessions was a great part of our therapeutic process.

Furthermore, knowing how we would spend the first ten minutes of the session helped Lucie attend consistently. It provided her with some sense of control and would be aware that we would not jump into anything as soon as the session started. As Lucie expressed how distressed she felt at the beginning of the session, I suggested practising a mindfulness check-in exercise to stabilise Lucie before discussing anything further.

The transcript starts with the last segment of the mindfulness exercise and leans into how Lucie has been coping since the phone call and how she has been feeling ever since. Lucie's ability to name her feelings as 'unsafe' was an important step, as we took some time in previous sessions to define what safety meant and how Lucie recognises when she is indeed feeling unsafe. Lastly, in our formulation, we established that her traumatic experiences left her feeling out of control, and such emotions are often the strongest ones when she feels triggered. During this extract, she explains how unsafe she feels in her own environment and how she feels out of control.

For this reason, I offered Lucie to practice the safe place imagery exercise to not only ground her but also in an attempt to empower her by providing with a space that is not accessible to anyone, even to me.

Due to the distress, the session went over for an extra 10 minutes. As mentioned briefly, we agreed early on that if Lucie ever needed 10 extra minutes to feel grounded and stable that would be appropriate. This flexible boundary helped Lucie not feel a burden for having a longer session when necessary. We agreed we would always use that extra time for grounding techniques or for easing into lighter conversations and check-in on how Lucie is feeling before ending the Zoom call. This is to ensure ethical and appropriate practice.

Transcript & commentary

9:18 – 19.18

T1: Do we have any thoughts going around our mind? … Is it talking in a slow pace? Fast pace? … Do we have a voice? Is it loud? Just notice what is on your mind. Just noticing…Watch how they come and go. They always do. They come and go. Notice if any of the thoughts are connected to some of your feelings or your…sensations in your body…If you can't notice that that's fine…Just…Just taking a moment. Whenever you are ready...just focus on your breath…Do that for as long as you are comfortable for, and when you are ready start wiggling your toes a little bit, and just open your eyes and come back to the room when you are ready.

In this section, I am practising the mindful check-in exercise as a response to Lucie's high distress. The rationale for using this intervention is its ability to cultivate mindful awareness, which is at the core of CFT. It is also a beneficial tool to use with clients who are either resistant to engage with mindfulness meditations exercises (Kolts & Gilbert, 2018) or clients such as Lucie, who struggle to engage fully with longer mindfulness exercises as they can also feel threatening as a result from the threat response being activated when engaging in self-compassionate exercises (Pauley & McPherson, 2010; Lawrence & Lee, 2014.) I felt it was important for Lucie for me to uphold our agreement to take time to do some grounding work before engaging in potentially distressing conversations, particularly when a triggered

event took place. I believe sticking to our agreements also supports the therapeutic alliance as it provides a sense of consistency but also accountability and my commitment from my part towards Lucie (Gilbert & Leahy, 2007).
Lucie has experiences of abuse where individuals use words, but their actions would never match. I have been very aware of this piece of information throughout the entire process of building the therapeutic process with her.

Additionally, I think this exercise also helped her decrease her sense of being overwhelmed in order to take a step back and truly examine what is going on for her and how she is actually experiencing this distress by taking more of an observant position. I still feel this exercise is a really great tool to use with clients who have a certain level of complexity that might create engaging with mindful exercises more challenging and use it as a practice that supports building that rapport with oneself that opens the door to self-compassion on the long term.

[silence] Client is slowly coming back to the room by opening their eyes and composing themselves.

T. 2: How are we feeling? [Inaudible]

C1: Yea, bit less anxious uhm

T. 3] That’s okay

C2: I noticed my thoughts were racing but

T. 4] Yes … Yes, right

C3: Yea…It’s funny I probably don’t on the surface maybe look quite calm

Therapist and Client exchange small smile and laughter together

C4: but underneath my thoughts are racing

T5: Yea, yea I mean it is often the case isn’t it the way we look and keep composure but within there is just so much going on

C5: Yea

T6: What's in our head, sometimes … usually it brings up then very strong feelings and then if we struggle to you know, express them or understand what they are then the body gets tiring you know and then you start feeling tension in your body… you always have this uhm, I guess this connection between the stuff on your mind

C6:]Yea

T7: some feelings you have and then your body. Sometimes we are just more in tune with what we are thinking, some people know first what they are feeling some other people they will say oh my god my body feels tense, you know it is very unique to the individual

C7:]Yea

T8: but this is a good start; because you had so much going on to just tune in and see okay

C8:]Yea

T8: what's happening within…you know, what's bringing…what's actually... what did this actually bring up for you? Because I know you are feeling quite anxious and feel a little better now, but what is this anxiety about, do you know?

C9: Uhm it's kinda like…sigh…I've worked very hard to create this safe space for myself and it feels like that has been invaded

T9: Okay…okay yes

C10: the space has been invaded in some way

T10: Mhm

C11: it just feels…[inaudible] things are unsafe uhm…sigh…like yesterday I was feeling very unsafe and uhm…and I know…I know it is kind of irrational in a way that my dad lives in Ireland but, but I put a tin on my front door just to…and…just…I think… I kept thinking about it and thinking about doing that and then I just did it and it made me feel a little bit better…so…

T11: I think it is understandable, I mean… you know…

C12: Yea

T12: Absolutely to feel quite unsafe, I think… I mean… I think you are quite sensitive right now this is a lot; a lot was brought back so quickly… you know

C13: Yea

T13: you didn't even expect it, it was… it's… it is very painful so you do what you can to protect yourself so if doing things like that are helpful…

My main struggle is sitting with how intense and painful her experiences are. I often used the supervision space to reflect on this. Here I struggled to find the 'right' words to paraphrase back to her. I felt rushed to respond in the face of her pain. My response came from a place of wanting to normalise the pain she has gone through as an abused child. Lucie's case is one that requires for me to stay grounded as I sometimes feel destabilised by her own pain. It triggers my desire to emphasise with her and recognise how difficult even just sitting with such feelings can be.

After careful consideration, I think I should've paraphrased in a simpler and more contained way to her; and perhaps acknowledge how she has been able to label the word 'unsafe', as that in itself is such a shift for Lucie to be able to recognise it, name it and communicate it so clearly. I think it would've been better practice if I had relied on theory more in this instance in order to guide the session rather than coming from a more emotional place due to my own difficulty of containing her at this moment. I believe even simply bringing back the core themes of CFT, such as highlighting Lucie's recent ability to notice her pain for what it is, and her willingness and commitment to turning inwards and showing courage to take the steps to address the suffering would have been better suited as a response. It would have been more appropriate to feedback to Lucie that she was naming an internal experience, and normalising it rather than feeling critical about it (Gilbert, 2015).

C14:]Yea

T14: I mean, why not. If that one specific behaviour helps and it is not harming you or anyone else

In this response, I refer to her history in engaging in self-harming behaviour and to the discussions we had at the start of therapy when we identified what coping strategies were maintaining difficulties or actually worsening her well-being in the long term. Although Lucie no longer self-harms nor engages in substance abuse anymore, we discussed her previous behaviours and reflected on the importance of engaging in coping strategies that do not harm herself or others. My intention here is to confirm to Lucie that there is no need to be critical about the behaviour she engaged in, as it is human to seek behaviours that make us feel safe.

C15:]Yea

T15: You know, there is nothing wrong with that but it's… I guess it is more about how do I…how do I feel a little bit more okay because I know right now, I am feeling more fragile.

My attempt here was to shift the focus from an external coping strategy to affect, and bring awareness to one's internal states when we know we feel vulnerable/or are going through a difficult time, and to slowly take the habit of checking-in with oneself, naming affect and develop compassionate soothing ways of relating to oneself during such times that can alleviate distress.

C16:] Yea

Knowing Lucie from a few sessions now, I felt from her response she was not feeling ready or willing to go into more in-depth conversations, or I have not been clear enough in my attempt of trying to aim to discuss affect more. So, I proceeded lightly by asking about her coping strategies instead, as that is relevant information to gather regardless.

T16: How have you been coping I guess, ever since that happened? Even since you've felt so triggered? What have you been doing….What else have you been trying to do to feel okay?

I aim to identify what other coping strategies she has been engaging in to assess not only what she has been doing, but whether Lucie has felt critical about how she has been coping since this is a pattern that surfaces for her. As we formulated, she has a tendency of being

critical about not only her feelings but how she copes with them, which only worsens her sense of self-worth, lowers her mood and increases anxiety (Kolts, 2016.) Here I intend to assess whether this has also been playing out and determine whether Lucie has been cultivating some self-compassion throughout this process, or whether that remains challenging for her to implement when triggering events arise in her day-to-day life.

C17: Uhm, actually because I got my…my depot injection last week and also my asthma injection it made me very tired so over the weekend I did do a lot of sleeping during the day uhm and I did that too I think regardless of whether I got the phone call or not you know I think I needed to do that so uhm, so I did a lot of that and uhm

C18: Sigh

C19: I did spend a little time in the garden I think on Saturday uhm just sat out and because I was…I think it was more sunny on Saturday uhm, and I didn't go to any of my zoom groups. Again, I don't really feel up to talking much uhm, and just then earlier today I went on a zoom group, but I just went on to listen, I did not actually participate so… I was just there really uhm

C20: Sigh…

T17: But that's okay. Sometimes, some days we just need to show up and that is enough.

I am attempting to normalise Lucie's feelings and behaviour. We explored her tendency in previous sessions how, unless she engages as she believes she should be in tasks or with others, she becomes very critical about herself. In this response, I try to indirectly remind Lucie that it is okay to not always be able to deliver at our best and to model a compassionate self to her (Liddell & Goss, 2017.) However, I do feel my answer is rushed and should have given Lucie more space to elaborate on her answer. I suspect this is due to my rushed desire to un-shame Lucie as I am aware of her sensitivity to it.

C21: Yea, yea

T18: [Inaudible] You showed up. If listening was enough, then it was still a beneficial, you know, way of spending your time

C22: Yea, yea

T19: It happens, absolutely

[Inaudible] Overlap between client and therapist due to Zoom glitch –

T20: Oh, keep going, no, no, I'm sorry, Zoom problem

Client and Clinician share a laugh about the misunderstanding due to Zoom technical issues as it has happened before in other sessions.

C23: I don't know what I was going to say there so it's fine

T21: Are you sure?

C24: Client nods yes

T22: I was thinking because you feel like your space has been kinda invaded we could do kind of an imagery exercise because that is a space that nobody will ever be able to invade from you

In this response, I used my meta-skills to observe the situation and make a clinical judgement as to what intervention would be beneficial for Lucie at this moment in time. It has been determined by evidence-based research that a core competence of applying CFT is to practice flexibly within this framework and respond to the client's needs as they arise during sessions (Liddell & Goss, 2017.) The safe place imagery exercise is an intervention practised in CFT due to its benefit in supporting clients to develop and/or strengthen their soothing systems (Kolts & Gilbert, 2018.) The rationale behind my decision to use a safe place imagery exercise stemmed from Lucie's distress located in feeling out of control and powerless in her environment. My instinct was to introduce this exercise to ground Lucie but also to give her something that could feel is hers to empower her, hoping that it would soothe the distress that she currently feels as if she has no space of herself.

