The Experience of Living with an Anorexic Voice

an Interpretative Phenomenological Analysis

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Declaration:

I hereby declare that the work submitted in this dissertation is the result of my own investigation except where otherwise stated.

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“All truths are easy to understand once they are discovered; the point is to discover them.”

— Galileo

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Abstract

Background: Current Anorexia Nervosa (AN) research concurs early clinical descriptions of an eating disorder depicted for some individuals as an 'internal voice' (Tierney & Fox, 2010). The internal voice referenced in AN literature has more recently been referred to as the anorexic voice (AV). For the most part, the AV is recognised as internally generated, importantly, it is often reported as an experience altogether alien to one`s sense of self, distinct from one`s inner thoughts and dialogue hence why it is called a 'voice'. Often depicted as hostile and intense, the AV is considered omnipotent, powerful and negative in relation to AN pathology (Noordenbos & Van Geest, 2017; Pugh & Waller, 2016; Pugh, 2020). These depictions of the AV have been largely valuable when investigating symptom severity as well as in the context of AV contributions to AN relapse. Much is still unknown about this phenomenon as awareness of its influential role in AN has emerged primarily in the past decade. Largely absent from AN literature are the intricacies of individual experience of the AV over the course of the entire AN illness trajectory (from onset, through maintenance, relapse and recovery) as recounted in first person narrative accounts. This suggests aspects of the AV currently overlooked could be unearthed by means of qualitative investigation and further contribute to the existing knowledgebase of both this phenomenon and its connection to AN.

Aims: The study aimed to gain a rich and detailed understanding of the way in which individuals with AN experience the AV. This study aimed to capture the AV experience

from the point of illness onset through to recovery, it also sought to provide the health professions with helpful insights into what individuals with AN who report an AV are possibly experiencing.

Methodology: Six semi-structured interviews were conducted with women who identified as recovered from AN and who confirmed an experience of the AV in conjunction with their illness. The verbatim transcripts were analysed by using Interpretative Phenomenological Analysis (IPA).

Findings: Three superordinate themes *(The Perils of Self-Acceptance During Puberty; The Anorexic Voice Battleground; Healing Through Compassion)* and ten subordinate themes emerged.

Conclusions: The findings indicated an experience of the AV as closely aligned with AN symptom emergence. The AV was referred to as a separate internal 'voice', depicted by participants as unique from other inner thoughts and dialogue. Initially experienced as benevolently enticing AN engagement, as illness progressed, AV presence became malevolent. Eventually, the demanding AV narrative began to feel controlling, particularly within treatment when participants strived for a life without AN. Amidst feeling controlled by the AV, participants experienced a greater emergence of self-directed compassion during the recovery process. Participants relayed their experience of self-directed compassion as healing, an antidote to AV hostility. Participants reported how the AV presence was not directly addressed in treatment and so after treatment

ended, the AV presences remained. The current study provides a foundational knowledge of the under researched area of the AV as experienced in conjunction with AN illness from first person narrative accounts. The findings, future recommendations and conclusions within this study are discussed in reference to the praxis of Counselling Psychology (CoP) and are applicable to aiding other health professions working with this clinical population.

Keywords: Anorexic Voice, Anorexia Nervosa

GLOSSARY OF TERMS

AV	Anorexic Voice
AVH	Auditory Verbal Hallucination
AN	Anorexia Nervosa
ED	Eating Disorder
NICE	The National Institute for Health and Care Excellence
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders 5th Edition
ICD-11	International Classification of Disease 11th Revision
BMI	Body Mass Index
RCT	Randomised Control Trial
CBT-E	Enhanced Cognitive Behaviour Therapy
SSCM	Specialised Supportive Clinical Management
MANTRA	Maudsley Model of Anorexia Nervosa Treatment for Adults
TAU	Treatment as Usual
IPT	Interpersonal Therapy

CFT	Compassion Focused Therapy
EFT	Emotion Focused Therapy
CBT	Cognitive Behaviour Therapy
ACT	Acceptance and Commitment Therapy
EMS	Early Maladaptive Schema
FPT	Focal Psychodynamic Therapy
BAVQ-R	Beliefs about Voices Questionnaire
EDE-Q	Eating Disorder Examination Questionnaire
IPA	Interpretative Phenomenological Analysis
GT	Grounded Theory
ATA	Applied Thematic Analysis
DA	Discursive Analysis

INTRODUCTORY REFLEXIVE STATEMENT

Reflexivity directs inward reflection to the source of our thinking processes. In other words, reflexivity can be defined as a central component of being human; using intuition, lived experience, reflection and thinking to consider intersubjective dynamics in relation to both the researcher`s position and the research findings (Finlay & Gough, 2003; May & Perry, 2017). Willig (2008) states that the qualitative researcher implicates themselves into the study via the process of analysis. To safeguard this implication, reflexive practice facilitates introspection of biases, assumptions and personal interest in the name of transparency while knowledge between participant and researcher is constructed. Assumptions, biases and personal desires must be succinctly and clearly addressed by the researcher, in doing so, reflexivity within qualitative research affords the researcher the responsibility of allowing the reader to effectively evaluate the research. Reflexivity is effectively a strategy for quality control (Berger, 2015).

The practice of reflexivity is applicable to both counselling psychology practice and qualitative research. Counselling psychologists (CoP) are concerned with the enhancement of positive growth and mental health of individuals facilitated via a dialogical position of curiosity. Dixon and Chiang (2019) argue, the practice of reflexivity as a CoP is an ethical, responsible and responsive undertaking as CoP's examine, through practice and research, their own and others assumptions, worldviews and values. As a qualitative researcher in the discipline of CoP, a curious interaction with

another comes with the responsibility to acknowledge that neither practitioner nor researcher can claim objective truth as new knowledge is co-constructed. Therefore, reflexivity is applicable to both one's identity as a practitioner and a qualitative researcher.

Constant change evolves around assumptions, biases, emotional states, beliefs, values, our past, our present, fears and hopes. Here I convey my initial reflexive thinking as I began this research journey. I was drawn from multiple angles to explore the experience of the anorexic voice (AV). Firstly, not having an eating disorder I have reflected on why this specialist area fascinates me. I am certain it relates to my past experiences of attention to meticulous grooming and aesthetic detail, strongly encouraged by those close to me on both a micro and macro level. This experience placed the external body on a throne. Emerging from this, a body focused means of emotion regulation, a body focused response to any and all stress felt both internally and externally. Turning inward and using the body as a tool was, I learned, a powerful means of expression, repression or expulsion in the face of emerging and unfolding affects. Relational experiences have taught me, the human condition, under extreme duress, is resourceful. Personal growth and therapy have taught me how to relate to the body in a curious compassionate manner to promote vitality and reduce suffering. Once I began working on an eating disorder ward I could comprehend the distress of the patients. I noticed their adaption to an uncanny world within a body that was equally mirrored as

vast, needy and frightening, I felt I could move toward their frame of reference from a position of curiosity, similarity of experience and desire to help.

Secondly, my desire to uncover the hidden anorexic voice (AV) stems from my experience working on an eating disorder ward in the capacity of a healthcare assistant, assistant psychologist and later a trainee CoP. Patients often confided in me about a voice they titled their *eating disorder voice* intruding upon them at all hours of the day, distracting and taunting them relentlessly. The patient narrative accounts depicting the voice they heard as completely separate to their sense of who they felt they were enraptured me. I found it both saddening and fascinating and was struck by the similarities in their experiences and frequency to which this was occurring. I was saddened to hear of their pain and internal conflict. Simultaneously I was aware of a stirring within my identity as a practitioner to both understand more about this and to contemplate how to address this dilemma in a meaningful way.

My fascination was driving my active interrogation of the literature surrounding this concept. I was aware of the AN literature and approach to treatment strongly encouraging the idea of separating out the eating disorder related thoughts and behaviours from one's healthy aspect of self. This was depicted in books I was reading such as *Life without Ed* (Schaefer, 2004) and *Skills-based Caring for a Loved One with an Eating Disorder The New Maudsley Method* (Treasure et al., 2016). I was curious to know how this idea of separation paired with the experiences I was hearing and how patients would perceive this. The idea that we internalise or externalise parts of ourselves

as a process of development or process of protection from pain was not new to me. Disconnected parts of oneself occur as a means to avoid, reduce or get rid of pain. This is widely acknowledged within individual, group, couple and family-based models of therapy. The reference to parts of self is not restricted to one school of thought or model of therapy but is accepted in many if not all, spanning creative movement art therapy (Levine & Levine, 1999), psychoanalytical theories of human development and cognitive models of therapy like Schema therapy (Young & Klosko, 2019). It is understood, the rejected parts of ourselves are brandished destructive and unhelpful to the whole self. My personal experience and path of psychological growth taught me, in order to heal, a process of finding, getting to know and accept hidden parts or rejected parts of self is necessary. Rediscovering these destructive parts means they could become allies not our enemy. I knew in order to help the client group I was working with, I needed to first understand the experience of the voice as per patient's subjective experience as this information was sparsely available to me via the AN literature.

In pursuit of this research, it was imperative to think ahead in terms of pondering how to maintain the integrity of the interview data interpretation. I began to hold in mind my assumptions and experiences through writing in a reflective diary and memoing my thoughts about the research and area of investigation. I liaised with other professionals and lay persons to discuss their thoughts, insights and to help uncover lines of thought I myself had not uncovered. I noticed I held the assumption the AV was always punitive and I assumed every patient experienced it. I assumed this because in sessions, often, the

therapeutic alliance and level of emotional depth between patients and myself was hindered, patients appeared preoccupied and disturbed by their experience of hearing the AV while in session. I also assumed, based on my experience of numerous patients confiding in me about their experience that the potential participant pool would be forthcoming and I wouldn't have to advertise the study for too long before reaching my interview participant quota.

I was intrigued to source simple psychological interventions that could be utilised in session in an effort to address this third element in the therapy room and as an attempt to meet the patient fully as a result. I was informed by the literature I was reading at the time, *Making Sense of Voices The Mental Health Professional's Guide to Working with Voice-hearers* (Romme & Escher, 2000) and *Transformational Chairwork* (Kellog, 2014). I learned patients were often prescribed antipsychotic medication to aid with alleviating the experience of the voice they heard and to aid other aspects of AN like lack of insight and delusional beliefs related to food, weight and shape that impacted negatively on treatment engagement. Therefore, I was advised, addressing the voice in therapy was not considered necessary. If I did not address this aspect of patient experience in session when it came up, I felt dishonest and it was not congruent with my epistemological position within the framework of counselling psychology. I learned from patients how they respected professional curiosity into their experience of the voice, this fuelled my commitment to pursue this research area. Sharing my experiences with professionals and those close to me and listening to their experiences became part

of my research journey. Professional growth through my training but more importantly, personal growth through therapy, has taught me, what we knew 20 years ago has expanded today, is continuing to expand and won't stop. Change is inevitable. Why would this not be the case with anorexia nervosa (AN) treatment and the associated AV? I chose to place the AV as something relevant in sessions, it had something to say, a phenomenon worthy of time and energy. I wanted to listen.

I hoped through exploring the AV using IPA the relationship the person has with the voice and vice versa will be uncovered. My hope for this study is to support greater awareness of, and insight into, the effects of the AV on individuals, to further inspire research within this topic and aid treatment interventions spanning private, primary and specialist sectors.

1- INTRODUCTION

1.1 Overview

This study aimed to explore the ways in which individuals with anorexia nervosa experience the phenomenon known as the ‘anorexic voice’. The term Anorexia Nervosa, will be abbreviated to AN and the ‘anorexic voice’ will be abbreviated to AV from this point onward for reader convenience. The inner voice some individuals with anorexia recount hearing, is perceived as something separate to one’s inner thoughts and dialogue and has been shown to play a driving role in anorexic pathology. More specifically, this study looked at experiences of the AV spanning illness trajectory from onset to recovery using first person narrative accounts. This introduction will thus begin with a definition of AN, prevalence rates and offer a brief overview of anorexic aetiology and prognosis. From there on, the treatment standard for anorexia will be introduced in the context of acknowledging the complexity of this illness. Further, the consideration of the phenomenon, the AV, as an important factor of illness complexity will be introduced. Lastly, this section will offer the reader a synopsis of the applicability and value of embedding the discipline of counselling psychology at the forefront of anorexic research and treatment. The chapter concludes with a brief clarification of some of the key terms used throughout the study followed by the study rationale. An in-depth critical evaluation of the AV will be provided in the proceeding section of the study, the critical literature review.

1.2 Introducing Anorexia Nervosa

Richard Morton, an English physician provided the first medical description of AN in the late 1600's and reported the symptoms he witnessed as an affliction associated with appetite but it wasn't purported a medical issue requiring serious intervention for another two hundred years (Garrett, 1998). Prior to Richard Morton, self-inflicted starvation was once associated with religious piety, thought of as 'holy' transcendence and affiliated in some instances with sainthood, documented as far back as the 1st century (Bell, 1985). This prestigious recognition and honour of piety was not afforded to all, lower classes particularly 16th century women who 'self-starved' were considered demonic and labelled 'witch' (Brumberg, 1988). The term 'anorexia nervosa' as we have come to know in contemporary terms, is not associated with a witch or a saint but was coined in the latter half of the 19th century by an English Physician, Sir William Gull. It has since been referred to in medical terms with its definition used to distinguish it from other eating disorders (Pearce, 2004).

Presently, there is general consensus regarding the definition of AN amongst the *National Institute for Health & Care Excellence*, NICE (NICE, 2017), *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* DSM-5 (American Psychiatric Association, 2013) and *International Classification of Diseases 11th Revision*, ICD 11 (World Health Organization, 2018). To view the formal definition of AN according to the DSM-5 please refer to (Appendix A). AN as described by NICE (2017) is a process of intentional suppression of weight gain by means of either

food/fluid restriction or via excessive exercise coupled with food restriction resulting in starvation. Accompanying severe dieting is a denial of the seriousness of the resulting emaciation (WHO, 2018). The DSM-5 (American Psychiatric Association, 2013) concurs this description but also reports an accompanying intense fear of weight gain associated with the illness presentation which is controlled through behaviours focused on weight suppression. In addition, the DSM-5 (American Psychiatric Association, 2013) criteria of AN states a person must be engaging in weight suppression lasting at least three consecutive months. Much the same as both NICE (2017) and DSM-5 (American Psychiatric Association, 2013) the ICD-11 (World Health Organization, 2018) includes reference to an ideal weight criteria of minimum 18.5 kg/m2 for all persons over 18 years of age. If one's weight is lower than 18.5 kg/m2 there is considerable marked risk to physical and psychosocial health from nutritional deficits. Malnutrition can also compromise cognitive functioning making this weight threshold a decisive factor when assessing AN diagnostic criteria.

All three classification guidelines agree, AN is defined by a significantly low body weight in accordance with developmental stage, age and height excluding any other health condition or unavailability of food. Dietary restraint is at the core of AN as is an over control of eating habits such as food avoidance and sustained dietary checking. AN is associated with body image disparagement, there is an intense fear of weight gain and exertion of control over the body through excessive body checking or complete body avoidance due to feeling immense body disgust. AN is distinguished from other eating

disorders like bulimia nervosa (BN) and binge eating disorder (BED) in respect of the presence of an intense concern about weight and the ability to control it, such that, preoccupation with trivial changes in weight manifest as either frequent weight checking or altogether avoiding weight checking but remaining concerned about it. An intense fear of weight gain is absent from the diagnostic criteria for BN and BED (Fairburn, 2008).

Concerning AN associated behaviours, there are two subtypes of AN; restricting (AN-R) characterised by a calorie deficit and may include excessive exercise in an effort to quell weight gain. The second subtype of AN is known as binging/purging type (AN-BP) defined by perceived over-eating, compensated via purging or laxative use. According to Fairburn (2008) purging is a collective noun used to describe self-induced vomiting or the misuse of diuretics or laxatives in response to actual or perceived binge episodes. Binge eating is less common in AN (Fairburn, 2008) none the less, it can occur as a response to severe dietary restraint. The function of purging is fuelled by feelings of immense guilt for eating, the focus is always directed toward using behaviours that will maintain a low weight. Both restrictive and purging subtypes have underlying psychological motivational factors in maintaining a low weight which are widely reported to promote a feeling of internal cohesion and control (Fairburn et al., 1999). Fairburn and Harrison (2003) suggest the manifestation of over evaluation of self-worth based on controlling and evaluating shape, eating and weight and the value placed on self-control maintains AN. Due to the nature of AN and the impact chronic weight

suppression and malnutrition has on the body, it is associated with high medical risk. Therefore, physical risk concern is addressed through weight restoration treatment. Body mass index (BMI) is the primary guiding tool discerning illness severity levels and is used as the primary indicator of recovery.

1.3 Prevalence Rates, Aetiology and Prognosis

AN has a high multimorbidity rate, a mortality risk five times greater than that of the general population and the highest mortality rate of all mental health disorders (Maximillian & Quadflieg, 2016; Demmler et al., 2020). Attaining accurate prevalence data is difficult as indicated by Smink et al., (2012) however it is known that a female majority presents with AN. Based on the DSM-5 (American Psychiatric Association, 2013) criteria for eating disorders, current lifetime prevalence rates across the U.K stand at 1.6 million people (Wood, & Knight, 2019). Annual estimates across the U.K and Ireland pinpoint 37 newly diagnosed cases per 100 000 found in younger populations aged 10-19 years (Petkova et al., 2019).

In respect of aetiology of AN, it is complex and multifactorial. Zipfel et al, (2014) describe AN as an enigmatic illness whereby genetic factors, psychosocial mechanisms and interpersonal factors amalgamate to trigger AN and sustain illness. Treasure et al., (2003) suggest the exact aetiology is unclear. A systemic review on the neurobiology of anorexia by Phillipou et al., (2014) report research findings largely inconsistent concerning AN aetiology thus neurobiological treatment options are

considerably lacking. From a sociological perspective, it is widely reported, pressure from aesthetic female body ideals during puberty including social changes regarding widespread social media use influencing accessibility, quantity and quality of content related to body ideals are hypothesised to contribute to AN onset (Micali et al., 2013; Stice et al., 2017; Klump, 2013). Additionally, research suggests environmental stressors contribute to onset of a multitude of eating disorder presentations, including AN (Borrell-Carrio et al., 2004; Gabbard, 2009). The environment relates to both family and society. Giordano (2021) considers the context of family and society as important contributing factors to AN, disputing the premise that AN is solely 'intra-psychic' meaning, a construct of the mental health of the individual, but rather, potentially a response to relational issues, a coping mechanism for stressful complex familial and societal dynamics. The 'Diathesis-stress Model' described by Meehl (1962) and supported by Dixon (1998) and Gilbert (2001), propose an interaction between environmental stressors and an individual`s vulnerabilities emerge as threat response symptoms, in other words, risk factors increase in the presence of negative life events. In the case of AN, adolescent onset is widely reported (Andres-Pepina, 2020) and so with a view through a Diathesis-stress Model lens, the risk of developing AN may concur with stressors experienced during, for example, developmental milestones. More specific to AN, a combination of the environment, developmental changes and an effective coping strategy, food manipulation, is used to navigate overwhelming affects and external stressors. Over time AN is used as an emotion regulator. Following illness

onset, O`Hara et al., (2015) state a ‘bottom up’ process, the processing of external information in real time, contributes to reward responses from anorexic behaviours linking to the overall maintenance of AN. Over time, the behaviours and the corresponding reward responses become habitual and thus harder to treat. Through the course of AN, what ensues is physical complications, psychological comorbidities and social consequences as illustrated in various research findings (Munro et al., 2017; Katzman, 2005).

Complicating overall prognosis rates for AN, Khalsa et al., (2017) point out, standardised definitions of AN recovery are absent from the existing literature. A review of prognosis outcomes in the latter half of the 20th century by Steinhausen (2002) estimated 50% of patients achieve full recovery, 30% improve and the remaining 20% remain chronically ill. To recover from this complex illness, early intervention for AN is essential. Unless treated within the first 3 years of onset, outcomes are poor, even when treatment is finally provided (Neale & Hudson, 2020; Treasure & Russell, 2011).

1.4 Anorexia Nervosa Treatment

AN treatment is imperative to touch upon briefly with respect to highlighting the scope of treatment effectiveness as a prelude to introducing the focal aspect of this study, the phenomenon, the anorexic voice (AV) and its role in AN. An overview of first line recommended psychological treatments recommended by NICE (2017) are mentioned in this introductory section and can be viewed in (Appendix B). It is no mean

feat to treat AN, the efficacy of current treatments for AN is limited, resulting in among the highest relapse rates of any mental illness and a long-term recovery rate of less than 50% among those who survive it (Steinhausen, 2002). AN treatment includes a multidisciplinary approach. To date and outlined by Treasure (2019), no standalone medication for AN treatment exists. There is no one clear contender in terms of psychological treatment for AN (DeJong et al., 2012). NICE (2017) guidelines recommends the following treatments for AN, Enhanced Cognitive Behavioural Therapy (CBT-E; Fairburn, 2003), Cognitive Behavioural Therapy for Anorexia (CBT-AN; Pike et al, 2003), Specialist Supportive Clinical Management (SSCM; McIntosh, 2006) and Maudsley Model Anorexia Nervosa (MANTRA; Schmidt & Treasure 2012; Schmidt & Treasure, 2013). Standardised treatment protocols vary somewhat in their overall treatment applicability however, all address motivation for treatment and focus on weight restoration, similarly all have accumulated numerous RCTs in their name (Byrne et al., 2019; Zipfel et al., 2014). Conducting RCT's is helpful to assess current treatment usefulness and encourage future research. Additionally, it has been suggested, a trained practitioner using a protocol enhances treatment outcome as per van den Berg et al., (2019). Moreover, targeting motivation for treatment, in this highly ambivalent clinical group, has been shown to produce effective treatment outcomes compared to low-intensity treatment protocols such as guided self-help for AN. However, standalone motivational work has not been shown to outperform primary treatments such as CBT-

E but is integrated as part of the model instead, as per findings by Dension-Day et al (2018).

Treatment outcome is determined in two primary ways; quality of life and the effect of AN on weight. According to Fairburn et al., (1999), constituents impacting quality of life and weight suppression derive from psychological symptoms of fear and avoidance which are thought to be the maintaining mechanisms in AN psychopathology. The cluster of cognitions, over evaluation of shape/weight and fear of weight gain, are hypothesised to drive AN behaviours e.g. restriction, this drives weight loss. AN recovery outcomes are measured using both BMI levels to monitor the reversal of adverse physical complications of a supressed body weight and the Eating Disorder Questionnaire (EDE-Q; Fairburn & Beglin, 1994). The EDE-Q is a self-reported measure of the afore mentioned cluster of cognitions and behaviours including of measure of restraint or food avoidance occurrence (Fairburn et al., 1993). The following subscales formulate the EDE-Q; *weight concern, shape concern, restraint, eating concern.* Although varying from one another to a certain degree, primary AN treatments aim to target weight restoration, psychological processes underpinning AN and behaviours maintaining AN.

Discerning the effectiveness of current treatments for AN, a systemic review by Galsworthy-Francis and Allan (2014) comparing CBT-E to treatment as usual (TAU) and standalone nutritional interventions reported, EDE-Q scores from baseline to end of treatment improved in all three treatment groups and on all subscales. Restraint, which

focuses on food avoidance, showed significantly greater improvement overall. Respectfully, only CBT-E demonstrated significantly less relapse rates pertaining to weight targets. One reason for this perhaps, CBT-E in effect, targets weight restoration as a key aim in addition to offering psychoeducation and assertive skills acquisition. The additional components of CBT-E, addressing aspects of AN associated with understanding the function of unhelpful eating behaviours, may account for why nutritional interventions alone were not as significant to recovery. Unfortunately, specific CBT-E skills contributing to recovery outside of weight targets are not clearly defined in AN literature. Individual differences in clinician characteristics and large variability in how CBT-E is delivered, makes it hard to acuminate CBT-E's explicit contributions to remission rates outside of weight recovery measures like BMI and EDE-Q restraint subscale scores.

Byrne et al., (2017) systemic review found CBT-E, MANTRA and SSCM failed to demonstrate significance with respect to overall treatment effect sizes, despite all three having varying treatment approaches. Murray et al., (2019) randomised control trial (RCT) treatment outcome review for AN spanning almost thirty decades found, for overall treatment effect sizes at the end of treatment, weight was reported significant. However, at the end of treatment, there was no significant effect on psychological outcomes nor the presence of significance in treatment effect size for weight or psychological outcomes at the point of follow-up. Murray et al., (2019) review suggests, at follow up, relative to comparative studies, there is no sustained augmentative effect of

specialised treatments in terms of weight and psychological based symptom shift. Worryingly, the lack of significance for psychological outcomes lead to the conclusion that persistent psychological symptomology, even in the context of weight-based improvements, represent a detriment to long term prognosis. Despite CBT-E showing some improvements in outcomes for AN pertaining to both weight and psychological symptomology, it has not been shown to be superior to other types of treatment. It remains, remission rates are less than 25% 1 year after a course of CBT-E (Sodersten et al., 2019). Following discharge from treatment, many individuals continue to struggle with body image issues, negative self-evaluation, sociocultural pressures and aesthetic ideals of 'beauty in thinness' (Smethurst & Kuss, 2016). As a result of this ongoing struggle after treatment, Khalsa et al., (2017) argue a BMI above clinical standards may not fully constitute full remission as relapse rates are found to be highest within a 12-month period following treatment meaning weight restoration alone is not sustaining recovery. It is fair to say, current treatments are modest at best.

Concordantly, Atwood and Friedman (2020) CBT-E systemic review purports treatment specifically targeting underlying psychological processes that tie into the ego syntonic nature of AN, i.e. the perceived usefulness of the disorder, such as emotion regulation, experiential avoidance and distress tolerance, means addressing the full complexity of the disorder outside of weight-based targets could contribute to greater recovery rates. CBT-E and other primary AN treatments are built on the premise that AN has two core psychopathologies, over-evaluation of weight and shape, and the

control of weight and shape. Whilst both can be argued to be a hallmark of AN, quantitative and qualitative research into the ego syntonic nature of AN demonstrate that AN is a multi-faceted functional tool for individuals for which underlying complexities maintaining the illness require greater intrinsic analysis in treatment. Gregertsen et al., (2017) argue the functional nature of AN may be far more complex than the illness merely being a means of attaining a thin body coveted as a result of overvaluing weight and shape. This is supported by the research findings to date demonstrating treatment is modest and relapse remains high. Kezelman et al., (2015) argue research aimed at understanding the psychological sequala of AN, during weight restoration treatment remain scarce. Lavender et al., (2015) propose greater emphasis from treatment models in addressing underlying psychological factors and drivers found in both the acute and weight restored phases of AN, such as emotion regulation, could help bolster overall AN recovery. Even if individuals were weight restored post treatment, if psychological underpinnings and meanings attributed to behaviours driving AN remain intact, the risk remains, individuals may feel unheard and relapse seems likely. It appears the AN treatment research findings to date highlight an important point, to address AN recovery, outside of weight gain criteria, the core underpinnings of AN psychological psychopathology require further intrinsic examination.

1.5 Introducing the Anorexic Voice

This introduction section will attempt to outline the current conceptualisation of the anorexic voice (AV) with respect to AN theoretical literature. The AV is a poorly

understood phenomenon, much of the research to date is exploratory but the constituents of the AV that are known, in relation to AN and its position as a potential barrier in treatment and recovery, will be discussed. It must be made clear, due to the emergence of this phenomenon primarily in the last decade, the DSM-5 (2013) diagnostic criteria for anorexia (Appendix A) does not mention the AV experience but this research contribution will hopefully offer valid reasoning as to how and why the AV deserves to be a point of consideration when discussing this illness. The following chapter in this study, the critical literature review, will further attempt to address relevant research and empirical literature relating to the AV experience including, viewing the AV through the lens of prominent psychological theories of AN as well as discussing how hearing voices informed research has assisted AV understanding.

The last decade has seen an increasing acknowledgement from eating disorder literature of an emerging aspect of AN known as the ‘anorexic voice’ (AV). The description of an internal ‘voice’ from a striking number of individuals with AN is largely becoming an area of AN research interest hoping to uncover nuances about the AV that will contribute to new knowledge concerning AN aetiology and more importantly AN treatment. The AV refers to an internal ‘voice’ anorexics associate with their disordered thoughts and feelings, or rather a personification of anorexic associated beliefs, behaviours and feelings manifesting with the onset of anorexia (Ling et al., 2021). The AV is not simply a metaphorical experience, but for those who vouch its presence, it is a multi-voiced internal world Pugh, (2020), meaning, it is sensed in

addition to one's familiar internal dialogue. Due to the sense that it is an addition to one's familiar internal dialogue, it is considered a 'sub-self' or discrete component of personality because it has embodying needs, feelings, behaviours, is focused on AN goals and is perceived as almost completely removed or fractured from the individuals total self-experience, in other words, it is felt as a separate part of the 'whole' self (Pugh, 2020; Graham et al., 2019; Sands, 1991; Noordenbos & van Geest, 2017). The AV is pronounced a 'voice' as it is experienced as different to an individuals' inner dialogue and importantly it is referred to as a voice by those who experience it (De Giacomi, 2019; Ling et al., 2021). In describing the AV, individuals attest to experiencing their mind being consumed with the voice of anorexia, whereby, when this happens they cannot focus on what they perceive to be their inner dialogue, a dialogue present before anorexia onset. It expresses comments on the individual's eating, weight and shape and instructs the individual to engage in behaviours associated with restriction or compensation (Hormoz et al., 2018; Pugh, 2020). In support of numerous accounts of the AV as a 'sub-self' it is thought to be differentiated from typical eating disorder cognitions such as self-criticism as per Pugh and Waller (2017). Additionally, the commentary heard from the voice regarding eating, weight and shape is recounted as a second or third person (Pugh and Waller; 2017; De Giacomi, 2019). It is commonly referred to as a pseudo hallucination, meaning, individuals know it is internally generated as opposed to attributing the experience to external causes. Similarly, it is also described as a pronounced aspect of inner speech but perceived as alien to one's

sense of self (Hormoz et al., 2018; Pugh & Waller, 2017). Early descriptions of the AV from Williams and Reid (2012) and Tierney and Fox (2010) describe it as dominating the individuals' sense of self as illness transpires. In addition, it has been reported to take over the more rational part of a person's thought processes resulting in interpersonal distress as conflict is experienced between the individual and AV related criticisms and demands.

Here, the historical foundations of the AV is provided. An eating disorder voice related experience was first recorded in the latter half of the 20th century by a nurse treating eating disorders, Hilde Bruch (1978). Since then, further descriptions were recorded through first person narrative accounts, referring to the voice as "real and terrifying" (Claude-Pierre, 1997, p. 94) and a "strange high voice as hard as steel" (Fathallah, 2006, p. 31). Leder (2021) purport the visceral body of the anorexic takes on a 'voice' experienced as demanding and threatening. It must be noted, it is considered friendly in nature towards the individual at illness onset, by supporting and encouraging AN behaviours, however, for reasons not entirely known, it eventually becomes criticising and altogether harsh in its narrative and demands. The AV's benign presence at illness onset, plays a pivotal role in supporting the achievement of anorexic goals and blocking emotional distress (Dolhanty & Greenberg, 2007a; Dolhanty & Greenberg, 2009b; Pugh, 2016). With illness progression, Williams and Reid (2012) state how it changes from guiding to hostile. Pugh and Waller (2016a; 2017) found, voice commentary of and contributions to distorted behaviours, directly related to the appraisal

of eating, shape and weight within the maintenance of AN. Conclusively, Forsen Mantilla et al., (2018) report, as time goes by, the AV-individual relationship begins to resemble a real-life, highly negative and enmeshed type of relating, whereupon, the AV dominates the individual negatively influencing symptom levels and self-image.

Personal accounts depict the relationship with the AV as "love, hate…cannot escape" (Weaver et al., 2005 p. 8). Often, the AV is defined as entrapping, severely affecting self-worth and rendering individuals submissive to its demands, reinforcing global powerlessness (Higbed & Fox, 2010; Pugh, 2016). Eventually the presence of the AV becomes a major challenge in the treatment and recovery process. Individual narrative accounts, depicted in Weaver et al., (2005) describe the AV as wielding 90% internal power over the person. What is striking in the narrative accounts of the AV, is the close affiliation or connection the individual has with the AV even when it is experienced as controlling and harsh. It is widely recorded in AN literature, the anorexic's sense of self is expressed to be a shared space with the illness, separation from AN evokes tremendous fear. The "ego syntonic" i.e. creation of inner harmony, nature of AN means individuals value their disorder. An interwoven relationship between illness and identity can perpetuate the endorsement of positive beliefs about the disorder. Forsen Mantilla (2017) conceptualised AN as an enmeshed dyadic relationship and the AV perceived to be separate but a relatable voice. Despite the AV's growing criticism when individuals enter treatment, they often continue to value the AV, a testament to the strong connection established with the AV and an increasing challenge presented to

professionals treating the illness (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams et al., 2016).

1.5.1 Treatment Resistance and Relapse: The Anorexic Voice

AN research has highlighted the AV is perhaps a core aspect of anorexic psychopathology and a potential barrier to recovery. Additionally, preliminary research is calling attention to the AV's contribution to treatment resistance and relapse (Hampshire et al., 2020; Hibbs et al., 2020; Graham et al., 2019). This section will briefly introduce the discussion concerning the AV as a potential psychological barrier in treatment, this will be discussed in greater depth in the following section, critical literature review.

The AV is widely defined as controlling, perceived as an external entity, it holds a primary role in destructive eating behaviours and distorted cognitive processes (Higbed & Fox, 2010; Pugh, 2016a; Forsen Mantilla et al., 2017; Hibbs, 2018). However, the core characteristics of the AV are not known. The emergence of research into the AV is in its infancy. The absence of longitudinal AV research means many questions remain like, *to what degree are patterns of relating to others influencing or impacting AV-individual style relating? How do individuals make sense of the AV experience through the course of illness and in recovery? How can the AV be effectively treated? What constitutes the mechanisms of change in AV presence from guiding to*

hostile? Additional studies are needed to elucidate the nature of the AV and its role in AN in order to answer some of these questions.

Presently, cognitive-behavioural (Hormoz et al., 2018) psychodynamic (Davis, 1991) humanistic (Hibbs et al., 2020) and systemic treatments (Pugh & Salter., 2018; Simpson & Smith, 2020) affirm AV presence in AN pathology but have treaded upon the AV via indirect means and as a result of treating varying other features of AN such as, restrictive thinking styles, maladaptive core beliefs, ruminations and distorted beliefs about eating, food, body shape and weight as well as illness value, emotion regulation and interpersonal schemata. It must be pointed out, these psychological approaches to AN treatment will be explored in greater detail in the following chapter pertaining to AV hypothesis. In continuation, the 'coming into awareness' of the AV presence via explorative means, such as those mentioned above, illustrates the AV's weaving presence within a diverse number of features considered core aspects of AN. Supporting this, an AV metanalysis implemented the AV in AN development and maintenance (Aya et al., 2019) however, systematic research, in an effort to explore the AV further and understand it in greater depth could potentially benefit from a valid and reliable measurement tool. Hampshire and colleagues (2020) have considered the usefulness of this and devised the first measure produced for AN critical internal dialogue, it has come at a critical timepoint, the Experience of an Anorexic Voice (EAVE-Q) is an 18 item scale with 5 domains correlated significantly with ED symptomology, psychological distress and quality of life. The use and impact of the

EAVE-Q remains to be seen but the research developers hope that it will aid future research to increase understanding of AN and support the continued development of person-centred treatments. Preliminary research is calling attention to the fact that the AV is occupying a role in obstructing effective treatment as it becomes dominant over a person's sense of self through the course of illness (Williams et al., 2016; Higbed & Fox, 2010). It must be emphasised, a factor said to drive the behaviours of people with AN is this inner voice, the personification of anorexic pathology. Bearing this in mind, it is essentially problematic that it is not currently spotlighted as a primary earmark in treatment given its potential position as a core psychological underpinning of AN. Conclusively, less-developed research topics such as the AV naturally operationalise as exploratory in their infancy until greater swaths of knowledge can support evaluative critique and so, it is hoped this research contribution will support the validity of recognising the AV as an important component of AN.

In closing this introduction section, it is necessary to briefly point out the AV's role in potentially obstructing recovery i.e. AV perceived seductiveness. It is documented that the AV enters individuals' lives during periods of uncertainty, it is seductive in terms of it provides a sense of identity, superiority, companionship, facilitates emotional avoidance, supports low self-esteem and under developed identity management (Graham et al., 2019; Tierney & Fox, 2010; Espindola & Blay, 2009). Complicating recovery is both the domination of the AV in spite of its critical nature as well as a lack of understanding on the part of both professionals and patients as to why

this experience occurs in AN onset in the first instance. It is known that it offers safety and reassurance, as accounted by individuals (Williams et al., 2016) and in as much as the illness is used as a tool to detach from painful thoughts and emotions, so too is the presence of the AV, arguably making it hard to dislodge.

Although the question remains as to why or how the AV presence comes about, once it is experienced, it is suggested that a stage-like progression in AV perception and relating unfolds. Pugh (2020) review of AV literature proposes what appears to be a stage-like AV-individual relating style. At illness onset the AV-individual relationship or mode of communication is friendly and supportive. As illness transpires, the AV is perceived as increasingly self-critical, controlling and antagonistic. It is not understood as to why this change occurs but eventually, perceived power of oneself once dominated by the AV, is taken back by the individual through a process of AN de-centring. Finally, the AV fades, but may not completely disappear. Conclusively, Pugh's (2020) stage-like progression is not absolute but rather suggestive and based on research findings to date (Brown & Charles, 2019) describing AV-individual affiliation. Greater insight into AV perception and experience are needed to affirm or add to existing literature of AV-individual affiliation and stage-like pattern of relating.

On a final note, preliminary findings concerning this particular phenomenon gives credence to its amenability for further investigative research in an effort to discern its nature and role in AN illness, treatment and recovery. Less-developed research topics naturally operationalise as exploratory in their infancy, contestably, it is not only mature

research topics that are considered appropriate for serious research inquiry, admittingly, it might be an advantage when research topics have matured because there is usually a plethora of data open to evaluative criteria and critique. Nevertheless, less-developed research topics offer fruitful adjuncts to existing gaps in foundational knowledge.

1.6 Relevance to Counselling Psychology

The term counselling psychology will be abbreviated to CoP for reader convenience from this point. In explaining CoP relevance to this research topic, it has been proclaimed by Ponterotto et al., (2008) that qualitative research methods and the practice of CoP go hand in hand. For example, humanistic (Roger's, 1980) and psychodynamic approaches (Freud, 1895, as cited in Gay 1995) of which are embedded in CoP practice, were originally anchored in qualitative style research e.g. via case study collection which hosted the development of many theories within psychology and psychotherapy. Supporting this, The Handbook Of Counselling Psychology by Woolfe et al., (2009) determine, both are compatible with phenomenology and humanistic approaches and are committed to a central focus on the relationship. Not being constricted to qualitative methods of enquiry, CoP's, while maintaining a philosophical underpinning in identity, continue to practice in institutions like the *National Health Service* (NHS) where there is a focus on positivist practices such as 'evidence-based practice' and use of diagnostic measures concerned with pathology. Foster (2015) states, both evidence-based practice and practice-based evidence, however, are highly relevant to CoP aims and that neither approach is more valid, meaning, CoP's can work

effectively within positivist settings and frameworks such as NHS settings where AN is primarily treated.

One might enquire as to the position of suitability of CoP's conducting research in this particular field, compared to other psychologists who are recruited and trained primarily in NHS psychiatric settings and working with pathology, in particular working with AN and other eating disorders. In response to this, Milton (2010) proposes CoP's are trained to be capable of generating research, disseminating knowledge and collaborating in the wider world with other applied psychologists, policy makers, service development and conducting collaborate interventions. Importantly, CoP training mirrors other applied psychology training with respect to core professional competencies, meaning, they are well placed amongst fellow applied psychologists to conduct research and clinical practice within their chosen specialised area of interest (HCPC, 2015). Further, an important part of CoP post qualification is continued research activity as well as recognising that practice takes the form of both research and psychotherapy with clients as per Kasket and Gill-Rodriguez (2011).

This study uniquely contributes to CoP clinical practice. If the value CoP's bring to AN treatment is specialist practice and individual centrality, then it is important we understand this under research topic and take an inquisitive stance to the AV as a central aspect of the individual experience of AN. Acquiring a greater understanding of the subjective factors surrounding the AV experience, professionals working with AN

might be better placed to challenge existing assumptions about AN and advocate for increased sensitivity towards, and better treatment of, those experiencing an AV.

In light of this, unexplored areas of research that hold great meaning are often researched by CoP's as emphasis is on the context of the individual. Specifically, CoP's exploring AN sufferers' experiences of the phenomenon AV can contribute to the understanding of subjective experience, better inform treatment practices, help address any research-practice gaps, and further identify staff training needs for those working with this phenomenon. This is imperative as Kasket (2013) points out (as cited in Davey, 2011, p. 1-20) CoP's are concerned with 'real world problems' and so contributing to AN understanding can make a difference to the real difficulties experienced by this group of individuals and help professionals treating them. By exploring the way in which a person makes sense of an AV experience, as per the methodology used in this research, interpretative phenomenological analysis (IPA) and from the lens of CoP as a scientist-practitioner, we can learn more about the AV-individual connection as well as attempt to understand how the AV is conceived and constructed by those experiencing it and the impact this has on the wider understanding of the AV in illness onset, maintenance and through recovery.

1.6.1 Researcher Position

The researcher identifies with a 'pluralistic' approach outlined by Cooper and McLeod (2010) which is imbedded in CoP. Pluralism (Cooper & McLeod, 2011) is defined as a philosophical concept that accepts a full range of perspectives that are all

plausible but mutually conflicting, because of this, pluralistic therapy embodies collaboration. The basic principle of pluralism proposes, different people are helped by different means at different times. If we want to know what is most likely to help someone, a good position to take is to communicate openly with them.

