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Exploring voices and relationships in anorexia nervosa

Part A: Relationships and recovery: A literature review and meta-ethnography exploring the role of relationships in the process of recovery from anorexia nervosa

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Part B: Voices from the past: A qualitative analysis of the “anorexic voice” in treatment and recovery

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Summary of the MRP Portfolio

Part A: Part A is a systematic review of published literature on the role of relationships in recovery from anorexia nervosa (AN). Four online databases were systematically searched for relevant articles and meta-ethnography (ME) was used to synthesise the studies. Ten papers were identified as relevant to the review question. Three third-order ME constructs were generated: 'initiating, maintaining or re-connecting to nourishing relationships', 'transforming or distancing oneself from difficult relationships' and 'nurturing the relationship with the self'. The findings suggest that both intra- and interpersonal relationships are important for recovery. Important relationships included family, partners, friends, peers and healthcare workers. The relationship with AN, the anorexic voice (AV) and the 'self' were pinpointed as crucial in the recovery process. Transformation within these relationships was often required for recovery to occur.

Part B: Part B is a qualitative study of the AV in recovery. Fourteen participants with a past diagnosis of AN were interviewed about their experience of an AV and how it changed with recovery. Reflexive Thematic Analysis was used to evaluate the interview data. Five themes were identified in the data: *1. Allegiance, 2. Relationship becomes toxic, 3. Realisation & motivation, 4. Recovering from the AV, 5. Reclaiming life.* The results suggest that individuals often move through a series of stages in their relationship with the AV. Initially the AV is a comforting and supportive presence, but the relationship soon becomes abusive and toxic. A catalyst occurs which prompts realisation and provides motivation for change. Recovering from the AV is a complex and gradual process, which includes dialoguing with the voice, learning to modify responses to it, building a different relationship with the voice and separating from it. Recovery is often followed by an ongoing period of reclaiming life from the influence of the AV.

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Major Research Project

Part A: Literature review

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Abstract

Background and aims: Anorexia nervosa (AN) is a complex and often chronic eating disorder (ED) with severe psychological, physical and social consequences including high rates of mortality. AN can be difficult to treat and relapse rates are high. In recent years there has been a growing body of qualitative studies describing factors important to recovery from the perspective of individuals who have overcome AN. Many of these studies mention relationships as integral to the process of recovery. This paper will review those studies with the aim of identifying which relationships and relational factors facilitate recovery.

Method: Four online databases were systematically searched for relevant articles published between January 2000 and 27 September 2021. Additional papers were identified through Google Scholar and by hand-searching the reference lists of key papers. Meta-ethnography (ME) was used to synthesise the studies compiled in this review.

Results: Ten papers were identified as relevant to the review question. Three third-order ME constructs were generated: 'initiating, maintaining or re-connecting to nourishing relationships', 'transforming or distancing oneself from difficult relationships' and 'nurturing the relationship with the self'.

Conclusions: The findings suggest that both intra- and interpersonal relationships are important for recovery. Important relationships included family, partners, friends, peers and healthcare workers. The relationship with AN, the anorexic voice (AV) and the 'self' were pinpointed as crucial in the recovery process. Transformation within these relationships was often required for recovery to occur.

Keywords: anorexia, relationships, recovery

1.Introduction

Anorexia nervosa (AN) is a complex and often chronic eating disorder (ED) with severe psychological, physical and social consequences including high rates of mortality (Chidiac, 2019; Frank et al., 2013; Arcelus et al, 2011). Individuals with AN experience extreme anxiety about gaining weight which drives them to restrict their food intake and/or exercise excessively, causing emaciation and extremely low weight (American Psychiatric Association, 2013). Anorexia has been labelled as complex and difficult to treat and relapse is common, estimated to be somewhere between 9-52% (Khlasa et al., 2017; Halmi et al., 2005). Recovery is complex and multi-faceted including both physical and psychological aspects. Previous research has made use of markers such as weight restoration and scores on self-report measures to indicate recovery (Lund et al., 2009; Fairburn & Beglin, 1994). However, authors have drawn attention to the fact that psychological distress and unhelpful coping techniques may still persist after physical recovery (Kenny et al., 2021; Löwe et al., 2001). There is indeed a lack of consensus on the definition of recovery. A panel of 21 international experts indicated that a comprehensive definition of recovery from AN should include physical, psychological, behavioural and quality of life markers, but concluded that even physical markers can be problematic to define (Dawson et al., 2015). Research with people in recovery from AN suggests that recovery is subjective and can mean different things to different people (Darcy et al., 2010). For the purposes of this review participants will be considered recovered either if they have been clinically assessed to be so or if they self-define as recovered.

