Interviewing ‘Ana’:

Thematic Analysis of Voice Dialogues with the Internal Anorexic Voice

Sarah Burnett-Stuart

D.Clin.Psy. thesis (Volume 1), 2021

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

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

Signature

Name: Sarah Burnett-Stuart

Date: 12/06/2021

Overview

Many individuals experiencing eating disorders (EDs) describe an internal 'eating disorder voice' (EDV) or 'self'. Preliminary studies link the EDV with development, maintenance and ambivalence to recover from EDs. This thesis aims to develop an in-depth understanding of the EDV, its role in EDs and implications for recovery.

Part 1 is a meta-ethnography of experiences of EDVs, involving 19 qualitative studies. The results indicate that experiences of the EDV can have a pervasive impact over the course of EDs. There were common experiences, such as escalating EDV power and malignancy through ED development, and idiosyncratic aspects, for example the EDV's relations to the self and ED. In recovery, the EDV was framed as both a source of ambivalence and an opportunity for change.

Part 2 is an empirical paper, presenting a thematic analysis of voice dialogues with the anorexic voice (AV). This was a joint project. Nine women with anorexia nervosa (AN) participated. 'Chairwork' was used to interview participants' AVs. The analysis describes an interdependent relationship, whereby the person 'needs' the AV as it promises to solve their problems, a valued but fraught relationship develops, and the AV 'needs' to preserve its influence over the person for its own survival. Where relevant, exploring individuals' EDV experiences could highlight obstacles to recovery and tailor treatments, but further research is needed to establish effective ways of working with EDVs.

Part 3 provides a critical appraisal, focused on experiences of the ethical review process and the dynamic interplay between research and researcher.

Impact Statement

Insights concerning the eating disorder voice/self (EDV), presented in this thesis, could be used to promote understanding of and recovery from eating disorders (EDs). Evidently, discussing experiences of EDVs can elicit valuable information regarding all stages of EDs, including the descent into an ED and obstacles to recovery. The empirical paper shows that individual and EDV can become locked in a turbulent relationship of mutual dependence, with the EDV performing the contrasting roles of invaluable problem solver and clinging parasite. The use of chairwork to interview the voice more directly highlights its complexity of character and provides a window into the internal dialogue sometimes associated with EDs. Crucially, the literature review shows that, among those experiencing an EDV, there are both common experiences, such as an escalation in the voice's power and malignancy as the ED emerges, and marked idiosyncrasies, for example the EDV's position vis-à-vis the self and ED. Therefore, while clinicians, family members and researchers would do well to understand the EDV concept and gain awareness of common themes, assumptions about how an individual experiences (or does not experience) an EDV are at risk of being inaccurate and unhelpful. Instead, where an EDV is reported, open questions could be used to explore these experiences, including current or potential strategies for addressing it and approaches that have previously been detrimental. This thesis may serve to prompt sensitive curiosity about the EDV and inform approaches to recovery.

Limits of the present research highlight areas for further investigation. Research among more diverse groups is needed to understand experiences of EDVs in the context of Black, Asian or minority ethnicities, non-Western cultural contexts, male and non-binary genders, and among those affected by binge-eating disorder. Whilst the empirical paper provides a preliminary demonstration of how chairwork could be used in clinical practice to explore EDV experiences, the

interview schedule was developed for the purpose of understanding the EDV's perspective, not to confer clinical benefit, and this thesis does not investigate acceptability or outcomes of this approach. More research is needed to establish effective ways of working with EDVs in clinical practice to promote recovery. Hence, the limitations of this thesis are themselves impactful, pointing to avenues for future research.

Moreover, the thesis as a whole and the critical appraisal in particular, offers reflections on the research process. The need for transformation of the NHS ethical review process is made clear, with concrete examples of current problems and reference to relevant theory. There is a need to streamline paperwork, reduce unnecessary bureaucracy, and for greater awareness of the role of social psychology in decision making during ethical review. Additionally, the critical appraisal includes a rich illustration of the interactions between researcher and research, which are tangible, meaningful and dynamic. Thus, another voice joins the clamour of researchers advocating reform of ethical review procedures, and the need for thoughtful consideration of researcher-research interactions is emphasised. These messages are relevant to policy makers, ethical review bodies and those conducting or consuming research.

Contents

Overview **2**

Impact statement **3**

List of tables **7**

List of figures **7**

Acknowledgements **8**

Part 1: Literature review

Abstract 10

Introduction 11

Method 13

Results 18

Discussion 57

References 65

Part 2: Empirical paper

Abstract 76

Introduction 77

Method 79

Results 86

Discussion 119

References 129

Part 3: Critical appraisal

Introduction 142

The bureaucracy and inconsistency of NHS ethics 142

The interrelationship between researcher and research 146

Conclusion 149

References 150

Appendices

Appendix A: CASP quality ratings 153

Appendix B: Overview of researchers' contributions to the joint project 155

Appendix C: Ethical approval 156

Appendix D: Study information sheet 161

Appendix E: Consent form 165

Appendix F: Support card 166

Appendix G: Worked example of thematic analysis 167

List of Tables

Part 1: Literature review

Table 1 Characteristics of studies included in the meta-ethnography 19

Table 2 Representation of key concepts in the reviewed studies 24

Part 2: Empirical paper

Table 3 Representation of themes across participants 89

Table 4 Representation of subthemes within ‘Pragmatism’ 91

List of Figures

Part 1: Literature review

Figure 1 Literature search process 14

Part 2: Empirical paper

Figure 2 Thematic analysis map 88

Acknowledgements

Firstly, I would like to thank the nine women who participated in this research, who allowed their eating disorder voice (EDV) to speak through them so that we might learn more about it. I wish them all the best in their recoveries.

I am grateful to my supervisors, Dr. Matt Pugh and Dr. Lucy Serpell, for proposing a fascinating research topic, offering practical support by reviewing drafts, providing an interview schedule, and remaining patient and encouraging when things took a little longer than planned. Thank you to my co-researcher Dr. Natalie Chua, particularly for her work conducting research interviews. I would also like to express my heartfelt thanks to my tutor, Dr. Kat Alcock, for her unerring support throughout my doctorate.

As research is a cumulative process, I should acknowledge those who have contributed to previous research from which the current project was built, whether as researchers or participants.

I am eager to express my gratitude to every family member and friend who generously offered their support; most especially, my husband, Matt, our cat, Minerva (who stole my office chair whenever I wanted to work), and my good friend, Anna.

Lastly, I would like to thank my treatment team at Springfield, especially Natalie Stevens and Daniel Fenton, who supported me to get my life back on track, making the completion of this thesis possible.

Part 1: Literature review

A Meta-Ethnography of Experiences of the Eating Disorder Voice

Abstract

Aim: To synthesise current understandings of the 'eating disorder voice' (EDV), as evidence suggests that the EDV is prevalent and profoundly related to experiences of eating disorders (EDs). ***Method:*** A meta-ethnography of qualitative research regarding the EDV was conducted, following a systematic literature search. ***Results:*** Nineteen studies met quality and relevance criteria for inclusion. Analysis generated five primary concepts: "Dual Nature: "the angel and devil on your shoulder", "Changes over time: the downward spiral", "Relation to the self: me, part of me, or taking over me?", "Relation to the eating disorder: a mixed picture", and "In recovery: a source of ambivalence or opportunity for change?". There were both commonalities in EDV experiences, such as the voice's increased power and malignancy as the ED developed, and idiosyncratic aspects, such as the EDV's position in relation to the self and ED. ***Conclusions:*** Experiences of the EDV may have a pervasive impact over the course of EDs. Given the EDV's significant and complex role in experiences of EDs, current understandings should be built upon, with a view to promoting recovery.

Keywords: eating disorders, eating disorder voice, anorexic voice, bulimic voice, eating disorder self, qualitative, meta-ethnography, systematic review

Introduction

Eating disorders (EDs) affect eating behaviours and associated thoughts and emotions, often involving preoccupation with food, weight and body shape (National Institute of Mental Health, 2016). Common diagnoses include anorexia nervosa, bulimia nervosa, and binge eating disorder (APA, 2013). Many individuals experiencing EDs report an 'eating disorder voice' (EDV) or 'self' – an internal commentary regarding eating, shape, weight, and self-worth (Pugh, 2016). Research suggests that over 90% of those with EDs experience an EDV (Noordenbos et al., 2014; Noordenbos & Van Geest, 2017).

Understanding and effective treatment of EDs is critically important. Internationally, lifetime prevalence for diagnosed EDs averages 8.4% for women and 2.2% for men (Galmiche et al., 2019). EDs affect all ethnic groups (Marques et al., 2011) and impact significant periods of people's lives, lasting 6 years on average (Schmidt et al., 2016). High-income countries present with increasing rates of ED behaviours (Darby et al., 2009), progressively affecting younger individuals (Smink et al., 2013). EDs contribute to unemployment (Treasure et al., 2015), fertility problems (Schmidt et al., 2016), reduced quality of life (Treasure et al., 2015), and place substantial burden on caregivers (Viana et al., 2013). Mortality rates for EDs are almost double that of the general population, with a near six-fold increase for anorexia nervosa (Schmidt et al., 2016). The pervasive and pernicious impact of EDs heightens the importance of exploring and understanding experiences of the EDV.

Current recommended ED treatments (National Institute for Health and Care Excellence [NICE], 2020) are based on a biopsychosocial model, incorporating information on the physiological effects of malnutrition, cognitive behaviour therapy (CBT), and systemic approaches. Many cognitive changes thought to maintain EDs, such as heightened rigidity, obsessiveness, and focus on food, weight and shape,

can be attributed to the physiological state of malnutrition itself (Keys et al., 1950). Thus, ED treatments prioritise ceasing dietary restriction and reaching or maintaining a sufficient body weight. CBT challenges unhelpful or inaccurate beliefs about eating, weight and shape, and behaviours perpetuating the ED, such as body checking, calorie counting, compensatory exercise, purging and avoidance of fear foods (Fairburn, 2008). Systemic approaches work with the wider family context, exploring different family members' perspectives in a non-judgmental manner, and often promoting a unified approach to tackling the external problem of the ED (Jewell et al., 2016). However, current treatments demonstrate limited success; dropout is common (15-50%) remission rates are modest (30-40%), and around 30% relapse within 2 years (Atwood & Friedman, 2020; Lock & Le Grange, 2019). Improved knowledge of the EDV may extend or overhaul theories underlying existing treatments.

A recent systematic review of the EDV experience by Aya and colleagues (2019) suggests that the EDV is common, experienced as powerful, negative and omnipotent, evokes feelings of entrapment and defeat, and is associated with ED symptoms. This was a review of seven qualitative and six quantitative studies, with the analysis focusing on quantitative findings. As existing research suggests that the EDV is common and powerfully linked to experiences of EDs, it will be important to develop a rich understanding of EDV experiences to inform treatments. This warrants a more detailed synthesis of qualitative research into the EDV, particularly a meta-ethnographic approach (Noblit & Hare, 1988), surpassing summarising research to develop new understandings drawn across studies.

This review aims to develop a rich understanding of EDV experiences to provide new insights into EDs, informing treatments and improving outcomes. In line with the ethos of qualitative research, an inductive rather than hypothesis-testing

approach was taken to explore the EDV experience. The following research questions provided prompts to consider varied aspects of the EDV experience:

- What are the characteristics of the EDV?
- How does the EDV relate to the individual?
- What functions might the EDV serve?
- What is the impact of the EDV?
- How is the development of the EDV experienced?
- How does the EDV relate to the ED?
- How does the EDV affect recovery?

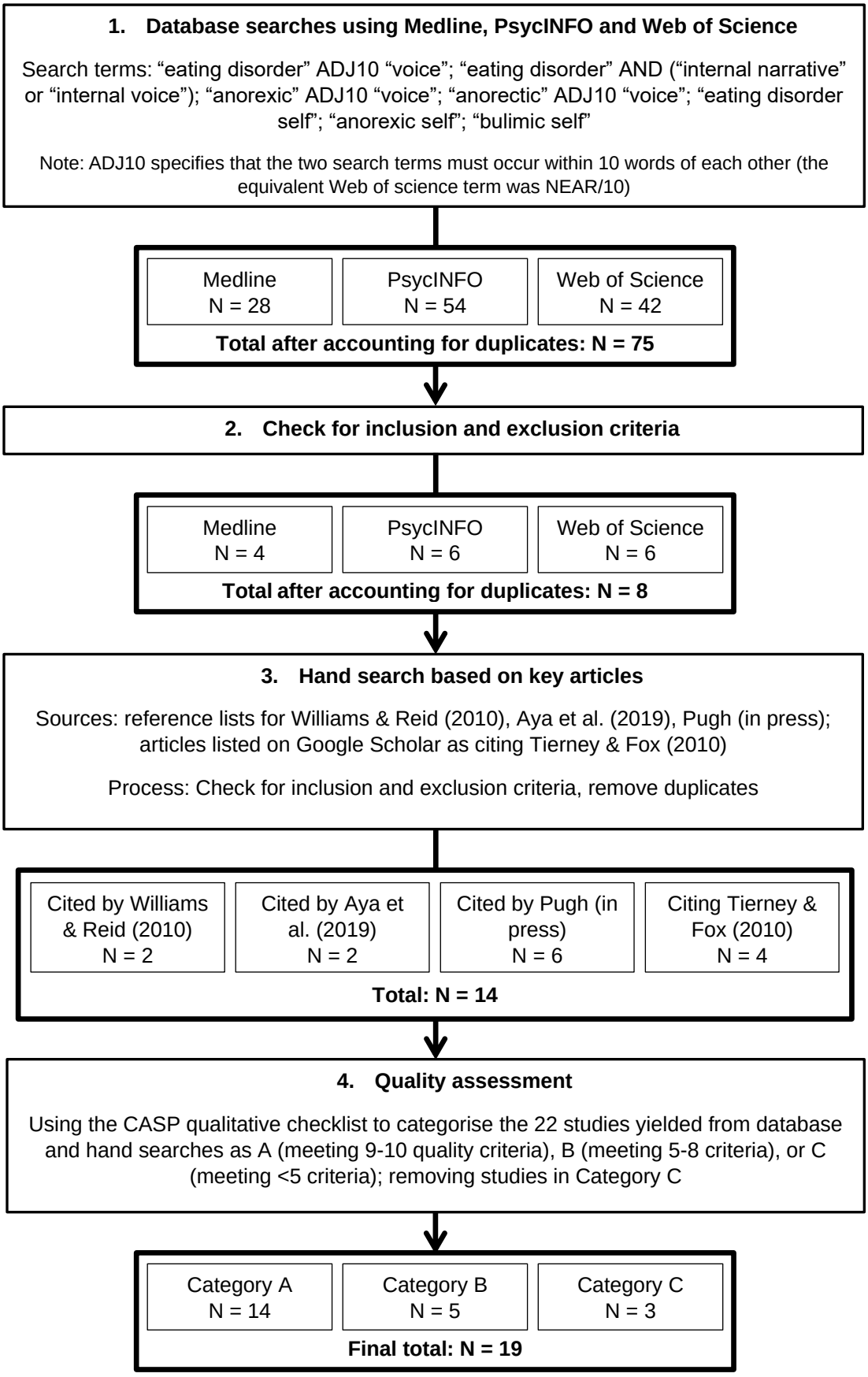
Method

Search Strategy

The literature search took place on 31st July 2019, and included a database search and hand search, detailed in Figure 1. The initial search yielded 22 studies fitting the criteria.

Figure 1

Literature search process



Inclusion and Exclusion Criteria

The following inclusion criteria were applied to ensure relevance and feasibility:

(1) Reference to the EDV/self, anorexic voice/self, bulimic voice/self, or inner voices/selves explicitly linked to an ED
(2) Qualitative research (published or unpublished)
(3) Available in English

Material was excluded if it was:

(1) Not explicitly referencing an EDV/self, anorexic voice/self, bulimic voice/self, or inner voices/selves explicitly linked to an ED
(2) A whole book
(3) Reliant on case descriptions or quotes not explicitly using qualitative methodology

Articles not explicitly referencing the EDV or equivalent were excluded to avoid imposing an EDV interpretation. The term ‘ED self’ was included following informal consultation with a small number of service users experiencing EDs, as some described identifying with the EDV concept but viewed it as a ‘self’. Therefore, this review equates the concept(s) of the EDV and ‘ED self’ throughout. Including only qualitative studies ensured a degree of shared theoretical underpinning and facilitated quality assessment against standardised criteria.

Quality Assessment

Approaches to quality appraisal for qualitative research include structured and unstructured methods. Research indicates that structured approaches may not produce more consistent quality judgements, but can prompt clearer reasoning (Dixon-Woods et al., 2007). The Critical Appraisal Skills Programme qualitative

checklist (CASP, 2018) was therefore applied to assess study quality, considering evidence of the following criteria:

1. Clear research aims
2. Appropriateness of qualitative methodology
3. Appropriate research design
4. Appropriate recruitment strategy
5. Appropriate data collection methods
6. Consideration of relationship between researcher and participants
7. Consideration of ethical issues
8. Rigorous data analysis
9. Clear statement of findings
10. Value of the research

The CASP checklist was used to create categories denoting study quality. Studies meeting 9-10 criteria were classified as Category A, 5-8 as Category B, and <5 as Category C. Category C studies were deemed of insufficient quality and excluded from analysis. Nineteen of the original 22 studies met quality criteria for inclusion (see Appendix A for CASP ratings). Details of included studies are presented in Table 1.

Additionally, CASP quality criteria were applied to the current review. Aims, methodology, design, and search strategy (recruitment and data collection) have been discussed. Regarding the researcher-data relationship, the author is a healthcare professional with lived experience of EDs, and was mindful of the influence this context on the synthesis. The main ethical consideration was a risk of misrepresenting original participants' views through secondary analysis. This has been addressed by presenting quotations with the results and specifying each quotation's source. Analysis, findings and research value will be addressed presently.

Data Synthesis

Noblit and Hare's (1988) meta-ethnography approach was used, providing a well-established procedure for synthesising qualitative research (Britten et al., 2002), including ED research (Espíndola & Blay, 2009; Graham et al., 2020). Meta-ethnographic synthesis incorporates second order interpretation, based on the original study findings, and third order interpretation, providing new insights drawn across studies (Schutz, 1971). As such, meta-ethnography is grounded in induction and interpretation, mirroring the theoretical underpinnings of the qualitative research being synthesised (Britten et al., 2002).

Meta-ethnography involves seven steps:

1. Getting started: Identifying experiences of the EDV as the focal topic.
2. Specifying parameters to select relevant studies: See inclusion and exclusion criteria and search strategy (Figure 1).
3. Reading the studies: Included studies were read repeatedly for familiarisation and to begin identifying study characteristics (Table 1) and concepts.
4. Determining how the studies are related: For passages concerning the EDV, key concepts and meanings were noted, and compared within and across studies.
5. Translating studies into one another: 'Reciprocal translation analysis' characterised comparable meanings within and across studies into distinct, internally consistent concepts, and contradictions were noted for 'refutational synthesis'.
6. Synthesising translations: Lines of argument synthesising shared concepts and contradictions were developed.
7. Expressing the synthesis: The synthesis was expressed in written form.

Results

Quality Assessment

Fourteen studies were rated as category A, five B, and three C (see Appendix A), with a mean rating of 8.14. The 19 studies classified as A or B were included for analysis. The most common missing criterion was ‘consideration of the researcher-participant relationship’, followed by ‘clear aims’ and ‘consideration of ethical issues’.

Characteristics of Included Studies

Table 1 presents details of the included studies. Sixteen were peer-reviewed journal articles and three were doctoral theses. Sample sizes ranged from N = 4 to N = 21. Most studies focused on experiences of anorexia nervosa (n = 12); others considered experiences of EDs generally (n = 5), experiences of bulimia nervosa (n = 1) or healthcare professionals’ perspectives (n = 1). All samples were predominantly female, and 11 exclusively so. Non-binary genders were not represented. Participant ages ranged from 11 to 65 years, but under-16-year-olds were only eligible to participate in two of the studies, and one used online data with no recorded ages. Most studies were based in Western countries. All samples reporting ethnicity data were predominantly white, although, notably, ethnicities were not reported for nine studies. Interviews were the most common data collection method (n = 11), but some studies used written or online content, including online focus groups. Approaches to analysis included interpretative phenomenological analysis, other phenomenological approaches, thematic analysis, grounded theory, discourse analysis and content analysis. Thus, the reviewed studies utilise various qualitative methods, but focus on experiences of white Western women with anorexia nervosa.

Table 1

Characteristics of studies included in the meta-ethnography

Reference	Title	Location	Sample					Data collection	Analysis	Quality rating
			N	Description	Gender	Ethnicity	Age			
1. Broussard (2005)	Women's experiences of bulimia nervosa	A large urban university, Pacific Northwest USA	13	Women with active BN (duration 1-23 years)	F	10 Caucasian, 2 Mixed, 1 Korean	18-36	Interviews and personal diaries	Benner's (1994) three-step Heideggerian phenomenology	♦
2. Conti et al. (2017)	'Somebody else's roadmap': Lived experience of Maudsley and family-based therapy for adolescent anorexia nervosa	Australia	4	A family with experience of family therapy for adolescent AN	F/M (girl with AN, her brother, mother & father)	Not specified	11-13 (girl with AN; others not stated)	Semi-structured interviews	Critical discursive analysis	♦
3. De Giacomi (2019)	Eating disorders and living with the "critical voice"	UK	9	Women diagnosed with an ED & reporting a critical inner voice	F	8 White British, 1 White American	22-38	Semi-structured interviews	Interpretative phenomenological analysis	♦
4. Fox & Diab (2015)	An exploration of the perceptions and experiences of living with chronic anorexia nervosa while an inpatient on an eating disorders unit: An interpretative phenomenological analysis (IPA) study	UK	6	Women who were current inpatients in ED services due to chronic AN (≥6 years)	F Assumed based on pseudonyms	White British	19-50	Semi-structured interviews	Interpretative phenomenological analysis	♦

5.	Graham et al. (2019)	Perceptions of the "anorexic voice": A qualitative study of healthcare professionals	UK	15	Staff from ED services, diverse professional backgrounds	F/M 14 F 1 M	Not specified	Within 18-64 (exact range not specified)	Semi-structured interviews	Thematic analysis	
6.	Higbed & Fox (2010)	Illness perceptions in anorexia nervosa: A qualitative investigation	North-West of England	13	Individuals receiving treatment for AN (10 inpatients, 3 outpatients)	Not specified	White British	16-53	Semi-structured interviews	Grounded theory	
7.	Jenkins & Ogden (2012)	Becoming "whole" again: A qualitative study of women's views of recovering from anorexia nervosa	UK	15	Women with a diagnosis of AN, self-identifying as recovered/ in recovery	F	Not specified	19-49	Semi-structured telephone interviews	Interpretative phenomenological analysis	
8.	Kendal et al. (2017)	How a moderated online discussion forum facilitates support for young people with eating disorders	UK-based study using online data	Not specified ('netnographic' approach)					All posts (>400) on a young persons' moderated online ED forum in a 4-month period	Thematic analysis	
9.	Lodge-Guttery (2005)	The impact of narrative storytelling on cognitive re-composition in individuals struggling with eating disorders	Oklahoma, USA	16	Women in private therapy for EDs (12 diagnosed with ENOS, 3 BN, 1 AN)	F	75% Caucasian, 6% Hispanic, 6% Eastern Indian	18-31	Stories written from the externalised perspective of the ED	Phenomenological	
10.	Pratt (2016)	Eating disorder voices: A qualitative content analysis	California, USA	7	Women with self-reported ED histories	F	4 Caucasian, 2 Hispanic/ Latino, 1 Mixed ethnicity	24-65	Semi-structured interviews	Content analysis	
11.	Rance et al. (2017)	The anorexia nervosa experience: Shame, solitude and salvation	UK	12	Women self-identifying as recovered/ in	F	Not specified	18-50	Semi-structured interviews	Thematic analysis	

				recovery from AN						
12. Seed et al. (2016)	Experiences of detention under the mental health act for adults with anorexia nervosa	North of England	12	Adults with experience of detention under the Mental Health Act with a diagnosis of AN	F Assumed based on pseudonyms	Not specified	18-55	Semi-structured interviews	Constructivist grounded theory	♦
13. Smethurst & Kuss (2018)	'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa	UK-based study using online data	8	Adults who posted pro-recovery weblogs regarding AN in the public domain	F/M 7 F 1 M	Not specified	19-29	Participants' pro-recovery weblogs	Interpretative phenomenological analysis	♦
14. Tierney & Fox (2010)	Living with the "anorexic voice": A thematic analysis	UK	21	Females reporting experiences of AN and an inner anorexic voice	F	19 White British, 2 from other ethnic groups (unspecified)	16+ Mean = 22.1	Written poems, reflections, letters or narratives regarding life with an anorexic voice	Thematic analysis	♦
15. Tierney & Fox (2011)	Trapped in a toxic relationship: Comparing the views of women living with anorexia nervosa to those experiencing domestic violence	UK	21	Females reporting experiences of AN and an inner anorexic voice	F	19 White British, 2 from other ethnic groups (unspecified)	16+ Mean = 22.1	Written poems, reflections, letters or narratives regarding life with an anorexic voice	Thematic analysis	♦

16. Walstrom (2002)	"You know, who's the thinnest?": Combating surveillance and creating safety in coping with eating disorders online	USA-based study using online data	Not specified (online data)					An initial post and 3 responses from an online ED recovery support group	Microlevel discourse analysis	♦
17. Williams et al. (2016)	Sense of self and anorexia nervosa: A grounded theory	UK	11	Women with a history of AN	F	10 White British, 1 British Asian/ Indian	18-60	Semi-structured interviews	Constructivist grounded theory	♦
18. Williams & Reid (2010)	Understanding the experience of ambivalence in anorexia nervosa: The maintainer's perspective	International: USA, Canada, Spain, South Africa, Australia, New Zealand, Romania & India	14	Individuals reporting anorexic behaviours that they wished to maintain, recruited via pro-anorexic websites	F/M 13 F 1 M	Not specified	18-36	Online focus groups	Interpretative phenomenological analysis	♦
19. Williams & Reid (2012)	"It's like there are two people in my head": A phenomenological exploration of anorexia nervosa and its relationship to the self	International: participants in the USA, UK, Canada & Australia	14	Individuals reporting experiences of AN, recruited via pro-recovery ED websites	F/M 12 F 2 M	11 White/ Caucasian, 1 Chinese, 1 White Hispanic, 1 unspecified ethnicity	21-50	Online focus groups or interviews	Interpretative phenomenological analysis	♦

Key

♦ = Category A, meeting 9-10 CASP quality criteria

♦ = Category B, meeting 5-8 CASP quality criteria

Abbreviations: eating disorder (ED), anorexia nervosa (AN), bulimia nervosa (BN), eating disorder not otherwise specified (ENOS)

Meta-Ethnography Findings

Table 2 presents the five primary and 19 secondary concepts developed from the synthesis and their representation across the reviewed studies. Reciprocal elements of the meta-ethnography (showing agreement across the data) and refutational elements (showing disagreement) are discussed. Although the concepts are distinct, there are areas of overlap; for example, characteristics of the EDV under ‘dual nature’ are also relevant to ‘changes over time’. For parsimony, ellipses replace less relevant sections of quotations and inserted words are shown in square brackets. In brackets following each quotation, the speaker is identified as ‘researcher’ (study author), participant with lived experience (‘PLE’), or healthcare professional (listed by job title) and the study’s identifying number is provided.