The researcher is aware that no specific psychotherapeutic approach can be considered superior to other approaches for the treatment of AN (Zipfel et al., 2014; Murray et al., 2019) therefore, AN is viewed as multifaceted and diverse because each individual is unique in their subjectivity. Hence, an open approach, such as a pluralistic one, to both treatment and research practice can be valid and meaningful in exploring important questions perhaps not yet asked or answered. The researcher echoes a collaborative approach concerning AN research, such that, participant-level data is vital to identify individual needs and foster in-depth understanding of individual positioning. Diversity and multiplicity in AN research and care is championed by the researcher.

The researcher believes the use of critical thinking (Yanchar et al., 2008) in the process of embarking on this research study, can only serve to increase a pluralistic attitude toward AN and the AV understanding. The researcher believes, embodying rigor in practice, holding an ethical stance, making use of reflexive thinking and allowing an open, no persuasive, respectful, and caring critical dialogue with divergent views on the matter of the AV, should be pursued at any cost.

1.6.2 Clarification of Some Key Terms

The researcher must clarify the label or terms, ‘anorexic voice’ (AV) ‘anorexia nervosa’ (AN) and ‘anorexic’ used in this study and derived from both participant dialogue and the literature, is arguably stigmatising and could be described as over-pathologising. The researcher holds a critical realist position, which will be discussed further in the latter part of the study under the title Method Section, but in relation to labelling, ‘anorexia nervosa’ and ‘anorexic voice’ as referred to in this study, are presented as ‘real’ objects, viewed through various lenses with varying constitutive effects. The participants in this study received a diagnosis anorexia, while some may have questioned the clinical utility of the diagnostic label, they attested to being ‘anorexic’ in terms of describing and defining their illness experience. Hence, the use of the chosen terms are not intended to be stigmatising here but to convey participant experience. Moreover, the use of the term ‘anorexic’ referring to a person with AN, is intended to be a practical shorthand.

The term ‘anorexic voice’ is arguable stigmatising, as some participants reported, to this end, the researcher has since reflected deeply on the use of this terminology. The term ‘anorexic voice’ was coined in the last decade, however participants confirmed the relevance of the term in aiding the description of their particular experience. For the purpose of research clarity, the term ‘anorexic voice’ is used in describing this particular phenomenon and was chosen over a broader definition ‘eating disorder voice’, because this study is concerned with AN only. Also, the researcher wanted to stay true to

participant narrative as the term ‘anorexic voice’ was used by participants throughout the interview process in relation to relaying their experience. Finally, the term ‘anorexic voice’, is arguably socially constructed, as with other socially constructed labels and terms, it might change over the course of time as it is known that labels and terms are subject to the meaning making of the individuals that use them (Broomfield et al., 2021).

1.7 Rationale for the Study

The present study aimed to gain in-depth understanding of the experiences of people who identify with experiencing the ‘anorexic voice’ or (AV) through exploring the lived experience of this phenomenon.

The limited existing knowledge of the AV, in conjunction with the potential issues people may be facing when experiencing this phenomenon through the trajectory of their illness such as, interpersonal difficulties and conflict, a general misunderstanding or non-awareness from eating disorder professionals of the AV, limited understanding from professionals of how to target it in treatment, poor mental health outcomes, high morbidity and high relapse rates indicates the importance of gaining knowledge of the experiences of the AV as it may be a fruitful nuanced future target in AN treatment.

Additional focus was placed on the relationships the person had with the AV in respect to their illness as well as providing a platform for experiences to be heard, it was hoped that the insight gained from this research would lead to an increase in the knowledge and understanding of this phenomenon, which could potentially help fellow

eating disorder researchers investigate further, the AV, to discover the true nature of this phenomenon because this would informed treatment and care, professional understanding and potentially target destigmatising the disclosure of hearing an AV amongst the anorexic population. Moreover, it was hoped the study findings could have implications for counselling psychologists working with clients who attest to an AV experience in relation to providing a window into what this experience may be like from their perspective.

It was not intended that the research provide a total explanation for the AV nor to assume the findings are illustrative of all anorexic individuals with an associated AV, as a qualitative study with a small sample size would not allow the findings to be generalised. However, it was hoped that the provision of a detailed description of the experience could go some way in achieving this goal indirectly.

2 - CRITICAL LITERATURE REVIEW

2.1 Overview

What follows within this chapter is a critical review of the literature and the empirical findings relevant to the topic of research. Firstly, an overview of the retrieval of studies applicable to the research topic is presented, please see Tables 1 and 2 for an example of some of the qualitative and quantitative research informing the critical literature review. Secondly, a brief overview of the terminology used in the literature review is offered, proceeded with considerations about the place of the AV in anorexia

diagnostic criteria as well as discussing the evolving descriptions in an attempt to understand this phenomenon. Consideration is given to the psychological theories of anorexia in exploring how the AV might be hypothesised. Discussion then turns to the findings thus far concerning the AV within the respective quantitative and qualitative research. Finally, the chapter ends with identifying gaps in knowledge concerning the AV in anorexic treatment, lastly the chapter ends with the research questions and aims.

2.2 Retrieval and Selection of Studies for This Review

Most of the studies selected for this critical review focus on the phenomenon the AV. Study selection methods employed varied. Online resources, such as Google Scholar and London Metropolitan University library search tool was easily accessible and abundant with relevant material. NICE guidelines (2017) were checked for secondary references. Research studies reviewed included, but were not limited to, those located in peer reviewed journals found using PsychInfo, Pubmed, Wiley online Library and Taylor and Francis. The following key search terms included '*anorexia nervosa', eating disorder', 'auditory verbal hallucination', 'hallucinations', 'anorexic voice',* '*inner voices'*, '*anxiety and hearing voices'*, '*critical inner dialogue', 'anorexia experience'*.

The search began broad then focused on recent studies, particularly on quantitative and qualitative research regarding AN pathology and treatment. The primary studies chosen can be viewed in Table 1 and Table 2. Most of the studies selected for this critical review focus on the characteristic aspects of the AV, its role in the aetiology

of AN and extended criticisms regarding its epistemology. As this review focused on critical inner dialogue, it was deemed necessary to utilise studies that examined a broader range of research investigations into 'hearing voices' literature with reference to how this may be applicable to the treatment of the voice expierence in AN. Theoretical positions relevant to the division of counselling psychology are included.

2.3 Terminology

A rationale for the terms used throughout the proceeding chapter will be provided. The following terms will be used, 'anorexic voice' (AV), 'auditory verbal hallucination' abbreviated to AVH, 'malevolence', 'benevolence' and 'omnipotence'.

To begin, it can be argued the term 'anorexic voice' or AV, emerged in this study because of dissatisfaction with using the broader term 'eating disorder voice'. Although the term 'eating disorder voice' is applicable to anorexia, it is also synonymous with other varying eating disorder presentations. The term AV was chosen to distinguish this particular phenomenon, experienced by those with anorexia nervosa, from other eating disorder diagnosis. Notably, it is not the intention of the researcher to invalidate other eating disorder diagnosis subjective experience of related voice hearing, rather, the rationale for the use of the term AV is, firstly, to respect continuity of terms used within this study and secondly, to uphold continuity of terms used in preceding anorexic literature pertaining to the 'anorexic voice'.

The term 'auditory verbal hallucination', abbreviated to 'AVH', is widely used in hearing voices and psychosis informed research. The rationale for the use of this term

is based on the reference to ‘auditory hallucinations’ and ‘voice-hearing’ in preceding AV literature (Aya et al., 2019; Pugh & Waller, 2017) which has been largely informed by the field of psychosis and hearing voices research base, as a means to elucidate AV characteristics in further understanding this phenomenon. How hearing voices literature has informed current understandings of the AV will be addressed later in this chapter.

Hearing an unknown ‘voice’ or hearing one’s own voice as a monologue of thoughts, is not confined to individuals considered ‘patients’ or even pathological (Laori, 2012; Romme & Escher, 1993). To assume this, is running the risk of disabling an individual in making meaning of their experience and finding adequate and helpful information about their experience (Romme et al., 2009). Epidemiological studies suggest that voice-hearing is a relatively common experience in the general population, an AVH experience was found to occur in 0.7% of the general U.K population (Johns et al., 2004), Upthegrove et al., (2016) systemic review concerning hearing voices, reported 10-20% of confirmed instances of an AVH occurred in those without a mental health diagnosis, meaning, an experience of this kind is not confined to a mental health diagnosis of any sort.

This means, the use of the term and associated characteristics are presented in this study for informative purposes and not suggestive of being linked to a diagnosis such as psychosis or schizophrenia. Principally, the term AVH is used widely in psychosis literature, of which, hallucinations, auditory or otherwise, are considered a hallmark (APA, 2013) and irrespective of whether the voice-hearing experience causes distress or

impairment of functioning. However, the use of this term in relation to elucidating AV nuances, and its use in this study, does not imply the two are mutually exclusive. It is true to state, the rise of the hearing voices movement in the 1980`s, led by Romme and Escher (1989) attempted to shift public and professional attitude of voice hearing experiences away from being labelled psychotic or associated with mental illness (Moskowitz et al., 2011), instead, identifying these experiences as having personal, relational, and cultural significance and meaning. The phenomenological similarities in voice hearing across clinical and non-clinical populations have helped strengthened the contention that voice hearing may be reliably associated with psychosocial variables and not the result of a clinical diagnosis per se. Borne out of the hearing voices movement, a large quantity of research in line with both psychosis and lay persons experiences of hearing voices, understandably, anorexic research has more recently been using the hearing voices extensive data base as a reference point in appreciation of the emerging phenomenon the AV. Therefore, in researching the AV, appreciating the literature on hearing voices is unavoidable and so this study will make appropriate, careful and necessary use of the term AVH.

The terms ‘malevolence’, ‘benevolence’ and ‘omnipotence’ frequent hearing voices literature and are often used to describe the characteristics and style of relating to the experienced ‘voice’. These terms can be found in both qualitative and quantitative research concerning the AV (Hormoz et al., 2019; Forsén Mantilla et al., 2019). In respect to upholding rigor and consistency, the researcher has chosen to apply the same

terminology used in preceding AV research to describe the AV-individual relating style as well as using these terms when talking about AV characteristics.

The term ‘malevolence’ means to wish bad towards a person or possessing qualities of causing harm or wanting to harm (Cambridge University Press, n.d). In contrast, ‘benevolence’ is the quality of being kind and helpful (Cambridge University Press, n.d). ‘Omnipotent’ has origins in 14th Century French and Latin language, it means ‘almighty’ or ‘possessing infinite power’ (Cambridge University Press, n.d). In Psychology, as per the American Psychological Association (2013) the term ‘omnipotent’ is used to describe a subjective belief that one can control events outside of the self via the use of a thought or wish. In terms of AV research to date, these terms are synonymous with depicting the relating qualities between an individual and the ‘voice’, the voice is experienced as either benevolent or malevolent as well as being perceived as an omnipotent presence (Pugh, 2020).

On a final note, stigma and ambivalence is often associated with terms or phrases akin to ‘hearing voices’ such as ‘auditory verbal hallucination’, this has been deeply thought about on behalf of the researcher. The reader is directed to the reflexive statements in this study for greater insight and reflections offered to such concerns and discusses how the researcher has addressed them.

2.3.1 The Anorexic Voice

This section will talk about the anorexic voice in relation to AN diagnostic criteria followed by historical depictions of the voice experience in relation to how these have amalgamated over time to help form the preliminary understanding we hold today. Finally, ending with a brief summary.

A definition and reference to an eating disorder ‘voice’ or ‘anorexic voice’ is absent from the diagnostic description and criteria in the DSM-5 (Appendix A; APA, 2013) for anorexia nervosa. Meaning, it is not seen as a necessary feature of AN diagnostic criteria. Arguably, absenteeism does not predicate exclusion or make the impact of this experience on AN development, maintenance and recovery redundant. Contrastingly, it is an aspect of the disorder that is emerging in the literature in reference to areas of concern, particularly, treatment drop-out rates and illness maintenance (Graham et al., 2019; Maisel et al., 2004; Smethurst & Kuss, 2018). Although the AV is not listed as necessary criteria for an anorexic diagnosis, preliminary research has started to perceive the AV as an important contributor to AN pathology. As such, it is widely known, many healthcare professionals will treat an aspect of a disorder, that may otherwise be excluded from the diagnostic criteria, because its presence negatively impacts the individual (Cuzzolaro & Donini, 2016), in line with this, eating disorder professionals are starting to find novice ways to work with the AV presence in support of optimising recovery (Pugh, 2016).

It is true that the AV is lacking a formal place in AN diagnostic criteria. A major consideration to contemplate when debating the inclusion of a new information into the DSM–5 (APA, 2013) and ICD-11 (World Health Organisation, 2011) is to question the need for the addition. In other words, the extent to which this would help clinicians become aware of and treat a distinct group of people, who may not be served under current diagnoses. Arguably, additional or altered information would not be needed if it does not improve patient care. Drożdżowicz (2020) describes diagnostic manuals as offering quick and efficient operationalized criteria with limited mention of phenomenological experiences, which if used, could aid patient care and greatly inform professionals. It could be suggested, inclusion of the AV experience in formal diagnostic descriptions could offer considerable benefit if the usefulness and validity were considered accordingly, in terms of empirical research findings. However, anorexic diagnostic criteria has been accused of being inflexible and over-pathologising in the past (Giordano, 2009), focusing heavily on medical health concerns and leaning towards objective empirical truth, thus, reducing interest in the phenomenological and individual experience of the disorder (Morgan, 2015). If the AV was mentioned in the diagnostic description of anorexia, it would mean capturing a rich, complex domain of anorexic experience which could positively impact patient care and support professionals approaching this enigmatic illness.

Additionally, in deliberating why it might be valid and useful for AN criteria to accommodate the AV experience, Qian and colleagues (2021) systemic review and meta-

analysis of eating disorders (ED), reported an upward trend in AN prevalence rates in the last three decades. In response to this, the researchers suggest focusing on new diagnostic criteria evaluation as a means to access eating disorders, like anorexia, comprehensively. This position supports the argument for the necessity of continued research into AN nuances, traits and characteristics that are contributing to illness development and relapse rates, of which, the AV is a potential candidate. Further supporting the position of Qian and colleagues (2021) is the knowledge that a substantial lack of effective outcomes in AN exist at present and relapse is highest in the first 60 days after acute psychological treatment for this clinical group (Walsh et al., 2021; Zipfel et al., 2014). Acknowledging the AV in diagnostic criteria has the potential to improve clinical and treatment outcomes for patients with eating disorders as per Aya et al (2019) as well as increase the role of patients' experiences to a greater extent than by merely applying criteria from current diagnostic manuals in the process of clinical reasoning.

It must be pointed out, new criteria inclusion is not so easily achieved. Decisions to include criteria pertaining to diagnosis in the two major diagnostic manuals DSM–5 (APA, 2013) and ICD-11 (World Health Organisation, 2011) means change considerations are based on careful evaluation of the scientific advances in research underlying a disorder, as well as the collective clinical knowledge of experts in the field. The aim of establishing new information pertaining to an existing diagnosis of anorexia, is not to create a new diagnosis, rather to promote the development of a new aspect of

the illness, the AV phenomenon, in a manner that is communicated clearly and internationally. Conclusively, this could mean wider awareness of anorexia overall, impacting for example, the delivery of treatment and greater in-depth research. Understanding and classifying AN and its constituents is an ongoing process. Finally, with that said, over time, the AV, following further empirical research, may appear in future revision of AN criteria. Until then, AV research is stealthily gaining momentum as a curiosity within the eating disorder field.

Moving away from the absence of the AV as a feature in the diagnostic criteria for anorexia, the reader is directed towards the discussion concerning historical references to the AV in consideration of our current understanding. To date, the AV is understood to be highly conflicting, encouraging disordered eating often met with individual resistant responses (Bruch, 1978; Tierney & Fox, 2010). It is overwhelmingly hostile and capable of 'taking over' a person's internal world particularly when they are acutely ill (Williams & Reid, 2012). The AV is characteristically repetitive, inflexible, perseverative, and ruminatory (Graham et al., 2019; Pugh, 2020).

The first depictions of an AV appeared in first person narrative accounts four decades ago (Bruch, 1978). Since then, the AV has been talked about as the following, 'pro-anorexic voice' (Bell, 2009), 'the voice' (Evans, 2011; Pierce, 2008; Tucker, 2015), 'male-engendered voice of anorexia' (Warin, 2010) and 'the dictator' (Hautzig, 2008). The AV has been referenced in numerous biographical books (Evans, 2011, p. 150; Hay, 2010, p. 94), illustrated in film depicting life with anorexia (Chalk & Rahman-Jones,

2017), referenced in qualitative and quantitative literature as well as being mentioned on the U.Ks leading eating disorder charity website (BEAT, 2021). Moreover, the AV has been described at times as embodying the voice of a different gender to the hearer (Warin, 2010), or felt as a separate person and referenced as 'she' by Hay (2010). Maisel et al., (2004) refer to the voice phenomenon as 'a/b voice' meaning, anorexia and bulimia voice and liken it to an exaggerated aspect of a person with disordered eating who is self-striving for perfection. Shelley, (1997) describes the AV as two voices in one head, both conflicted. This depiction of two entities occupying one space is echoed by Schaefer (2004) who separates her associated AV from what she considers her own voice, her AN voice is named 'Ed'.

Conclusively, the information gathered over the years has helped describe and attempt to define the AV as well as offer a summary of its function. The voice experience has been hypothesised to serve a protective function as it is psychologically advantageous to experience internal conflicts as voice-like (Ling et al., 2021) but the content of the AV is both relevant and worth engaging, in that, the AV takes a position of coaching and guiding the individual in anorexic behaviours at illness onset (Williams & Reid, 2012). The AV is loudest when vulnerability is highest (Evans, 2011). Later, with illness progression, the individual is drawn towards voice demands until the AV highjacks the person's life as per Nasseff (2020). Finally, recovery descriptions have demonstrated a means 'letting go off' or 'silencing' the AV in an attempt to move away from its demands and ultimately move away from the illness (Lamoureux & Bottorff, 2005).

In summary, the lack of mention of the AV phenomenon in the diagnostic criteria for anorexia is not necessarily problematic as diagnostic criteria are meant to index rather than thoroughly describe illnesses. Yet, the rich reservoir of first personal accounts of the AV, depicted through the decades, reveals ways in which professional practice and patients' course of recovery could be enhanced if greater inclusion of phenomenological experiences, like that of the AV, were considered in formal diagnostic descriptions.

2.3.2 Hearing Voices Informed Research Contribution

Firstly, the discussion here is focused on describing how hearing voices informed research has aided in the general understanding of the phenomenological experience of voice hearing. Secondly, consideration is given to how AN literature has adapted hearing voices terminology and conceptualisations in attempts to understand lived experience of the AV. Lastly, novice attempts to work clinically with the AV derived in the last decade, will be discussed as they are borne out of established hearing voices clinical interventions.

Hearing voices literature has aided, thus far, initial understandings of the AV. Leading experts in the hearing voices movement, Romme and Escher (2000), attest to voice hearing as more common than we think and present in both patient and non-patient populations. Kantorski (2018) states, when experiences of voice hearing occur, but are equated in the first instance to psychosis, this is grossly misleading and halts wider phenomenological enquiry. The acceptability that voice hearing occurs outside of diagnosed

mental illness is evidenced in research showing voice hearing occurring across cultures, within religious experiences and reported amongst bereaved individuals, viewed as relatively normal in these circumstances and not attributed to psychosis (Phalen et al., 2019). Moreover, prior to the 17th century such experiences were valued within a cultural context and only garnishing attention from medical professionals in the 18th century. To assume voice hearing equates to psychosis or schizophrenia without observing context lends to stigmatizing attitudes and invalidation of the subjective experience (Telles-Correia et al., 2015). Importantly, Cortsens et al., (2018) point out, voice characterisation differences are evidenced as small when comparing non-patients, patients with a non-psychotic diagnosis and patients with formal schizophrenia diagnosis. Additionally, Baumeister et al., (2017) systematic review comparing non-healthy and healthy voice hearer experiences, is supportive of a 'voice continuum' view, constituting varying degrees of voice impact, whereby, positive voice hearing experiences amount to lower stress while negative voice hearing experiences result in high distress and impaired functionality.

With that, a factor in determining the nature of transition of voice experience from non-clinical to requiring clinical intervention, seems to lie in the response one has to the voice experience in terms of beliefs, appraisal, attribution of significance and attributing it to an external source, this results in loss of ownership and agency (Garety et al., 2001). Furthermore, the way coping is ensued, regarding problems and conflicts implicated by voice onset and maintenance is also a determining factor. Active reactionary

coping via voice narrative challenge or passive reactionary responses such as ‘going along’ with the voice and ‘indulging’ it appears to impact agency and sense of control over the voice (Laroi, 2012).

How the knowledge of hearing voices research translates to AN literature investigating the AV, can be seen in varying forms. One such form is the terminology used in current AV literature in describing voice characteristics of which, also appear in voice hearing research, like ‘malevolent’ and ‘benevolent’ as well as describing voice-hearer relational patterns by using terms such as ‘voice omnipotence’ and ‘inner bully’. Further, as the hearing voices phenomenon is considered primarily a dissociative process (McEnteggart et al., 2017) as well as a reaction to life stress (Cortsens et al., 2018; Parry & Varese, 2021; Hayward, 2010), it is true that most individual’s report the AV as internally generated, but usually described as alien to one’s sense of self, and this may be a result of dissociative processes (Longo et al., 2021). In terms of voice hearing in anorexia and a link with life stress, Pugh et al., (2018), De Giacomi (2019) and Van Ijzendoorn and Schuengel (1996) concluded that, in some anorexics, stressful childhood experiences, critical family environments and parental experiences might lead to an ED as well as an illness associated voice as mediated by dissociation.

Pugh and Waller (2017) and Pugh et al (2018) support the distinction between the AV and the auditory hallucinations found in psychosis to some degree, as well as the amnesic ‘personality alters’ described in dissociative identity disorder. Distinctions between the AV and ‘alters’ in dissociative identity disorder, is the lack of amnesia and

extreme depersonalisation with AV presence, both are hallmarks of emerging personality 'alters'. However, it must be noted, AN and psychosis appear to overlap in multiple ways (Solmi et al., 2018) because psychosis and AN indeed share a range of clinical characteristics, like disordered behaviour, both have sometimes been described as having delusional qualities and in a minority of accounts, the voice of anorexia is described as having an external origin (Kelly, et al., 2004). These points have led to the conclusion that voices, such as the AV, might be best conceptualised as dissociative, rather than psychotic, and related to the multiple 'selves' or 'parts' and modes of information-processing which are common to all individuals (Moskowitz et al., 2011).

Supporting Baumeister et al., (2017) proposal that voice hearing could be assumed to be viewed via a spectrum, it may be more accurate to hypothesise that the AV lies at a varying point on a continuum between inner speech and auditory hallucinations perhaps, for different individuals and at different points in time (Pugh & Waller, 2018), for example, the voice is intrusive and 'loud' at AN onset and during treatment (Williams & Reid, 2012), however, quietens and reduces in volume once the person has considered themselves recovered to a degree (Lamoureux & Bottorff, 2005; Baldwin, 2019). All in all, a less contentious stance in this case is to accept the experience of the AV as a human experience in relation to one's illness. Arguing whether the AV is a 'pseudo' or 'true' hallucination i.e. voice hearing versus voice experiencing, or a symptom of psychosis, is altogether unhelpful because attempts to distinguish true from pseudo hallucinations have continually failed in research attempts in the past and offers no clinical relevance.

Perhaps, as Moskowitz and Cortens, (2008) illuminate, the crux of the concern at hand is whether a voice hearer becomes distressed by their voice to the extent they need support from mental health services.

Conclusively, the accounts of the AV indeed offer insight into the distressing nature of the AV as illness progresses, this warrants addressing the voice experience in supporting AN recovery. Current novice attempts to address the AV in a clinical setting have largely relied on clinical interventions deemed appropriate for voice hearers with other mental health diagnoses. The primary approach within other diagnostic domains for voice hearing is 'Making Sense of Voices' (MSoV; Corstens et al., 2012; Romme & Escher, 2008). This incorporates dialoguing procedures to facilitate communication between voices and the voice-hearer. The aim of talking with voices is to get to know their meaning, intention and to resolve voice-hearer conflicts (Corstens, et al., 2012) as well as providing an understanding and increased control over voices. The concept of 'getting to know' the AV as a 'part' of the individual and linking the patient's dissociated self-states is not lost on professionals attempting clinical work with the AV. Interventions borne out of the dialoguing procedures have been attempted by Ling and colleagues (2020) investigating dialogical experiences between voice hearer and voice in anorexia whereby Hibbs et al., (2020) have used emotion focused therapy in an attempt to reduce individual shame experiences and reduce voice-individual conflict. Dolhanty and Greenberg (2007) as well as Pugh (2016) have used the 'empty chair' technique to enquire

about voice biography, meaning and intention in relation to AN, while Reeves and Sackett (2020) have utilised narrative family therapy to address the AV directly in therapy sessions. Moreover, CBT for hearing voices is based on the premise that distress occurs when an individual makes sense of his or her experiences in a threatening way, thus, the nature of the belief about threat from a voice is a strong predictor of distress, the beliefs are therefore targeted in treatment (Brett et al., 2009). Finally and promisingly, Mulkens and Waller, (2021) have been looking at how adaptions and new developments for CBT-E for AN could foster addressing the AV in much the same way CBT for psychosis addresses threatening voices in terms of using imagery to foster individual-voice alliance and understanding.

2.4 Psychological Theories of AN and Associated AV

Here, consideration is given to the psychological theories of anorexia in exploring how the AV might be hypothesised. General space limitations preclude a thorough review of the, frankly vast, literature around AN's development and maintenance from the perspective of varying psychological theories and so the researcher is concerned with focusing on an overview of some of the more salient aspects of psychological theory in the hope to shed light on understanding the AV. For the sake of clarity, the researcher has categorised the most applicable AN psychological theories as follows; psychoanalytical, cognitive, humanistic, dialogical and interpersonal. Lastly the researcher will offer the reader a summary.

2.4.1 Psychoanalytical

Moving human curiosity away from neurology to subjective experiential meaning, Freud developed a theory of psychic construct. The impulsive primitive construct “Id” holds all unconscious drives it is kept at bay by the voice of reason and law, the “Superego”, conscious processing takes place in the “Ego” (Gay, 1998, p. 37). Although AN was not directly explored by Freud, Object Relations theorist, Melanie Klein, postulated AN derives from aggressive primitive impulses and anxieties, unmodified in infant development they intrude into adulthood (Schaverien, 1995, p. 65). Rudge and Fuks (2016) stipulate the manifestation of a voice hearing experience in AN as a sadistic “superego” with an overdemanding insistence on obedience. Psychoanalytic thinking on ‘hearing voices’ and AN, appreciates the complexity of developmental milestones, because of this, psychoanalytic hypotheses complement other contributing factors proposed within the aetiology of AN and support relational therapeutic interventions.

Psychoanalytic theory considers AN symptoms, defence manifestations against disruption of development. Therapeutically, change is incurred within the transference. Kohut`s Self Psychology (1977) referred to ‘self-object’ importance and hypothesised, an interrupted empathic attunement between parent and child could contribute to later life personality disturbance. Kohut believed, AN was a disorder of ‘Self’ concerning the separation-individuation complexities as discussed in Wooldridge (2016). Moreover, narrative accounts describing AV-individual enmeshment and purported individual-AN

separation as evoking terror, demonstrate the deep level of connection between AN and the person.

On the back of this, Object Relation theorists suggest AN pathology is linked to failures regarding the internalisation of caregivers good and bad qualities in peaceful union. Balanced integration provides containment and trust within thoughts, feelings and the world through the course of development. This process is known as separation-individuation (Mahler, 1994). Unsuccessful navigation through early developmental processes can lead to insecurity within connection to self and others and limited self-reliance capacity (Garner & Garfinkel, 1997). Additionally, an inability to internalise balancing maternal functions and self-regulate as a separate self, known as "object constancy ", can result in dissatisfaction, low self-esteem, projection and a "splitting" defence (Garner & Garfinkel, 1997). Splitting is the active separation of feelings and thoughts into extremes, all good or all bad, accompanied by reality coping failures. Having less structure internally, can lead to sensing the environment as disturbing or relying on the environment to provide structure (Berger, 1999). If the division or splitting of parts of self occurs one might argue this part is dissociated in some respect from the whole persons sense of self, dissociative disorders are characterised in the DSM-5 (2013) by a disruption of and/or discontinuity of psychophysiological process, altering accessibility of memory and knowledge, integration of behavior, and ultimately sense of self. For Freud, the motive is defence, as the ego, faced with an experience which arouses such a distressing affect the person casts it to one side, felt as unresolvable, contradictory

and incompatible with their sense of self ultimately splits the ‘part’, Freud names this a survival strategy (McCarthy-Jones, 2012).

Concludingly, and supportive of the psychoanalytic view of hearing voices origin, Pugh et al., (2018) conducted the first study establishing links between childhood trauma, dissociation, and internal voices in AN individuals and found dissociation is a partial mediator of the relationship between reported childhood emotional abuse and a greater level of ‘voice’ power, meaning the degree to which the person feels they have reduced power in the face of the voice experience. However, this study was correlational and cross-sectional in nature, it cannot imply causality, but offers fruitful insights in the role of dissociation, or split ‘parts’ manifesting as ‘voices’ in anorexic illness and childhood adverse experiences. Further enquiry into early life experiences and the AV connection could help answer an existing gap in knowledge concerning the relationship with the AV as reflective of early attachment and external patterns of relating.

Notably and as discussed, one of the most prominent psychological theories for AN derive from the school of psychoanalysis. Psychoanalysis has illuminated early childhood relations and psyche development which has helped the conceptualisation of voice manifestation within multiple contexts. The voice, whether it be that of the whole person or a ‘part’ of the person, such as the AV, would be viewed by Freud as a manifestation of unconscious conflict and tension with the purpose of psychoanalysis to release. At the origin of psychoanalytic practice, the ‘voice’ appears as both a material support for the symptom of and access to the unconscious. This supports greater

phenomenological enquiry into the experience felt when the voice is present. Finally, Carl Jung understood voice hearing as possessing a clear link between voice context during onset and that of the individuals past history, by means of psychoanalytical enquiry, devising this link via therapeutic means is a crucial element to unlocking overall voice experience and meaning making.

2.4.2 Cognitive

The second most prominent psychological theory for AN derives from the school of cognitive behaviourism. Frist, a brief historical account of this psychological theory will be provided for reader clarity followed by applicability to AN and in respect of application of theory to the AV.

In contrast to the popular late 1800's introspection of the human mind via psychoanalysis, the early 1900's witnessed the emergence of American psychologist John B. Watson branch of human enquiry titled behaviourism. Behaviourism suggests complex behaviours are learned via the persons interaction with the environment through conditioning responses. *Operant conditioning*, the deployment of reward or punishment in response to a behaviour and *classical conditioning*, engaging in an act via unconscious associations with the external environment (Blackman, 1974). The spirit of behaviourism provided evidence of its effectiveness via an empirical approach by working with learned unwanted behaviour and responses in order to modify them. Shortly thereafter, the 'cognitive revolution' (Beck et al., 1979) emerged headed by psychoanalyst Aaron

Beck who believed the absence of cognitions from behaviourist interventions were redundant to lasting psychological change and downplayed human complexity. He argued, cognitions constitute thoughts, mental images, beliefs and perceptions, fundamentally a person is concerned with the meaning of such unwanted behaviours and emotions, therefore, overtime both theories meshed together, today known as cognitive behaviour therapy. Presently, discrepancy in what fully constitutes a cognitive-behaviour approach distinct from other psychological models exists. Largely an inclusive position, Tolin (2010) argues cognitive-behaviour therapy encompasses methods of, relaxation training, exposure therapy, behavior rehearsal and cognitive restructuring. In contention, Mayo-Wilson et al., (2014) disagree that social skills, mindfulness, exposure work and relaxation techniques constitute a cognitive-behaviour approach. Discrepancy and inconsistency also exist in the delivery of disorder-specific treatment protocols, with some favouring behaviour approaches for AN (CBT-ED; Fairburn, 2008) above cognitive or interpersonal (MANTRA; Schmidt et al., 2019).

It is true to state, the past two decades have propelled the position of cognitive-behaviour therapy (CBT) in occupying an important role in mental health services in the U.K. CBT is not without its share of struggles as a mainstream psychological model (Robertson & Thornton, 2021; Durham et al., 2000) it is used for both broad issues as well as complex disorders that require adaption to patient characteristics and circumstances notwithstanding the pressures professionals face to deliver it in a time limited and effective way. The effectiveness of CBT for eating disorders is suboptimal and for

AN is less pronounced (Manasse et al., 2020; Zipfel et al., 2014). When the father of CBT for eating disorders, Oxford University based Professor, Christopher Fairburn, was asked “Is evidence-based treatment of anorexia nervosa possible?” he answered “barely (Golds, 2017, p. 5)”. Sobering as that statement appears, so too is the critical examination of Van den Berg et al., (2019) metanalyses on the efficacy of treatment for anorexia, findings show an inability to establish differences between psychological treatment and control conditions regarding weight gain and/or eating disorder pathology, suggesting the field still lacks psychological interventions of enough strength for added value to be detected. Even so, it is still a primary core treatment option for anorexia (NICE, 2017).

Deciphering the cognitive-behavioural view of AN is the important role of thoughts and behaviours and less concern for early life experiences. For AN, this means targeting ‘core pathology’ around shape, weight and eating, maladaptive thoughts, eating behaviours, assumptions and overvalued core beliefs (Fairburn et al., 1993). Garfinkel and Garner (1982) describe the negative reinforcement of food avoidance and weight-loss reaching a ceiling height, whereby, AN thoughts and behaviours become self-perpetuating. Moreover, Waller et al., (2003) state, maladaptive attitudes and beliefs which lend to avoidance of emotional experience means anorexic behaviours are adopted as strategies to achieve this.

In respect of the AV and a cognitive-behaviour viewpoint, the reader is directed to Pugh and Waller (2017) findings concerning AN voice characteristics that are related to key features of eating disorder pathology, whereby a perceived positive

intent/benevolent AV exerted the most deleterious effects upon attitudes towards shape, weight, and eating. Unsurprisingly, it appears the benevolent or friendly voice is encouraging AN engagement, this has been widely documented (Tierney & Fox, 2010). What the cognitive-behavioural approach to voice hearing, introduced by Clinical psychologist, Anthony Morrison and colleagues (2004) would stipulate here, is the way events, like hearing voices, are interpreted, will have consequences for how we feel and behave, over time, the responding feelings and behaviours maintain the belief about the influence of the voice. The way a person interprets a voice experience accounts for distress and disability rather than the mere experience, moreover, emotional and behavioural responses to voices are influenced by their appraisal (Chadwick & Birchwood, 1994). And so, cognitive-behaviour positioning would attest to a threat related cognition being activated via AV narrative or even AV presence surrounding AN core fears i.e. food/weight, if this is the case, it may prompt 'safety seeking behaviours', meaning, voice interpretation leads to AN engagement that further maintain dysfunctional assumptions and AN associated beliefs. The AV is documented to be guiding AN behaviours at illness onset, powerlessness is evident with illness progression (Tierney & Fox, 2010). What proves tricky here in terms of the AV presence is the 'availability' of a safety behaviour rather than the 'usage' that maintains threat belief and limits new learning (Thwaites & Freeston, 2005). This could be taken to mean the presence of the AV, the underlying appraisal of this presence, regardless of engagement with it, might constitute 'availability', thus maintaining dysfunctional AN engagement.

Moving towards pondering how cognitive-behavioural therapy might address the AV, eating disorder professionals such as Waller et al., (2007, p. 236) suggest imagery is useful in "challenging the anorexic voice" and Goodman and Villapiano (2013, p. 31) promote *challenging thoughts* as they are related to a "faulty belief system". The key here is the awareness and then 'challenge' aspect of these interventions. More accurately, cognitive therapy surmises that distancing from unwanted thoughts and behaviours can reduce conflict and provide space to make an informed decision regarding behaviour response. This may prove tricky if the AV is a continued presence, in which this has been reported to be the case even after recovery albeit, volume is reduced (Jenkin & Ogden, 2012). Additionally, challenging a potentially ego syntonic aspect of AN may prove futile if the voice is benevolent and appraised as helpful, equally it may prove too difficult to challenge a malevolent controlling AV. Therefore, hearing voices professionals would claim, cognitive-behaviour approaches focus less on reducing the experience of voices, the aim is to reduce the voice hearers distress (Smailes, et al., 2015), an aspect of AV intervention that appears lacking in respect of the suggested challenging. Contrastingly, a suggestion from hearing voices experts, Romme and Escher (2000), might argue that intimacy is important in the relationship with voices. The acceptance and development of intimacy, the very opposite of distancing, is one strategy that may lower distress. Albeit, this would be in the context of moving closer rather than distancing from the AV in order to regain control to reduce its influence in AN engagement.

On a final note, a critic of the cognitive-behaviour approach to understanding the AV in AN is the lack of a phenomenological enquiry position as it might be considered reductant in terms of cognitive-behaviour conceptualisations concerning maladaptive human behaviour and cognitions. Such enquiries include the impact of the AV and its meaning to individuals such that anorexic individuals tend to be anxious at baseline and so food restriction has a calming effect and so a reasonable enquiry might ask how does the AV fit into this (Pollatos et al., 2008). Lack of intrinsic enquiry re this psychological model when treating AN is evident in the extensive literature accounting for high relapse rates in this client group despite being weight restored at the end of treatment (Kaplan et al., 2009) meaning, the underlying pathology associated with weight suppression in the first instance might not be targeted effectively (the reader is directed to the systemic review and meta-analyses by Murray et al., 2019). Possible reasons for poor outcomes with cognitive-behavior therapy include, the large degree of psychoeducational material with extensive skills acquisition including working with fixed cognitions stemming from the cognitive rigidity of anorectic individuals. Additionally, the ego-syntonic nature of AN creates difficulty in actively working toward change in a direct therapy such as this one. For some individuals, the AV is present at illness onset and after a course of treatment, but the focus of CBT on disorder-specific symptoms primarily concerned with BMI outcome is potentially ignoring what is known about this disorders clinical reality, psychopathology, aetiology and the burden of this disorder for which the

AV has a primary role. The position of CBT as the front line AN treatment option, regarding disorder-specific symptoms, proposes that attempts to reduce particular symptoms i.e. food avoidance, is successful if BMI increases, but in actual fact, has little effect relative to other treatments on relieving the burden of the disorder (the reader is advised to refer to Zipfel et al., 2014). As an example, patients may find an increase in weight with a treatment solely focused on structured eating, relative to a less focused treatment. Yet it is known the majority of individuals seek a reduction in the burden of their disorder, which is often captured by non-disorder-specific measures, for example, in maintaining recovery from AN, living according to personal values is found to greatly increase quality of life (Cockell et al., 2004). Conclusively, the burden of the presence of the AV is coming to light but cognitive-behaviourist interventions lack the power to redress the impact of this phenomenon at present.

2.4.3 Humanistic

Humanistic psychology, borne out of the 19th century era 'romantic movement' as well as existential and phenomenological philosophy, attempts to answer 'what it means to be fully human' and seeks to address 'how that understanding illuminates the fulfilled life' (Schneider et al., 2001). It is Carl Rogers (1902-1987) who this section will focus on in relation to reference to the AV in AN as he provided the central clinical framework for the humanistic therapies. Carl Rogers, the 'father of psychotherapy research' (Elkins, 2009) is classified as one of the most eminent psychologists of the 20th century, second only to Sigmund Freud. He believed in a 'non-directive' approach to

human enquiry in that people are capable of problem solving by means of generating insight, making their own conclusions about their issues and the therapist facilitates client led process, accepts their position and helps to clarify client feelings (Rogers, 1942). He developed the Person-Centred psychological approach.

In brief, Carl Rogers Person-Centred psychological approach (1951) explains how everyone has an ‘organismic valuing process’; an innate ongoing process where experiences are accurately valued according to whether they are good/or not for the individual. The ability to connect with this inherent wisdom as a guide to actualisation and promote change/growth, is termed ‘locus of evaluation’. However, experiencing great difficulty in knowing subjective feeling and thinking states, along with a poor perception of self (self-concept) hinders the organismic valuing process resulting in an external, rather than internal, ‘locus of evaluation’, meaning, trust and value is not placed in oneself as a means of guidance but external sources i.e. society and people guide what might be helpful/or not for an individual (Mearns & Thorne, 1999). Facilitating a place to evaluate oneself are what Rogers terms ‘conditions of worth’; we acquire these in childhood based on messages we receive from significant others. Negative conditions of worth negatively impact ones organismic valuing process, internal worth and value become conditional on the approval of external sources, resulting in poor self-concept and uncertainty of one’s own thoughts and feeling states (Rogers, 1951; Bryant-Jeffries, 2006). In working with clients, Rogers established therapist ‘core conditions’ (Rogers, 1961). Mearns and Thorne (1999) explain, when the client senses the therapist's use of the core

conditions, they will become trusting towards the therapist. Three of the total nine widely recognised core conditions are included here. The first, ‘empathy’; the therapist's ability to sense "the feelings and... meanings which the client is experiencing in each moment (Rogers, 1961, p. 62)”, second, ‘unconditional positive regard’; therapist’s warm, acceptant attitude towards the client and thirdly, ‘congruence’; therapist's communications are "genuine and without front or facade (Rogers, 1961, p. 61)”. Mearns and Cooper (2005) maintain, the combination of unconditional positive regard, empathy and congruence facilitates the therapists experience of relational depth i.e. profound contact and engagement when they are with a client, said to facilitate intersubjective change this is the crux of the humanistic psychological approach.