Qualitative studies of AN have highlighted the importance of personal and interpersonal factors for recovery such as motivation, meaningful activities, developing a sense of purpose and relationships (LaMarre & Rice, 2021; Bowlby et al, 2015). Relationships have been acknowledged as important for recovery in a range of mental health difficulties including depression, post-traumatic stress disorder, psychosis and substance misuse to name a few (Hallgren et al., 2017; Liebman et al., 2020; Green et al., 2008; Stevens et al., 2015). This literature suggests that relationships have a reciprocal influence on mental health difficulties and can provide support and buffering to stressful situations, and an arena for recovery to be worked through mutually and supportively. The nature and style of interaction in relationships has also been highlighted as a key influence in mental health difficulties (Birtchnell, 2016; Hayward et al., 2017).

In recent years there has been a growing body of research describing factors important to recovery from the perspective of individuals who have overcome AN. Many of these studies mention intra- and interpersonal relationships as integral to the process of recovery (Nilsen et al., 2020; Williams et al., 2016; Keski-Rahkonen et al., 2014). Additionally, interpersonal and socio-emotional factors have been identified in both the development and maintenance of AN (Lie et al., 2019; Treasure & Schmidt, 2013).

ED research suggests that relationships with family, romantic partners, friends, peers and staff are important recovery factors (Bulik et al., 2011; Woods, 2004; Bell, 2003; Hsu et al, 1992). Indeed, treatments that involve an individual's family are recommended for both adults and young people (National Institute for Health and

Care Excellence, 2017), and such treatments have been shown to be effective (Lock, 2015). Relationships with partners can influence treatment and recovery (Bulik et al., 2010). Difficulties with friendships have been noted in the development of AN (Westwood et al., 2016), and re-connecting with friends or making new friends has been highlighted as important for recovery from AN (Nilsen et al., 2020). A review of qualitative studies exploring treatment and recovery in adolescents found that peer relationships in inpatient settings could either promote or impede recovery depending on the characteristics of the relationships (Bezance & Holliday, 2013). Similarly, relationships with healthcare staff can both positively and negatively influence recovery factors (Rienecke et al., 2016; Zugai et al., 2013)

A recent meta-ethnography (Stockford et al., 2019) exploring women's recovery from AN similarly highlighted the importance of meaningful relationships. Interestingly, the relationship with the 'self' was also flagged as important for recovery. The meta-synthesis suggested that women with AN experience feelings of powerless in their relationships, often feel disconnected from themselves and that their identity can become entwined with AN. The relationship with the 'self' was also identified as an important recovery factor in an earlier meta-ethnography (Duncan et al., 2015). This meta-ethnography additionally pinpointed the relationship with the anorexic voice (AV) as central to recovery. The AV is an internal 'voice' experienced in AN that can be critical and controlling, it often criticises the individual's weight and shape and encourages them to engage in extreme weight-loss practices (Pugh & Waller, 2017).

Qualitative research into the lived experience of recovery from the perspective of recovered individuals has the potential to generate unique insights into the type and nature of relationships that are helpful to recovery.

1.2 Need for review

In recent years there have been several reviews that synthesise the lived experience of AN, AN treatment or the lived experience of recovery from AN (Karlsson et al., 2021; Stockford et al., 2019; Sibeoni et al., 2017; Duncan et al., 2015; Bezance & Holliday, 2013; Westwood & Kendal, 2012; Espindola & Blay, 2009). In addition to this there have been reviews of qualitative studies investigating subjective experiences of particular relationships for people with AN (Salzmann-Erikson & Dahlen, 2017). Additionally, there have been reviews of the AV experience (Aya et al., 2019; Pugh, 2016), which encompassed the relationship with the AV. These reviews either focused on recovery in general or the experience of specific relationships. All of the reviews exploring the lived experience of recovery from AN concluded that relationships were pivotal for recovery (Karlsson et al., 2021; Stockford et al, 2019; Duncan et al., 2015; Bezance & Holliday, 2013). However, there has not been a review with a specific focus on intra- and interpersonal relationships and their impact on recovery. Therefore, this review will specifically examine relationships and their role in recovery from AN as reported in qualitative studies of the lived experience of recovery from AN.

1.3 Aims

This review will critically evaluate and synthesise qualitative studies that explore the role of relationships in recovery from AN. The primary aim is to ascertain if and how

relationships and relational characteristics assist recovery. Qualitative studies regarding the lived experience of recovery from AN that include information on relationships will be identified and evaluated. The review questions are:

- Do relationships facilitate recovery from anorexia nervosa?
- Which relationships are important to recovery?
- What relationship characteristics facilitate recovery?
- Are changes in relationship dynamics necessary for recovery from AN?