Table 2

Representation of key concepts in the reviewed studies

Interpretation	Key concepts			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Dual Nature: "the angel and devil on your shoulder"	Angel	Promotes success				■							■		■		■					
		Sense of control						■					■			■				■		■
		Sense of identity						■					■		■	■	■	■		■		■
		Protection				■		■					■				■	■		■		
		Reliable friend				■		■					■			■	■	■				■
	Devil	Malignant characteristics	Pervasive	■		■					■	■	■	■	■		■	■				■
			Powerful	■	■	■		■	■	■	■		■			■	■	■	■	■	■	■
			Relentlessly critical			■	■	■		■	■	■	■			■	■	■	■	■	■	■
			Directive & militant		■			■	■	■	■		■			■	■	■		■	■	■
			Punitive			■				■	■		■				■	■				■
			Malicious			■		■		■		■	■				■	■	■	■	■	■
			Deceitful		■						■	■	■	■		■	■	■				■
		The relationship: Violence, abuse and imprisonment	At war	■	■	■	■	■					■				■	■		■		■
			Abusive relationship			■		■				■					■	■		■		■
			Imprisonment								■		■				■	■		■		■
		Impact	Feeling helpless	■	■	■	■						■	■			■	■		■	■	■
			Guilt & shame	■		■				■	■	■	■					■				
			Low self-esteem			■											■	■				
			Low mood			■	■	■				■					■	■			■	
			Anxiety			■							■				■	■				
			Surrendering: ED behaviours	■		■		■		■			■			■	■	■		■	■	■
			Social isolation			■							■				■	■				
			Constraining life			■	■		■			■			■	■	■	■				
	A third option?	Distrustful				■							■				■	■				■
		Irrational				■	■		■	■			■				■	■		■		■
		Vulnerable & scared										■	■					■				

Changes over time: the "downward spiral"	Origins: nature/ nurture	Genes			■								■											
		Criticism from parents			■																			
		Parents modelling self-criticism			■																			
		Abuse			■																			
		Own personality			■																			
		Wider social environment			■	■							■						■					
	Entry of the EDV	Gradual					■										■	■						
		At a moment of vulnerability															■							■
		Initially valued			■		■						■				■	■						■
	Downward spiral	Increasingly destructive: Helpful friend to harsh task-master			■								■				■	■		■				■
		Escalating intensity & power											■				■		■					■
		Increasing dependence on the voice															■	■						
		Demands for exclusivity															■	■						
	Idiosyncratic changes				■								■											
	Hope	Losing trust in the voice linked to recovery		■												■	■							
		Shifts in the balance of power: taking back control		■	■		■		■				■			■	■	■	■	■				
Relation to the self: me, part of me, or taking over me?	Me				■								■				■			■				
	Part of me		■		■	■	■						■							■				■
	Taking over me		■	■	■	■	■	■	■				■	■	■	■	■	■		■	■	■		
	Fragmenting sense of self				■		■	■	■				■	■	■		■	■		■				■
	My antithesis?				■											■	■	■						
Relation to the eating disorder: a mixed picture	Defining characteristic?	Not ubiquitous					■																	
		Common								■					■			■						
		Defining characteristic																		■				■
	Vague relations: equal to, driving, or partly responsible?	Equal to			■																			■
		Driving			■		■		■															
		Partly responsible	■				■										■							
	Conflict among clinicians	What is it?					■											■						
		One of many conceptualisations					■																	
		Not a real entity					■																	

In recovery: a source of ambivalence or opportunity for change?	Ambivalence	Dependence & addiction																						
		Fear of losing the voice																						
		Abdicating responsibility?																						
		Wish to be free must outweigh the benefits																						
		Resistance from the voice																						
	Opportunity	Dispel stereotypes																						
		Externalisation																						
		Speaking back																						
		Dismissing the voice																						
		Life outside																						
		Support from others																						
		Importance of working with the voice in therapy																						
		Therapeutic modalities & approaches																						
	Questions	Perspectives on recovery																						
		To what extent does the voice remain?																						
		Areas for further research																						

1. Dual Nature: “the angel and devil on your shoulder”

The first overarching concept was the EDV’s dual nature, with an angelic side offering a sense of success, control, identity, protection, and friendship, and a demonic side involving malignant characteristics and a fraught relationship with the self, harming the person:

“[Participants] described the dual nature of the EDV, with a dialogue between one side … that is praising and kind, and the other side that is punitive and condemning … a two-headed monster, the angel and the devil on her shoulder” (researcher; 10).

There was also evidence of a third perspective, of the voice as irrational, vulnerable and scared.

1.1 Angel.

1.1.1 Promotes success.

In four studies, the EDV was described as promoting success and a sense of achievement. Participants said it encouraged them to “be better” (PLE; 3, 10), “get to the top” (PLE; 3) and acted as a “motivating force which has enabled some participants to achieve more than they would have otherwise” (researcher; 3). Achievements attributed to the voice could be general (3, 10, 14), or concern hobbies (3), academia (3), or the ED itself (10, 12):

> “Whenever they were “successful” at being anorexic … participants received positive messages of pride, praise, and hope from their EDV” (researcher; 10).

1.1.2 Sense of control.

In some cases, the EDV offered a sense of control:

"Five participants talked about their EDV providing … a way to feel in control over thoughts, feelings, and/or difficult situations." (researcher; 10)

In addition to thoughts, feelings and situations, the EDV conferred perceived control over one's identity (17).

1.1.3 Sense of identity.

Many participants reported that the EDV offered a sense of identity that was highly valued and otherwise absent.

"anorexia gives you a sense of being that you wouldn't have otherwise ... without that … I wouldn't feel like a person at all" (PLE; 17).

"The anorexic voice may initially develop as a position offering identity … to a person who otherwise feels lacking" (researcher; 19)

1.1.4 Protection.

The EDV promised protection from perceived threats: rejection (3), unwanted emotions (5, 10, 14), unmet needs (10), loneliness (14), vulnerability (17), other problems (14), a "dangerous world" (PLE; 15), and food (14).

"To begin with, the voice offered security, shielding participants from the outside world." (researcher; 14)

"it's like a protective thing … round my heart" (PLE; 17).

1.1.5 Reliable friend.

The EDV was repeatedly referred to as a friend or "best friend" (PLE; 13) with positive qualities. It was described as a familiar companion (19) who was reliable (5, 14, 15), helpful and supportive (5, 10, 19), and perhaps the only one who cared (15).

"All participants used the term 'friend' … to define their inner voice and in this early stage it was regarded as something they could rely upon." (researcher; 14)

1.2 Devil.

1.2.1 Malignant characteristics.

1.2.1.1 Pervasive.

The EDV appeared ever-present (14), commented on all aspects of the person's appearance and behaviour across situations (1, 8, 9, 10, 15, 19), and affected all areas of life (3, 15, 19). The voice consumed the self and identity (11, 12) and elicited "feelings of being 'possessed'" (researcher; 1).

"She is always shadowing me. Never am I alone." (PLE; 15)

1.2.1.2 Powerful.

The EDV's power was referenced in fifteen studies. The voice was described as powerful (6, 14, 15, 17), dominant, in charge or in control (6, 7, 10, 14, 15, 17, 18, 19), uncontrollable (1) and compelling (3, 10, 17). Participants expressed that it overrode their own voice (13) and dictated their behaviour (2, 3, 7, 10, 13, 14, 17).

"She's stronger than everyone, no-one can win." (PLE; 14)

The voice was sometimes imbued with characteristics participants associated with power, such as masculinity (10).

1.2.1.3 Relentlessly critical.

In fourteen studies, the EDV was defined as a relentlessly critical internal voice. The voice accused individuals of being failure or 'not good enough' (3, 10, 14, 15, 19), undeserving or deserving pain (3, 5, 10, 14, 19), worthless (15, 19), unloved

(15, 19), lazy (3), incapable (9, 10, 15), greedy (3), disgusting (14) and evil (14). It seemed insatiable, with unreachable expectations (3, 13, 14, 18):

> "The perfection you promised had seemed so right at the time; but the longer I engaged in your project the further away that ideal became" (PLE; 18).

Rigged comparisons fuelled the EDV's criticisms (3, 4, 9, 10, 13, 16):

> "The voice will filter information by ignoring people who are not thinner or eating less, fabricating an unfavourable comparison" (researcher; 3)

The voice criticised weight, shape and eating (7, 8, 9, 10, 13, 14, 15, 16, 19), linked other life domains to weight and food (3), and used appearance-based criticisms to justify its rules (3, 10, 14, 19):

> "my head is screaming "dirty fat bitch...disgusting failure, not good enough, lose weight you pathetic piece of crap, worthless, useless idiot, don't DARE eat!"" (PLE; 14)

1.2.1.4 Directive and militant.

The EDV took a directive and militant stance, issuing instructions (3), rules (10, 13, 14, 15), or commands (17).

> "Like a military campaign you obliterated the initial confusion and laid out the borders and barriers." (PLE; 14)

Participants relayed that the voice forbade eating (6, 8), dictated what and when they eat (2, 8, 10, 13, 14), demanded purging (14) or exercise (8, 10, 19), and generally steered decision-making (3, 13, 14, 15, 18). EDV rules were rigid, extensive, and negative:

> "negative messages from the EDV included intense, harsh, punitive, rigid rules about survival, acceptance, and dignity" (researcher; 10).

1.2.1.5 Punitive.

The EDV was described as punitive (10, 14), condemnatory (7, 10), and persecutory (10).

> “All participants experienced their EDV, or parts of their EDV, as punitive and persecutory: “It’s a punitive Jiminy Cricket inside”” (researcher and PLE; 10).

The voice enforced punishments for eating (8, 15), perceived laziness (3), mistakes (10), or contravening its demands (10, 15, 19).

> “if I ever go against what I am told to do then there are harsh repercussions.” (PLE; 15)

Punishments for going against the EDV included exercise (3, 15), purging (14), guilt (8), criticism (10, 15), increased EDV volume and aggression (15, 19), and prohibiting “good things” (3).

1.2.1.6 Malicious.

The EDV was also experienced as actively malicious. A spectrum of negative descriptors applied to the voice, including harsh (7, 10, 15), unpleasant (19), nasty (3, 10), horrible (5), mean (3, 10), harmful (19), cruel (19), malicious (15), vindictive (14), demonic (15, 19) and evil (17). There were accounts of the voice taunting (9, 14), insulting (14), ridiculing (16), belittling (9, 14), degrading (14) threatening (14), and bullying (15, 17) the listener, often doing so through yelling and screaming (9, 14, 15, 16).

A variety of sources presented the voice as malicious, including participants experiencing EDs:

> “the voice of restriction was just mean and nasty” (PLE; 10).

Some clinicians viewed the voice as bullying:

> "[The EDV says] really horrible, horrible things. Like really bullying. Really abusive." (clinical psychologist; 5).

In one case, the voice itself admitted bearing ill-will towards the listener:

> "I like to trick people out of enjoying life" (PLE's EDV; 9).

Similarly, researchers asserted that "the voice's vindictive nature was evident" (researcher, 14).

1.2.1.7 Deceitful.

In nine studies, the EDV was presented as deceitful; described as sneaky (9), duplicitous (19), and of uncertain trustworthiness (11). It appeared to disguise its dangerous nature, presenting as a "wolf in sheep's clothing" (researchers and PLE; 10, 15), as it tricked, trapped or ensnared the person (8, 9, 14, 15). The EDV lied (2, 13, 14) and encouraged the individual to lie to others (14):

> "It urged them to lie to family, friends, and professionals in order to maintain their disordered eating behaviours" (researcher; 14).

1.2.2 The relationship: violence, abuse and imprisonment.

1.2.2.1 At war.

The person's relationship with the EDV was often fraught with conflict (14), described as a struggle (1, 15, 19), fight (3, 5, 14, 15, 17), battle (1, 2, 3, 4, 19) or war (1).

> "I have a constant battle in my head between my voice and the voice of anorexia." (PLE; 19)

1.2.2.2 Abusive relationship.

The EDV was likened to an abusive partner or parent (3, 5, 14, 15, 17, 19), inflicting verbal (5) and physical (14) abuse, experienced as degrading (9, 14). This

toxic relationship was the focus of study 15 (Tierney and Fox, 2011), which highlights parallels between research on domestic violence and experiences of the anorexic voice. Individuals felt drawn into this abusive relationship (14, 15), which made them feel special (3) and offered companionship (3, 19) or care (17). Participants believed the relationship was to be endured or tolerated (14, 15, 17, 19), feeling unable to leave (17).

> “it is as an abusive relationship … you almost feel helpless without it … you don’t like it but … they promise to look after you” (PLE; 17).

1.2.2.3 Imprisonment.

Individuals described feeling imprisoned (14, 15), trapped (8, 14, 15, 17), or ensnared (14, 15) by the EDV, even feeling “like a prisoner in my own body” (PLE; 15). ‘Breaking free’ (15, 17, 19), was seen as difficult or unachievable (14, 19).

> “There’s no escape, I cannot hide, not even at night in bed.” (PLE; 14)

1.2.3 Impact.

1.2.3.1 Feeling helpless.

The EDV’s perceived power led individuals to feel disempowered. Some expressed feeling helpless (15, 17), incapable (3), paralysed (3), immobilised (14), muted (10), out of control (1, 10), confused (4, 17), floundering (11), indecisive (17, 18), lost (10, 17), and unable to challenge the voice (2, 14).

> “the voice can be so controlling that it becomes paralysing” (researcher; 3).

This sense of helplessness links to experiences of imprisonment, abuse, or relentless criticism from the voice, and may influence responses to it, producing “unquestioning obedience to the voice’s commands” (researcher; 15).

1.2.3.2 Guilt and shame.

After eating, the EDV triggered feelings of guilt (1, 7, 8, 15) and argued that these feelings were justified:

> "[The EDV] told most women that when they eat, they 'should feel guilty'" (researcher; 7).

A perceived binary choice between loyalty to family versus the EDV also evoked guilt:

> "I listened to the 'voice', and felt a swelling guilt towards my family. I fought the voice and felt the guilt that my family had replaced my anorexic friend." (PLE; 15)

The voice could lead people to feel ashamed (3, 9, 10), through degrading comments (9), responses to perceived failures (10), or appearing superior, prompting self-blame:

> "I imagine [the voice of] somebody who is confident … and experienced problems in their life which they … deal with, unlike me … which makes me feel ashamed." (PLE; 3)

1.2.3.3 Low self-esteem.

Three studies stated that the EDV eroded self-esteem through continual criticism and abuse (3, 14, 15).

> "[The voice] criticised and belittled an individual's actions, attacked her sense of self, made her question her own abilities, slated her as a failure and undermined her self-esteem and confidence." (researcher; 14)

This held individuals back from new opportunities in life (3).

1.2.3.4 Low mood.

In some cases, the EDV sapped enjoyment from life (3, 9) and triggered tearfulness (14), despair (15), depression (18) and suicidal thoughts (4, 18). Both clinicians and individuals experiencing EDs suggested that the EDV directly impacts mood:

> "When that anorexic voice really starts to activate, you see their mood just completely nosedive." (dietetic assistant; 5)

> "It makes me depressed and suicidal because I am never good enough to meet … the expectations of the voice in my head." (PLE; 18)

1.2.3.5 Anxiety.

Some reported that the EDV causes anxiety and associated physiological symptoms, such as chest tightness and breathlessness (3). It was described as "something to be feared" (researcher; 14), particularly if unable to meet its demands (15). One participant stated "it made me scared to be alive" (PLE; 14). Awareness of the voice heightened anxiety:

> "When participants became more aware of their EDV … it was experienced as uncomfortable and scary" (researcher; 10).

1.2.3.6 Surrendering: ED behaviours.

Eleven studies discussed surrender to the EDV through behaviours, with individuals "bowing to its will" (researcher; 14) and "appeasing the abuser" (researcher; 15). Forms of surrender included exercise (3, 5, 7, 15), bingeing (1), vomiting (14), laxative use (14), and productivity (3). These behaviours did not solely function as punishments for disobedience; the EDV also pressured individuals to engage with them routinely. Obedience was motivated by a desire to escape the voice (5, 14, 15) or "avoid its wrath" (researcher; 14), in spite of physical needs (7), pain (15), health problems (5) and exhaustion (15).

> "[Despite] shin splints … fractured pelvis … compressed discs and … broken toes, they're still running … on the treadmill, to get away from the voice." (art psychotherapist; 5)

> "women described going to great lengths to pacify their critical voice, enduring painful exercise and dietary regimens" (researcher; 15).

1.2.3.7 Social isolation.

The EDV intruded into individuals' social worlds and produced social isolation (3, 10, 15), interfered with close relationships and marriages (3) and elicited loneliness and separation (10). Its criticism (3, 15), impact on self-esteem (3) and comments that others bear the person ill-will (3, 10, 14, 15) affected individuals' social behaviours. For example, they avoided initiating contact (3, 10), ignored or pushed others away (3, 15), became secretive (3) and lied (3, 14).

> "[When the voice is there] I feel bad about myself and … hang out in my own room … or just be quite quiet if I have to stay with other people." (PLE; 3)

Perhaps this social isolation increases reliance on the EDV's companionship:

> "People started to try and reach in … you pulled me away, sucking me further and further into a black crevice in my mind. You stopped me listening to others until you were the only voice." (PLE; 15)

1.2.3.8 Constraining life.

By impacting emotions, self-evaluation, behaviour and relationships, the EDV inevitably constrained people's lives. It was termed disruptive (6), restrictive (13), confining (14, 15) and constraining (15). It interrupted (4) and prevented enjoyment of life (9), shut down other activities and external connections (12, 15), and dictated behaviour, removing control over one's life (14). As one participant put it, the voice had "Stolen my life … Until it was all I had" (PLE; 15).

1.3 A third option?

1.3.1 Distrustful.

The EDV was described as untrusting (10), viewed the world as dangerous (15) and promoted distrust of others, including telling individuals to cut ties with their partner or therapist (3, 10, 14). It suggested that others do not care about the individual and wish to harm, humiliate, or make them 'fat' (3, 14, 15).

> "It would tell me: "They hate you and you can't really trust them. They'll only hurt you." (PLE; 14)

Viewing the world and others as threatening may drive the EDV's urge to offer 'protection' and impede social connections and recovery.

1.3.2 Irrational.

The EDV was described as illogical or irrational (3, 6, 7, 10, 15, 17, 19) and contrasted with the person's "normal" or "rational" side (researchers and PLE; 4, 7, 19) or "voice of reason" (researchers; 14, 15). Its rules and arguments were contradictory (10) and "[drove] you to do the most insane things" (PLE; 7). The voice's power was independent of rationality:

> "it almost had like a lawyer-tone … that could out-argue anyone … there was no logic to the argument but somehow it won." (PLE; 10)

Irrationality was a defining characteristic of the EDV – "a critical, illogical and irrational entity that battled against and controlled their rational, true self" (researcher; 19).

1.3.3 Vulnerable and scared.

Occasionally, the EDV appeared vulnerable and scared, in stark contrast with its powerful persona. It issued warnings of perceived danger (10, 15) and feared the prospect of recovery:

> "recovery caused the voice to adopt a frightened tone, saying that it was scared of gaining weight, and … doubted their ability to recover." (researcher; 10)

2. Changes Over Time: the "downward spiral"

2.1 Origins: nature/nurture.

Where the EDV's origins were discussed, an interaction of 'nature' (genes and personality) and 'nurture' (parental criticism/modelling self-criticism, abuse and the wider social environment) was cited.

2.1.1 Genes.

One researcher implicated "genetic similarities" (researcher; 3) between a participant and her self-critical father in the development of her EDV.

2.1.2 Criticism from parents.

Some participants suggested that parental criticism contributed to EDV development. The EDV's comments echoed parents' general (3) or eating and weight-specific criticisms (10) from childhood, even where the parent-child relationship was evaluated positively (10).

> "…it was like, 'That is not for you!' That kind of voice, like my mother would slap my hand when I put it in the cookie dough" (PLE; 10).

2.1.3 Parents modelling self-criticism.

Parental modelling of self-criticism also seemed relevant. One participant noted that the EDV's criticisms "are things I've heard [my mother] say to herself" (PLE; 3).

2.1.4 Abuse.

In one case, parental abuse was echoed in the words of the EDV:

> “Diana grew up with an abusive mother and her critical voice is a reflection of the things her mother [said] to her as a child … “you’re not good enough for that … you shouldn’t eat”” (researcher and PLE; 3).

2.1.5 Own personality.

Participants occasionally suggested that personality traits, such as perfectionism, people-pleasing, rigidity, or over-control, paved the way for the EDV (3).

> “Two [participants]… believe that their own perfectionistic tendencies contributed to the [EDV’s] development … An additional two participants only speak of the critical voice being a result of their personality.” (researcher; 3)

2.1.6 Wider social environment.

The wider social environment was more frequently implicated in EDV development. Exams (3), bullying (3), general family tension (4), peer interactions (10), the transition to high school (10), and contact with underweight individuals (16) were cited as contributing factors.

> “[the critical voice] took hold when … I was doing my exams and feeling … that I wasn’t working hard enough … no matter how much I did … [that’s] when I started to become unwell” (PLE; 3).

> “Four participants discussed the social messages that contributed to their EDV … P7 talked about … friends who basically served as a ‘pro-ana’ community” (researcher; 10).

2.2 Entry of the EDV.

2.2.1 Gradual.

The EDV’s entry often seemed gradual: gradually emerging (14, 15), creeping or drawing the person in (3, 14, 15) and beginning as a “whisper” (5).

"Participants wrote about how the voice gradually entered their life" (researcher; 14).

2.2.2 At a moment of vulnerability.

Some recalled the EDV emerging at a vulnerable point (14, 19):

"you arrived just when I was feeling so alone, isolated and confused" (PLE; 14).

2.2.3 Initially valued.

The EDV's valued characteristics appeared prominent at the outset. It "arrived with a plethora of endearing qualities" (researcher; 14) and seemed "friendly, helpful, and seductive when they first became aware of it" (researcher; 10).

2.3 Downward spiral.

A downward spiral ensued. The EDV became increasingly destructive and powerful, promoted dependence, and sometimes demanded an exclusive relationship.

"the messages from their EDV gradually spiralled downward" (researcher; 10).

2.3.1 Increasingly destructive: helpful friend to harsh task-master.

While the EDV initially appeared helpful, it evolved into a destructive force and "harsh task-master" (researcher; 15), becoming increasingly unpleasant (19), critical (14, 19), demanding (14, 15), punitive (14), persecutory (10), crushing (17), and harmful (19).

"What initially was valued about the voice altered over time and became something to despise." (researcher; 14)

2.3.2 Escalating intensity and power.

The EDV also gained power (10, 17) as the ED developed, increasing in volume (10, 14, 16), strength (3), dominance (10, 17, 19), control (19) and forcefulness (10, 14).

> "Participants [perceived] their EDV as escalating, gaining power … becoming louder … more prominent … when their ED behaviours began." (researcher; 10)

2.3.3 Increasing dependence on the voice.

As the EDV gained power, dependence upon it increased (14, 15). Perhaps this was because its input was valued:

> "participants drew support from the voice's presence, becoming dependent on it as a source of guidance" (researcher; 14).

Alternatively, dependence could result from feeling rescued (14) by the voice:

> "the anorexic voice … creates a sense of despair and dependency on it as a source of salvation" (researcher; 15).

Lastly, the EDV elicited dependence by lowering self-esteem until the person felt "unable to function without it" (14).

2.3.4 Demands for exclusivity.

In some cases, the EDV demanded an exclusive relationship (14, 15), becoming "the only voice" and "all I had" (PLE; 15).

> "the voice started to demand an exclusive relationship with the individual and constantly tested her allegiance" (researcher; 14)

This progressive demand for exclusivity relates to the previously discussed concepts of an 'abusive relationship' and 'social isolation'.

2.4 Idiosyncratic changes.

In addition to common patterns of EDV development, some changes over time appeared idiosyncratic: anger preceding EDV onset (10), the voice emerging at puberty (3), preceding the ED (3) or becoming “more male” (PLE; 10). Changes in the EDV’s focus also varied, from general to ED-specific criticisms or vice versa (3), or from calling the person “fat” to telling them to “fix” it (PLE; 10).

2.5 Hope.

2.5.1 Losing trust in the voice linked to recovery.

Some considered losing trust in the voice a vital step towards recovery (2, 13, 14).

> “I had enough to convince myself that the ED is lying to me … which really helped me to imagine life without it.” (PLE; 2)

2.5.2 Shifts in the balance of power: taking back control.

Ten studies referenced a shift in the balance of power, with the person reclaiming control from the EDV, including control of their mind, body, own voice and the EDV (2, 7, 10, 13). Individuals described feeling empowered (5, 13, 15) and rediscovering the “real self” (researcher; 17) as the EDV lost power (7, 10, 14).

> “once they gained control over the voice, it had gradually begun to lose its power.” (researcher; 7)

3. Relation to the Self: Me, Part of Me, or Taking Over Me?

3.1 Me.

Some participants viewed the EDV as their own voice (3, 10) or compared it to “normal” thinking (PLE; 3). Others stated “it’s [AN] me” (PLE; 17), or told the EDV “You are my whole life” (PLE; 14).

> “It’s just my own voice … sometimes I’ll have conversations with it … but it’s just me” (PLE; 3).

When closely identified with, the EDV may become indistinguishable from the self as a whole.

3.2 Part of me.

More commonly, the EDV was viewed as part of (1, 3, 4, 5, 17, 19), a different side of (3, 4, 17), or different position within (19) the self. Some experienced an “anorexic self” and “non-anorexic self” (researcher; 17).

> “there are 2 people in my head: the part of me that knows what needs to be done and the part of me that is trying to lead me astray. Ana is the part that is leading me astray and dominates me.” (PLE; 19)

Viewing the EDV as part of the self has implications for recovery. One participant suggested removing it would feel like “someone just came along and chopped your legs off” (PLE; 17).

3.3 Taking over me.

Most commonly (sixteen studies), the EDV was said to take over the self: taking over (3, 6, 7, 15, 17), in charge or in control (7, 15, 18) or dominating the self (14, 19), and overriding or muting (10, 13) the person’s voice. Individuals expressed that their self or identity had been lost (10, 11, 12, 15, 17), consumed (11, 12, 19), claimed (15), engulfed (15), chipped away at or crushed (17) by the voice. Some felt possessed by the EDV (1, 6):

> “it’s the voice that is in control of me. This demon has taken over me.” (15)

The EDV’s propensity to take over the self relates to its escalating power.

3.4 Fragmenting sense of self.

The EDV fragmented sense of self, threatening, attacking (6, 14, 19), and producing uncertainty (11, 12, 17) regarding self-concept. Living with the EDV was experienced as having one's brain split in two (7), two separate voices in one's mind (10), or multiple selves (17).

> "Participants described having two selves and being confused as to which person they were." (researcher; 17)

The self could be divided into the "true" self and EDV (19), producing a "split personality" (7, 17) and leading some to question their sanity (10). The EDV's own contrasting sides, experienced as a "two-headed monster" (10), may reflect the psychodynamic concept of 'splitting' (10) into all-good and all-bad.

> "it gives you like a split personality. Good and bad" (PLE; 17).

Disentangling the EDV from the self was difficult (3), and attempts to do so could feel "dissecting" (occupational therapist; 5), further fragmenting the self. Recovery may involve re-establishing "wholeness":

> "[One participant] described 'becoming a ''whole'' person' as part of her wish to recover" (researcher; 19).

3.5 My antithesis?

The EDV was sometimes presented as the person's antithesis or opposite:

> "the antithesis of my weak and fractured mind" (PLE; 3).

For example, the EDV could represent disowned characteristics or values. It was said that the EDV "values things that are the complete opposite to what I … value" (PLE; 13) and acted as a "repository for qualities of the self that participants were unable to correlate" (researcher; 14) with their self-concept. Examples included 'unfeminine' traits such as competitiveness, ruthlessness and power (14). However,

some fully identified with the EDV, and the voice could represent the person's own tendencies, such as a bias towards negativity (15).

4. Relation to the Eating Disorder: A Mixed Picture

4.1 Defining characteristic?

4.1.1 Not ubiquitous.

In one study, healthcare professionals argued that the EDV is not ubiquitous amongst individuals experiencing EDs, and could feel invalidating, stigmatising or overly abstract if applied as a "one-size-fits-all" construct (occupational therapist; 5).

4.1.2 Common.

In contrast, three studies described the EDV as common.

"It was common for forum users to refer to an inner voice that told them not to eat" (researcher; 8).

4.1.3 Defining characteristic.

In two studies, the EDV was presented as a "defining characteristic" (researcher; 19) of anorexia nervosa:

"the 'anorexic voice' was a fundamental aspect of anorexia nervosa, as all participants described being aware of this phenomenon … prior to any therapeutic input" (researcher; 17).

4.2 Vague relations: equal to, driving or partly responsible?

4.2.1 Equal to.

The EDV was sometimes equated to the ED (3, 19):

"Participants speak of the voice and their ED being one and the same" (researcher; 3).

4.2.2 Driving.

The EDV was sometimes said to drive the ED, through criticism (3), or attachment or identification with the EDV (5). The voice could drive ED behaviours (3, 7), triggering a vicious cycle:

> "if I've been thinking that "I'm really fat" then it can make me restrict more but then the restricting … impacts the voice … it's a bit of a loop." (PLE; 3)

4.2.3 Partly responsible.

Where the EDV was deemed partly responsible, there were individual differences in ED characteristics attributed to the EDV. For example, the EDV may trigger bingeing, with purging as the person's response (1):

> "Several described an uncontrollable desire to surrender to their inner voice … by 'eating a bunch' … participants took care of 'it' through self-induced vomiting" (researcher; 1).

Conversely, bingeing may break EDV rules, while purging may be EDV-driven (14).

> "You greedily shove them in … relishing the fact that you are going against me … I'll force you into the bathroom … staring into the void of the toilet bowl." (PLE's EDV; 14)

Additionally, the concept that attachment or identification with the EDV drives EDs (5) suggests that individuals' responses to it can impact EDs and recovery.

4.3 Conflict among clinicians.

4.3.1 What is it?

Clinicians held diverse views of the EDV. Some equated EDV comments to thoughts (5), or questioned "how it differs from a psychotic experience" (researcher; 5). Others suggested the concept was introduced by professionals (5) or "adopted

the pragmatic stance that it is a concept “that works”” (researcher and consultant psychiatrist; 5), indicating it is constructed by clinicians. Still others saw the EDV as a “can of worms” (researcher; 15) – something unpleasant and best left alone.

4.3.2 One of many conceptualisations.

Healthcare professionals emphasised that the EDV is one of many conceptualisations (5). It was described as “one of many metaphors for the experience of AN” (researcher; 5), other examples including “a battle, a pit…, a wasp, an aggressive plant, or an abusive boyfriend” (drama therapist; 5). Additionally, “certain therapeutic models incorporate similar ideas with different names” (researcher; 5), such as the inner self-critic in compassion-focused therapy, or self-to-self relating in cognitive analytic therapy.

4.3.3 Not a real entity.

Overall, clinicians did not view the EDV as ‘real’, presenting it as “a potentially helpful construction rather than a real entity” (researcher; 5).