C25:]Yea

T23: If you want we can do that a little bit now so it can help you, something that is quite relaxing as well so it might be something quite helpful for you today especially if you are a bit

more passive so if you are feeling a bit too raw to engage as the usual that's not a problem then we can def do that it might reassure as well the sense of 'people can take things from me, this person can still… ' even though like you said, he's not, he's not here, he's not coming to the door tomorrow, probably not but the feeling is different. This is the difference isn't it between what I know, what is 'rational' and emotions, and emotions are important. So, if you want I can definitely run an exercise with you now, so you can really just have a space that no matter what, nobody can take that away from you and when we are feeling very, you know, raw there's a space you can always access, if you choose to access it.

Lucie started to cry silently. Therefore, I decided to take my time to paraphrase in order for Lucie to have her space to stay in touch with her emotions. I intended to deliver empathy and demonstrate to Lucie that we can explore a way that could help soothe this painful situation, which would also answer to her current need to be a little bit more passive. I hoped that by choosing interventions that would fit the current moment would make her feel seen, and show that we can still make use of this sessions no matter what state she is in. I do believe I could have added more theory in this response. Particularly when I feedback to Lucie her experience of 'knowing rationally' that there is no actual threat but at the same time, feeling and reacting as if she is in danger. I could have brought the core rationales of CFT regarding the complexity of our brains and of survival instincts. Even if we have discussed them before, I think this was a perfect opportunity that I could have grabbed to reinforce that concept (Gilbert, 2014).

C26: Yea (tears coming down the face of the client)

T24: Completely your own. You design…you choose when you think about it, you don't need to share it with anyone this is your own and it can calm a lot, especially if we are feeling this raw and the environment, we are in suddenly does not feel like it is enough

C27: Yea, because I think at the minute I feel really stuck

T25: Yea

C28: I don't know how I feel just…I don't know how to…. express what…what's going on for me…uhm…it's that feeling of being frozen, in a way I think

T26: The freeze mode…that's okay

Reflective Discussion

A. Therapeutic Alliance

I strongly believe that this piece of work demonstrated my ability to work flexibly with clients and within a modality. I discovered that practising in this manner fits with my values, highlighting that I have preference to work with integrative frameworks. I believe the context of the pandemic and having to deliver therapy over Zoom tested my ability to work creatively to ensure safety. I noticed I emphasised on safety even more. We used the chat room for Lucie to type when she felt too overwhelmed to express herself, or to type in her safe word when she felt she was dissociating too much. We also established a visual code, so Lucie could show me on zoom if she felt she was going to have an asthma attack during the session. She often loses the ability to speak due to shortness of breath. Exploring such ways of keeping her safe and collaborating on setting the ground rules of therapy was crucial to do any therapeutic work. Although I have always known from the theory of the importance of the therapeutic alliance, I believe this is the strongest I have ever built.

Another aspect I believe contributed to the alliance was that I brought more of my authentic self to the sessions. I believe this stems from being a woman and being able to connect with certain issues she experienced (such as the pressure of the ideal body for instance) Although I sometimes struggled to contain her emotions due to this closeness, I also believe it strengthened the relationship. It allowed me to use supervision to reflect on matters such as: how to discuss body image between two women who do not share the same body type but yet experience the same societal pressure. On a professional level, this reinforced my skills to work creatively and identify what my therapeutic style is. On a personal level, it also made me reflect about my own identity as a woman, and how much this influences my therapeutic work. This overlap between personal and professional development in this case was incredibly valuable.

B. Using CFT in the context of child sexual abuse and asthma

My personal experience of using CFT within this context made me reflect of the usefulness of the flexibility of the model. It provided the opportunity to work creatively and explore all relevant factors involved in the complexity of the client. Exploring feelings of shame and how they connect with different aspects of Lucie helped work with an evolving formulation and indirectly de-shame her experiences through that process. The core values of the modality allowed me to explore systemic issues, her PTSD symptoms, and the way she relates to herself flexibly throughout our sessions.

Relying on the core values of the modality allowed us to continue the exploration of Lucie's difficulties, particularly when it came to work on her soothing system and explore the challenges she encountered there, by linking it to the formulation but also in the understanding of how it can feel overwhelming due to the connection between the threat and soothing system. I strongly believe CFT was the right decision to use to work with Lucie, as it allowed us to work flexibly and rely on the CFT framework to explore a multitude of issues and identify how they relate to one another and maintain the presenting problem.

C. Binge eating and childhood sexual abuse

This brings me to reflect on binge eating behaviours and childhood sexual abuse. It is well-known that eating disorders have a strong link with sexual abuse (Moyer, DiPietro, Berkowitz & Stunkard, 1997). A key factor in my therapy with Lucie was to not always discuss her difficulties in relations to her asthma, but also explore other important factors. In our discussions, we also made space to discuss this link between eating disorders and abuse. I prompted Lucie to access services for her binge eating. This process helped de-shame her, as she initially understood her behaviour as being responsible for her weight gain, and as a result her asthma. The shame she felt about her weight, about her bingeing, and about how unsafe she feels in a world ruled by men was incredibly important to discuss.

Although not at the forefront of the case, such other factors are important. We could not address everything due to the limitations of the service, but I believe the acknowledgement of the complexity and multilevel factors involved were a core component that also reinforced our therapeutic alliance. Although I had to make sure we would not 'deviate' too much, I believe I learnt to step out of that fear and truly leaned on my Counselling Psychology core values, which to me are founded in our ability to consider each aspect of someone; to see and develop a holistic understanding of the individual. I believe that the emphasis on the therapeutic alliance and modelling a safe and compassionate relationship was the key to this case.

D. Recommendations

As Counselling Psychologists work in health psychology services too, I believe some health-related core components should be added in training programmes. According to Chwalisz & Obasi (2008), the field of Counselling Psychology is of extreme importance in health psychology as the approach is rooted in prevention, wellness, developmental and holistic towards individuals (Raque-Bogdan, Torrey, Lewis & Borgers, 2013).

The biopsychosocial model used within health psychology gives the perfect opportunity for counselling psychologists to use their skills to contribute to the field. After working in two health psychology services, the way I make sense of Counselling Psychology in health is that it is extremely needed and beneficial. And although I have enjoyed 'learning on the job', I now align with the notion that health should be discussed within counselling training programmes. I believe there is a need for a stronger alliance between health and counselling psychology. This would allow us to work more holistically between teams and improve the quality of care we provide to clients.

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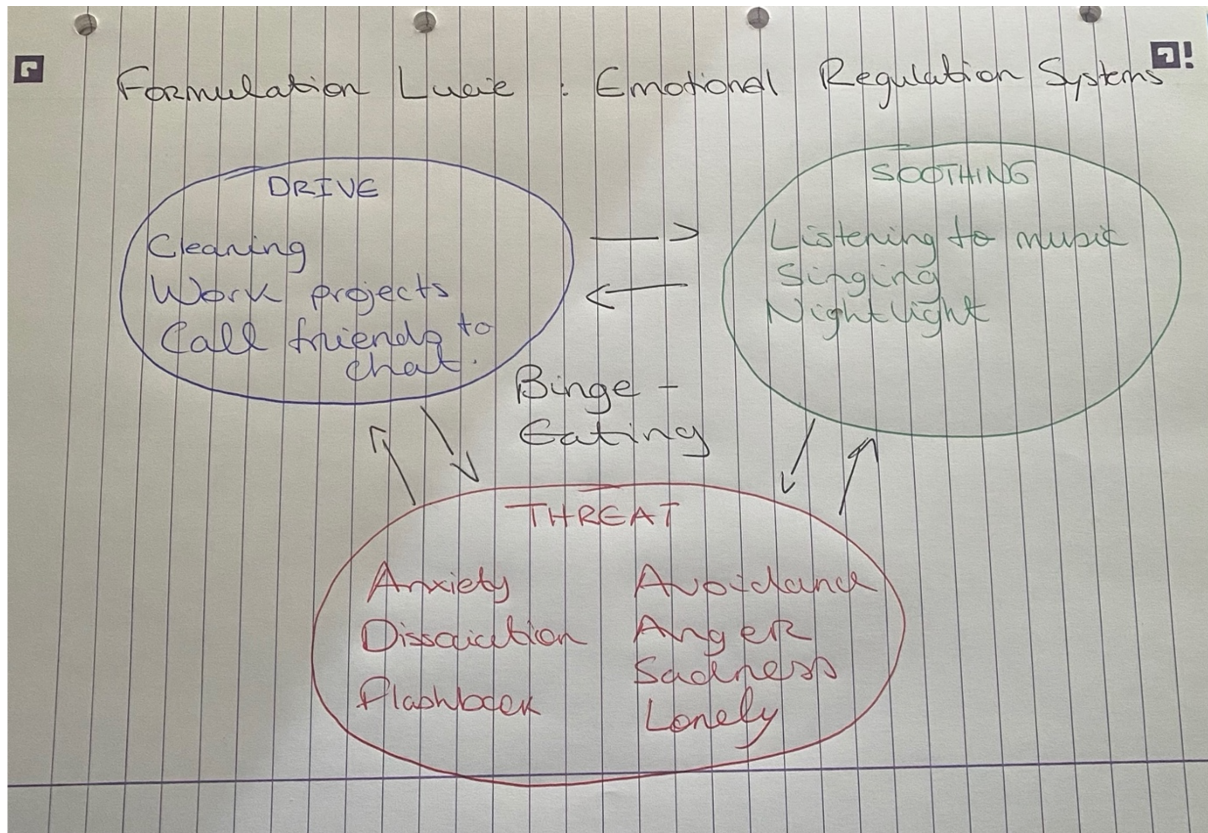
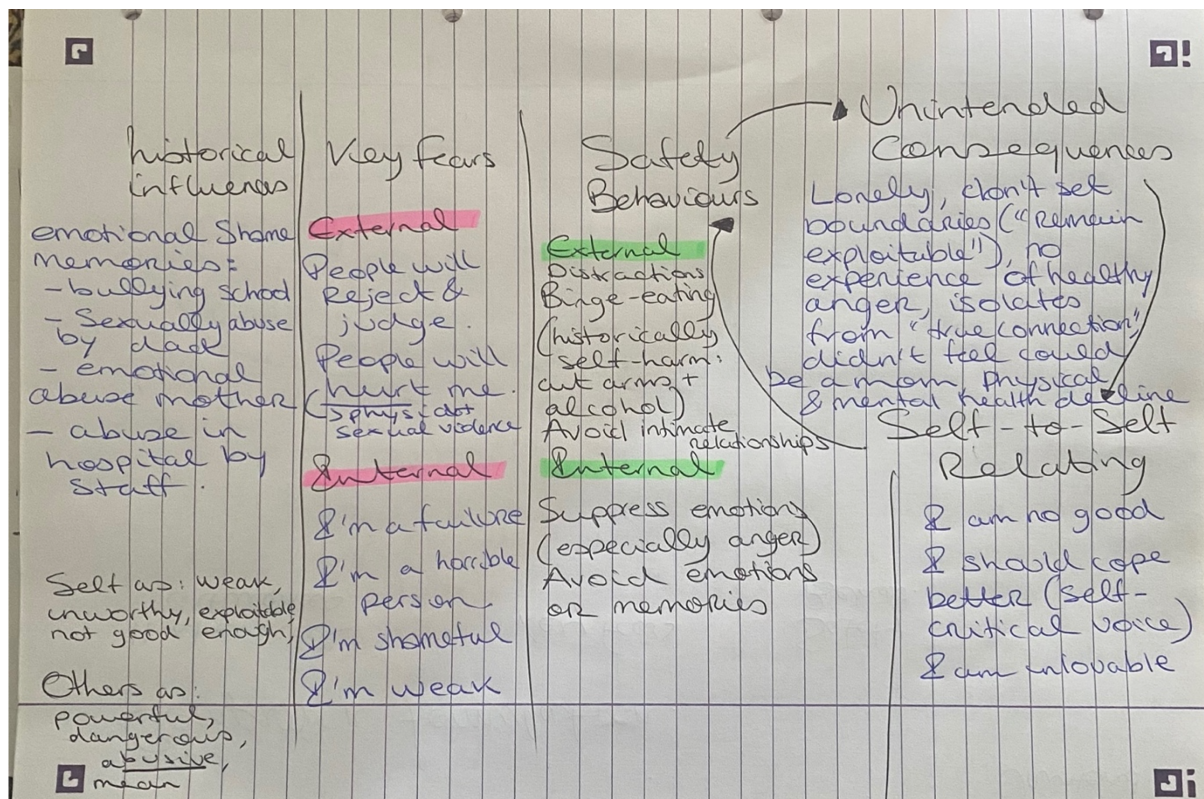
Appendix

Figure 1. Formulation: Emotional Regulation Systems



This formulation was developed with Lucie at the beginning of our therapy. Her binge eating behaviour was a factor that she was not sure where to place, as on the one hand the urge to eat appears due to her highly activated threat system, she feels like an impulse because she is "doing something" and she "feels" appeased for it, even though the behaviour is not helpful as guilt and shame appear soon after. At the beginning of our therapy, we agreed to live it in the middle to remind Lucie of the complexity of some phenomena and the fact that we can make sense of them in our sessions, once we have gained a better understanding of binge eating behaviours and her other coping strategies. For this reason, it stays in the middle of the formulation.