2.Method

2.1 Search methodology

A systematic search of online databases was conducted on 27th September 2021. The following databases were searched: Psycinfo, CINAHL Plus with Full Text, Web of Science and PubMed. Journal articles published between January 2000 and September 2021 were searched for. The following search terms were used to search titles and abstracts: (anorexi* AND recover* AND relationship*). Additional papers were identified through Google Scholar and by hand-searching the reference lists of key papers. More comprehensive search terms were trialled whilst scoping for a literature review title (e.g. 'eating disord*' and 'bonds'), but these produced an unmanageably large set of studies, many of which were irrelevant to AN. Therefore the succinct strand shown above was used for the purposes of this review.

2.2 Inclusion & exclusion criteria

Inclusion and exclusion criteria are shown in Table 1 below. Studies were included if they were published in the English language in a peer-reviewed journal. Only

qualitative studies were included as they generate in-depth descriptions that would allow relevant detailed information about relationships to be extracted (Stenfors et al., 2020). Studies were included if participants had suffered from AN and the focus of the study was the subjective lived experience of recovery from AN, to ensure that subjective data relevant to AN was gathered. Studies that used mixed ED samples were excluded to similarly ensure that the data was relevant to AN. As mentioned in the Introduction, recovery can be difficult to define and idiosyncratic in nature, so studies in which participants considered themselves as recovered or in recovery, or had been clinically assessed to be recovered were included. Studies that were published prior to January 2000 were excluded to ensure that only current, up-to-date information was gathered and synthesised (Patsopoulos & Ioannidis, 2009).

Table 1 – Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
English language	Not published in the English language
Published in a peer-reviewed journal	Published prior to January 2000
Qualitative techniques were used for data collection and analysis, either alone or as part of mixed methodology	Unpublished articles, case studies, theses, book chapters or review articles
All participants had previously suffered from AN	AN was not the primary difficulty or the study used a mixed ED sample
The focus of the study was the subjective lived experience of recovery from the point of view of individuals who have recovered from AN	Participants were still in treatment, had not been defined as recovered, or did not consider themselves to be recovered
Study participants considered themselves as recovered or in recovery, or had been clinically assessed as recovered	Investigated recovery from the point of view of staff or family

2.3 Quality review

There is dispute over how and whether to appraise the methodological quality of qualitative studies due to fundamental issues of epistemology and ontology (Murphy et al., 1998). For example, relativists argue that it is not possible to judge qualitative research against external criteria. Proponents of meta-synthesis suggest that qualitative studies should not be critically assessed for methodological quality because it may lead to useful studies being excluded for minor methodological flaws (Bondas & Hall, 2007; Sandelowski et al., 1997). Additionally, no checklist has been created that is suitable for appraising qualitative studies prior to secondary analysis and synthesis (Campbell et al., 2011). It has been argued that that methodology does not necessarily determine the quality of a study, and that studies should not be excluded from a meta-ethnography based on standardised critical appraisal (Toye et al., 2013; Ljungburg et al., 2015; Sattar et al., 2021). In light of this, meta-ethnographies often make use of an appraisal tool to briefly identify “fatally flawed” studies that should be excluded, but an in-depth quality appraisal is not conducted (Dixon-Woods et al., 2007; France et al., 2019; Campbell et al., 2011; Mousa et al., 2021; Klevan et al., 2021; Bootsma et al., 2020; Germeni et al., 2018).

Campbell et al., (2011) propose the use of two screening questions which were utilised to screen studies in this ME:

1. “Does the article report findings of qualitative research involving qualitative methods of data collection and analysis and are the results supported by the participants’ quotes?”
2. “Is the focus of the article suited to the synthesis topic?”

The Critical Appraisal Skills Programme (CASP) UK Qualitative Studies Checklist (n.d.) was used to briefly assess quality. This standardised tool is designed to support systematic appraisal of qualitative research studies with respect to value, relevance and trustworthiness (CASP, n.d.). The checklist has been used successfully in several other recent MEs concerning EDs (Eaton, 2020; Graham et al., 2020; Fogarty et al., 2018). The checklist produces a score out of ten, with a higher score indicating higher quality. None of the studies were deemed "fatally flawed" and articles with lower scores were not excluded, because a failure to describe methodology does not necessarily equate to a poorly-conducted study, and quality ratings do not necessarily mean that the study lacks detailed and useful conceptual insights (Sattar et al., 2021). However, the study with the highest rating was used as the 'index study' (Sattar et al., 2021), which was reviewed first generating concepts that were translated to the other studies, thus shaping the outcome of the synthesis. Latter studies were reviewed in order of quality rating and date of publication from highest to lowest.