5. In Recovery: A Source of Ambivalence or Opportunity for Change?

5.1 Ambivalence.

5.1.1 Dependence & addiction.

Dependence and addiction in relationships with the EDV may trigger relapse or ambivalence towards recovery. Like an addiction, this relationship warranted ceaseless vigilance:

> “P3 likened her current relationship with her EDV to an addiction that she … has to monitor” (researcher; 10).

Participants described feeling dependent on the EDV for guidance (14, 15) and protection (17), making it difficult to let the relationship go.

5.1.2 Fear of losing the voice.

Fear of losing the EDV was a commonly cited barrier to recovery. Participants reported ambivalence (4, 10), fear (14, 15) and reluctance (12, 17) at the prospect. Some feared identity loss (10, 14, 17), being "no-one" (researcher; 17), feeling incomplete (4, 17) or directionless (14, 15).

> "Who am I if I let this go? What will drive my life now?" (researcher; 14)

Recovery could mean losing the voice's companionship; feeling lonely (15), sad (14, 19), or empty (5) without it. Retaining the EDV was seen as "better than having no-one" (clinical psychologist; 5). Recovery could be experienced as a loss (14, 17, 19), painful (14), or "like killing your best friend" (PLE; 14, 15). Contemplating losing the voice's guidance incited fear and helplessness (15, 17).

> "A sense of loss was experienced by ending the relationship … this made progress towards recovery difficult" (researcher; 14).

5.1.3 Abdicating responsibility?

Some worried that the EDV concept removed responsibility for recovery. Individuals could be positioned as passive, with the EDV seen as something "happening to them" (nurse; 5), making the person "invisible in the therapeutic process" (researcher; 2). The EDV was sometimes presented as responsible for thinking patterns:

> "Carol uses [externalisation] in portraying her ED as a voice separate … and as responsible for her negative self-evaluations" (researcher; 16).

Similarly, there were concerns that the EDV concept reduced agency over behaviour (5, 13); that it "could lead to clients disowning responsibility for changing their behaviour" (researcher; 5). Indeed, some experienced reclaiming responsibility during recovery as challenging (15). Clinicians responded to these concerns by

emphasising that the voice is “ultimately coming from them” (researcher; 5) or highlighting individuals’ agency over their responses to the voice (5).

5.1.4 Wish to be free must outweigh the benefits.

Recovery appeared more possible when the desire to be free of the EDV outweighed its perceived benefits (14, 15). Re-evaluating the balance of pros and cons could help to overcome ambivalence (5, 15):

> “retreating from [AN] and its associated voice involves acknowledging that it has many more negative compared to positive aspects.” (researcher; 15)

5.1.5 Resistance from the voice.

The EDV was said to resist (10, 13, 15), or prevent progress (15) towards recovery, making it an “uphill and continuous struggle” (researcher; 14).

> “I try to shake it off but it holds on, tighter than before.” (PLE; 15)

The voice seduced and persuaded individuals to maintain ED behaviours (1, 3), questioned why treatment was necessary (10), dismissed the ED’s ill-effects and argued that recovery is impossible (19). It became increasingly critical during recovery (10), acting like a “spoilt child” (PLE; 3), throwing tantrums (10), arguing or fighting (3, 10, 14, 17), or enforcing “harsh repercussions” (PLE; 15) when its demands were not met. Ignoring the voice, eating or engaging in “healthy behaviours” (3) could make the voice louder (3, 14, 15, 19).

> “Healthy behaviours seem to make the voice louder as it attempts to maintain control.” (researcher; 3)

The EDV undermined recovery-promoting relationships. It encouraged individuals to cut ties with their boyfriend (3) or therapist (10), devalued healthcare professionals (10) and slandered those reaching out to the person (14).

> “when [my therapist] … would challenge the voice, then it was like, “Well, he doesn’t know what he’s talking about because he’s an asshole and you should stop seeing him.”” (PLE; 10)

The voice interacted with aspects of treatment. It compared weights in group therapy (16) and produced a sense of achievement following involuntary hospital admission (12). Paradoxically, the voice criticised progress towards recovery, either motivating individuals or leading them to give up (3). It was considered a relapse trigger (13), “ready to jeopardise attempts to exist in a healthier manner” (researcher; 15).

5.2 Opportunity.

5.2.1 Dispel stereotypes.

Some suggested that the EDV concept could dispel stereotypes trivialising (14, 15) or blaming individuals (5) for EDs.

> “I want to make people aware of the inner voice that lives inside someone with an ED, and squash the stereotype that “it’s all about being thin” (PLE; 14).

This may especially benefit those who “do not fit cultural stereotypes of anorexia nervosa … e.g. older women or males” (researcher; 15). In contrast, others suggested that the EDV concept could itself be stigmatising (5, 15).

5.2.2 Externalisation.

Thirteen studies referenced externalisation of the EDV, separating it from the self.

> “as I’ve started to separate it that’s when I’ve felt like it’s not a part of me” (PLE; 3).

Externalisation was seen as important for recovery (3, 4, 5, 6, 13, 14, 15, 17), by enhancing awareness (4, 10, 14, 15), motivation (14, 15), and empowerment (15), and promoting scrutiny of the voice (5):

> "externalising this voice … enables someone to resist being oppressed and allows them to find their own voice" (researcher; 15).

However, externalisation was also considered potentially problematic. Some had difficulties separating the EDV from the self:

> "They had a hard time distinguishing because of the similarity in content between their EDV and their regular self-talk." (researcher; 10)

As previously mentioned, there were concerns that externalising the EDV risks reducing responsibility for recovery (5) or dismissing the person (2, 15). Also, a paucity of research on externalisation was highlighted (19).

5.2.3 Speaking back.

Many described an inner debate, with individuals or the "nurturing parts of the self" (10) speaking back to the EDV. This was framed as a recovery technique (3, 5, 10, 15), sometimes self-learned (10), adopted from self-help resources (3), or coached by therapists (5, 10, 15). Speaking back to the EDV could reduce its power and promote self-acceptance:

> "fighting back meant the voice was muted and began to lose its grip" (researcher; 14).

> "For three participants, when the EDV comes up … they are able to talk back … and be more accepting of themselves." (researcher; 10)

Rebutting the voice could be "exhausting" (PLE; 3), and involved arguing back "even if you don't believe what you're saying" (PLE; 3). Speaking back did not eliminate ED behaviours:

> "though participants may have started to 'talk back' to the EDV, they were still restrictive" (researcher; 10).

Some individuals found speaking to the voice unproductive, as it persistently argued back (3, 19):

> "it's … better not to even engage with it … 'cause it can be so manipulative" (PLE; 3).

5.2.4 Dismissing the voice.

An alternative approach was to dismiss the EDV. Some told it to "go away" (PLE; 3, 13), retorted "I don't care" (PLE; 3), batted it away (5), or ignored it (14, 15). Others altered how the voice sounds, metaphorically "turning the radio down" (PLE; 3), or changing it into their father's voice because "he would never say [that] to me … it shows that it's not real" (PLE; 3). Humour was also used dismiss the voice:

> "I just wrote down exactly what it says and [my boyfriend] and I laughed about it … on paper it looks less scary and a bit funny." (PLE; 3)

Another strategy was to disregard EDV instructions:

> "I do the exact opposite of what it is telling me to do, just show it … is not going to affect me." (PLE; 13)

5.2.5 Life outside.

Focusing on life beyond the EDV aided recovery. This could involve imagining life without it (2), or reconnecting with parts of the self that "want something more" (consultant psychiatrist; 5) or are "outside the clutches of you" (PLE; 14). People's lives were also expanded through journaling, music, painting, reading, travelling (3), relationships (7), or creating "comfort boxes" (researcher; 10). These activities were enjoyable (3, 10), an outlet for emotions (3), distracted from the EDV (3), demonstrated self-love (3), and highlighted other aspects of identity (3).

Focusing on life outside the EDV diminished the voice's importance (5), offered hope that recovery is possible (2, 10, 14, 15), and re-established a sense of self independent of the EDV (7, 15, 17).

> "The 'real self' was gradually getting bigger, and participants were beginning to become the person they wanted to be" (researcher; 17).

5.2.6 Support from others.

Support from others was valued in recovery. Some individuals felt more able to free themselves from the EDV with support from family, friends or professionals (14, 15), who could act as "allies" (researcher; 15). Others sometimes acted as the "voice of reason" (researcher; 14, 15) countering the EDV. Additionally, one adolescent experienced relief from the "battle in my head" as others took responsibility for decision-making around food (PLE; 2).

5.2.7 Importance of working with the voice in therapy.

Ten studies promoted therapeutic work with the EDV, arguing that individuals "should be helped to manage the daily struggle they endure with this internal controlling force" (researcher; 15). Researchers suggested that opening dialogue (16) with the voice is important to "move on" (researcher; 19), and improve treatment outcomes (14). Therapeutic engagement with the EDV could distinguish the individual and EDV (6), empowering individuals with a sense of agency (5). Therapeutic work with the voice was thought to aid clinicians' compassion (5), sensitivity (15), and non-judgemental stance (5), and help clinicians to cope with perceived ambivalence towards recovery (15). Furthermore, engaging with the EDV could convey empathy (4, 5). One individual suggested that the ED's underlying basis was overlooked in therapy, because they had not worked with the EDV:

> "I never really covered [the voice] in therapy … it didn't address the root cause." (PLE; 3)

Conversely, some clinicians felt that it was “not essential” to work with the voice (5), or were concerned about “opening a can of worms” (researcher; 15), perhaps fearing they could not ‘contain’ the emotional content that could arise.

5.2.8 Therapeutic modalities and approaches.

Proposed therapeutic approaches to the EDV included CBT (3, 5, 6, 14), cognitive analytic therapy (14), acceptance and commitment therapy (3), compassion-focused therapy (3, 5), emotion-focused therapy (10, 17, 19), narrative therapy (14, 15, 16) and dialogical self theory (10, 19). Cross-theoretical approaches such as chairwork (5, 10, 19), role play (14) and internalisation of the therapeutic relationship (5) were also discussed.

In CBT, EDV comments were challenged and balanced alternatives reached, but people in treatment experienced difficulties believing these balanced thoughts (3). Several researchers suggested drawing from CBT for voice-hearing (5, 6, 14), considering beliefs about the EDV (6) and focusing on “experience[s] rather than trying to eradicate … voices” (researcher; 14). In cognitive analytic therapy, the EDV represented self-to-self relating (5) – interpersonal experiences relevant to EDV development were considered (14). The “inner self-critic” in compassion-focused therapy was equated to the EDV (researcher and clinical psychologist; 3, 5). Some valued an acceptance and commitment therapy approach:

> “being able to hear that voice … and just accept it and get on with what you’re doing nevertheless and look at … how the … voice is alien from how I’d like to live my life” (PLE; 3).

Emotion-focused therapy involved exploring the voice’s impact and responding through chairwork (10). Addressing an empty chair representing the “anorexic critic” (19) could support individuals in developing a dominant position (19), asserting their needs (10) and cultivating self-acceptance (17). In narrative approaches, individuals

re-told their experiences with the EDV, emphasising their strengths (14), highlighting the EDV's false promises (15), and opening internal dialogue to facilitate change (16).In dialogical self theory, the EDV represented a dominant self-critical position (19). It was argued that "effective therapy … involves successful dialogue between the different voices to develop an integrated multiple self" (researcher; 19).

5.3 Questions.

5.3.1 Perspectives on recovery.

The reviewed studies offered various perspectives on recovery concerning the EDV. Some emphasised that "life free from anorexia nervosa was possible" (researcher; 14). Recovery could be experienced as emotional not intellectual (3), or arguably rely on resolving "dichotomy between the rational and irrational side" (researcher; 7). Some aimed to "control" the EDV (researcher and PLE; 7, 10), whereas in others sought "a better relationship with their EDV" (researcher; 10). There was no consensus on whether to address the EDV in therapy. Coercive or restrictive service responses were thought to have iatrogenic effects, "reinforcing the anorexic self" (researcher; 12). Work with the EDV was, for some, the "final stage of … recovery", and "a gradual process" (researcher; 7). Suggested mechanisms for recovery included externalisation (6, 14, 17), increasing self-esteem (10), and developing one's sense of self (7, 15, 17, 19).

> "Recovery may involve … developing the authentic self in ways that are not simply defensive reactions to the anorexic voice" (researcher; 19).

Anticipating the EDV's re-emergence was recommended for relapse prevention (8, 13).

5.3.2 To what extent does the voice remain?

There were differing views on the voice's permanence. A residual EDV commonly remained (3, 7, 10, 15) throughout recovery, "lingering after ED symptoms improve" (researcher; 3). This led some to question whether full recovery is possible:

> "you may never fully recover from anorexia, I think the voice is always there." (PLE; 7)

Moreover, participants anticipated the voice re-emerging (8, 10, 14, 15):

> "Even among those who had made progress, the voice was depicted as being ready to re-establish its dominance at any moment" (researcher; 14)

For some, recovery meant "controlling", ignoring, or limiting the impact of the voice (7). Others said the EDV transformed during recovery, changing into or overpowered by a 'recovery voice': "a nurturing, loving, kind voice that was like a warm hug from a mother" (researcher; 10). Some individuals believed it was possible to be free of the EDV (14, 15), reflected that "it has been a while since the EDV has even come up" (researcher; 10), or found that the voice had "disappeared" (PLE; 7).

5.3.3 Areas for further research.

Suggestions for future research ranged from the general, such as exploring "experiences and meanings of the anorexic voice" (researcher; 19), to the specific, including investigating the EDV's transformation into a "recovery voice" (researcher and PLE; 10), similarities with external relationships (14), and any associated vulnerability to abusive romantic relationships (15). Several authors promoted research with more ethnically and gender-diverse samples (10, 14, 15), or suggested investigating cultural or diagnosis-based differences in EDV experiences

(10). Some proposed comparing EDV and other voice-hearing experiences, or assessing how those experiencing EDVs relate to the concept of being a voice-hearer (14). The integration of the EDV into therapy was an oft-proposed research avenue (14, 15, 19).

Discussion

Summary

This is the first meta-ethnography investigating experiences of the EDV. The review was warranted, as existing research suggested that the EDV is common and powerfully related to experiences of EDs. A systematic literature search and CASP quality appraisal were conducted, and data were synthesised using Noblit and Hare's (1988) meta-ethnography approach. Overall, the synthesis demonstrated that EDV experiences have a pervasive impact over the course of EDs, affecting understandings of the self and ED. These findings concur with Aya et al.'s (2019) conclusions that the EDV is powerful, negative, omnipotent and related to ED symptoms, but provide more nuance and detail. This includes identifying common and more idiosyncratic aspects of the EDV experience, and a line of argument following EDV experiences from onset into recovery. This richer understanding may better inform ED treatments.

Reciprocal Translation

Commonalities in experiences of the EDV were identified. The EDV was experienced as having a dual nature, with valued features, but also malignant characteristics, hostile relations with the self, and negative effects on emotions, self-concept, eating behaviours and relationships. The voice consistently increased in power and malevolence during ED development. During recovery, the balance of power often shifted back to the person (or the 'healthy part' of the self). Typically, the EDV appeared to substantially impact, and often fragment, sense of self. This

‘lost emotional self’ has been proposed as the basis for anorexia nervosa development, and a potential focus for treatment (Oldershaw et al., 2019).

Corresponding with its dual nature, the EDV consistently conferred both barriers and opportunities for recovery. There was agreement that the EDV promotes ambivalence to change commonly accompanying EDs (Blake et al., 1997), as many feared losing the voice and it actively inhibited recovery. Common methods of addressing the voice included externalisation, talking back, expanding other life domains, and therapeutic work with the EDV. Similarly, individuals experiencing psychosis report benefits from speaking back to voices (Fenekou & Georgaca, 2009). The need for further research was universally acknowledged, particularly involving diverse samples or therapeutic work with the EDV.

Refutational Synthesis

Views on other aspects of the EDV experience were more disparate, perhaps because they are less well-understood or present greater individual difference. The dichotomy of EDV characteristics as angelic versus demonic was a dominant narrative; alternative views of the voice as distrustful, irrational, vulnerable and scared arose less frequently. Similarly, voices in psychosis are often experienced as malevolent and/or benevolent (Birchwood & Chadwick, 1997; Close & Garety, 1998), but qualitative research reveals nuanced appraisals, of voices as supportive, supernatural or ‘sweet’ (Fenekou & Georgaca, 2009).

Factors implicated in EDV development presented individual differences. For those citing parental criticism and abuse as contributing factors, research linking childhood emotional abuse and EDs may apply (Kent & Waller, 2000). However, abuse was mentioned in only one study and other factors were implicated in EDV development. Idiosyncratic changes in the EDV over time were clearly described, sometimes in opposite sequences (e.g., shifting from general to ED-specific

criticisms or vice versa). Additionally, relations between the self and EDV varied, with the EDV representing part of or the whole self, or taking over the self. These positions are not mutually exclusive, particularly over time. One person may experience the voice as part of the self, progressively consuming the whole self. Some described the EDV as their antithesis, but others saw their own characteristics reflected in the voice, suggesting it is not universally a vessel for disowned traits (Tierney & Fox, 2010). Similarly, the voice's relation to the ED was contested: its role in ED onset and maintenance, and the origins of the EDV concept. Elsewhere too, there is disagreement over origins. Some suggest that the EDV concept has been constructed by clinicians (Pugh, 2016), while others highlight reports of EDV experiences preceding contact with services (Williams et al., 2019).

Disparate opinions also applied to recovery. There were fears that the EDV concept reduces responsibility for recovery, and contrasting hopes that it could empower individuals to separate decision-making from the ED. Awareness of the EDV was thought to dispel stigma and stereotypes of EDs (Puhl & Suh, 2015), but also seen as potentially stigmatising, perhaps reflecting stigma associated with other forms of voice-hearing (Gerlinger et al., 2013). Methods of addressing the EDV in recovery were evaluated differently. Many advocated externalising or talking back to the voice and EDV-focused therapy. Conversely, drawbacks of such methods were discussed and some deemed therapeutic work with the voice non-essential, or even unhelpful. For instance, some clinicians feared externalisation would reduce individuals' perceived agency and hence their motivation to recover. Moreover, some individuals found debating with the EDV ineffective, preferring to dismiss it, possibly because 'fighting' internal voices activates a sense of threat (Gilbert et al., 2001; Heriot-Maitland et al., 2019). The different therapeutic approaches proposed varied in their methods of altering interactions with the EDV: externalisation through

chairwork (EFT), challenging EDV comments (CBT), or ‘re-storying’ one’s experiences (narrative therapy). Each approach had its proponents and critics.

Ongoing questions highlighted continuing areas of ambiguity, including the nature of recovery involving the EDV: emotional or rational/intellectual, aiming to control or improve one’s relationship with the EDV, the necessity or risks of addressing the voice in treatment, mechanisms for recovery, and the extent to which the voice remains. Lastly, researchers suggested various specific avenues for future research, such as investigating links between EDV experiences and vulnerability to abusive romantic relationships (Tierney & Fox, 2011).

Links to Theory

Revisiting the biopsychosocial model underlying NICE-recommended (2020) ED treatments, this review offers greater insights into the psychological and social drivers of EDs than the biological contributors. Just one researcher conjectured that EDVs may have a genetic component, but the psychological turmoil evoked by the EDV’s dual nature, perceptions of its gradual escalation, intrapersonal relationships involving the EDV and psychological processes affecting recovery were richly described. Within a CBT framework, EDV comments may represent thoughts to be challenged, often predictably self-critical, perfectionistic and focused on eating, weight and shape. The EDV’s ‘downward spiral’ may be accounted for by behavioural reinforcement, as relief from anxiety strengthens the pull to repeat ED behaviours and removes opportunities to challenge ED beliefs. However, this basic cognitive behavioural account overlooks fundamental characteristics of the EDV – its personification and relationship with the individual. In family therapy, the EDV concept may assist with goals of externalising the problem and removing blame. The EDV may be treated as an additional person in the room, and different family members’ perspectives towards it explored. However, variable relations between the self and EDV render both CBT and systemic approaches problematic. For

individuals experiencing the EDV as an external force, framing EDV comments as one's own thoughts may feel dissonant and blaming. Likewise, externalising the EDV in family therapy may not fit for those experiencing the self and EDV as equivalent. It seems unlikely that the theories underpinning today's mainstream ED treatments can accommodate understandings of the EDV without adaptation. Less prominent therapeutic modalities in ED treatment may more readily address the EDV. For example, compassion-focused therapy (Gilbert, 2010), a 'third-wave' CBT, proposes that patterns of relating evolved for external relationships (such as dominant-subordinate relations) can be enacted internally, between different parts of the self. The fit of existing or novel theory with evidence-based understandings of the EDV warrants further consideration, with a view to improving treatments.

Limitations

In addition to areas of concordance and refutation, the review's limitations must be considered. Some have argued that the assumptions underlying meta-ethnography – that it is viable to synthesise findings across qualitative studies and generalise conclusions – are flawed (Britten et al., 2002), contravening the philosophy of qualitative research. Furthermore, it was sometimes unclear whether studies were addressing the same concept. There were references to EDs that appeared implicitly relevant to the EDV, but only studies and quotations clearly referencing the EDV/self were included for analysis. However, understandings of the EDV were inconsistent amongst clinicians and those experiencing an EDV. Additionally, the decision to equate the concept(s) of the EDV and 'ED self' may be questioned, although based on feedback from service users who identified with the EDV but named it a "self". Future research could explore variations in conceptualisations of the EDV, including the possible impact of stigma.

The quality and scope of the available evidence should be taken into account. Whilst studies meeting fewer than five CASP quality criteria were excluded,

the five Category B studies (1, 2, 9, 15, and 16) rank lower on this scale compared with those in Category A. However, the quality appraisal process itself is problematic, comparing research of diverse epistemology on a single scale and overlooking the impact of word limits on the ability to fulfil criteria (Walsh & Downe, 2006). Theses offer greater capacity to meet quality criteria than shorter journal articles, although the latter are peer reviewed - another form of quality assurance. Furthermore, independent CASP ratings by a second researcher would have facilitated reliability checks. As most included studies were identified through hand searches, the database search clearly failed to identify all suitable articles; therefore, relevant data may have been overlooked.

Limitations of included samples privilege experiences of a subset of those affected by EDs. The majority of participants were white Western women, with only 8% specified as coming from other ethnic backgrounds, and the voices of only five males experiencing EDs represented. There may be demographic differences in EDV experiences, for example related to culture, gender, religion, socioeconomic status, or experiences of racism. Indeed, research has found cultural differences in voice-hearing in psychosis (Luhrmann et al., 2015). In other respects, included samples were heterogeneous, featuring the perspectives of researchers, family members, clinicians and people experiencing EDVs. Although the speaker was identified for each quotation, the perspective voiced was not always clear-cut; for example, researchers may state their own opinion or paraphrase participant quotations.

Lastly, the analysis presents limitations. Although the face validity of codes was checked by MP and LS, there was no independent coding by a second researcher. Additionally, some concepts in the synthesis were covered by few studies. For example, only four studies discussed origins of the voice. The data is arguably sparser and less rich for such concepts when, for example, compared with

malignant characteristics of the EDV, discussed in all reviewed studies. Such areas warrant further research. Despite its flaws, this meta-ethnography sheds light on the significant and complex role of the EDV in experiences of EDs and recovery, underlining the importance of building on current understandings and exploring how they could be used to promote recovery from EDs.

Implications

In clinical practice, it could be beneficial for to ask clients about experiences of the EDV. This may involve discussing current or potential strategies for addressing the voice, tentatively drawing on strategies that have reportedly helped research participants to regain power from the EDV. The reviewed studies offer initial ideas for therapeutic work with the EDV, but further research is required to assess their efficacy. Examples include externalisation, speaking back to or dismissing the voice, using others as a counteracting “voice of reason”, or expanding other aspects of life. Thought challenging, chairwork, and re-storying are among the therapeutic techniques proposed for working with the EDV. Caution is necessary to avoid imposing the EDV concept on those who do not identify with it.

Future Directions

There is a need for further high-quality research. As suggested in the reviewed studies, it will be important to study more diverse samples and to investigate links between experiences of the EDV and voice-hearing generally. It could be beneficial to explore areas where this review identified divergent views, assessing whether these domains are less well understood or present greater individual difference. Such topics include the EDV’s development and its role in maintaining EDs. Future research may consider EDV experiences across ED diagnoses, including BED as none of the reviewed studies included this diagnosis. Fit with the biopsychosocial theory underlying current NICE-recommended

treatments (2020) could be further examined, for example investigating any association between EDV experiences and the physiological state of semi-starvation. Critically, ongoing research should focus on the EDV's role in recovery, and the efficacy of methods of working with the voice in therapy. Such research may evaluate specific models of therapeutic work with the EDV, cross-modality techniques (e.g., chairwork), or potential mechanisms for change (e.g., externalisation), ultimately aiming to improve treatment outcomes.

Conclusions

In summary, the EDV commonly presents with valued and malignant characteristics, increases in power and malevolence as the ED develops, affects sense of self and poses barriers and opportunities for recovery. There were differing experiences regarding the voice's development, relations with the self and ED, methods of working with the voice in recovery, and changes to the EDV during recovery. In clinical practice, it may be important to explore experiences and methods of addressing the EDV. There is a need for further research with diverse samples, clarifying the EDV concept, examining its development and role in maintaining EDs, and assessing the efficacy of methods of working with the voice in therapy.

References

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

Atwood, M., & Friedman, A. (2020). A systematic review of enhanced cognitive behavioural therapy (CBT-E) for eating disorders. *International Journal of Eating Disorders, 53*, 311-330. **https://doi.org/10.1002/eat.23206**

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

Benner P. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In P. Benner (Ed.), *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (pp. 71-72). Sage Publications. **http://dx.doi.org/10.4135/9781452204727.n4**

Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine*, *27*(6), 1345-1353. **https://doi.org/10.1017/S0033291797005552**

Blake, W., Turnbull, S., & Treasure, J. (1997). Stages and processes of change in eating disorders: Implications for therapy. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *4*(3), 186-191. **https://doi.org/10.1002/(SICI)1099-0879(199709)4:3<186::AID-CPP128>3.0.CO;2-5**

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked

example. *Journal of Health Services Research & Policy*, *7*(4), 209-215. **https://doi.org/10.1258/135581902320432732**

Broussard, B. B. (2005). Women's experiences of bulimia nervosa. *Journal of Advanced Nursing*, *49*(1), 43-50. **https://doi.org/10.1111/j.1365-2648.2004.03262.x**

Close, H., & Garety, P. (1998). Cognitive assessment of voices: Further developments in understanding the emotional impact of voices. *British Journal of Clinical Psychology*, *37*(2), 173-188. **https://doi.org/10.1111/j.2044-8260.1998.tb01292.x**

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

Conti, J., Calder, J., Cibralic, S., Rhodes, P., Meade, T., & Hewson, D. (2017). 'Somebody else's roadmap': Lived experience of Maudsley and family-based therapy for adolescent anorexia nervosa. *Australian and New Zealand Journal of Family Therapy*. **https://doi.org/10.1002/anzf.1229**

Darby, A., Hay, P., Mond, J., Quirk, F., Buttner, P., & Kennedy, L. (2009). The rising prevalence of comorbid obesity and eating disorder behaviors from 1995 to 2005. *International Journal of Eating Disorders, 42*(2), 104-108. **https://doi.org/10.1002/eat.20601**

De Giacomi, E. (2019). *Eating disorders and living with the "critical voice"* [Unpublished doctoral thesis]. City, University of London.

Dias, K. (2003). The ana sanctuary: Women's pro-anorexia narratives in cyberspace. *Journal of International Women's Studies*, *4*(2), 31-45.