But why is this important? Firstly, if human beings come into the world with an innate tendency to positively value experiences and enhance the organism, via organismic valuing process, then the aetiology and motivation of AN comes into contention. What we know about the narrative of the AV begs the question of the aetiology of the AV’s motivations and goals, given the humanistic position proposing humans are actualising organisms motivated to grow and develop “in ways which serve to maintain or enhance the organism (Rogers, 1959, p. 196)” and that self-actualisation is present “at all times (Rogers, 1980, p.118)”. In an attempt to understand aspects of self that are antagonistic to growth, Ryan and Deci (2002) argue there are ‘parts’ of individual agency that do not act for essential wellbeing. However, this view of ‘parts’ directly opposes the

position that the organism functions all of the time as a ‘whole’ (Rogers, 1959). Moreover, Rundle (2017) suggests unusual experiences, although perhaps dysfunctional, such as the AV phenomenon, may be present to optimise the potential of the organism and viewed as a positive manifestation or a ‘part’ of the actualising tendency worthy of enquiry. In terms of applying a Person-Centred frame for working with such ‘parts’ in regards to the AV, perhaps offering unconditional positive regard for example and valuing the totality of the client (Mearns, 2003), including the ‘parts’ that struggle to achieve a satisfying existence, means the unconditionality position acts as a counterweight to the clients conditions of worth which have restricted their growth. Equally, a humanistic informed therapy developed by Fritz Perls (1951) named Gestalt, meaning “wholeness” supports the concept that conditions for growth may become limited at particular points in life, but facilitating awareness in clients’ of these limited ‘parts’ restores wholeness (Greenberg & Dompierre, 1981). And so, putting the AV in a position to be heard in the therapy process as seen in Dolhanty and Greenberg (2007, 2009) ‘chair work’ offers the client an opportunity to experience ‘limitations’ or dysfunctional phenomenon in a new and emotionally vivid way.

The question of why meaning-oriented organisms develop extrinsic motivations and goals, borne out of an external locus of evaluation, in the first instance and to the degree they become associated with poor psychological health, is answered by Cooper (2013) who explains that if intrinsic goals are not validated or met in childhood, but

external ways of behaving are, and this continues for example, an individual could experience greater happiness via adapting to external conditions of validation. This may account for the manifestation of an embodied illness such as anorexia and in turn the AV. And so, Mearns (2003) explains an implicit aim of Person-Centred working is to help the client internalise their locus of evaluation.

In terms of what a humanistic positioning or Person-Centred approach could offer to the understanding of the AV we look to Rogers' (1961) ideas about 'self', described as a process of 'becoming', whereby the self is fluid and not a fixed entity, actualisation is a mechanism for optimisation of the organism, meaning enquiry and curiosity lie at the heart of this approach to human sense making and meaning making. Warner (2014) coins this 'processing'. How this processing would play out in terms of aiding actualisation, Wharne (2018) poignantly describes the presence of another 'voice' in the therapeutic setting as a form of communication which others would do best to hear. This means recognizing the AV as an interpersonal way of relating and talking to the client about this experience in its totality can lead to actualisation and healing. Avoiding or bypassing this experience could maintain the presence of the AV and lead to relapse (Hibbs et al., 2020; Smethurst & Kuss, 2018).

Essentially what a humanistic approach is encroaching upon is the non-assumption that there is one true version of reality, or in other words, that an AV experience is somehow a failure to correctly perceive the world and requires intervening with a rationalized objective explanation which would ultimately ignore the intersubjective aspects

of the phenomenon. This is not the humanistic position and has been challenged by Heidegger (1962) who explains how a person is always constructing the meaning of their world, their own self and mutually with others, before stopping to think about it. This ties in with Rogers claim, self-actualisation is present "at all times (Rogers, 1980, p.118)" . With this viewpoint, Milios (2019) highlight integrating patient perspectives, insights, and values into treatment approaches as paramount to gain insight into their experience of perpetuating factors of AN of which the AV plays a role. The crux of a humanistic perspective, that clinicians are a guest within the individuals' world of experience, is of tremendous relevance when working with clients who experience a different reality or who have unusual experiences, where vulnerabilities may be idiosyncratic. Person-Centred principles are applicable to therapeutic work with AN but it is not listed as a recommended intervention (NICE, 2017) however the value of Person-Centred principles is evident in AN literature, (the reader is directed to refer to Sibeoni et al., 2020; Jenkins & Ogden, 2011; Paulson-Karlsson & Nevonen, 2012; Graham et al., 2019).

In conclusion, it is true to state Carl Rogers research did not entirely fit with the 'if-then' linear scientific thinking one might see in cognitive-behaviour therapy for example, humanistic positioning even goes so far as to align with anti-psychiatry thinking ideas that link with Laing (1990) and Thomas Szasz who talked about "for the practice of pathology…the person as a human is unimportant (Szasz, 2011, p. 18)" meaning, 'pathology' and 'norms' do not exist for humanistic practitioners but rather, the human being is "an active, meaning-seeking organism that, in whatever circumstance, strives to

do its best (Cooper, 2013, p. 21).” This equates to the premise that in all phenomenon concerning human experience, there exists meaning-seeking processes at play even if it manifests in a dysfunctional manner. This takes the reader to a final note, the core underpinnings of humanistic psychology principles when applied, can serve to open the door to AV insights if one simply takes time to enquire alongside the client this undetermined experience.

2.4.4 Dialogical

A brief introduction here will follow with applicability to AN and the anorexic voice. Dialogical self-theory, developed by Dutch Psychologist Hubert Hermans refers to a philosophy of language and a social theory based on Russian philosopher Mikhail Mikhailovich Bakhtin’s (1895–1975) premise that “life is dialogic and a shared event; living is participating in dialogue. Meaning comes about through dialogue (Coghlan & Brydon-Miller, 2014, p. 73)”. Bakhtin’s concepts of ‘self’ ‘I’ and ‘other’, common terms used to indicate personal identity, are not absolute or isolative but rather relative and dialogical (Vice, 1997). This means dialogical relations not only exist between individuals but dialogical relations also exist between oneself in the form of motivational voices (Hermans et al., 1993; van Ersel, 2011). Hermans theory proposes the dialogical self is multivocal with various ‘I-positions’ also called ‘voices’ existing simultaneously. A person can take several positions, even opposing positions in relation to situations, events or another person. The voice is considered the tool in which “necessary relationship of

communication is established (Salgado & Hermans, 2009 p. 11)" this means, the communication processes of dialogical voices build a sense of identity within oneself via a getting to know one another, simultaneously, dialogical exchanges with others are considered the mechanism of which the "sense of being a person is created (Salgado & Hermans, 2009 p. 11)".

It must be pointed out, the notion of 'voice' as a dialogical understanding of psychotherapy processes of change, are recognised in other terms in psychology, for psychoanalytic theory there is reference to 'internal objects' and cognitive conceptualisations of internal information organisation are titled 'schema'. Unlike psychoanalytic conceptualisations, say, object relations theory (Scharff, 1996), internalised 'objects' i.e. good/bad mother who meets/frustrates ones needs, are considered unchangeable images once internalised. For Hermans argument, the multivocal voices in dialogical theory are potential 'selves' this translates to meaning the voices represent what a person might become, would like to become or fears becoming. Contrastingly, cognitive-behaviour therapy might conceptualise this as possible goal drives and aspirations that are cognitively manifested and stem from a single 'I' position/voice. An example of Hermans possible 'self' emerging out of multi dialogues can start with a premise, this could be a person wishing to become a better scientist perhaps and so a particular voice would be assumed in the sentence "There is somewhere in myself a better scientist than I am, with whom I sometimes converse (Hermans et al., 1993, p. 217)". This distinction between

‘I’ and ‘me’ here can be traced back to the American philosopher and psychologist William James (1842-1910) who made a distinction between different ‘selves’, he believed different ways of being emerge in different social contexts and multiplicity of ‘selves’ amount to defining selfhood (Salgado & Hermans, 2009). However, James described a unification of self-identity through time and continuity by the volitional *I*, whereas in dialogical theory “the *I* fluctuates among different and even opposed positions, and has the capacity imaginatively to endow each position with a voice so that dialogical relations between positions can be established (Hermans, 2001, p. 248)”. Additionally, Hermans explains each voice is considered to have a valuation attached to it, valuing something is associated with feelings and motives thus, meaning is encompassed within each voice.

Hermans et al., (1993) explains, rarely do the voices work in tandem, there is usually a push pull dynamic. This is based on his belief that humans are pre-wired to experience tension and conflict, the internal selves in conflict are continuously influencing one another through dialogue. In extreme cases, traumatic events may cause internal voices to become entirely dissociated and disconnected or ‘split off’ from one another, resulting in a fragmented sense of self (Pugh, 2020; Watkins, 1978). He goes on to ascertain, the landscape of internal dialogues have varying independent meanings, memories and feelings, he terms this an ‘internal society’ and implies psychological impairment stems from discordance between internal I-positions/voices (van Ersel, 2011).

I will now direct the reader to the varying I-positions/voices proposed by Hermans and Dimaggio (2004) and then discuss them in relation to the way individuals have described relating to the AV. According to Hermans and Dimaggio (2004) the voices are subjected to power dynamics with some dominating or suppressing others as well as each voice embodying its own value system and motivations. Power dynamics within the internal society can manifest as the dominance of maladaptive voices called *tyrannical internal dialogues,* minimal voice presence is called *uniform internal dialogues,* non-cooperation between voices is called *conflictual internal dialogues,* rigid organisations of voices are known as *inflexible internal dialogues* and voices that are chaotic in their interactions are called *disorganised internal dialogues*. The types of voices playing out internally are considered multifaceted with some taking caring positions, dominant or criticising. Anorexia literature has come to understand the AV as multifaceted, it is highly conflicting "by eating every day I am challenging the anorexic voice (Hale, 2011, p. 114)", it is repetitive and inflexible "I had finally given my illness everything it asked for and still the voice just would not stop (Evans, 2011, p. 150)" and tyrannical "relentless taunts from the ED voice pervading her every moment (Alexander, 2017, p. 54)". There have been reports of conflictual dialogues, accounts of supporting the AV and AN behaviours and some opposing them (the reader is referred to Cutts, 2009; Tierney & Fox, 2010). The AV is capable of 'taking over' during acute illness "everyone's best efforts hadn't been enough to quieten the controlling anorexic voice in my head (Hay,

2010, p. 72)" this is an example of Hermans monolithic dialogues also evidenced in findings from Williams and Reid (2012).

In term of self-dialogues and AN recovery, changes in the dialogical self-appear to carry value in recovery. Contrasting the hostile controlling AV one could argue, is the adaption of a compassionate stance to oneself. Self-compassion entails responding to personal distress with kindness not judgement. Dudley et al., (2018) explored voice hearers associations between the constructs of mindfulness of voices, self-compassion, and distress from hearing voices and found self-compassion mediated the relationship between mindfulness of voices and severity of voices. Stretching the implementation of self-compassion towards AN recovery, one study found anorexic women reported less eating pathology on the days they practiced greater self-compassion above usual standards (Kelly et al., 2020). In another, Kameo (2021) report self-compassion as an adaptive mindset found it was related to increased likelihood of continued positive self-talk. Additionally, Kelly et al., (2014) demonstrated that eating disorder patients who participated in self-compassion early in their treatment had better treatment outcomes at a 12-week follow-up than the control group. With that, the value in strengthening adaptive internal voices which counteract the AV have been documented from first person accounts "when I loved myself enough I stopped listening to the eating disorder voices (Lawrence, 2011, p. 90)". Importantly, compassionate dialogues replacing the dominant AV impact power dynamics with power favouring the individuals compassionate dialogue creating a space between the person and the more destructive anorexic dialogue.

Kelly et al (2021) qualitative findings show, cultivating self-compassion in AN recovery yielded improved health; personal development like growth and coping; improved outlook; and enhanced social relationships.

An important question to consider is how could this theory work practically for AN treatment? Adapting Hermans (1993) theory and amalgamating it with systemic theory, an approach titled Open Dialogue (Seikkula & Olsen, 2003) has demonstrated highly successful results in Finland for hearing voices experiences in psychosis. Open Dialogue takes a non-medical, validating, collaborative approach. Participant results report significantly less medication is required as well as reduced hospital admissions and greater levels of successful social functioning (Aaltonen et al., 2011). On the back of this, the first study of its kind for AN, Ling et al (2021) interviewed anorexic women after one Open Dialogue session, results indicated helpfulness and value in separating oneself from the AV, better AV understanding and participants reported feeling a mixture of hopefulness, motivation but fear of recovery. Ling et al., (20121) results hold promise for future investigations into using this approach in AN for a distressing AV presence, in building an open dialogical approach validating the AV presence could be helpful in tackling this enigmatic illness as research has widely documented how AN can make it possible to retreat into protective/numbing 'bubble'. The illness offers a way to be in the world that responds to and ameliorates distress with the widely documented understanding of 'safety' in living *through* AN (Lavis, 2018; Smith et al., 2016). Further, with the Open Dialogue approach practitioners work with that intersubjective form of

communication and because the AV is often described as alien to the self (possibly due to dissociative processes) as per Pugh et al., (2018), research has demonstrated despite the difficulty it brings, getting to know oneself (implicit learning) is perceived as helpful for AN recovery (Isaksson & Ghaderi, 2021; Cole et al., 2014; Lamoureux & Bottorff , 2005). Seed et al., (2016) champion treatment goals focusing on quality of life, this may mean holding onto parts of their 'anorexic self' but in a safe way, this could be interpreted to mean holding the AV in a curious stance but in a non-destructive manner.

Conclusively, Salgado and Hermans (2009) advocate for the usefulness of a dialogical approach where issues of relating mind and body are concerned and see it as a useful tool to unite antinomies, such as that of the AV and the other aspects of the individual via a continued process of dialogical negotiation. Finally, another way of viewing the dialogical perspective of subjective multiplicity is assisting an open dialogue with the client to work through multiple ways of 'being-with' ones multiple voices which may prove useful in AV-AN alignment.

2.4.5 Interpersonal

The interpersonal theory of personality will be briefly outlined, for the sake of time and space, focus will take place on the role/impact of anxiety experienced in early life, for a thorough understanding of this complex theory the reader is invited to read *The Interpersonal Theory of Psychiatry (1953*). Freudian psychoanalytical psychiatrist Harry Stack Sullivan (1892-1949) developed a theory of personality (Kleman et al., 1984)

based on a psychobiological approach to understanding mental health. Invested in understanding interpersonal relationships between people and how they might impact anxiety, satisfaction of needs, interpersonal security/relief from anxiety and self-system/protecting oneself from anxiety (Sullivan, 1953) he opposed the cognitive-behaviour premise of intrapersonal mechanisms contributing to mental illness. Prominent here, the belief that humans need interpersonal security because unabated anxiety feels insecure and according to Interpersonal theory distorts development and personality in later life (Conci, 2010). Important to Interpersonal theory is the impact of early relationships on one's sense of self, meaning, early experiences determine connectedness with others and with oneself. For example, when an infant's anxiety is not relieved and it perpetuates, too much anxiety can result in what Sullivan terms 'somnolent detachment' (Barton Evans III, 2006) also described as a sort of 'falling asleep', a protective response from threatening anxiety tensions and considered to account for later life experiences of dissociation. Moreover, where anxiety cannot be abated, one simply dissociates in order to cope "in dissociation…one shall carry on within awareness processes which make it practically impossible while one is awake to encounter uncanny emotion (Sullivan, 1953, p. 240)". Dissociation of anxiety states is described as "not-me…the organisation of experience with significant people that has been subjected to such intense anxiety…that it was impossible for the …person to make any sense of (Sullivan, 1953, p. 239)".

An important question is how might the Interpersonal theoretical perspective relate to AN and the AV. Firstly, regarding anxiety, anorexics tend to have specific temperament traits e.g., harm avoidance, negative emotionality, rigidity, perfectionism (Dahlenburg et al., 2019; Fassino et al., 2002, 2004; Rotella et al., 2016) as well as leniency toward an anxious temperament (Marzola et al., 2020) illustrating early childhood anxiety. These aforementioned traits are highly implicated in the development and maintenance of AN (Kaye et al., 2009; Wierenga et al., 2014). Secondly, childhood anxiety onset as well as lifetime anxiety disorder is found in AN (Kaye et al., 2004; Woolridge, 2018). Lastly, anorexics report marked harm avoidance, dissociation presence, specifically with binge-purge AN subtype, as well as interoceptive process dissociation i.e. a disconnect of understanding and feeling what's going on inside the body (Atiye et al., 2015; Longo et al., 2021; De Lernia et al., 2019). It is fair to say, high anxiety states can be associated with critical inner dialogue often representational of family members and similar in phenomenological qualities to the internal voices found in psychosis and eating disorders (Eschenwecker, 2021).

Moving towards what has been discussed so far and relating it to the AV. Early anxiety states and later dissociation has been a topic of interest in AN research by Pugh et al., (2018) who found the relative power of the AV was positively associated with experiences of childhood emotional abuse, this relationship was partly mediated by dissociation. Moreover, research is suggesting experiences of childhood trauma and dissociation-proneness may be behind AV generation which is experienced as differentiated

or ‘split-off’ from a person’s sense of self (Watkins, 1978) akin to depictions of dissociation as described in Interpersonal theory. Concordantly, the AV may reflect experiences of early maltreatment such as criticism and rejection, further fuelling anxiety and negatively impacting self-concept, this has been corroborated by De Giacomi, (2019) qualitative research highlighting the thematic links between the content of the AV and the voices of critical caregivers. Conclusively, corroborating inner dialogical experiences borne out of prolonged anxiety experienced in childhood, as per Interpersonal theory, hearing voices research by Longden et al., (2012) and Perona-Garcelan et al., (2012) found parental emotional abuse was internalised as distressing images or introjected self-criticism, but experienced as ‘not me’ and ‘voice-like’, mediated by dissociation.

Supporting Interpersonal theoretical findings, it has been noted, primary difficulties of AN surround the identification, tolerance and integration of emotions into the self and sense of self within the social world, exasperated by anxiety and starvation effects (Startup et al., 2021; Oldershaw et al., 2015; Oldershaw & Startup, 2020). Few AN therapies are designed to directly target trait-related symptoms specific to AN as well as include a person’s primary support network in treatment, priding itself as different to other treatment models based on its inclusivity of an interpersonal approach to AN treatment is the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA; Schmidt & Treasure 2012; Schmidt & Treasure, 2013). Time limited, focused on developing a ‘non-anorexic identity’, and trialling group based therapy (Startup et al., 2021) whereby qual-

itative analysis has captured the value of the relational aspect of this treatment, MANTRA targets affective interpersonal deficits in both anorexics and their support network (Christensen & Haynos, 2020; Dore et al., 2017). MANTRA argues, cognitive-behaviour approaches may be useful but they can enable 'safe' intellectualising, so the individual remains emotionally 'cut off' blocking social and emotional processing (Ogden et al., 2006). Therefore, a core intervention target is the emotional and social mind because emotional processing, particularly in interpersonal contexts is a great struggle for this client group (Christensen & Haynos 2020). MANTRA is as effective as other recommended treatments at improving AN outcomes (Byrne et al., 2017 & Schmidt et al., 2012) notably, outcome is still modest at best (Cardi et al., 2020).

Critically, MANTRA acknowledges the presence of the AV but frames is as 'self-criticism'. Here, MANTRA acknowledges the self-to-self experience as underpinned by social relationships. The extent to which self-criticism is related to negative AV content or even plays a role in its aetiology requires further investigation, additionally, the voice experienced as 'separate' is something that sets self-criticism and the AV apart. Crucially, being self-critical, dwelling on mistakes and a sense of inadequacy as well as feeling self-disgust/hate is widely found in AN (Noordenbos et al., 2014; Moncrieff-Boyd et al., 2014; Lester, 1997). In parallel, the self-critical function and AV function have commonalities as Gilbert et al., (2004) describes, self-criticism is related to desires to try to self-improve but also to take revenge on, harm or hurt the self for failures. This mirrors AV relatedness trajectory. In hearing voices literature, Scott et al.,

(2020) found negative voice content in an AVH was associated with negative views of self. Sullivan described an evolution of the child's 'sense of self' borne out of relationships with others, over time, internalised. An excessive experience of anxiety negatively impacts self-concept i.e. how one perceives oneself, with one's core self-system susceptible to lowered self-esteem, viewing oneself as "bad" or frightening (Sullivan, 1953). In argument, it may not be the case the child did not receive positive affirmative care, rather, the role of anxiety to such a degree can dissociate affirmations therefore the stressful impact holds a greater grip. Conclusively, identifying how voice content relates to self could be useful in challenging perceived self-discrepancies and in contemplating how to enact valued parts of self, i.e. self-AV integration given people who hear voices relate to the voices and to people within their social environment in similar ways (Birtchnell , 1996). MANTRA uses externalisation via letter writing based on the seminal ideas of James Pennebaker (Esterling et al., 1999) to overcome avoidance of emotions thus writing about the AV and AN as a form of self-observation is an attempt to integrate the self-criticising AV, an intervention supported by and considered useful by Hibbs et al., (2020) and Pugh and Rae (2019). Promisingly, Startup et al., (2021) group MANTRA treatment has actively implemented other novice treatments such as chair work with the AV as per Hibbs et al., (2020). What is clear from this, novice ways to treat the AV are coming to the forefront of NICE (2017) via recommended treatments like MANTRA shining greater light on the influential role of interpersonal difficulties and how integrating the

AV could prove beneficial in symptom reduction as well as contribute to unknowns concerning AN aetiology.

2.5 Summary

In summary the reader has been invited to a brief overview of the terminology used in the literature proceeded by considerations about the place of the AV in anorexia diagnostic criteria as well as discussing the evolving descriptions in an attempt to understand this phenomenon.

Happily, the psychological theories of AN presented incorporate knowledge from philosophy, psychiatry, psychology, sociology and so on, this demonstrates an array of positions willing to theorise AN and pinpoint effective solutions to the distress it causes. Consideration has been given to exploring how the AV might be hypothesised. There have also been attempts to explore the reasons behind the AV as informed through hearing voices, or, psychosis literature in hope it might provide a more comprehensive view of AV nuances.

Yet, despite this vast landscape of literature dedicated to AN still no consensus has been drawn regarding the AV aetiology until recent attempts by Pugh (2020) to assemble multiple theoretical perspectives, of which some are included in the literature review in this study so as to make sense of this phenomenon the ‘anorexic voice’. Moreover despite the large body of research to treat AN it often seems to fail and, certainly, rates of relapse continue to be unacceptably high highlighting new areas of interest into

this illness could offer something of value. Evidently, there remains a gap in the literature that, if filled, could help us better understand AV functionality, AV-individual connection and nuances and how to effectively address this aspect of AN in duality with treating the other illness features. The implications for the present study then are to try and enrichen understandings of AV-individual connection and dynamic by exploring patients' experiences with a particular emphasis on the meaning they give to the AV. Given the risks associated with anorexia, an ethical imperative exists to do all we can to understand the AV in AN in order that we can help minimise the factors which cause it and maximise the factors that protect against it.

Discussion now turns to the respective quantitative and qualitative AV research to consolidate findings and identify gaps in AV knowledge. Lastly the chapter ends with treatment implications, implications for the current study and the research questions and aims.

2.6 Quantitative Research Investigating the Anorexic Voice

To understand the limited findings on the AV despite numerous published autobiographical accounts and references over the past few decades, a helpful resource of information to date is the systemic review of the AV conducted by Aya et al., (2019) in which the researchers identified thirteen peer-reviewed articles all largely in agreement that the negative characteristics and responses to the AV are associated with eating disorder symptoms. Here, a critical review of the findings and limitations of some of those

studies will be outlined. Table 1 and 2 highlight the prominent quantitative and qualitative studies looked at for the purpose of this study.

To begin, Pugh (2016) declared, poor AN treatment outcomes were fuelling the development of novel maintenance models of AN, Pugh (2016) reviewed ED research implicating the AV in AN and sought to examine its role in the persistence of eating pathology. This review was followed with further interest of the AV in AN. Shortly thereafter, Pugh and Waller (2016) examined whether the perceived power and nature of the AV was related to AN eating pathology, this research came off the back of research interest into hearing voices in ED populations as per Noordenbos et al., (2014) who reported ED individual's described hearing a frequent illness related 'voice'. For Pugh and Waller (2016), having no AV scale to measure the experience of an AV available to them as one didn't exist, reliance on hearing voices psychometric tools were used; *Beliefs about Voices Questionnaire* (BAVQ; Chatwick et al., 2000) and *Voice Power Differential Scale* (Birchwood et al., 2000) these were marked against the *EDE-Q* (Fairburn, XX) to establish effect on AN pathology. Findings illustrated, high AV power was associated with greater negative eating attitudes while the interaction of greater voice power and malevolence was associated with a lower BMI. This illustrates a rooted position of the AV in AN pathology. Thereafter, Pugh and Waller (2017) exploratory study aimed to determine voice characteristics and individuals' responses associated with AN pathology e.g. BMI, eating cognitions and attitudes as well as exploring if AN subtypes

(restrictive AN; Binge/Purge AN) are linked with AV characteristics. They found a benevolent/friendly AV encounter was associated with high AN engagement, highlighting the AV as a sort of 'scaffold', enticing the person closer to illness engagement. Supporting this, Persson and Turesson Alfaro (2020) reported, the AV embodies security and predictability for the person as opposed to a sense of being out of control, this security can act as an invitation to trust its narrative. Perhaps the perceived belief and intent around the benevolent voice is experienced as ego syntonic, cocooning and less distressing, therefore maintaining overall AN pathology. This is supported by previous research into AN maintenance whereby AN beliefs and illness attachment is perceived as a kinship (Gregertsen et al., 2017). Further, Pugh and Waller (2017) found those with stronger AV presence presented with more negative eating attitudes, more severe compensatory behaviours, a longer illness duration, and a greater propensity toward binge-purge behaviours, thus reinforcing the role of the AV in illness severity. However, the exact constituents facilitating voice change, benevolence to malevolence are unclear and not explained in these studies.

Mindful interpretation would denote correlation does not imply causality, important here, the concept of voice 'power' as well as malevolence emerging with a reduced BMI. These results suggest the AV power position or belief about the AV position in relation to the person i.e. seen as more powerful than them, may be playing an influential role in eating psychopathology in AN. Pugh and Waller (2017) findings support Noordenbos et al., (2014) and Noordenbos and Geest., (2017) research findings

whereby, low self-esteem was correlated with higher ED voice frequency and voice criticism positively associated with a reduced BMI. Individuals with low self-esteem are highly dependent on external cues for validation, cognitively accepting of external information, even threatening feedback, if it`s consistent with self-identified schemas (Baumeister, 1993; Briere & Runtz, 1990) and so, beliefs in AV content and its power over them could negatively impact recovery. Therefore, one could infer the malevolent presence, akin to a bully, might make 'prompting' or 'buffering' oneself in treatment harder and may account for compensatory externalised behaviours such as binge-purge and/or high relapse rates. A pressing question here emerges, "is voice power a mediator of treatment effect?". In an attempt to answer that, Birchwood et al., (2018) hearing voices research suggests, voice omnipotence is a good predictor of harm compliance, therefore, AV quantitative research discussed above points toward the potential benefit in addressing the AV in the early stages of illness when its benevolent and powerful as a means to halt the probability of greater harm to self through AN engagement on the back of a powerful AV presence.

Limitations exist however, firstly, in both studies Pugh and Waller (2016; 2017) the length of time participant groups reported their illness was 7 years, this could constitute a severe and enduring AN (Schmidt et al., 2015) presentation in which the AV might be perceived or engaged with differently compared to say, individuals meeting criteria for a recent AN onset (≤3 years). Secondly, what this research doesn't tell us is how the AV might be influential/vary for persons in example day/inpatient versus

outpatient community or between genders, if at all. Finally, participants in both studies completed self-report measures only, what stands out here is the querying of participant ability to comprehend the concept of voice hearing as associated with AN given this topic is largely unspoken. Compounding this, the measures are derived from the hearing voices mental health domain, primarily used in psychosis assessment. Equally, Noordenbos et al., (2014) and Noordenbos and Geest., (2017) employed the BAVQ-R (Chadwick et al., 2000) in their ED research. It must be stated, stigma around disclosure of voice hearing, particularly as the AV is a newly investigated phenomenon, might prompt socially acceptable answers, or intentional reporting bias. Had these studies been mixed methods for example, this would possibly mitigate potential intentional reporting bias via an accompanying interview which would provide an opportunity to explain fully the concepts being enquired about.

A correlational and cross sectional study by Pugh et al., (2018) found ED voice power related to experiences of childhood emotional trauma mediated by dissociation. The benefit of this finding, in practice, formulation of AV experiences may benefit from considering how they relate to past relationships and extended views of self and others, which may represent targets for psychological intervention. However in limitation, participant recruitment was not consistent and the sample size small. Some participants were recruited at the point of assessment and others at a time point while in treatment. The issue with this, participants' mental state or eating disorder symptoms could impact the risk of dissociative states even influence trauma recall or impact upon

experiences of voice hearing. Therefore, replication studies and longitudinal studies looking at early childhood adversity, dissociation and AV experience would be of benefit to further the findings of Pugh et al., (2018). Concludingly, Pugh et al., (2018) throw light on an important grey area of AN assessment whereby childhood emotional abuse is not routinely enquired despite evidence of adverse childhood experiences linked with ED and potentially AV as per Morrison (2021) grounded theory analysis investigating experiences of negative childhood events and the AV. Bypassing potentially vital historical information of this kind, it could be argued, neglects the chance to contextualise AV-related experiences, in which doing so, would provide empowerment and opportunity for meaning-making concerning the AV experience as well as inform practice.

It must be observed, systematic research to explore the AV further would benefit from a valid and reliable measurement tool. With that, Hampshire et al., (2020) developed the Experience of an Anorexic VoicE Questionnaire (EAVE-Q). The EAVE-Q is an 18-item scale with five domains correlated significantly with eating disorder symptoms, psychological distress, and quality of life. Measuring the presence and significance of the AV in AN, the psychometric properties of the EAVE-Q have been found to be good with Cronbach's a = 0.83 and test-retest reliability classed as moderate. Developed at a pinitol timepoint, the EAVE-Q is the first measure of a critical internal dialogue in AN. Used once in Hibbs et al., (2020) brief intervention applying emotion-focused therapy to work with the 'anorexic voice' within anorexia nervosa it is the hope

of the developers that it will aid future research to increase understanding of AN and the continued development of person-centred treatments.

2.7 Qualitative Research Investigating the Anorexic Voice

In recent years, there have been a number of studies exploring AN sufferers' experiences of an anorexic internal 'voice' experience employing qualitative methodology. These have been primarily focused on the experiences of women and adolescent girls description of their perceived relationship not only to the illness per se but to the unique experience of the voice-associated aspect of their illness (Higbed & Fox, 2010; Tierney & Fox 2010; Williams & Reid, 2012). To name a few, one study focused on the relationship quality AN sufferers` had with the AV (Williams et al., 2016), while Graham et al., (2019) sought to understand ED professionals perception of the anorexic 'voice' experience. Others have focused on the overall experience of eating disorder voice hearing (e.g. Pratt, 2014; Noordenbos et al., 2014; Scott et al., 2014; Persson & Turesson Alfaro, 2020) while Jenkins and Ogden (2012) shone light on the AV in view of overall AN recovery. Pugh (2020) review of the AV attempted to clarify how and why internal voices contribute to disordered eating, and sought to help contextualise the AV via varying theoretical frameworks, some of these frameworks have been discussed earlier in the literature review. The latter group have highlighted a number of common themes concerning the AV (Williams et al., 2016; De Giacomi, 2019; Hibbs et al., 2020).

The reader will be introduced to some of the pivotal findings amounting from the qualitative data available in reference to the AV. Firstly, the AV perceived at

illness onset is supportive and this is of central importance (Tierney & Fox, 2011). In particular, the AV provided a justified and confirming means of coping, thereby increasing the need for the eating disorder (Williams & Reid, 2012). Understanding, trustworthiness, consistency, availability and safety in presence are all characteristics that, when felt via voice interaction i.e. acting in accordance to voice demands and suggestions, can facilitate this type of supportive relationship (Tierney, 2008; Higbed & Fox, 2010). However, troublingly, as illness progresses so too does the AV demands amounting to what eventually manifests as being 'bullied' by the AV narrative and perceived coercion ensues regarding AN behaviour engagement resulting in felt distress, high anxiety, a sense of loss of control over ones rational thoughts and behaviour as well as a sense of non-individuation from illness identity (De Giacomi, 2019; Pratt, 2014; Persson & Turesson Alfaro, 2020). Jenkins and Ogden (2012) analysis offers participant insight into the AV-individual conflict "something else inside me that would overtake me ... it drives you to do the most insane things" and De Giacomi (2019) describes the conflict as activating the internal threat system of fight and flight. And so what of this? Well, as AN continues to remain poorly understood worldwide, research and theory have largely moved away from understanding its aetiological causes, instead, addressing potential maintaining factors and so treatment providers, if encouraged to reflect on the inner turmoil experienced by the AV-individual dynamic, according to Graham et al., (2019) might be better informed, therefore, respond with a desire to help, thus reducing judgment and blame towards the patient. Albeit, this understanding may in turn reduce the risk of professional

burnout, practitioner compassion fatigue and stigmatising attitudes towards ED sufferers of which is widely reported (Brelet et al., 2021). Moreover, greater professional awareness of such AV-individual suffering might help heal perceptions of anorexics who have historically reported professionals treating AN as insensitive and ignorant about AN and who hold a lack of belief in AN recovery (Fox & Diab, 2015).

Secondly, many studies have utilised varying qualitative approaches demonstrating opportunity to observe and infer a diverse range of AV particulars with some referring to ways in which the AV might be addressed in therapeutic intervention. An inductive analytic approach by Persson and Turesson Alfaro (2020) analysed data via AN recovery blogs managed by AN diagnosed individuals who reported an AV. One could argue, this method could facilitate a greater sense of ease, rapport and more detailed personal disclosure from behind the computer screen (James & Busher, 2006) in particular when discussing conceivably stigmatising attributes of self, additionally, extracting a potentially slower-paced, thoroughly fleshed out response and a rich narrative. In criticism, anonymity of blogging can raise issues about whether material is authentic and true, there is a risk of deliberate identity manipulation and deception as per Ackland (2013). However, these circumstances are not unique to online research, and manipulating the truth can occur too in surveys, face-to-face interviews or focus groups (Wilson et al., 2015). Williams et al., (2016) sense of self and AN, a grounded theory (GT) provided a sociological approach (Willig, 2003) meaning convergences within a relatively large sample supported a wider conceptual explanation whereby a novel theory emerged

organically, in criticism, this method discounts subtle nuances in the responses and experiences of participants, as is the nature of GT. Nonetheless, the researchers developed a theoretical framework of the nature of the relationship between the self and AN. Findings show, the self is considered shared with AN, moreover, the AV is a shared occupant within the persons inner dialogical space and separating the self from AN is appraised as crucial to recovery. Supportive of targeting the AV in treatment, Jenkins and Ogden (2012) found participants favouring controlling the AV as a means to recover, for one participant this meant getting "to the point when I have that voice but I would not really listen to it". Controlling the AN voice is thus associated with the resolution of a dichotomy between the rational and irrational side of one's inner dialogical process. In a similar vein, De Giacomi (2019) interpretative phenomenological analysis (IPA) qualitative study concerning voice hearing across the entire ED diagnostic spectrum, found, ED voice hearing was central in illness. Participants` in this study reported CBT limitations in addressing voice influence. However, one cannot infer CBT was only a limited experience for the AN participants, as the participant sample group varied in ED diagnosis also generalisations mustn't be made given IPA uses small participant samples, non-representative of larger group sets. However, if we look to Collie (2020) grounded theory analysis of individuals' perceptions of whether the AV was impacted during CBT-E. Participants reported CBT-E as superficial, bypassing underlying reasons contributing to illness and AV development as well as an exasperated AV presence when using CBT-E mandatory food diary logs. Lastly, some participants alluded to the AV remaining

domineering during initial stages of CBT-E, amounting to struggles in treatment engagement. However, recruitment involved participant self-reported confirmation of receiving CBT-E, meaning, inaccurate reporting could potentially take place. Also, the researcher failed to offer explicit reasons as to why participants felt CBT-E as a model of therapy failed to address the AV, moreover, we often fail to consider the individual therapist's contributions to treatment effectiveness to which this could have played a part in participant experience of non-effectiveness of therapy on AV presence outside of the therapeutic model. Nevertheless, the reported findings suggest perhaps a useful precursor to helping clients to engage in a more behavioural and change orientated therapy, such as CBT-E, could benefit first from a time limited treatment approach aimed to target the AV, such as emotion focused therapy (EFT) as per Hibbs et al., (2020) who observed differences for motivation to change and increased hope of recovery in AN diagnosed participants who received 6 sessions of EFT treatment for AN and found shame reduction via targeting the AV in these 6 sessions.

Thirdly, Ling et al., (2021) IPA study exploring the experience and acceptability of single session Voice Dialogue intervention with AN clients experiencing an AV found participants supported the potential of such an intervention to establish a more constructive relationship with their AV and support motivation to change. However, the research couldn’t demonstrate if Voice Dialogue, as an intervention, would impact long term voice frequency or reduce distressing AN behaviour. For future replication, perhaps Task Analysis as per (Pascual-Leone et al., 2014) an ‘observe in action’

method could be useful in ascertaining Voice Dialogue mediating AV-individual dialogue change over time to build a detailed description of detailed description of voice duration, frequency etc from this, Task Analysis can infer causal models of change. Also participants received one session, it could be suggested one session is too little exposure for any observable change, perhaps that is why a qualitative methodology was employed here as a starting position to future quantitative pre and post analysis of Voice Dialogue research for AV. Albeit, therapy training is based on the premise that therapy is an ongoing process and it could be argued one session may not be enough to both render critical evaluation of an intervention or instil change, however, Dryden (2016) developed the single-session integrated CBT method with the belief that for some, one session is enough to enforce some meaningful change, but it is within the scope of practitioner competency to know when one session is not enough. Further and conclusively, quantitative research might prove fruitful in analysing the process of change of the AV-individual relationship as mediated by externalisation using voice dialogue techniques.

Lastly, Tokarska and Ryżanowska (2018) retrospective thematic analysis interpretation of textual externalisation methods used in AN treatment like letter writing to AN which was framed in the context of building a 'Dialogical-Self' within therapy. The researchers found two emerging participant groups concerning AV responding, three quarters of the sample attributed their inner dialogical self as largely dominating the AV while the remaining participant sample not only positioned their 'healthy' or non-anorexic inner dialogue beneath the AV narrative but this group also felt unable to

use meaningful resources or social support to cope with their illness. Talari and Goyal (2020) find benefit in retrospective studies in that rare disease, manifestations and outcomes can be observed via this means of analysis. However, a major limitation of this research is that since the researchers depended on a review of previously written letters, originally not designed for data collection for research, some information is bound to be missing. Equally, good practice means researchers should avoid over generalisation of results but exercise caution in claiming cause-effect relationship within retrospective studies. Concludingly, externalising techniques, like narrative writing, arguable allow a person to convey and actively communicate with the AV, even personify the AV to promote a means of separation and facilitate a process in which the person could learn active ways to position themselves as the dominant and rational voice above the AV. Individual story accounts are of personal interest to the researcher, here, the power of a story is nicely described by Maya Angelou (1970) when she says "There is no greater agony than bearing an untold story inside you". Finally, it is fair to say Narrative Analysis (Cresswell, 1998) which, uses letter writing, has a central concern with meaning making which proves useful in AV investigation and is founded on the principle that our life accounts are constructed as stories shaping our human experience. In criticism though, it only considers how people create and use stories to make meaning of their experience, neglecting the acknowledgment of other potentially important processes such as the use of discourse or symbolism.

In summary, there is limited quantitative research with greater qualitative research available, albeit still a restricted number on the AV considering the body of research published over the decades on AN. Nonetheless the reader has been afforded an opportunity to view research findings to date demonstrating how the AV has a powerful, negative and omnipotent nature and is a protagonist in AN pathology. Findings conclude its ambiguity, benevolent and enticing AN engagement as well as for some individuals punitive and attacking when at a reduced BMI status and its lingering presence after treatment has ended. It would appear that more knowledge is needed in the United Kingdom regarding the ways in which the AV impacts AN disordered eating symptoms, beliefs about self, beliefs about the illness, internal power dynamics of the AV-individual and how early life experiences amalgamate in order to inform our understanding within the healthcare professions and within Counselling Psychology in particular. The move to address the maintenance structures underpinning this illness have borne novel approaches to AV enquiry as per qualitative findings demonstrate additionally they equally promote continued novel intervention investigation of the AV.

2.8 Implications for the Current Study

The fundamental premise of this research topic is reflected nicely in Linacre (2021) headline, published in the British Psychological Society (BPS) online news blog discussing eating disorders "Eating disorders are a systemic issue, not an individual issue, so everybody has to work as a team to help a person to get better". As a Counselling Psychologist practicing in an eating disorder setting, a strong pull exists to uphold

the truth of this statement in that this study although the work of the researcher it is hoped will belong to the community of ED researchers and inform both scientist-practitioners and patients alike. The researcher is reminded of the NICE (2017) general principles of care concerning working with AN by acknowledging persons' accessing treatment may find it difficult or distressing to discuss their illness, notwithstanding AV disclosure, as well as knowing they are vulnerable to stigma and shame. And so, this research study carefully opens the door to talking about potentially stigmatising topics i.e. voice hearing as well as heightening the unfortunate reality that relapse rates for this group are high (Fichter et al., 2006) and how professionals are considered naïve to the extent of the suffering AN causes impacting treatment seeking, disclosure of internal experiences, treatment dropout and relapse rates (Fox & Diab, 2015; Ramjan & Fogarty, 2019). Professional treatment is considered the best hope for AN recovery (Dejong et al., 2011) and so an obligation rests with professionals working with this group, including the researcher via this study, to attempt to grasp an understanding of AN illness generation, illness processes and try to find ways to reduce distress in experience via knowledge generated. This study, by utilising a qualitative approach hopes to offer an account of AV-individual expierence through the trajectory of illness onset to recovery as well as produce a greater understanding of what is not known about the AV experience to both complement existing research, offer new information and propel consciousness of and aid action in thinking for future intervention development in targeting this enigmatic component of AN.