To further bolster the quality review of studies, the classification system utilised by Fox et al., (2015) was employed. Within this system studies are classified as follows:

A - Study scored 8.5 or above on the CASP checklist (n.d.), which equates to a low likelihood of methodological flaws
B – Study scored between 5-8 on the CASP checklist (n.d.), which equates to a moderate likelihood of methodological flaws
C – Study scored less than 5 on the CASP checklist (n.d.), which equates to a high likelihood of methodological flaws

2.4 Method of synthesis

Several methods are available for synthesising qualitative research (Barnett-Page & Thomas, 2009). Meta-ethnography (ME) (Noblit & Hare, 1988) was used to synthesise the studies compiled in this review, because it provides a systematic method for inductively interpreting and synthesising data from multiple studies. With this method it is possible to synthesise studies that use different study designs, and it allows for interpretation of both primary (e.g. participant quotes) and conceptual data (e.g. themes). This use of primary data ensures that the authenticity of original data is preserved in ME synthesis. ME is rooted in the interpretivist paradigm and can produce novel, applicable concepts from sets of qualitative studies (Noblit & Hare, 1988). The 7-step approach to ME described in Sattar et al.'s (2021) guide was followed, incorporating (1) identifying an area of interest, (2a) defining the focus, (2b) locating relevant studies, (2c) deciding which studies to include, (2d) quality appraisal, (3) reading the studies, (4) determining how the studies are related, (5) translating the studies into one another, (6) synthesising the translations and (7) expressing the synthesis.

The papers were transferred into NVivo (Version 12 Pro) to aid organisation and coding of concepts. Relevant excerpts were grouped together and compared against each other to aid in the processes of determining how the studies were related and translating them into each other. In line with previous MEs pertinent data was catalogued according to whether it was a first- or second-order construct (Duncan et al., 2014; Malpass et al., 2009). 'First-order construct' refers to primary source data in articles and 'second-order construct' refers to the primary authors' interpretations of that data. 'Third-order' constructs are developed during the ME process by