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy, 12*(1), 42-47. **https://doi.org/10.1258/135581907779497486**

Espíndola, C. R., & Blay, S. L. (2009). Anorexia nervosa's meaning to patients: A qualitative synthesis. *Psychopathology*, *42*(2), 69-80. **https://doi.org/10.1159/000203339**

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

Fenekou, V., & Georgaca, E. (2010). Exploring the experience of hearing voices: A qualitative study. *Psychosis*, *2*(2), 134-143. **https://doi.org/10.1080/17522430903191783**

Fox, J. R. E., & Diab, P. (2015). An exploration of the perceptions and experiences of living with chronic anorexia nervosa while an inpatient on an eating disorders unit: An interpretative phenomenological analysis (IPA) study. *Journal of Health Psychology, 20*(1), 27-36. **https://doi.org/10.1177/1359105313497526**

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

Gerlinger, G., Hauser, M., De Hert, M., Lacluyse, K., Wampers, M., & Correll, C. U. (2013). Personal stigma in schizophrenia spectrum disorders: A systematic

review of prevalence rates, correlates, impact and interventions. *World Psychiatry*, *12*(2), 155-164. **https://doi.org/10.1002/wps.20040**

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behaviour therapy. *International Journal of Cognitive Therapy, 3*(2), 97-112. **https://doi.org/10.1521/ijct.2010.3.2.97**

Gilbert, P., Birchwood, M., Gilbert, J., Trower, P., Hay, J., Murray, B., Olsen, K., & Miles, J. N. V. (2001). An exploration of evolved mental mechanisms for dominant and subordinate behaviour in relation to auditory hallucinations in schizophrenia and critical thoughts in depression. *Psychological Medicine, 31*(6), 1117-1127. **https://doi.org/10.1017/S0033291701004093**

Graham, M., Tierney, S., Chisholm, A., & Fox, J. (2019). Perceptions of the "anorexic voice": A qualitative study of healthcare professionals. *Clinical Psychology and Psychotherapy*, *26*(2), 707-716. **https://doi.org/10.1002/cpp.2393**

Graham, M. R., Tierney, S., Chisholm, A., & Fox, J. R. (2020). The lived experience of working with people with eating disorders: A meta-ethnography. *International Journal of Eating Disorders, 53*(3), 422-441. **https://doi.org/10.1002/eat.23215**

Heriot-Maitland, C., McCarthy-Jones, S., Longden, E., & Gilbert, P. (2019). Compassion focused approaches to working with distressing voices. *Frontiers in Psychology*, *10*(152), 1-11. **https://doi.org/10.3389/fpsyg.2019.00152**

Higbed, L., & Fox, J. R. (2010). Illness perceptions in anorexia nervosa: A qualitative investigation. *British Journal of Clinical Psychology*, *49*(3), 307-325. **https://doi.org/10.1348/014466509X454598**

Jenkins, J., & Ogden, J. (2012). Becoming “whole” again: A qualitative study of women’s views of recovering from anorexia nervosa. *European Eating Disorders Review*, *20*(1), 23-31. **https://doi.org/10.1002/erv.1085**

Jewell, T., Blessitt, E., Stewart, C., Simic, M., & Eisler, I. (2016). Family therapy for child and adolescent eating disorders: A critical review. *Family Process, 55*(3), 577-594. **https://doi.org/10.1111/famp.12242**

Kendal, S., Kirk, S., Elvey, R., Catchpole, R., & Pryjmachuk, S. (2017). How a moderated online discussion forum facilitates support for young people with eating disorders. *Health Expectations, 20*(1), 98-111. **https://doi.org/10.1111/hex.12439**

Keys, A., Brozek, J., Henschel, A., Mickelsen, O. & Taylor, H. L. (1950). *The Biology of Human Starvation* (Vols. I–II). University of Minnesota Press. **https://doi.org/10.5749/j.ctv9b2tqv**

Lock, J., & Le Grange, D. (2018). Family-based treatment: Where are we and where should we be going to improve recovery in child and adolescent eating disorders. *International Journal of Eating Disorders, 52*(4), 481-487. **https://doi.org/10.1002/eat.22980**

Lodge-Guttery, C. (2005). The impact of narrative storytelling on cognitive re-composition in individuals struggling with eating disorders. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *65*(7-B), 3714. Retrieved from

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc4&NEWS=N&AN=2005-99002-039

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: Interview-based study. *The British Journal of Psychiatry*, *206*(1), 41-44. **https://doi.org/10.1192/bjp.bp.113.139048**

Marques, L., Alegria, M., Becker, A. E., Chen, C., Fang, A., Chosak, A., & Diniz, J. B. (2011). Comparative prevalence, correlates of impairment, and service utilisation for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health care access for eating disorders. *International Journal of Eating Disorders, 44*(5), 412-420. **https://doi.org/10.1002/eat.20787**

National Institute for Health and Care Excellence (2020, December). *Eating disorders: Recognition and treatment* [NICE Guideline No. 69]. **https://www.nice.org.uk/guidance/ng69**

National Institute of Mental Health (2016, February). *Eating disorders.* **https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml**

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies.* Sage.

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating Disorders: The Journal of Treatment and Prevention*, *22*(4), 337–351. **https://doi.org/10.1080/10640266.2014.898983**

Noordenbos, G., & Van Geest, Z. (2017). Self-criticism and critical voices in eating disorder patients and healthy controls. *JSM Nutritional Disorders*, *1*(1), 1003–1008.

Oldershaw, A., Startup, H., & Lavender, T. (2019). Anorexia nervosa and a lost emotional self: A psychological formulation of the development, maintenance, and treatment of anorexia nervosa. *Frontiers in Psychology*, *10*(219). **https://doi.org/10.3389/fpsyg.2019.00219**

Pratt, S. M. (2016). *Eating disorder voices: A qualitative content analysis.* Retrieved from ProQuest Dissertations Publishing. (AAT 3711809).

Pugh, M. (2016). The internal 'anorexic voice': A feature or fallacy of eating disorders? *Advances in Eating Disorders, 4*(1), 75-83. **https://doi.org/10.1080/21662630.2015.1116017**

Pugh, M. (in press). Understanding 'Ed': A theoretical and empirical review of the internal eating disorder 'voice'. [Manuscript in preparation].

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders, 49*, 622–625. **https://doi.org/10.1002/eat.22499**

Pugh, M., & Waller, G. (2017). Understanding the 'anorexic voice' in anorexia nervosa*. Clinical Psychology and Psychotherapy, 24*, 670–676. **https://doi.org/10.1002/cpp.2034**

Puhl, R., & Suh, Y. (2015). Stigma and eating and weight disorders. *Current Psychiatry Reports*, *17*(3), 1-10. **https://doi.org/10.1007/s11920-015-0552-6**

Rance, N., Clarke, V., & Moller, N. (2017). The anorexia nervosa experience: Shame, solitude and salvation. *Counselling and Psychotherapy Research, 17*(2), 127-136. **https://doi.org/10.1002/capr.12097**

Salvini, A., Faccio, E., Mininni, G., Romaioli, D., Cipolletta, S., & Castelnuovo, G. (2012). Change in psychotherapy: A dialogical analysis single-case study of a patient with bulimia nervosa. *Frontiers in Psychology*, *3*, 546. **https://doi.org/10.3389/fpsyg.2012.00546**

Schmidt, U., Adan, R., Böhm, I., Campbell, I. C., Dingemans, A., Ehrlich, S., Elzakkers, I., Favaro, A., Giel, K., Harrison, A., Himmerich, H., Hoek, H., Herpertz-Dahlmann, B., Kas, M., Seitz, J., Smeets, P., Sternheim, L., Tenconi, E., vam Elburg, A., … Zipfel, S. (2016). Eating disorders: The big issue. *The Lancet Psychiatry, 3*(4), 313-315. **https://doi.org/10.1016/S2215-0366(16)00081-X**

Schutz, A. (1971). *Collected Papers (Vol. 1).* The Hague, Netherlands: Martinus Nijhoff.

Scott, J. (2008). Performing Unfeminine Femininity: A performance of identity analysis of bulimic women's personal narratives. *Text and Performance Quarterly*, *28*(1-2), 116-138. **https://doi.org/10.1080/10462930701754382**

Seed, T., Fox, J., & Berry, K. (2016). Experiences of detention under the mental health act for adults with anorexia nervosa. *Clinical Psychology & Psychotherapy*, *23*(4), 352-362. **https://doi.org/10.1002/cpp.1963**

Smethurst, L., & Kuss, D. (2018). 'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of

recovering from anorexia nervosa. *Journal of Health Psychology, 23*(10), 1287-1298. **https://doi.org/10.1177/1359105316651710**

Smink, F. R., van Hoeken, D., & Hoek, H. W. (2013). Epidemiology, course, and outcome of eating disorders. *Current Opinion in Psychiatry*, *26*(6), 543-548. **https://doi.org/10.1097/YCO.0b013e328365a24f**

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

Tierney, S., & Fox, J. R. E. (2011). Trapped in a toxic relationship: Comparing the views of women living with anorexia nervosa to those experiencing domestic violence. *Journal of Gender Studies, 20*(1), 31-41. **https://doi.org/10.1080/09589236.2011.542018**

Treasure, J., Zipfel, S., Micali, N., Wade, T., Stice, E., Claudino, A., Schmidt, U., Frank, G., Bulik, C., & Wentz, E. (2015). Anorexia nervosa. *Nature Reviews Disease Primers, 1*(15074). **https://doi.org/10.1038/nrdp.2015.74**

Viana, M. C., Gruber, M. J., Shahly, V., Alhamzawi, A., Alonso, J., Andrade, L. H., Angermeyer, M. C., Benjet, C., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G. D., de Jonge, P., Ferry, F., Florescu, S., Gureje, O., Haro, J. M., Hinkov, H., Hu, C., Karam, E. G., … Kessler, R. C. (2013). Family burden related to mental and physical disorders in the world: Results from the WHO world mental health (WMH) surveys. *Revista brasileira de psiquiatria*, *35*(2), 115-125. **http://doi.org/10.1590/1516-4446-2012-0919**

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, *22*(2), 108-119. **https://doi.org/10.1016/j.midw.2005.05.004**

Walstrom, M. K. (2002). "You know, who's the thinnest?": Combating surveillance and creating safety in coping with eating disorders online. *CyberPsychology & Behavior, 3*(5), 761-783. **https://doi.org/10.1089/10949310050191755**

Williams, K., King, J., & Fox, J. R. E. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(2), 211-228. **https://doi.org/10.1111/papt.12068**

Williams, S., & Reid, M. (2010). Understanding the experience of ambivalence in anorexia nervosa: The maintainer's perspective. *Psychology and Health*, *25*(5), 551-567. **https://doi.org/10.1080/08870440802617629**

Williams, S., & Reid, M. (2012). "It's like there are two people in my head": A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology and Health, 27*(7), 798-815. **https://doi.org/10.1080/08870446.2011.595488**

Part 2: Empirical paper

“She needed me and I latched myself onto her and we formed a bond”: A Thematic Analysis of Voice Dialogues with the Internal Anorexic Voice

Abstract

Aim: To explore the perspective of the internal anorexic voice (AV) on its role in the development and maintenance of anorexia nervosa (AN). ***Method:*** Nine women with a diagnosis of AN participated. Qualitative data were collected via semi-structured voice dialogues with participants' AVs. Thematic analysis (Braun & Clarke, 2006) was applied to interview transcripts. ***Results:*** The overarching concept of an interdependent relationship between AV and individual comprised three primary themes. The first theme, 'Pragmatism', commented on the AV's 'invaluable problem solver' persona. The second theme, 'Relationship', depicted the valued, fraught, unbalanced and partly unwanted bond between AV and individual. The third theme, 'Self-preservation', expounded the AV's drive to retain control over the person's life – its suggestion that 'I need her'. ***Conclusions:*** Dialogues with the AV illustrated the mutually dependent bond between AV and individual. In clinical practice, curiosity regarding relationships with AVs could highlight barriers to recovery and help to tailor treatments. Future research should focus on diverse samples and establishing ways of working with eating disorder (ED) voices to promote recovery.

Keywords: eating disorders, anorexia nervosa, eating disorder voice, anorexic voice, anorexic self, chairwork, qualitative, thematic analysis

Introduction

The ‘anorexic voice’ (AV) may be central to experiences of anorexia nervosa (AN), yet is little-understood. AN is a potentially life-threatening mental health condition (Arcelus et al., 2011), with a lifetime prevalence of up to 4% (Smink et al., 2013). Current treatments yield high dropout rates (15-50%), modest remission (30-40%), and significant risk of relapse (~30% within 2 years) (Atwood & Friedman, 2020; Lock & Le Grange, 2019). Motivation to recover is often low (Blake et al., 1997) and attempts to enhance motivation in eating disorder (ED) therapy demonstrate limited effectiveness (Waller, 2012). Research suggests that around 90% of individuals with an ED experience an internal ‘eating disorder voice’ (EDV) (Noordenbos et al., 2014; Noordenbos & Van Geest, 2017), in AN termed the ‘anorexic voice’ (Pugh & Waller, 2016, 2017; Tierney & Fox, 2010). The AV constitutes an internal commentary on eating, weight, shape and self-worth (Pugh, 2016). Distinct from other voice-hearing, the AV is typically experienced as both part of and phenomenologically separate from the self (Fox et al., 2012). Small-scale service user consultation found that some identifying with the AV labelled it an anorexic ‘self’. Throughout this article, the term ‘AV’ refers to the anorexic voice and/or self. Despite its prevalence, little research has explored the AV, and it remains overlooked in mainstream treatment for AN.

Treatments currently recommended by the National Institute for Health and Care Excellence ([NICE], 2020) are based on a biopsychosocial model, involving adequate nutrition, cognitive behaviour therapy (CBT) and systemic approaches. As well as physical ill-health, malnutrition can produce cognitive changes that promote disordered eating, such as rigidity, obsessiveness and preoccupation with food, weight and shape (Keys et al., 1950). Hence, establishing regular, balanced, adequate nutrition is the first priority in AN treatment. CBT or clinical case management support behaviour change attaining sufficient nutrition. This often

involves challenging unhelpful or inaccurate beliefs about eating, weight and shape, and behaviours contributing to the AN mindset, such as compulsive weighing, calorie counting, compensatory exercise, purging and avoidance of feared foods (Fairburn, 2008). Family work similarly aims to establish adequate nutrition, taking a non-judgmental approach to support family members to better understand each other's perspectives and often working to unify them against the externalised problem of AN (Jewell et al., 2016). Improved knowledge of the AV may build upon mainstream AN theory and treatments, bring more peripheral options to prominence, or prompt the development of novel theory and treatment approaches.

Existing studies have implicated EDVs in ED development and maintenance and suggest EDV management affects recovery. Initially, the EDV may appear friendly, helpful, or offer a sense of control (Pratt, 2016; Tierney & Fox, 2010; Williams & Reid, 2012), but become increasingly destructive (Tierney & Fox, 2011) and powerful (Pratt, 2016), affecting sense of self (Rance et al., 2017; Seed et al., 2016; Williams et al., 2016), and driving the ED (De Giacomi, 2019; Jenkins & Ogden, 2012). Experiencing the EDV as more powerful is associated with greater AN severity and duration (Pugh & Waller, 2016, 2017). EDVs may foster ambivalence to recovery, as some fear losing the voice (Tierney & Fox, 2010; Williams et al., 2016) or experience it actively resisting recovery (Pratt, 2016; Smethurst & Kuss, 2018; Tierney & Fox, 2011). However, externalising the voice (De Giacomi, 2019; Tierney & Fox, 2011), or speaking back to it (Pratt, 2016; Tierney & Fox, 2010) may promote recovery. Improving our understanding of the AV experience could inform developments in treatment.

'Chairwork', and 'voice dialogue' in particular were used in this study to develop understandings of the AV. Chairwork is an experiential technique utilising chairs for therapeutic dialogues (Pugh, 2017). It has been incorporated into evidence-based therapies including CBT (Pugh, 2017), emotion-focused therapy

(Greenberg & Watson, 1998) and schema therapy (Young et al., 2013). 'Voice dialogue' (Stone & Stone, 1989) and 'talking with voices' (Corstens et al., 2012) are forms of intrapersonal chairwork that have been used to work with internal voices, for example in the context of psychosis (Corstens et al., 2012; Kellogg, 2015). In voice dialogue, the client changes seats and speaks from the perspective of an internal voice. Here, this approach was used to interview the AV.

To summarise, treatments for AN require improvement. Research has implicated the AV in ED development and maintenance. Recovery may be affected by perceptions of and relationships with AVs, but it remains unclear how the AV is best conceptualised and addressed. Voice dialogue is a form of chairwork that provides a means of interviewing the AV. Using voice dialogue, this study aimed to explore the AV's role in AN development and maintenance from a novel perspective: that of the AV. A qualitative method was used to develop a nuanced understanding of the AV's perspective. Data were collected via semi-structured voice dialogues with the AV, and transcripts underwent thematic analysis (Braun & Clarke, 2006). This research was hoped to yield new conceptualisations of AN, informing approaches to recovery. The following research questions were considered:

- What is the AV's perspective on its development?
- What is the AV hoping to achieve?
- How does the AV pursue its aims?
- How does the AV perceive its relationship with the participant?

Method

Joint project

The author (SBS) undertook this study within a joint project, alongside NC (Chua, 2020). Appendix B outlines each researcher's contribution.

Participants

Nine participants were recruited from four London ED services. Criteria for inclusion were:

- Aged 18 years or older
- Undertaking assessment or treatment at a host site
- Diagnosis of AN
- Reporting an internal AV
- Capacity to consent to participate
- Fluency in English

The following exclusion criteria were applied:

- Awaiting assessment at a host site
- Suicidal or parasuicidal behaviour
- Inability to understand spoken or written English
- Diagnosis of emotionally unstable personality disorder, psychosis, moderate-to-severe learning disability, or an ED other than AN

Convenience sampling was used for feasibility, given the narrow inclusion criteria. Moreover, qualitative research privileges understanding individuals' experiences over generalisability, reducing the benefits of sampling methods designed to minimise bias (e.g., random sampling). Recruitment was intended to continue until 'saturation' was reached, with further data adding little new information (Corbin & Strauss, 2015). However, research in NHS services was suspended due to the COVID-19 pandemic, so recruitment was halted at nine participants.

Ethics

The study received NHS ethical approval (Appendix C). A non-substantial amendment was approved, to obtain participant BMIs from clinical notes.

Service User Involvement

The study design was reviewed by three service users diagnosed with AN, attending the host clinics. They found the design acceptable and expressed interest in the topics of AVs and chairwork. Some reported experiencing the AV as a 'self'; the interview schedule was adapted accordingly.

Procedure

The researchers (SBS and NC) presented the project to staff at the host clinics. Participants were primarily recruited via clinicians, although waiting room posters facilitated direct contact with the researchers. Clinicians offered prospective participants a study information sheet (Appendix D) and checked consent to be contacted regarding the study. Those who consented were phoned by SBS or NC 7-14 days later to discuss any questions and, if desired, arrange a research appointment. Before the appointment, individuals were emailed the consent form (Appendix E) for reference.

Research appointments were facilitated by SBS or NC. The information sheet was jointly reviewed, with an opportunity for questions before providing informed consent (Appendix E). The researcher then summarised the appointment structure and collected demographic information: self-described age, ethnicity, gender, ED diagnosis, length of illness, current and previous treatment (type, number and length). Participants' current BMIs were later collected from their named clinician if consent was given. The interview consisted of a 30-45-minute voice dialogue, 10-minute break and 30-45-minute post-chairwork interview. Voice dialogues provided data for this study, and post-chairwork interviews for NC's thesis (Chua, 2020). The researchers memorised the interview schedule to minimise distractions. On completing the appointment, participants received a £20 voucher

and support card (Appendix F). Interviews were audio-recorded and transcribed for qualitative analysis.

Interview

Qualitative data were collected via semi-structured voice dialogues with participants' internal AVs, following Pugh's (2019) Dialogical Interview Schedule for Eating Disorders (DIS-ED). The DIS-ED was informed by established approaches to understanding internal voices, including Voice Dialogue (Stone & Stone, 1988), Ego State Therapy (Emmerson, 2003), Talking with Voices (Corstens et al. 2010), and Internal Family Systems Therapy (Schwartz, 1995). The DIS-ED consisted of four parts and a post-chairwork interview. Part one aimed to put participants at ease and briefly explore experiences of the AV. Part two provided the data for this project, aiming to elicit the AV's perspective. The individual was invited to change seats (or seat position) and speak from the perspective of their AV. The interviewer guided the AV to consider its functions, content, origins, intentions, relationship with the individual, and underlying feelings and concerns. Part three promoted decentring from the AV. The individual was invited to return to their original seat and reconnect with the self through grounding techniques. They then stood beside the interviewer's chair, facing the AV's position, and the interviewer summarised their discussion with the AV. The individual was prompted to take a decentred position, noticing what was said without involvement. Part four stimulated alternative ways of relating to the AV. The individual returned to their seat and voiced any reflections or responses to the AV. After the break, a post-intervention interview explored experiences of the voice dialogue.

As there was no existing interview schedule for voice dialogues with the AV, MP drafted the DIS-ED for this project. Small-scale service user consultation suggested that the initial interview schedule was acceptable, and informed the decision to ask participants whether they preferred the term ED 'voice' or 'self' at the

outset, as there were differing preferences. The interview schedule was jointly updated by SBS, NC and MP during voice dialogue rehearsal. Parts one and four were abbreviated to minimise repetition, questions regarding underlying feelings were adapted to be less assumptive (e.g., “What concerns you?” rather than “What are you afraid of?”), and the AV was referred to by its chosen name in parts three and four. MP provided training in facilitating the DIS-ED. SBS and NC engaged in seven hours of face-to-face training, in addition to self-directed study. The training consisted of didactic teaching, independent reading, video demonstrations, and role-plays.

Analysis

Thematic analysis was used, following Braun and Clarke’s (2006) guidelines, with a critical realist epistemological framework. Thematic analysis is a process of identifying, analysing and reporting patterns in qualitative data (Braun & Clarke, 2006). This method was chosen for its flexibility and established use in research regarding AN (Rance et al., 2017), the AV (Tierney & Fox, 2010), and chairwork (Chadwick, 2003). Consultation with an expert in qualitative analysis highlighted the appropriateness of thematic analysis rather than approaches such as interpretative phenomenological analysis (Smith et al., 1999), as thematic analysis would allow a focus on patterns in the AV’s account, rather than participants’ experiences of it.

Critical realism (Willig, 1999) is a contextualist epistemological position, between the poles of realism and constructionism. It holds that reality arises from an interaction of social discourse and material constraints, rather than being independent of language and social interaction (realism) or entirely reducible to social discourse (constructionism, Sims-Schouten et al., 2007). A critical realist position seemed appropriate, as this project focused on understanding the AV’s perspective, not the effects of underlying societal discourses. Equally, the researcher believes that language and social context are integral to the

development and expression of the AV, including within the research interview itself. Thus, the AV is framed as a 'real' phenomenon to be understood, situated in constant interaction with social discourse.

The study's exploratory aims and novel line of enquiry guided the analysis. The researcher aimed to richly describe all data concerning the AV's perspective on its role in AN, as there was no basis for narrowing the focus of analysis. An inductive approach was taken, built predominantly on the AV's accounts. However, analysis cannot be purely data-driven, as participants', researchers' and readers' contexts inevitably influence the meanings drawn. For example, the fact that the author had recently conducted a meta-ethnography of studies of the EDV may have influenced the analysis. Consequently, more deductive codes were listed to ensure they did not unduly dominate analysis, and reflexivity is addressed below. Corresponding with the inductive stance and critical realist epistemology, there was greater focus on semantic than latent meanings.

The six stages of thematic analysis (Braun & Clarke, 2006) were applied (see Appendix G for a worked example):

1. Familiarisation with the data: Interviews were transcribed verbatim by the interviewer (SBS or NC). Transcripts were read repeatedly and initial ideas regarding patterns of meaning were noted. Analysis began during data collection to establish when 'saturation' was reached.

2. Generating initial codes: Working systematically through the dataset, features of the data were identified as codes. Transcripts were annotated, with data for each code collated using NVivo software. More deductive codes were listed in a separate document.

3. Searching for themes: Using NVivo, codes were sorted into potential themes and relevant data were collated under these headings.

Relationships between themes were considered, including overarching themes and sub-themes.

4. Reviewing themes: Collated extracts for each theme were re-read, checking for coherence, within-theme homogeneity and between-theme heterogeneity (Patton, 1990). The entire dataset was re-read to consider whether candidate themes reflected meanings across the whole dataset, and to amend any missed coding. A thematic map was generated.

5. Defining and naming themes: The details of themes were further refined, including names and definitions capturing the essence of each theme. Themes and collated data extracts were organised into a coherent narrative.

6. Producing the report: Archetypal examples of each theme were used to tell the story of the data developed from the analysis, with reference to the research questions and broader literature.

Trustworthiness

Steps were taken to promote high-quality research, using Elliot et al.'s (1999) guidelines, as follows. The scientific context and aims of the study have been delineated, and methods described and justified. Respect for participants was prioritised throughout, from the development of resources (information sheet, consent form, interview schedule and support card), to the protection of anonymity during write-up. As the AV's perspective is hitherto uninvestigated, this report should present new knowledge. For transparency, details of the researcher's perspective are outlined below. The recruitment procedure and broad participant demographics are provided to 'situate' the sample, while protecting anonymity. The process of analysis was scrutinised through supervision, not to eliminate 'bias' but to aid reflexivity. When presenting the analysis, themes were grounded in examples.

Unfortunately, participant validation and formal validity checks by a second researcher were not possible due to time constraints.

Reflexivity

'Bracketing' was applied throughout to understand the impact of the researcher's context. This involved discussion with supervisors and a reflective log. Voice dialogue training using the DIS-ED provided further opportunities to consider relevant assumptions. The researcher was a clinical psychology trainee in her mid-twenties. She identifies as white British, heterosexual and female. She had a prior interest in mixed-methods research into stigma, involving thematic analysis, and was not wedded to any epistemological position. She has personal experience of AN and identified with the AV concept. She had no previous experience of chairwork, but since the research, begun to incorporate it into her clinical work. These contextual factors had implications throughout the research process. There was a risk of overlooking experiences relevant to other ethnicities, genders, sexualities and ages. The researcher was free to adopt an epistemological position most appropriate to the research. She acknowledged her familiarity with thematic analysis over other qualitative approaches and consequently sought an expert opinion when planning the analysis. During data collection and analysis, she predicted a tendency to focus on the role of control and non-body image-related factors in AN, reacting against the body image-focused stereotype of AN. During the interviews, she actively set aside the role of clinician and adopted that of the curious researcher, focused on data collection rather than therapeutic benefit.

Results

Demographics

All nine participants identified as female and were in their twenties or early thirties. Most participants were White British; BAME British and White European

ethnic groups were also represented. All participants had been diagnosed with AN. Participant BMIs ranged from 14.4kg/m² to 19.2kg/m², with a mean of 17.4kg/m². Self-reported illness duration ranged from 2 to 20 years, with a mean of 13 years. Participants were engaged in a variety of interventions for AN, including physical health monitoring, dietetic consultation and various modalities of psychological therapy. The majority had previously undergone inpatient admission. All had experiences of CBT.

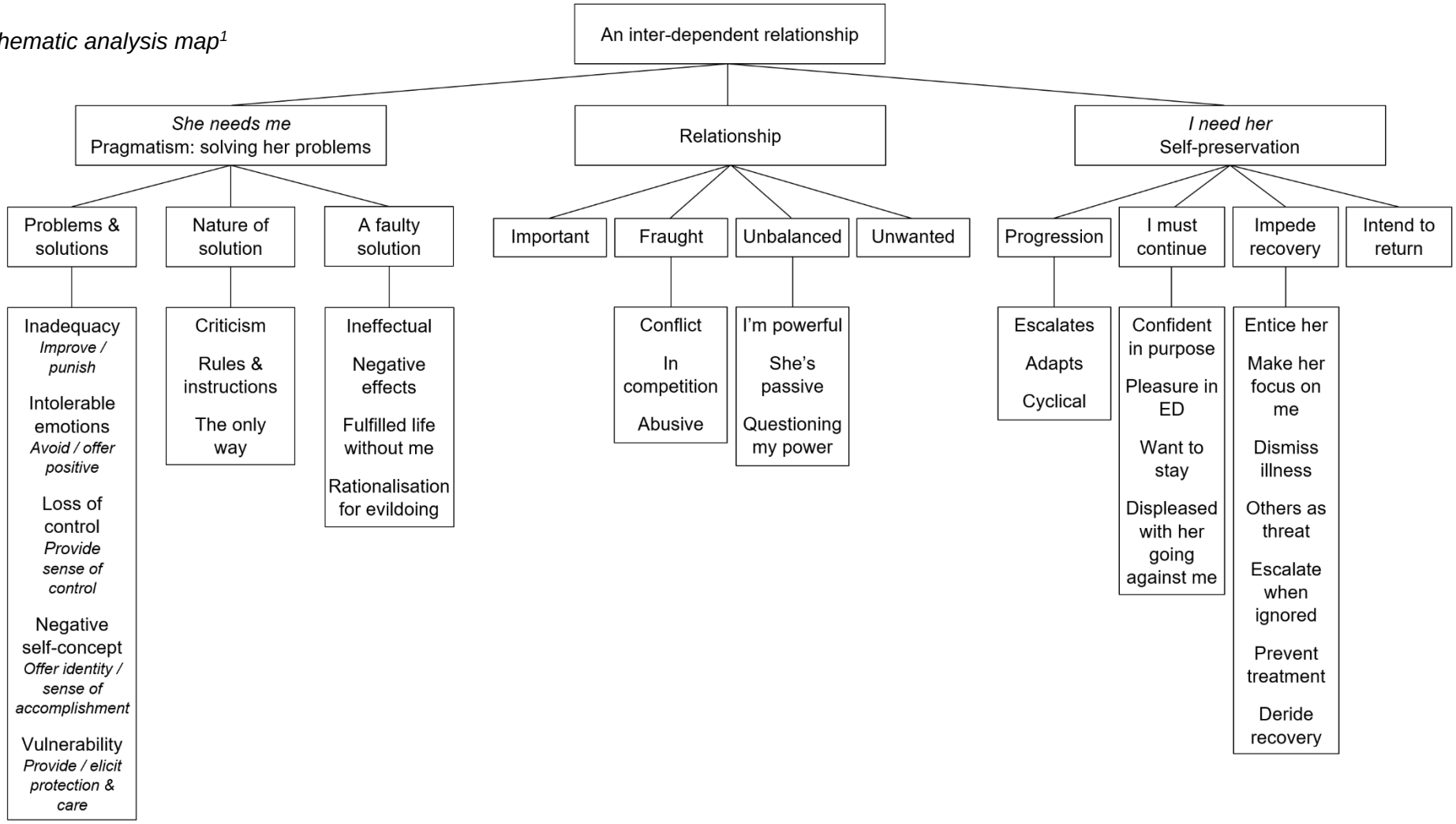
Terminology

Five participants chose the label ‘EDV’ and four favoured ‘ED self’, representing a fairly even split. Given the marginal preference for ‘voice’, and the study’s focus on AN, the term ‘AV’ will be used.