2.9 Research Questions and Aims

The existing literature, research and treatment guidelines of AN provoke many questions such as “How do individuals experience and give meaning to their relationship with the AV”, “What meaning is attributed to the presence of the AV”, “How has the experience of the AV contributed to the course of illness onset and AN recovery?”. This study clearly asks the question that needs to be answered: how do individuals with Anorexia Nervosa experience the anorexic voice? This study aims to develop insights into the way participants experience this phenomenon. To address the research question, this study, offering an in-depth analysis of individual experience, is required. The following research aims are proposed.

1. This research aims to fill the gap that exists in the knowledge of the AV, to enlighten and support current and future quantitative and qualitative findings on the AV as a construct of AN.

2. This research aims to understand the subjective experience of relating to the voice, understanding the meaning and experiences of the AV associated with its presence within illness onset, maintenance and recovery.

3. A final aim is to expand the knowledge base in the field of eating disorders and clinicians treating AN. This research aims to better inform counselling psychology professional practice, so professionals

can expand on what they already know about EDs and anorexia aetiology, so as to move forward with therapeutic interventions that can address the AV.

Table 1

Quantitative Studies

Author	Title	Study Hypothesis	Sample Characteristics	Design	Results
Pugh et al, (2018)	Do eating disorder voice characteristics predict treatment outcomes in anorexia nervosa? A pilot study	Therapy would result in a reduction in both eating pathology and voice characteristics.	n=14 self-report measures EDE-Q BAVQ-R VPDS	cross-sectional design	Voice Power Reduced p = 0.02 Sig voice characteristics not related to BMI increase
Pugh & Waller (2017)	Understanding the anorexic voice in anorexia nervosa	Varying anorexia pathology would result in sub-groups dependant on particular voice characteristics	n= 49 BAVQ-R VPDS	correlational research design descriptive	Two subgroups identified with distinguished differences in AV strength mediating AN symptom severity
Noordenbos & Van Geest (2017)	Self-criticism and critical voices in eating disorder patients and healthy controls	ED participants show greater self-criticism. Hearing voices is greater in frequency compared to healthy persons	n= 189 (AN 92, HC 59)	cross-sec-tional design	ED group had greater voice presence compared to healthy controls. Low BMI showed greater voice frequency

Table 2

Qualitative Studies

Author	Title	Participant Demographics	Qualitative Approach	Findings
Higbed & Fox (2010)	Illness perceptions in anorexia nervosa: A qualitative investigation	n= 13 participants all receiving AN treatment M age= 28	Grounded Theory	1. Making sense of AN 2.Relationship between AN and the self. 3. The recovery struggle 4. Coping with treatment
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	n= 14 Females= 12 Males= 2	IPA	Four themes 1. Relationship with AN 2. Perfection 3. Controlling self through the body 4. Battling the anorexic voice
Graham (2018)	Perceptions of the "anorexic voice": A qualitative study of healthcare professionals	n= 15 mental healthcare professionals	Thematic Analysis	Two major themes 1. The AV is a vehicle for increasing com-passion 2. It's not a one-size-fits-all

3 - METHODOLOGY

3.1 Overview

This section describes the methodology, procedures and ethical considerations in this research. Attention is given to the epistemology underpinning the methodology and its compatibility with counselling psychology`s philosophical stance.

3.2 Quantitative and Qualitative Research

Traditionally, and outlined in Babbie (2012), quantitative research has been used for the empirical investigation of observable data via statistical and mathematical analysis and posits a realist view of the world. Qualitative research is interested in how humans experience their social and internal world, analysis is focused on individual narrative (Hammersly, 2013). Distinctions between quantitative and qualitative research is reflected in how the data is observed and analysed. Objective versus subjective, realist versus relativist. Qualitative data analysis investigates intrinsic, micro level aspects of human processes and experiences, within a wider macro level social world.

Both revere in the necessity of providing validity and reliability to research data output, how this is tested differs. Quantitative research validifies research data by analysing the truthfulness of the data, the accuracy when inferring cause and effect and when observing correlation (Polit & Beck, 2008). Both qualitative and quantitative research are concerned about the homogeneity of their sample or participant pool. For example tests used in quantitative analysis e.g. chi-square test, will test for homogeneity**.** This test

determines if two or more populations/subgroups of a population have the same distribution of a single categorical variable i.e. examples of categorical variables could be race, sex, age group among others. Therefore, in quantitative research homogeneous means being the same in structure or composition. Homogeneity in qualitative research is important if the researcher want to understand and report the thinking and experience of a particular group of people, who depending on the research question, have something in common in which they are willing to talk about.

Qualitative research recognises the need for validity, no researcher is completely objective. The researcher is invited to include reflexivity to ensure assumptions, biases or inferences abstain from analysis. Newman et al., (1998) delineate how reliability in quantitative research is measured via the replication of findings, maintaining an internal consistency within results and test re-testing using the same instruments. For qualitative data, a peer review audit of analysed data assists with reliability. Peer reviewed auditing according to Smith (2007), involves a third party allocated to independently search the data for common themes that correspond to the raw data. Additionally, the researcher commits to reliability by keeping a paper trail of the data that offers clarity to a third party who can follow the steps and analyse it with ease. As mentioned, quantitative and qualitative research strives for homogeneity. Both research methods differ in terms of how causal questions are asked of peoples, how X would play in role in the development Y and what processes are involved is an important

qualitative point of interest. Quantitative research might ask, to what extent does X vary in accordance to Y (Maxwell & Woofitt, 2005).

Qualitative research has historical underpinnings in psychology, nursing and sociology (Brinkmann, 2017; Holloway & Wheeler, 2013; Marvasti, 2003). Respectively, it is widely used in the field of counselling psychology. It complements counselling psychology's pluralistic embrace of diversity and multiplicity which opposes monism, that of reducing diversity to one singular principle or law (Cooper & McLeod, 2011). Counselling psychology takes a holistic view and embraces individual differences considering multiplicity in meanings (Wampold, 2003). Applying a qualitative approach to investigating the AV within a counselling psychology framework was deemed appropriate for an under investigated and unique aspect of AN.

Quantitative research methods have been employed in investigating the maintenance cycle of AN and the role of AV in AN maintenance (Pugh, 2016). The current study is concerned with meaning making regarding the AV presence, relational components and overall AV experience over the course of illness. Qualitative research with phenomenological underpinnings best employs the means to seek out AV experiences. Previous qualitative research has explored an eating disorder voice (Weaver et al., 2005; Tierney & Fox, 2010). De Giacomi explored experiences of an inner critical voice in varying eating disorder presentations not exclusive to AN. Professionals working with EDs agree the AV is important and worthy of investigation (Graham et al., 2019). The debate about what constitutes recovery in AN outside of BMI levels remains

problematic. Investigating the AV experience acknowledges the impact of intrinsic cognitive and psychological symptoms in recovery in addition to healthy weight.

3.3 Research Design and Rationale

Exploratory research commonly uses qualitative approaches, allowing for a small sample size using narrative accounts in investigating unexplainable phenomena according to Elliot and Timulak (2005). Semi-structured interviews were employed. The data was analysed using interpretative phenomenological analysis (IPA). The compatibility with the Counselling Psychology framework is reflected in the stance that, IPA, is first and foremost, rooted in humanistic based values as characterised by Lyons and Coyle (2015). The therapist is not all knowing or observing but contributes their whole self to the process of allowing a meeting at relational depth and within another's experience (Williamson, 2013; Cooper, 2019; Mearns & Cooper, 2018). Just as the Counselling Psychologist seeks a deep and rich understanding in their work so too can the researcher using IPA as the guiding frame. This position very much fits with the researchers understanding of the discipline of Counselling Psychology and the position of a psychological researcher.

3.4 Ontological and Epistemological Positions

3.4.1 Ontological Position and Epistemological Position

Here, the choice of methodology was considered in terms of ontology and epistemology and informed by Hesse-Biber and Leavy (2011). Firstly, borne out of the

mid-18th Century ‘Enlightenment’ period was the philosophy of science, or rather the beginning of enquiry regarding a number of assumptions about the nature of reality i.e. ontology and the nature of knowledge i.e. epistemology as well as the development of suitable research methods to aid such enquiries. From this, a vital question was pondered concerning the appropriateness of utilising the same methods to study the human world as those used to study the natural world. Wherein positivism is primarily concerned with using quantitative, objective studies of behaviour, an alternative to the traditional empirical positivist model arose, that of subjective studies of experience. And so, humanistic and phenomenological concerns have led to the emergence of the expanding use of qualitative research as well as the extension of the field of Counselling Psychology wherein Counselling Psychology’s core values are based on philosophy and practice which honours individuals' meaning-making and social context (Strawbridge, 2016; Willig, 2008). It must be made clear, ontology and epistemology are not considered independent of one another. Matters relating to what can be known about the nature of what exists in the world, is considered an ontological inquiry whereas epistemology is concerned with the study of the nature of knowledge and how we obtain it (Burr, 2003).

Secondly, and as per Willig (2013), epistemology posits views on what can be known and it is concerned with the theory of knowledge. As configured in Punch (2013), epistemology asks questions such as; *what relationship exists between the knower and what can be known? What can I know? and what kind of knowledge is not available?* Epistemology’s concern with the theory of knowledge can be seen by means of helping

in defining how we study and generate knowledge and importantly, what forms of knowledge are possible and legitimate. Epistemology has been known to be hard to grasp in particular with new researchers, however it is mentioned here as it remains a crucial element in both the social sciences and for this particular study which employs a qualitative methodology concentrating on subjective studies of experience. Of importance, is the researchers' chosen methodology and how it aligns with the researchers chosen epistemological position. The researcher has considered the importance of first considering their epistemological position in line with selecting a research method. In this consideration, it would be helpful to discuss briefly some of the thinking processes of the researcher, the following is outlined below.

The focus of this study was an interest in the way in which patients diagnosed with AN experience the anorexic voice or rather a 'voice' experience related to their illness. It is not about locating the true 'nature' of AN or the true 'nature' of the anorexic voice and then 'cure' it as a positivist might seek to do. Rather, the focus is intended to surround issues of experience and meaning and a qualitative design would provide the research question with rich and in-depth narrative. The primary goal of qualitative research and in particular, this research, is the gathering of participants accounts of their experience and meaning of the AV (Willig, 2008) thus, connecting individual accounts to their particular context and their wider social and cultural contexts, for example, contributes to the overall meaning experience. The sort of answers that qualitative research offers are thought of as contextual descriptions or interpretations. These are

drawn from personal lived experience, therefore, this line of approach appeared best suited to the type of question asked by the researcher.

Counselling Psychologists are scientist-practitioners and so it is important to mention the core philosophy of the researcher underpinned in this study as a Counselling Psychologist conducting research. Firstly, the philosophy of science holds a realist ontological stance, this is the belief there is a singular, identifiable 'reality' and that it 'exists', independent of human awareness (Willig, 2008). Epistemologically, a positivist view means phenomena and concepts are defined through empirical categories in which a direct relationship exists between these and people's experience and understanding (Willig, 2008). As mentioned above, the researcher is not concerned with the 'nature' and 'cure' of the anorexic voice but the 'experience of' and the 'making sense of' such an experience. It must be noted, according to Madill et al., (2000) qualitative research can equally be rooted in a realist ontology as that of quantitative research, or an acceptance of the theory of 'truth' and seeing ones world as knowable and objectively identifiable. For example, Grounded Theory (Glaser & Strauss, 1967) as a method of analysis would seek to generate knowledge about the 'reality' of what is going on with a person and utilise a method that could develop an explanatory account of psychological and social processes. The researcher however, posits a position of, relativism, because this rejects the realist notion of 'truth', instead taking the view that there are multiple constructed 'realities' (Madill et al., 2000; Willig, 2008). It is fair to state, relativists consider all experiences to be shaped and moulded by the social, cultural, historical and

linguistic contexts in which they are embedded and so language within social interaction is seen to be of central importance because it does more than describe a person's 'reality', it determines a person's 'reality' (Burr, 2015; Madill et al., 2000). If the researcher was interested in the language used to decipher meaning of the AV, then utilising the relativist position would have been suitable because relativist qualitative research is not interested in investigating the experience itself but the way a particular experience is discursively communicated in a particular context. And so, analytic methods like Foucauldian Discourse Analysis (Arribas-Ayllon & Walkerdine, 2008) would be deployed to explore the relationship between subjectivity and language for example. Additionally, Foucauldian Discourse Analysis is used to explore the power relationships within society as expressed through discourse. Further, a more extreme relativist view is social constructionism which posits knowledge is developed out of the interactions individuals have with each other and that knowledge is socially constructed, acquired though ones history, culture, social environment and of course language (Davy, 2010). Social constructionism emphasises the construction of a phenomenon through language. However, its emphasis on language is in consideration of social behaviour as dictated by culture and history etc., and so social constructionism does not concern itself with language as linked with cognition (Willig, 2013). This was not deemed appropriate for the research question at hand which is reflective of experience and meaning making.

Further, somewhere between realism and relativism lies critical realism. Critical realism shares the realist premise of a 'real' world existing independent of human

thought. However, according to the writings by Bhaskar (2008) and Finlay (2002) critical realism distinguishes the ‘real’ world from the ‘observable’ world, endorsing that individuals experience real events and phenomena in quite different ways and dependent on the nature of their perceptions and beliefs. Altogether, what this means is, the world as we know it, is constructed via the ‘observable’ and not necessarily what is ‘real’. Consistent with critical realism, is the acknowledgement of the inherent subjectivity between humans. In conducting research, this means one could never wholly understand the participants' view of the world, but partially develop a ‘sense’ of how they process and feel their experiences (Smith et al., 2009). The researcher takes the position of critical realism as proposed by Bhaskar (1976), because this is underpinned by a realist ontology with a relativist epistemology. Importantly, critical realism suited the research question and aims.

Subjective meaning making holds experiential truth as per Baghramian (2004) while language, from which knowledge is filtered, is imperative in understanding named experiences. Interpretivism, configurated by O` Donoghue (2006) was deemed a necessary addition to help the researcher understand the meanings placed on situations and behaviours by others in an effort to make sense of their world. Bhaskar (2008), a critical realist, states, knowledge exists in two forms. The first is a result of social activity created by humans and the second is a knowledge of things independent of human creation or interference (Bhasker, 2008). Bhasker`s (2008) knowledge of things is not unlike Aristotle’s argument of empiricism, that all knowledge is sense experience (De

Groot, 2014). We use our senses to understand the essence of something, the base for building template concepts of the world. Critical realism ponders the properties humans and society have that actually enable them to be objects of knowledge, as discussed in Danermark et al., (2005).

Conclusively, in regard to the chosen qualitative method and use of IPA, the researcher and participant have an intersubjective relationship and the overall aim, through hermeneutics is to come to a shared understanding of truth (Newson & Newson, 1975). A critical realist position is compatible with both IPA and Counselling Psychology. The shared truth that is portrayed in the narrative of qualitative research employing IPA has been steeped in and emerged through both social structures and embodied personality, both of which are compatible with counselling psychology values and philosophy recognising that human beings are relational in nature (BPS, 2018).

3.4.2 Methodological Criticisms of IPA

IPA is a qualitative approach designed for the purposes of psychological research and exploring individual lived experience (Smith et al., 2009) with that, it is not without limitation but in saying that, limitations equally do not imply the quality of the study will be impaired. How well the approach is utilised rests heavily on its application. Brocki and Wearden (2006) point out, the failure of the researcher to address adequately the theoretical preconceptions brought into the study and/or the intrinsic role they play in interpreting the data can impact quality. How the researcher impacts the study is a key concern of IPA and the researcher alike. The researcher has limited these concerns within

the current study by reflecting on preconceptions, values and motivations throughout the research process. Reflexivity is explicitly referenced in three main sections of this study, Introduction Reflexivity, Methodological Reflexivity and Discussion Reflexivity. Validity is also important, during the process of analysis Brocki and Wearden (2006) state analysis can be checked and interpretations validated by other academics or professionals. The researcher ensured to have analyses checked by supervisors involved in the study and independently checked by academic peers.

IPA has been criticised for its reduced recognition of the role of language (Love et al., 2020), however, it can be argued that participant experience is also weaved through language. Moreover, the researcher considered this criticism in the context of the nature of the participant sample which has been associated with emotional inexpression (Startup et al., 2021). Where IPA seeks rich and meaningful narrative, the researcher sought to mitigate any conversation stagnation via prompts located in the interview schedule, this was a technique that could help encourage them to open up and speak about their experiences fluidly. To assume the position that IPA is suitable for only those who are eloquent in expression whether they be the interpretative researcher or the participant is indicative of rendering IPA as merely descriptive and not interpretative. As demonstrated, techniques can be used to ensure a rich flow of narrative between researcher and participant is present. A critical overview of IPA by Tuffor (2017) is so bold as to argue that IPA is a forward-looking research approach, that it adopts a flexible and versatile design in understanding human experience.

On a final note, the small sample sizes used in IPA give way to the criticism of generalisability within the method. The researcher supports the view held by Smith et al. (2009) that the use of a small number of participants permits greater depth of analysis, on the back of this, small sample numbers are not meaningless, quite the contrary, findings from IPA studies show a contribution to and influence of theory (the reader is directed to read Pringle et al., 2011). Equally, presenting a small sample size, as per this study, the researcher holds strong the findings will pose broader questions about the AV than have previously been asked, questions that hopefully inspire a critic of existing literature as well as expanding future research. Despite the noted limitations of IPA, the method is considered consistent with the aim of this study and with the philosophical underpinnings of Counselling Psychology.

3.5 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analyses (IPA) is the chosen method for this research. The analysis will be conducted within the guidelines recommended for IPA outlined by Smith (2007). IPA is idiographic and is curious about a particular experience (a process, event or relationship) and not the attributes of larger groups of people, this influenced the choice of IPA for this research. IPA seeks to explore how individuals make sense of both internal experiences and wider experiences of the world (Smith, 2009). IPA has a commitment to staying true to first person experiences and does this by means of in-depth analysis (Smith, 2015). IPA is used widely in the health psychology field, in its early days IPA was used to explore experiences of identity (Rohleder &

Lyons, 2015). Over time, the use of IPA as a research method has been used in other disciplines, Sociology, Psychology and Educational Psychology (Rohleder & Lyons, 2015; Williams, A., 2016). IPA involves narrative data gathering and thorough analysis. Smith (2015) outlines its usefulness when exploring under researched, unique and dynamic topics where identity, sense making and sense of self are the primary focus of investigation. The compatibility of using IPA to explore the research questions related to the AV was deemed a good fit and in line with this research's overall theoretical framework.

IPA draws on theory from three philosophical and epistemological wells of knowledge seeking and meaning making, namely phenomenology, idiography and hermeneutics.

3.5.1 Phenomenology

According to Giorgi and Giorgi (2003), IPA is phenomenological, it explores individual perceptions and experiences of the world. As discussed by Giorgi et al., (2017), phenomenology is concerned with the phenomenon of consciousness, it was pioneered by Edmund Husserl. Informed by Detmer (2013) it is understood that Husserl was influenced by the philosopher Franz Brentanos, who studied the processes and phenomenon of being aware; consciousness, the acute awareness of *awareness,* or "intentionality". From this, Husserl defined phenomenology as the philosophical act of reflecting upon core consciousness, a total awareness of self and the world as experienced from first person perspectives. Consciousness is considered intentional and

is directed toward all objects within the world whether they are concrete, visible and tangible objects, an image, dream or memory of an object or a missing object (Giorgi et al., 2017). Husserl believed in transcending one's natural involvement with experiences of the world and objects through an act pure reflection. Pure reflection as stated by Bailey (2013), constitutes experiencing in its fullest form, cognitive states, sensory input, emotions, free will, judgements, subconscious drives and desires. From the reflection of one's subjective world and internal states, the process of understanding oneself better is in motion, additionally, Husserl was interested, through phenomenology, human relations as described by Bailey (2013) and Moran (2005). Moreover, IPA shares a core fundamental aspect, "intersubjectivity", the process of relating to another's subjective experience in an attempt to reach a shared understanding. True intersubjectivity has limitations. One has to rely on interpretation, which is mixed up with the interpreters own true experience of the world. IPA addresses this through the use of idiography and hermeneutics in an attempt for the interpreter to stay as close as possible to the original experience as it was described.

3.5.2 Idiography

IPA practices idiography, the concentration on detailed analysis of the context and details surrounding a particular and how individuals come to understand that particular phenomena (Smith, 2009). IPA makes an idiographic commitment to pay close attention to individual experience. The research topic warrants the type of in-depth analysis offered through IPA. The AV is considered a peculiar, unique and under

investigated phenomena where little is known about the variance in individual experience throughout illness and recovery. The idiographic nature of IPA can be applied to understanding aspects of anorexic behaviour maintenance.

In limitation, an idiographic concentration of a particular does not give answers as to why these experiences occur and what constitutes individual differences in relation to the experience.

3.5.3 Hermeneutics

Martin Heidegger, according to Sheehan (2017) defined hermeneutics as an in-depth level of interpretation. In line with this, IPA is considered hermeneutic, it interprets and offers explanations through the use of language as outlined by Smith (2009). The nature of IPA points to a process involving the evaluation of a particular phenomenon whereby an interpretation is elucidated. For the researcher, interpretation of the perspective and experience of another is done through an attempt to stay as close as possible to their description, while bracketing one's own understanding, is called "double hermeneutics" as outlined in Smith (2009). It is the effort of the researcher to grasp the insider perspective as stated in Breakwell et al., (2006).

3.6 Rationale for IPA and Compatibility to Counselling Psychology

Informed by Eatough and Smith (2017) and Smith and Osborn (2015), IPA was chosen as the most appropriate method to investigate the experience of the AV. IPA is interested in intrinsic detail to processing both participant and researchers experiences

in creating a new understanding of topics that are usually overlooked, under researched and emotionally laden. Other qualitative methods, Thematic Analysis, have been used to highlight the existence of the AV on a macro level (Tierney & Fox, 2010) and within a social context of aesthetic ideals and female experiences of the body (Moola & Norman, 2017). Little attention has been given to exploring the process of experience of the AV including such aspects of being with the voice, the emotional, cognitive and discourse expression it embodies. In-depth analysis of the AV using IPA has not been done before within qualitative research. IPA as a method can accommodate theory and practice in the scope of understanding AN as it upholds merit in creating a new understanding of a phenomenon of AN because it stays true to the phenomenon's essence. In uncovering the meaning of an experience using IPA, the practical implications can be applied to bio-psycho-social theoretical models in treating E.Ds.'

It's a fundamental requirement to align the epistemological position of both the researcher and chosen qualitative method. IPA leans in the direction of a constructivist epistemological stance in that, individuals, based on the world they live in, construct their own meaning of that world (Rasmussen, 1998). Counselling psychology commits to a journey of exploring subjective, intersubjective experiences, facilitating growth and accepting that individuals are both social and relational, in essence, the Other is welcomed into the therapy room (BPS, 2009; Cooper, 2009). Yeh and Inman (2007) attest, IPA shares CoP values, it aids with the process of voicing experiences that may otherwise be unheard and uninterpreted. Both IPA and counselling psychology use

reflexivity to bracket preconceptions about the research as well as encompassing the same epistemological position. As discussed by Denicolo et al., (2016), both IPA and counselling psychology recognise research cannot be completely neutral.

3.6.1 Alternative Methods

Other methodological approaches were considered and discounted such as Discursive Analysis (DA). Both DA and IPA are interested in individual subjectivity within the context of the discourse of an individual's feelings and individual behaviour. However, DA is closely aligned with social constructivism as its epistemological position and the belief that language upholds the basis for ones understanding of social reality. Meaning and knowledge is constructed through established social categories and shaped by social rules (Willig & Stainton-Rogers, 2013). DA emphasis on language brushes away the importance cognitions play in sense making, in IPA this is a crucial component of how one interacts, engages with and makes sense of such social categories and rules (Smith, 2015). As the primary focus in this study was not on gaining a socio-linguistic understanding of meaning produced by discourse, instead the researcher wanted to focus on the 'sense making' of how individuals understood their experience from a more internal perspective. Reflectively, this type of method allows the researcher to take a constructivist approach concerning how an individual uses language to construct versions of their world, resulting in discourse being constructed rather than reflected. If this was applied to the AV investigation, it would mean looking at how discourses have effects in the social world that are 'real' in terms of the life experiences

people go through, Burr (1995) defines discourses as meanings, metaphors, representations and statements amongst other things, whereby taken together, produce a version of events. Different discourses can centralise around a person or a topic and frame it in a certain way as if that frame of reference is based in reality. An example of this in relation to this research topic would be, categorising those who claim to experience hearing voices as somehow uncanny and removed from others in some way constructs a subject position that can be taken up by individuals personifying the discourse, so too can others in society position those individual's in that manner (stigmatise them and mislabel them as psychotic). The discourse around voice hearing is stigmatising at best and a social pariah at worst, for AN individual's to be viewed in such light on expression of an AV when already seeking mental health treatment is a very real threat to their social and individual status. As Burr and Dick (2017) put it plainly, practice is the realm in which discourse has real effects upon people. Investigating the AV using DA would mean looking at the wider social implications of discourse such as 'hearing voices' or 'hearing ones illness' in AN, and would involve an emphasis on power, meaning, how these discourses would play out in mental health settings treating AN because individuals may be constrained by this. Again IPA, was favoured because it was concluded that interpreting the AV using IPA`s methodology was considered a more appropriate method in staying true to the research aims, which surround the persons experience as related to emotion and cognition and IPA can do this better than DA could on this occasion.

Grounded theory (GT) and IPA share a similarity as both methods draw on themes through the process of systematic analysis, however, differ in respect of GT principles being based on action and interaction formations shaped by society and culture as per Pickard (2013) and Frost (2011). In addition, micro-level individual experiences are not the centre of focus. Moreover, Charmaz (2006) affirms, empirical data is ultimately drawn to macro level concepts and theories. In contrast to GT, focusing on macro-level importance, IPA offers a subjective account of individual states and experiences in relation to a particular phenomenon that would otherwise have been unnoticed or overlooked. IPA does not seek to explain the phenomena or processes constituting it but rather bring into awareness what the experiences of 'being in the world' with the phenomena is like, as described by Heidegger (1962) and Frost (2011).

GT is prominent throughout AN literature with studies investigating the anorectic individual's sense of self (Williams, K., 2016), personality characteristics that contribute to anorexic prototypes (Wechselblatt et al., 2000) and GT has been used to define what body experiences mean for individuals through the course of weight restoration treatment (Fendel et al., 2018). IPA is better suited to under-researched populations and was chosen for this reason in relation to this research topic. Reflexivity has received explicit attention in GT in the past two decades and out of respect of addressing the effects of researcher-participant interactions (Hall & Callery, 2001) however, the same researchers also argue that GT in-of-itself offers reflexivity via the researchers 'use of

self' in the process of developing the research question and conducting analysis therefore, a reduced importance of reflexivity was not unusual in GT's early days. More recently, Charmaz (2014) the founder of constructivist GT, stresses reflexivity importance in all aspects of GT and Gentles et al., (2014) emphasises the "relative recentness" of reflexivity use in GT but none the less suggests its relevance. In line with Kasket (2011), reflexivity adds a greater bracketing force to the researcher's assumptions and interactions with the research that could compound it or alter the natural expulsion of rich data surrounding the investigated phenomenon. In the application of GT to the AV in anorexia, attention is directed to a study by Jackson et al., (2011) titled, *Developing positive relationships with voices: a preliminary Grounded Theory*, here, the researchers explored the phenomenon of 'voice hearing' within a relational framework. In regards to the AV, using GT to explore the anorexics experience in a relational framework could be informative if particular attention was given to AV hearers who view the experience positively. Considering the AV is initially befriending of the person at the onset of illness, it would be of interest to see what mediating factors impact on the relationship with the voice at this stage. GT is a qualitative methodology that could address some of these queries. However, this was not the intent of the researcher upon embarking on AV investigation and so future research might consider this avenue of enquiry. Moreover, GT principles of constructivism state reality and knowledge is embedded in social processes therefore, the underlying phenomenon of the AV could not be fully explored with a GT

lenses and so IPA was employed to make sense of and interpret the meaning of private thoughts and feelings about the AV.

Applied Thematic Analysis (ATA), best suited to large data sets, draws on the non-observant position to the use of language within a narrative and uses coding to pinpoint thematic commonality (Guest et al., 2012). The superordinate themes in IPA guide the researcher to more intrinsic meaning making called subordinate themes and so IPA delves into deeper analysis of a particular phenomenon than what ATA can illustrate. There is also an oversight of intrinsic focus on convergence and divergence of participants narrative in ATA when drawing up themes as outlined in Braun and Clarke (2013).

ATA falls under an ontological position of bounded relativism with a social constructionist epistemological position allowing for a large quantity of data that seeks understanding of common experiences within a human, social and cultural context. Contrasting this, the ontological position of the researcher is critical realism, capturing one's reality via critical examination, the phenomenon of the AV and the reality of its experience is channelled best through the methodology of IPA. As per Forrester (2010), the critical realist position formulates that knowledge is unique to its context, place and time and not objective, this means it`s open to be influenced through various perceptions. In using ATA in exploring the AV in anorexia, the advantages lie in ATA's advantage of gathering a large quantity of qualitative data pertaining to AV expierence, ATA offers this route via analysis of and providing themes to numerous resources such as diaries,

qualitative surveys, vignettes, secondary sources, story completion tasks, creative art work and creative writing and poetry. All of which would provide rich and varied insights. With subtle similarities between IPA and ATA the researcher fundamentally wanted to ask experiential questions while basing the analysis of interview data within a phenomenological framework therefore IPA seemed the more credible method of going about this. It was ultimately decided ATA was discounted for preference IPAs experiential account and use of a small sample size.

3.7 Procedure

3.7.1 Participants

In line with IPA guidelines (Smith et al., 2009; Smith, 2015), six participants were deemed an appropriate sample size. Homogeneity of the sample was achieved by recruiting participants who met the criteria for the research, in that respect they were all female, had an AN diagnosis, defined themselves as AN recovered, experienced the AV and this term resonated with them. Albeit, they had a diverse mix of personal variables (i.e. race and age). Nagy Hesse-Biber & Leavy, 2006) state, homogeneous sampling in qualitative research seeks members similar to one another, this may be that they share the same race, gender etc depending on the research question, equally and important to this research, homogenous sampling is appropriate to gain in-depth understanding about

how these people grouped together for the research study think about or experience a particular issue, in this case, the AV.

. All six participants were interviewed over the course of 4 months. All interviews took place remotely via Zoom Conferencing© (2016) which allows for a password protected interview access link.

3.7.1.1 Participant Demographics

The participants were all in remission of their ED. All participants had sourced information about the research project through various ED support charities or via an online media account set up for the purpose of recruitment. The charities have not been mentioned in the participant description table to protect confidentiality. Pseudonyms are used throughout this thesis, including Table 3. to protect participant anonymity.

3.7.1.2 Inclusion and Exclusion Criteria

Participants were required to meet the inclusion criteria of having received a diagnosis of AN in the past. Participants were required to be AN symptom free i.e. recovered or in the latter stages of recovery from AN. It was expected that identifying as recovered, they might have experienced a shift in their sense of self and be able to talk about how the AV impacted their experience. It is fair to say, recovery is an arbitrary concept, the nature of recovery in this context is framed as leaving the illness behind and returning to life or ‘normality’. The researcher was guided by De Vos et al., (2017)

concept of AN recovery criteria, AN recovery is considered the remission of eating disorder pathology, thus increased dimensions of psychological well-being and self-adaptability/resilience, a decrease in eating disorder behaviour and cognitions and renewed autonomy. In particular participants, were required to be discharged from NHS ED services treating AN as NHS ethical approval was not sought for this study. In addition the researcher thought deeply about the recruitment aspect of the research in considering criteria for inclusion whereby having read Armstrong et al., (1992) summary of participant characteristics often associated with poor recruitment response, many characteristics play a part in poor recruitment. Two of those characteristics stood out in terms of contemplating the participant sample for this study, (i) persons with recent illness or poor present health and (ii) those engaged in high use of medical care. Bearing these two characteristics in mind and pre-empting the ability to recruit enough participants, the researcher and supervisory team agreed to include participants whose AN and AV experience was located in the past and considered recovered in line with the criteria mentioned above.

Further, participants were required to be based in the United Kingdom including Northern Ireland and the Republic of Ireland in order to participate. Conclusively, upon staying true to IPA frame of allowing participant experience to come through in all its raw essence as much as possible the researcher was mindful of not implying the AV experience is aligned with pathology i.e. hearing voices as associated as a symptom of psychosis. The researcher therefore, upon deep discussion with the supervisory team

deemed using a hearing voices screening questionnaire such as Beliefs about Voices Questionnaire (BAVQ-R) (Chadwick et al., 2000) which measures beliefs, feelings and behaviour associated with the experience of hearing voices in five subscales (malevolence, benevolence, omnipotence, resistance, engagement) would be inappropriate, misleading and potentially stigmatising of the participant experience of and their understanding of their AV experience. No 'hearing voices' related questionnaires were used in the study. The researcher collected information from participants such as asking if they had any other metal health diagnosis. The researcher, upon starting the interview would clarify that the title of the study resonated with the participant in that they felt their AV experience aligned to that of a 'voice' associated with AN illness. However the connotations and issues arising from talking about the AV in the context of 'voice hearing' has since been reflected on in great depth by the researcher and can be seen in the reflexive statements as well as addressed in the introduction and literature review sections of this study.

Table 3
Demographic Information

	Participant	Age at Interview (years)	Years with AN Diagnosis (years)	Current Living Status Characteristics	Country of Residence	Additional Mental Health Diagnosis
1	Sam	19	2	Living with parents	Scotland	Anxiety
2	Jillian	24	9	Living with spouse	Northern Ireland	Depression Anxiety PTSD
3	Vanessa	36	8	Living with Spouse	Ireland	-
4	Linda	27	14	Living with Spouse	Northern Ireland	Anxiety Depression
5	Beth	24	2	Living alone	England	Anxiety Depression Unspeci-fied Phobic disorder
6	Rachel	20	5	Living in student accommodation	Northern Ireland	Depression

3.7.2 Recruitment

Recruitment followed IPA recommendations of a small homogenous sample size. When 6 participants were interviewed and data analysed, recruitment ceased. Recruitment from the UK, Northern Ireland and Republic of Ireland involved the distribution of an information flyer (Appendix B) to various ED charity organisations (Appendix I).

3.7.3 Interview Schedule

The researcher was familiar with the interview schedule. It was discussed within supervision. Using open ended questions with additional prompts stimulated greater quality data (Appendix G). A participant distress protocol was included and used if necessary during the interview (Appendix E).

3.7.4 Interview Process

Participants could meet at London Metropolitan Library or online via Zoom Conferencing©. If requested, the researcher would opt to travel to the participants home with an appropriate risk management plan (Appendix H). Firstly, the information sheet was reviewed (Appendix D). The informed consent form and audio consent form were then introduced (Appendix A and C). Upon verbal consent, the participant was invited to then sign both consent forms.

Interviews lasted between 60 and 100 minutes. According to Smith et al., (2009, p. 60) interviews can last between 45-90 minutes. The additional time listed here is the

totality of time that elapsed when the interview began thus including introductions, after interview process of sending the debrief etc which was discussed with the participant is all included in the total time. An identical semi-structured schedule was used with each participant, depth of exploration varied between participants. Questions remained open ended, allowing the participant to formulate thoughts and express them freely this is considered good practice as per, Loiselle et al., (2011). Coming back to the interview schedule in an attempt to cover all relevant areas of discussion was done throughout the interview process. Time was allocated at the end to invite the participant to discuss anything they felt was important but didn't get an opportunity to say.

Debriefing (Appendix F) was carried out when the interview ended. Debriefing allowed time for observation and to address any risk to the participant. A reflexive diary was kept by the researcher after each interview ended as a means of personal reflection.

3.8 Ethical considerations

3.8.1 Ethical Approval

Ethical approval was sought and granted by London Metropolitan University Research Ethics Review Panel (Appendix N).

3.8.2 Confidentiality and Anonymity

Following the BPS Code of Ethics and Conduct (2009) every effort was made to protect the true identity of the participants. Maintaining anonymity is vital, a pseudonym is used throughout to uphold anonymity. Every effort was made to protect

confidentiality. Informed consent forms along with personal participant details are securely stored separately to written transcripts. Identifying information is permanently deleted from interview transcripts and audio recordings. Audio recordings are protected on an encrypted, password protected audio device and stored in a locked safe under the responsibility of the researcher.

3.8.3 Informed Consent

Inclusion criteria stated participants had to be over 18 years, have a diagnosis of AN, have fluent spoken and written English with capacity to give informed written consent. A flyer (Appendix B) and a description of the research was given to the participants (Appendix D). A contract of participation was signed by both the participant and researcher which stated consent had been given for the interview to be recorded and transcribed for the purpose of the research (Appendix A and Appendix C). Participants were required to be recovered and discharged from inpatient or community services at least 6 months at the time of interview. Participation was on a voluntary basis, no incentives were offered. There is no conflict of interest or affiliation with the chosen charities on behalf of the researcher.

3.8.4 Debriefing and Distress Protocol

A reminder was given of the right to withdraw from the research up to 2 weeks after interview. A debrief form was issued (Appendix F). The debrief included a list of supportive organisations and the researcher and supervisor`s contact details.

In the instance of distress, the researcher followed the distress protocol (Appendix E). This was devised in collaboration with the researcher's supervisor, the researcher was familiar with it. If participants found a question distressing they were free to decline answering.

In the instance of participant unavailability to travel to London Metropolitan University for the interview then a second location was assigned. A risk management plan was devised for the instance of meeting participants at their home (Appendix H). The researcher would inform a trusted person with the interview address and expected time of return in an effort to minimise risk.

3.9 Method of Analysis

3.9.1 Data Synthesis, Analysis and Interpretation

Regarding IPA analysis, the researcher has followed Smith et al. (2009) 6 steps: 1. reading and re-reading, 2. initial noting, 3. developing emergent themes, 4. searching for connections across emergent themes, 5. moving to the next case, 6. looking for patterns across cases (Smith et al., 2009, pp. 82-107).

Interviews were recorded and listened to numerous times. Each interview was transcribed and read numerous times. The left hand margin of each printed transcript was used to note unfocused observations, thoughts, language use and initial musings, the overarching heading for this process was titled exploratory comments. This process allowed salient and significant ideas and emerging topics to be highlighted in which they

captured the participant's accounts of their experiences. Smith et al., (2009) stress the importance of staying close to the semantic content to identify the way in which the participant talks about, makes meaning of and thinks about the phenomena. Staying close to the data gives space to identify idiosyncrasies revealing unique individual experiences (Smith et al., 2009). These notes were used to create preliminary concepts as each transcript was further annotated, by making interpretative notes in right-hand margin, the overarching heading on the right-hand margin was titled emerging themes. Continuously revisiting the notes in relation to the transcript was necessary to identify themes and emerging and connecting relationships. Helpful in this process was the in-depth concentration on the participants' use of language. In engaging in their use of language, interrelating patterns developed organically from their comment, this helped provide additional content and meaning. Correlated words were clustered together on a separate sheet of paper in an attempt to produce a representing overarching concept or sub-ordinate theme as they emerged from the words used by each participant, this was done for each separate interview.

This process amounted to the researcher becoming influenced by a particular transcript which transpired to seeking similar thoughts/comments in other transcripts. Getting caught up in this meant the researcher was required to pull back from assumptions and expectations and use the reflexive diary to help 'bracket' assumptions and expectations in an effort to keep them separate from participants' actual experiences.

An electronic Microsoft Word© document of the transcript was created. A table was devised, the overarching heading inserted was developing emergent themes. There were three columns in the table, the left column heading was exploratory comments, the middle column was original transcript and numbered sentences finally the right column was titled Emerging themes. A list of all emerging key themes was noted on the right hand margin alongside the referenced page number and transcript paragraph. There are superordinate themes in IPA and subsequent sub-themes. Both Super-ordinate and subthemes were put into a table with the corresponding paragraph number and related quotes. Themes gathered together forming super-ordinate themes are comprised of both the researcher's interpretations and a reflection of the participants description. The integration process was cyclical, meaning, checking the raw data closely to ensure that the themes made sense, stayed close to the participants experiences and were as much as possible redundant from the researchers assumptions but remained true to the organic unfolding of the participants' experiences. Themes that were not well represented, meaning they didn't flow with the other themes, they didn't represent the true raw data etc. were excluded. Remaining themes are considered representative of the whole sample.

Similarities and differences between themes, across all interview transcripts, was done via the process of abstraction and subsumption, finally, grouping them into one large table for comparison (Appendix M). Abstraction (Appendix K) is a process of clustering similar emerging themes related to a wider context. Subsumption (Appendix

L) is the process of pulling superordinate themes together from the clusters devised in abstraction. All the corresponding themes were analysed, and similar themes were given labels that identified their conceptual nature, this was done in accordance to ‘good practice’ as described by Smith et al., (2009). The researcher created names for the clusters, these were discussed in meetings with the primary supervisor to ensure the analytic process was on the right track. This process of liaising with the supervisory team meant revisiting and relabelling emergent themes to allow the development of a more comprehensive clustering. Thereafter, in a separate table, all listed themes were grouped alongside their corresponding labels, paragraph numbers and quotes. This process gave clarity and organisation to the data in the form of common themes which helped with the process of writing the narrative. The aim was to produce over-arching themes that represented the individual lived experience of each participant as best as possible while also representing higher-order theoretical ideas. An example of the transcript analysis process, that of participant 1 (Sam), participant 2 (Jillian) and participant 3 (Vanessa) is located in Appendix L.

Each interview transcript was representative of the individual, drawing out distinctions. It was important to ‘bracket’ the themes that emerged in one transcript from the subsequent transcripts and to treat each transcript independently. This process aids with the emergence of developing themes.

3.9.2 Four Principles of IPA

Qualitative methods ensure validity and reliability via data analysis, third party theme verification and reflexivity (Willig, 2001; Smith, 2008) The four principles of IPA guide quality. Smith (2008) describes the principles as flexible and pluralistic.