Figure 2. Compassion Formulation



This formulation was written after the initial formulation in Figure 1. In this formulation, it was easier for Lucie to locate her binge eating than in the other formulation. Therefore, we continued to use this formulation format for the rest of the sessions. This was because this format was easier for Lucie to understand, and she engaged with it as we wrote/updated our formulations as we went along. However, we sometimes built on the first formulation to try to update it, and to emphasise the relationship between the three systems and the complexity of the human mind.

Figure 3. Updated formulation.

The image below shows a diagram we drew together to understand how we can have feelings about what we are feeling or thinking, and how these feelings can maintain or worsen the experiences of these internal states by the way we respond to them. This was done because Lucie was very self-critical of herself, and this was used to demonstrate how her self-critical voice was causing more damage than it was helping. This allowed us to explore how it would be to introduce a compassionate voice instead and how that might change what we drew together.

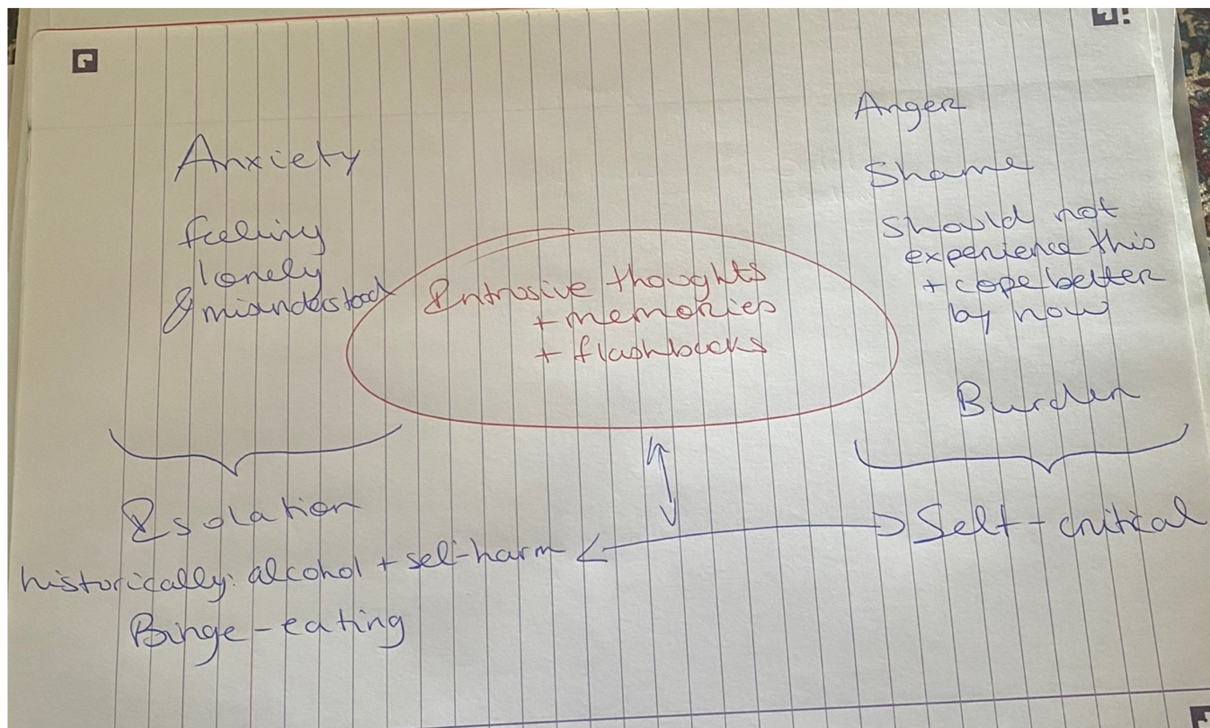
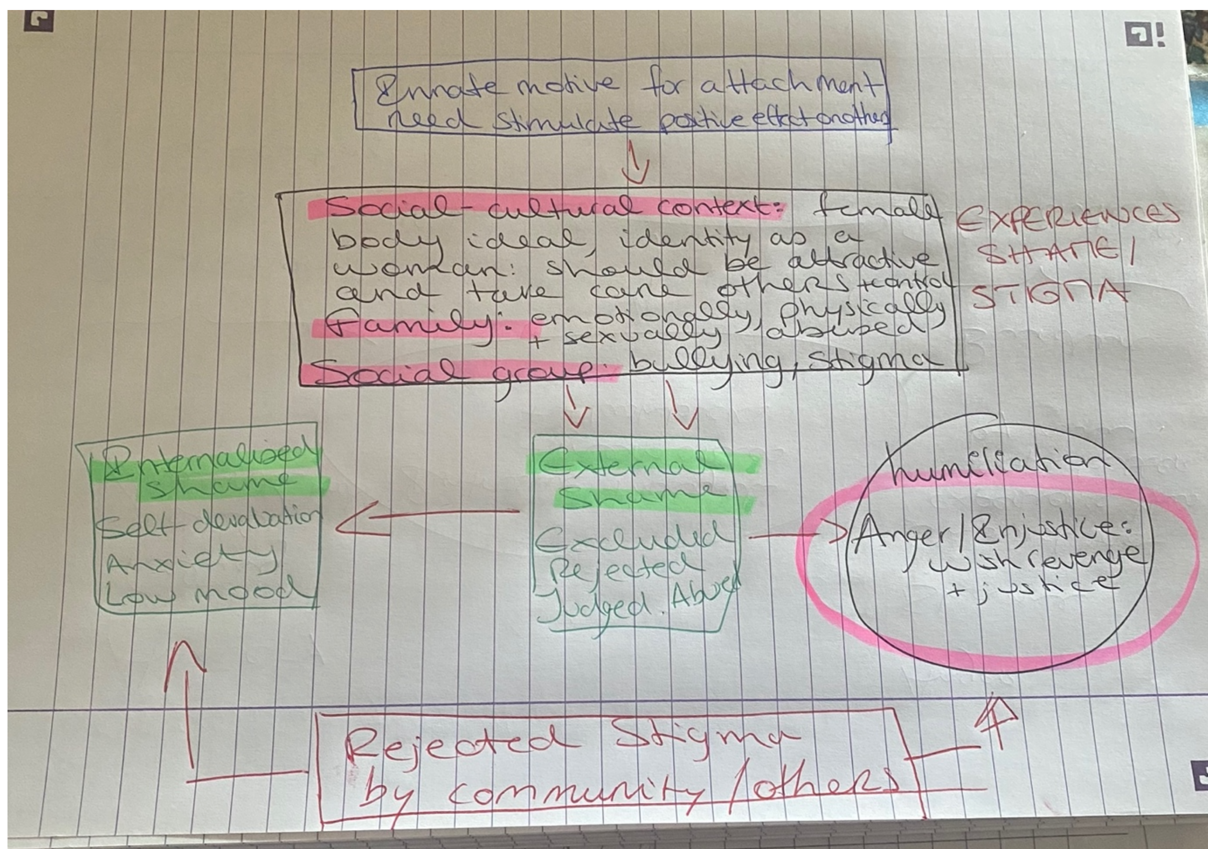


Figure 4. Formulation of shame



We used this format to explore experiences of shame in the sessions, in particular to work on internal and external fears and learn how they relate to each other and to other factors. It was also useful in terms of normalising attachment seeking and why we are sensitive to feelings of belonging as human beings.

PART III - Sexual Perfectionism mediates General Perfectionism and Female Sexual Functioning in Women with Anorexia Nervosa

A submission for the Journal of Sex Research

About the authors

Miss Pauline Chiarizia is a doctoral student who conducted this research as part of the requirements to complete the Professional Doctorate in Counselling Psychology at City, University of London. The work was supervised by Dr Angie Cucchi, who is a Charted Counselling Psychologist registered with the Health and Care Professions Council (HCPC) as well as with the BPS. She is also a senior lecturer in Psychology and Counselling. If you wish to contact us about the study, please use the contact details below.

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Additional note: City Health Care Partnership CIC, Breathe Therapies, Eating Disorder Association - NI and NIWE Eating Distress Service supported this study.

Unstructured abstract

The study investigated whether sexual perfectionism mediates perfectionism and sexual functioning (SF) in women with anorexia nervosa (AN). 378 women (aged 18 years and older) completed an online survey: 164 of whom had AN and 214 were healthy controls. Participants completed the Eating Disorder Examination Questionnaire, the female sexual functioning index, the Frost multidimensional perfectionism scale, the MSPQ, and the female sexual distress scale. Path models showed that sexual perfectionism (SP) mediated between perfectionism and SF, with high sexual distress levels in AN. The role of sexual distress in relation to SP and SF in AN is highlighted.

Abstract

Objective: This study investigated whether sexual perfectionism (SP) mediates between perfectionism and sexual functioning (SF) in women with AN. This hypothesis stems from evidence highlighting the importance of exploring psychosocial factors that impact on SF in AN. As perfectionism is linked to AN, and evidence recently explored SP in association to SF in women, it is crucial to determine whether this clinical population may be concerned with SP in relation to SF.

Method: Participants (aged 18+) (N=378) were recruited through an independent social media research account, but also via the social media platforms of City Health Care Partnership CIC, Breathe Therapies, Eating Disorder Association - NI and NIWE Eating Distress Service, who supported the study. 164 women with AN and 214 women in the healthy controls completed an online survey with the following measures: the Eating Disorder Examination Questionnaire (6th), the female sexual functioning index, the female sexual distress scale (Revisited), the Frost multidimensional perfectionism scale and the MSPQ. Path models were conducted for each group to compare results.

Results: SP plays a mediating role in the indirect association between perfectionism and SF in women with AN; an indirect association that is also mediated through the component of sexual distress. Self-oriented SP showed to play a mediating role, whereas partner-oriented SP played no mediating role between perfectionism and SF. Partner-prescribed and socially prescribed SP only play a mediating role between perfectionism and SF through the component of sexual distress in women with AN.