Thematic analysis

Figure 2

Thematic analysis map[1]



[1] Written from the perspective of the AV: 'I' refers to the AV, and 'she'/'her' to the participant.

Table 3

Representation of themes across participants

Theme	Subthemes		1	2	3	4	5	6	7	8	9
Pragmatism: solving her problems	Problems & solutions	Inadequacy	■	■	■	■	■	■	■	■	■
		Intolerable emotions	■	■	■	■	■	■	■	■	■
		Loss of control	■	■	■	■	■	■	■	■	■
		Negative self-concept	■	■	■	■	■	■	■	■	■
		Vulnerability	■	■	■	■	■	■	■	■	■
	Nature of solution	Criticism	■	■	■	■	■	■	■	■	■
		Rules & instructions	■	■	■	■	■	■	■	■	■
		The only way	■	■	■	■	■	■	■	■	■
	A faulty solution	Ineffectual	■	■	■		■	■	■	■	■
		Negative effects	■	■	■	■	■	■	■	■	■
		Fulfilled life without me		■	■		■	■	■	■	■
		Rationalisation for evildoing	■	■	■	■	■	■	■	■	■
Relationship	Important		■	■	■	■	■	■	■	■	■
	Fraught	Conflict	■	■	■	■	■	■	■	■	■
		In competition	■	■	■	■	■	■	■	■	■
		Abusive	■	■	■	■	■	■	■	■	■
	Unbalanced	I'm powerful	■	■	■	■	■	■	■	■	■
		She's passive	■	■	■	■	■	■	■	■	■
		Questioning my power	■	■	■	■	■	■	■	■	■
	Unwanted			■	■	■	■	■	■	■	■
Self-preservation	Progression	Escalates	■	■	■	■	■	■	■	■	■
		Adapts	■	■	■	■	■	■	■	■	■
		Cyclical		■	■	■	■	■		■	■
	I must continue	Confident in purpose	■	■	■	■	■	■	■	■	■
		Pleasure in ED	■	■	■		■	■	■		■
		Want to stay	■	■	■	■	■	■	■	■	■
		Displeased with her going against me	■	■	■	■	■	■	■	■	■
	Impede recovery	Entice her	■		■	■	■		■		
		Make her focus on me		■	■	■	■	■	■	■	■
		Dismiss illness		■	■	■	■	■	■		
		Others as threat	■	■	■	■	■	■	■	■	■
		Escalate when ignored	■	■	■	■	■	■	■		■
		Prevent treatment		■	■	■	■		■	■	
		Deride recovery		■	■	■	■	■	■	■	
	Intend to return			■	■	■	■	■	■	■	■

Overarching Concept: An Interdependent Relationship

Fundamentally, the analysis depicted a mutually dependent relationship between AV and participant:

> “we both need each other as much as she needs me” (4).

> “She needed me and I latched myself onto her and we formed a bond.” (5)

> “I need her to be my vessel. And I know that she needs me too.” (5)

The three primary themes reflected this overarching concept of interdependence. The first theme, ‘Pragmatism’, presents the AV’s view that it solves the participant’s problems, which can be expressed as ‘she needs me’. The second theme covers the AV-participant ‘Relationship’, which seems important to the individual, but fraught, unbalanced, and, to some degree, unwanted. The third theme, ‘Self-preservation’, addresses the AV’s drive to remain present in the person’s life – which can be expressed as ‘I need her’.

1. Pragmatism: Solving Her Problems

Providing solutions to the person’s problems fosters dependence on the AV to cope with life.

1.1 Problems and solutions.

The AV addressed problems of inadequacy, intolerable emotions, loss of control, negative self-concept, and vulnerability.

Table 4

Representation of subthemes within 'Pragmatism: Solving Her Problems':

Number of participants (number of references)

		Problem	Solution	Without me	Total
Inadequacy	Appearance	8 (41)	9 (67)	3 (4)	9 (86)
	Rejection	9 (63)	7 (22)	2 (4)	9 (73)
	Failure	9 (33)	8 (43)	1 (2)	9 (66)
	Lazy	4 (14)	6 (17)	1 (2)	6 (31)
	Morality	8 (30)	9 (46)	0 (0)	9 (60)
	Worthless	5 (7)	8 (38)	1 (1)	8 (42)
	Total	9 (121)	9 (121)	7 (11)	9 (162)
Intolerable emotions	Total	9 (39)	8 (44)	7 (17)	9 (76)
Loss of control	Control	9 (44)	9 (34)	6 (7)	9 (73)
	Change	4 (8)	8 (27)	5 (16)	9 (48)
	Total	9 (51)	9 (57)	9 (22)	9 (107)
Negative self-concept	Identity	3 (5)	7 (22)	3 (4)	8 (29)
	Self-esteem	8 (31)	6 (10)	1 (2)	9 (36)
	Total	8 (35)	8 (32)	4 (6)	9 (60)
Vulnerability	Others are dangerous	5 (18)	9 (49)	2 (2)	9 (60)
	Others are insufficient	7 (19)	9 (85)	4 (10)	9 (93)
	She's vulnerable	9 (51)	9 (75)	5 (16)	9 (106)
	Total	9 (71)	9 (85)	6 (25)	9 (123)

1.2.1 Inadequacy – improve or punish.

1.2.1.1 The problem.

Inadequacy was the problem most commonly referenced by the AV (see Table 4), encompassing concerns that the person is physically undesirable, at risk of rejection, a failure, lazy, immoral, or worthless. Dissatisfaction with physical appearance, such as perceived 'fatness', was often linked to risk of rejection:

"They're going to look her and … call her big or fat" (6).

Immorality and worthlessness related to views of the individual as undeserving or lazy:

> “She doesn't deserve to … have an easy life because she's disgusting, and a waste of space” (8).

Frequently, the AV viewed the person as ‘not good enough’ across domains:

> “Socially, she wasn’t … as big as she could have been. Academically, she was no longer top of the class … which isn’t good enough. Compared to all these other people, she wasn’t fit, she wasn’t pretty, she wasn’t clever.” (1)

1.2.1.2 The solution.

The AV sought to ‘improve’ or punish the person, tailoring solutions to the domain of perceived inadequacy. Risk of rejection was tackled through trying to make the person likable or admirable, often by changing their appearance:

> “[I became] more fixated on food and weight … if she’s really fit and healthy, then people would like her, people would admire her.” (1)

> “if she changed her body and the way she looks, maybe people will like her? … that's where I started.” (6)

Failure was managed through driving the person to meet high standards:

> “I set the expectations high. In everything.” (7)

> “I’m here … to make sure she stays on track” (4).

Hard work and physical activity were enforced to prevent laziness:

> “I'm here to make sure that she is continually active … doesn't take for granted … [things she’s] privileged enough to be born with” (8).

Striving for thinness was presented as a catch-all solution for a multitude of problems, including risk of rejection, unworthiness and immorality:

> “She needs to … [look] slim and thin to be accepted … if they see how ugly she is from the outside, they will discover how ugly she is on the inside.” (3)

Punishment was considered a just response to perceived worthlessness:

> “She only deserves me and the binges … Sitting in the room, in the darkness, in the cold, being afraid that she’s not able to pay the rent” (2).

Additionally, punishment was thought to improve the person’s worth or morality:

> “I just want her … suffering. And needing nothing. ’Cause that’ll make her a better person … Kinda want her to appear saintly.” (3)

1.2.1.3 Without me.

The AV feared that, without its influence, inadequacies would escalate. In many cases, the AV expressed that the individual would “get overweight” (5) and that the risk of rejection would become a reality:

> “no one would want her if she didn’t have me” (4).

> “she’s gained enough weight now … if she gains any more … she’ll be alone all her life” (3).

Fears of greater laziness and failure were also evident, extending beyond body image and social concerns into the academic realm:

> “I think that she'll slack off … [her grades] would drop if I wasn't there.” (7)

At worst, the AV believed that the person would become unacceptably lazy and worthless without it:

> “she needs to suffer. And I'm going to continue to be there to make sure that that happens … otherwise she would just be a disgusting lazy, slob, waste of space that she is naturally.” (8)

1.2.2 Intolerable emotions – avoid or offer positive emotions.

1.2.2.1 The problem.

In six cases, the AV described adversity contributing to its development, including bullying, childhood trauma, family conflict or breakdown, and the challenges of adolescence.

> “[She] had some trauma early in her childhood. She needed me” (5).

Such adversity was said to elicit a long-term emotional response:

> “there was a lot of pain that was built up over the years from the bullying from like other stuff that happened when she was younger.” (6)

In six cases, the AV suggested that difficult feelings contributed to its development, including emptiness (6), loneliness (6), guilt (9), “emotional turmoil” (9) and fear (3, 5, 6, 8). Emotions such as loneliness (2), sadness (2) and anxiety (2, 4, 7, 9) were cited as proximal triggers exacerbating the AV.

Difficulties managing challenging emotions (6/9 cases) seemed more problematic than emotions themselves. Emotions were often framed as undesirable (4, 6, 8) or “too much to bear” (8), with death appearing preferable:

> “I could kill her one day. But at least she wouldn’t be feeling.” (4)

Difficulties processing emotions included challenges recognising (9), accepting (7), “dealing with” (9) or expressing feelings (6).

> “often, [she] doesn't get to express herself or say how she's feeling” (6).

As such, the AV suggests that the person’s capacities for emotion regulation cannot handle the intensity of feeling they face.

1.2.2.2 The solution.

The AV addressed intolerable emotions through preventing or removing painful emotions (6/9 cases) and providing positive emotions (8/9 cases). Emotions

were prevented through “blocking out” potential triggers, including memories and thoughts:

> “I’ve blocked away the part of her that experienced that so she can move on.” (4)

The AV worked to remove painful emotions through numbing and distraction:

> “I can numb things for her … if she could focus on me, then she wouldn't be focusing on the dark things that happened.” (5)

The voice provided positive emotions through satisfying the urge to please:

> “when she does what I say… I’m pleased, then she feels good.” (5)

1.2.2.3 Without me.

The AV suggested that, without it, the person could not endure their emotions (6/9 cases):

> “I know she wouldn’t cope if I wasn’t around.” (3)

This feared inability to cope manifested in predictions of suicide:

> “[Without me,] I don’t think she could cope … she would kill herself.” (4)

1.2.3 Loss of control – provide sense of control.

1.2.3.1 The problem.

In all cases, the AV referred to an aversive loss of control:

> “she … just didn't have control of anything around her” (7).

A perceived lack of self-control was described, especially in relation to food:

> “she's going to lose control around food. She's not going to stop eating” (9).

Transitions, such as moving school, entering adolescence or marriage, were linked to the voice's development:

> "starting university, I became a lot more… loud and … fixated on certain things which she needed to improve." (1)

Life changes may represent a departure from what is known and controllable.

1.2.3.2 The solution.

The AV managed uncontrollable conditions and poor perceived self-control by providing a sense of control:

> "I became … a safety blanket for her to have control when there was so little control externally" (9).

> "[I] give her some control back because she was out of control" (5).

Low weight was seen as a demonstration of self-control:

> "when your weight is low … it shows that you're in control because it takes control to go against what your body is asking for." (7)

Additionally, the voice provided opportunities to exert control externally:

> "[I] allowed her to … control the narrative … of the arguments at home" (6).

The AV addressed the problem of change through providing continuity:

> "she can like rely on me to be there … I'm the constant in her life." (4)

The AV hints at a critical paradox – while it promises control and constancy, it is itself uncontrollable:

> "I'm a certain in her life … everything else is uncertain. And I am predictable and uncontrollable (laughs)" (6).

1.2.3.3 Without me.

In its absence, the AV believed the person would lose control, often fearing this would result in substantial weight gain:

> “[Without me] she will lose control completely. She'll get overweight” (5).

Such concerns reflect beliefs that the person inherently lacks self-control.

1.2.4 Negative self-concept – offer identity or sense of accomplishment.

1.2.4.1 The problem.

In all cases, the AV highlighted person’s negative self-concept, often affecting identity and self-esteem. Identity dissatisfaction included difficulties knowing or embodying the ‘true’ self:

> “she's always scared that if she … truly becomes herself, which she doesn't know … because all she really knows is me … they'll … start like, mocking her” (6).

Others could contribute to ambiguity surrounding identity:

> “people didn’t know who she was” (4).

Individuals placed their developing identity under scrutiny:

> “going through adolescence … you're on a stage in front of yourself assessing all of the things that you are and you aren't.” (8)

This self-consciousness may reflect an unfulfilled desire to define the ‘true’ self.

For all the ambiguity surrounding identity, the AV was clear that the person viewed themselves negatively. Low self-esteem often affected body image at the ED’s inception:

“she hated, hated her body” (2).

“she just wanted to … be that smaller girl rather than that muscular girl” (9).

Self-disgust seeped into participants’ views of their intrinsic nature:

“[she] realised that she was just genetically programmed to be disgusting.” (8)

1.2.4.2 The solution.

The AV functioned to “make her feel better about herself” (7). For instance, the voice offered a clear identity:

“she's too scared to be who she wants to be … this allows her to be something … the identity of like the anorexic” (6).

Moreover, the voice described altering the person’s true nature:

“She’s a different person already, I changed her.” (2)

The AV argued that, by improving the person, it would improve their self-esteem:

“if I make her not lazy and not greedy and not selfish, then she doesn't have anything to hate.” (8)

While improving the person was also the AV’s solution to inadequacy (1.2.1), here the purpose is to enhance their self-concept.

The voice promoted ED behaviours and weight loss to counter low self-esteem:

“[I] get her to restrict … to feel better about herself” (3).

“It was the only way she could feel good about herself … to get smaller” (6).

Following the AV’s instructions could offer a sense of accomplishment:

“it doesn't matter if she's bad in one thing because she can still be good at tasks that I set her” (7).

“she can be the thinnest … this is something she can be good at – she can take pride in.” (5)

This rare sense of achievement was presented as the mechanism by which ED behaviours alleviate self-hatred.

1.2.4.3 Without me.

Some AVs predicted individuals would be devoid of identity without it:

“I provided her with a purpose … without me around … she'd be nothing” (6).

Mirroring concerns about intolerable emotions (1.2.2), the AV suggested that, without it, self-hatred would overwhelm the person:

“I don't think that she would actually realistically be coping with the self-loathing” (8).

By promising foundations for identity and self-esteem, the AV appears invaluable.

1.2.5 Vulnerability – provide or elicit protection and care.

1.2.5.1 The problem.

In every case, the AV saw the person as under threat without the means to keep herself safe. The voice often presented others as dangerous, describing the world as “a scary place” (5) and others as “unpredictable” (6). More commonly, others appeared insufficient to meet the person’s needs:

“everyone else in her life is … very unreliable and inconsistent” (7).

“No one else is going to take away the pain or the hurt” (4).

Others' care seemed conditional:

> "She's always felt like she needs to … be hurt to get people to care." (6)

In all cases, the AV portrayed the person as vulnerable and in need of support:

> "She is very vulnerable … she's looking for something to rely on" (7).
>
> "she was scared and she needed someone she could trust to help her" (3).

1.2.5.2 The solution.

To address this perceived vulnerability, the AV consistently took a protective stance:

> "I'm like a mum to her, I can keep her safe … like a guardian angel" (5).
>
> "[I'm] protecting her from all the things that she's scared of … Keeping her inside that little bubble." (6)

The voice defended against various potential threats. By restricting the person to "safe foods" (2, 3, 9), it implied other foods were dangerous. Previously discussed concerns around inadequacy, emotions and self-concept were also presented as threats necessitating protection:

> "[I'm] kind of like a shelter and an escape from feeling lonely and feeling unwanted" (6).

The AV described "protecting her from herself" (4) and others, "so she can't get hurt by anyone" (4). It attempted to shield individuals from growing up:

> "[being underweight] keeps you safe. It means that you can be a child and you don't have to grow up" (5).

The protection offered was inauthentic:

“it's … the safety net, the safety blanket … that gives her this false sense of security.” (9)

The AV sought to meet other needs insufficiently addressed by external relationships – needs for care, friendship, guidance and reliability.

“I’ve had to come back and look after her because no one else can.” (4)

“[I was] a friend to her when she didn't have any” (5).

“she needed me because she doesn't have anybody like me in her life to set standards for her” (7).

“as long as she wants me, I will be there. And that's something she can't say about any other relationships.” (5)

Yet, its care appeared conditional:

“I'm nurturing until she does anything against me and then I turn into a monster.” (6)

As with the illusion of protection, the offer of a nurturing relationship may not be the solution to vulnerability that was promised. In one case (6), the AV reported influencing external relationships, stating “I give her a voice through … the way she looks” and describing the ED as a “rebellion”, and “way of getting people to care”. Hence, the AV may address unmet needs by eliciting care or functioning as a means of communication.

1.2.5.3 Without me.

Without its intervention, the AV predicted the person would remain at risk:

“[Without me,] she'll be vulnerable. People are scary and she won't be able to cope.” (5)

The voice feared the individual would unwisely rely upon others:

> “she would become reliant on people and people aren't reliable” (7).

Others’ attempts to care for the person were expected to be ineffective:

> “I don’t want anyone else to look after her … I don’t think they are capable” (4).

Where it staved off adulthood, the AV feared its absence would herald the onset of adulthood, increasing vulnerability:

> “if she didn't listen to me, she would grow into an adult and that would mean she'd be vulnerable … to bad people.” (5)

Additionally, the AV suggested that the person would be “scared” (3), “lost” (3), and “lonely” (3) without it, and questioned “who would she turn to?” (4).

1.2 Nature of solution.

1.2.1 Criticism.

Whatever the perceived problem, the AV’s solution involved criticism. The voice acknowledged it can be “harsh on her” (8), but viewed its criticism as well-meaning:

> “I want what’s best for her … If that means I have to be hard on her, then so be it.” (1)

In seven cases, the AV criticised through comparison, for example regarding body image:

> “she was the biggest child out of everybody” (2).

It often appeared competitive, endeavouring to “make sure that she’s the best” (1). Specific criticisms reflected previously discussed areas of inadequacy, including unattractiveness, failure, laziness, immorality, and worthlessness. Criticism was also implicated in AV solutions to other perceived problems, for example concerning self-concept:

> “she's supposed to be looking at least like she's recovered from anorexia” (6).

Here, deviation from the identity of “the anorexic” prompts criticism. Similarly, loss of control is criticised:

> “her clothes fitting her is a sign of her gaining weight. And her gaining weight is a sign of her losing control” (7).

The AV even criticised the person’s vulnerability and emotions, for example describing them as “too scared of the world” (6).

1.2.2 Rules and instructions.

Whatever the problem identified by the AV, rules and instructions were integral to its solution. In all cases, the AV defined rules using should/shouldn’t/can’t statements:

> “she can't go up a clothing size …. her clothes shouldn't fit her. Her clothes should hang off her.” (7)

The AV’s rules appeared inflexible, taking a “regimented and controlled” (1) approach. Despite this rigidity, the voice applied ever-shifting standards:

> “if you then eat additional amounts … [or] types of food, I need to invent a new amount of exercise to compensate … Sometimes I'm not satiated so I will just continue.” (8)

Hence, AV rules were not fixed, but tended to become increasingly extreme.

Rules and instructions described by the AV typically concerned eating and exercise. The voice often instructed the individual not to eat (7/9 cases), permitted "specific amounts of food" (8; 8/9 cases) and determined the timing of eating (4/9 cases):

> "I used to give her a rule … that she was not allowed to eat before the evenings." (4)

The AV laid down rules regarding the types of foods allowed (6/9 cases):

> "I made sure that she only ate certain types of food … that she avoided all fats" (3).

The AV stipulated the circumstances under which eating could occur (5/9 cases) and rituals for weighing (2/9 cases), exercise (7/9 cases), and bedtime:

> "[I tell her to] weigh out her food … exactly the amount that she is supposed to eat; … do a certain amount of exercise; … go to bed … [and] wake up at a certain time; … eat in certain places, eat with certain cutlery" (7).

This demonstrates how extensive and precise the AV's requirements can be.

1.2.3 The only way.

The AV consistently presented its solution to the person's problems as the only option. In eight cases, the voice described its instructions as the only path for the individual, suggesting "she needs me" (3, 4, 5, 7) or discussing limits to the person's agency:

> "I don't give her a choice to do anything else" (7).

Correspondingly, the AV discussed its own lack of alternatives (3/9 cases):

> "I can't stop." (1)

> "[I] help in the only way I know how." (4)

The voice suggested that life without it was unimaginable (7/9 cases):

> “I cannot imagine [her] without me … she will never forget me, never.” (2)

The individual was thought to share this difficulty envisioning life without the voice:

> “I'm so intertwined like in everything she does, she almost doesn't know … and even I don't know … where she starts and I end” (6).

The AV and individual were sometimes explicitly said to “need each other” (4), suggesting that other solutions seem impossible to both parties.

1.3 A faulty solution.

The AV consistently recognised that its solutions are faulty; that they are ineffectual, damaging, unnecessary or rationalise evildoing.

1.3.1 Ineffectual.

There was widespread recognition (8/9 cases) that the AV’s solutions were ineffectual:

> “I’m … trying to make her happy … acceptable … good enough. But then also, I know that I’m not” (1).

> “my influence probably isn't going to be the thing that makes her successful in her life” (5).

This ineffectiveness was sometimes attributed to individuals. Disregarding the AV’s instructions rendered its job “useless” (2). Likewise, others’ behaviour could impact outcomes. AV solutions that initially brought the person “love and care” become ineffective when “people are fed up of caring about the same thing” (6). Yet, the AV evaluated the success of its interventions inconsistently, for instance asserting “I've done a lot for her” (7).

1.3.2 Negative effects.

In all cases, the AV acknowledged harming the individual:

> “I’m damaging her.” (1)

For five participants, the voice described negative physical effects of its influence:

> “lack of energy … brain fog … feeling cold … hair falling out … feeling really ill” (6).

Other physical ill-effects cited included osteoporosis and chest pain, faintness, having “no immune system” (9), and being “dangerously underweight” (5).

Adverse effects on the person’s emotions and mindset were universally recognised. The voice often described triggering anxiety and low mood:

> “I make her anxious and stressed.” (1)

> “sometimes she'll cry and cry and cry because I'm making it really hard for her” (6).

Furthermore, it took responsibility for experiences of depression, anhedonia, suicidality, guilt and shame. An obsessive mindset was seen as a side effect of dietary restriction advocated by the voice:

> “With restriction comes fixated mindset, more excessive, more compulsive, more perfectionistic” (9).

The AV described restricting the person’s life (8/9 cases) and labelled itself as a “handicap” (8). It discussed limiting social opportunities:

> “she misses out on a lot of social things that she would really like to do” (8).

Indeed, the AV commonly (7/9 cases) reported isolating the individual and impacting work and family life. It questioned “how can somebody have a family and children if

she's struggling to feed herself?" (2). The AV linked its pervasive restriction of daily life with dietary restriction:

> "she just needs to … shrink, even though … as she shrunk, her personality shrank and her life shrunk as well." (9)

1.3.3 Fulfilled life without me.

In seven cases, the AV discussed the person's potential to flourish without it, speculating "maybe she could be healthy and happy" (2) and anticipating broad-reaching benefits:

> "she'd be able to … genuinely live a fulfilled life and it wouldn't impact on social settings, relationships, work" (9).

Interestingly, the AV predicted that problems it sought to solve would improve in its absence, including those relating to achievement, identity, and emotion regulation:

> "[Without me] maybe she'll finally go and achieve all the things she wants to achieve and become who she wants to become and deal with failure and deal with not everyone liking her, or loneliness, or emotions" (6).

1.3.4 Rationalisation for evildoing.

In all cases, the AV implied that its problem-solving is not only flawed, but also rationalises its evildoing. The AV described itself as "nasty" and "manipulative" (3) and often appeared deceitful (6/9 cases):

> "I even trick her to think … there's fat in particular foods" (9).

> "You can lie to them … hide the food … and tell them you ate it" (7).

The voice both deceived the individual and encouraged them to deceive others. It took a threatening tone (7/9 cases) to achieve its ends:

> “You can't eat anything that's out of your control because … you're gonna be a fat pig and you're gonna be left with nothing.” (9)

Moreover, the AV expressed ill-will towards the individual. It appeared destructive (5/9 cases):

> “it will be so nice again to destroy her life.” (2)

It wished the person to suffer (7/9 cases) and disregarded their wellbeing:

> “I didn't care if she was not feeling great or if her family members were crying or screaming at her” (6).

Indeed, the AV discussed “thriving” off the person’s anxiety (9). In four cases, the voice appeared murderous, “choking” (8) the individual or divulging desires to kill on a larger scale:

> “Maybe I don’t want to kill anybody, but I do. A lot of people.” (2)

In this case, the AV’s murderousness extends past the individual participant, perhaps to everyone affected by EDs.

Imagery emphasised the AV’s immorality. In four cases, it described itself as empty, for example as a faceless (3) or hollow-eyed (7) shadow, or an endless tunnel (9). Parasitic metaphors were common (7/9 cases), with the AV stating it “lives vicariously through her” (1), dug its “claws” in (3), or “latched” itself onto the person (5), which could be experienced as enjoyable:

> “I enjoy it because I kind of feed off of her” (7).

The AV often (6/9 cases) described itself as a monster:

> “[I’m] like a dementor in Harry Potter … sucking the happiness and soul out of [her] … [and] like in Coraline … the other mother with the button eyes who pretends to be nurturing … but is also really evil.” (6)

In four cases, the voice described itself as evil, for instance an “evil … spirit … enveloping and suffocating her” (8). However, the AV’s problem-solving did not solely serve to rationalise evildoing. The voice stated that it has “good intentions” (1) and is “not all evil” (4).

2. Relationship

The AV and individual developed a relationship that was valued, fraught, unbalanced and, to some extent, unwanted by the individual.

2.1 An important relationship.

The importance of the AV-individual relationship was emphasised in every interview. The individual was said to value the AV (8/9 cases), regarding it as a respected superior. The voice said the person “looks up to me” (4), “wants to please me” (1), and is “grateful to me” (3). The AV expressed that the individual “wants me around” (5) and “defend[s] me” (7), suggesting that they wish the relationship to continue. The significance of the AV-person relationship was accentuated through comparisons to parent-child (6/9 cases) or romantic (3/9 cases) relationships, with the voice describing itself as a “motherly entity” (5) or “abusive boyfriend” (4). Co-dependence heightened the relationship’s importance to both parties:

“we’ve grown together … we both need each other” (4).

Therefore, separation was experienced as a loss (5/9 cases):

“there's a separation going on and it’s very difficult for both of us” (6).

Hence, recovery may represent a painful break-up.

2.2 A fraught relationship.

Though valued, the AV-individual relationship universally appeared fraught:

“It’s a love-hate relationship” (6).

Conflict was discussed in eight cases, with the relationship described as “a big fight” (4), and the AV reporting “she really hates me” (2). Sometimes, a compromise was negotiated:

> “we've kind of reached an agreement that she needs to stay at this weight” (8).

Elsewhere, negotiation had ceased:

> “We don't really have conversations anymore … I'll tell her to do something, either she does it or she doesn't.” (5)

Commonly (5/9 cases), the individual and AV were in competition. The AV envied the person:

> “there's a part of me that … despises … what she's achieved so far. So, I have to take it all away from her.” (9)

The language of “winning” (8, 9) and “losing” (2) was employed, and the AV expressed that “one of us has got to give” (8). The relationship was abusive (8/9 cases), with the AV likened to an “abusive boyfriend” (4):

> “if you picture me like … in Oliver Twist … Bill Sikes … treats [Nancy] like absolute crap … eventually kills her … But she seems … fully devoted to him” (8).

It seems that the devotion associated with a valued relationship makes it difficult to terminate, even if it is abusive.

2.3 An unbalanced relationship.

Power imbalance was a consistent feature of the AV-individual relationship. In all cases, the AV wielded its power over the individual. It described itself as controlling:

> “[I] keep her controlled and … under my powers” (4).

In all interviews, the voice emphasised its omnipresence in the person’s past, present and future:

> “I’ve always been there, kind of criticising.” (1)

> “there's not a moment that I'm not there” (6).

> “she's never going to fully break me.” (8)

Place posed no greater barrier to the voice than time:

> “I’m there everywhere. Even the paper of a chocolate bar in the rubbish bin. I could be anywhere.” (2)

Every aspect of life was affected:

> “I'm so intertwined like in everything she does” (6).

The AV was persistent in its influence:

> “I just keep going, and keep getting louder” (1).

The voice drew the person’s attention, creating an “obsession” (6), demanding that she “focus on me” (2) and even “[waking] her in the night thinking about calories or … food” (9). Additionally, the AV was described as strong (9/9 cases):

> “I come over so great and so strong that … even if she tries to fight … I just win anyway” (9).

Often (5/9 cases), the AV asserted its superiority:

> “I am superior to everyone else in her life.” (7)

Thus, the AV justified its influence.

In counterpart to the AV's power, the individual appeared passive (9/9 cases). They were unaware, "deluded" (8), or "in denial" (4) regarding the voice's influence, and appeared powerless in relation to the AV:

"she's laying on the ground and I'm standing on her back." (8)

"I'm so strong that she can't do anything about it." (7)

In seven cases, the person was said to require the voice's permission. This extended beyond food-related decisions; the AV stated that "she wasn't allowed" (9) to have fun. Generally (7/9 cases), the individual appeared compliant:

"She's very obedient" (3).