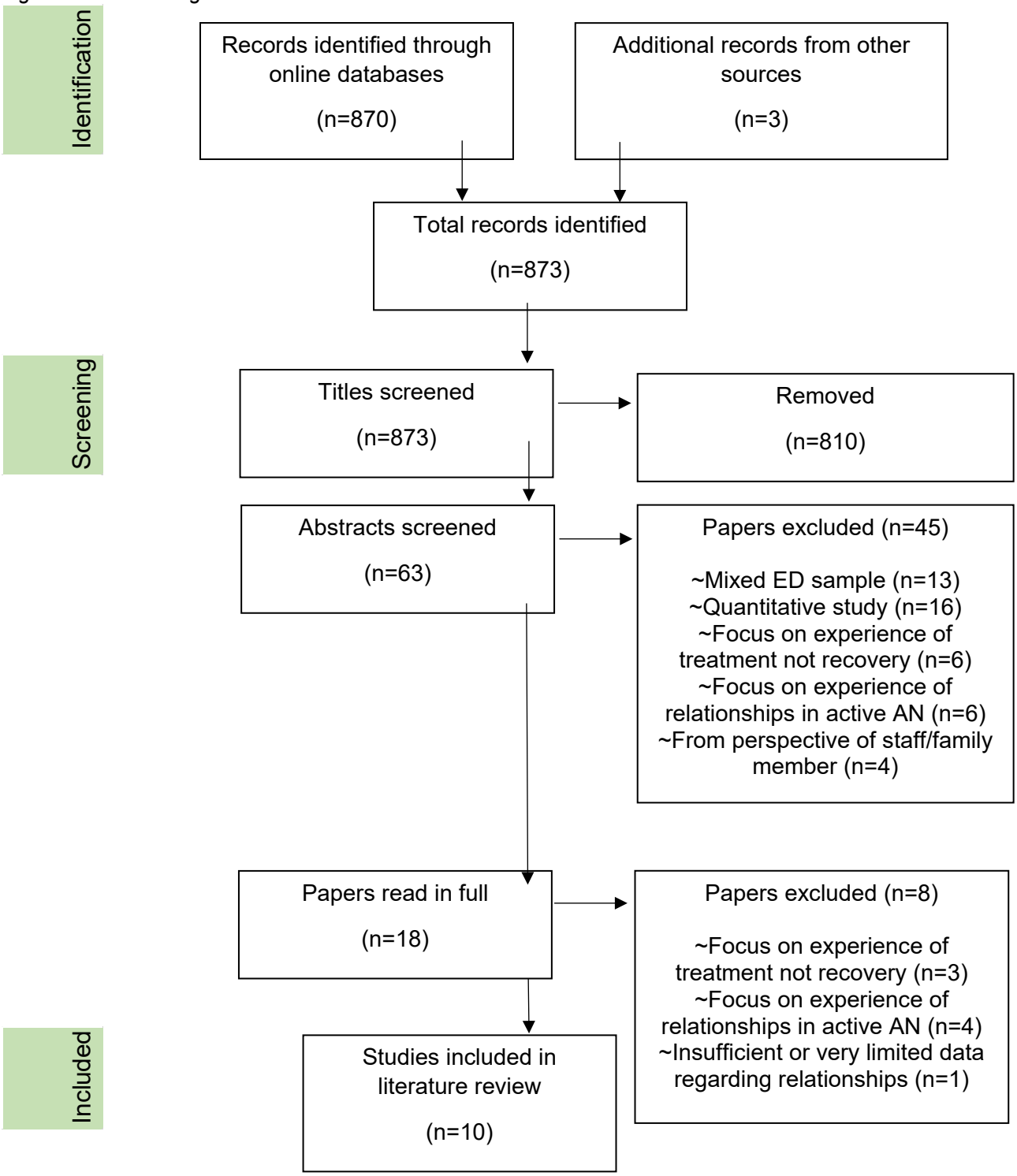
translating and synthesising the first- and second-order constructs from all papers included in the review. Synthesising the data in this way allows for new concepts to emerge beyond those created in the original papers (Espindola & Blay, 2009). 'Reciprocal translation' was used to merge similar first- and second-order constructs into wider, more detailed categories (Duncan et al., 2014). Reciprocal translation involves a systematic process of comparing themes, concepts and metaphors across papers. These categories were synthesised by a process of 'lines of argument' (Noblit & Hare, 1988), whereby higher order interpretation is achieved through consideration of the constructs yielded across all papers in the review. The meanings and metaphors from individual papers were ‘translated’ into each other to create new interpretations that represented the findings across papers, either by creating overarching categories that applied across papers or by extracting new categories by analysing the meanings within first- and second-order constructs. This process is shown in Appendix H.

ME is by nature an interpretive method and it is therefore not impervious to inadvertent researcher bias. A reflective journal was kept during the ME process to bring awareness to the student's own beliefs and opinions. Reflections were discussed with a peer to ensure that any potential biases were kept in awareness and addressed during synthesis.

3.Results
3.1 Prisma diagram

The literature search process is shown in Figure 1 below.

Figure 1: Prisma diagram



3.2 Identified studies

Ten papers were identified as relevant to the review questions and they are briefly summarised in Table 2 below. The ten studies included a total of 227 participants, only one of whom was male. Three studies made use of Interpretive Phenomenological Analysis, three used Thematic Analysis, three used Grounded Theory and one study used Content Analysis. Most studies (7) collected data through interviews, the remaining three collected data from weblogs (2) and personal published accounts (1). It was not possible to ascertain the nationality of participants for all studies. For those where it was possible, three were conducted in Canada, one in the UK, one in Sweden and one in New Zealand. Key findings are summarised in the last column of the table.

Table 2: Summary of papers

Author/year	Title	Journal	Participant group	Participants	Qualitative method	Data collection method	Country	Key findings
Smethurst & Kuss (2018)	'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa	Journal of Health Psychology	Female = 7 Male = 1 Mean age 23.9 (SD 3.6)	8	Interpretive phenomenological analysis	Weblogs	Unknown	Results suggest supportive relationships, regaining control & recognising consequences of the ED benefit recovery
Bradley & Simpson (2014)	Inside the experience of recovering from anorexia nervosa: An interpretative phenomenological analysis of blogs	Counselling, Psychotherapy & Health	Female = 5 Male = 0 Mean age 35 (SD unknown)	5	Interpretive phenomenological analysis	Weblogs	Unknown	Results highlight the importance of interpersonal connections in facilitating recovery, a lack of appropriate treatment services was identified as a barrier
Hay & Cho (2013)	A qualitative exploration of influences on the process of recovery from personal written accounts of people with anorexia nervosa	Women & Health	Women and men in recovery from AN Gender and mean age unknown	31	Thematic analysis	Personal published accounts	Unknown	Personal relationships and specific psychotherapies / treatments are important in recovery