Firstly, *sensitivity to the context* as is described by much of the IPA literature means an emphasises on the importance of 'immersing' oneself in the data (Smith, 2008;l Smith et al., 2009). From this immersion emerges patterns and meanings reflected outward from participant narrative. Reflexivity and attention to interpretation produce fruitful interpretations that are close to the participants truth (Overenget, 2004).

Secondly, *commitment and rigour* refers data attentiveness during analysis. The degree to which the recording was internalised and each transcript analysed, demonstrates commitment. Rigour is demonstrated through the data collection including sufficient participant numbers.

Thirdly, *transparency and coherence,* identified via reflexivity. Honesty regarding intent and assumptions around the investigation of the AV lends to the readers assessment of the researchers' interpretations and conclusions. Transparency is evident in the methodology. The written narrative offers the reader a coherent, rich account of the AV and its intrinsic effects and meanings as described by the participants.

Lastly, *impact and importance* states what the research offers the reader, something of value, importance and use (Smith, 2008). The researcher is focusing on an

intrinsic characteristic of AN in an effort to shed further light on the aetiology of AN. Participant participation is evidence of the importance this topic holds for individuals who shared their experience.

METHODOLOGY REFLEXIVE STATEMENT

This reflexivity statement offers validity to the analysis as I reflect on the recruitment and interview process. Reflecting on the recruitment and interview process, a prominent aspect stood out. The consideration of the participants' viewpoint of the novel term 'anorexic voice' used in conjunction with the recruitment flyer mentioning 'auditory verbal hallucination' (AVH). I engaged with the thought processes of the women in relation to this term. This may have been encouraging for some women to speak about their experience of this phenomenon but also off-putting to others, namely those who did not feel confident disclosing this and may have created a selection bias in the participant sample. In devising the recruitment flyer of this research, I failed to fully appreciate the stigmatic attitudes in relation to hearing voices. I was not unaware that the term AVH was synonymous with symptoms of psychosis and schizophrenia, however, AVH are also known to occur in both the general population and varying other mental health diagnosis (Johns et al., 2004; McCarthy-Jones & Longden, 2015) nonetheless stigmatic attitudes negatively impact those who hear voices as per Corstens et al., (2014). This is something I could have reflected on in greater depth when considering the terminology. I failed to consider the full impact of my assumption that an AVH is entirely synonymous

with an anorexic voice experience, partly because I was also holding in mind other similarities between AN and psychosis as per my experiences of working on an eating disorder ward. One such similarity, an AVH occurring alongside the loss of contact with reality or lack of insight as per Fernyhough (2016) is not confined to psychotic experiences because loss of contact with reality or lack of insight are well documented in AN literature (Bruch, 1962; Vandereycken, 2006). Additionally, the experiences previously reported to me by patients were not dissimilar to those outlined in the psychosis literature describing an AVH as an auditory component occurring in isolation of corresponding external stimuli and accompanying a strong sense of reality as per Alderson-Day (2016) or a vivid perception of hearing one's own thoughts spoken by an unknown voice (Humpston & Broome, 2016). Alongside that, I was aware of how voice characteristics such as power and malevolence as depicted in the AN voice experience are not altogether dissimilar to those described in psychosis literature pertaining to some experiences of an AVH (Pugh & Waller, 2017). Lastly and importantly, at the time I was drafting the research flyer, the terminology for describing the inner voice experience in anorexia was limited. The term 'eating disorder voice' was dotted throughout the eating disorder literature, but to use this implied non-specification of the type of eating disorder being investigated and I was specifically looking at anorexia. The first time I came across the term 'anorexic voice' and the first time I had seen the eating disorder voice referenced this way, was in a published paper by Pugh (2016). This paper came to my attention as recruitment flyer was drafted, I felt including both terms, anorexic voice and AVH,

would perhaps grasp the full concept of the phenomenon I was investigating and reach those who could identify with one or the other or both terms.

It was apparent from the interviews that a preference was reported for the term anorexic voice over AVH. Participants reported disclosure of hearing voices provoked fear in being sectioned under the mental health act or being perceived amongst their community and family as deviant. This created a tension between the 'clinician' and the 'researcher' in me as a counselling psychologist trainee. This tension contributed to finally deciding to use the term 'anorexic voice' for the main title of the study in order to be specific and clear in what I was referencing and to maintain consistency alongside new research discussing the same phenomenon using this terminology.

In preparation of my first interview I acknowledged my role would switch to interviewer and researcher rather than therapist. I read about conducting interviews when using an IPA methodology and so Smith, Flowers & Larkin (2009) helped navigate me as I familiarised myself with example interviews and grasped the flow between interviewer and interviewee. This was helpful to adjust my interaction slightly with the participants as I refrained from too much empathic responding and paraphrasing, as I would be inclined to do as a therapist. Instead, I allowed my interview questions with additional prompts lead me and let the participants talk freely without too much interjection from me.

Assumptions and biases surfaced through the process, it was important to notice them and to notice was going on for both myself and the participants, our impact on each

other and the potential impact on the data. One of my initial pre-suppositions was that individuals with a diagnosis of AN would not be able to fully articulate and express their emotions during the interview, they would present with a rigid, detail focused information processing style. If this were the case, I felt I would struggle to elicit their experiences and be able to explore their meanings by using various prompts and cues. I was aware of how my experience contributed to this view. Seeing patients in a hospital setting, emaciated and unable to engage therapeutically until reaching a target weight has impacted on this viewpoint. That all individuals with AN have a weak central coherence and shallow expression of emotion was an assumption of mine. It has been identified that individuals with AN have a positive bias toward local detail processing, thus a weak 'central coherence'; limitations in seeing the bigger picture, according to Southgate et al, (2008). Additionally Oldershaw et al., (2019) reported individuals with AN display a 'lost emotional self' indicative of the devastating effects of the illness. My projection onto the participants perceived inability to fully expand and articulate subjective experience, meant I reviewed the structure of my interview questions. I allowed for additional prompts and cues to safeguard premeditating instances of silence or constraint in emotional expression. In supervision, and in line with Finlay (2002) position on allowing the participants voice to come through in a manner conducive to them, was deemed crucial, and was not to be blocked out. In review, as I was conducting interviews, I learned I did not need to interject additional prompts unnecessarily as the flow of the dialogue was both expressive and rich.

By undergoing reflective practice I became aware of previously unbeknown blind spots and anxieties which I was then able to bracket appropriately while staying close to the voice of the participant (Finlay & Gough, 2003). Bracketing refers to the mitigation of potentially inimical preconceptions that could skew the research process as per the understanding that the researcher inevitably influences the research (Tufford & Newman, 2010). My commitment to processing surfacing biases and preconceptions was evident in my knowledge that bracketing is an action process an ongoing self-awareness. I conducted regular memoing, reflexive journal writing and kept a dialogue with colleagues to unveil presuppositions that could interfere in the research. Continuing my position of maintaining reflexivity in motion, I came to understand the data collection, my position as a researcher and the method of qualitative research was all interconnected. Therefore, I allowed sufficient emotional and intellectual space after each interview to continue my method of reflexive writing. In this space, I free associated via journaling and pulled out key themes and words through memoing.

To this end, I had several new insights about the recruitment and interview process: disclosure experiences, negative attitudes concerning AN and an awareness of own beliefs and language used with participants.

4 - ANALYSIS

4.1 Overview

This section presents the findings of this study in detail. IPA was used to analyse six participant transcripts. The themes presented hope to offer a detailed insight into the experience of the AV. Themes are structured and presented in chronological order to reflect the aims of the research question. Careful detail was applied to each transcript interpretation, conveying the nuances of each participants subjective experience while staying true to IPA`s objective concerning "double hermeneutics", meaning making as derived from another's meaning making experience (Smith & Osborn, 2015). Each theme is illustrated with carefully chosen participant narrative extracts representative of the theme. Not all themes presented are mutually exclusive but are assimilated and relate to one another. There are three superordinate themes and ten subordinate themes. The themes are structured to allow for a coherent flow of narrative. Beginning with AN onset and initial experience of the AV, a move toward AV evolution within illness maintenance emerges and finally, a focus on AV relational experiences within recovery. Exceptional data, themes considered noteworthy, but lacking overall power and eventually deducted from the final superordinate theme selection, are presented and discussed in Table 5.

Through analysis, the concept of 'voice control' and a 'split self' was prominent in all transcripts. When describing AV onset, narrative accounts consistently depicted an inner experience of peculiarity coupled with a feeling of powerlessness over internal or

external influences. The concept of feeling controlled was expressed at various points throughout interviewing regarding symptom onset, course of illness and recovery experience. 'Voice power' was described as a trajectory, benign at first symptom onset, gaining momentum through the course of illness and heightened at treatment. Temporally, concerns regarding a felt sense of peculiarity and a felt internal separateness seemed to have a consistent presence from the early beginnings of AN until the present day. The analytical process, arranging and rearranging themes, the concept of 'split self' and 'voice power' was broken into smaller segments: master themes and consequent subthemes. Not all themes explicitly discuss and name 'split self', 'control' and 'voice power', it is notable that the thread of these concepts was present throughout the process. The analysis begins by presenting *The Perils of Puberty and Feeling Accepted*, the latter themes, *The Anorexic Voice Battleground* and *Healing Through Compassion* relay the experiences and impact of living with the AV.

Improving readability, short utterance, 'um', 'em', 'eh' and long pauses between words were removed from the transcripts unless considered important to the process of interpretation. Empty square brackets indicate some material of the original transcript has been omitted. Square brackets containing a description refer to non-verbal gestures and communications. Three dots signify a brief pause. All identifying information is removed to protect participant anonymity.

Table 4
Master Themes and Subthemes with Quotes

Superordinate Theme	Subordinate Theme	Quote
The Perils of Self-Acceptance During Puberty	Developing Body	It started all really the disordered way of thinking at 12 when I was an early developed child I began developing larger hips and I began puberty quite early on (Sam, 14-18)
	Emotional Ambivalence About Self	I found the voice got bigger because I was sadder…in my head I thought that if I make myself smaller things will be okay…it's the idea maybe that you make yourself so thin you disappear but that doesn't happen you can't become air (Rachel, 276-288)
	Who Am I Anyway	Try and think of who I am without anorexia because I have had it for years through teenage years and grown into an adult so a lot of my character is taken up by 'I have anorexia' this is my character, but if you separate the two you kind of have to discover who you are without the anorexia (Linda, 168-175)
The Anorexic Voice Battle Ground	The Flight Into Battle	If I feel like something is out of control…but if I feel like my life is kind of feeling a bit spirally is when the voice kind of, is louder …for me personally it was kind of a way to manage social anxiety maybe anxiety about a house move or exams for me it was an anxiety coping mechanism…as a way in addition to bolstering self-esteem and self-worth (Jillian, 996-1032)
	Cognitive Dissonance	At the time, the voice didn't sound completely like mine because some of the things it would say would contradict some of the things I believed in myself (Linda, 304-315)

Superordinate Theme	Subordinate Theme	Quote
Healing Through Compassion	Battle Fatigue	[ ] I know obviously people of all ages are [ ] getting effected by eating disorder but within myself I don't think that I would have enough strength to cope with that like even vomiting it's such an exhausting experience like I cannot even imagine spending one day like that, one hour [ ] so exhausting and a young body is much different than mature body I'll put it that way [ ] Yeah it's really hard to imagine that I could live life like that (Vanessa, 387-400)
	Reconciliation	Even in full recovery I imagine you still have to check yourself and still have to kind of go "right I'm not feeling great today I need to be aware here" I imagine that's the way it's going to be forever (Linda, 1046-1053)
	Being Nice to Oneself	Like now when I am having my internal dialogues sometimes I will criticise myself, but I will not act upon those critics. Like sometimes I will look into my body and I am not always completely happy with the way I look, but I won't have the need-the voice is not there to say `now you need to, I don't know cut yourself because a piece of fat. But now I am like `oh yeah it's there` I am not very happy because of it, but I am not going to hurt myself (Vanessa, 933-947)
	Reclaiming	For me I think I have at least found ways to quieten at least, even if it's still there but just to be perhaps, like how I can stand up to it (Beth, 591-594)

4.2 Master Theme 1: The Perils of Self-Acceptance During Puberty

The first master theme has three subordinate themes. Four participants referred to the subordinate theme '*Developing Body*'. Five participants appear in '*Emotional Ambivalence About Self*'. All participants appear in '*Who am I Anyway*'. Participant 6, Beth, alluded to concepts of '*Developing Body*' and '*Emotional Ambivalence About Self*', however a sufficient quote could not be extracted from the transcript to fully support incorporation into the master table. Participant 3, Vanessa, described AN onset occurring later into adolescence as a result of a bereavement and so the lack of a suitable quote for '*Developing Body*' is absent from the master table.

The master theme covers the period preceding onset of anorexic symptoms, namely, puberty changes, or in the case of participant 3, Vanessa, bereavement. Accounts relating to this time period refer to the initial awareness of the AV its role in steering developmental changes. This process of change is mediated by a struggle to differentiate a sense of safety within self from a threatening process. Moving away from illness identity and feeling inconsequential on both a micro and macro level are also pivotal aspects of this theme.

4.2.1 Developing Body

Four participants spoke about puberty onset. Altogether they felt ambivalent about bodily changes highlighted with utterances like "developing larger hips", "hefty", "fat", "the elephant in the room". Sam expresses an example of this in the following excerpt, "It started all really the disordered way of thinking at 12 when I was an early

developed child I began developing larger hips and I began puberty quite early on" (Sam, p. 1, 14 - 18)

Noticeable cognitive changes are labelled "disordered". The language used is reflective of her CBT therapy experience. Development is occurring in the body of a "child". A sense of childhood being taken away too soon permeates. A feeling of fear radiates as puberty was understood to be occurring prematurely, impacting cognitively and physically. Below, the reader is directed to Jillian's account.

> I would have perceived myself as a bigger child...farmers daughter type build [ ] rather than a lot of the people that were in my class at school were kind of very dainty and quiet pixie like I very much and was also the tallest of all the boys as well...I kind of very much felt like the elephant in the room (Jillian, p. 27, 889 - 900)

A self-critical analysis of self within a societal context radiates. An expression of self in comparison to others, propels body shame, highlighting her experience of feeling like an oddity. Perhaps the whimsical description of a delicate physique is a wish to remain suspended within the safe realm of childhood, bound within a childlike body. A feeling of loneliness comes through. Emphasising separateness, a derogatory, historically offensive word for heavy set people is used, it seems Jillian is body shaming in retaliation against unstoppable change. Below, Linda offers her experience.

> I was a teenager there was a lot of denial around it, so I had denied there as a problem, at the end of the day I was just losing weight because I was quiet hefty prior to that you know for the lack of a better term, hefty (Linda, p. 1, 27 - 32)

As can be seen above, confronting hidden and previously non acknowledged issues, Linda's excerpt earnestly asserts "at the end of the day I was just losing weight because I was quiet hefty prior to that". Feeling larger than what is perceived acceptable, a sense of self-peculiarity is illuminated in all three women's accounts. Startlingly, Linda also self-criticises with "hefty". Below, Rachel offers her experience.

> I had quiet low self-esteem through primary school sometimes quiet badly bullied and to me I would have defined myself as a fat child because I, my parents fed me well is all I can say so I had always noticed I was different, different size so that was always conscious in my head (Rachel, p. 9, 265 - 272)

Lowered esteem and being bullied, left a feeling of great sadness here. Rachel attributes blame on her body. Akin to Sam, Jillian and Linda, the descriptive nature of being perceived as physically sizable is erroneous. Stating she always felt different, reinforces distance from others was present in the face of feeling peculiar as well exasperating low self-worth and value as a result of bullying experiences. Highlighted here, feeling rejected by peers and feeling unsafe within the process of change.

4.2.2 Emotional Ambivalence About Self

A pervasive sense of ambivalence about oneself that five participants felt regarding a changing body impacted a sense of worth and value. Value and worth was contingent on perceived body acceptability to maintain a sense of coherence during uncontrollable bodily changes. The AV is accounted for in three of the narratives and is consistently present, reactive to affect and an acting mind manager. Central to this theme, an expressed volatility regarding adjustment processes, coupled with, feeling inconsequential on both a micro and macro level. Starting with Sam the reader is directed below for her excerpt.

> this type of body was sort of unacceptable you know I was coming into a larger female body and I wanted to be like the other females especially at that age in my class so yeah I started off with a really restricted diet (Sam, p. 1, 21 - 27)

Fear, anger and retaliation emanates. Feelings of disgust come through in stating “this type”. An adult female body is “larger”, meaning, it`s segregating Sam from her childlike peers. Here, a sense that change came too soon, prematurely severing her identity as an age related female and child amongst her peers. Below, in Jillian’s account discontent is present in relation to body changes. This is in the context of receiving treatment for AN.

> when I put on half a pound or whatever the internal voice was freaking like just we need to get this under control, we need to get this sorted, we need to put a stop to this, we need to like get a handle on this in some capacity or when I was

> being weighed or weighing myself and I had put on weight be kind of like sort of … a lot of it for me when I am my most sick is it kinda becomes verbalised and then when I, in terms of your… you feel you kind of let go, you've let yourself go would be the actual words in my head (Jillian, p. 4, 105 - 117)

Jillian reported struggling with the voice in recovery when the AV demanded weight reversal. Jillian describes an internal dialogue urging her to regain control, as if acting as a mind manager. Chaos ensues and is indicative of the role her body plays in a sense of internal cohesion. A sense of something unmanageable and dangerous appears with weight inspection, it seems to have felt unbearable. A sense of defeat and shame is felt when recounting the AVs ridiculing conclusion of her. In the excerpt below, Vanessa's intrinsic sense of uncertainty about her physical appearance and evaluation of perceived competence were altogether floundering and prominent throughout childhood.

> I think it's, how do I put this, I think that my self-concept and my image of myself and my self-esteem were never in a really good place…and when growing up and…I think that my eating disorder and that voice, it was just a solid foundation of something that existed since forever (Vanessa, p. 22, 721 – 729)

Vanessa described how ED, and separately, "that voice", may have been "a solid foundation" a permanent and everlasting experience. A pivotal moment met with compassion by the researcher. Perhaps what Vanessa is depicting is the ED and AV emerging out of a motivational and cognitive need to maintain, enhance or preserve a

vanquished sense of worth and value felt, “since forever”. Later in the interview and coupled with this pervasive feeling of low worth, Vanessa disclosed bereavement was a trigger for AN onset. Following this is Linda’s experience depicted below. Linda’s negative self-evaluation is depicting a global sense of personal ineffectiveness.

“It doesn’t matter it’s just if you step on the scale that morning your heavier than you were yesterday then confidence is completely gone in your job...in whatever you’re doing it`s just impacting on every part of your life” (Linda, p. 13, 407 - 412). .This opening line is wroth with feelings of fear as her insecurity and felt inadequacy soaks into every crevice of life. Communicated here, a comprehension of worth and value contingent on weight. In the excerpt below, Rachel goes on to ascertain her experience in the following.

> I found the voice got bigger because I was sadder [ ] and it became more of a coping mechanism for the world around me [ ] because in my head I thought that if I make myself smaller things will be okay [ ] it’s the idea maybe that you make yourself so thin you disappear but that doesn’t happen you can’t become air (Rachel, 10, 276 - 288)

The voice intrudes with sadness onset, an observation that the voice at this point served as a protector, a coping mechanism. Prior to this, Rachel reported strong emotional expression meant weakness. The draw to “make myself smaller” implies a compromising proposition to dampen feelings of sadness through body modification or emotion eradication. The voice is an acting mind manager in the face of threat. Reality

checking, Rachel demonstrates an inquisition pertaining to previous cognitive processes "that doesn't happen you don't become air".

4.2.3 Who Am I Anyway

All of the participants reflected on self-concept in relation to AN. This subtheme includes feeling a divide within oneself. Feeling both a union and dissolution between self and illness, illness identity and labels are explored in the context of discovering selfhood in relation to AN. Prominent emotions evoked and expressed include, anger, acceptance and loss. Overarching this theme was the concept of arrested development. In the following extract Vanessa describes herself in relation to the AV during early stages of illness onset.

"I felt it was 98% the voice and only 2% of me in there" (Vanessa, p. 6, 168 - 169) This split is portrayed disproportionally. Clearly communicated is felt insignificance, echoing her previous excerpt. "2% of me in there" ties in with the question of who she is amidst the dominant presence of the voice. Following on from this is Sam's narrative in the quote below.

> I've always gone against what I wanted to do in a way, and I would say that that has really fed into my identity but also in terms of seeing my eating disorder as not my identity but in a way not being ashamed of the experiences I have been through so it does make up a part of who I am and you know I can`t change that [ ] I don't know who I would have been, or you know who I would have grown up to be without…should I not have had my eating disorder [ ] I try and sort of

> get back to who I want to be instead of what my eating disorder wants me to be (Sam, p. 17, 485 - 492)

"gone against what I wanted to do in a way", implies a continuous level of denial regarding pursuit of true wants and desires, impacting a sense of wholeness and identity. Not feeling "ashamed" a retrospective pondering occurs in respect of how self-concept might have evolved without AN. Echoing Vanessa's account, a sense of self without ED is non-existent, aspects of Sam have been moulded by AN. Redefining self, reworking and retracing steps highlights a sort of arrested development. Jillian was home-schooled, she had chronic fatigue syndrome prior to AN. A sense of isolation and vulnerability is felt in the narrative below.

> I don't feel it has affected my identity now because I have other interests whereas at the time I wasn't able to do anything because I was so unwell [ ] it was probably one of the only things that I had [ ] I wasn't able to go out with friends, I wasn't able to sit my exams I didn't have another identity outside of my eating disorder really [ ] and I was too unwell to establish one I think (Jillian, p.16, 533 - 547)

The concept of purpose and direction through the action of engagement is illuminated. A sense of identity was impacted by a lack of external engagement, resigning herself to being ill depicts powerlessness. Isolation meant little opportunity to develop a core self. At the time of the interview, having "other interests" enriched a later sense of identity, "It hasn't effected my identity now". Illness and identity fusion come

through “it was probably one of the only things that I had”, being physically unwell reduced experiencing fundamental needs of connection and achieving. From the excerpt below, Linda`s narrative implores renewed discovery echoing her previous disclosure concerning acceptance and reducing AN denial.

> try and think of who I am without anorexia because I have had it for years through teenage years and grown into an adult so a lot of my character is taken up by ‘I have anorexia’ this is my character, but if you separate the two you kind of have to discover who you are without the anorexia (Linda, p. 6, 168 - 175)

Stating AN is an intricate part of life, ambivalence appears as an underlying tone. The concept of letting go or evolving without AN is discussed. Ambivalence is penetrable with the idea of separating herself from AN. The reader is now directed to Beth’s experience as narrated below. This bleak revelation paints a picture of vitality being stripped away.

> I guess because it has taken away all of my hobbies I used to enjoy and I also I was quiet [ ]…and spontaneous [ ] my life is ruled by instruction, and that I can’t really go anywhere… I feel bound by rules (Beth, p. 16, 477 - 490)

There is a felt sadness and loss, a feeling of isolation similar to Jillian’s account. An embroiling sense of being “bound” to the illness is present. The echo of Beth and the disorder being two separate selves inhabiting the same space is a common pattern seen

in the previous four women's` account. Mirroring this, the excerpt below relays who Rachel feels she is in relation to the disorder.

> now I see myself as 'hi I'm Rachel' you know, but during that time I was 'hi I`m Rachel I have depression, I have anorexia nervosa, I have…I have, I have, I have' [tone gets louder][ ] at that time I felt I was, Rachel and I am sick [ ] it's taken me a lot of time to go you know this isn't who I am [ ] I am Rachel and that is all I am whereas before it was I am the anorexic person (Rachel, p. 29, 877 - 922)

Frustration permeates here with the need to add mental health labels onto the back of introducing herself. A fusion with mental health labels meant losing her true self in the process as she later discussed. Akin to Jillian, feeling defined by illness feels one dimensional. "I have" is repeated with a noticeable increased tone, illuminating frustration. It feels as though Rachel`s' sense of self is illness bound and hijacked. Time takes centre stage, contributing to her quiet confidence "this isn't who I am".

4.3 Master Theme 2: The Anorexic Voice Battle Ground

The second master theme consists of four subthemes. The first subtheme, *The Flight into Battle* portrays the early stages of AN for four participants. All six participants experience an internal impetus to act or behave in a way that would alleviate a felt sense of disquiet stemming from either internal or external anxieties and stressors. All six women implicate the role of the AV in AN onset, management and negative affect regulation.

With *Cognitive Dissonance*, an overlay of psychological discomfort experienced between consonant and dissonant cognitions and behaviours stemming from AN that ultimately seeped into the other subtheme`s. Within *The Phantasy of Control*, all participants exclaimed how the voice exuded extensive control over every constituent of their body, emotions and relationships. This controlling force it appears, was offering management and security for overwhelming internal affects while simultaneously creating devastating felt consequences accounted for in many of the excerpts. Of the five participants presented in *Battle Fatigue*, mental and physical exhaustion appears as a prominent feature of AN and AV experience.

4.3.1 The Flight into Battle

Each participant shared a similar experience of a felt sense of disquiet stemming from either internal or external anxieties and stressors. Through the process of alleviation, either via changing or adding in a new behaviour or cognition to alter the magnitude of feeling overwhelmed, the input and position of the AV is recounted and affirmed. Some participants describe the role of the AV in relation to anxiety management. Participants discussed the onset of ED symptoms as a means to "to cope with stress", "to get rid of something", "an anxiety coping mechanism". In consequence, a double bind emerges as expressed by one participant who stated, during times of not giving into voice demands, she was left feeling "useless" and perpetually anxious. Another participant discussed a feeling of being blindly side-lined by how quickly the

disorder took over out of her awareness. Jillian begins by discussing her experience as can be seen in the following excerpt.

> if I feel like something is out of control [ ] but if I feel like my life is kind of feeling a bit 'spirally' is when the voice kind of, is louder [ ] for me personally it was kind of a way to...to manage social anxiety maybe anxiety about a house move or exams for me it was an anxiety coping mechanism…as a way in addition to bolstering self-esteem and self-worth (Jillian, p. 30, 996 - 1032)

The AV getting "louder" is mediated by uncomfortable affective states. Associated to the sphere of love and belonging we see "social anxiety". Safety needs are also present with "a house move" as is self-actualisation via "exams". Here, AV volume seems to signal premeditated danger associated with elements of adjustment. It seems, self-esteem and self-worth were reinforced through ED. The concept of adjustment distress, ties back into Jillian's excerpt in *Who Am I Anyway*. Limited social interactions and external outlets, meant a focus inward and utilisation of the body as a tool to foster achievement and satisfaction via AN. ED engagement aided the realignment of an internal sense of chaos, interceded by the AV. Moreover, Sam's felt power from AN could be interpreted as control and mastery but also a form of denial or defence against overwhelming anxiety as can be seen below

> when I felt I was in that power and I had that power I just wanted to you know continue having that sort of power and that's how it got me into such a low

> weight [ ] it was confirmed that I was no longer getting teased or picked on because I had more acceptable body (Sam, p. 3, 79 – 87)

A feeling of jubilation and satisfaction comes from her narrative. Newfound power is an antithesis to her earlier excerpt expressing complete helplessness. The process of physical change had been altered, the confirmation of this success was peer acceptance. The reader is directed now to Vanessa's sharing on how bereavement created a compulsion to omit an intolerable "something".

> when my friend committed suicide I just knew I had to get rid of something and that was the only way to get rid of things then as I was denying food and other things to myself more and more I felt the need to…to convince myself that it wasn't me doing that to myself so I basically I created a monster [ ] basically I entered the world of eating disorders not even knowing what it was it was after a series of few events in my life, being physically sick and losing some weight and my friend committing suicide [ ] and yeah it was basically a combination, I lost weight and I liked it (Vanessa, p. 3, 75 - 100)

Vanessa demonstrates vulnerability in her connection to painful affects, this shows a reflexive capacity in her openness. Vanessa describes the creation of a monster borne out of a conviction that her actions may have been perceived as objectionable. The need to distance herself from bereavement and ED behaviours meant displacement onto the creation of a monster, a separate Other. Like Sam, Vanessa also experienced satisfaction. As for Linda, her account is as follows

> it was at the back of my head but I had no time for it and then in there was a whirlwind of things happened my grandfather was diagnosed with cancer [ ] my grandmother was diagnosed with terminal cancer at the end of the year and in the middle there was [ ] us buying a house and it was very stressful and in September time it started moving creeping in and then it took over my life more and more (Linda, p. 2, 62 – 71)

A series of arduous life events was central to AN onset. An acceleration of circumstances felt threatening to perceived internal cohesion. Hopelessness envelopes potential loss with Grandparents diagnosis`s, a sense of a rapid snowballing effect emanates bringing on uncertainty and chaos. A feeling of being blindsided comes through, insinuating a quiet shift and dissociated engagement with ED becoming observable once its position in her daily life became blatant. For Beth and her experience below it is noted it is not uncommon for participants to describe a vicious cycle in their relationship to food, emotions, behaviours, this ties into relational patterns with the AV and is something to be curious about.

> when it's telling me negative things I feel even more useless than I was [ ] that makes it harder to recover, when it`s encouraging me that makes me feel like you know like I have it, and when I'm not listening to it, if I- if I give into it and give up, I feel really anxious (Beth, p. 11, 332 - 342)

Insults from the voice will complicate the appreciation of recovery, meaning, Beth describes feeling 'useless' from the AV insults, this in turn, as she describes, makes

recovery that bit more harder as a result of feeling ‘useless’. An inconsistent response pattern, such as insulting and encouraging, may relate to AN maintenance, in that, when the AV is insulting this seems to erode Beth’s confidence as she accounts feeling ‘useless’, however, when she is encouraged this equally makes it hard to recover because she is feeling good from AV encouragement. Therefore, AN maintenance it seems here is a ‘back and forth’ dilemma, insults result in feeling ‘useless’ therefore recovery is difficult, equally, an encouraging stance from the AV entices AN engagement. This demonstrates insecure attachment with the voice, in that Beth’s confidence in herself appears to be fragile and swayed easily by the AV. Illustrating juxtaposition, “if I give into it and give up I feel really anxious”, despite the positive affect when it`s “encouraging me”, anxiety remains, in turn, renewing the momentum of the vicious cycle. Rachel named her AV Alan, she refers to Alan throughout the transcript and can be seen referred to in the following excerpt.

> For a lot of people it would maybe be ‘oh be skinner’ but mine, mine was…Alan was more like ‘oh you will get so small nobody- you`ll just, nobody will notice you` and you`ll get too light and that will just be it’ you know, ‘nobody wants to be near [you] nobody wants… nobody finds any comfort in you, if you disappeared no one would [notice]’. [ ] For me it wasn’t a vanity thing it was definitely a way to cope with stress (Rachel, p. 11, 330 - 344)

The echo of a quote about difference from *Developing Body,* comes through. In an effort to minimise difference, Alan interjects “you will get so small” alluding to body

mass reduction. The body, used as a tool for affective change, will incur invisibility, indicative of Rachel being unimportant. In *Emotional Ambivalence About Self* she mentioned a need to "disappear", here, Alan is stating no one wants to be "near you" reinforcing this idea of disappearing. Paradoxically, disappearing via starvation would illicit attention, not indifference.

AN was not "vanity" but alleviated "stress". In the interview, Rachel disclosed her sister's death proceeding AN onset. Parallel to Vanessa, bereavement resulted in anguish with a need to cope. Rachel spoke of supressing emotions because they were perceived as weakness. With that, lacking an alternative emotional vent, Alan supressed disturbing emotions and experiences. Alans insults would further support the predication of unimportance, reinforcing greater emotional suppression.

4.3.2 Cognitive Dissonance

Each participant described the role of the AV within everyday decision making that was fraught with indecisiveness and apprehension. The sense of the voice being perceived as something separate came through in this subtheme in addition to exploring how they navigated perceived forced compliance. Altogether, participants described an experience that was disagreeable because of the conflicting nature of the demands and overt behaviour. This theme starts with Linda as follows.

> at the time I realised it wasn't my voice it was two months later [after treatment] and I realised that I wouldn't do this to myself. [ ] I never had confidence or self-esteem as child anyway, but I like to think I wouldn't do this to myself, at

> the time [ ] the voice didn't sound completely like mine because some of the things it would say would contradict some of the things I believed in myself (Linda, p. 10, 304 - 315)

Treatment would have challenged dissonant relations between Linda and AN. There is an element of disbelief, shock and horror deriving from this excerpt. A dissuading sense of behaviour and cognitive dissonance emerges as the offer of reward or threat of punishment from AN demands are not adhered to and appear to lose sway. The overt behaviours and cognitive processes engaged in during illness were incongruent with her beliefs after all. In the interview she spoke about separating the AV from her authentic self, this was an important recovery process. Dissonance in AN behaviours remained through illness because she retained her belief that it wasn't truly congruent with her wants, she states, the voice "wasn't completely like mine", a contradiction existing even before recovery. Sam expresses herself in the following way.

> [ ] I was so fearful of gaining weight if you like and going against the anorexic voice I just kept on going along with the anorexic voice and kept on going along with what it was telling me to do in a way because it was easier (Sam, p.15, 411 - 414)

Fear of weight gain was compounded by fear of "going against the anorexic voice", mirroring Beth's experience of fear of the AV in *The Flight Into Battle*. Fear of weight gain is intolerable, as previously acknowledged in earlier excerpts, *Developing Body*. This situation is disharmonious and demonstrates an insecure connection with the

voice. Added cognitions serve to reduce dissonance, reduce tension and bolster justification in carrying out the forced compliant behaviour. It seems Sam adopted the attitude that going along with the voice was not such a hassle after all, this would serve to diffuse tension. Being caught in a major discrepancy was causing a greater magnitude of dissonance, the feared outcome was holding more weight than the action of defying the demands of the voice. The importance of self is diminished by going along with the AV. Eloquently, it appears Jillian has a new perspective, seeing the "wood for the trees", long term goals cannot be achieved with ill health.

> for me the biggest would have been the separation between my conscious cognitive goals in life and my sort of knowledge of what my behaviour, the impact of what that was in terms of my life goals, in terms of my physical health and I...I cognitively reasoned that that was you know, not like sort of, having that sort of behaviour was not conducive to where I wanted to go. But then I was still having these like very separate like kind of compulsions and voices that were kind of like goals and internal dialogue kind of separated in terms of sort of what they wanted you to do (Jillian, p. 3, 78 - 92)

She uses the term "cognitively reasoned" which stems from her experience of cognitive therapy and indicates her ability to challenge AN beliefs. Jillian spoke of the necessity of aligning goals and behaviour and begins a process of reasoning. This implies the behaviour of AN was outside the bounds of cognitive reason. Her account conveys an experience of depersonalisation. A separate "internal dialogue" and "goals" were

forming, highlighting the dissonance felt in continuing AN while maintaining a bill of health, the prospect of marrying both created tension. Subsequently, Beth distinguishes her voice and "that voice", based on intentions and "wants".

A normal voice is different because of what that voice wants and what I want it's not rational and what's mine is rational" (Beth, p. 2, 58 - 61). What the voice wants is not natural, this highlights dissonance between "rational" and "not rational". Deciphering rationality means disputing the narrative produced by the voice, allowing for clarity in thinking and engaging in a reasonable critic of self before acting. The voice as illogical perpetuates an internal sense of dissension. The voice, an emotional blocker, is impeding engagement in reasonable evaluation and problem solving outside of AN behaviours. For Rachel, she honestly describes her experience in the following quote.

> [ ] it felt like I wasn't in my body [ ] it felt like Rachel was here and this was a person who was not really living who was just walking about trying to obtain these goals that <u>this</u>, Rachel, didn't want [ ] (Rachel, p. 19, 575 - 582)

Rachel details her experience of detached semblance, similar to Linda, Jillian and Beth. Stating "it felt like Rachel was here" demonstrates being automaton, she is "not really living" and "walking around" in a rather catatonic like stupor "trying to obtain these goals". Emanating here is a sense of Rachel having altogether disappeared, a sort of out-of-body suspension. Discomfort in goal seeking is outlined with "<u>this</u> Rachel didn`t want", this shows dissonance and conflict between the different aspects of herself.

4.3.3 The Phantasy of Control

Apparent in each account was a need for both protection from intolerable affects derived from either a changing body or difficult life circumstances. The existence of an omnipotent and controlling voice was a central experience for all participants. Through the course of illness an incongruence emerged between the wants and desires of the women and the demands imposed on them by the voice. The voice was altogether idiosyncratic, experienced as simultaneously internal and external. As time went by, feeling controlled reinforced self-concept breakage. Threaded throughout each excerpt is a description of conflict between the individual and the AV. The AV grew louder and intense at times of duress, it was termed 'a monster', 'ghoul', 'devil'. Sam describes her experience below.

> my sort of understanding of the anorexic voice is this voice that you hear within yourself real sort of dictating what you can and cannot do, so for example what you can and cannot eat, what you can and cannot wear [ ] when I was at my worst actually it was quite hurtful and demanding it was telling me to do all these things that I really didn't want to do you know, I didn't, you know the true Sam if you like didn't want to stand in a room and be really cold you know it wasn't really a friend it was quiet demanding and instead of me being in control, it was actually in control (Sam, p. 5, 122 - 186)

The AV depicted as "this voice", indicates separateness. Sam described power at illness onset, contrastingly Sam is feeling inferior and wounded. Relaying previously

stated cognitive dissonance, Sam reiterates demands imposed on her did not concur with her desired wants. The phrase “the true Sam” articulates voice separateness. A power struggle is depicted. Disenfranchised, a sense of being duped by the AV relationship emanates. Attention is directed to Jillian, here Jillian provides an example of compliance in the face of trepidation.

> I don’t think a lot of them [people who do not have anorexia] have ever experienced something else in their head controlling their choices even if they don’t want to do them [ ] so I used to go for a run every day after school [ ] I didn’t want to do it I physically dreaded it a lot of the times, but I had to do it, I had to do it, I had to do it...and I was being told I had to do it...to me that’s more like a possession [ ] than anything else [ ] at the height of everything it’s not even a conversation because your voice isn’t the most dominant one there or even present at all sometimes (Jillian, p. 26, 845 - 869)

An assumption that persons without AN would not experience this voice. Repetition emphasises feeling controlled, a depiction of an inconsistent relating to the AV comes through, clinging but also feeling entrapped by closeness. The AV is experienced as independent, she has become an automaton, as she likens it to being possessed. Enthralled in her illness is dominance of one voice and loss of another. Loss of power is conveyed as the presence of self-determined inner speech expires. And so, Vanessa converses with the voice as illustrated below

> I never had hallucination but there was another entity in my head [ ] that I would have conversations with eh basically telling me what to do and how to do things I know that is just me and it's something I have invented (Vanessa, p. 1, 31 - 39)

It is a self-invented entity but loss of autonomy is apparent, *'telling me what to do and how to do things'.* Vanessa spoke in the interview of feeling frightened and insulted by things the voice would say. Following this, Linda believes she knows what's best, the voice doesn't.

> I know what's best for me logically, but it doesn't and sometimes it wins and sometimes this side wins, it's kind of like a constant battle now so, it's just an abusive relationship basically [ ] in terms of grief it`s really loud, stress definitely, when I am down in myself it`s really loud, really there and other times when I am more confident or I have achieved something that I am really proud of its lower and I can go and I can eat and I can do whatever I want and it will not be there, but there is never a day when it is not there just times during the day when it`s louder or when it`s quieter (Linda, p. 11, 367 – 390)

A battle supervenes between the voice and Linda, competing power and control emanates. Likening the power struggle to an abusive relationship, the AV leaves Linda defeated, devalued and wounded. The voice is experienced as "loud", mirroring Linda's depiction in *Emotional Ambivalence About Self,* increased voice presence is mediated by overwhelming emotions. The word "loud" supposes an auditory component. Volume is

contingent on stress levels. Paradoxically, voice volume increases in reaction to distressing affects, however, voice volume is in itself distressing. In the excerpt below, Beth spoke of the voice as distinct from inner speech.

> a voice inside of you that isn't coming from me and is quiet loud telling me to restrict and to do exercise [ ] I would best describe it as a devil in my head telling me what's good to do and what's not good to do (Beth, p. 1, 17 - 25)

She spoke about it being solely related to eating, weight, exercise, this led to wonderings regarding her level of disclosure and how this links with her relational style to the voice. A sense of Beth as an observer and recipient within her own mind is an echo of feeling split off within a conceptualised sense of self.

Reference to the AV as "devil", insinuates a sort of Machiavellianism. Similarly, other accounts refer to the voice as a monster, being possessed and a ghoul. Constructing fairy tale-like metaphors for fearful objects serves to emphasise a helpless position in relation to a fantasy figure who is dominant. In the next excerpt, from Rachel, another reference to an abusive relationship implies a power and control dynamic.

> for me to describe it as an abusive relationship is easier because people know what that is rather than saying 'oh there's a little voice in my head if I eat over a certain amount of calories or if I don't exercise this amount of calories today [ ] this little voice tortures me (Rachel, p. 7, 195 - 203)

Here another reference to an abusive relationship implies a power and control dynamic. Stigma around AV was a focal point of Rachels narrative, relaying her

experience in the context of a more acceptable social construct was inferred as a defence from being perceived as deviant or invalidated. The voice “tortures me” adds layering to her endorsement that the relationship is abusive. This excerpt is indicative of engagement then withdrawal. .

4.3.4 Battle Fatigue

Five participants spoke about mental and physical exhaustion from interactions with the AV. One participant, Beth, was excluded, a suitable quote could not be extracted. The concept of time in this subtheme relates to exhaustion and fatigue from illness onset to long after recovery. Participants` accounts indicate body and mind exhaustion from AV engagement starting with Vanessa’s account.