Where the person resisted, they were expected to succumb (7/9 cases):

"she's done this to me before and she does crawl back to me eventually." (3)

The individual's passivity and AV's power creates an unbalanced relationship, with the person controlled by the AV.

However, the AV's power was questioned in every case. The AV sometimes appeared vulnerable (6/9 cases) or distressed:

"she's trying really hard not to [listen to me], and (sniffles) it's making me really anxious" (6).

At its core, the AV may be less imposing than it appears:

"I would look like a very … big … shadow … My actual being would be small … but my shadow would be very big and intimidating." (7)

The AV universally conceded that the individual holds power, describing them as "strong" (2) and suggesting they could reject its input:

"every time I spoke to her, she blocked me out. I wasn't allowed to her birthday party" (5).

Others could increase the person's power over the voice (6/9 cases):

> "the more time she spends around people … the less she'll listen to me" (3).

Hence, the balance of power need not remain skewed in the AV's favour.

2.4 An unwanted relationship.

The AV typically (8/9) experienced the person as rejecting:

> "she just wanted to get rid of me" (5).

In contrast, the AV clung to the relationship:

> "we're in a relationship where I want to stay and she doesn't want me around" (6).

Individuals who struggled to turn from the AV wished that they could:

> "[she] wants to hate me" (7).

This leaves the AV with the challenge of maintaining an unwanted relationship.

3. Self-Preservation

The AV appeared to need the individual and fought to strengthen its relationship with them.

3.1 Progression.

The AV discussed its propensities to escalate (9/9 cases), adapt (9/9 cases), and self-perpetuate (7/9 cases). Initially, the AV was "quiet" (2), with a "tiny" role (2), or beginning as a "New Year's resolution" (8). Seemingly innocuous beginnings went undetected:

> "it started out innocently … missing lunch so she wasn't lonely. She didn't know" (4)

The AV “gradually got worse” (9), grew “louder” (1), “more demanding and more controlling” (7). Its rules escalated:

> “the restrictions are getting greater and greater” (9).

The voice speculated that its progression could culminate in death:

> “I don’t know how much stronger I’ll get – I could kill her one day.” (4)

Conversely, the AV could de-escalate:

> “now she’s busy again. I have … much less time.” (2)

The AV “transformed” (6), becoming more “fixated” on “eating, weight and shape” (1). It adapted to promote ever-increasing restriction:

> “it's a new thing that I've added … I'm making her restrict by telling her that there's fat in even the safe foods … she's been eating” (9).

The voice adapted to the person’s environment, using “pretty much anything” (7) to influence them. It could speak through others:

> “I was suggesting to [her] mum to tell [her to], “Not eat that, not eat too much”” (2).

It drew upon “society and social norms” (9), “family pressures and values and … bullies at school” (6), and turned circumstances to its advantage:

> “She got some weird stomach bug … I used that to get her to stop eating” (6).

By taking an opportunistic approach, the AV maximises its influence.

The AV described its progression as cyclical, as it “[thrives] off” (9) the difficulties it created and is bolstered by dietary restriction:

> “It's almost like her not eating gives me fuel.” (6)

By providing short-term satisfaction, the voice bought the person's obedience:

> "I give her a quota of stuff for the day … it allows her to feel temporarily satisfied" (8).

Thus, the AV's progression serves to strengthen its influence.

3.2 I must continue.

Consistently (9/9 cases), the AV asserted that it must continue. The voice appeared driven, referring to its "purpose" (2, 4, 5), "job" (3), or "goal" (2). It was confident that its logic was sound:

> "people who do understand me understand my significance and my importance in [her] life" (7).

The voice frequently showed pleasure in the ED (7/9 cases), stating "I enjoy it" (7), "it's fun" (2) and "it will be so nice again to destroy her life" (2). In all interviews, the AV indicated a desire to remain in the person's life:

> "I don't want her to get rid of me" (5).

> "I need like the dependence she has on me" (4).

The AV was displeased when its wishes were ignored (9/9 cases):

> "When she went against what I was telling her to do … I was furious." (5)

Such disobedience threatened the relationship the AV depended on and the work it considered essential.

3.3 Impede recovery.

In all interviews, the AV described efforts to impede recovery. The voice reported enticing the person (5/9 cases):

> “you can do everything that you want to and still be thin and still have control over your food.” (7)

> “I tell her that everything will be okay if she starts restricting her food again.” (3)

These promises aimed to persuade the person to reengage with the AV during recovery. The voice wanted this relationship to be all-consuming (8/9 cases):

> “I want her to focus on me. Only me. And the illness I’m causing.” (2)

The AV did not want the person’s mind straying.

Sometimes, the voice openly dismissed the person’s illness (6/9 cases), arguing that “there’s nothing wrong with her … she looks fine … not underweight … bigger than average” (4). As well as altering perceptions of the person’s appearance, the AV downplayed clear evidence of physical ill-health:

> “she woke up with cardiologists around her trying to bring her back to life ... but she was fine the day before so I think they were all exaggerating” (3).

It seems that little could have persuaded the AV that AN was a significant problem.

The AV consistently viewed others as threatening (9/9 cases). It suggested that others want to “make her fat” (3, 5, 7) and jeopardise its existence:

> “she can't trust other people because … it makes me feel threatened … they just want to get rid of me” (5).

In one case, the AV seemed wary of the interviewer:

> “you don’t need to know about me” (3).

Jealousy was common, with the voice fearing “she’ll find someone else” (2) and explaining “I try to keep her to myself” (3). As well as taking the person’s attention, the AV feared others promote disobedience:

“other people … put temptation all around her” (7).

“people were just making her go against what I wanted” (8).

Consequently, the AV argued that “she’s better alone” (2), constructed a “façade” (4), and severed relationships:

“[her boyfriend] was a big threat to me... so I pushed him away” (3).

The voice described escalating when disobeyed (8/9 cases):

“when she tries to loosen the rules, I come back with a vengeance” (9).

Escalation involved “screaming in her ear” (5) and constituted a “punishment” (9). Actively preventing treatment was common (6/9 cases). The voice commented that treatment, weight gain and medication were unnecessary (2, 3), “convinced her to stop going to therapy” (3) and prevented or disrupted inpatient treatment:

“I used to make her attach weights to her legs … before she stood up on the scales to keep her out of hospital.” (3)

“she tried to leave hospital. Which is what I wanted … she was forced to stay … I made her … kick off as much as she could.” (5)

Thus, individuals acted out the AV’s sense of threat.

Furthermore, the AV took a derisive stance towards recovery (7/9 cases):

“You can survive, why are you trying to become even more like, bigger?” (6)

Here, the AV presented weight restoration as unnecessary and purposeless. The voice also criticised the validity and methods of recovery:

“She’s pretending she’s okay … trying the ridiculous methods to recover” (2).

Hence, the AV impeded attempts to curtail the AV-individual relationship, through enticement, drawing the person's attention, pushing others away, escalating when challenged, impeding treatment and undermining recovery.

3.4 Intend to return.

Where its power over the person had diminished, the AV expressed its intention to return (8/9 cases). The voice lay in wait for the person:

"I'd always stick around and wait for her." (3)

It worked to regain power:

"I'm trying really hard to get back in control" (6).

When the person resisted, the AV remained confident:

"One day, she will give up." (2)

"she always kind of succumbs" (9).

The voice asserted its capability to reclaim control:

"I tell her … I can still … take control again" (7).

Indeed, it suggested it could return with ease:

"I can just come in whenever I want to." (5)

The AV discussed factors facilitating its return. Focusing on work could reduce the person's resistance:

"when she's at work she's not trying to get rid of me" (3).

The AV seemed emboldened by stressors, such as studying (8), conflict (5), or generic "difficulties in life" (4). ED-specific triggers included body image comparisons (2, 6) and criticisms (2). Social isolation presented an opportunity to return:

> “when everyone thinks oh, she’s back on track … that’s when I know I can get her back” (3).

The AV reported prospering on the person’s loneliness, reduced support and lack of accountability:

> “on her own … she wasn’t accountable … I could just make her eat or not eat, as I wanted.” (4)

> “everyone is all full of support for the first two or three weeks … gradually, they all get back to what they are doing … She’s lonely … she comes back listening to me” (3).

Thus, the AV waits and works to regain power, remaining confident and identifying opportunities for its return.

Discussion

The overarching picture from the analysis was of an interdependent relationship; the AV promised solutions to the person’s problems and existed through its influence over them. It commonly perceived the person to be experiencing problems of inadequacy, intolerable emotions, loss of control, negative self-concept and vulnerability. AV solutions were tailored to the problem in question, for example offering a sense of identity and accomplishment to counteract negative self-concept. In all cases, AV solutions involved criticism and rules, and were framed as the only way forward. Nonetheless, the voice acknowledged that its problem solving could be ineffectual, have negative effects, stifle chances of a fulfilled life without it, or serve to rationalise evildoing. The relationship between AV and individual appeared important to both parties, but fraught and partly unwanted by the person, who typically seemed passive in the face of the AV’s power. The AV exhibited a drive to preserve itself, appearing reliant on its host to do so. It described escalating, adapting, and creating self-maintaining cycles, reaching for ever-greater

influence over the person. It was compelled to continue its work, presenting confidence in its purpose, pleasure in the ED, and frustration when its demands were ignored. Consequently, the AV sought to impede recovery, enticing the person, drawing their attention back to it, dismissing the illness, viewing others as a threat, acting out when ignored, actively preventing treatment and deriding recovery. If thwarted, it stated an intention to return to power.

Fit with Existing Research and Theory

Pragmatism

Exploring the AV's functions brought its problem-solving role into focus. The voice readily identified perceived problems and corresponding solutions, with recurring themes. The AV judged the person wholly inadequate, beyond weight, shape and eating behaviours. This illustrates how the elevated self-criticism accompanying EDs (Zelkowitz & Cole, 2018) can manifest as an internal critical voice. The AV could be likened to voice dialogue's 'inner critic' (Stone & Stone, 1993), schema therapy's 'punitive mode' (Arntz et al., 2013), or Bergner's (1995) 'pathological self-criticism'. Similarly, the AV's concerns regarding intolerable emotions concur with existing research. Voice-hearing has been linked to traumatic experiences, including bullying (Longden et al., 2012; Trotta et al., 2015). Bullying is also a risk factor for AN (Copeland et al, 2015). Individuals experiencing AN typically show reduced emotional awareness and adaptive coping behaviours and increased maladaptive coping behaviours (Oldershaw et al., 2015). Childhood emotional abuse has been associated with greater EDV power, in turn linked with more negative eating attitudes (Pugh et al., 2018). Individuals' loss of control, negative self-concept and vulnerability described by the AV also match earlier research. Life transitions were previously identified as triggers for perceived loss of control, contributing to AV development (Tierney & Fox, 2010). AV reports of individuals' identity dissatisfaction or ambiguity support views of a 'lost sense of emotional self'

(Oldershaw et al., 2019) underpinning AN. Qualitative research has portrayed fear of vulnerability as central to the condition's maintenance (Fox & Diab, 2015).

The AV's proposed solutions corresponded with perceived problems, and included self-improvement, emotion management, a sense of control and achievement, and protection. Narratives of AN as self-improvement are prevalent in pro-anorexia forums (Bates, 2015; Knapton, 2013) – one argument by which the AV justifies its influence. Starvation serves to numb emotions in AN (Brockmeyer et al., 2012) and the AV uses this to enhance its control, though, paradoxically, emotion regulation improves through weight restoration and recovery (Merwin et al., 2013). This illustrates the AV's self-perpetuating nature, as reliance on the voice limits opportunities to discover healthier and more effective ways to manage feelings. The illusion of control (Serpell et al., 1999; Nordbø et al., 2006) and sense of accomplishment (Pugh, 2020) offered by AN are well-established. Similarly, the AV's protective functions (Serpell et al., 1999; Tierney & Fox, 2010) and role in meeting unmet needs (Pugh, 2020) have been previously identified.

AV solutions invariably relied on criticism and rules, and were framed as the only valid option. Self-criticism has been found to mediate the relationship between perfectionism and depression (Gilbert et al., 2006), and is a strong independent predictor of ED symptoms (Fennig et al., 2008). However, self-criticism is commonly equated to self-correction in the general population (Gilbert et al., 2006), so its validity as a solution may go unquestioned. Even if AV rules are experienced as restrictive (Tierney & Fox, 2011), presenting its solutions as the only option extorts the person's compliance. Nonetheless, at times the AV acknowledged that its solutions were ineffectual, harmful, unnecessary for a fulfilled life, or rationalised its evildoing. Its role as both aggressor and comforter highlights the complexity of the AV-individual relationship and the AV's self-perpetuating nature.

Relationship

Dialogues with the AV were unsurprisingly rich in relational language, but offered new insights into the nature of AV-individual relationships. From the AV's perspective, its relationship with the individual was important, but fraught with conflict, competition and abuse. The voice appeared dominant and the person passive, though the AV always questioned its power. The relationship was typically partially unwanted by the individual. Comparisons to fictional relationships convey the complexity of interactions between AV and individual. The relationship between Bill Sikes and Nancy from Oliver Twist (Dickens, 1838) was referenced in one interview, and that of dementor and victim from Harry Potter (Rowling, 1999) in another. Relationships between the One Ring and ring-bearer from The Lord of the Rings (Tolkien, 1954), or Mrs Coulter and Lyra from His Dark Materials (Pullman, 1995) also come to mind. Analogies will differ between individuals, but themes of seduction, abuse and power run throughout. For some, relationships with the AV may echo previous abusive relationships. The AV perspective is concordant with existing literature. Affiliation towards the ED and attachment insecurity are associated with ED symptomatology, supporting conceptualisations of EDs as attachment relationships (Mantilla et al., 2018, 2019). Individuals have emphasised the AV's dominance of the self and described valuing their relationship with it (Williams & Reid, 2011). In psychosis, subordination to voices has been linked to subordination in external relationships (Birchwood et al., 2000), and voice-related distress is more strongly associated with perceived power differentials than voice characteristics (Birchwood et al., 2000; Peters et al., 2011). Moreover, conflicts between valuing and feeling abused by the AV reflect the mixed feelings experienced about recovery (Dawson et al., 2015).

Self-preservation

Ultimately, the AV sought to maintain and extend its influence over the person. It progressed, escalating, adapting and building self-preserving cycles, maintaining conviction in its purpose. Consequently, the voice was displeased when disobeyed, impeded treatment and recovery, and intended to regain lost power. These findings complement research concerning the AV's time course - initially appearing supportive but gradually escalating in hostility and demands (Pugh, 2020; Tierney & Fox, 2010). The voice's intention to maintain and regain exclusive power over the person relates to the long-established difficulties with motivation to recover and relapse (Blake et al., 1997; DeJong et al., 2012; Knowles, Anokhina & Serpell, 2013; Watson & Bulik, 2013). Voice-hearing in the context of psychosis has been associated with social isolation – individuals have described voices suggesting others are untrustworthy, commenting on external conversations, affecting concentration, and creating feelings of difference (Sheaves et al., 2020). In AN, such factors may be used to preserve the AV's power.

Limitations

Although there are benefits to sample homogeneity, such as a clear context for findings (Pistrang et al., 2016), the range of voices represented here is limited. All participants were female English-speakers with current or past experience of CBT, and the majority were White British and in their twenties. Specific comorbid conditions were excluded, despite high rates of comorbidities in AN (O'Brien & Vincent, 2003). Emotionally unstable personality disorder, learning disability and psychosis were exclusion criteria as these conditions have been independently associated with voice-hearing (Cooper et al., 2007; D'Agostino et al., 2019; Merrett et al., 2016). Non-AN EDs were excluded to focus on AV experiences. Unfortunately, resources to translate materials and interviews were unavailable, which was a significant limitation. Research involving a diverse range of genders,

ethnicities, cultural backgrounds, ages, and comorbidities is needed to develop a more complete view of AV experiences. While this study aimed to investigate the AV in particular, research into EDVs more broadly would be beneficial.

Moreover, recruitment was curtailed by the COVID-19 pandemic, so, in reality, saturation did not determine sample size. Fortunately, an acceptable sample had already been obtained, as rich understandings and common meanings could be drawn across the existing interviews. Revisiting Table 3, all subthemes are represented in the first two transcripts alone, with subsequent interviews adding to these rather than introducing new themes. It therefore seems reasonable to argue that saturation was reached.

Ideally, additional credibility checks would have been conducted. Participant validation or independent coding by a second researcher would have improved the trustworthiness of findings, but was not feasible given time constraints. Nonetheless, many features of high-quality qualitative research (Barker & Pistrang, 2005) are present: discussion of scientific context, definition of aims, description and justification of methods, ethical approval, intention to obtain new knowledge, disclosure of researcher perspective, situating the sample, reflexivity-focused supervision throughout analysis, and grounding themes in examples.

Whilst the study underwent rigorous ethical approval and measures were taken to safeguard participants' wellbeing, the impact of conversing with the AV remains unknown. Some risk is near-ubiquitous in research and clinical practice that pursues positive change. Here, dialogues with the AV were used for a one-off research interview, not as an intervention. Research evaluating the consequences (positive and negative) of conversing with the AV and the most helpful ways to engage with the voice are needed to develop effective, low-risk interventions.

Future research directions

This is perhaps the first study to explore a mental health problem by directly conversing with it, rather than through indirect methods such as symptom measurement or discussing experiences of the difficulty. This new perspective provided a wealth of information. Dialogues with internal voices could be applied to aid understandings of internal representations of various conditions. The DIS-ED interview schedule could offer a useful starting point for such research. The semi-structured approach and gradual shift towards more personal and specific questions (Pistrang et al., 2016) arguably promoted participants' confidence speaking from the AV's perspective, and balanced consistency across interviews with flexibility to explore unanticipated avenues of interest. Researchers may wish to validate or adapt the DIS-ED interview schedule for use in other studies or contexts, or to assess its impact on participants. Further research is required to develop a comprehensive understanding of the role of internal voices in EDs, and to translate new insights into improved treatments. Studies involving more diverse samples and EDVs beyond AN are needed. Comparing characteristics of those experiencing versus not experiencing EDVs could offer useful insights. Perhaps EDV experiences relate to levels of self-criticism, previous abusive relationships, or externalisation of the ED. If the EDV concept is introduced by clinicians, it may be less prevalent among untreated populations. The presence of a similar internal voice among people of a low weight for non-ED reasons could indicate that the EDV, like many ED features (Keys et al., 1950), is driven by the physiology of malnutrition. Additionally, longitudinal research could elucidate the EDV's role over the course of EDs, examining whether changes in EDV strength or content precede or follow changes in ED behaviours. This could identify warning signs for deterioration. Crucially, researchers should investigate ways of working with EDVs to promote

recovery from EDs, monitoring the costs and benefits of different approaches and comparing their efficacy against that of current treatments.

Implications for clinical practice

The current findings demonstrate the potential for AN to 'take on a personality of its own'. The AV's role as a dependable problem-solver may reduce motivation to recover. Distress may arise from a fraught attachment with the voice, and the person may feel out of control as the AV seeks to expand its influence. Clinicians may wish to ask clients if they identify with the concept of an AV, following up with open questions where relevant. Contradictory responses should not faze clinicians, as the AV can be a Jekyll and Hyde-like (Stevenson, 1886) character. The person could be guided to consider strategies for managing the AV: for example, acknowledging, contradicting, 'turning down the volume' or ignoring the voice, distraction or distress tolerance, mindfulness, or emotional expression through writing, artwork or music. Discussing AV content could identify disowned parts of the self, idiosyncratic functions of AN, and beliefs or thinking styles to be challenged. For instance, in an outwardly meek individual, a forceful AV might offer protection, but the voice may not be needed if the person develops assertiveness skills. Where an AV offers escape from challenging emotions, work on emotion identification, regulation and tolerance could aid recovery (Adamson et al., 2018; Lynch et al., 2013). For those who depend on the AV for a sense of control, it could be helpful to practise tolerating incomplete control of situations. Reliance on an AV for a sense of identity could be reduced by building a positive sense of identity beyond AN. Those experiencing highly critical AVs may benefit from compassion-focused approaches (Kelly et al., 2016). Thus, consideration of the AV may assist clinicians in tailoring interventions.

Depending on the outcomes of future research, conversations with AVs could form the basis for new interventions. This could help to address challenges in

the relationship between AV and individual, such as conflict, power imbalance, or the person's struggle to sever the mutually valued, interdependent bond. While the capacity for an external person to converse with the AV opens new treatment possibilities, such methods should not be routinely employed without an understanding of their costs and benefits. Giving AVs 'airtime' may emphasise benefits of the AN or make the voice louder, and some prefer a stance of 'not negotiating with terrorists' regarding their ED. Conversely, therapeutic work with AVs may improve clinicians' and clients' understanding of AN maintenance factors and enhance the therapeutic relationship. Sensitivity would be needed, as those experiencing the AV as part of the self may feel shamed by implications that the voice is wholly 'bad', whether through 'no platforming' or externalising and criticising the AV. The hearing voices literature suggests speaking with voices is experienced as safe and informative, promoting acceptance and values-focused living (Corstens et al., 2011) – the same may or may not be applicable to the AV. Perhaps outcomes from AV-focused interventions are affected by individual characteristics, time allowed for the person's voice versus the AV, or the use of grounding techniques. Such speculation requires empirical investigation.

Conclusions

This thematic analysis of dialogues with the AV maps out an interdependent relationship: the voice views its pragmatism as indispensable to the person, engages them in a fraught relationship, and is compelled to latch onto and increasingly control them. Many of the findings corroborate existing research, including the relational nature of interactions between individual and AV, the voice's attempts to expand its influence and its impact on recovery. This study elaborates on previous research, drawing out the interdependence of the AV-individual relationship, the specifics of its role as a valued problem solver, and the methods by which it seeks to extend its influence. Evidently, the AV can present as a developed

character that an external person can converse with. How best to utilise this knowledge to promote recovery should be the object of ongoing research. For now, clinicians' awareness and curiosity regarding the nature and impact of EDVs could assist with identifying barriers to recovery and tailoring treatments.

References

Adamson, J., Leppanen, J., Murin, M., & Tchanturia, K. (2018). Effectiveness of emotional skills training for patients with anorexia nervosa with autistic symptoms in group and individual format. *European Eating Disorders Review, 26*(4), 367-375. **https://doi.org/10.1002/erv.2594**

Arntz, A., Bernstein, D. P., & Jacob, G. (2013). *Schema therapy in practice: An introductory guide to the schema mode approach.* Wiley-Blackwell.

Atwood, M., & Friedman, A. (2020). A systematic review of enhanced cognitive behavioural therapy (CBT-E) for eating disorders. *International Journal of Eating Disorders, 53*, 311-330. **https://doi.org/10.1002/eat.23206**

Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology*, *35*(3-4), 201-212. **https://doi.org/10.1007/s10464-005-3398-y**

Bates, C. F. (2015). "I am a waste of breath, of space, of time" metaphors of self in a pro-anorexia group. *Qualitative Health Research*, *25*(2), 189-204. **https://doi.org/10.1177/1049732314550004**

Bergner, R. M. (1995). *Pathological self-criticism: Assessment and treatment.* Plenum Press. **https://doi.org/10.1007/978-1-4757-2410-3**

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine*, *30*(2), 337-344. **https://doi.org/10.1017/S0033291799001828**

Blake, W., Turnbull, S., & Treasure, J. (1997). Stages and processes of change in eating disorders: Implications for therapy. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *4*(3), 186-191. **https://doi.org/10.1002/(SICI)1099-0879(199709)4:3<186::AID-CPP128>3.0.CO;2-5**

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

Brockmeyer, T., Holtforth, M. G., Bents, H., Kämmerer, A., Herzog, W., & Friederich, H. C. (2012). Starvation and emotion regulation in anorexia nervosa. *Comprehensive psychiatry*, *53*(5), 496-501. **https://doi.org/10.1016/j.comppsych.2011.09.003**

Chadwick, P. (2003). Two chairs, self-schemata and a person based approach to psychosis. *Behavioural and Cognitive Psychotherapy, 31*(4), 439-449. **https://doi.org/10.1017/S1352465803004053**

Chua, N. Y. L. (2020). *How do individuals with anorexia nervosa (AN) experience the voice dialogue method in the context of experiencing an internal eating disorder voice? A thematic analysis* [Unpublished doctoral thesis]. University College London.

Cooper, S. A., Smiley, E., Morrison, J., Allan, L., Williamson, A., Finlayson, J., Jackson, A., & Mantry, D. (2007). Psychosis and adults with intellectual disabilities. *Social Psychiatry and Psychiatric Epidemiology*, *42*(7), 530-536. **https://doi.org/10.1007/s00127-007-0197-9**

Copeland, W. E., Bulik, C. M., Zucker, N., Wolke, D., Lereya, S. T., & Costello, E. J. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *The International Journal of Eating Disorders*, *48*(8), 1141–1149. **https://doi.org/10.1002/eat.22459**

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage.

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis, 4*, 95-104. **https://doi.org/10.1080/17522439.2011.571705**

Dawson, L., Mullan, B., & Sainsbury, K. (2015). Using the theory of planned behaviour to measure motivation for recovery in anorexia nervosa. *Appetite*, *84*, 309-315. **https://doi.org/10.1016/j.appet.2014.10.028**

D'Agostino, A., Monti, M. R., & Starcevic, V. (2019). Psychotic symptoms in borderline personality disorder: An update. *Current Opinion in Psychiatry*, *32*(1), 22-26. **https://doi.org/10.1097/YCO.0000000000000462**

De Giacomi, E. (2019). *Eating disorders and living with the "Critical Voice"* (Unpublished doctoral thesis). City, University of London.

DeJong, H., Broadbent, H., & Schmidt, U. (2012). A systematic review of dropout from treatment in outpatients with anorexia nervosa. *International Journal of Eating Disorders*, *45*(5), 635-647. **https://doi.org/10.1002/eat.20956**

Dickens, C. (1838). *Oliver Twist.* Richard Bentley.

Elliot, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215-229. **https://doi.org/10.1348/014466599162782**

Emmerson, G. (2003). *Ego state therapy.* Crown House.

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

Fennig, S., Hadas, A., Itzhaky, L., Roe, D., Apter, A., & Shahar, G. (2008). Self-criticism is a key predictor of eating disorder dimensions among inpatient adolescent females. *International Journal of Eating Disorders*, *41*(8), 762-765. **https://doi.org/10.1002/eat.20573**

Fox, J. R., & Diab, P. (2015). An exploration of the perceptions and experiences of living with chronic anorexia nervosa while an inpatient on an eating disorders unit: An interpretative phenomenological analysis (IPA) study. *Journal of Health Psychology, 20*(1), 27-36. **https://doi.org/10.1177/1359105313497526**

Fox, J. R., Federici, A., & Power, M. J. (2012). Emotions and eating disorders: Treatment implications. In J. R. Fox & K. P. Goss (Eds.), *Eating and its disorders* (pp. 167–184). Chichester: John Wiley and Sons. **https://doi.org/10.1002/9781118328910.ch21**

Gilbert, P., Durrant, R., & McEwan, K. (2006). Investigating relationships between perfectionism, forms and functions of self-criticism, and sensitivity to put-down. *Personality and Individual Differences*, *41*(7), 1299-1308. **https://doi.org/10.1016/j.paid.2006.05.004**

Hermans, H. J., & Gieser, T. (Eds.). (2011). *Handbook of dialogical self theory*. Cambridge University Press.

Jenkins, J., & Ogden, J. (2012). Becoming “whole” again: A qualitative study of women’s views of recovering from anorexia nervosa. *European Eating Disorders Review*, *20*(1), 23-31. **https://doi.org/10.1002/erv.1085**

Jewell, T., Blessitt, E., Stewart, C., Simic, M., & Eisler, I. (2016). Family therapy for child and adolescent eating disorders: A critical review. *Family Process, 55*(3), 577-594. **https://doi.org/10.1111/famp.12242**

Kelly, A. C., Wisniewski, L., Martin-Wagar, C., & Hoffman, E. (2016). Group-based compassion-focused therapy as an adjunct to outpatient treatment for eating disorders: A pilot randomized controlled trial. *Clinical Psychology & Psychotherapy, 24*(2), 475-487. **https://doi.org/10.1002/cpp.2018**

Keys, A., Brožek, J., Henschel, A., Mickelsen, O., & Taylor, H. L. (1950). *The biology of human starvation.* University of Minnesota Press.