Discussion: These findings suggest that SP should be considered in association with SF. They demonstrate the importance of understanding SF in the context of sexual distress in women with AN. The data sensitises practitioners to consider these themes in their clinical work with clients who report difficulties with SF.

Keywords: anorexia nervosa, eating disorders, sexual functioning, sexual distress, perfectionism, sexual perfectionism

Introduction

Sexual functioning (SF) in women with AN has been explored in association with experiences of trauma, with little attention paid to other psychosocial factors that may contribute to this phenomenon (Dunkley, Gorzalka & Brotto, 2016). Those difficulties with SF in this population are common but the understanding of the biological and psychosocial themes that may impact on this phenomenon remains limited (Price et al., 2020). 80% of women reported having such difficulties, including women with AN, with evidence stressing they experience higher levels of difficulties with SF than women without any eating disorder (Cassioli et al., 2019).

One of the key factors of AN is perfectionism, which has been defined as a *'tendency to set high standards and employ overly critical self-evaluations'* by Frost and Marten (1990) (p.559, Dahlenburg, Gleaves & Hutchinson, 2019). Perfectionism is one of the main risk and maintenance factors for AN, also impacting on the likelihood of relapse after treatment (Lloyd, Yiend, Schmidt & Tchanturia, 2014). Indeed, research has shown interest in determining the effectiveness of targeting levels of perfectionism in AN (Tchanturia, Larsson & Adamson, 2016) and integrating partners in the recovery process (Bulik, Baucom, Kirby & Pisetsky, 2011). In fact, interpersonal relationships are one of the most important factors contributing to a positive QoL for women with AN (De Ruysscher, Annicq, Vandevelde & Claes, 2015;2016) and they have expressed a desire for positive physical intimate experiences (Newton, Boblin, Brown & Ciliska, 2006). These findings align with theoretical understanding of the importance of having a positive sense of one's physical intimate experiences, as they are strongly correlated with the overall QoL (Dunkley, Gorzalka & Brotto, 2016).

Evidence of the impact of SF on women's QoL has accumulated over time, with studies emphasising the psychosocial factors that may be involved in the phenomenon of female SF, rather than reducing it to a biological framework (Panahi, Anbari, Javanmardi, Ghoozlu & Dehghankar, 2021; Bronner, Elran, Golomb & Korczyn, 2010). Indeed, the initial exploration of SF is found in the work of Masters and Johnson (1970), who observed the physiological aspects of sexual behaviour and led to the creation of a theoretical model that emphasised the physiological components involved (Masters & Johnson, 1970). However, the literature that has critically reflected on the work has highlighted the lack of inclusion of psychological components in the model (Hayes, 2011).

The conceptualisation changed with the work of Rosemary Basson, who proposed a circular model of female sexual response, focusing on both physical and psychological factors. For example, a female who wants to have sex with her male partner may focus on the sexual stimulation he provides and, if this is satisfactory, her sexual desire and arousal may increase and lead her to further engage in sexual activity. Thus, motivations to engage in sexual experiences can be influenced by factors such as the level of intimacy with the partner, the desire to feel attractive or even loved, or to try to reduce feelings of guilt due to infrequent sexual experiences (Basson, 2005). These examples of factors at play highlight the need to move towards a biopsychosocial understanding of female SF and to better identify the range of psychosocial factors associated with it.

Female sexual problems are classified by the American Psychiatric Association, but because of the history attached to early psychoanalytic and psychiatric work, feminist criticism flourished. The authors expressed that female sexual difficulties should not be reduced to a mere psychiatric disorder but should also be classified as medical problems. Indeed, some authors stated that *"not all female sexual complaints are psychological*" (Berman, Berman & Goldstein, 1999). However, other feminist critics emerged and considered the process of categorising female SF because of the great success of Viagra (Angel, 2012) and argued that ignoring other psychosocial factors concerning female's SF would be an inappropriate understanding of the complexity of the phenomenon.

Given these arguments, changes within the DSM-V have involved shifting the understanding of SF from a linear model to a circular model, in which sexual desire is no longer seen as the starting point for the process of sexual responses nor as the main reason for engaging in sexual activities (Ferenidou, Kirana & Athanasiadis, 2017) and now recommends considering the levels of distress associated with SF difficulties. The World Health Organisation emphasises the importance of incorporating psychosocial factors in understanding SF. Individuals should not be reduced to their physical symptoms, but rather bring in other considerations such as whether they feel satisfied and fulfilled by their current physical, emotional, and social experiences of their sexual life (World Health Organisation, 2006, p. 35). The work of Öberg and Fugl-Meyer (2004) illustrates this by showing that 45% of their participants did not experience distress despite reporting low levels of interest and frequency of orgasm (Öberg & Fugl-meyer, 2004).

Data has highlighted that some women report that they are not satisfied with their ability to reach orgasm, but that this does not cause significant psychological distress and does not negatively impact their overall level of satisfaction with their sexual life (Basson et al, 2001).

SF cannot be understood without the context of the individual and whether it causes psychological distress. Moreover, the literature has been interested in exploring psychosocial constructs and their possible implications for understanding female SF. Snell (2001) developed a multidimensional model of SP that aims to assess perfectionist tendencies regarding the self as a sexual partner. Because of the evidence that perfectionism can have a significant impact on many areas of a person's life, the research examined whether perfectionism might also be one of the potential multidimensional psychosocial components worth studying in relation to sexual well-being (Snell, 2001). This model consists of four components: self-oriented, partner-oriented, partner-prescribed, and socially prescribed SP (Stoeber & Harvey, 2016).

Self-oriented SP refers to people who set unattainable standards for themselves as sexual partners. Partner-oriented SP, on the other hand, refers to the high expectations individuals have of their sexual partners. Partner-prescribed SP refers to the beliefs that individuals hold about the expectations their partner may have of them, while socially prescribed SP refers to individuals who set unattainable expectations for themselves but are rooted in their understanding of what society expects of them as sexual partners (Stoeber et al., 2013).

An important notion to consider is that each woman may have a different view in terms of what needs to be perfect when it comes to being a sexual partner. Some women may be perfectionists in terms of their ability to achieve orgasm, while others may have unrealistic expectations in terms of sexual competence, for example (Kluck, Hughes & Zhuzha, 2018). Moreover, self-oriented SP was associated with the tendency to blame oneself for sexual difficulties; that partner-prescribed SP had an impact on SF with respect to arousal and lubrication, and that partner-oriented SP also had an impact on women's levels of sexual satisfaction and SF. Although the topic of SP is recent and requires further exploration, current findings on the topic encourage the exploration of SP and its association with SF. Furthermore, SF is a key factor in QoL, which can also be compromised by mental health disorders (McMillan et al., 2017).

As many mental health disorders have an early onset, usually during adolescence or young adulthood, this can influence sexual identity development and healthy SF (Impett, Schooler & Tolman, 2006). AN has traditionally been considered a condition that occurs during puberty, focusing on the biological, physiological, and social changes that occur throughout this developmental stage (Kimura, Tonoike, Muroya, Yoshida & Ozaki, 2007).

The work of Eddy, Novotny and Westen (2004) was the first to link sexuality, personality and AN; they argue that other studies have suggested that sexual difficulties can be seen as a by-product of AN, with some evidence that dietary restrictions, particularly starvation and hormone depletion, have an impact on libido.

Biological factors such as low body weight and hormonal factors were the focus of early explorations of sexuality and AN; but sexual difficulties are observed even after weight recovery, suggesting that the difficulties are more complex than simply the result of biological factors. Despite methodological limitations, the results suggest that perfectionism, being such a crucial component of AN, may be relevant to sexual difficulties in this clinical population (Eddy, Novotny & Westen, 2004). The topic of sexual difficulties in women with AN has begun to receive some attention since the 2000s, with evidence showing that they engage in intimate relationships, its importance on their QoL, and have an interest in having more emotionally and physically positive intimate relationships.

Considering the emerging evidence linking SP and SF in women, and the difficulties that women with AN experience in their SF, as well as the strong evidence of perfectionism in this clinical group and its impact on various aspects of their QoL, it can be hypothesised that sexual perfectionism may mediate the relationship between perfectionism and SF in women with AN.

Methodology

Ethical Approval

This study is compliant with the Code of Human Research Ethics from the BPS and obtained ethical approval by the Department of Psychology Research Ethics Committee from City, University of London in June 2020 (Reference: ETH1920-0944).

Participants and Recruitment

The inclusion criteria consisted of women being over 18 years of age who had been diagnosed with AN by a registered health professional (clinical group) or women with no previous mental health diagnosis (healthy control group).

To distinguish between participants in each group, they were asked whether they had been diagnosed with AN by a registered health professional and were advised not to participate if they had another mental health disorder on the information form. Indeed, participants were not permitted to participate if: they are not of 18 years old or above, have never received a diagnosis of AN by a licensed registered healthcare professional or experience suicidality, or

any other mental health difficulty at the time of completion of the survey. Potential participants were invited, via social media platforms, to complete an online questionnaire. The research material was also shared on the social media platforms of the following organisations that supported the study: City Health Care Partnership CIC, Breathe Therapies, Eating Disorder Association - NI and NIWE Eating Distress Service. Participants were given all the information necessary to make an informed decision about their participation, knowing that their participation was voluntary and anonymous. They gave their consent online before starting the questionnaire and were aware of the possibility to withdraw from the study by closing the web browser.

Target sample size

An a priori analysis was carried out, showing that it would be preferable to have 308 participants in the clinical group and a minimum of 200 participants for the healthy control group. The observable variables considered were age, diagnosis of AN, BMI, education level, employment status, relationship status, menopause, and medication, while the latent variables considered were perfectionism, SP, sexual distress, and SF. The predicted effect size was 0.6, suggesting a medium level, derived from studies of the association between perfectionism and AN and the relationship between SP and SF in the general population.

Measures

Eating Disorder Examination Questionnaire (6th edition)

The Eating Disorder Examination Questionnaire (EDE-Q) is a self-reported questionnaire regarding eating psychopathology and is scored on a 7-point scale. It entails 28 items with four subscales: Shape Concern, Weight Concern, Eating Concern and Restraint. Empirical evidence determined that the scale meets appropriate standards in terms of validity and internal consistency (Luce, & Crowther, 1999). The data from Kelly and Karter (2014) indicates the following Cronbach’s alpha values: .89 for shape concern, .81 for weight concern, .88 for eating concern, .83 for restrict and an overall score of .96 (Kelly & Carter, 2014). It is essential to emphasise that the inclusion of this measurement tool is not intended to diagnose participants, but simply to be used as a screening tool to identify participants who belong to the clinical or healthy control group.

Frost multidimensional perfectionism scale

This present study is based on a multidimensional approach to understanding perfectionism and uses the Frost multidimensional perfectionism scale to assess perfectionism. The scale is a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) and is constructed by four subscales: organisation, worry about making mistakes, parental expectations, and

personal standards. This scale was developed as the conceptualisation of perfectionism shifted from a unidimensional to a multidimensional approach and has been frequently used within studies exploring perfectionism in eating disorders (Slof-Op't Landt et al, 2016). The study followed the recommendation of previous studies to interpret percentiles above 90 as a sign of dysfunctional perfectionism, and high overall scores as problematic levels of perfectionism.