> [ ] I know obviously people of all ages are [ ] getting effected by eating disorder but within myself I don’t think that I would have enough strength to cope with that like even vomiting it’s such an exhausting experience like I cannot even imagine spending one day like that, one hour [ ] so exhausting and a young body is much different than mature body I’ll put it that way [ ] Yeah it’s really hard to imagine that I could live life like that (Vanessa, p. 12, 387 – 400)

Age, experience and reflection illustrate the influence of time. An awareness of mind-body synchronicity, ED consequences now seem draining. Vanessa, recovered and older, demonstrates a unification of self-concept. Her tone reflects disbelief, a new emotional experience is suggested here, unable to “imagine” having lived this way is

reflective of self-compassionate understanding. For Sam, the reader can glimpse behaviour and cognition fatigue, 24/7.

> it's mentally draining and having to think about and acting on these thoughts all the time twenty four seven like no break it`s exhausting even now in recovery I have to actively wake up and fight against these compulsive thoughts all the time [ ] They've become such a habit and it would become a habit to follow the anorexic voice all the time and so when I was in the midst of my eating disorder [ ] it just became so exhausting (Sam, p. 14, 396 - 407)

Lethargy and entrapment emanates with "no break", "exhausting". Recovery involves battling intrusive "compulsive thoughts". The exhausting experience during illness is now in relation to relapse prevention. Sam is reflexive and patient in her understanding of AN pathology. Familiarity could feel coaxing or threatening adding pressure to stay alert. Jillian honestly expresses her viewpoint below.

> sometimes people would be speaking to you [ ] internally your trying to have a conversation with this voice that's like 'right when we get home we gotta do this' [ ] meanwhile somebody else is just another voice [ ] trying to manage like a multiple conversation whilst you've also got a conversation ongoing in your head it's really hard and really frustrating when you're on 500 calories and you're really miserable (Jillian, p. 34, 1141 - 1159)

An image here of being pulled in multiple directions, parallel to Sam, mental exhaustion is clear. Seemingly, Jillian would rather divert attention to the voice,

demonstrating her bond with the voice during illness. Preoccupation with it and security within engagement is inferred. Next, with Linda, fatigue and an image of life being drained stands out.

> It [the anorexic voice] can feed of all of them whether it`s anger, sadness, grief it just feeds and it's been really difficult at times to separate it from me while grieving [ ] because you know when you're going through grief and sadness and all you kind of have to remember to look after yourself [ ] and it's been really difficult this time it warns you off yourself, 'go away' from your body and your just feeling attacked (Linda, p. 30, 989 - 1000)

Linda`s grieving process was smothered by the AV, resentment and sorrow is reflected. Detailing a battle, the AV opposed self-care. Whether the AV "feeding" was a defence against threatening emotions is unclear, however, the voice opposed Linda caring for herself in the way she wanted, she was left feeling "attacked". The thread of fatigue is depicted here with Rachels narrative.

> it's like having a backpack on your back at all times and you know you have sat down on the sofa and you know you should take it off, but my backpack is like 'nah I'm still going to stay here, I make your outfit, you know you can't take me off' that's what it feels like (Rachel, p. 15, 446 - 452)

Here, the depiction of being constantly encumbered with the AV brings about a sense of fatigue, a sense of being crushed and consumed.

4.4 Master Theme 3: Healing Through Compassion

For all participants, recovery involved a process of separation-individuation, mental separation from the AV, applying boundaries and unifying self-concept. Mediating this, self-compassion, emotional attunement and adaptive emotional regulation. Participants spoke of undertaking a journey of reclaiming autonomy mediated by a change in meaning associated with AV function. For some, naming the voice was helpful in resolving separation-individuation complexities. Ultimately, reclaiming mastery over AN provided a reaffirmed wholeness and improved self - relations.

4.4.1 Reconciliation

This theme explored how participants experienced and negotiated their recovery in relation to the AV and AN. Participants` experience varied from developing a truce with the voice to feeling a stronger sense of identity by making the presence of the voice compatible with their changing self-concept. Beginning with Linda, being vigilant of the AV stands out.

> even in full recovery I imagine you still have to check yourself and still have to kind of go ‘right I’m not feeling great today I need to be aware here’ I imagine that’s the way it’s going to be forever, people just think once you gain weight your grand [fine] you can go on ahead’ but it’s like anything you need to work hard on it (Linda, p. 32, 1046 – 1053)

Vigilance facilitates recovery when ambivalent affects arise, this requires an attuned internal awareness. This is a long term commitment, weight gain is only one feature of recovery. Relational healing and a "getting to know oneself" is required. Much like a parent develops infant attunement, Linda's tuning into her mind and body to decipher what she needs much like the process of separation-individuation. A rapprochement reached between Linda and the AV, with its ambient presence, is a laborious process. Next, for Sam, a mature self-reflexive capacity is witnessed in the excerpt below with careful consideration of the positive and negative experience of AN.

> I don't know who I would have been, or you know who I would have grown up to be without… should I not have had my eating disorder [ ] so that really, I reflect on that quiet a lot (Sam, p. 17, 494 - 500)

A process of "metta", befriending oneself in loving kindness. "Metta" is a sign of moving towards psychological flexibility and an understanding of suffering, in effect, reducing suffering. Working towards her authentic self, self-actualising, which Sam spoke about earlier in the subtheme, *Who Am I Anyway*, is part of recovery. As discussed later, reducing blame and conflict, creates inner peace. Here, Jillian plainly states her position.

> an easy truce maybe would be the best way, I think that a lot of the time at the minute is still…a lot of it is on autopilot in terms of the behaviours, I've managed to cut out most of them. I rarely count calories [ ] it really just a lot of the times you try to work out what brings it on (Jillian, p. 29, 976 - 993)

"An easy truce" depicts a battle coming to a halt. Overt behaviours are the language of understanding relapse signs. Like Linda, Jillian is implying relapse prevention requires attunement to "what brings it on", demonstrating a deeper level of connection and awareness of self. The relational component of healing follows weight gain and reduction of eating disordered behaviours. As for Vanessa, her narrative below provides clarity on her experience.

> it definitely has had an impact on who I am as a person I am still trying to discover who I am as a person em…I think there is something in that saying what doesn't kill you makes you stronger. It is a part of me it belongs to my past, but [who] are we? We are now, it is our past and including transferring into our future (Vanessa, p. 21, 695 - 702)

A philosophy of strength and growth "what doesn't kill you makes you stronger" central to the resolution of friendly relations with the AV involving an acknowledgement of the "impact on who I am as a person". A continued discovery of self is maintained. Making Vanessa`s past compatible with the present is necessary to future proof self-discovery and identity. Following this, Rachel describes "a stage" of awareness and reconciles this by choosing an option that would alleviate distress outside of AN.

> it became a stage of 'okay, right I'm having a bad day I need to do X, Y or Z to make this day better'. I could go down this route which would result in really unhealthy behaviours or I could go down the nice happy route where I go talk

> to someone or go for a drive or go do some art you know. There are other things out there whereas before there wasn't this half there was only that half (Rachel, p. 19, 555 - 567)

Demonstrating autonomy over informed decision making is in contrast to the previous constraints endured from obeying the voice. She acknowledges there are "other things out there". A once divided self, at the time of the interview she acknowledged a fuller sense of self in recovery mediated by investment in value based experiences. And so, for Beth, she is "seeing that more and more", the division allows space to relate with greater assertion "being able to answer back" and felt power in relation to the voice.

> the more it talked to me the more I feel it's something separate [ ] I'm seeing that more and more that it's something separate now [ ] being able to answer back determine that what its saying is wrong [ ] that I am really powerful (Beth, p. 5, 138 – 149)

A process of separation and individuation is clear, observing the voice but owning her responses. The restoration of power is tillage to a fertile ground of resolution and improved friendly relations.

4.4.2 Being Nice to Oneself

Participants address the concept of self-directed compassion. Responding to the AV with kindness is an attempt to restore effective self-communication. All participants acknowledged recovery meant altering the process of relating to oneself in the presence

of the AV, however, for two of the participants, the extraction of a sufficient quote that would fully relay this subtheme was absent. Therefore, four participants are present in this subtheme. Vanessa begins here in describing her experience.

> Like now when I am having my internal dialogues sometimes I will criticise myself, but I will not act upon those critics. Like sometimes I will look into my body and I am not always completely happy with the way I look, but I won't have the need-the voice is not there to say 'now you need to, I don't know cut yourself [ ] because a piece of fat' But now I am like 'oh yeah it's there' I am not very happy because of it, but I am not going to hurt myself (Vanessa, p. 28, 933 - 947)

In the absence of the AV, punishing urges are absent. No longer fusing with a superior force, Vanessa seems to demonstrate a healthy self-concept. In the realm of tolerating anxiety, she has mastered holding distress. Reduced is the need to alter or eliminate rising intolerable affects. Next, Sam holds reflections on internal criticism, finding a middle path via reconciliation and self-directed compassion, this is made clear.

> you don't want to be critical towards it you want to come back with a more compassionate voice more of a loving voice, especially if you think that, you know, when you don't know when the voice is gonna go if you think that you are going to have to live with this your whole life [ ] be as kind towards yourself as you can because you have to carry it around with you every day (Sam, p. 22, 633 - 646)

An emergence of restored power emanates, Sam appears to have the upper hand. A sense of waking from the spell of childhood wounds emerges along with a sense of growing with compassion into adulthood. Linda eloquently portrays her experience in the following excerpt.

> that's the whole point of the anorexia that it`s separated me from my feelings [ ] It's only really this year that I've come to the realisation of that, that it`s ok for me to feel sad or angry you know [ ] I expected that once my grandmother passed my whole world would end and I would explode and I wouldn't be able to cope but because I have actually acknowledged the fact that I need to feel this, it's been easier to sit with it (Linda, p. 28, 911 – 938)

Unification, thoughtfulness and empathic attunement are clearly illustrated. Simultaneously, loss and sadness emanate as Linda concedes "the whole point" of AN was to separate her from her feelings. Previously, she spoke of a process of separation and a constant battle of win and lose. Linda is mastering the process of separation-individuation from the AV. She disclosed surprise at how well she coped with bereavement. Importantly, Rachel recounts her experience of recovery in hospital as one she "chose".

> I know a lot of people are forced into recovery, but I chose it, I remember that week in hospital I went 'I don't want to be in here again' because I was surrounded by people stuck in their own head and very stuck on their own

internal voice whereas I was kind of able to go hold on a minute this isn't right nobody should have to feel like this (Rachel, p. 15, 430 - 441)

The word "chose" contrasts the loss of autonomy spoken about earlier in the interview when she described being lost within herself while obtaining AN goals. Rachel is realigning and practicing autonomy over mind and body, counteracting previous descriptions of disconnection. Rachel compared AN to an abusive relationship, now she is protesting an end to suffering.

4.4.3 Reclaiming

Six participants appear in this subtheme. This subtheme conveys the wider context of reconnection to self, prior to AN onset. Two participants spoke of a reduction of voice power coinciding with the materialisation and pronunciation of their own authentic, less destructive voice. One participant spoke about the usefulness of therapy in constructing meaning making through language and a therapeutic relational experience. Beth's self-determination is expressed below, postulating a position of self-retrieval. Here, Beth has found ways to "quieten at least" the AV.

"for me I think I have at least found ways to quieten at least, even if it's still there but just to be perhaps, like how I can stand up to it" (Beth, p. 20, 591 - 594). This is telling of a lasting AV presence, albeit reticent presence. Quieting the voice is indicative of the intensity previously experienced. Having "found ways" could be the retrieval of resources reclaimed. Being able to "stand up" to the voice lies in contrast to

previous inferiority. A sense of reclaiming internal strength emanates. And so, Sam conveys her thoughts here.

> okay I have had this eating disorder for so many years and I've had to deal with this voice for so many years but I don't have to listen to it and you know ultimately I am the one in control I am the one who can make these choices (Sam, p. 21, 591 - 596)

This frame of reclaiming is an antithesis to depictions in *Phantasy of Control*. Wholeness and self-transcendence flows, a distinguishable gradation of mastery envelopes "I don't have to listen to it", "ultimately I am the one in control". Opposing conformity in *Cognitive Dissonance,* maturity is demonstrated here. For Vanessa, what stands out is The opposite of *Who Am I Anyway* appears.

"I feel big and the voice is tiny [ ] what I would say is 'I told you, even though I was whispering, I told you I am gonna win'" (Vanessa, p. 30, 975 - 981). Referencing whispering could pertain to a sense of inferiority during illness, overcome, persistent determination follows "I told you I am gonna win". Suggestable, the aspects of herself AN denied are now integrated, she feels she has won. Moving through this theme, it can be observed in the excerpt below, Jillian reclaimed her own voice through therapy, this is an antithesis to feeling possessed in *Phantasy of Control*.

> for me I kinda I had gone through counselling and therapy [ ] I kind of got through that procedure of separating out myself from the kind of internal voice

> that is not me [ ] at the time of being unwell that separation was not there at all and it just sounded like me (Jillian, p. 2, 46 - 58)

The use of the word procedure suggests the undertaking of a methodical and purposeful process attributable to perhaps a stage of development, separation-individuation, that was necessary. Exhaustion and frustration from multiple voices in *Battle Fatigue* are reduced, the AV is separated out and defined as "not me" it merely mimicked her. Jillian spoke in the interview of naming the voice, a process of externalisation to reaffirm an authentic self. And so, for Rachel AV is present but not fully established as seen in her excerpt below.

> he's definitely still there but he's not a prominent character, you kind of go 'sshh' and he goes away again but I think for most people who have gone through a recovery process it's a case of their voice is still there but it's whether or not you choose to listen to it (Rachel, p. 9, 251 – 258)

Rachels language conveys a confidence also exuded in *Who am I Anyway* as it appears she is moving away from feeling bound to Alan. Removed from the torturous relationship described in *Phantasy of Control*, Rachel`s experience is enveloped in choice, emerging power and choosing not to listen.

4.5 Summary of the Analysis and Exceptional Data

Analysis of participants narratives provides an exploration of the process of experiencing an AV through the course of AN and the re-establishment of a core sense

of self thereafter. Emphasised was the contribution of the AV in AN onset and maintenance. Participants described the reintegration process of a familiar but foreign aspect of themselves experienced with ambivalence, felt to be outside of the realm of autonomy. This raised questions related to recovery, particularly preparedness to seek out other non-destructive methods of emotion regulation, as well as self-concept as participants explored what this meant for them in relation to both AN and the AV.

The search to find meaning in their illness and their relation to the voice was profound. The presence of the voice spanned illness onset and remained persistent in presentation, albeit reduced in volume well into recovery. Analysis explored the process of puberty leading to illness onset. Bereavement was important in illness onset or relapse for half of the participants.

The analysis yielded exceptional data. Exceptional data can tell the reader something about a central theme, however, it is excluded primarily because it deviates from a main characteristic or plotline of a central theme. The following subthemes deviated from the main research question of this study concerning lived experience of the AV, nonetheless, produced important and novice insights to the direct relevance of the AV. Table 5 summarises the exceptional data subthemes.

Table 5

Exceptional data

Exceptional Subthemes	Quote
Importance Placed on Food and Weight	emphasis I feel is put on the physical to get up peoples weight to make sure they are healthy and stuff and maybe a little bit of the actual psychological help only comes later which is really it should come earlier [ ] whenever they are going through the re feeding (Rachel, 836-850)
Therapy Experience	she spent a lot of time talking to me about things around the anorexia so it's not just focused on my food its focused on so who are you as a person what do you enjoy and em you know what's your support network and you know talking about things surrounding it that could influence me to be stressed about (Linda, 621-628)
Labelling and Fear of Disclosure	I`d feel like absolutely terrified, absolutely terrified of being sectioned. I don't quite know why I feel like having admitted that there was effectively voices in my head was like [laughs] check one of the mental health act [ ] it's kind of like the fear of god was put into me about being sectioned basically [ ] so I wouldn't have discussed any kind of internal dialogue (Jillian, 624-640)

4.5.1 Exceptional Data: Importance Placed on Food and Weight

Participants felt physical rehabilitation superseded psychological distress. Accordingly, psychological distress was equally important. Some participants stated therapy accessibility came too late in recovery.

> emphasis I feel is put on the physical to get up peoples weight to make sure they are healthy and stuff and maybe a little bit of the actual psychological help only comes later which is really it should come earlier (Rachel, p. 28. 836 – 850)

> I probably took a back step when I got to CAMHS to be honest because the focus was on bringing you in, monitoring your weight. I never had a counselling session with CAMHS, I never had one [ ] I never had any discussion with them about what it was like in my head (Jillian, p. 19. 606 – 618)

Rachel suggests psychological help was secondary. This feels invalidating and may tie into her perception of suffering and invisibility. Earlier therapeutic communication might have offered an opportunity for validation, empathy, and safety, imperative because participants spoke of the voice getting louder in recovery.

Jillian describes addressing the physical components of AN without psychological input. Maybe, taking a step back was a sign of rejection sensitivity, a response to professionals perceived lack of interest in psychological difficulties.

Below, Sam described increasing and maintaining weight. Conflictingly, the AV presence is pervasive implying it was not addressed in treatment.

Linda affirmed, addressing the psychological components of AN was imperative in both understanding and addressing the AV. Focus on weight alone meant addressing intrinsic psychological components of AN were left unexamined.

> If I didn't want to be admitted as you know an inpatient and be on a drip I'd have to you know eat proper meals, you know recover and get up to a healthy weight and maintain it, but the voice is so, yeah it's so pervasive and destructive that my recovery has been up and down up and down for like 5 years (Sam, p. 19, 548 – 556)

> In three recoveries I have never had the emotional side of things questioned [ ] this is what I am using anorexia for I never once realised I was using anorexia to avoid feelings [ ] never once had someone come to me and ask what you really feel (Linda, p. 26, 860 – 873)

4.5.2 Exceptional Data: Therapy Experience

All participants received therapeutic support. Therapy experience was predominantly CBT orientated "pro`s and con`s list" (Linda, p. 24, 778), "rationalise irrational beliefs" (Jillian, p. 18, 602), "distorted thoughts" (Sam, p. 6, 160). Some participants talked about being thwarted in what they wanted to explore and helpless in

determining when therapy could be accessed. Stigma related to hearing voices created a barrier to AV disclosure.

For Linda, therapist responsiveness, empathic reflection and a new relational experience was restorative, she discussed the biopsychosocial frame helped recovery.

> She [therapist] spent a lot of time talking to me about things around the anorexia so it's not just focused on my food it`s focused on so who are you as a person what do you enjoy and em you know what's your support network and you know talking about things surrounding it that could influence me to be stressed about (Linda, p. 19, 621 - 628)

Beth, apprehensive about being labelled psychotic, *Labelling and Fear of Disclosure* was reluctant to speak in depth about the AV. Her communicative style in the interview was blunt, perceived as a guarded approach to disclosure. "I've hinted I've hinted at it but not said it directly but I've never said a specific voice" (Beth, p. 12, 364 – 369)

Sam received CBT therapy, the focus was food and weight orientated. The voice was never discussed directly as indicated below.

> In terms of speaking about it during session there, em not directly or fully, it was more what it was I was having and whilst that could be to do with what the voice is telling you to do, so say food choices (Sam, p. 309 - 315)

Vanessa, living in Ireland during the interview, received treatment outside of the U.K and Ireland. The only participant to not receive CBT therapy in treatment, her

therapeutic experience surrounding addressing the voice was relational, the cornerstone of her recovery. “there wasn’t so much talking or rationalising it was just I’m here and that’s it. Whatever you do I won’t [ ] reject you, I will protect you, I am here” (Vanessa, p. 14. 438 – 441)

Rachel stated that she would have benefitted from CBT methods during the early stages of treatment. This quote reflects her earlier quote, *Importance Placed on Food and Weight*, the importance placed on weight gain above psychological input addressing underlying anorexic processes. “I defiantly could have used a lot of CBT methods during that time, but they were taught to me maybe 5 or 6 months into treatment” (Rachel, p. 28. 847 – 850)

4.5.3 Exceptional Data: Labelling and Fear of Disclosure

Reluctance to disclose the AV because of stigma, being labelled psychotic or being sectioned under the MHA was present. For one participant, having the diagnostic label was helpful.

> I spoke to one of my nurse when I was an in-patient but it’s not something I wanted to share [ ] they`d think I’m crazy [ ] I’d rather them not think there is something else wrong with me like an experience a psychotic experience (Beth, p. 7, 200 – 211)

Beth mistrusted professionals not to interpret her experience as psychotic. Confusion of her experience comes through, albeit she shared her experience with a Nurse although appears reluctant in doing so.

> I`d feel like absolutely terrified, absolutely terrified of being sectioned. I don't quite know why I feel like having admitted that there was effectively voices in my head was like [laughs] check one of the mental health act [ ] it's kind of like the fear of god was put into me about being sectioned basically [ ] so I wouldn't have discussed any kind of internal dialogue (Jillian, p. 19. 624 - 640)

For Jillian, disclosure meant prejudice, invalidation, misunderstanding and judgements around hearing voices.

For Vanessa, she maintained that a holistic approach to treatment is beneficial as it encompasses a larger part of the struggle with AN, as indicated below. She challenges assumptions of ED as singular, treated in accordance to a diagnostic category and absent of accompanying psychological distress "so basically holistic approach, being there and just listening and keeping in mind that people with eating disorder are already tortured and suffering very deeply [ ] keeping in mind that they are humans and not just a diagnosis" (Vanessa, p. 24, 775 – 783), "the people that I did trust I would write down on paper or whisper 'there is this and this happening in my head it's not me doing this'" (Vanessa, p. 11, 348 – 351)

For Rachel, it was easier to have the diagnosis, indicated in the quote below. Simultaneously, in the interview she disclosed her recovery meant letting go of diagnostic label identification. Helpful in informing others, labels do not define her, outlined in *Who Am I Anyway*, "once you have a diagnosis of something it's easier to go

okay I have this rather than oh I don’t feel well or stuff like that it makes it easier to say” (Rachel, p. 17, 520 – 524).

5 – DISCUSSION

5.1 Overview

The aim of this section is to present the main findings of the analysis into a wider framework and in relation to the extant literature. This section discusses the findings from the IPA analysis relating to the research question concerning the experience and meaning placed on the AV in relation to AN onset, maintenance and recovery. Having chosen to explore the meanings that participants give to the experience of the AV, this study puts forth an alternative view, in that individuals themselves narrate their experience of the 'voice' of anorexia from illness onset through to recovery. Its findings make an original contribution to the field, some qualitative studies have touched on the AV subjective meaning via creative expression (Tierney & Fox, 2010) and a few authors have focused on the 'inner world' experience of the 'voice' from the perspective of participants across the vast spectrum of eating disorder presentations (Pugh & Esposito, 2018; De Giacomi, 2019). This is the first investigation to explore how the participants made sense of their anorexic 'voice' in terms of illness progression, highlighting, how the AV directly impacted their experience after treatment ended.

In this section the researcher will explore the study's themes in greater depth, considering the ways in which they support existing theory and research, whilst also drawing attention to areas where novel understandings or questions have emerged. An evaluation of the study will consider its various strengths and limitations. It is the researchers hope the study's findings will have practical utility and, ultimately, benefit

those who struggle with AN and an associated ‘voice’ which causes distress. Implications for CoP discipline and practice will be discussed. Finally, inclusive in this section are some suggestions for clinical practice and future avenues of research.

5.2 Superordinate Theme 1: The Perils of Self-Acceptance During Puberty

This superordinate theme discusses how the participant’s AN onset was shaped by developmental changes, depicted as noticeable changes in both thought processes concerning the body as well as noticing actual bodily changes. These changes stirred up uncertainty about participants’ body and uncertainty of one’s body in relation to close others such as their peer group. The emotion that came through in this theme was one of fear, fear concerning an unfamiliar body but fear of being ostracised from peers because of a changing body. Developmental changes during puberty were identified, for the most part, as an AN antecedent. In terms of linking findings with the current research, there is a plethora of literature espousing adolescence with AN onset, specifically, advanced pubertal development and early pubertal timing are considered significant with respect to ED onset in females (Bulik, 2002; Klump, 2013; Rohde et al., 2014). The first three subordinate themes demonstrate the depth of change experienced by participants as they transition their identity from child to adolescent with the expectation of further transitioning in identity, that of adolescent to adult. The initial stage in their journey toward AN onset aligns with the literature, where a developing identity, that of mind and body, are seen as critical timepoints for AN onset, what this means is and as previously discussed in the Introduction section, pressure from aesthetic female body ideals during

puberty are hypothesised to contribute to AN onset (Micali et al., 2013). Further, the subordinate themes *Developing Body, Emotional Ambivalence about Self* and *Who am I anyway* tie into what was discussed in the Introduction section, namely, the AV experienced as an internal 'voice' anorexics associate with their disordered thoughts and feelings, rather, a personification of anorexic associated beliefs, behaviours and feelings manifesting with the onset of anorexia (Ling et al., 2021). Albeit, the AV is not reduced to a metaphorical experience, it is a multi-voiced internal world Pugh, (2020). Participants evolving body and emergence into adolescence was greeted by the AV, meaning, it was sensed in addition to one's familiar internal dialogue as illness started. Altogether, this superordinate theme demonstrated the period preceding onset of anorexic symptoms and the initial awareness of the AV's role in steering developmental changes. Participants recount seeking a sense of safety within self, of which AN was manifested, from what was perceived as a threatening process (developmental changes and external world changes) that they deemed to have no control over. Moreover, feeling inconsequential on both a micro and macro level are also pivotal aspects of this theme.

5.2.1 Coping with Adversity

The findings show that the participants' negative perceptions of body changes meant more than just ambivalence to body change, albeit this was considered very important. Fear of changes in the body, particularly fear of weight gain/body checking/body avoidance is in fact associated with higher levels of eating disorder pathology and is widely studied in anorexia (Calugi et al., 2018) so much so, that the

core treatment, CBT-E, is based upon the premise that overvaluation of shape and weight, of which is considered a core psychopathology of AN and a primary clinical feature is targeted in CBT-E. Glashouwer et al., (2019) systemic review, looking at AN onset, maintenance and relapse in respect of body image disturbance, affirms there is some evidence suggesting body image disturbance is related to AN illness trajectory, arguably, although participants openly describe body image disturbance, there exists problems with regard to the terminology used in the body image field because, no exact definition is offered in the DSM-5 (APA, 2013) AN criteria re body disturbance. This means, interpretational differences between clinicians and researchers, regarding the definition of 'body disturbance' can greatly impact AN research. Body image disturbance can be interpreted from many perspectives like cognitive-affective, perceptual and behavioral (Fairburn et al., 1999; Vossbeck-Elsebusch et al., 2015), further, Glashouwer et al., (2019) argue, interconnections exist between these components and no research is demonstrating one component is attributed to greater body image disturbance above another (e.g. cognitive-affective versus behavioural). What we have learned from the subordinate theme *Developing Body,* is the perception of a frightening process of body change as well as the onset of 'distorted' thoughts associated with body changes played a role in the beginnings of AN engagement for most participants.

For the women in this study, ambivalence to body changes were considered erroneous to the extent that the women describe a sort of 'intervening' in an attempt to

halt and stop these changes. The process of interrupting body changes is accompanied too by the AV presence. On the back of this, the reader is directed here to what Jillian (p. 4, 105-117) recounts in *Emotional Ambivalence About Self,* regarding this 'intervention of changes to the body' i.e. to halt changes, as accompanied by the AV presence *"*when I put on half a pound or whatever the internal voice was freaking like just we need to get this under control, we need to get this sorted, we need to put a stop to this, we need to like get a handle on this in some capacity". In reflection, on what has been stated about AV emergence in the context of the adverse changes discussed here, is the support for Bruch's (1978) theory concerning AN development as a sort of, flawed solution, to impairments in overall identity development. Further, Jillian's narrative echoes past accounts of individuals attesting to experiencing their mind being consumed with the voice of anorexia, in that, the AV expresses comments on the individual's eating, weight and shape and instructs the individual to engage in behaviours associated with restriction or compensation, in reaction to adverse body changes, namely, perceived weight gain (Hormoz et al., 2018; Pugh, 2020). Moreover, as per Pugh (2020) review of AV literature proposing a stage-like AV-individual relating style, the view here could be that of demonstrating the AV-individual relationship, or mode of communication, as starting out as encouraging and supportive, meaning, encouraging active change via AN engagement. Important to note, the premise for 'active change' is spurred on by perceived threatening body changes and dissatisfaction with the body in the first instance, as per Sam (p. 1, 21 - 27) " this type of body was sort of unacceptable", also

with Jillian (p. 27, 889 - 900), “the elephant in the room”, and lastly Rachel (p. 9, 265 – 272) “I would have defined myself as a fat child”.

Participants’ negative perceptions of body changes were also about difficulties they experienced within their social circles and amongst their peers, a large part of which related to their identity, at that point, as a child. The sense that changes came too quickly emanated from the first subordinate theme *Developing Body*. The findings also highlighted ways in which participants’ ‘child identity’ changes were negotiated, interpersonally, through comparing and contrasting against their peers. For example, Jillian (p. 27, 889-900) denotes her changing body shape to that of a “farmers daughter type build [ ] rather than a lot of the people that were in my class at school were kind of very dainty and quiet pixie like… I…was also the tallest of all the boys as well”. Additionally for Sam (p. 1, 14 – 18) “It started all really the disordered way of thinking at 12 when I was an early developed child”. What these passages tell us is 1. body comparison evaluation is rather distressing for participants and 2. The process of thinking about the impact of the changes to the body were noted as ‘distorted’ in nature, rather, Sam’s thinking also perceived to ‘change’. The findings here concur with the metanalytic review by Mysers and Crowther (2009) regarding social comparison as a predictor of body dissatisfaction, in which the researchers tell us, comparing oneself unfavourably to another, on the basis of appearance, can in fact lead to dissatisfaction with one’s own appearance. Also relating to the existing literature, in particular that of Micali et al., (2015) findings concerning, childhood body dissatisfaction, which when

persistent body dissatisfaction is present then this is considered a strong predictor of eating disorder cognitions, for girls in particular.

It is documented that the AV offers safety and reassurance (Williams et al., 2016) and in as much as the illness is used as a tool to detach from painful thoughts and emotions, so too is the presence of the AV. As per Rachels account (p. 10, 276 – 288) in *Emotional Ambivalence About Self,* safety and reassurance came from the AV during a difficult time in her life "I found the voice got bigger because I was sadder [ ] and it became more of a coping mechanism for the world around me". Rachels views concur with Lavis (2018) research describing how the anorexic illness can offer a way to 'be in the world' that equally responds to and ameliorates distress, here, Rachels account provides a critical lens into what the AV is doing *for* (offering safety) as well as *to* her (supporting her). Conclusively, Rachels experience is echoed in the existing literature in terms of the voice experience serving a protective function, in that, the AV takes a position of coaching and guiding the individual in anorexic behaviours at illness onset (Williams & Reid, 2012). And, Evans (2011) equally points out, the AV is loudest when vulnerability is highest. Consider here, the 'buy-in factor' or 'seductiveness' of the AV experience during a time of sadness as per Rachels account, that the voice experience perceived as supportive and shouldering her distress could be aligned with playing a role in potentially alleviating that distress. This we can tentatively hypothesise via consideration of Baumeister et al., (2017) systematic review, comparing non-healthy and

healthy voice hearer experiences, findings highlighting positive voice hearing experiences amounting to lower felt stress.

Finally, behavioural consequences from the repeated patterns of behaviour that underpin the development of AN like restricting food intake, choosing less calorific foods etc., over time, become habitual. As is seen in *Emotional Ambivalence About Self* with Sam (p. 1, 21 - 27) "I started off with a really restricted diet" and in *Developing Body* with Linda (p. 1, 27 - 32) "I had denied there as a problem, at the end of the day I was just losing weight because I was quiet hefty", these behaviours are initiated to achieve a specific goal, in this instance, weight loss, this is in turn is reinforced because it is positively rewarding. With repetition, and supported by the literature in particular by Treasure et al., (2020), the actions become automatic and entrenched until they are activated with no conscious effort in response to a stimulus or cue. Further supporting this, Garfinkel and Garner (1982) attest to the negative reinforcement of food avoidance and weight-loss reach a ceiling height, and so, AN thoughts and behaviours become self-perpetuating. Simultaneously and in line with where the AV might fit into the initial behaviours of AN at illness onset, the reader is directed to the postulation that the AV is considered by ED researchers to be a separate 'part' of the 'whole' self, in other words, as discussed earlier in the study, the AV is a discrete component of personality because it has embodying needs, feelings, behaviours, is focused on AN goals, this is widely documented (Higbed & Fox, 2010; Pugh, 2016a; Forsen Mantilla et al., 2017; Hibbs, 2018). Bearing this in mind, and on a final note, if we look to what Vanessa (p. 22, 721

– 729) relays in *Emotional Ambivalence About Self* "I think that my eating disorder and that voice, it was just a solid foundation of something that existed since forever" we can interpret, she perceived the AV as a 'part' of her and felt it to be present for as long as she can remember, however, the beginning of illness for this participant brings forth the 'voice' of illness from an unknown, yet familiar place, that "existed since forever".

5.2.2 Anorexia Identity

Here, the reader is directed to the discussion around AN identity in respect of the subordinate theme *Who Am I Anyway*. In this subordinate theme, all of the participants reflected on their self-concept in relation to AN emergence. To begin, for clarification purposes, identity and self-concept will be defined. Identity, refers to who a person is, qualities a person possess that make them different from others. Self-concept, according to Rogers (1959) refers to how you perceive your unique characteristics, your behaviour and abilities, in that, self-concept is made up of an ideal self or how you *want* to be, how you *actually* see yourself and how you value yourself in comparison to others. Markus and Cross (1990) refer to identity and self-concept as our theory of our personality, Lewis (1990) declares, having an awareness of *self,* of which, identity and self-concept are components, is central to what is means to be human and facilitates what we know or *can* know about ourselves. How is this relevant to this subordinate theme? Well, according to Rogers (1959), when a mis-match occurs between how you see yourself and your ideal self-image, this paves the way for uncertainty within ones perception of self. Here, in this subordinate theme, what emerged from participant

narrative was an incongruent self-concept, importantly this influenced their self-identity. The researcher is reminded of Hilde Bruch (1978) declaration, AN signifies the resultant struggle for self-identity and autonomy, with that, an example is seen with Sams (p. 17, 485 - 492) expression of incongruence of perception of self and uncertainty of self-identity, "I've always gone against what I wanted to do in a way and I would say that that has really fed into my identity…I try and sort of get back to who I want to be instead of what my eating disorder wants me to be". This passage is telling the reader something about a conflict between *her wants* versus her *AN wants* and how this has moulded/impacted her sense of who she is or in other words, her identity. This is also telling of a move away from AN engagement and a renewed contemplation of an identity outside of the illness, to do this though, Sam is talking about needing to "get back", a sort of 'undoing' and in this process she can begin to think anew about her sense of who she is without AN. In respect of how this sits with the literature, studies have concurred, individuals move toward AN and report sharing a sense of self with AN (Williams, et al., 2016; Hay, 2010). Shelley, (1997) talks specifically about a shared space with the AV within anorexia and describes this as two voices in one head, both conflicted. The literature concerning recovery attempts from AN are filled with descriptions of individuals 'letting go off' or 'silencing' the AV in an attempt to move away from its demands and move away from the illness (Lamoureux & Bottorff, 2005). The 'shared' space with AN according to Stockford et al., (2019) leaves a fragmented sense of self after AN enmeshment ends. Focusing for a moment on the 'enmeshed' aspect of AN,

the researcher points to what Linda (p. 6, 168 - 175) eloquently described as a detangling of herself and her illness "if you separate the two you kind of have to discover who you are without the anorexia". This implies difficulty in figuring out 'who am I in the world?' type of contemplation if *not* anorexic, so to say. Another example of identity, built up around illness, comes from Rachels (p. 29, 877 – 922) account "it's taken me a lot of time to go you know this isn't who I am [ ] I am Rachel and that is all I am whereas before it was I am the anorexic person". Here, the non-anorexic aspects of her identity appear to take on increased meaning and priority.

What stands out is Vanessa's excerpt, she reminds us how a sense of self-identity can get lost in the AV presence. The reader is reminded that the AV has been reported as highly conflicting, repetitive, inflexible and tyrannical (Hale, 2011; Evans, 2011) as well as 'taking over' the individual (Hay, 2010; Williams & Reid, 2012). For Vanessa (p. 6, 168 - 169) "I felt it was 98% the voice and only 2% of me in there" here, the voice of anorexia is completely dominant. This concept of voice dominance has been explored in ED research, with Jenkins and Ogden (2012) qualitative research into AN recovery, the researchers highlight how the dominant AN side of a person i.e. AN engagement, is driven by the AN voice, in which the researchers further describe as undermining a sense of self and allowing the body to be in charge. Further, Higbed and Fox (2010) as well as Tierney and Fox (2010) talk about the ferocity of the dominating AV, but despite this, it is often valued. Vanessa previously talked about self-concept and an image of herself never being in a good place, but "that voice it was just a solid

foundation of something that existed since forever" (p. 22, 721 – 729) and so something that is already in existence isn't entirely 'new', it might however be said to be expanding itself to a greater degree than previously experienced. What is ringing through, however, is the dominating presence of the AV for Vanessa, encroaching on her self-identity.

5.2.3 Summary

Life adversities meant a sense of powerlessness emerged, this was felt in relation circumstantial changes, actual bodily changes, changed cognitions in relation to developmental changes as well as perceived difference amongst peers for these women played a significant role in AN onset. It could be surmised, an initial alluring relationship to the AV arose from a place of feeling threatened by the uncontrollable changes happening at AN onset. Altogether, participants described the voice in varying ways, for most it was somehow familiar, it supported weight loss as well as its presence expanding with sadness. The familiarity of the AV, at illness onset, is supported Dolhanty and Greenberg (2007a) and Pugh (2016) findings indicating AN behaviours are initially mediated by a supportive AV presence. *Who Am I Anyway* portrays AN as taking over their identity to become the primary focus of attention. This supports findings indicating AN as ego syntonic in nature and individuals valuing their disorder (Forsen Mantilla, 2017; Gregertsen et al., 2017). Additionally, the function that serves to protect, is ultimately exaggerated, lending to the 'buy in' seductive factor of AN and the AV. AV presence was mediated by perceived internal or external threat, appearing to increase in volume when stress or sadness was present, this ensconced its position as an emotion

regulator complexity fully relied on by participants. In summary, narratives in this theme indicated changes to self-identity as AN emerged. For some, their identity became solely aligned to AN in which a retracing of steps back to self was necessary in recovery. Finally, self-concept incongruence emerged, seen via conflict between perception of self (actual self) and how one wants to be (ideal self).

5.3 Superordinate Theme 2: The Anorexic Voice Battle Ground

This superordinate theme discusses the meaning participants placed on the AV in respect of being unwell with AN. The following four subordinate themes discussed, 1. *The Flight into Battle 2. Cognitive Dissonance 3. The Phantasy of Control 4. Battle Fatigue* interpret how participants link their illness with the AV presence and what this felt like for them. The themes also go some way in addressing the intricacies of the AV as participants relay the changing connection they had with the voice, a sort of fluid movement from feeling supported and encouraged to feeling controlled and trapped in its presence. The themes themselves also go some way in addressing the research question via exploration of the in-depth experience of an anorexic associated 'voice' in conjunction with other cognitive and behavioural experiences of the illness, as illness progresses. The themes move the narrative, in a sense, along the trajectory of AN emergence to AN maintenance. Within this maintenance cycle, the concept of being controlled by the AV stood out. The participants narrative in the context of control aligns with the AN literature which confirms control as a common theme in not only anorexia but across the eating disorder spectrum at large, typically AN is described as an illness

of pathological self-control (Bruch, 1978; Gulliksen et al., 2015) moreover, control leaks into aspects of life for anorexics that are perceived as unbearable and chaotic, such as family dynamics (Selvini-Palazzoli, 1974) as well as wider sociocultural contexts (Orbach, 1985). Studies such as Williams and Reid (2010) and Serpell et al., (1999) as an example, acknowledge the illness as a whole, can feel controlling to patients and previous qualitative and quantitative studies have acknowledged that individuals can feel controlled by the AV narrative/presence in particular (Pugh & Waller, 2017; Jenkins & Ogden, 2012; Williams & Reid, 2012). How this study diverges from these others is the expansion of details in participant narratives as to the feelings, thoughts and meaning of being controlled by the AV. Another divergence is the emergence of fatigue as proceeded by feeling controlled. *Battle Fatigue* offered a lens into the mental and physical exhaustion features of AN and AV experience. This surprised the researcher given this has not been reported in the literature as a direct consequence of the conflict arising with the AV in illness. Indeed, fatigue and recovery contemplation have been reported at large in the AN literature (Bohrer et al., 2020) but the narratives in this study go further in exploring what this felt like in the context of the AV presence to which this has not been reported before. With respect to *Cognitive Dissonance*, an overlay of psychological discomfort experienced between consonant and dissonant cognitions as well as AN behaviours ultimately seeped into the other subtheme`s. Conclusively, all six women implicate the role of the AV in AN onset, management and negative affect regulation.

5.3.1 The Flight into Battle

The participants in this study all described a felt sense of disquiet stemming from either internal or external anxieties and stressors, through the process of alleviation, either via changing or adding in a new behaviour or cognitions to alter the magnitude of feeling overwhelmed (by this the researcher means AN engagement), the input and position of the AV is recounted and affirmed. Participants made sense of their AN engagement in relation to the AV experience, for example "I just kept on going along with the anorexic voice and kept on going along with what it was telling me to do" (Sam, p.15, 411 - 414). This 'going along' experience represents a common theme in the AV literature, as such, Williams and Reid (2012) qualitative research found the AV provides a justified and confirmed means of coping, thereby increasing the need for the eating disorder, moreover Williams et al., (2016) sense of self and AN, a grounded theory, found the self is considered shared with AN, in other words, the AV is a shared occupant within the persons inner dialogical space, for this reason, going along with the voice, may not have felt too tedious at illness onset for Sam.