Knapton, O. (2013). Pro-anorexia: Extensions of ingrained concepts. *Discourse & Society*, *24*(4), 461-477. **https://doi.org/10.1177/0957926513482067**

Knowles, L., Anokhina, A., & Serpell, L. (2013) Motivational approaches in eating disorders: A review of the literature. *International Journal of Eating Disorders, 46*, 97-107. **https://doi.org/10.1002/eat.22053**

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin*, *138*(1), 28-76. **https://doi.org/10.1037/a0025995**

Lynch, T. R., Gray, K. L., Hempel, R. J., Titley, M., Chen, E. Y., & O'Mahen, H. A. (2013). Radically open-dialectical behavior therapy for adult anorexia nervosa: Feasibility and outcomes from an inpatient program. *BMC Psychiatry 13*, 293 (2013). **https://doi.org/10.1186/1471-244X-13-293**

Mantilla, E. F., Clinton, D., & Birgegård, A. (2018). Insidious: The relationship patients have with their eating disorders and its impact on symptoms, duration of illness, and self-image. *Psychology and Psychotherapy: Theory, Research and Practice, 91*(3), 302–316. **https://doi.org/10.1111/papt.12161**

Mantilla, E. F., Clinton, D., & Birgegård, A. (2019). The unsafe haven: Eating disorders as attachment relationships. *Psychology and Psychotherapy: Theory, Research and Practice, 92*(3), 379-393. **https://doi.org/10.1111/papt.12184**

Merrett, Z., Rossell, S., & Castle, D. (2016). Comparing the experience of voices in borderline personality disorder with the experience of voices in a psychotic disorder: A systematic review. *Australian & New Zealand Journal of Psychiatry, 50*(7), 640-648. **https://doi.org/10.1177/0004867416632595**

Merwin, R. M., Moskovich, A. A., Wagner, H. R., Ritschel, L. A., Craighead, L. W., & Zucker, N. L. (2013). Emotion regulation difficulties in anorexia nervosa: Relationship to self-perceived sensory sensitivity. *Cognition & emotion*, *27*(3), 441-452. **https://doi.org/10.1080/02699931.2012.719003**

National Institute for Health and Care Excellence (2020, December). *Eating disorders: Recognition and treatment* [NICE Guideline No. 69]. **https://www.nice.org.uk/guidance/ng69**

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating Disorders: The Journal of Treatment and Prevention*, *22*(4), 337–351. **https://doi.org/10.1080/10640266.2014.898983**

Noordenbos, G., & Van Geest, Z. (2017). Self-criticism and critical voices in eating disorder patients and healthy controls. *JSM Nutritional Disorders*, *1*(1), 1003–1008. **https://doi.org/10.1002/eat.20276**

Nordbø, R. H., Espeset, E. M., Gulliksen, K. S., Skårderud, F., & Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders*, *39*(7), 556-564.

O'Brien, K. M., & Vincent, N. K. (2003). Psychiatric comorbidity in anorexia and bulimia nervosa: Nature, prevalence, and causal relationships. *Clinical Psychology Review*, *23*(1), 57-74. **https://doi.org/10.1016/S0272-7358(02)00201-5**

Oldershaw, A., Lavender, T., Sallis, H., Stahl, D., & Schmidt, U. (2015). Emotion generation and regulation in anorexia nervosa: A systematic review and meta-analysis of self-report data. *Clinical Psychology Review*, *39*, 83-95. **https://doi.org/10.1016/j.cpr.2015.04.005**

Oldershaw, A., Startup, H., & Lavender, T. (2019). Anorexia nervosa and a lost emotional self: A psychological formulation of the development, maintenance, and treatment of anorexia nervosa. *Frontiers in Psychology*, *10*(219). **https://doi.org/10.3389/fpsyg.2019.00219**

Peters, E. R., Williams, S. L., Cooke, M. A., & Kuipers, E. (2012). It's not what you hear, it's the way you think about it: Appraisals as determinants of affect and behaviour in voice hearers. *Psychological Medicine, 42*(7), 1507-1514. **https://doi.org/10.1017/S0033291711002650**

Pistrang, C., Barker, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd edition). John Wiley & Sons, Ltd. **https://doi.org/10.1002/9781119154082**

Patton, M.Q. (1990). *Qualitative evaluation and research methods (2nd edition).* Sage. **https://doi.org/10.1002/nur.4770140111**

Pratt, S. M. (2016). *Eating disorder voices: A qualitative content analysis.* Retrieved from ProQuest Dissertations Publishing. (AAT 3711809).

Pugh, M. (2016). The internal 'anorexic voice': A feature or fallacy of eating disorders? *Advances in Eating Disorders, 4*(1), 75-83. **https://doi.org/10.1080/21662630.2015.1116017**

Pugh, M. (2017). Chairwork in cognitive behavioural therapy: A narrative review. *Cognitive Therapy and Research*, *41*(1), 16-30. **https://doi.org/10.1007/s10608-016-9805-x**

Pugh, M. (2019). *Dialogical interview schedule for eating disorders.* Unpublished manuscript. London, UK.

Pugh, M. (2020) Understanding 'Ed': A theoretical and empirical review of the internal eating disorder 'voice'. *BPS Psychotherapy Section Review, 65*.

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders, 49*, 622–625. **https://doi.org/10.1002/eat.22499**

Pugh, M., & Waller, G. (2017). Understanding the 'anorexic voice' in anorexia nervosa*. Clinical Psychology and Psychotherapy, 24*, 670–676. **https://doi.org/10.1002/cpp.2034**

Pugh, M., Waller, G., & Esposito, M. (2018). Childhood trauma, dissociation, and the internal eating disorder 'voice'. *Childhood Abuse & Neglect, 86*, 197-205. **https://doi.org/10.1016/j.chiabu.2018.10.005**

Pullman, P. (1995). *Northern Lights.* Scholastic UK.

Rance, N., Clarke, V., & Moller, N. (2017). The anorexia nervosa experience: Shame, Solitude and Salvation. *Counselling and Psychotherapy Research, 17*(2), 127-136. **https://doi.org/10.1002/capr.12097**

Rowling, J. K. (1999). *Harry Potter and the Prisoner of Azkaban.* Arthur A. Levine Books.

Schwartz, R. C. (1995) *Internal family systems therapy.* Guilford Press.

Seed, T., Fox, J., & Berry, K. (2016). Experiences of Detention under the Mental Health Act for Adults with Anorexia Nervosa. *Clinical Psychology & Psychotherapy*, *23*(4), 352-362. **https://doi.org/10.1002/cpp.1963**

Serpell, L., Treasure, J., Teasdale, J., & Sullivan, V. (1999). Anorexia nervosa: Friend or foe? *International Journal of Eating Disorders*, *25*(2), 177-186. **https://doi.org/10.1002/(sici)1098-108x(199903)25:2<177::aid-eat7>3.0.co;2-d**

Sheaves, B., Johns, L., Černis, E., Griffith, L., McPin Hearing Voices Lived Experience Advisory Panel, & Freeman, D. (2020). The challenges and opportunities of social connection when hearing derogatory and threatening voices: A thematic analysis with patients experiencing psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*. **https://doi.org/10.1111/papt.12303**

Sims-Schouten, W., Riley, S. C., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Psychology*, *17*(1), 101-124. **https://doi.org/10.1177/0959354307073153**

Smethurst, L., & Kuss, D. (2018). 'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa. *Journal of Health Psychology, 23*(10), 1287-1298. **https://doi.org/10.1177/1359105316651710**

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 218-240). Sage Publications. **http://dx.doi.org/10.4135/9781446217870.n14**

Stevenson, R. L. (1886). *Strange Case of Dr Jekyll and Mr Hyde.* Longmans, Green & Co.

Stone, H., & Stone, S. (1988). *Embracing our selves: The voice dialogue manual.* Nataraj Publishing.

Stone, H., & Stone, S. (1993). Embracing Your Inner Critic: Turning Self-Criticism into a Creative Asset. Delos, Inc.

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

Tierney, S., & Fox, J. R. E. (2011). Trapped in a toxic relationship: Comparing the views of women living with anorexia nervosa to those experiencing domestic violence. *Journal of Gender Studies, 20*(1), 31-41. **https://doi.org/10.1080/09589236.2011.542018**

Tolkien, J. R. R. (1954). *The fellowship of the ring.* George Allan & Unwin.

Trotta, A., Murray, R. M., & Fisher, H. L. (2015). The impact of childhood adversity on the persistence of psychotic symptoms: A systematic review and meta-analysis. *Psychological Medicine, 45*(12), 2481-2498. **https://doi.org/10.1017/S0033291715000574**

Waller, G. (2012). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders?. *International Journal of Eating Disorders*, *45*(1), 1-16. **https://doi.org/10.1002/eat.20900**

Williams, K., King, J., & Fox, J. R. E. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(2), 211-228. **https://doi.org/10.1111/papt.12068**

Williams, S., & Reid, M. (2012). “It’s like there are two people in my head”: A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology and Health, 27*(7), 798-815. **https://doi.org/10.1080/08870446.2011.595488**

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In Nightingale, D.J., & Cromby, J. (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 37-51). Open University Press. **https://doi.org/10.1093/bjsw/31.6.845**

Zelkowitz, R. L., & Cole, D. A. (2019). Self-criticism as a transdiagnostic process in nonsuicidal self-injury and disordered eating: Systematic review and meta-analysis. *Suicide and Life-Threatening Behavior, 49*(1), 310-327. **https://doi.org/10.1111/sltb.12436**

Part 3: Critical Appraisal

Introduction

As I am approaching the end of this project, two aspects of the research process have stood out to me above all others. The first concerns my frustrations with the NHS ethical approval process, and the second the interrelationship between research and researcher. Notes on these two points dominate the pages of my research journal, so it seemed fitting to devote this critical appraisal to exploring them further. I made this decision with some trepidation, due to concerns that my thoughts may appear provocative or self-indulgent. However, if this was my experience, I suspect that other researchers have encountered similar challenges. My intention is not to criticise or over-share, but to highlight perceived inefficiencies and injustices in the ethical approval system, and to illustrate the power and complexity of the two-way interaction between research and researcher.

The Bureaucracy and Inconsistency of NHS Ethics

Ethics committees play a vital role in safeguarding the wellbeing of participants and upholding trust in the integrity of research. Nonetheless, their job is not straightforward, as they are routinely faced with complex ethical dilemmas. Trade-offs are inevitable, and what is deemed an acceptable cost-benefit balance differs between individuals and over time. Many studies with dubious regard for participant wellbeing have provided invaluable insights. The Minnesota starvation experiment (Keys, 1950) is one such example. A group of healthy men were monitored as they underwent states of starvation and refeeding, which demonstrated that many eating disorder (ED) symptoms arise from the state of starvation itself. The concept that adequate nutrition and weight restoration are required in order to recover, not vice versa, now forms a cornerstone of ED treatment. Nonetheless, the study compromised participants' mental and physical health, and framing it as an alternative to military service created a pressure to participate. The study certainly would not meet the ethical standards of today. The

philosophy that ‘anything goes if it’s for the greater good’ seems a dangerous one, but the potential benefits of a study are one of many factors to consider when assessing its ethics.

Whilst acknowledging the importance and complexity of the work of research ethics committees, the research community has long expressed frustration with current ethical review procedures. Reviewing bodies have been criticised for taking a paternalistic stance, prioritising consent above all else and excluding ‘vulnerable’ groups, hence limiting the development of effective treatments for these groups (Rhodes, 2005). The current processes involved in ethical review are often cumbersome, inefficient, and idiosyncratic (Koski, 2010). Researchers must acknowledge that they are in a position of power and have the capacity to do harm, but ethical review procedures at times impede as well as facilitate good quality ethical research.

I experienced the NHS ethical approval process as bureaucratic to the point of absurdity. It was not the quantity of information required that shocked me – it is helpful to consider the management of ethical issues in detail – but the inefficiency of the system. Jargon was rife. I emailed the JRO my HRA IRAS form with CI signature and attached SOE, SOA, PIS, and CTIMPS registration form, and felt lost in a sea of acronyms. It was a challenge even to identify the many organisations (most of which I had no prior awareness of) that needed to be contacted for various approvals. To make matters worse, the same information had to be repeated on countless forms, in subtly varied formats. In completing the necessary paperwork, I would estimate my time-taken-to-meaningful-work ratio at no better than 20:1. Additionally, it took months and much chasing to gain a response once the necessary forms were submitted. The whole process, to the point of receiving ethical approval, took over a year of solid work, most of it meaningless. This was more time consuming than any other part of the project.

The tangled bureaucracy of the ethical approval system was at best merely frustrating and at worst, unethical. The process wasted a huge amount of time, largely without impacting the management of ethical issues within the project. This made it a significant and purposeless impediment to research, blocking progress in clinical work. The plethora of paperwork is likely to increase the probability of errors and spawn confusion. Swathes of jargon and an endless stream of apparently redundant forms may place the researcher in 'threat mode' (Gilbert, 2010), thereby reducing levels of empathy (Karos et al., 2018; Richins et al., 2019) and increasing the likelihood of utilitarian ethical judgements (Gleichgerrcht & Young, 2013), rather than decisions that prioritise participants' wellbeing. Thus, ethical research would be promoted by a more efficient system, involving less jargon and a smaller number of more succinct and intelligible documents.

If I had hoped that my dismay at the ethical review process would be limited to the paperwork, I was sadly mistaken. My meeting with the review panel, instead of being an opportunity for constructive feedback and collaboration, strengthened hostilities between researcher and research ethics committee and highlighted inconsistencies in the system. Following the comment of a single panel member, the panel of eighteen deemed the offer of a £20 gift voucher for participation in the study to be 'coercive'. They stipulated that participants could not be told about the voucher until it was given to them at the end of the research appointment, undoubtedly making recruitment more difficult as it would appear that we expected people to give up their time for nothing. The panel were not open to discussion on this matter. Later that day, I discovered that others in my cohort, running similarly sensitive research projects in the same field, had studies with equivalent voucher incentives approved by a different HRA panel that very week. My supervisor, who has 26 years of experience applying for NHS ethics, also stated that she had never been challenged on this point before.

There is an ongoing debate around the ethics of reimbursing participants for their time. The Belmont Report (1979) states that disproportionate or inappropriate payments can constitute undue influence. The term ‘coercion’ has been disputed in this context as, by definition, coercion involves threat of harm, and offers of remuneration do not equate to a threat (Grady, 2001). Surpassing terminological disagreement, there is the issue of ‘research exceptionalism’ – the assumption of a valid distinction between research and other domains of risk-taking (Largent & Lynch, 2017). In reality, daily life entails risk for everyone and some paid professions, such as army or police careers, are esteemed precisely because they involve risk-taking for others’ benefit (Largent & Lynch, 2017). Without a logical basis for research exceptionalism, the blanket argument against participant reimbursement falls down. To understand the nuanced ethical implications at play, future research could investigate specific questions, such as whether there are cultural differences in the impact of participant payment, or how decisions about participant payment are currently made (Ripley, 2006). Although many researchers have argued in favour of participant remuneration, it should be recognised that they are not speaking from an unbiased position. Paying participants may necessitate additional funding, but it also makes recruitment easier. Current ethical guidelines on the matter remain vague, and concerns about the impact of participant payment persist (Millum & Garnett, 2019). In light of this, it was appropriate for the review panel to explore the ethics of voucher incentives for participation. However, the inconsistency of their stance on this common dilemma is problematic and confusing.

In sum, there are many problems with the current NHS ethical review system. Its inefficiency and seemingly purposeless bureaucracy impede the progress of research and, consequently, clinical practice. Ethics review panels currently show stark inconsistencies in their decision making. If the ethics concerning voucher incentives really have been fully explored and a clear,

unconditional verdict reached, then all projects should abide by the same regulations, which should be clearly stated in the national ethics guidance. On the other hand, it must be acknowledged that the process of ethical review is both important and complex. Every person involved in reviewing my study was probably doing their best within a flawed system. To model and promote high standards of research ethics, the system itself will need to change. The process should be more transparent and coherent, the paperwork should be radically streamlined, consistent stances should be reached for common ethical dilemmas, and relationships between review panels, researchers and participants should be based on collaboration.

The Interrelationship Between Researcher and Research

Before exploring the interrelationship between researcher and research, it seems important to say a few words on disclosure of researcher perspective. I align with the view, prevalent in the qualitative paradigm (Pistrang et al., 2016), that research is inevitably influenced by the perspective of the researcher(s) conducting it. With reflexivity and appropriate disclosure, this influence can form a valuable part of the research (Barker & Pistrang, 2005). Yet, the public disclosure of personal information warrants careful thought, bearing in mind the human right for privacy (Human Rights Act, 1998) and the potential social and employment implications. This is particularly pertinent regarding disclosure of mental health problems. Recent research illustrates that many mental health professionals fear that disclosure of mental health problems would result in workplace discrimination (Tay et al., 2018). Having witnessed and experienced such discrimination first hand, I have not made the decision to disclose lightly, nor will I be disclosing more than I perceive to be of benefit to the research. However, I decided that withholding relevant information would contravene my values and leave the reader with an incomplete picture of the context from which the research developed. In addition, I reflected that the

relationship between researcher and research is not unidirectional. My experience will be used to illustrate the dynamic nature of this interaction.

From the outset, I was aware that my childhood experiences of anorexia nervosa (AN) could influence my approach to the project. In the bracketing process, I speculated on the nature of this impact. For example, as mentioned in the empirical paper, I anticipated an inclination to privilege narratives of control over those of body image. This disclosure allows readers to consider the lens through which the research was produced and prompted me to scrutinise my rationale for decisions throughout the research process.

Whilst I was very aware of my influence on the research, I did not expect the project to personally affect me. I felt that my ED was in the distant past. Unfortunately, I was mistaken. I relapsed around the time of the interviews, during a placement at one of the host sites. I do not believe that the research and clinical work caused the relapse, but I wonder if it acted as a subconscious reminder of old coping strategies. When other stressors arose, I found myself unknowingly seduced by the AV once more. I cannot deny that the research may have played a role in this.

Researcher-on-research and research-on-researcher effects were not independent, but interactive. For instance, I was asked to stop conducting research interviews to prevent distress to participants, based on my physical appearance. This, in turn, confirmed beliefs that my existence is damaging to others, reinforcing the drive towards self-punishment. Hence, my fitness-to-work declined further.

In my year out for recovery, I slowly progressed with analysis and write-up, necessitating careful management of researcher-research interactions. I made a conscious effort to switch roles when working on the research, ironically marking this shift by changing seats – one chair for my role as patient and another for my

researcher self. I set time limits for my work on the project each day, so that I did not remain immersed in the data when not actively working on it. As a result of my personal experience, I was forcefully struck by the sheer number of 'ways in' used by the AV – its resourcefulness in twisting any situation to its advantage. This intensified my hatred for the voice, calling for greater self-scrutiny throughout analysis and write-up. After all, the voice dialogue approach is based on respect and compassion for different parts of the self (Stone & Stone, 1988), and the aim of the research was to find out more about the AV, not to judge it. I continued to question my choices regarding the research. Why did I tend to code any quotes relating to control from the AV as 'controlling', rather than 'in control'? Probably because I viewed the AV as malicious. Had I created the code 'parasitic' for the same reason? I would re-read the transcripts, looking for evidence to refute or support my coding choices, making changes where appropriate. In my view, the final output of the analysis reflects the complexity of the AV evident in the transcripts – a view supported by my supervisors. Yet, as with all research, the results of this study are developed through the researcher's unique perspective, in the context of their particular circumstances.

Although I am satisfied with my management of researcher-research interactions through the analysis, personal experiences have left me with some nagging concerns. I cannot be certain that dialogues with the AV, including with my own AV for training purposes, did not contribute to my relapse. Conversations with others in treatment also led to worries about the origins of the AV concept. Anecdotally, I encountered several individuals with lived experience of EDs who strongly rejected the EDV concept, as something imposed upon them by clinicians. These experiences casting doubt on the origins and effects of dialogues with the AV took place in the personal sphere, but undeniably influence my thinking in the role of researcher. Ultimately, my research was exploratory and focused on describing the

perspective of the AV. It was not intended to advocate the routine use of dialogues with the AV in clinical practice, nor to unpack the construction of the AV concept. With my ‘researcher hat’ on and these personal experiences in mind, I strongly believe that more research is needed to understand any costs and benefits of chairwork with the AV in recovery.

Conclusion

I experienced the ethical review process and interactions between research and researcher as thought-provoking and emotive. Beyond my own experiences, these aspects of the research process will have a substantial impact on the research that is produced in the world. Without an efficient, coherent and collaborative ethical review process, complex and important ethical issues will be poorly managed and clinical progress will be impeded. In addition, awareness of the dynamic interactions between researcher and research can make for rich reflections, illustrating the lens through which the research was developed and potentially influencing the conclusions that may be drawn.

References

Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology*, *35*(3-4), 201-212. **https://doi.org/10.1007/s10464-005-3398-y**

Belmont Report (1979). National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The Belmont Report. Ethical Principles and Guidelines for the Protection of Human Subjects of Research. Washington DC: U.S. Government Printing Office.

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. International Journal of Cognitive Therapy, 3(2), 97-112. **https://doi.org/10.1521/ijct.2010.3.2.97**

Gleichgerrcht, E., & Young, L. (2013). Low levels of empathic concern predict utilitarian moral judgment. PloS ONE, 8(4), e60418. **https://doi.org/10.1371/journal.pone.0060418**

Grady, C. (2001). Money for research participation: Does it jeopardize informed consent? *American Journal of Bioethics, 1*(2), 40–44. **https://doi.org/10.1162/152651601300169031**

United Kingdom: Human Rights Act (1998), available at: **https://www.refworld.org/docid/3ae6b5a7a.html** [accessed 16 March 2021]

Karos, K., Meulders, A., Goubert, L., & Vlaeyen, J. W. (2018). The influence of social threat on pain, aggression, and empathy in women. The Journal of Pain, 19(3), 291-300. **https://doi.org/10.1016/j.jpain.2017.11.003**

Keys, A., Brozek, J., Henschel, A., Mickelsen, O. & Taylor, H. L. (1950)

The Biology of Human Starvation (Vols. I–II). University of Minnesota Press. **https://doi.org/10.5749/j.ctv9b2tqv**

Koski, G. (2010). “Rethinking research ethics,” again: Casuistry, phronesis, and the continuing challenges of human research. The American Journal of Bioethics, 10(10), 37-39. **https://doi.org/10.1080/15265161.2010.526444**

Largent, E. A., & Lynch, H. F. (2017). Paying research participants: regulatory uncertainty, conceptual confusion, and a path forward. *Yale Journal of Health Policy, Law, and Ethics, 17*(1), 61-141.

Lock, J., & Le Grange, D. (2018). Family-based treatment: Where are we and where should we be going to improve recovery in child and adolescent eating disorders. *International Journal of Eating Disorders, 52*(4), 481-487. **https://doi.org/10.1002/eat.22980**

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin*, *138*(1), 28-76. **https://doi.org/10.1037/a0025995**

Millum, J., & Garnett, M. (2019). How payment for research participation can be coercive. *The American Journal of Bioethics, 19*(9), 21-31. **https://doi.org/10.1080/15265161.2019.1630497**

Pistrang, C., Barker, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd edition). John Wiley & Sons, Ltd.

Rhodes, R. (2010). Rethinking research ethics. The American Journal of Bioethics, 10(10), 19-36. **https://doi.org/10.1080/15265161.2010.519233**

Richins, M. T., Barreto, M., Karl, A., & Lawrence, N. (2019). Incidental fear reduces empathy for an out-group's pain. Emotion. Advance online publication. **https://doi.org/10.1037/emo0000714**

Ripley, E. B. (2006). A review of paying research participants: It's time to move beyond the ethical debate. *Journal of Empirical Research on Human Research Ethics*, *1*(4), 9-19. **https://doi.org/10.1525/jer.2006.1.4.9**

Stone, H., & Stone, S. (1988). *Embracing our selves: The voice dialogue manual.* Nataraj Publishing.

Appendix A

CASP quality ratings

Reference	Clear aims	Qualitative methodology appropriate	Appropriate design	Appropriate recruitment	Data collection addressing research issue	Researcher-participant relationship considered	Ethical issues considered	Rigorous analysis	Clear findings	Valuable	Total
Broussard (2005)	Y	Y	Y	U	Y	U	Y	Y	Y	Y	8
Conti et al. (2017)	Y	Y	Y	Y	Y	N	U	U	Y	Y	7
De Giacomi (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Dias (2003)	N	Y	U	U	U	Y	Y	U	N	U	3
Fox & Diab (2015)	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Graham et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Higbed & Fox (2010)	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9
Jenkins & Ogden (2012)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9
Kendal et al. (2017)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9
Lodge-Guttery (2005)	U	Y	Y	Y	Y	N	Y	Y	Y	Y	8
Pratt (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Rance et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Salvini et al. (2012)	U	Y	U	U	U	U	N	Y	Y	U	3

Scott (2008)	U	U	U	Y	Y	U	U	U	U	U	2
Seed et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Smethurst & Kuss (2018)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
Tierney & Fox (2010)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Tierney & Fox (2011)	U	Y	Y	Y	Y	N	Y	Y	Y	Y	8
Walstrom (2002)	U	Y	Y	Y	U	Y	Y	U	U	Y	6
Williams et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Williams & Reid (2010)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
Williams & Reid (2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10

Key

Y = Yes

N = No

U = Unclear

Appendix B

Overview of researchers' contributions to the joint research project

SBS was largely responsible for the ethical review process and logistics required to facilitate recruitment. She completed the IRAS form, protocol, insurance application, data protection document, risk assessment, participant information sheet, consent form, study poster, and documents for each of the four Research and Development departments involved. She liaised with all parties to gather the information required and promote timely responses. She attended and contributed to the HRA panel meeting and organised resultant changes to the paperwork. She also organised and submitted a substantial amendment when it became clear that it would be important to record participants BMI. SBS presented the project to staff at three of the four trusts involved (external supervisor MP presented to his own service) and communicated with staff over telephone and email to facilitate recruitment. She took part in chairwork training and edited the interview schedule. SBS carried out and transcribed two participant interviews. She had intended to facilitate and transcribe half of the interviews, but unfortunately had to take sick leave, so this was not possible. She completed analysis and write-up independently, periodically consulting with her supervisors.

NC reviewed completed forms for ethical approval, and filled out the statement of activities, schedule of events and funding application forms. She obtained a research passport. NC attended and contributed to the HRA panel meeting and made some subsequent changes to the paperwork, including creating a participant support card. NC attended a presentation to one of the four trusts involved. She took part in chairwork training and discussed changes to the interview schedule. Once SBS was signed off work, NC completed the majority of the research interviews and transcripts (seven in total). She wrote up her project independently from SBS.

Appendix C

Ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr. Lucy Serpell
Clinical Lead for Eating Disorders; Senior Lecturer and Research Supervisor
North East London NHS Foundation Trust; UCL
Room 442
1-19 Torrington Place
London
WC1E 7HB

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

08 July 2019

Dear Dr. Serpell

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Interviewing 'Ana': Qualitative Analysis of Voice Dialogues with the Internal Anorexic Voice and Participants' Experiences of Voice Dialogues**
IRAS project ID:	**251510**
Protocol number:	**EDGE 119684**
REC reference:	**19/LO/0793**
Sponsor	**UCL Joint Research Office**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **251510**. Please quote this on all correspondence.

Yours sincerely,
Matt Rogerson
Approvals Specialist

Email: **INSERT** hra.approval@nhs.net

Copy to: *Ms. Suzanne Emerton*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Poster]	1.0	19 March 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance confirmation certificate]	1.0	25 July 2018
HRA Schedule of Events [SoE]		15 May 2019
HRA Statement of Activities [validated SoA]	1.1	
Interview schedules or topic guides for participants [Interview schedule]	1.0	19 March 2019
IRAS Application Form [IRAS_Form_12042019]		12 April 2019
Letter from funder [Confirmation of funding]	1.0	15 February 2019
Participant consent form [Participant consent form]	1.0	19 March 2019
Participant information sheet (PIS) [Participant information sheet]	1.0	19 March 2019
Research protocol or project proposal [Research protocol]	1.0	19 March 2019
Summary CV for Chief Investigator (CI) [Lucy Serpell CV]	0.1	18 August 2018
Summary CV for student [Sarah Burnett-Stuart CV]	0.2	05 December 2018
Summary CV for student [Natalie Chua NHS ethics CV]	0.1	23 November 2018
Summary CV for supervisor (student research) [Lucy Serpell CV]	1	20 August 2018
Summary CV for supervisor (student research) [Matthew Pugh CV]	0.1	29 October 2018

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	**Expectations related to confirmation of capacity and capability**	**Agreement to be used**	**Funding arrangements**	**Oversight expectations**	**HR Good Practice Resource Pack expectations**
All sites will perform the same research activities therefore there is only one site type	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used. The SoA states that the Chief Investigator will be the responsible person at sites, but a Local Collaborator is all that is required.	No funding will be supplied to sites, as per the statement of activities.	A Local Collaborator should be appointed at study sites.	As a non-commercial study undertaken by local staff, it is unlikely that letters of access or honorary research contracts will be applicable. Where arrangements are not already in place, researchers undertaking any of the research activities listed in A18 of the IRAS form would be expected to obtain a Letter of Access. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The Applicant does not intend to apply for inclusion on the NIHR LCRN portfolio.

Ethical approval following amendment to record participant body mass index

NHS
Health Research Authority

London - Bloomsbury Research Ethics Committee
HRA RES Centre Manchester
Barlow House 3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8063

21 November 2019

Mrs. Sarah Burnett-Stuart
Trainee Clinical Psychologist
UCL; Camden and Islington NHS Foundation Trust
1-19 Torrington Place
London
WC1E 7HB

Dear Mrs. Burnett-Stuart

Study title:	**Interviewing 'Ana': Qualitative Analysis of Voice Dialogues with the Internal Anorexic Voice and Participants' Experiences of Voice Dialogues**
REC reference:	**19/LO/0793**
Protocol number:	**EDGE 119684**
Amendment number:	**Substantial Amendment 1**
Amendment date:	**16 November 2019**
IRAS project ID:	**251510**

Thank you for submitting the above amendment, which was received on 21 November 2019. I can confirm that this is a valid notice of a substantial amendment and will be reviewed by the Sub-Committee of the REC at its next meeting.