Jenkins & Ogden (2012)	Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa	European Eating Disorders Review	Female = 15 Male = 0 Mean age 28.3 (SD 8.0)	15	Interpretive phenomenological analysis	Semi-structured telephone interviews	Unknown	Recovery is achieved through therapy, close relationships and resolving 'dichotomies'
Federici & Kaplan (2008)	The patient's account of relapse and recovery in anorexia nervosa: a qualitative study	European Eating Disorders Review	Female = 15 Male = 0 Mean age unknown	15	Thematic analysis	Semi-structured interviews	Canada	Recovery involves internal motivation to change, recovery as a work in progress, the perceived value of the treatment experience, developing supportive relationships, awareness and tolerance of negative emotion and self-validation
Granek (2007)	"You're a Whole Lot of Person"—Understanding the Journey Through Anorexia to Recovery: A Qualitative Study	The Humanistic Psychologist	Female = 5 Male = 0 Mean age unknown	5	Grounded theory	Open-ended interviews	UK	AN may be a relational process that involves a maladaptive desire for self-worth mediated through control of eating and weight

Nilsson & Hagglof (2006)	Patient perspectives of recovery in adolescent onset anorexia nervosa	Eating Disorders	Female = 58 Male = 0 Mean age unknown	58	Content analysis	Semi-structured interviews	Sweden	The most important aspects in their recovery: friends, own decisions, activities, treatment, family of origin, and own family
Lamoureux & Bottorff (2005)	"Becoming the Real Me": Recovering from Anorexia Nervosa.	Health Care for Women International	Female = 9 Male = 0 Mean age unknown	9	Grounded theory	Open-ended interviews	Canada	Recovery involves rediscovery and redefinition of the self
Weaver et al. (2005)	Understanding women's journey of recovering from anorexia nervosa	Qualitative Health Research	Female = 12 Male = 0 Mean age unknown	12	Grounded theory	Semi-structured interviews	Canada	Recovery is characterised by a journey from 'perilous self-soothing' to 'informed self-care'
Tozzi et al. (2003)	Causes and recovery in anorexia nervosa: The patient's perspective	The International Journal of Eating Disorders	Female = 69 Male = 0 Mean age unknown	69	Thematic analysis	Open-ended interviews	New Zealand	The three most commonly cited factors contributing to recovery were supportive non-familial relationships, therapy, and maturation

3.3 Quality review

All ten articles included in this review met the screening question criteria proposed by Campbell et al., (2011). In addition, as has been carried out in other recent meta-ethnographies (Duncan et al., 2015; Parslow et al., 2017), a brief quality review was conducted using the CASP checklist (n.d.) to ensure that studies included in the review were not “fatally flawed”.

Following the method used by Fox et al., (2015), studies were classified A-C. All of the studies identified by this review were classified as either ‘A’ (6) or ‘B’ (4) with a mean rating of 8.6. If any of the studies had been classified as ‘C’ they would have been deemed “fatally flawed” and removed from the synthesis, however all of the studies were rated as low-moderate likelihood of methodological flaws. The main reasons for studies losing points are listed below in order of frequency of occurrence:

- It was unclear if the relationship between the researcher(s) and participants had been adequately considered
- There was insufficient detail given to ascertain if there were robust processes to ensure ethical standards
- There was insufficient detail regarding data collection and how this was carried out
- There was insufficient detail about data analysis

Quality ratings are shown in Table 3 below. For the remainder of the paper the studies will be referred to by the number given to them in the first column of Table 3.

Table 3: Quality ratings

#	Authors	Title	Quality rating
1	Nilsson & Hägglöf (2006)	Patient perspectives of recovery in adolescent onset anorexia nervosa	10 (A)
2	Bradley & Simpson (2014)	Inside the experience of recovering from anorexia nervosa: An interpretative phenomenological analysis of blogs	9 (A)
3	Jenkins & Ogden (2012)	Becoming 'Whole' Again: A Qualitative Study of Women's Views of Recovering From Anorexia Nervosa	9 (A)
4	Federici & Kaplan (2008)	The patient's account of relapse and recovery in anorexia nervosa: a qualitative study	9 (A)
5	Lamoureux & Bottorff (2005)	"Becoming the Real Me": Recovering from Anorexia Nervosa.	9 (A)
6	Tozzi et al. (2003)	Causes and recovery in anorexia nervosa: The patient's perspective	9 (A)
7	Hay & Cho (2013)	A qualitative exploration of influences on the process of recovery from personal written accounts of people with anorexia nervosa	8 (B)
8	Granek (2007)	"You're a Whole Lot of Person"—Understanding the Journey Through Anorexia to Recovery: A Qualitative Study	8 (B)
9	Weaver et al. (2005)	Understanding women's journey of recovering from anorexia nervosa	8 (B)
10	Smethurst & Kuss (2018)	'Learning to live your life again': An interpretative phenomenological analysis of weblogs documenting the inside experience of recovering from anorexia nervosa	7 (B)