MSPQ

The MSPQ is a Likert scale ranging from 1 ‘not at all characteristics of me’ to 5 ‘very characteristic of me’, and is composed of four components: self-oriented, partner-oriented, partner-prescribed and socially prescribed SP (Stoeber & Harvey, 2016). The scale has been shown to have good reliability, with an alpha score for all subscales of >.84 (Stoeber, Harvey, Almeida & Lyons, 2013; Kluck et al, 2018).

Female Sexual Functioning Index

The female SF Index is a self-report measurement tool that assesses various aspects of female SF such as desire, arousal, lubrication, orgasm, satisfaction, and pain (Rosen et al., 2000; Wiegel, Meston & Rosen, 2005). The scale includes responses for "no sexual activity" in some items. This may compromise the results by giving lower scores for women who have not been sexually active in the last four weeks compared to women who have. These responses were treated as missing values, and mean scores were calculated instead, as recommended by previous studies (Stoeber & Harvey, 2016). This measure has been used in previous studies of SF in eating disorder and has shown good reliability with an alpha coefficient of 0.82 (Dunkley, Gorzalka, & Brotto, 2020, Rosen et al., 2020). The use of this measure in the present study was not designed as a diagnostic tool for sexual dysfunction, as this is not the purpose of the study.

Female Sexual Distress Scale – Revisited

The self-report Likert scale by Derogatis and colleagues was developed to assess personal sexual distress and was revised in 2008 by adding a 13th item to increase sensitivity. The scale has been shown to achieve a specificity of 76.6% in terms of its ability to detect the presence or absence of difficulties in SF (Ter Kuile et al., 2006), and the present study found an alpha coefficient score of 0.95, highlighting the relevance of including this measure (Ghassami, Ashghari, Shaeeri, Soltaninejad & Safarinejad, 2014).

Statistical Analysis

Data Cleaning

Missing values

A total sample of 426 participants was initially collected, but 43 cases with less than 95% of data were identified, bringing the total to 383 participants. In addition, as mentioned above, 'no sexual activity' responses on the SF Index were also treated as missed values, by calculating mean scores (Stoeber & Harvey, 2016).

Outliers

Five cases of outliers in the age variable, namely participants over 55 years of age and two participants over 60 years of age. The decision was made to exclude participants from the data as it would be inappropriate to generate further results. The absence of data would not allow the analysis to support a good understanding of participants in this age range and could have a negative impact on the overall results (Delice, 2010). Five participants were therefore excluded, giving a total of 378 participants. Other outliers have all been managed by using the recommended equation Z = (z x s) + X - to replace scores (Field, 2018).

Principal Component Analysis (PCA)

PCA was carried out to identify whether it is possible to exclude certain variables that are less relevant to the primary hypothesis. This was done because of the work with large scales that involved many variablesIt was considered possible to work with a more concise dataset, able to capture the essence of the research question. However, the scree plot result, the eigenvalues and the correlation matrix of the components reported in the appendix in Tables 1, 2, 3 and 4 underline that extraction is not appropriate in this case as it would risk distorting the studied phenomenon and therefore the results would not accurately contribute to the current literature.

Normality

To test for normality, the sample size (N=378) and the objective of performing a structural equation model, more specifically path analysis, were taken into consideration. Kim (2013) recommends referring to histograms and boxplots rather than relying solely on Kolmogorov-Smirnov or Shapiro-Wilk tests when the sample size is greater than 300 (Kim, 2013). They also recommend that the cut-off score for a sample size above 300 for skewness can be between -2 or +2 and -7 and +7 for kurtosis (Kim, 2013). Brown (2006) suggests that skewness scores between -3 and +3 and kurtosis scores between -10 and +10 are considered acceptable values in the context of using structural equation models (Brown, 2006). According to such recommendations, normality was assumed.

Independent T-Tests and Pearson Correlations

To establish that the clinical group differed from the healthy control group, independent t-tests were performed, followed by Pearson correlations to identify whether the association between the variables was statistically significant before path models were performed.

Multicollinearity

As the Pearson correlation scores indicate strong significant correlations between them, a multicollinearity test was performed to ensure that there were no issues before running the path analysis models. All VIF scores were below the threshold of 2.5 (Johnston, Jones & Manley, 2018;2017;) indicating no multicollinearity issues.

Path analysis

Path analysis is known for its ability to examine multiple variables and their associations with each other. It is essential to stress that path analysis does not assume causality or determine whether the model is correct. Path analysis is best viewed as a means of 'testing' a model rather than adopting a 'model building' approach, which means that it only generates a structural model and does not involve a measurement model as it uses measured variables rather than other types of structural equation models that work with multiple regression or factor analysis.

Model fit statistics cannot be generated and are not reported in the results sections. In response to the literature highlighting that exploring alternative theoretical models is considered good practice in structural equation model analyses (Morrison, Morrison & McCutcheon, 2017), combined with the suggestion to understand the complex phenomenon of SF in association with levels of female sexual distress (American Psychiatric Association, 2013), the sexual distress variable has also been linked to the question of whether it plays a role in the potential mediating relationship between perfectionism, SP and SF. Path models for each domain of the SP were conducted and compared between the clinical group and the healthy control group. Therefore, a path model for self-oriented, partner-oriented, partner-prescribed, and socially prescribed SP was conducted separately for the two groups.

Results

Participants

Table 5. Descriptive Statistics

	Clinical Group			Healthy Control Group		
	N	Mean	Std. Deviation	N	Mean	Std. Deviation
Age	164	3.2	1.43	214	2.8	1.24
Education	164	2.9	1.04	214	3.6	.99
Employment status	164	2.9	2.13	214	3.5	2.31
Relationship status	164	2.6	1.57	214	2.4	1.43
Diagnosis	164	1.0	.00	214	2.0	.00
BMI	164	2.3	1.37	214	2.3	.88

Table 6 presents the demographic scores in percentiles in the Appendix.

Eating Disorder Examination Questionnaire: Clinical group Scores

75.6% of the women in the clinical group had clinically significant scores on the Eating Disorder Examination Questionnaire. Specifically, 61% of the clinical group showed significant clinical scores on the restrict subscale, 79% reported significant clinical scores on the shape subscale, 84.8% reported significant clinical scores on the weight concern subscale and 67.7% of the clinical group scored clinically significant scores on the eating concern subscale.

Sexual Functioning and Sexual Distress Scores

8.5% of the women with AN reported difficulties in their SF, and 91% of them scored above the cut-off point of 26.5, indicating that they did not have problems with SF. However, 81.7% reported high levels of sexual distress. In the healthy control group, 12.6% of people had difficulties with SF, 87.4% of them scored as having no problems in this area, but when looking at sexual distress, 51.6% scored high.

Perfectionism and Sexual Perfectionism Scores

Findings showed that 10% of the women AN had clinically dysfunctional perfectionism, with 50% reporting problematic levels of perfectionism. In the healthy control group, 10% also reported clinically dysfunctional levels of perfectionism. They also scored higher than the clinical group on SP, with 25% having overall scores above 24.75, whereas in the clinical group only 25% scored above 20. However, the clinical group had higher scores on partner-oriented SP, with 50% scoring above 24, while 50% of the healthy control group scored 23.

Reliability tests

Cronbach's alpha statistical test was used to detect reliability of the items of the scales. This was performed for each scale: EDE-Q scale, with a good value of Cronbach's alpha (a= .959); the perfectionism scale, also showed good reliability (a = .945); SP, showed high reliability too (a= .940); SF, showed high reliability (a= .915); sexual distress, also showed good reliability (a= .954).

Independent T-Tests

There was a significant difference in the scores between the clinical group (M=4.65, SD=1.83) and the healthy control group (M=2.63, SD=1.59) in the restrict subscale; $t(376) = 11.38$), $p = <.001$. There was a significant difference between the clinical group (M=5.48, SD=1.60) and the healthy control group (M=3.75, SD=1.79) in the shape concern subscale; $t(376) = 9.74$, $p = <.001$. There was also a significant difference between the clinical group (M=5.47, SD=1.46) and the healthy control group (M=3.71, SD=1.77) in the weight concern subscale, $t(376) = 10.28$, $p = <.001$. Lastly, there is also a significant difference between the clinical group (M=4.46, SD= 1.54) and healthy control group (M=2.39, SD=1.317) in the eating concern subscale, $t(318.754) = 13.69$, $p = <.001$.

Results show that there is a significant difference between the clinical group (M= 2.09, SD=.65) and the healthy control group (M=2.69, SD=.77) on the overall perfectionism scale, $t(376)=-8.01$, $p = <.001$. Regarding SP, the results show that there is a significant difference between the clinical group (M= 17.71, SD=4.33) and the healthy control group (M=21, SD=4.90) on the total scores, $t(376) =-6.78$, $p = <.001$. Moreover, scores for the SF Index show that there is a statistical significant difference between the clinical group (M= 35.98, SD= 6.43) and the healthy control group (M= 33.27, SD= 5.69) on the global scores of the SF Index, $t(376)= 4.34$, $p = <.001$.

Additionally, results show that there is a statistically significant difference between the clinical (M=2.99, SD=.98) and the healthy control group (M=2.21, SD=.90) on the Sexual Distress Scale, $t(376)=7.926$, $p = <.001$.

Pearson's Correlations

Table 7. Pearson Correlations: across both groups

		Perfectionism	Sexual Functioning	Sexual Perfectionism	Sexual Distress
Eating Disorder Examination	Pearson Correlation	-.473**	.354**	-.393**	.483**
Perfectionism	Pearson Correlation		-.168**	.553**	-.352**
Sexual Functioning	Pearson Correlation			-.102*	.525**
Sexual Perfectionism	Pearson Correlation				-.459**

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Multicollinearity Check

Due to the Pearson correlations above, multicollinearity was tested to ensure that it was not a concern before proceeding with the path analysis. The VIF scores reported were below the threshold of 2.5, indicating that there were no such concerns and that the path analysis could proceed (Johnston, Jones, & Manley, 2018;2017).

Path models

Model specification

Path models were calculated using AMOS statistical software (version 26) and represent a theoretical model that SP may mediate the relationship between perfectionism and SF in women with AN. This primary hypothesis stems from recent evidence linking SP and SF in women in the general population (Stoeber, 2013, 2016). As this is an understudied area and women with AN have high levels of perfectionism (Lloyd, 2014) and difficulties in SF have been documented (Bulik, 2003), it is important to contribute to the literature by investigating this matter.

Parameter Estimation

As the data were normally distributed, maximum likelihood parameter estimation was preferred over other estimation methods (Kline, 2005). All cases of missing values and outliers were dealt with throughout the data cleaning process, so that no missing values or outliers were present at the path analysis stage. This is relevant for all models presented. Table 8 shows all significant scores for all models for both groups in the appendix, whereas Table 9 – 18 show standardised regression weights and variances scores for all models.

The path models below indicate whether sexual perfectionism mediates between perfectionism and sexual functioning.