For some participants, to describe the role of anorexia in relation to anxiety management is interesting, but not entirely new, anorexia has been represented in the literature as a silencing of the self by the 'anorexic voice' (Grange, 2021) and used as a means of 'anxiety management' (Liliedahl & Sjökvist, 2021; Smethurst & Kuss, 2018). On a wider scale, anxiety and anorexia is a saturated research area, this is helpful in respect of linking current research with the findings here. It is heavily documented that

anorexics tend to have a leniency toward an anxious temperament (Marzola et al., 2020) as illustrated in early childhood anxiety, anxious traits are highly implicated in the development and maintenance of AN as documented by Kaye et al., (2009) and Wierenga et al., (2014), further, childhood anxiety onset as well as lifetime anxiety disorder is found in AN (Kaye et al., 2004; Woolridge, 2018). But what is unique to the current study, is not that anxiety per se is impacting the women but the finding that participants discussed AN symptoms as a means to "to cope with stress" (Rachel, p. 11, 330 - 344), "to get rid of something" (Vanessa, p. 3, 75 - 100) and "an anxiety coping mechanism" (Jillian, p. 30, 996 - 1032) but this coping was *facilitated* by AV narrative e.g. "there was another entity in my head [ ] that I would have conversations with eh basically telling me what to do and how to do things" (Vanessa, p. 1, 31 - 39) and Beth (p. 1, 17 - 25) "a voice inside of you that isn't coming from me and is quiet loud telling me to restrict and to do exercise…telling me what's good to do and what's not good to do". So far, the narrative from the women is suggestive of the presence of anxiety and life stress as tolerated through AN, in turn, AN is facilitated by the AV. On the back of this, the researcher wishes to draw attention to the current treatment recommendation for AN as per NICE (2017), use of CBT-E for AN, in which, alongside weight restoration, clinicians are advised to enhance self-efficacy i.e. the belief in ones capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1977). With participants description of intolerable anxiety/stress and utilising AN to cope, of course enhancing self-efficacy could prove beneficial in the move away from destructive

behaviours. The findings are suggestive of the usefulness of AV enquiry as a barrier to enhanced self-efficacy though, the justification for this? because AV research has affirmed through first person testaments the voice is powerful, negative and omnipotent in nature (the reader is directed to Aya et al., 2019 systemic review of the 'eating disorder voice' experience). Not only that, once AN is ensconced, the AV is hard to dislodge, and can make recovery attempts fraught with greater stress, an example of this in the literature comes from Jenkins and Ogden (2012) qualitative analysis findings describing the voice as: 'something else inside me that would overtake me ... it drives you to do the most insane things'. An example in this study can be seen as per Beth (p. 11, 332 – 342) "when it's telling me negative things I feel even more useless than I was [ ] that makes it harder to recover". The findings are suggestive of the AV facilitating the coping of participants experienced anxiety/life stress through AN means, meaning the AV is potentially a fruitful target alongside targeting other NICE (2017) recommended areas of treatment, like cognitive restructuring, mood regulation, social skills, body image concern, self-esteem etc. However and on a final note, the AV is not a current target in mainstream treatment, any mention of it is absent from what is considered the 'core pathology' of AN, which is shape, weight and eating, maladaptive thoughts, eating behaviours, assumptions and overvalued core beliefs (Fairburn et al., 1993).

5.3.2 Cognitive Dissonance

Over time, it seems like, in instances where AV commands aroused unpleasant tension, dissonance emerged. Emotional dissonance is a discrepancy in emotions based

on internal conflicting feelings and attitudes (Brotheridge, 2001). Experiencing cognitive and emotional dissonance, participants began to consider, or re-evaluate, the alignment of their core beliefs with their externalised behaviour (AN symptoms) in contention with AV demands, put plainly, a change in attitude and behaviour was aroused. Egan et al., (2007) state, attitude change comes about when individuals seek to make their attitudes consistent with their behaviour. An example of this can be seen with the excerpt from Jillian (p. 3, 78 - 92) "for me…the separation between my conscious cognitive goals in life and my sort of knowledge of what my behaviour…in terms of my life goals, in terms of my physical health...I cognitively reasoned…that sort of behaviour was not conducive to where I wanted to go". Clear here, Jillian having inconsistent cognitions creates discomfort, so much so, a motivation to alter existing beliefs (thoughts & behaviours) is set in motion, so as to make cognitions consistent, in order to reduce discomfort. Concludingly, AN behaviours/cognitions appear inconsistent with her health and future goals.

In terms of AN research, and touching on cognitive-behaviour theory in respect of discussing cognitive dissonance, cognitive theory surmises, distancing from unwanted thoughts and behaviours can indeed reduce conflict. Distancing provides an opportunity to make an informed decision regarding behaviour response. Goodman and Villapiano (2013, p. 31) promote *challenging thoughts* as they are related to a "faulty belief system", this may be interpreted to mean, challenging both the AN cognitions and behaviours e.g. *thought:* I must restrict to prevent weight gain; *behaviour*: restrict food intake; *belief:*

food is bad for me restriction is good. This however, may prove tricky if the AV is a continued presence perceived to be controlling. In that instance, moving away from the AV might prove arduous. Research has supported the difficulty in moving away from AN demands due to a threatening AV presence, as seen with Tierney and Fox (2010, p. 248) qualitative analysis on AV experience, one participant described the AV as follows "It turned me against people…they hate you and you can't really trust them. They'll only hurt you. You don't need them.". Therefore, in 'moving away' from AV demands and the illness itself, it is widely suggested this motivation must come from within the patient despite the difficulty this brings. If the attitudinal shift is involuntary, meaning it is externally motivated i.e. mandated by family/professionals etc., the attitudinal changes are much harder to achieve. For example, Hay (2010, p. 72) "everyone's best efforts hadn't been enough to quieten the controlling anorexic voice in my head". Furthermore, Bowlby et al., (2015, p. 7) qualitative research investigating the meaning of recovery, as per the perspective of AN recovered professionals reports, "a core aspect of recovery involves learning to differentiate between the voice of the eating disorder and the individual's true and authentic internal voice, and then choosing to act on behalf of one's authentic self by taking action against the voice of ''Ed.''.

Moreover, noticing a discrepancy between self-dialogue and AN-dialogue brought the voice narrative into question, here Linda (p. 10, 304 - 315) ponders, "the voice didn't sound completely like mine because some of the things it would say would contradict some of the things I believed in myself". Through the interview Linda

described dissonance in AN behaviours remained through illness because she retained her belief that it wasn't truly congruent with her wants. Contemplating AN research regarding this topic, Stockford et al., (2019) systemic review of women's recovery from AN, suggests, the emergence of a 'fragmented sense of self' before a turning point, wherein, insight and commitment to recovery is thus developed. This fragmented self, described by Stockford et al., (2019) comes about from a re-evaluation of the value of AN in relation to life/future and is portrayed as a 'push-pull' dynamic between the person and the AV. Touching on Dialogical theory here, this theory would determine conflict between 'inner voices' as a push-pull dynamic. Dialogical theory, as per Hermans and Dimaggio (2004) attest internal dialogues as playing power dynamics, with some dominating or suppressing others as well as each voice embodying its own value system and motivations. Power dynamics can manifest as *tyrannical internal dialogues*, and *conflictual internal dialogues* for example. Here, the passage from Jillian and Linda portray a conflict between AV wants and values versus the persons own core values and wants, of which, lie outside of AN. With respect to the valuing system of varying inner dialogues mentioned in Dialogical theory, the researcher is drawn to what Carlsmith and Aronson (1963) findings regarding a person's decision to derogate (stop) an action when dissonance is aroused. They argue, a decision, to derogate (stop) an action, is driven by a process of 'devaluation', because dissonance engenders the formation of a *value based system*. When evoked, this *value based system*, it could be suggested, forced participants in this study to tally 1. extenuating life trajectories against 2. pursuing AN behaviours.

As mild AV threats continued, dissonance increased, over time, participants derogated the AV because they started to devalue it. This could explain the eventual dislodging of beliefs around the value of AN despite its persistent presence.

On a final reflection concerning this subordinate theme, contributing factors to dissonance varied for participants, as they would, because each individual was different and valued different things, but nonetheless, factors to dissonance were value based and self-actualising. This compliments findings from Mulkerrin et al., (2016) regarding the role of value contemplation in AN, prior to recovery commitment. In the same breadth, Nordbo et al., (2012) recognised value based living when contemplating AN recovery counteracts feelings of indifference, hopelessness and powerlessness, which are often present when there is a lack of other goal types or meaningful life goals.

5.3.3 The Consequences of Voice Power

Participants were deeply reflective of a perceived controlling AV, a controlling AV has previously been referred to in the literature as ‘the dictator’ by Hautzig (2008) and Hilde Bruch (1978, p. 9) refers to anorexia as the “internal dictator” This was a central experience for all participants and supportive of what Nasseff (2020) viewpoint that the individual is drawn towards voice demands until the AV highjacks the person’s life. For Bowman (2006, p. 26), the AV manifests as “a constant pressuring, pulsing voice”. As previously discussed, through the course of illness, an incongruence emerged between the wants and desires of the women and the demands imposed on them by the voice. However *The Phantasy of Control* portrays the AV’s imposition in which,

according to Rudge and Fuks (2016) might look something like a sadistic "superego" with an overdemanding insistence on obedience.

Findings shine a light on the encapsulation of the depth of AN illness for the women. The voice was altogether idiosyncratic, experienced as simultaneously internal and external, this is supported within the literature accounting the AV as a separate part of the 'whole' self (Pugh, 2020; Graham et al., 2019; Sands, 1991; Noordenbos & van Geest, 2017), a pronounced 'voice', experienced as different to the women's inner dialogue and importantly, referred to as a 'voice' by those in this study as well as accounts in other studies (De Giacomi, 2019; Ling et al., 2021). Moreover, in describing the AV, individuals attest to experiencing their mind being consumed with the voice of anorexia, whereby, when this happens they cannot focus on what they perceive to be their inner dialogue, a dialogue present before anorexia onset. This consumption by the AV has been referenced in the literature as so loud, it "drowned out everything else" (Hornbacher, 1998, p. 69).

As time went by, feeling controlled reinforced self-concept breakage. Threaded throughout each excerpt is a description of conflict between the individual and the AV within the subordinate theme *The Phantasy of Control.* The AV grew louder and intense at times of duress, it was termed in a malevolent fashion "a monster" (Vanessa, p. 3, 75 - 100) and "devil" (Beth, p. 1, 17 - 25) as well as feeling "like a possession" (Jillian, p. 26, 845 – 869) and "quite hurtful and demanding" (Sam, p. 5, 122 – 186). What's more, Rachel (p. 7, 195 - 203) articulates her experience of withdrawing from the AV in this

subordinate theme and further explains her position as “for me to describe it as an abusive relationship is easier”. This poignant phrase encapsulates the powerlessness felt by Rachel. The change of AV relatedness (from benevolent/supportive to malevolent/bullying) experienced by the women correlate with the literature, emphasising that perceived AV control/power plays a central role AN maintenance. Leading experts in the field of AV research to date, Pugh and Waller (2016) examined whether the perceived power and nature of the AV was related to AN eating pathology and using hearing voices psychometric tools marked against the *EDE-Q* (Fairburn, 1993) to establish effect on AN pathology found, high AV power was associated with greater negative eating attitudes while the interaction of greater voice power and malevolence was associated with a lower BMI. This illustrates a rooted position of the AV in AN maintenance. A reminder here, although principle to participants reflection, AV power and control as described here is not a unique finding, individual narrative accounts, depicted in Weaver et al., (2005) describe the AV as wielding 90% internal power over a person or in other words “love, hate…cannot escape”, in similar vein, Higbed and Fox (2010) and Pugh (2016) express how the AV is defined as entrapping, severely affecting self-worth and rendering individuals submissive to its demands, reinforcing global powerlessness. In other words, the words of Grange (2021), the only “I” that remains belongs to the anorexic voice. What stands out in the findings is the role of stress as mediator of voice ‘volume’, here Linda (p. 11, 367 – 390) explains “when I am down in myself it`s really loud, really there and other times when I am more confident or I have

achieved something that I am really proud of its lower". Part of being controlled is the experience of the voice as 'loud' in nature more so at a time of distress. Evans (2011) describes the voice as growing louder with weight gain and Tuckers (2015) first person account depicts her non-anorexic voice as a mere 'hush' compared to the loudness of the AV in which she describes as having to "block … your ears" (Tucker, 2015, p. 345). The most common change experienced by participants was that they felt under siege by "a voice inside of you that isn't coming from me" (Beth, p. 1, 17 - 25). This interpretation came as participants reflected on how life was becoming enthralled by AN symptoms of which, the voice phenomenon was an extension.

Of note, the self-positioning regarding the individual versus the AV outlined in *The Phantasy of Control*. This is relevant because hearing voices informed research describes how placing oneself in a rank *beneath* ones internal voice phenomenon can negatively impact ones self-esteem and ability to counteract said voice, as such, Baumeister (1993) and Briere and Runtz (1990) maintain, if a person is inclined to experience low self-esteem (the reader is directed to Noordenbos (2017) who found greater voice power meant greater reduction in self-esteem) or even feel vulnerable, arguably the women in the study at this point in time would be considered vulnerable, can be cognitively accepting of negative feedback if it is in any way shape or form, consistent with ones self-identified beliefs about oneself. On the back of this, Kim et al., (2020) talk about the long term effects of emotional dissonance as tension building and, in turn, lowers self-esteem. In addition, as per Birchwood et al., (2018) hearing voices

research suggests, voice omnipotence is a good predictor of harm compliance, an example of this as per findings here come from Jillian (p. 26, 845 – 869) “I don’t think a lot of them [people who do not have anorexia] have ever experienced something else in their head controlling their choices even if they don’t want to do them”. An example from the literature comes from Tucker (2015, p. 80) “the voice has swallowed the rest of my brain up. It has become me”. Moreover, accessing safety in distance from the voice was not possible. Consequently, participants were reflective of a sense of helplessness in asserting themselves against the voice. Despite ongoing dissonance, voice power remained high, illustrating the complexity of the AV in AN maintenance.

Five women spoke about mental and physical exhaustion from interactions with the AV in *Battle Fatigue*, an interesting observation throughout the transcripts was the language used in reflection of this exhaustion in the context of recovery contemplation. Here, Sam (p. 14, 396 – 407) expresses her fatigue “it’s mentally draining”. What’s more, although obsessional thinking, not directly discussed in this study, is noteworthy in the context of recovery contemplation within *Battle Fatigue* especially for Sam who described fatigue from obsessional thoughts and compulsions associated with AN. Obsessiveness has been associated widely with AN illness (De Giacomi, 2019; Enoch & Kaye, 1998) and is considered an exhausting experience. Withal, further research into this personality trait, as associated with AV intricacies, might yield insightful new data concerning the process of AV relatedness and recovery. Furthermore, for Vanessa (p. 12, 387 – 400) she reflected on her age at the time of the interview in comparison to her

time as a younger person with AN in the context of bodily exhaustion “so exhausting and a young body is much different than mature body…it’s really hard to imagine that I could live life like that”. Hence, the exhaustion from AV commands and AN engagement became measured against mind and body resources and a contemplation of whether or not to compromise those resources given the exhaustion. Jillian (p. 34, 1141 – 1159) recalled this time to be “miserable” as well as frustrating when “trying to manage like a multiple conversation whilst you’ve also got a conversation ongoing in your head”. Within the psychological literature, namely Pugh (2020), although not fully understood as to why a change occurs, but eventually, perceived power of oneself once dominated by the AV, is taken back by the individual through a process of AN de-centring. Here, the findings show a feeling of exhaustion, fatigue and a sort of being almost ‘fed up’ of the situation at hand, this might constitute this said ‘de-centring’. Likewise, Linda seems to have a revelation of the situation in that, she recognises the downside to AN and AV demands “It [the anorexic voice] can feed of all of them whether it`s anger, sadness, grief it just feeds and it’s been really difficult at times to separate it from me while grieving”, with this insight comes a lightbulb moment, “it warns you off yourself, ‘go away’ from your body”. In connecting to the literature, this awareness of the AV commanding Linda to move away from her body during time of distress, Williams et al., (2016) theorises that the illness is used as a tool to detach from painful thoughts and emotions, additionally, Rundle (2017) suggests unusual experiences, although perhaps dysfunctional, such as the AV phenomenon, may be present to optimise the potential of

the organism and viewed as a positive manifestation or a ‘part’ of the actualising tendency worthy of enquiry. This command to ‘go away’ from the body, as instructed by the AV, it could be suggested is a dysfunctional protective response to distress operating as a ‘part’ of the ‘whole’ self. On a final note, these suggestions, as per the findings, are not hard and fast facts, mere interpretations. Further understanding of the links between exhaustion as reported in this study and reduced AV control could offer new insights and extend what has been unearthed here.

5.3.4 Summary

The above subordinate themes have interpreted the significance of the maintenance stage of AN illness as impacted by the voice phenomenon. During this period the women became greatly entwined with AN symptomology and further fledged to AV commands. Collectively, these changes from being aligned and supported by the voice to being controlled and trapped were viewed as “abusive”. Conclusively, fear and anxiety mixed with the embers of AV devaluation, amounted to eventual participant fatigue, as depicted in *Battle Fatigue*. Participants, it appeared, as the interviews went on expressed how they became despondent as dissonance continued. In spite of this, fatigue seemed a vital variable in recovery contemplation. Participants recounted, opting for recovery was a conscious tiring process.

5.4 Superordinate Theme 3: Healing Through Compassion

One of the aims of this research was to explore and attempt to understand the

subjective meaning and experiences of the AV as it is related to illness recovery. This final superordinate theme portrayed a shift in meaning making concerning AV functioning, in turn, this positively impacted both, AV-relatedness, in other words, how the individual connected to the AV presence and its narrative around AN engagement as well as positively impacting self-directed relatedness. Self-directed relatedness is the relationship the individual has with respect to who they are as a person. This occurred after moving through AN treatment.

For all participants, recovery involved a process of externalising the anorexic illness, or, externalising the AV narrative and openly challenging the AV demands, so as to begin to observe objectively the narrative and urges that accompany it which lead to AN symptom engagement. For the women, this meant a process emerged which was mental separation from the AV. Helpful to participants, as relayed in their interviews, the application of boundary setting, meaning, setting boundaries around how much they were going to 'act on' unhelpful thoughts towards themselves as per Sam (p. 22, 633 - 646) "you don't want to be critical towards it [the voice] you want to come back [respond] with a more compassionate voice more of a loving voice". Acting on demands from the AV would mean keeping up with anorexic behaviours and rituals, as well as hurt the individual in the long term, ultimately they would stay unwell. In an effort to reduce dissonance between wants/desires for a healthy life and AN behaviour engagement, participants described a greater unification in self-concept once they began to move away from anorexia and focus on their healthy living goals. Moving away from

acting on the AV commands and utilising recovery meant achieving self-directed healthy goals and building a new relationship with themselves outside of their eating disorder. Mediating this, self-compassionate responses in the face of AV derogative statements directed at them, greater emotional self-attunement and learning adaptive (healthier alternative) emotional regulation strategies e.g. Rachel (p. 19, 555 - 567) "it became a stage of 'okay, right I'm having a bad day I need to do X, Y or Z... I could go down this route which would result in really unhealthy behaviours or I could…talk to someone". Participants spoke of undertaking a journey of reclaiming autonomy, not being swayed by their illness any longer, helped them to further stop engagement with the AV demands. For some, naming the voice, to externalise it as a separate entity facilitated de-fusion from AV intrusions i.e. a space to observe the AV commands and which allowed decision making to occur, deciding to act on the AV commands or not, an example of this can be seen with Beth (p. 5, 138 – 149) "the more it talked to me the more I feel it's something separate [ ] I'm seeing that more and more that it's something separate now [ ] being able to answer back determine that what its saying is wrong". Ultimately, reclaiming mastery over AN provided a reaffirmed wholeness within their body and mind and this improved self-relations.

5.4.1 Moving Towards Recovery

All the participants identified and described in great detail the process of reconciliation, therefore this theme was appropriate to include as the narrative guided the researcher in naming this theme in this manner. Reconciliation is, by definition both,

1. A situation whereby two or more people become friendly again after they argued and 2. The process of making two opposite beliefs, ideas or situations agree (Cambridge University Press, n.d). Similarly, but regarding internal conflicts, where it *feels* like two opposing sides in *one* person, we could argue, reconciliation is self-relatedness in the absence of hostility as per Salter McNeil (2020). The subordinate theme *Reconciliation* highlighted participants experience of negotiating their recovery in relation to the AV and the illness as a whole. For Jillian (p. 29, 967) developing "an easy truce" with the voice demonstrated the reduced intensity of AV-Jillian power dynamic previously witnessed in *Phantasy of Control*. Respectfully, Dialogical theory would state, changes in the dialogical-self carries value, i.e. a reduced conflict amongst internal dialogues is valuable and worthy of achieving. Supporting this statement, Salgado and Hermans (2009) advocated for the usefulness of a dialogical approach where issues of relating mind and body, are concerned, this is applicable to anorexia. They see it as a useful means to unite antinomies, in this instance, we could argue the antinomies are 1. the AV and 2. the non-anorexic dialogue of the person. Unification occurs via a continued process of dialogical negotiation. A truce is an example of a negotiation. This is in line with a novice AV intervention from Ling et al (2021) who interviewed anorexic women after one Open Dialogue session, results indicated helpfulness and value in separating oneself from the AV, greater AV understanding and participants reported feeling a mixture of hopefulness and motivation for recovery. A more cognitive perspective as per Morrison et al., (2004), would suggest that the merit of interpretation of the 'voice', will

have consequences for how we feel and behave, over time, the responding feelings and behaviours maintain the belief about the influence of the voice. Jillian positioning herself as equal or in effect *not less than* allows an interpretation of AV narrative perhaps to feel less threatening, meaning she can interpret the AV from a space where she has greater confidence disputing it. Supporting this, hearing voices experts Chadwick and Birchwood (1994) maintain emotional and behavioural responses to voices are influenced by how they are appraised, appraising the AV as non-dominating and less influential provides opportunity for recovery.

For Vanessa (p. 21, 695 - 702) in *Reconciliation*, the illuminating identification that a unification is the way forward shows an acceptance, that although the anorexic voice is part of the illness, its equally part of her "I am still trying to discover who I am as a person…It [the voice] is a part of me it belongs to my past, but [who] are we? We are now, it is our past and including transferring into our future". Tying this in with the literature, the researcher is reminded of a humanistic stance on this position of unification of which Vanessa talks about. For Rogers' (1961), ideas about 'self', are described as a process of 'becoming', meaning, the self is not a fixed entity, but its moving its 'fluid' and actualisation is a mechanism for optimisation of the organism, meaning, enquiry and curiosity lie at the heart of this approach to human sense and meaning making. In Vanessa's acknowledgement of discovering herself and acknowledging the AV is a part of her past, present and future, is what Wharne (2018) would describe as a form of communication between the hidden 'voice' obtained inside in which others and self

would do best to hear. This means recognising the AV as an interpersonal way of relating. In a therapeutic setting as facilitated by the therapist, this would mean talking to the client about this experience in its totality (past, present, future) so as to lead the person in the direction of actualisation and healing. Ultimately, avoiding or bypassing this experience could be detrimental, in other words, unifying the trickier 'parts' of self could maintain (fix) the presence of the AV and lead to relapse as supported by anorexia researchers Hibbs et al., (2020) and Smethurst and Kuss (2018).

To support the women in recovery, an important area to focus on was reclaiming autonomy as seen in the subordinate theme *Reclaiming* "I have at least found ways…like how I can stand up to it [the voice]" Beth (p. 20, 591 – 594), choosing to recover off their own merit, "I chose it [recovery]" Rachel (p. 15, 430), not being swayed by their illness any longer "I am the one in control I am the one who can make these choices" as per Sam (p. 21, 596) or feel insignificant "I feel big and the voice is tiny" Vanessa (p. 30, 975). This helped to further stop engagement with the AV demands. For some, therapy supported this shift which was depicted as a "procedure of separating out myself from the internal voice that is not me" (Jillian, p. 2, 46-47), further, Rachel described a new found distance between herself and the AV "it's a case of their voice is still there but it's whether or not you choose to listen to it (p. 9, 251 – 258). Relevant research evidence suggests that 'separating self' or externalising the AV as per in the therapeutic model, MANTRA, externalisation via letter writing which is then read aloud, is based on the premise that this intervention facilitates overcoming avoidance of emotions. In

respect of this, it could be tentatively suggested, as per the women's account, choice in autonomy is increased once a distance is created between self and AV. Thus, writing about self-versus-anorexic voice as per MANTRA or talking out loud about the AV in therapy as a form of self-observation is an attempt to integrate the self-criticising AV, an intervention further used and supported by Hibbs et al., (2020) and Pugh and Rae (2019). Additionally, Mearns (2003) Person-Centred perspective would ascertain, the reclaiming of autonomy and reduction of reliance on external validation AN engagement as facilitated by the AV narrative, is a helpful move to assist the client in internalising their locus of evaluation.

Furthermore, recovery for the women on one level meant non requirement of professional intervention for AN symptoms. However, interpersonal recovery was an ongoing process in terms of living with the AV, albeit, its presence was reduced, Rachel (p. 9, 251) "he's [the voice] definitely still there but he's not a prominent character, you kind of go 'sshh' and he goes away again" and Beth (p. 20, 591) "I have at least found ways to quieten at least, even if it's [the voice] still there". As per the literature, a factor in determining the nature of transition of voice experience from non-clinical to requiring clinical intervention, is the *response* one has to the voice experience in terms of beliefs, appraisal, attribution of significance and attributing it to an external source, which results in loss of ownership and agency (Garety et al., 2001). In terms of recovery, the women appeared to change their appraisal of the AV, this helped reduce its negative impact on them. Finally, the way voice coping is ensued in recovery is also a determining factor

for keeping the voice at bay, alternative emotional coping, it seemed, as well as learning to integrate the AV and distance self from responding via 'going along' with the voice, appeared for the women to bolster recovery despite AV presence.

5.4.2 The Importance of Compassion

Compassion, according to Gu et al., (2017) is defined as the emotional recognition and perception of the suffering of others, coupled with a desire to alleviate it. Participants described numerous instances of how increasing self-directed compassion and kindness, akin to their awareness of their suffering via their illness, was restorative. Contrasting the hostile controlling AV, it seems the adaption of a compassionate stance to oneself held merit. The expression of compassion towards self is clear in the subordinate subtheme *Being Nice to Oneself,* for example, "I am not going to hurt myself" Vanessa (p. 28, 947), "you want to come back with a more compassionate voice more of a loving voice" and Sam (p. 22, 633 – 646). Profound experiences of self-compassion expressed in the interviews, is in line with other studies that have explored experiences of compassion focused interventions/rituals positively impacting sustained recovery and improved quality of life. Dudley et al., (2018) exploration of voice hearers associations between the constructs of mindfulness of voices, self-compassion, and distress from hearing voices, found, self-compassion mediated the relationship between mindfulness of voices and severity of voices. Regarding AN recovery, Kelly et al., (2020) found anorexic women reported less eating pathology on the days they practiced greater self-compassion above usual standards. Additionally, Kameo (2021) found the

adaption of a self-compassionate mindset increased the likelihood of continued positive self-talk. Further, Kelly et al., (2014) demonstrated participation in self-compassion early in ED treatment meant better treatment outcomes. Not ignoring first person accounts discussing the value in strengthening adaptive internal voices which counteract the AV have equally shown eminence “when I loved myself enough I stopped listening to the eating disorder voices (Lawrence, 2011, p. 90)”. Importantly, a recent study by Kelly et al (2021) qualitative findings show, cultivating self-compassion in AN recovery yielded improved health; personal development like growth and coping; improved outlook; and enhanced social relationships. On a wider scale, the construct of compassion i.e. the universality of suffering, understanding this and thus feeling moved by witnessing the suffering of others, emotionally connecting with their distress, and further tolerating uncomfortable feelings like distress, for example, allows a space in that one can remain open to and accepting of another’s suffering is altogether profound for the participants, who, during illness maintenance, endured self-inflicted suffering. This compassionate position is a 360 degree turn from *The Phantasy of Control*. Incorporating compassion interventions in AN treatment to a greater degree would be of immense benefit because research has evidenced a link between compassion and self-compassion with psychological health and wellbeing (Bluth & Neff, 2018; Cassell, 2018).

5.4.3 Summary

In summary, the participants descriptive comments throughout the superordinate theme *Healing Through Compassion* were interpreted to be clustered

around a sort of trial and error process of reducing voice power by propping their position against the AV as greater in strength, enforcing their autonomy over their decision making, putting their non-anorexic self needs above AV demands and altogether this it appeared to result in changes concerning AV meaning (*it's a part of them but not entirely dominating them*) and relatedness (*learning to live in tandem with this part of themselves*). As Seed et al., (2016) would argue, focusing on quality of life may mean holding onto parts of the 'anorexic self' but in a safe way, or in other words, holding the AV in a curious stance but in a non-destructive manner. Reconciliation, empowerment and self-compassion are central aspects of AN recovery as per Duncan et al., (2015) and equally appear so as demonstrated in this study. In tightening the process of recovery, hearing voices research can inform us that targeting the presence of the AV and its power is imperative to distress reduction (Chadwick & Birchwood, 1994; Mountford & Waller, 2006), on the back of that, targeting AV power via future research may be a fruitful avenue of enquiry in the future.

5.5 Relating Research Findings to Existing Literature

5.6 Exceptional Data Review

The exceptional data provided insight into how participants perceived AN treatment as well as expressing fear about AV disclosure. Participants described frustration about weight gain focus to the detriment of psychological input. Weight gain is necessary in AN treatment, however, BMI indicators do not constitute full remission, barriers to recovery remain even if sufficient weight is achieved (Khalsa et al., 2017; Smethurst & Kuss, 2012). The consequence of this, negative service engagement and an inability to address the AV in a meaningful way.

Diagnostic labelling induced terror in disclosing the AV for fear of retribution or judgement. Stigma in disclosing hearing voices is widely documented and contributes to non-treatment seeking and negatively impacting relationships (Silva et al., 2017). AV discussion being largely non-existent, can lead to illness continuation, lack of trust in professionals and add to social stigma. Professionals lack of acknowledgement of all aspects of AN, including the AV, can leave individuals feeling misunderstood and mistrustful (Fogarty & Ramjan, 2016; Persson & Turesson Alfaro, 2020).

Descriptions of cognitive and relational therapy experiences highlighted, not one approach fits all. Behavioural interventions were considered beneficial during initial stages of recovery. Research supports the usefulness of CBT-E improving eating pathology and weight gain (Dalle Grave et al., 2020). Participants advocated relational

experiences in therapy as hugely beneficial in helping to feel safe within themselves despite AV presence. Stockford et a., (2019) attests to the relational aspects of ED recovery as bolstering recovery maintenance.

5.7 Future recommendations

Research into the AV in anorexia is limited. This study has contributed to the literature by providing a voice for women with a diagnosis of anorexia who experienced an illness related 'voice'. In doing so, it also identified several areas that would benefit from further investigation and considered starting points for further research.

To add to the existent literature, a large, detailed and diverse collection of experiences in the words of those who identify as experiencing an anorexic voice would be of great benefit. Understanding the subjective experiences of AV, how it differs across populations should be a central concern to ED practitioners as well as inform future effective therapeutic intervention. In devising perhaps an AV phenomenological survey (open and closed questions), distributed across the UK and Ireland, inclusive of all genders and ages, but for those with an anorexic diagnosis, could ascertain further knowledge regarding for example, AV structural characteristics e.g. loudness as well as, say, voice identity. This type of enquiry would also be helpful in gathering a diverse range of perceptions of terminology used, as hearing voices literature attests to high stigma and shame associated with such expressions as 'hearing voices' or any voice phenomena experience (McCarthy Jones, 2012). One major reason as to why this would be helpful, systemic empirical research on the phenomenology of the AV remains scarce.

Using a mixed methods analysis, a data driven analysis like thematic analysis could offer richness via theme development as well as catering to larger participant sample sizes.

Alternatively, the use of a focus group for those with an AN diagnosis to capture discussion and debate about the AV would be a convenient and relatively quick way to gather data. Focus groups can indeed be used for sensitive topic discussion (Silverman, 1997). The idea of group members building upon each other's responses can manifest as elaborated accounts of the experience to a greater degree than individual interviews. A focus group can be digitally recorded and transcribed verbatim for ease and analysed for example, using thematic content analyses. However, a drawback of focus group analysis however is the rarity to which the interactive nature of the group dynamics are analysed (Kitzinger, 1994) however in terms of gathering crumbs of gold from the narrative in a focus group re the AV topic, this would be a vital option to consider for future research.

On the topic of stigma around disclosure of a 'voice' in anorexia, it would be fruitful to quantify the attitudes of ED professionals towards voice phenomena in anorexia. Borne out of the exceptional data in this study was the fear that professionals wouldn't understand the emotional and social experiences faced by participants therefore, they withheld disclosure. An assumption cannot be made that non stigmatic attitudes are present in all practitioners despite the fact they work in the mental health arena. Of importance, would be to establish whether gender, theoretical orientation, discipline and years working in mental health would impact attitude towards AV disclosure. Treatment interventions and importantly, delivery of such interventions in

minimising distress from the AV, is greatly achieved if those delivering said treatment are either without/at least aware of stigmatic attitudes that they hold, as well as stigmatic attitudes that wider society might hold against those disclosing an experience of this kind.

As discussed throughout the study, IPA was applicable to the study aims. The methodology section highlighted how GT is not so well suited to this, however, a GT study could complement this one in terms of future research and taking the ideas established in this study to contribute to the development of an emergent theory on the anorexic voice through the trajectory of illness onset, maintenance and recovery.

Finally, investigating the AV in anorexia more generally could do well from acknowledging factors that participants described to have moved their sense of powerlessness to greater autonomy over decision making regarding AV engagement. Specifically, additional factors worth considering are

1. The role of mental fatigue as mediating individual decision making regarding AN engagement

2. To what degree are patterns of relating to others influencing or impacting AV-individual style relating

3. The extent to which NICE (2017) recommended treatment can be used to effectively target and reduce AV distress

4. Targeting powerful AV experiences (when it occupies the role of a friend) as part of AN early intervention pathways and alongside motivational interviewing at the start of treatment

5. Self-compassion interventions as a form of self-AV conflict reduction

6. Dialogical interventions to integrate the AV to reduce overall distress

5.8 Dissemination of this Research

Firstly, participants in this study who requested a copy of the final thesis, a copy will be disseminated to them. With this, participants will be afforded the opportunity to contact the researcher to discuss the thesis findings, ask questions and/or relay queries pertaining to the thesis. Secondly, the researcher will offer to discuss the findings of this thesis within eating disorder services of which the researcher is affiliated in the context of shared understanding, provide informed learning founded in accredited research and/or to be used to contemplate practice change. Further, it is hoped the shared knowledge of this thesis will be cast further afield to reach patients and professionals interested in this particular topic. There are two motives behind this, the researcher holds a strong belief in the importance of research and evidence, and its value for health service improvement, patient care and outcomes as well as the fact the researcher has a personal interest in this topic and so a desire to share these findings is high. Lastly, the current study has highlighted several areas as to how further change can come about for the client group in this study if the AV is considered deeply within the context of AN illness

as a whole. This thesis, it is hoped, will contribute to future practical change in how we, professionals, treat persons with anorexia.

5.9 Implications for Counselling Psychology

5.9.1 Counselling Psychology Ethos

This research has endeavoured to contribute to the existing research within the field of eating disorders by exploring patients' experiences of the 'voice' of anorexia, also termed the anorexic voice (AV), from the position of a CoP practitioner and researcher. This research is particularly relevant to CoP as it is a qualitative piece of research that has explored patients' lived experiences. According to Larsson et al., (2012) CoPs hold a responsibility to value a phenomenological experience of the individual without assumption and without non interrogative use of diagnostic labels, with that, IPA was utilised so as to gain in-depth expression of experience related to the AV. Cooper (2008) eloquently depicts CoP as concerned with understanding human beings as 'relational beings' who embody subjective and inter-subjective experiences, meaning, an explicit focus for CoP's is on humanistic values and intricacies. It seems that CoPs are in a good position to make valuable contributions while holding this stance as they, including the researcher, contribute to evidence base research. Cooper (2008) statement sits comfortably with the researcher and this ethos remained close to the researcher throughout the course of the study.

The scope for CoPs values and principles reaching policy makers and NHS vision boards can in fact be seen in the NHS Mental Health Implementation Plan 2019/20 – 2023/24 which outlined directives for ensuring adults with eating disorders will have greater choice and control over their care, as well as integrated community models of care. These developments are seen as synonymous with CoP philosophy and practice. Greater treatment choice and integrated community care are a vital step in seeing the 'whole' person and their needs, moving away from pathology and symptomology that are conveniently fitting for dominant medical models of care. True to CoP ethos is firmly recognising a person is not an 'objectified patient' but as Victoria Galbraith (2016) states, the person is an agent, capable of giving valuable information about themselves and their feelings regarding care received, their voices need to be taken seriously.

CoP was officially recognised in 1994 by the BPS as a distinct and unique profession (Corrie & Callahan, 2000), since then, CoP is continuing to use research, theory and practice to inform policy makers/healthcare systems in an effort to stay close to the core values of individual meaning making and reduce psychological distress by applying a person-centred approach as informed by said research, theory, and practice. As previously stated, the researcher holds firm, CoP's are concerned with 'real world problems', so too is the researcher who fiercely defends the subjective meaning of anorexic suffers experience of the AV and wills this to be heard. And so, contributing to AN understanding via this study it is hoped can make a difference to the real difficulties experienced by this group of individuals and help professionals treating them.

5.9.2 Counselling Psychology Practice

It is fair to say and according to Gillon (2007) CoP is a discipline that encompasses varying therapeutic approaches located within the traditions of humanistic, cognitive-behavioural, psychodynamic and existential therapy. In practice, what this looks like is depicted nicely by Milton (2012, p. 13) “working with clients we are continually navigating between grand narratives about psychological health and pathology on the one hand, and the attempt to find personalised accounts that are meaningful and helpful to individual clients”. In accordance with looking at participants subjective feelings and meanings in this study, as is imperative for a CoP (Strawbridge & Woolfe, 2003) this research found relevance in exploring AN related therapeutic approaches, used in individual formulation building in therapeutic practice, e.g., cognitive-behaviour, humanistic, psychodynamic and interpersonal theory as a foundation for which participants feelings/meanings could be organised. The integration of psychological theory and research with therapeutic practice is what makes CoP unique.

From this unique position the researcher feels a responsibility in CoP practice to address and hence, hear the unspoken or infrequently spoken aspects of individual distress in accordance with maintaining ethical CoP practice, "the expertise of CoP profession to explore the lived experience of people with mental distress from a diverse demographic" (DCoP, 2018, p. 8). CoPs have the opportunity to contribute to literature by providing research in scarcely studied areas to fill the gap between clinical practice

and research (BPS, 2005). The gap to be filled here, is understanding the AV phenomenon in anorexia. In practice, this means giving permission, space and safety for underrepresented or marginalised client groups or uncanny client experiences and use the therapeutic alliance/relational depth for healing. One major reason why this may be important in practice is the sobering realisation that when experiences of voice hearing occur, but are equated in the first instance to psychosis, this is grossly misleading and halts wider phenomenological enquiry (Kantorski, 2018). It is imperative to equip practitioner psychologists with the understanding that the acceptability that voice hearing occurs outside of diagnosed mental illness is evidenced in research showing voice hearing occurring across cultures, within religious experiences and reported amongst bereaved individuals, viewed as relatively normal in these circumstances and not attributed to psychosis (Phalen et al., 2019). CoP's do not hold fast to diagnostic criteria and as far as treating the AV in AN, it is widely known, many healthcare professionals will treat an aspect of a disorder, that may otherwise be excluded from the diagnostic criteria, because its presence negatively impacts the individual (Cuzzolaro & Donini, 2016). In practice, ED professionals are starting to find novice ways to work with the AV presence in support of optimising recovery (Pugh, 2016) this is vital because working with this particular client group, alliance building can be complicated (Sibeoni et al., 2017). As CoP numbers are increasing within NHS settings, CoPs are rapidly securing employment in specialist areas like eating disorders alongside NHS trained

clinical psychologists, the practice of CoP principles are ever more precious, valuable and thankfully, expanding.

5.10 Research Limitations

There are a number of important limitations to this study. Firstly, the research findings are representative of individuals within varying demographic locations. The majority of participants were based in the U.K. One participant was based in Ireland. Replication studies might consider how cultural differences impact AV findings as well as consideration of the specific regional healthcare system priorities, challenges and pressures and how this might impact on AN treatment experience.

Secondly, participants disclosed mental health medication intake, however, this was not discussed in the interview in relation to the AV experience. How and if participants increased nutrition and use of mood altering medication impacted decision making, or in part, worked in conjunction with perpetual dissonance in strengthening attitude change was not analysed. Further research into the use of mood altering medication and increased nutrition, in line with emerging dissonance, would be helpful in ascertaining the process of AV devaluation. As an adjunct to that, participants predominantly relied on their memory to account for events that happened according to them, many years earlier. With that, there exists a possibility that the participants had not reflected on past events accurately.

Thirdly, in addressing methodological limitations, IPA was the chosen method for which the interviews were analysed. The strength in using IPA is that it enables good quality data to be captured during interviews thus providing nuanced understandings of the AV phenomenon in anorexia illness. However, as is common with qualitative research the subjective nature of the approach can be its Achilles heel. This means, findings have come about both via participant narrative and the researchers interpretation of that narrative. Additionally, a small sample size cannot be used as a generalisation of all anorexics experience of the AV. Therefore, substantive conclusions and generalisations cannot be drawn from the data.

Lastly, the participants were all female, how and if the AV is perceived differently in males was not addressed in this study and may warrant future consideration.