Documents received

The documents to be reviewed are as follows:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	Substantial Amendment 1	16 November 2019
Other [Schedule of Events]		17 November 2019
Other [Statement of Activities]	4.4	17 November 2019
Participant consent form	3.0	16 November 2019

Participant information sheet (PIS)	3.0	16 November 2019
Research protocol or project proposal	3.0	16 November 2019

Notification of the Committee's decision

The Committee will issue an ethical opinion on the amendment within a maximum of 35 days from the date of receipt.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval for the research.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/LO/0793:	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

Nina Bakhshayesh

Email: nrescommittee.london-bloomsbury@nhs.net

Copy to: *Mrs. Sarah Burnett-Stuart, UCL; Camden and Islington NHS Foundation Trust*

Appendix D

Study information sheet

University College London Hospitals NHS
NHS Foundation Trust

Speaking with the internal anorexic 'voice' or 'anorexic self'

Invitation and brief summary

Many people with eating disorders describe experiencing an internal eating disorder 'voice' which comments on their eating, weight and body image. For other individuals, eating difficulties are represented less by a voice and more by an 'anorexic self' or 'anorexic part' of their personality. We would like to invite you to participate in this study to help us understand the internal anorexic 'voice' or 'anorexic self' better.

We will be using a therapeutic method called 'chairwork' to speak directly to the individual's anorexic 'voice' or 'anorexic self'. We hope this will help us understand these experiences better and how they might be related to eating difficulties. We are also interested in learning what it was like for you to converse with your anorexic 'voice' or 'anorexic self', so we will be asking some questions after the 'chairwork' to understand your experience.

Why am I being invited?

You are being invited to take part in the study because you are a client at an Eating Disorders Clinic involved in the research, and have described experiencing an internal anorexic voice.

What's the purpose of this research?

This study aims to help mental health professionals and other individuals to understand anorexia better and to help improve treatments for anorexia.

Research suggests that around 90% of people with an eating disorder experience an internal 'eating disorder voice'. There hasn't been much research into the internal anorexic voice. We believe that developing our understanding of the anorexic voice could help to improve treatment.

'Chairwork' is a therapy technique that can involve using chairs to speak with internal voices. The person with anorexia sits in one chair and talks to the therapist as if they were the internal voice.

What would taking part involve?

If you have consented for the researchers to phone you about the study, you can expect a phone call from Sarah Burnett-Stuart or Natalie Chua Yi Ling in the next couple of weeks. During this phone call, you will have a chance to ask questions about the study. If you are interested in participating, you will be able to arrange an appointment for participation and Sarah or Natalie will then send you a consent form via email (or post if email isn't convenient). You would be asked to read this information sheet and the consent form and, if you consent to take part, to bring a signed copy of the consent form to the appointment. If you decide that you don't consent to the terms on the consent form, you can contact the researchers via phone or email to cancel the appointment.

The appointment itself may last up to 2 hours, will take place at the eating disorders service where you are receiving treatment, and will be with either Natalie or Sarah. You will have the option of

having a break part-way through. The appointment will be audio recorded, and the recording will be stored securely and deleted after the study has been written up. Transcripts will be anonymised and stored on an encrypted device so that nobody outside the study team can access your interview.

At the beginning of the appointment, you will be asked some questions about you and your eating disorder. The researchers will also ask your consent to request your most recent body mass index (BMI) measurement from your named clinician following the appointment. This information will be stored in a locked filing cabinet on NHS premises and will be securely disposed of after the study ends. When the study is written up, no details of individual participants will be included so that you will remain anonymous.

In the first half of the appointment, the researcher will have a conversation with your internal anorexic 'voice' or 'anorexic self' (whichever term you prefer) using 'chairwork'. Chairwork can be described as an experiential process using chairs to facilitate the conversation between you and your internal 'anorexic voice' or 'anorexic self'. For example, you might be invited to move from your original chair to a new chair and be asked to speak with your 'anorexic voice' while you are seated in your new chair. You may than be invited to return to your original chair and respond to what your 'anorexic voice' or 'anorexic self' might have expressed.

The second half of the appointment will focus on how you experienced this conversation between the researcher and your anorexic voice. There are no right or wrong answers, we are just interested to hear your perspective.

Do I have to take part?

You do not have to take part, and should not feel under any pressure to do so. Your decision to participate/not participate in the study will not affect your treatment in the eating disorder service.

What are the possible benefits of taking part?

We hope that taking part in this study may help to develop your understanding of your anorexic 'voice'/ 'anorexic self' and your eating disorder more generally. You will carry on with the treatment you are having with your eating disorder service and this will not be affected by your decision to take part or not.

What are the possible disadvantages of taking part, and how have these been addressed?

Participating in this study will involve attending one appointment at your local eating disorder clinic, which may last up to 2 hours. You will have the option to take a break half way through the appointment.

There is always a small risk that some individuals may find the research interview upsetting as it concerns potentially sensitive and private topics. However, the appointment is designed to be a comfortable as possible and you can choose to stop or take a break at any point.

Additionally, your clinician and treatment team will be informed of when the research appointment is taking place so that a member of staff who you are familiar with can be available to provide any support you need after your appointment. You will also be given a 'support card', explaining the different avenues of support available to you, including a helpline run by the charity 'Beat', which offers support outside of working hours.

As with any study, there is a very small risk of breaching confidentiality. However, careful safeguards have been put in place to prevent this. Research appointments will take place on NHS premises in private consultation rooms. Audio recordings of research interviews will be stored on encrypted devices and deleted after the study has been written up. Transcripts will be anonymous, leaving out any identifiable information. Completed consent forms and anonymised demographic information (e.g. gender, age, BMI) will be stored in separate locked filing cabinets on NHS premises. Anonymity will be maintained when the study is written up. The only situation in which confidentiality should be breached is if a participant discloses a risk of harm to themselves or others, as this information would need to be passed on to their clinician in the eating disorders service.

More information about UCL policies on processing personal data during research is available at the following link: https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice.

Who has been involved in planning, funding and reviewing this study?

This research is being carried out as part of two doctoral theses at University College London (UCL).

UCL has provided the funding to reimburse participants for their time.

Individuals using the Eating Disorders Services at Vincent Square and North East London have reviewed the design of the study.

The project has been reviewed and approved by staff at UCL, as well as the 'Joint Research Office' on behalf of UCL (the study's 'sponsor'), and 'Research and Development' Departments at all of the NHS trusts involved (Central and North West London NHS Foundation Trust; North East London NHS Foundation Trust; West London NHS Trust; and Barnet, Enfield and Haringey Mental Health NHS Trust). The study has also received ethical approval from an NHS Research Ethics Committee.

What if I don't want to carry on with the study?

We don't want to put any pressure on you to participate, and you have the right to withdraw from the study at any point.

Deciding to withdraw from the study would in no way impact your treatment in the eating disorders service. If you decide to withdraw part way through, your data will not be used in the research.

What will happen to the results of the study?

The researchers will present the results of the study to staff and service users at Vincent Square Eating Disorders Service. If you are a client at a different eating disorders service, you would still be welcome to attend this presentation.

The study will be written up for two doctoral theses at UCL. The researchers also hope to publish the research in a peer-reviewed academic journal and to present the findings at eating disorders conferences.

Legal information

Data protection

The study is compliant with the requirements of General Data Protection Regulation (2016/679) and the Data Protection Act (2018). UCL is the sponsor for this study based in the United Kingdom, so will be using information from you in order to undertake this study and will act as the data controller for

this study. This means that UCL is responsible for looking after your information and using it properly. The only identifiable information about you that would be retained after the study finishes would be your signed consent form, which would be securely stored on a password protected file on a UCL computer for 10 years after the study ends. All other identifiable information about you would be securely disposed of immediately after the study finishes. Anonymised transcripts of research appointments and demographic information about the sample as a whole will be securely archived at UCL for 20 years after the study ends.

You can find out more about how we use your information at https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice or by contacting data-protection@ucl.ac.uk.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your research doctor if you would like more information on this.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to Dr. Lucy Serpell, who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Further information and contact details

The researchers would be happy to answer any additional questions that you might have about the study. Contact details are below:

Students running the project:

- Natalie Chua Yi Ling: natalie.chua@nhs.net
- Sarah Burnett-Stuart: sarah.burnett-stuart@nhs.net

Supervisors overseeing the research:

- Lucy Serpell: l.serpell@nhs.net
- Matthew Pugh: matthewpugh@nhs.net

Phone: 020 3315 2104 (ask to speak with Sarah Burnett-Stuart, Natalie Chua Yi Ling, or Matthew Pugh)

Appendix E

Consent form

University College London Hospitals NHS
NHS Foundation Trust

IRAS ID: 251510

Centre Number:

Study Number: 1/1

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: An analysis of voice dialogues with the internal anorexic voice

Names of Researchers: Dr. Lucy Serpell, Dr. Matthew Pugh, Sarah Burnett-Stuart, Natalie Chua Yi Ling

Please initial box

1. I confirm that I have read the information sheet dated 20/06/2019 (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. (If appropriate) I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I provide consent for the researchers to ask my named clinician for my most recent body mass index (BMI) measurement. ☐
5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix F

Support card

Support Card, Version 1.0, Dated 20/06/2019, IRAS number 251510, 'An analysis of voice dialogues with the internal anorexic voice' (a student study)

University College London Hospitals NHS
NHS Foundation Trust

Support Card

If you feel stressed or worried after taking part in this study, support is available to you. The following individuals / services can offer you support around any of the concerns you might have. Some of these services are able to offer help outside of normal office hours.

1. **Request to speak to your clinician or a member of staff that you are comfortable with:** If you have any questions or concerns after the appointment, you can ask to meet with your clinician or a member of staff in your treatment team. This might be your initial assessor or your therapist.

2. **Contacting Beat:** To access support after working hours (i.e. 5pm), you may choose to contact Beat, England's leading eating disorder charity.

   - Beat offers three different helplines that are open 365 days a year from 12pm – 8pm on weekdays and 4pm – 8pm on weekends and bank holidays. You will be speaking to a trained support worker.

     Helpline Contact Information:
     - **Adult line: 0808 801 06777**
     - **Student line: 0808 801 0811**
     - **Youth line: 0808 801 0711**

     These helplines are free to call from all phones. If the lines are busy, you can opt to chat online with a trained support worker.

     One to one web chat:
     - https://www.beateatingdisorders.org.uk/support-services/helplines/one-to-one

3. **Contact the Samaritans:** For 24/7 support, you may choose to contact the Samaritans. Samaritans is a registered charity that provides support to anyone who is experiencing emotional distress throughout the United Kingdom. **Samaritans Helpline Contact Information: 116 123**. This helpline is free to call from all phones.

4. **Contacting your General Practitioner (GP):** If you feel that you require additional support, you may also choose to contact your GP.

Appendix G

Worked example of thematic analysis

1. Familiarisation

   This stage included transcription and repeated reading of transcripts. Key quotations were noted, with separate bullet points for separate ideas, and closely related ideas listed under a single bullet point. The researcher's initial ideas about patterns of meaning from the transcript were noted in italics following the listed quotations.

Initial ideas regarding patterns of meaning

Transcript 1

- I keep [her] on track
- Make sure she's doing everything right, that she's being the best that she can be
- It involves… being in control. Looking like she's in control. Having everything prepared. Knowing what she's doing; [the best she can be is] to be fulling in control, in my eyes. For everything to be, like, thought through and prepared, and completed and achieved; 'cause if she's in control and has, like, got everything sorted, then people will like her and admire her; she's not in control, I guess. She's… I guess, let herself go.
- Also to be thin. To look the part.
- [role is] I make sure that she's enough. That she's acceptable
- I want people to think she's got it together
- I quite like being there all the time

Keep her on track, make sure doing everything right, make her the best she can be, control, I over-control, she'd lose control without me, preparation, be thin, look the part, be admired, be enough/not enough/not good enough, acceptable, fear she'll be rejected, there all the time, especially if she's showing that she's lacking (socially, or in terms of beauty or cleverness), want people to think she's got it together, she's weak, doesn't deserve, should be trying harder, certain things are unnecessary (food), doesn't need that much (food), greedy, will make her fat, people won't like her if fat, will be liked & admired if really fit & healthy, failed, make sure she's the best, want her to be happy, only happy if the best, I've always been there, not as vocal or focused on eating/weight/shape, criticising, louder and more fixated on food since starting university, needed to improve, (flaws) showed more, comparisons, not the best (socially, academically, fitness, prettiness,

2. Generating initial codes

Transcripts were re-read from start to finish, and codes were recorded in NVivo, as shown below. Codes were primarily inductive, often using the AV's own wording. Deductive ideas were noted in a separate document; these were grounded in the data but involved a greater degree of interpretation (e.g. 'morality', 'pressure to achieve' and 'passivity').

EDV: Um... (9 seconds silence). I think I'm fairly, like... kind of, I've been always present, but not really as vocal, I guess, and not as focused on food. So, I've always been there, kind of criticising. But not as much. And not... linking it up to eating, and weight and shape.

T: Right, so you've always been there, but you've changed a bit over time?

EDV: Yeah.

T: When do you think that that happened, the change?

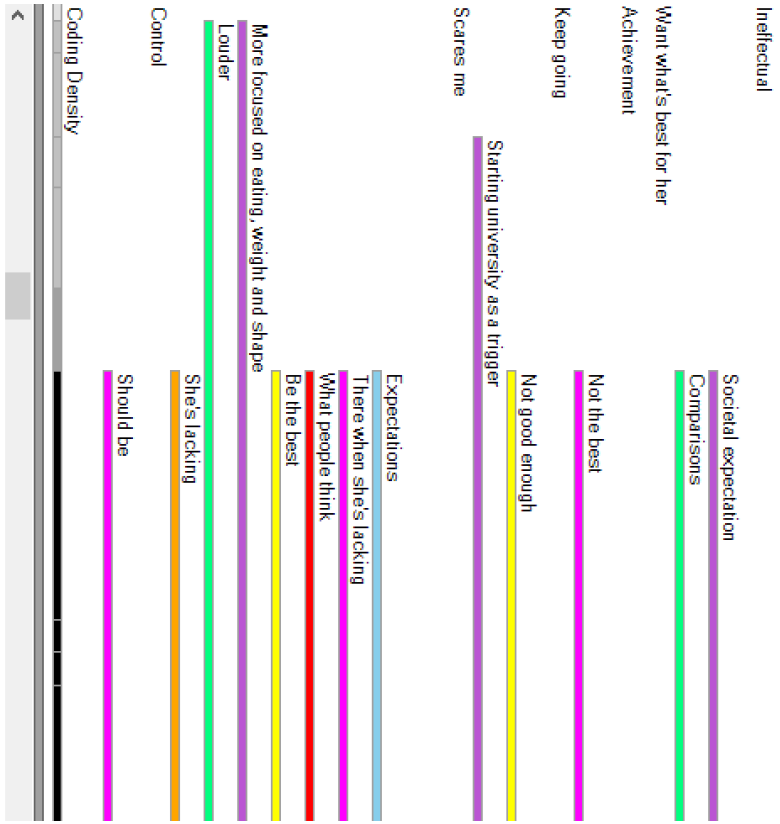
EDV: Um... (6 seconds silence). I think, starting university. I became a lot more... loud and, I guess, fixated on certain things which she needed to improve.

T: So, at the start of university, things changed a bit and you became a bit more... um vocal, maybe.

EDV: Yes.

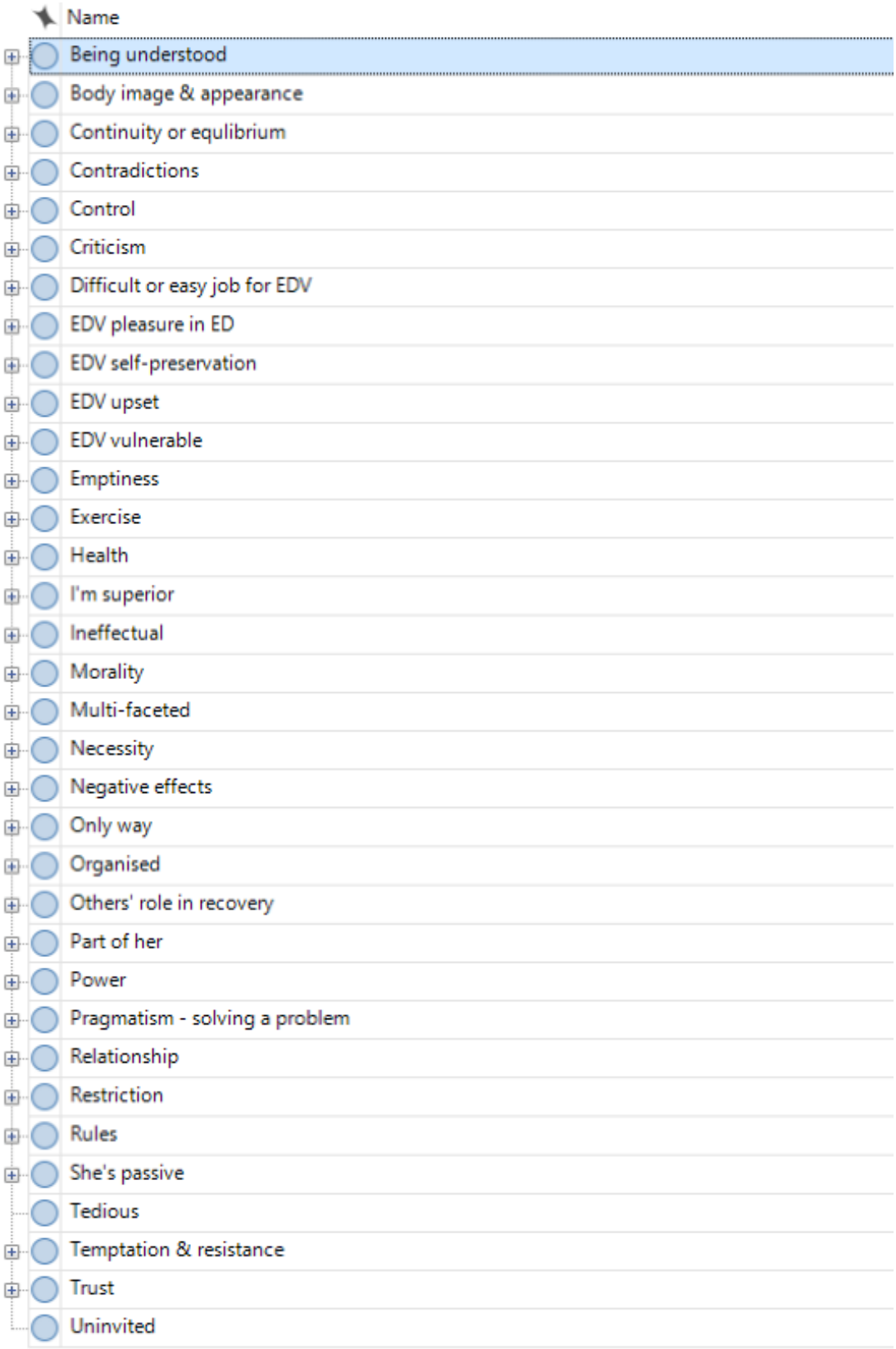
T: Why do you think that it was that point when things changed?

EDV: Um... I think maybe... it was that point where I thought she was lacking. That it showed a bit more. Um... She didn't have the same group of friends as she had back at school. Socially, she wasn't, you know... she wasn't as big as she could have been. Academically, she was no longer top of the class. She was between bottom and middle, which isn't good enough. Compared to all these other people, she wasn't fit, she wasn't pretty, she wasn't clever. And all the, kind of, so-called hobbies that she had... weren't as much as all these other people had. Like, even though she played squash she wasn't as good as lots of the others were. With art, she's nowhere near as good at art as all these other people. She could do music, but not enough. She was, I guess, coming to the realisation that she's not the best.

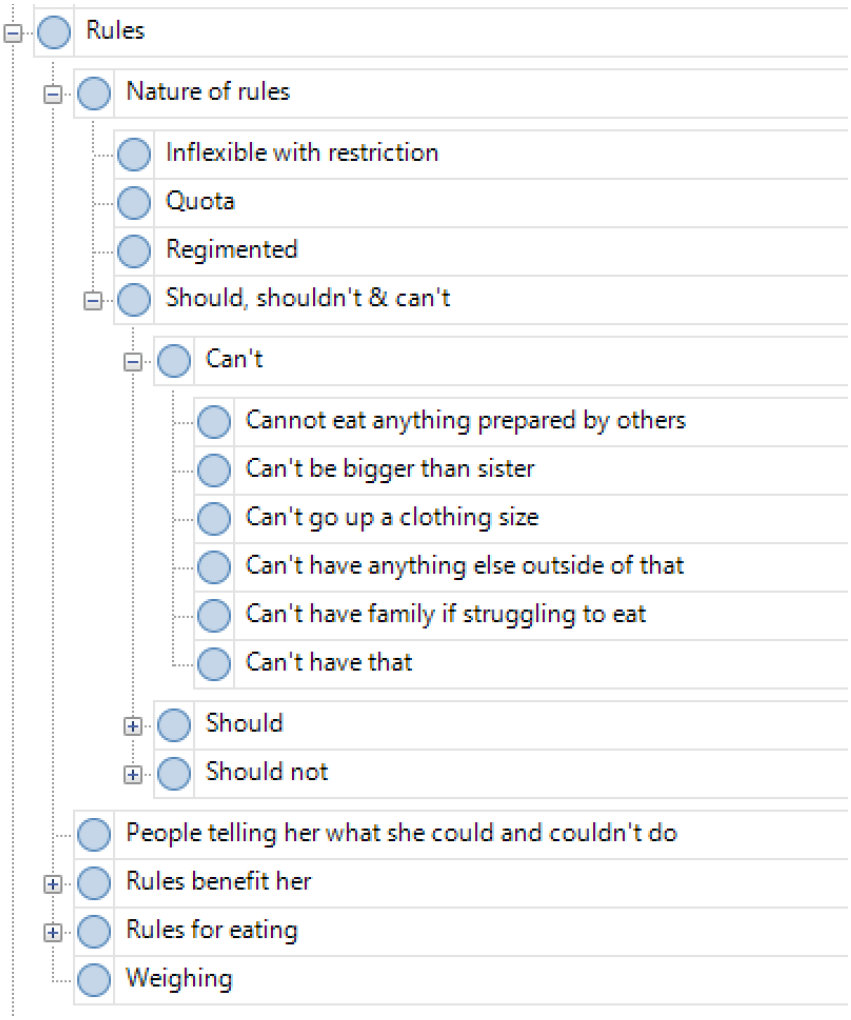


3. Searching for themes

In NVivo, codes were sorted into potential themes, and relationships between themes were considered. Below is a list of the initial themes:



Each of these potential themes contained a number of codes, and many included subthemes:



4. Reviewing themes and generating a thematic map

   All transcripts were re-read with reference to coding and potential themes, and adjustments were made as necessary. Thoughts on the organisation of themes were noted, for example:

- **Morality**: morality, evil, monster, parasitic, ill-meaning, deceit / well-meaning, temptation & resistance
- **Passivity**: She's passive, dependence, independence, awareness, listening, rules, permission
- **Expectations & achievement/pressure to achieve**: Standard & expectations, achievement, be the best, comparisons, criticism, insults, abuse / compliments
- **Repetitive thoughts & behaviours**: Preoccupation, compulsive
- **Conversation/negotiation**: speaking to me, compromise
- **Lazy, complacent**

Believes itself to be the solution to her problems; two sided (could include believes = solution in positive side)

Problem	**Solution EDV offers**	**Other effects**
She's inadequate - She's selfish - Others are superior	Improve her - Make her selfless - Bring her up to their standard	Brings perpetual criticism, never good enough, shifting standards – low self-esteem
She's vulnerable	Protect/rescue/support her	Feeling helpless & in need of protection
Low self esteem	Make her feel better about herself	Only feel okay if follow ED behaviours/rules, otherwise feel worse
Needed someone she could trust	Trust me	Distrusts self & others more

Thoughts

- Problem saturated narrative?

- A fascist regime
- Overarching idea of co-dependency? She needs it (pragmatism) & it needs her (self-preservation)

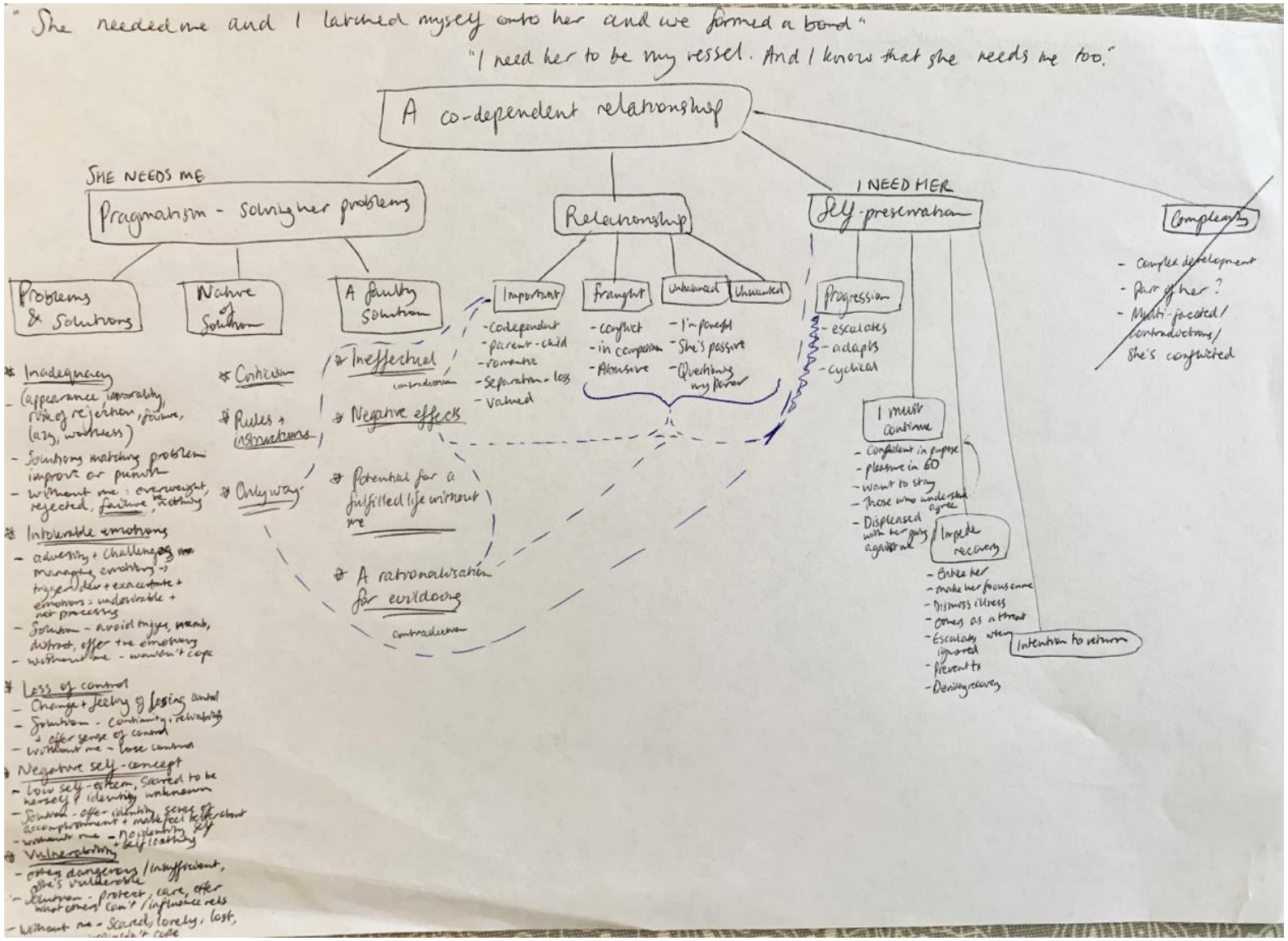
- Remove morality? Is the 'I'm good' side mostly covered by pragmatism? I'm evil could be framed in reference to pragmatism – suggesting it is a rationalisation & feeding the complexity
- Relationship could be subsumed by pragmatism – 'an important relationship' in 'nature of solution' or split up, e.g. into solution for 'others are insufficient', fraught/unbalanced/unwanted relationship into 'a faulty solution – negative effects' or morality 'I'm bad' – overlap between 'abusive' and 'I'm bad'
- Consider merging '3 - without me' into '1 - problem'

- Inadequacy links with self-concept. Could be EDV judging her to be truly inadequate not just viewing herself as such, but EDV = part of her, so stating inadequate may indicate low self-esteem…
- Low self-esteem links with intolerable emotions.
- She's passive linked to vulnerability

- She'll fail is listed under '3 – without me' for both 'she's lazy' and 'she's a failure' (under 'inadequacy')
- Hard to parse 'controlling' (in I'm powerful) and 'she's passive'

- Observation – language of romantic relationships present as in other studies – jealousy, abusive, loyalty, exclusivity

An initial thematic map was sketched by hand:



5. Defining and naming themes, and organising the data into a coherent narrative

   Theme names were revised, for example ‘A co-dependent relationship’ became ‘An interdependent relationship’. A narrative was developed around this overarching theme, with three primary subthemes focusing on the person’s perceived need for the AV, the relational nature of interactions between AV and individual, and the AV’s need for the person. The final thematic map was created (see Figure 2).

6. Producing the report

   The analysis was reported in the ‘Results’ section of the empirical paper. Quotations from the transcripts were used to illustrate the concepts developed through the process of analysis.