Figure 11: Clinical group model

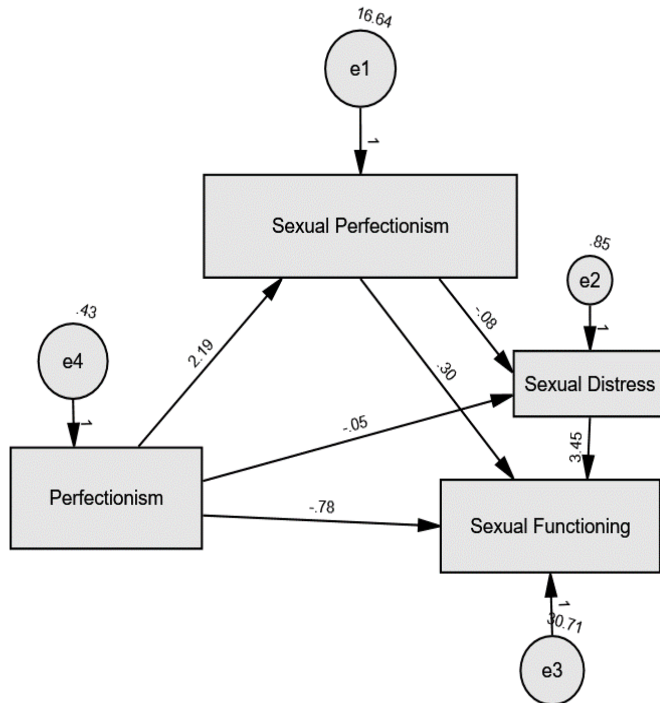


Figure 12: Healthy control group model

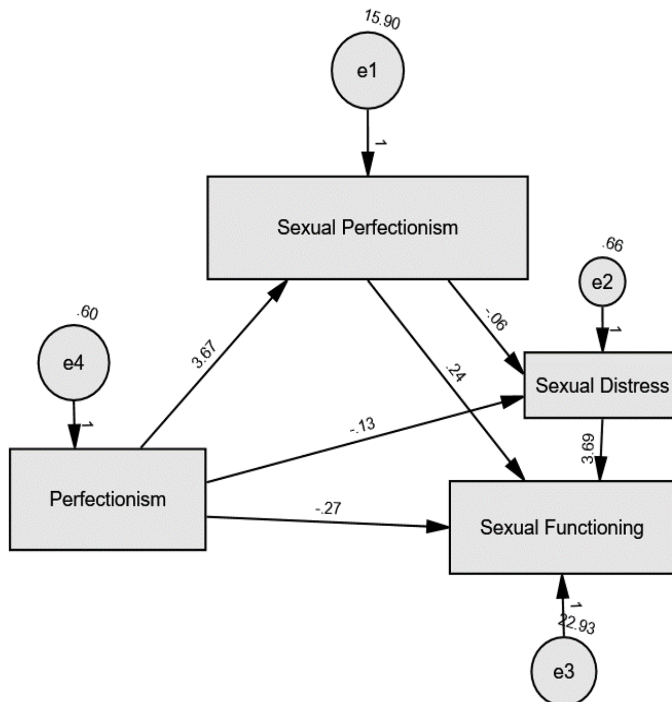


Figure 13: Path model indicating whether self-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the clinical group

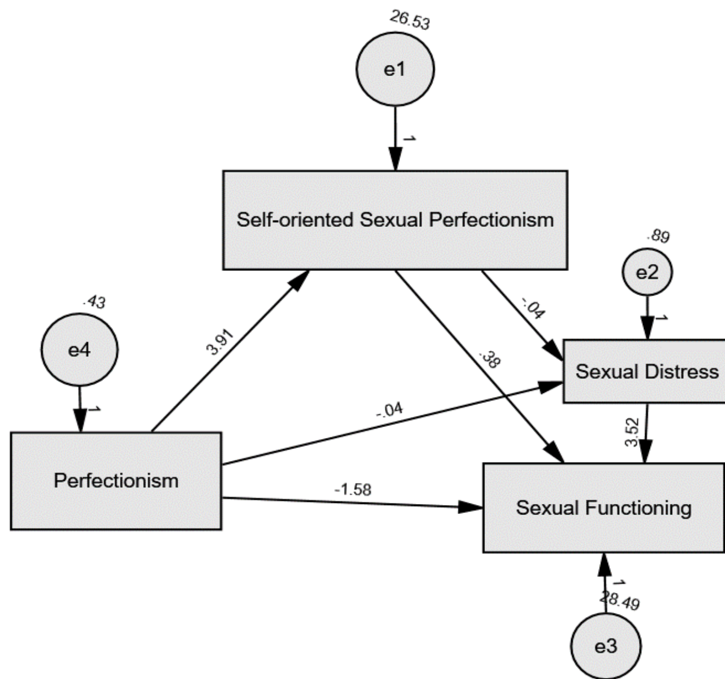


Figure 14: Path model indicating whether self-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group

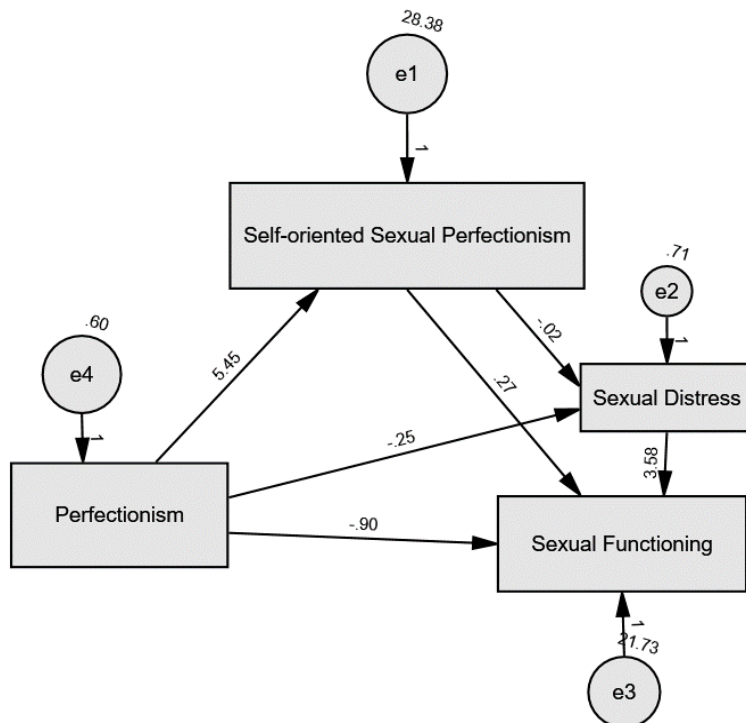


Figure 15. Path model indicating whether partner-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the clinical group

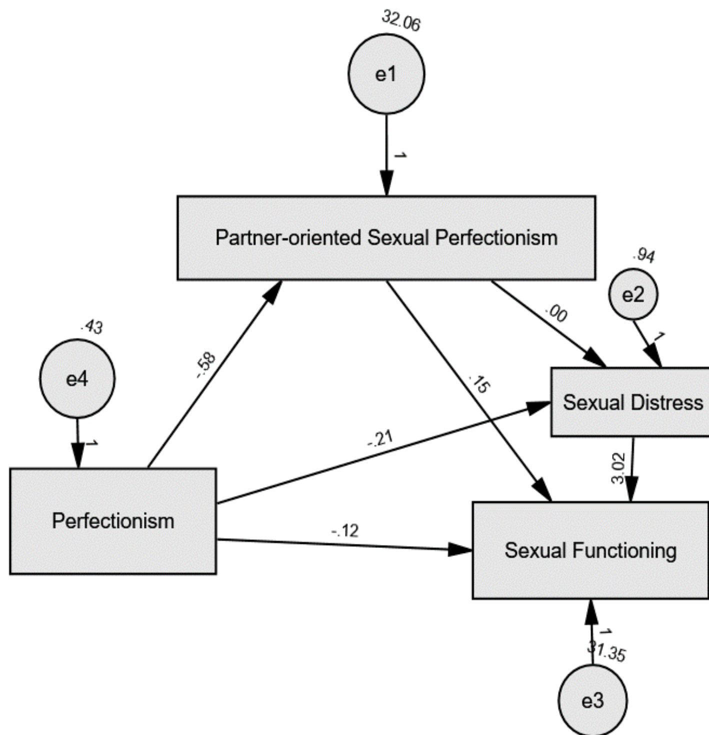


Figure 16. Path model indicating whether partner-oriented sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group

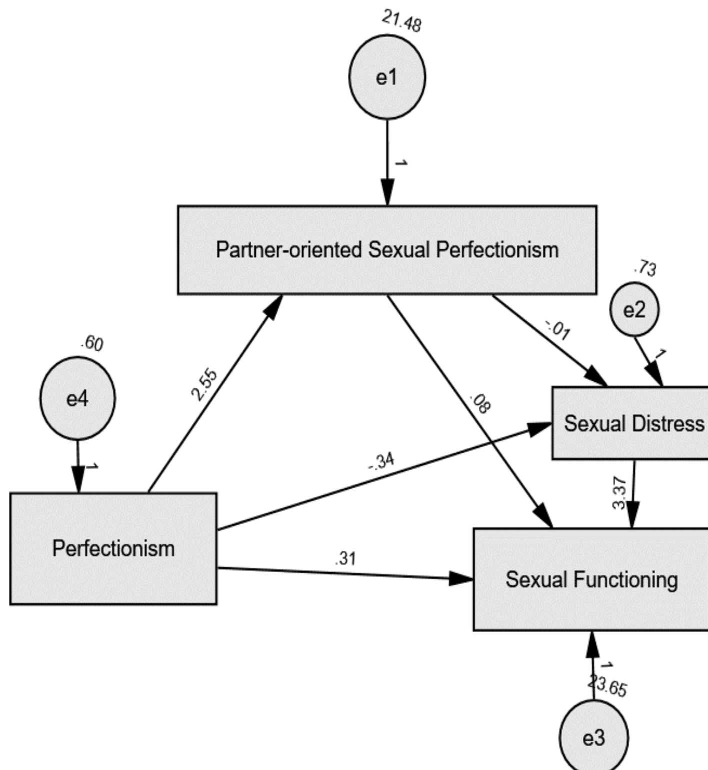


Figure 17. Path model indicating whether partner-prescribed sexual perfectionism mediates between perfectionism and sexual functioning in the clinical group

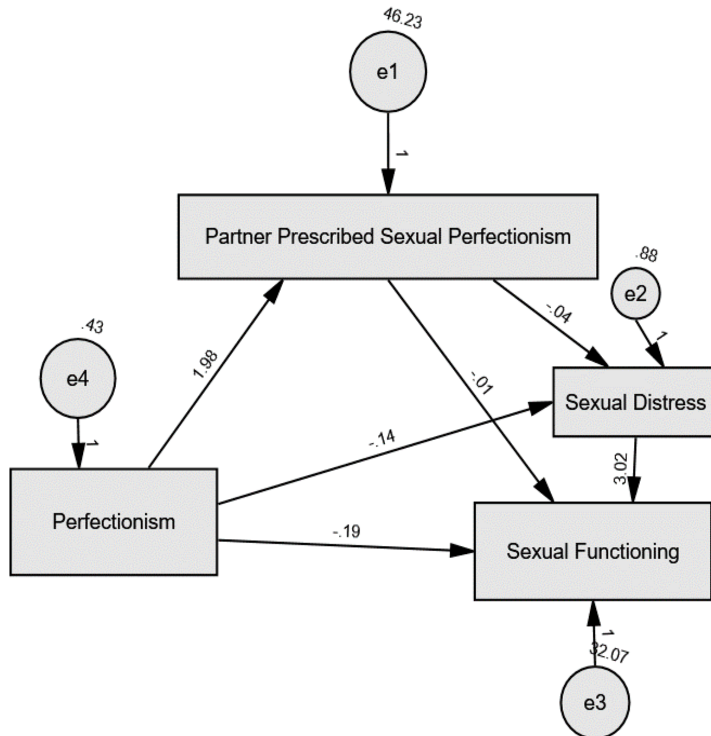


Figure 18. Path model indicating whether partner-prescribed sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group