5.11 Conclusion

Since the formal acknowledgement by the 19th century English Physician, Sir William Gull, that anorexia was an experience and illness causing immense distress and not associated with fanciful idealisations of holy piety or demonic associations and for those afflicted titled ‘witch’, thankfully, this illness is considered very real and imperative to treat. Since the turn of the 19th century, what has been witnessed within this research field are considerable attempts to contextualise the experience, search effortlessly for its aetiological roots and cleverly trial and error varying therapeutic models to assess distress reduction and support physical health, all of which are still

evolving. What this research has tried to do is contribute to the vast literature built up around this illness but to poke holes in new thinking around aspects of anorexia not yet fully understood or to a certain degree, even contemplated. This study was an exploration of how 6 women experienced and understood the anorexic voice phenomenon. It has contributed to further insight into this an area of research in anorexia, still in its tender years, but has implications for professionals working in services treating anorexia, therapeutic practice, research and last but not least policy.

Moreover, this area of research is a tricky one to position oneself as a CoP as the services primarily treating AN sit within a positivist biomedical umbrella, all the while the researchers position is to acknowledge a subjective multi-faceted view of this illness and the world in which its treated, somehow searching for a balance between responding to gaps in knowledge, gaps in treatment, gaps in aetiology while trying to maintain an open position of 'not knowing'.

Finally, the large quantity of responses to the study advert and the extent to which a number of people had to be turned away after recruitment ended is a testament to this topic as an area of interest in which people wish to discuss. Using IPA (Smith et a., 2009) has enforced a deep appreciation of participant experience. Interviews were full of rich expression and discussion around the topic. It is the researchers hope the interpretation offered holds participant truth and does them justice. The catering in this study to researcher reflexivity opened avenues of thought not previously pondered. The stigma around voice hearing in anorexia and beyond was important to reflect on. As a

CoP, the language used with clients, the societal stigmata around idiosyncratic phenomena and fear of how professionals might interpret client experiences were all thought deeply about and to a large degree, reflexivity supported professional and personal growth concerning these matters.

A final message from this study is a recognition of the sheer complexity in which humans experience their inner world. It is not a silent world, it is multi voiced, sometimes conflictual, sometimes harmonious, but not noiseless. In holding a curious and compassionate stance of enquiry towards oneself, participants eventually reduced the chaos of their inner world voices and learned to be with and within themselves in a more manageable and less destructive, if not opportunistic way.

5.12 Final Reflections

Firstly, the findings from this study have important implications for not only those who work with AN but for and within the systems in which they work. Secondly, the researcher hopes that the findings encourage the continued development of nuanced ways to incorporate the AV into treatment and is seen to be an aspect of AN maintenance worthy of being thoroughly understood and treated in parallel to the other important aspects of AN. Thirdly, it is hoped this qualitative exploration will encourage the implementation of a more person-centred approach to understanding AN outside of clinical core features concerned with pathology. Finally, it is hoped that, in light of all that has been said, addressing the ‘voice’ of AN in treatment might be considered, not so much a sign of a ‘disorder’, but a sign of a ‘voice’ within a person, their truth is linked

with this voice. And so, professionals may not always have the answers but a willingness to try to seek it out is the researchers final aspiration.

DISCUSSION REFLEXIVE STATEMENT

Reaching the end of the study felt like an onerous but rapturous journey fraught with professional and personal challenges. Highlighting what I have both brought to the research process and taken away, is the echoing parallel positioning of storyteller and performer. I inevitably influenced the research process, in turn, the research process influenced me (Corbin & Strauss, 2015). I was curious to find out more about a topic not investigated much before but revered as contributing to severe and enduring forms of anorexia nervosa (Pugh & Waller, 2016), conducive to rigid illness beliefs amounting to burnout and frustration within professionals (Graham et al., 2019). Through the course of completing the study, keeping a reflective journal, speaking to both professionals and lay persons, has led to a firm grounding of balanced perspective and open mindedness. Predicating balance in perspective was the reminder that the participant collective spoke of the complexity of their illness requiring input from a multitude of disciplines spanning across the biopsychosocial sphere, all worthy of consideration.

I am comforted by the fact that the participants found the study topic relevant, their interviews did not merely reflect their experience in so far as augment it. This study highlighted that AN complexity requires treatments that are reflective of this complexity, treatments that move beyond a focus on overt symptom modification and embrace the understanding that psychological difficulties have multiple causes and maintenance factors too vast for a singular model of intervention to reconcile. My awareness, curiosity

and respect for varying models of therapy has grown as a result of this study, further supplementing my enthusiasm for difference and where appropriate, unification.

The process of interviewing was amiable, I built a good repour with participants, the emerging themes were evident and overlapping but presented by each individual in varying ways. Halfway through analyses I was overcome with analyses paralysis, feeling entirely overwhelmed. I tried to stay focused on the question that grabbed my attention in the first instance, keeping my feet firmly fixed to the research aims and objectives. With regard to the scope of future quantitative and qualitative research into the AV, the numerous participants who failed to meet criteria for entry into the interview process, and were subsequently declined, holds testament to the breadth of individuals wanting to offer further insight into this research topic.

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Appendix A

DSM5

Disorder Class: Feeding and Eating Disorders. To diagnose Anorexia Nervosa, an individual must present with the following symptoms:

A. Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of the age, sex, developmental trajectory, and physical health (less than minimally normal/expected). *1*

B. Intense fear of gaining weight or becoming fat or persistent behaviour that interferes with weight gain.

C. Disturbed by one's body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of seriousness of low bodyweight.

Subtypes

Restricting type: During the last 3 months has not regularly engaged in binge-eating or purging.*2*

Binge-eating/purging type: During the last 3 months has regularly engaged in binge-eating or purging.*2*

Partial remission: After full criteria met, low bodyweight has not been met for sustained period, BUT at least one of the following two criteria still met:

- Intense fear of gaining weight/becoming obese or behaviour that interferes with weight gain
- OR
- Disturbed by weight and shape.

Full remission: After full criteria met, none of the criteria met for sustained period of time.

1

Severity is based on body mass index (BMI) derived from World Health Organization categories for thinness in adults; corresponding percentiles should be used for children and adolescents: Mild: BMI greater than or equal to 17 kg/m2, Moderate: BMI 16–16.99 kg/m2, Severe: BMI 15–15.99 kg/m2, Extreme: BMI less than 15 kg/m2.

2

Purging is self-induced vomiting or misuse of laxatives, diuretics, or enemas

Appendix B

Specialist Supportive Clinical Management

Specialist supportive clinical management (SSCM) typically consists of 20 weekly sessions and combines features of nutritional education, behavioural weight restoration strategies and supportive psychotherapy. SSCM (McIntosh et al., 2006) was originally developed as a comparison treatment for an Sommer beck treatment trial as a representative to what might be offered by an eating disorder professional such as a nurse or therapist.

Eating Disorder Focused Cognitive Behavioural Therapy

CBT combines behavioural experiments with rational exploration of a person's beliefs typically consisting of 40 sessions over 40 weeks. There are two types of CBT that have been manualised for AN – CBT-AN (Pike, 2003) and CBT-E (Fairburn, 2003). In clinical practice, they are indistinguishable. Both treatments target AN symptoms, encourage healthy eating to restore a healthy body weight. The provision of psychoeducation, behavioural monitoring, nutritional education, behavioural experiments, cognitive strategies and relapse prevention are key components of these therapies. Both CBT-AN and CBT-E also monitor weight and The main distinction between the two models is a theoretical one. CBT-AN specifically targets AN, CBT-E is based on a 'transdiagnostic' model meaning, all eating disorders are believed to be maintained by the same distortions

in thinking. CBT-E also works on mood intolerance as well as if necessary addressing clinical perfectionism, interpersonal deficits and low self-esteem (Fairburn 2008).

The Maudsley Model for Treatment of Adults with Anorexia Nervosa

The Maudsley Model for Treatment of Adults with Anorexia Nervosa or MANTRA was developed by Schmidt (2006; 2012) and Treasure (2013). It typically consists of 20 therapy sessions. MANTRA is usually offered to those with long standing AN it addresses AN sufferers' inflexible cognitive style and alexithymia. The core modules include emotion skills training and cognitive remediation therapy designed to improve cognitive flexibility. It is a manualised treatment, collaborative and is focused on using the manual workbook in session. Motivational interviewing techniques are used to help encourage behaviour change and symptom management, and family members are often involved to provide support.

Appendix C

Consent for Audio Taping and Interview Transcribing

Title of Research Study: "The experience of living with an Anorexic Voice
an Interpretative Phenomenological Analysis study

This form is to ask for your permission for the interview to be audio taped by the researcher.

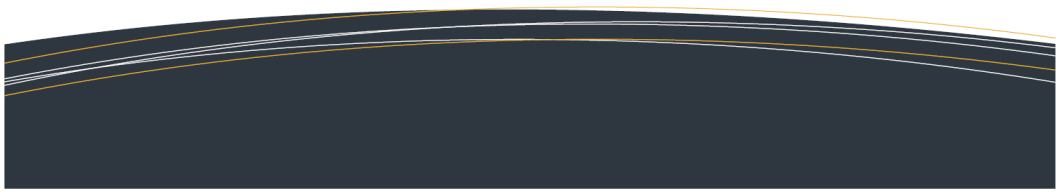
The tape along with the interview transcript will be subjected to encryption by anonymizing any personal details such as your name and date of birth. The tape will be securely stored away from any written records that contain identifying information. The tapes will be accessible to the researcher and the supervisors only. The tapes will be destroyed once the transcripts have been checked for accuracy.

The interview transcript is the product of research and so it may be used in consequent reports and/or presentations.

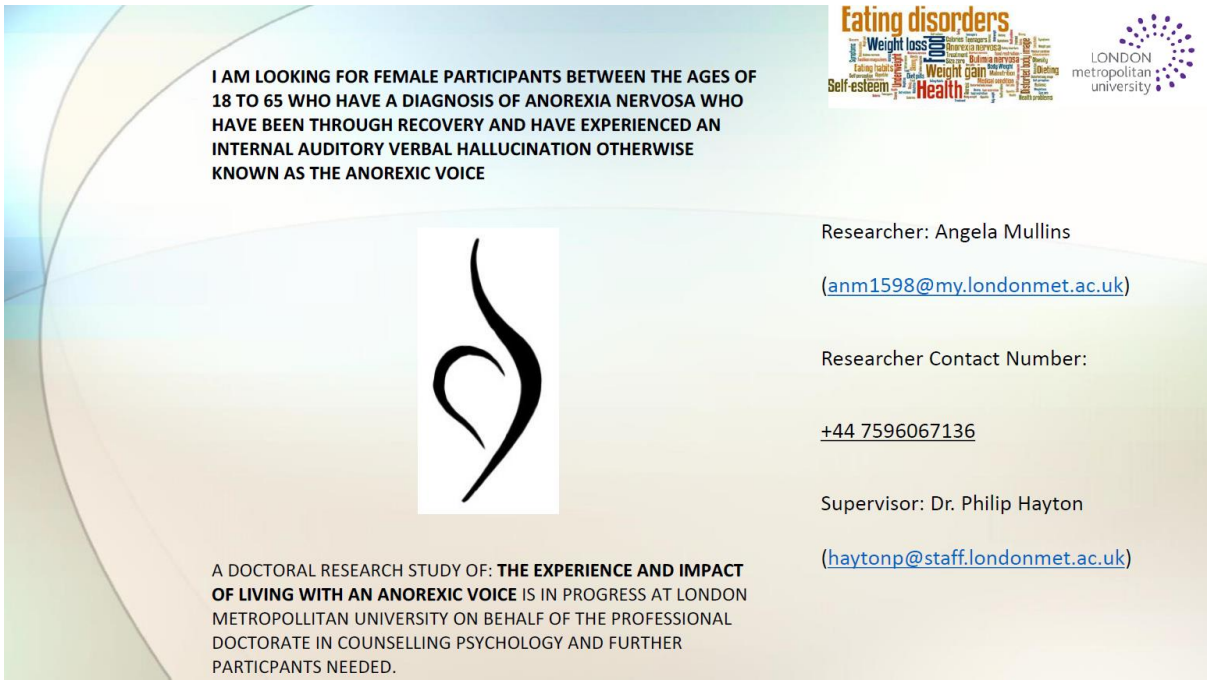
You have up to four weeks to withdraw consent after the completion of the interview. Withdrawing at a later stage will not be possible.

Name of Participant_____
Signature of Participant _____
Date_____

Name of Researcher_____
Signature of Researcher_____
Date_____



Appendix D


Eating disorders
Weight loss
Food
Weight gain
Self-esteem
Health
LONDON metropolitan university
I AM LOOKING FOR FEMALE PARTICIPANTS BETWEEN THE AGES OF 18 TO 65 WHO HAVE A DIAGNOSIS OF ANOREXIA NERVOSA WHO HAVE BEEN THROUGH RECOVERY AND HAVE EXPERIENCED AN INTERNAL AUDITORY VERBAL HALLUCINATION OTHERWISE KNOWN AS THE ANOREXIC VOICE
Researcher: Angela Mullins
(anm1598@my.londonmet.ac.uk)
Researcher Contact Number:
+44 7596067136
Supervisor: Dr. Philip Hayton
(haytonp@staff.londonmet.ac.uk)
A DOCTORAL RESEARCH STUDY OF: THE EXPERIENCE AND IMPACT OF LIVING WITH AN ANOREXIC VOICE IS IN PROGRESS AT LONDON METROPOLLITAN UNIVERSITY ON BEHALF OF THE PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY AND FURTHER PARTICPANTS NEEDED.

Appendix E

The British Psychological Society

Chartered Psychologist

Participant Consent Form for the Professional Doctorate in Counselling Psychology research project

Contact details for further information:

Researcher: Angela Mullins (anm1598@my.londonmet.ac.uk) *Counselling Psychologist trainee*

University Department: Psychology department/School of Social Sciences

Contact Number: +44 7596067136

Supervisor: Dr. Philip Hayton (haytonp@staff.londonmet.ac.uk)

Title of the study: *The Experience of Living with an Anorexic Voice. An Interpretative Phenomenological Analysis Study.*

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please complete this form after you have read the *Information Sheet* and/or listened to an explanation about the research.

The British Psychological Society

Chartered Psychologist

LONDON metropolitan university

Please tick the appropriate boxes	**Yes**	**No**
1. Taking Part		
I have read and understood the research information sheet dated DD/MM/YYYY.	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the research. Taking part in the research will include being interviewed and recorded (encrypted audio device)	☐	☐
I understand that my taking part is voluntary, I can withdraw from the research study at any time and I do not have to give any reasons for why I no longer want to take part.	☐	☐
2. Use of the information I provide for this project only		
I understand my personal details such as phone number and address will not be revealed to persons other than the primary researcher and Doctorate supervisor.	☐	☐
I understand that my words may be quoted in publications, reports, web pages, and other research outputs.	☐	☐
I understand that I will be assigned a pseudonym within the written research paper to protect my identity.	☐	☐
3. Use of the information I provide beyond this research study		
I agree for the data I provide to be archived within the remits of the Data Protection Act 1998.	☐	☐
I understand that other authenticated researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand that other authenticated researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐

The British Psychological Society
Chartered Psychologist

LONDON metropolitan university

	Yes	No
Legal use of information agreement		
I agree to assign the copyright I hold in any materials related to this project to Ms Angela Mullins.	☐	☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project and understand what the research study involves.

_____ _____ _____

Participant [printed] Signature Date

Researcher Statement:

I _____

Confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

_____ _____ _____

Researcher [printed] Signature Date

Appendix F

Participant Information sheet

Title of Research Study: "The experience of living with an Anorexic Voice an Interpretative Phenomenological Analysis study"

Who am I?

My name is Angela Mullins I am studying for a Professional Doctorate in Counselling Psychology at London Metropolitan University. I am interested in finding out about the lived experience of the Anorexic voice.

Who is monitoring this research study?

This research study follows the Code of Ethics by the British Psychological Society (2018). It has been given ethical approval by the Research Ethics Committee of London Metropolitan University. I am supervised throughout by Dr. Philip Hayton.

For questions you can contact me if you have any concerns you can contact me via phone or email as listed below

anm1598@londonmet.ac.uk +44759 6067136

What is the Purpose of this research?

This research aims to show that shared experiences of features of anorexia will demonstrate the need for a wider awareness of the anorexic voice and result in a more informed approach to understanding and treating this disorder. The findings from this

research could be used to improve the services that provide treatment to individuals with eating disorders. The research findings could also help trainees and qualified therapists learn more about anorexia and how to treat this disorder. I am looking for female participants aged between 18 and 65.

Who can take part?

1. Women aged 18 to 65 who:
    - Have received diagnosis of Anorexia Nervosa in the past
    - Have recovered or are in the rehabilitation stages of recovery from Anorexia
    - Do not have a diagnosis of Schizophrenia or Psychosis
    - Would be able to travel to London Metropolitan University Holloway road for the interview

If I want to take part, what will happen?

You can contact me via email or phone if you are considering taking part. I will contact you via phone to ensure you meet the given criteria before proceeding to the next stage. Before you decide whether to take part or not, you can contact me to ask any questions about the study.

I will arrange a suitable date and time to meet with you for a 1-hour interview about your experience of the anorexic voice. A brief questionnaire prior to starting the interview to ensure eligibility, the interview will be audio taped. Should you be unsuitable in terms of meeting the criteria I would not continue with a taped interview.

You will be reimbursed for any travel costs to attend the interview with a given valid receipt.

If you change your mind at any point about taking part prior to the interview, you can withdraw your consent. However, if you complete the interview you have four weeks thereafter to withdraw consent.

The interview will be transcribed and analysed. The findings will be written up as a Post-Doctoral thesis. All information obtained from you will be kept strictly confidential. If you pose a risk to yourself or others I am legally obliged to breach confidentiality, if this was to happen I would inform you. All data collected is stored in a secure location. Audio transcripts and audio tapes are not stored together to maintain anonymity. All personal information will be kept anonymous.

Risks?

Discussing past and present struggles related to eating disorders can provoke difficult emotions. Every step has been taken to minimise risk to you. If you became distressed during the interview I would assist you in contacting someone close to you who could support, you. The interview will be stopped and resumed on the basis you were happy to resume.

Benefits?

Your participation and offering your experience of anorexia and the anorexic voice will be beneficial in gaining a wider understanding of anorexia and associated impact. The information you provide will go towards providing informed knowledge of how to treat anorexia and the anorexic voice.

What will happen when the thesis is complete?

I will write up the thesis and present it including its findings. All data will remain anonymous and you will not be identified.

Appendix G

Distress Protocol

A distress protocol is to ensure the wellbeing of the participant and the researcher alike. It is used to minimize risk in relation to taking part in the research "The experience of living with an Anorexic Voice an Interpretative Phenomenological Analysis study". The participants in this study are deemed vulnerable as they have a diagnosis of anorexia nervosa and would have received both psychological and medical treatment for this.

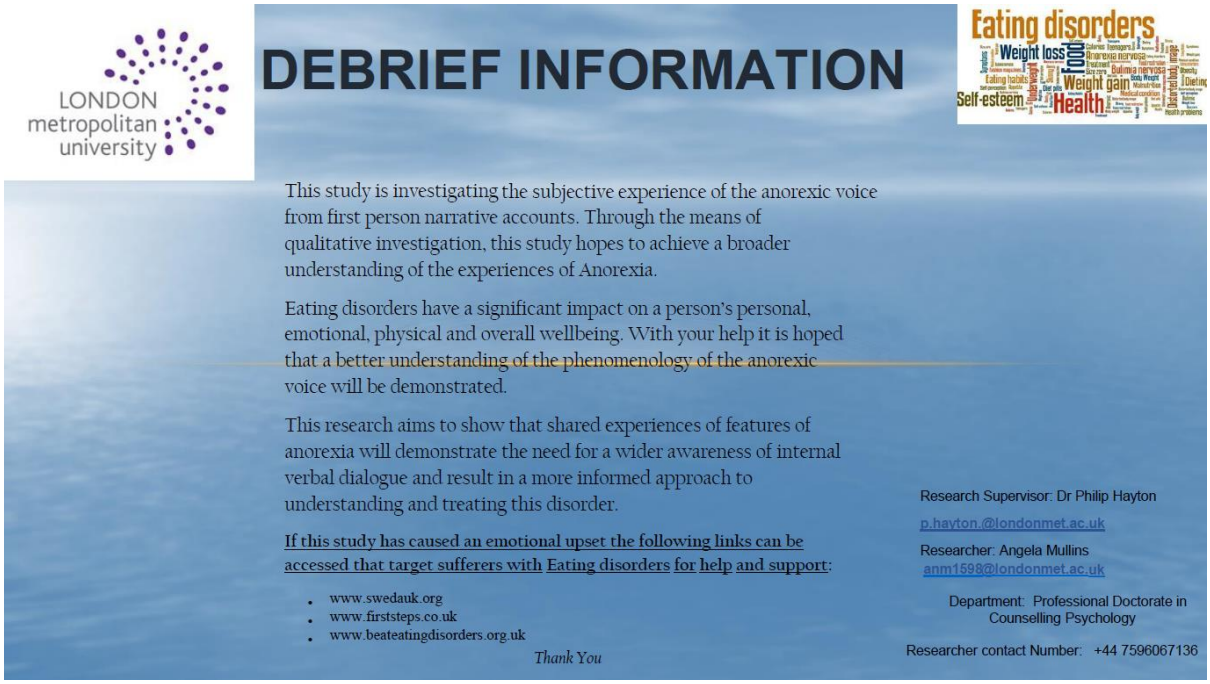
An outline of potential distress indicators will be given, the researcher is obliged to be aware of these. If distress occurs, an outline of interventions will be given that the researcher should follow. The researcher is expected to use their professional judgement in terms of distress signs that may be displayed by the participant. Suitable interventions will be utilised.

Every effort is made to prevent risk to participants in this research, the likelihood of the participant experiencing extreme distress is low, however every effort will be made by the researcher to observe the mental state of the participant and to intervene accordingly.

MILD DISTRESS	MODERATE DISTRESS	EXTREME DISTRESS
• RESTLESSNESS • TEARFULNESS • DIFFICULTY CONCENTRATING • VERBAL INDICATION OF DISTRESS	• VERBAL INDICATION TO STOP THE INTERVIEW • CRYING • SHAKING • VERBAL INDICATION OF FLASHBACKS, MEMORIES OR THOUGHTS THAT ARE DISTRESSING	• VERBAL/PHYSICAL AGGRESSION TO SELF OR RESEARCHER • SIGNS OF PSYCHOSIS • THREATENING BEHAVIOUR TO SELF OR OTHERS
ACTION OF RESEARCHER	**ACTION OF RESEARCHER**	**ACTION OF RESEARCHER**
• ASK PARTICIPANT IF THEY WOULD LIKE TO TAKE A BREAK • ASK PARTICIPANT IF THEY ARE OK TO CONTINUE	• STOP INTERVIEW • OFFER VERBAL REASSURANCE • SUGGESTIONS TO TAKE DEEP BREATHES	• TERMINATE INTERVIEW AND ISSUE DEBRIEF • ASSIST THEM WITH CONTACTING SOMEONE CLOSE

	• ASSIT THEM IN CONTACTING SOMEONE CLOSE TO THEM TO SUPPORT THEM • OFFER DEBRIEF SHEET	TO THEM TO SUPPORT THEM • IF THEIR SAFETY IS IN JEPORDY CALL FOR ADDITIONAL SUPPORT EG, GP • IF THERE IS INTENT ON HARM TO SELF OR OTHERS CALL POLICE AND/OR AMBULANCE

Appendix H


LONDON
metropolitan
university
DEBRIEF INFORMATION
Eating disorders
Weight loss
Food
Self-esteem
Health
Weight gain
This study is investigating the subjective experience of the anorexic voice from first person narrative accounts. Through the means of qualitative investigation, this study hopes to achieve a broader understanding of the experiences of Anorexia.
Eating disorders have a significant impact on a person's personal, emotional, physical and overall wellbeing. With your help it is hoped that a better understanding of the phenomenology of the anorexic voice will be demonstrated.
This research aims to show that shared experiences of features of anorexia will demonstrate the need for a wider awareness of internal verbal dialogue and result in a more informed approach to understanding and treating this disorder.
If this study has caused an emotional upset the following links can be accessed that target sufferers with Eating disorders for help and support:
www.swedauk.org
www.firststeps.co.uk
www.beateatingdisorders.org.uk
Thank You
Research Supervisor: Dr Philip Hayton
p.hayton.@londonmet.ac.uk
Researcher: Angela Mullins
anm1598@londonmet.ac.uk
Department: Professional Doctorate in Counselling Psychology
Researcher contact Number: +44 7596067136

Appendix I

Introduction

- Introduce myself
- Collect the consent form
- Allow time for any outstanding questions or queries about the interview
- Housekeeping nearest exit, pause for break etc
- Explain the withdrawal procedure e.g. the participant can decline questions or end the interview at any time

    - Questions

1. You have received a diagnosis of anorexia. To begin with, could you tell me about your experience of developing and subsequently living with an eating disorder diagnosis
2. Could you tell me what your understanding is of the term `anorexic voice` and your own experience of an anorexic voice. How do you make sense of it?

    - Prompts:

    - What thoughts, images and feelings related to your experience come to mind

3. What are your first memories of experiencing the voice?

    - Prompts:

    - what makes it unique

    - what distinct characteristics does it have such as if it is it male or female

    - could you describe what your reaction was when you first noticed it

4. I wonder whether you could tell me if people close to you and professionals you have worked with in recovery know you experience this?

    - Prompts:

    - (if yes) how have you explained your experience of it to them, so that they understand?

    - Was it helpful for you to tell others? (If no) what stops you from telling others? What would it mean for others to know about it?

5. Could you give an example of the things the voice would say?

- (if example given follow up with) What was that like for you to hear that? What effect would the voice saying that have on you, how might you respond/react?

6. What would role has the anorexic voice played throughout your eating disorder?

   Prompts:

   - Would you say the voice has been influential in relation to the onset, maintenance and recovery of your eating disorder?
   - If yes, how?
   - If no, why not?

7. How would you describe your relationship with the voice in the early days of first hearing it?
8. What about now, what kind of relationship would you say you have?
9. Were there times the voice would have a greater impact on you and how would that play out in terms of your relationship with both yourself and others?

   - Prompts:

- (if yes) were there any particular points throughout your eating disorder that you noticed the voice would have a greater impact on you? (If yes) how would that make you feel, how would you respond/react?

10. I am also interested in how you would describe the role/function/impact of the voice on your sense of self (identity)

    Prompts:

    - Did you encounter any changes in your sense of self/identity in terms of your relationship with the voice over the course of your eating disorder?
    - (If yes)what changes did you experience and what factors were involved in influencing these changes?

11. Is there anything regarding this topic that you think is important that I have not asked you about? Anything else you would like to add?

    - Thank you for your time.

Appendix J

1. Agree with participant the best location that is suitable to conduct an uninterrupted 60 minute interview
2. Secure the address where the interview will be conducted including the agreed time
3. In an envelope place the name of the location, the time the researcher aims to be at this location, the time researcher aims to leave the location and the contact details of the researcher's supervisor
4. This information will be given in a sealed envelope to a trusted person namely the researchers partner.
5. Agree with the trusted person that a phone call will be made to them once the interview is complete to ensure them of the researcher's wellbeing
6. In the case of the trusted person not receiving contact from the researcher at the designated time the trusted person can open the envelope to see the location and subsequently make their way to the destination
7. If the researcher is uncontactable and not at the location then the trusted person should contact the police
8. The trusted person will contact the researchers supervisor to inform them

Appendix K

www.swedauk.org

- *www.firststeps.co.uk*
- *www.beateatingdisorders.org.uk*
- *www.bodywhys.ie*
- *www.eatingdisordersni.co.uk*
- www.seedeatingdisorders.org.uk
- *www.eating-disorders.org.uk*
- *www.thebluetreeclinic.com*
- The tree of life clinic.

Appendix L

Box 1.1 Developing emergent themes JILLIAN P2 I: Interviewer P: Participant			
Exploratory comments	**Original Transcript & Numbered sentences**		**Emerging themes**
	I: Just to clarify, you have a diagnosis of	1	
	anorexia?	2	
	P: yeah	3	
	I: can you tell me a little bit about your	4	Experience of diagnosis
	experience of that of getting that diagnosis	5	
	and living with an eating disorder diagnosis	6	
First diagnosed with chronic fatigue syndrome BED ill nervosa Bulimia Nervos	P: so mine was a bit of a weird one I had	7	
	chronic fatigue syndrome and my kind	8	
	of…looking back now I probably had a binge	9	Medical treatment of
	eating disorder before I had any prior	10	symptoms
	diagnosis and my initial ehh sort of	11	
	symptoms ended up being that were	12	
	addressed in a medical way were bulimia	13	
	I: mmhmm	14	Tackling problems
Bulimia first	P: I was a bulimic diagnoses first and I	15	
Spoke to parents to illicit help	actually went and spoke to my parents	16	Distress of diagnosis
Experienced distress from the symptoms of her illness	because of the kind of level it was so	17	
Took responsibility and sought help	distressing in terms of the symptoms, I went	18	
	forward and said I need help	19	
	I: mmhmm	20	
Stating that bulimia `*came under control*` `whatever else` merged (formation of something she is unsure of) into a `disordered` eating – CBT language	P: as the kind of bulimia came under control	21	Physical impact of anorexia
	whatever else kind of merged into (laughs)	22	
	another sort of form of disordered eating and	23	Anorexia diagnosis
Diagnosed with anorexia then	so I was diagnosed with anorexia once my	24	experience
Restriction- main noticeable symptom	weight kind of became low and the	25	
Low weight was a factor in AN diagnosis	restriction was the main kind of symptom,	26	
	yeah so	27	
Symptom- of what was underneath this?	I: right	28	
	P: that was how the diagnosis came about, it	29	
Doctor diagnosed BN	took about…I think from my bulimic sort of	30	
	symptoms were declared through a doctor	31	
CAMHS – implies under age 18 years	ehh the official CAMHS appointment was I	32	Transcendence of illness

Box 1.1 Developing emergent themes P1 SAM		
Exploratory comments	**Original Transcript & Numbered sentences**	**Emerging themes**

Progress from wanting to fit in via restricting weight gain/body growth to getting physically unwell (30,31) *severe underweight* Diagnosis-presentation of underweight body Distinction made between classification of the `disorder` by participant (13-15) in terms of having disordered thoughts. Disordered thoughts precede food restriction. Change began after the thoughts to alter the body from developing further into a large female/adult body (24, 30, 31) in part as described from an inner sense of being different and cultural influences and pressure of what's normal Struggle with sense self-acceptance of both self and who she is amongst her peers? (43, 44) Did an inner critic play a role here? Is having a friendship group not constituting acceptance of self among others for participant? Larger body was making her a target to *pick fun at* (47, 48, 49) Bullying **Taking up more space than others/being noticeable/standing out from the crowd** Acceptance means being like the crowd- peers are children Larger body or being difference equals *`flaws` (50)* Solution focus is to halt/stop/*change my body* Regaining control of the change (52)	wanted to be like the other females especially at that age in my class so yeah I started off with a really restricted diet I: Yeah P: and from there it kind of got progressively worse and that's how by the age of 14 em I got to such a severe underweight that severely underweight that I was diagnosed with anorexia. I: So when you said and you were talking about having distorted thoughts you notice that from the age of 12 can you tell me a little about that because I know you had mentioned about a change in body and wanting to be like your peers were your distorted thoughts in and around body image and body appearance? P: Yeah so the disordered thoughts were very much around acceptance from other people because I wasn't accepted really at school and you know I did have friends but because you know I was developing into a larger body starting at an earlier age em my peers sort of you know it was easy to pick fun at you know comment on all the flaws. So I guess that's when em I thought well you know if I can change my body then I will be accepted by other people em I guess the disordered thoughts really came from me knowing that	25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53	Fitting in Restricted diet CBT influence Pre-pubescent Appearance Self-acceptance Bullying Extrinsic motivation to be like peers

Box 1.1 Developing emergent themes VANESSA P3

I: Interviewer P: Participant

Exploratory comments	Original Transcript & Numbered sentences		Emerging themes
	P: that I would have conversations with eh	34	Authoritative
	basically telling me what to do and how to do	35	
Dialogue between voice and herself	things, I know that is just me and it's	36	
Distinction between true self and condition	something I have invented, no matter if it's	37	
Voice generated by her	to do with…distinguished between what I	38	
	was and what my condition was	39	
	I: mmhmm and when you say entity do you	40	
	have a visual in your mind when you say	41	
	that? Can you describe a little bit about this	42	
	entity?	43	
	P: at times it has a specific shape or form	44	Shape and form component
	I: yeah	45	
Sense of it being something sinister, scary, non-defined	P: what I can recall is it was someone in a	46	Humanising the voice
	black cape	47	Adumbrate
	I: yeah	48	
	P: that's the closest I can go to	49	
	I: Okay, and would you see this visually or in	50	
	your mind's eye?	51	
Confined to her head	P: only in my head	52	
	I: yeah	53	
Denied hallucinations	P: I never had hallucinations of that kind not	54	
	visual not auditory not any kind of	55	
	hallucinations I always knew it was just	56	Invention of the mind
	something in my head that I've invented	57	
Diary writing is a process of internal reflection	I: and when did you first notice it was there?	58	
	P: I, I think when I first started writing my	59	Diary writing
	diary	60	
	I: yeah	61	
	P: so I was writing but then as I was like, I	62	
	think I initially started writing what was	63	
Writing about her experience and feeling disconnected from the writing as if its not her	happening to me but then I felt a need to	64	
	change it and I thought okay this is not	65	De personalisation
	coming from me this is someone else but	66	
	I: right		

Box 1.1 Developing emergent themes VANESSA P3 I: Interviewer P: Participant			
Exploratory comments	**Original Transcript & Numbered sentences**		**Emerging themes**
	P: I was just finishing high school at the time,	67	
	so I was seventeen and a half. I wasn't eating	68	Late adolescence
Bulimia Nervosa	but I had episodes, I had bulimic episodes as	69	
Control	well, you need to let go of that control every	70	
Denied using fingers to induce purging	now and again, but I never used my fingers	71	
	or anything else, it's just like I just opened	72	
	my mouth, and everything went out	73	
	I: right	74	
Began when she lost her friend to suicide	P: and I started that when my friend	75	
	committed suicide I just knew I had to get rid	76	Experienced bereavement
	of something and that was the only way to	77	
Getting rid of things (feelings)	get rid of things	78	Intolerability
	then as I was denying food and other things	79	Denying food and other things
Denying food and other things to oneself	to myself more and more I felt the need	80	
	to…to convince myself that it wasn't me	81	
Simile: comparing eating disorder with monster figure	doing that to myself so I basically I created a	82	Reification
	monster	83	
	I: right, and so when did you first start your	84	Disavow
Changing something abstract into something real: Reification	diary?	85	
	P: I think maybe it was six, seven months	86	
	after well having first symptoms	87	
	I: and so you began the diary to make sense	88	
	of what was going on for you?	89	
	P: yeah	90	
	I: and so how did you make sense of what	91	
	was going on for you ?	92	
	P: basically I entered the world of eating	93	
	disorders not even knowing what it was it	94	
	was after a series of few events in my life,	95	Series of traumatic events
Entered the world of eating disorder	being physically sick and losing some weight	96	
Ignorance to what ED was	and my friend committing suicide	97	
Series of life events	I: oh	99	

Step 2. Abstraction JILLIAN

1. Experience of relating to the voice 2. Meaning associated with the presence of the voice 3. Experiences contributing to illness 4. Experiences contributing to recovery

Line No	SUB-Theme	Research question No.
4	Experience of diagnosis	1
9	Medical treatment of symptoms	1
13	Tackling problems	1
15	Distress of diagnosis	1
20	Physical impact of anorexia	1
22	Anorexia diagnosis experience	1
30	Transcendence of illness	1
33	Process of change in presentation	1
82	dissociative state of consciousness	1
243	Depersonalization	1
245	Identity confusion	1
262	Dissociation	1
162	Lack of autonomy	1
267	Adolescence	1
337	Inner sense of self is split	1
852	Depersonalization	1
856	Psychoform dissociation	1
1158	Experience of Depersonalization	1
1177	Derealization	1

Appendix M

Step 2. Abstraction VANESSA

1. Experience of relating to the voice 2. Meaning associated with the presence of the voice 3. Experiences contributing to illness 4. Experiences contributing to recovery

Line No	SUB-Theme	Research question No.
26	Experience of another entity	1
31	Authoritative	1
40	Shape and form component	1
42	Humanising the voice	1
43	Adumbrate	1
51	Invention of the mind	1
59	De personalisation	1
80	Reification	1
136	Voice held sway	1
138	Bargaining	1
140	Kowtow to the voice	1
149	Insulting	1
162	Polar opposites	1
164	Escalating fear	1
165	Monster personification	1
175	Coercive control	1
177	Self-care prevention	1
179	Twenty four seven presence	1
187	Internal fighting	1
196	Therapy	1
204	Depersonalisation	1

Appendix N

Subsumption. Step 3 JILLIAN

STEP 3

SUB-Theme	Superordinate Theme
Experience of relating to the voice	
	Depersonalisation
Experience of diagnosis	dissociative state of consciousness
Medical treatment of symptoms	Depersonalization
Tackling problems	Identity confusion
Distress of diagnosis	Dissociation
Physical impact of anorexia	Adolescence
Anorexia diagnosis experience	Inner sense of self is split
Transcendence of illness	Depersonalization
Process of change in presentation	Psychform dissociation
dissociative state of consciousness	Experience of Depersonalization
Depersonalization	Derealization
Identity confusion	AN voice conspiring when in recovery
Dissociation	The driver
Lack of autonomy	Displaced self-governance
Adolescence	
Inner sense of self is split	**Coercive Control**
Depersonalization	emotional abuse
Psychoform Dissociation	Demanding
Experience of Depersonalization	Authoritative

Subsumption. Step 3 SAM

STEP 3

SUB-Theme	Superordinate Theme
Experience of relating to the voice	
	Loss of Sense of Self
Negative self-evaluation	Negative self-evaluation
Acquiescent	Anhedonia
Androgynous voice	Apathy
Anhedonia	Counterintuitive way of being
Apathy	Dissociation from the anorexic voice
CBT descriptive language	Feeling out of control
CBT language reference to behaviours irrational acts	Personal inadequacy
Coercive	Rejection of the voice as intricate part of self
Coercive control	Subservient
Counterintuitive way of being	Uncertainty
Dissociation from the anorexic voice	
Draining	**Coercive Control**
External locus of control	Acquiescent
Feeling out of control	Coercive control
Habit/obsessions/fixation	External locus of control
Internal conflict	Internal conflict
Loss	Quiet but still present

Subsumption VANESSA

STEP 3

SUB-Theme *Experience of relating to the voice*	Superordinate Theme
	Creating a Monster
Experience of another entity	Experience of another entity
Authoritative	Shape and form component
Shape and form component	Humanising the voice
Humanising the voice	Adumbrate
Adumbrate	Invention of the mind
Invention of the mind	Reification
De personalisation	Escalating fear
Reification	Monster personification
Voice held sway	The bad guy
Bargaining	
Kowtow to the voice	**Coercive Control**
Insulting	Authoritative
Polar opposites	Voice held sway
Escalating fear	Bargaining
Monster personification	Kowtow to the voice
Coercive control	Insulting
Self-care prevention	Polar opposites
Twenty four seven presence	Coercive control
Internal fighting	Self-care prevention

Table: Table of super-ordinate themes and quotes from Jillian Interview 2

Themes	Page/line	Key words
Experience of relating to the voice		
	3. 87-92	I was still having these like very separate like kind of compulsions and voices that were kind of like goals and internal dialogue kind of separated in terms of sort of what they wanted you to do
Depersonalisation	26. 850-859	so I used to go for a run every day after school... I didn't want to do it I physically dreaded it a lot of the times, but I had to do it, I had to do it, I had to do it...and I was being told I had to do it...to me that's more like a possession em than anything else
	35. 1165-1181	sometimes it's like a separate response…there's that interjection of opinion...from a voice that is not you or even what your feeling

Appendix O

Table of super-ordinate themes and quotes from Sam Interview 1.

Themes	Page/line	Key words
The Perils of Puberty and Feeling Accepted		
Developing Body	1. 8 - 9	it started all really the disordered way of thinking at 12 em when I was an early developed child I began developing larger hips and I began puberty quite early on
Emotional Ambivalence About Self	1. 11 - 14	this type of body was sort of unacceptable you know I was coming into a larger female body and I wanted to be like the other females especially at that age in my class so yeah I started off with a really restricted diet
	2. 27-28	I thought well you know if I can change my body then I will be accepted by other people

Table: Table of super-ordinate themes and quotes from Vanessa Interview 3

Themes	Page/line	Key words
Experience of Relating to the Voice		
	1. 30-32	I have never had hallucination but there was another entity in my head
Creating a Monster		
	3. 79-83	as I was denying food and other things to myself more and more I felt the need to…to convince myself that it wasn't me doing that to myself so I basically I created a monster
	5. 165-167	but then down the line I became de-pressed and more afraid of the monster getting bigger and bigger
Coercive Control		
	2. 35-36	there was another entity in my head...that I would have conversations with eh basically telling me what to do and how to do things

Appendix P

---------- Forwarded message ---------
From: **Angela Loulopoulou** <loulopoa@staff.londonmet.ac.uk>
Date: Fri, May 3, 2019 at 5:09 PM
Subject: Approval of DProf Counselling Psychology ethics application
To: Angela Mullins <Angela311287@gmail.com>

Dear Angela.

Your ethics application has been approved and you can now proceed with the research process or seek any further ethical approval required from an external organisation, of relevant.

Please see comment from the Chair of the Ethics Committee who approved your ethical application after it has been reviewed and approved from the Psychology ethics committee.

my signing off sheet is on p. 103. While the student is to be complimented with her supervisory team of an extremely detailed rationale for the research ethics, this could have been somewhat condensed in terms of the research document to be more specific about the ethical requirements in relation the general form. Moreover, the student appears to have submitted the same work TWICE in the document.

--
Kind Regards,

Angela

Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Ethics Review Committee for PG Psychology

Office hours 9.30-17.00 Tuesday to Thursday

Please email me if you would like an appointment, as I am not often at my desk.

Read my article at: http://www.tandf.co.uk/journals/banners/readmyarticle/ccpg.gif