3.4 Meta-ethnography

First- and second order interpretation

Twenty-six constructs were derived from the data through reciprocal translation. To maintain integrity of the interpretations, the language used to label and describe these constructs originates from the language used by participants and authors in the original studies. The first- and second-order constructs have been grouped into two categories: 'important relationships' and 'relational factors that facilitate recovery'.

Important relationships

This category contains the first- and second-order constructs regarding relationships identified as important to the recovery process. Inter- and intrapersonal relationships were cited as pivotal recovery factors. This included family, partners, friends, peers, healthcare staff and the relationship with the self, AN and the AV.

Family (# 1, 3, 4, 5, 6, 9, 10): Relationships with family were mentioned numerous times. Family of origin and own family were spoken about, along with specific relationships, particularly with parents or children.

"My family was very supportive at the beginning of my recovery, and I think that was the most important part ... for them to take the illness seriously ... their understanding [and] willing[ness] to accept that I wasn't deliberately doing this to make myself sick."

Partners (# 1, 3, 6, 8, 10): Many individuals stated that relationships with boyfriends, husbands, wives and other romantic partners were significant factors in their recovery.

"I had a stable boyfriend and he made me feel really good about myself. Like he paid a lot of attention to me and he really cared. So, that made me feel good about myself"

Friends (# 1, 2, 3, 4, 6, 8, 9, 10): Friends were said to play a crucial role in recovery from AN, with some studies (#1) citing this relationship as the most important for recovery.

"Several women described the key role of having loyal friends who supported them tirelessly and urged them determinedly to choose recovery."

Peers (# 4, 6, 7, 9): Connections with other individuals with lived experience of AN often made during inpatient stays or during group therapy were cited as important facets in the recovery journey.

"I was with fellow women that suffered with the same thing so that allowed me to be open about issues ... and because people were speaking about them, I was able to speak about them."

Healthcare staff (# 1, 2, 3, 4, 5, 6, 7, 8, 9, 10): Relationships with therapists, psychiatrists, nurses, dieticians and other healthcare staff played important roles in recovery.

"Although I often prayed that I would die from anorexia... a tiny flame of hope flickered within my heart after I met my current eating disorders psychiatrist... I trusted him the minute I met him and we have built a very strong therapeutic relationship that has been invaluable in my recovery process."

Anorexia and the anorexic voice (# 2, 3, 4, 5, 7, 9, 10): The relationship with AN and/or the AV was pinpointed as critical in the recovery process. Most often the AV was described as a "voice", but it was also sometimes referred to as "anorexic thoughts".

"The final stage of the women's recovery process was controlling the AN voice"

The self (# 1, 2, 3, 4, 5, 6, 7, 8, 9, 10): The intrapersonal relationship with the self was repeatedly identified as crucial to recovery. Factors such as the perception of the self, understanding of the self and self-treatment were deemed important.

"Thus, the women's accounts of their recovery focused on their increasing sense of self."

Relational factors that facilitate recovery

This category contains the first- and second-order constructs regarding relational factors that facilitate recovery.

General relationship factors

Healthy relationships (# 1, 2, 3, 4, 5, 6, 7, 8, 9, 10): Relationships that were authentic, consistent, attentive, loyal, supportive, understanding and non-judgemental were described as helpful to recovery. People that were available, honest, dedicated and caring helped participants to progress towards recovery. Relationships with these qualities made them feel valued and safe. These kinds of relationships also allowed them to begin communicating their suffering in a healthy way, and to begin to receive emotional support for their distress. Finding alternative ways to express and receive support for their distress increased their confidence in their ability to deal with negative emotions. Feeling that they were “cared for” and “taken seriously”, and that others had faith in their abilities was vital for their self-esteem.

“Participants reported that maintaining change following intensive treatment was strongly related to the availability, support and non-judgemental stance of family members and friends in the months following treatment.”

Developing trust (# 2, 3, 4, 5, 8): Developing trust in relationships gave individuals hope and made it possible for them to engage in the tasks of recovery. It allowed them to begin accepting support from the people around them whilst they navigated the difficult

journey of recovery. When they trusted other individuals they began to contemplate their alternative opinions and consider whether they might be true.