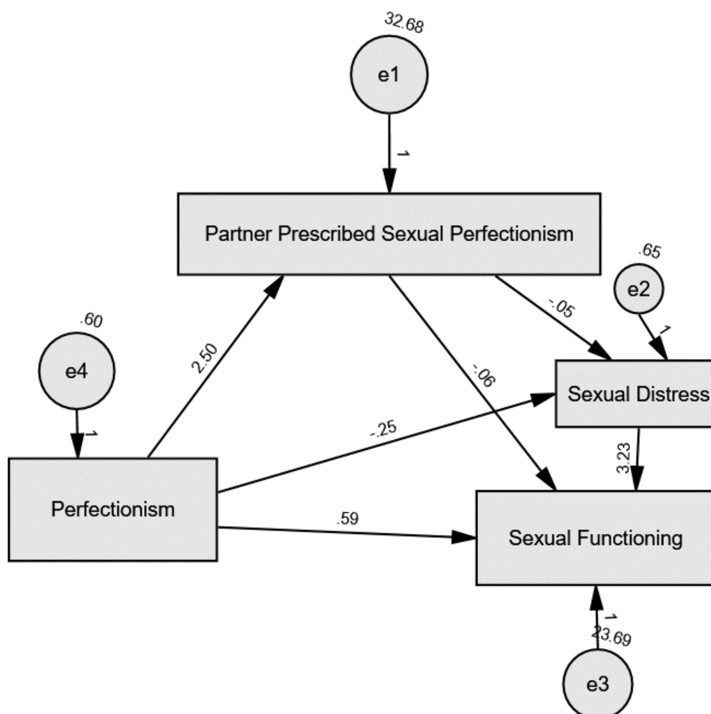


Figure 19. Path model indicating whether socially prescribed sexual perfectionism mediates between perfectionism and sexual functioning in the clinical group

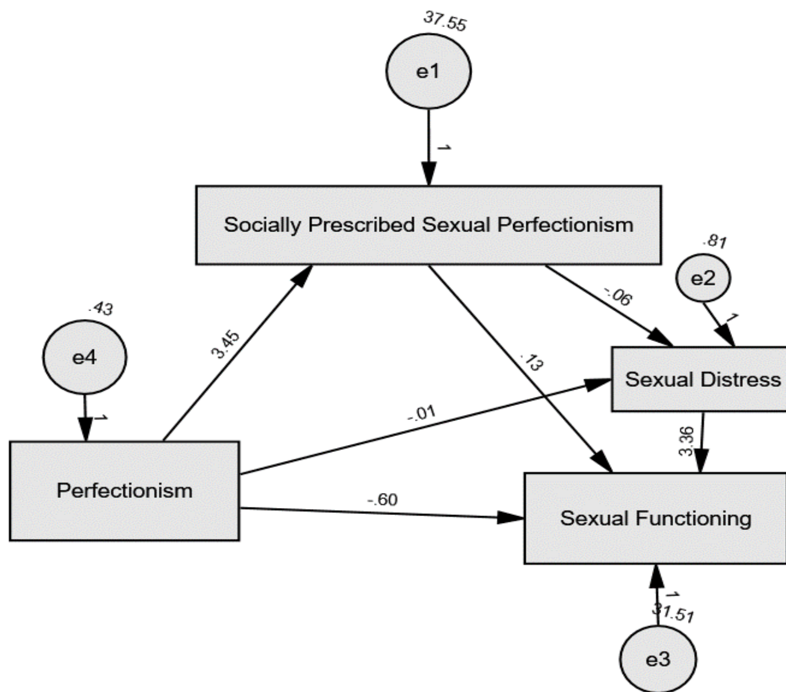
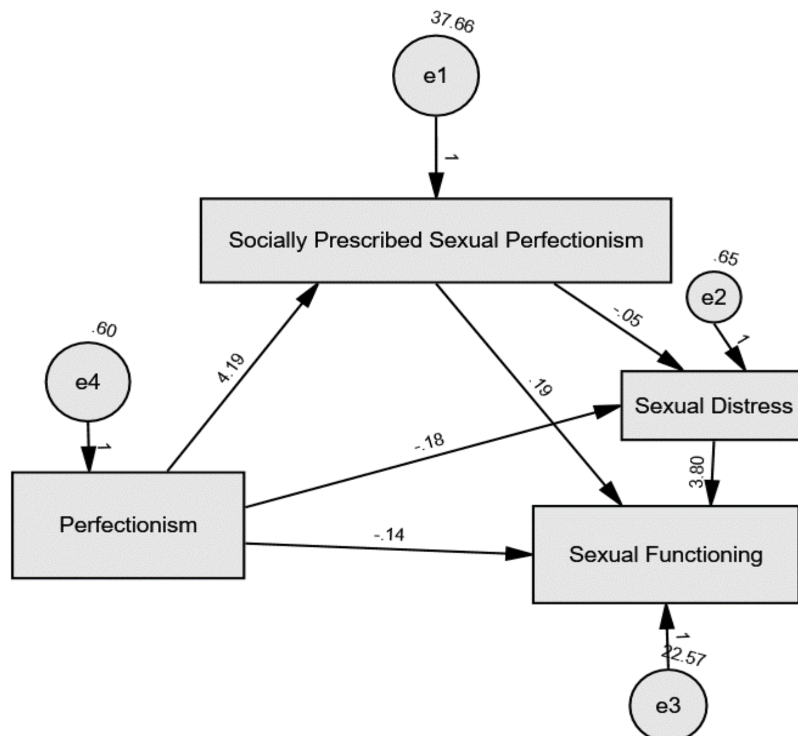


Figure 20. Path model indicating whether socially prescribed sexual perfectionism mediates between perfectionism and sexual functioning in the healthy control group



Discussion

Findings

The results show that SP mediates the relationship between perfectionism and SF in both groups. They highlight the importance of sexual distress in association with SP and SF in women with AN, and the existence of an indirect relationship between perfectionism, SP, sexual distress, and SF as well. Moreover, self-directed SP mediates the relationship between perfectionism and SF in women with AN, which is consistent with expectations in the literature that this would be a concern, as self-directed SP is rooted in high expectations of oneself as a sexual partner.

Self-oriented SP mediates the relationship between perfectionism and SF in the healthy control group, highlighting the importance of self-oriented SP in both groups. Given that the healthy control group has high levels of perfectionism, and that one of the main factors of perfectionism is that it is internally rather than externally motivated (Stoeber & Stoeber, 2009), the fact that self-oriented SP also mediates perfectionism and SF in the healthy control group is not surprising. Additionally, women tend to experience external pressures to please their partners, which could have been internalised (Kluck, Hughes & Zhuzha, 2018). However, it is not possible to state with certainty why participants exhibited high self-oriented SP, as this may arise from individual differences.

In fact, it is not possible to identify which specific aspects of self-oriented SP is of most concern, as some women may be perfectionist about their sexual skills, while others may be perfectionist about their arousal, for instance (Kluck, Hughes & Zhuzha, 2018). The results only suggest that self-directed SP is associated with SF and, more specifically, that it mediates the relationship between perfectionism and SF in both groups, with a stronger negative association between self-directed SP and sexual distress in AN than in the healthy control group.

Partner-oriented SP does not mediate the relationship between perfectionism and SF in either group. Partner-oriented SP may be related to other-oriented perfectionism but is applied to one's sexual partner (Stoeber & Harvey, 2016). People with other perfectionism have a lack of interest in other people and their feelings (Ayearst, Flett & Hewitt, 2012). They are indicated as being the opposite of what is positively associated with self-directed perfectionism.

It is understandable that the results show no association between perfectionism, partner-oriented SP, and SF, since the results showed a significant association between perfectionism, self-oriented SP, and SF, which can be considered complete opposites. Indeed, there was also no relationship between perfectionism, SP, sexual distress, and SF since individuals with high levels of other perfectionisms are known to show little interest in the needs of others.

Women who perceive their partners as having high expectations of them as sexual partners may experience distress because of their preoccupation with meeting these standards. These concerns may lead individuals to self-monitor during sexual experiences (e.g., checking whether they are sufficiently lubricated for instance); this focus on the self has been termed *'spectatoring',* which can be considered as the essence of the concept of SP, and has been shown to be associated with negative emotional impact (van Lankveld & Bergh, 2008). Individuals may become anxious and worry about their future 'sexual performance' (Rowland & Kolba, 2018).

Thus, the fact that partner-prescribed SP mediates the relationship between perfectionism and SF solely through sexual distress in both groups aligns with the literature linking sexual distress to SF and its potential role in relational dynamics (Pietras, Wiessner & Briken, 2022). This suggests that both the clinical group and the healthy control group are affected by partner-prescribed SP and its association with sexual distress and SF.

Moreover, evidence shows that societal norms that value women based on their ability to please others can have an impact on women who feel pressured to pursue unrealistic standards of themselves as a sexual partner (Cacchioni, 2007; Jackson & Scott, 2007). It can be hypothesised that internalising unrealistic beliefs about how a female's sexual experiences should be may increase the likelihood of experiencing higher levels of socially prescribed SP (Kluck, Hughes & Zhuzha, 2018). The role of sexual distress in relation to socially prescribed SP in women is predictable but is even more important regarding women with AN, as they are known to be sensitive to rejection or to anticipate the judgement of others (Cardi, Turton, Schifano, Leppanen, Hirsch & Treasure, 2017; Treasure & Hirsch, 2018;2017).

Thus, if we combine the fact that women feel more external pressure to 'perform' as a sexual partner with the increased sensitivity to rejection in women with AN, it can be assumed that they would be prone to socially prescribed SP. However, the results show that unless the indirect association between perfectionism, socially prescribed SP and SF is also mediated

by the concept of sexual distress, there is no association. This is an important difference from the healthy control group, where socially prescribed SP is shown to mediate the relationship between perfectionism and SF, even excluding the sexual distress component. The importance of sexual distress could also be greater in AN when it comes to socially prescribed SP, due to their level of sensitivity to the attempt to belong, which would highlight how sexual distress is a key component of how women with AN experience socially prescribed SP. Therefore, the results highlight the importance of sexual distress in the way women with AN experience not only their SF but also their SP.

Clinical Implications

The findings highlight how women with AN experience self-oriented, partner-prescribed, and socially prescribed SP, highlighting that they are much more concerned with how they will be perceived by their sexual partner or trying to meet what they perceive as societal norms or what is expected of them as a sexual partner. These findings align with previous evidence when trying to establish which areas of SP can be considered adaptive or maladaptive in women (Kluck, Zhuzha & Hughes, 2016). The perception by others of being a 'perfect' sexual partner is problematic, and this may apply to women with AN, as they experience high levels of sexual distress, which may be due to their control seeking tendencies (Lawrence, 1979), and their inability to control how others perceive them as sexual partners.

The results indicate the need to incorporate the factor of sexual distress when examining SP in relation to SF in this population. While self-oriented SP mediates the relationship between perfectionism and SF alone, partner-prescribed SP and socially prescribed SP only mediate this indirect association through sexual distress. This demonstrates the complexity of the phenomenon of SF and the need to understand it in the context of sexual distress, but also the importance of studying SP in relation to sexual distress and its indirect relationship with SF.

It can be argued that this evidence highlights the need to integrate these themes into psychological support services. Given that evidence has been gathered on the benefits of integrating themes of perfectionism and partner integration for women with AN in therapeutic settings, it could be argued that integrating themes related to SF and psychosocial factors that may influence it, such as SP, would be important to support individuals in their interpersonal relationships as well, an area that has already been established as challenging for this clinical population.

Strength

The main strength of this study is that it is the first to investigate SF in the context of sexual distress regarding SP in women with AN. It also opens the possibility for other research to build on this study and add to the existing literature regarding SF and the various psychosocial factors that may be involved in the phenomenon in AN, an area of research that has received more attention in recent years. In addition, the present study sought to examine the subject of SF by integrating variables that affect both the physiological and psychological aspects of SF.

Limitations and further recommendations

A factor that may have impacted on the outcomes is the sample of participants. Indeed, there was no specific age target for instance, which is relevant regarding SF as some individuals may be prone to experience difficulties with that could be the result of menopause or the early onset of menopause (Mishra & Kuh, 2006). This limitation has also been commented upon by previous evidence, who do stress for research to also focus on women who are in their forties or fifties (Stoeber & Harvey, 2016). Another limitation is the lack of identification of potential confounding factors that may have influenced the results: such as the inability to screen for symptom severity and the lack of indication of participants' engagement in psychological therapy for example.

Furthermore, there is conflicting evidence in the literature that AN peaks during the developmental phase of adolescence or early adulthood, a crucial period for exploring sexuality, of course, but there is also evidence that AN can occur later in life, often in the context of relationship breakdown or ageing. This is a factor that future studies should consider determining whether there are clinically relevant differences in SP that mediates between perfectionism and SF between early and late AN. In addition, it is recommended that future studies incorporate subtypes of AN in association with SF.

Moreover, it may be useful for future research to establish whether SP and SF could have an impact on the difficulties that individuals with AN are known to have in their intimate relationships. The mediating relationship between perfectionism, SP and SF indicates that further research needs to focus on those aspects of perfectionism that are directly associated with SP, and to further examine the role of SP in AN and its association with sexual distress.

Research could further establish which components of SF may be associated with SP and sexual distress. Such explorations would help shape clinical practice guidelines, or at least make practitioners aware of the need to consider these themes when working with clients who present with AN, encouraging them to discuss issues related to SF and SP with their clients to determine whether they also need psychological support in these areas.

Disclosure statement

The authors report there are no competing interests to declare.

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Appendix

Table 3. Eigenvalues of the 19 components extracted

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	30.853	26.828	26.828	30.853	26.828	26.828	11.651
2	11.090	9.644	36.472	11.090	9.644	36.472	6.793
3	6.854	5.960	42.432	6.854	5.960	42.432	7.987
4	5.978	5.198	47.630	5.978	5.198	47.630	6.565
5	3.891	3.383	51.013	3.891	3.383	51.013	9.791
6	3.554	3.091	54.104	3.554	3.091	54.104	11.279
7	3.143	2.733	56.836	3.143	2.733	56.836	11.851
8	2.958	2.572	59.408	2.958	2.572	59.408	5.298
9	2.300	2.000	61.408	2.300	2.000	61.408	11.356
10	2.169	1.886	63.294	2.169	1.886	63.294	6.772
11	2.011	1.748	65.042	2.011	1.748	65.042	10.010
12	1.677	1.458	66.500	1.677	1.458	66.500	13.352
13	1.626	1.414	67.914	1.626	1.414	67.914	10.014
14	1.484	1.290	69.204	1.484	1.290	69.204	14.732
15	1.376	1.197	70.401	1.376	1.197	70.401	1.955
16	1.312	1.141	71.542	1.312	1.141	71.542	6.466
17	1.252	1.088	72.631	1.252	1.088	72.631	14.589
18	1.221	1.062	73.693	1.221	1.062	73.693	6.109
19	1.044	.908	74.601	1.044	.908	74.601	6.949

Table 4. PCA Scree plot

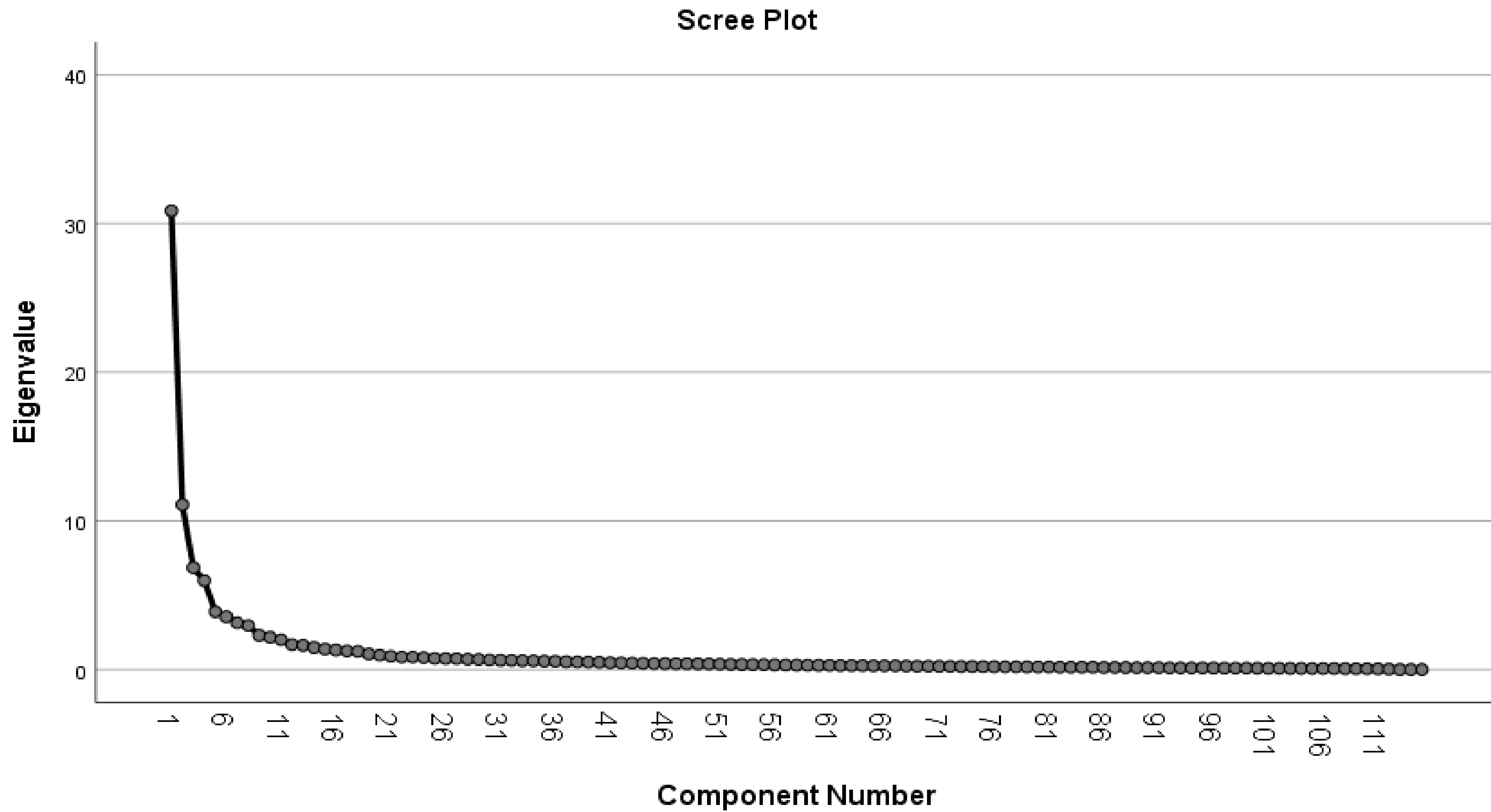

Table 6. Demographic Percentiles

Category	Subcategory	Clinical Group		Healthy Control Group	
		N	Valid Percent	N	Valid Percent
Age	18-25	69	42.1%	127	59.3%
	25-30	41	25%	44	20.6%
	30-35	24	14.6%	19	8.9%
	35-40	15	9.1%	13	6.1%
	40-45	5	3%	5	2.3%
	45-50	9	5.5%	6	2.8%
Menopause	Yes	9	5.5%	3	1.4%
	No	154	93.9%	210	98.1%
	No disclosure	1	0.6%	1	0.5%
Relationship status	Single	66	40.2%	87	40.7%
	Dating	7	4.3%	5	2.3%
	Relationship	51	31.1%	84	39.3%
	Engaged	7	4.3%	6	2.8%
	Married	31	18.9%	31	14.5%
	Divorced	1	0.6%	1	0.5%
	Widowed	1	0.6%		
Medication	Yes	90	54.9%	12	5.6%
	No	60	36.6%	183	85.5%
	No disclosure	3	1.8%	2	0.9%
	Other	11	6.7%	17	7.9%

Employment	Full time	63	38.4%	77	36%
	Part time	27	16.5%	23	10.7%
	Looking for work	17	10.4%	16	7.5%
	Not looking for work	14	8.5%	2	0.9%
	Student	32	19.5%	96	44.9%
	Disabled	10	6.1%		
Education	Less than high school	6	3.7%	2	0.9%
	High school graduate	49	29.9%	20	9.3%
	Bachelor’s degree	68	41.5%	76	35.5%
	Master’s degree	25	15.2%	93	43.5%
	Professional degree	11	6.7%	5	2.3%
	Doctorate	4	2.4%	16	7.5%
BMI	Underweight	48	29.3%	16	7.5%
	Healthy weight	72	43.9%	141	65.9%
	Overweight	11	6.7%	30	14%
	Obese	6	3.7%	19	8.9%
	No disclosure	27	16.5%	8	3.7%

Table 7. Path models: Significance results

Sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Sexual Perfectionism	.001	.001
Sexual Perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.679	.139
Perfectionism	→	Sexual Functioning	.267	.611
Sexual Perfectionism	→	Sexual Functioning	.007	.005
Sexual Distress	→	Sexual Functioning	.001	.001

Self-oriented sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Self-oriented sexual perfectionism	.001	.001
Self-oriented sexual perfectionism	→	Sexual Distress	.002	.043
Perfectionism	→	Sexual Distress	.762	.009
Perfectionism	→	Sexual Functioning	.027	.094
Self-oriented sexual perfectionism	→	Sexual Functioning	.001	.001
Sexual Distress	→	Sexual Functioning	.001	.001

Partner-oriented sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Partner-oriented sexual perfectionism	.392	.001
Partner-oriented sexual perfectionism	→	Sexual Distress	.718	.468
Perfectionism	→	Sexual Distress	.071	.001
Perfectionism	→	Sexual Functioning	.857	.531
Partner-oriented sexual perfectionism	→	Sexual Functioning	.051	.284

Sexual Distress	→	Sexual Functioning	.001	.001

Partner-prescribed sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Partner-prescribed sexual perfectionism	.015	.001
Partner-prescribed sexual perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.225	.001
Perfectionism	→	Sexual Functioning	.788	.207
Partner-prescribed sexual perfectionism	→	Sexual Functioning	.861	.369
Sexual Distress	→	Sexual Functioning	.001	.001

Socially prescribed sexual perfectionism: a mediating factor?

			Clinical group	Healthy control
Perfectionism	→	Socially prescribed sexual perfectionism	.001	.001
Socially prescribed sexual perfectionism	→	Sexual Distress	.001	.001
Perfectionism	→	Sexual Distress	.947	.028
Perfectionism	→	Sexual Functioning	.405	.778
Socially prescribed sexual perfectionism	→	Sexual Functioning	.086	.001
Sexual Distress	→	Sexual Functioning	.001	.001