“Trust in others allowed the women to begin to take in what others said and to consider alternate perspectives”

Letting people in (# 4, 9): Opening up to people and letting them in was an important step on the recovery journey. Often this allowed people to ask for and accept help. It also distracted from obsessive thoughts about eating and counteracted the loneliness created by AN.

“Letting others in also provides distraction from obsessive thinking about food and eating, validates women as people, not eating disorders, and counteracts the isolation of having AN.”

Setting boundaries and being assertive (# 4, 5, 9): Learning how to set healthy boundaries benefitted recovery. Some participants described how this was the first time in their life that they had set boundaries, and that encountering people that respected these boundaries made them feel validated and respected. It also made them feel empowered and helped them to discover their true sense of self. Assertive communication helped them to assert their own needs with other people.

“And this was me reclaiming myself.... Going through that process allowed me to

reclaim and even discover maybe a sense of self because for the first time in my life I actually set some boundaries.... I actually could speak up for myself and say this was okay or that was not okay.... I'd never done that before about anything"

Unconditional love, support and acceptance (# 2, 4, 5, 6, 8, 9): Receiving unconditional support, love and acceptance within relationships helped individuals to realise that they would be accepted regardless of their size, self-discipline or appearance. Additionally, it allowed them to stop relying on AN and instead begin to open up to support from real-life relationships. It created the emotional safety that they needed to make changes.

"Individuals who offered the women unconditional and unwavering support assisted them in learning to trust and build courage to move cautiously from relying on anorexia to relying on trustworthy individuals."

Expanding their social network (# 1, 2, 4, 5, 7, 9): Reconnecting or developing new relationships assisted recovery. Connecting to healthy relationships that were equal, supportive and respectful increased the amount of support available to them and magnified their sense of self-worth.

"Through forming new relationships with other trusted individuals, she experienced equality, commitment, and respect, which then empowered her"

Spending time with people not focussed on dieting or weight (# 1, 4, 5): Spending time with people that were not concerned with weight or dieting helped to shift their focus to other areas of life. Friendships with people that were not engaged in AN behaviours demonstrated alternative ways of living and enjoying life.

"Specifically, the adoption of a non-dieting approach by significant others and spending time with people who were less focused on body weight and shape, were perceived to be significant factors that contributed to the recovery process."

Distance from destructive or unhealthy relationships (# 4, 5, 6, 9): Resolving conflict was beneficial to the recovery process. However, if change was not possible in unhealthy relationships detachment was a key ingredient for recovery for many. Sometimes this involved removing themselves from negative environments or distancing themselves from difficult relationships. This included home environments, romantic relationships and friendship circles. Distancing themselves from negative relationships created space in their lives for them to invest in healthier relationships that met their needs and assisted their recovery.

"removing oneself from destructive and negative home environments, has served to facilitate adaptive change"

Peers

Open, honest, supportive peers (# 4, 6, 9): Being around peers who honestly discussed their struggle with AN helped individuals to reconnect to their emotions and to begin speaking about their own experiences. Peers who made them feel safe, supported, accepted and validated helped their recovery.

"Support from other women with eating disorders who have "been there too" is considered superlative, in that not only do women feel safe and accepted but they also are guided in naming and expressing their feelings"

Healthcare staff

Good therapeutic alliance: (# 2, 3, 4, 5, 6, 7, 9, 10): The quality of the therapeutic alliance influenced recovery. Staff who were collaborative, honest, trustworthy, supportive and validating helped recovery. Participants highlighted the importance of staff who listened, tried to understand and made them feel safe.

"The importance of feeling that one's therapist has taken time to understand and form a personal bond with the client was highlighted"

Anorexia or the AV

Challenging AN or the AV (# 2, 3, 5): Challenging the AV or the "anorexic mindset" helped individuals to defeat the urge to listen and comply, and as a result the AN/AV became "weaker". Most often the challenging was done by the individual themselves,

but some participants revealed that having “someone they trusted” challenge AN/AV was helpful for recovery. “Gentle” challenging from others was appreciated as opposed to direct confrontations, which were perceived as unhelpful to the recovery process.

“Some of the women found that challenging the AN voice within their heads repeatedly helped them overcome their desire to listen to it. Lisa describes ‘The more often you can challenge those knee-jerk cognitive responses, the weaker they'll become, till most of them do die out entirely.”

Ignoring or refusing to listen to the AV, non-compliance (# 3, 5, 9, 10): Not listening to the AV and ignoring its commands supported recovery. Non-compliance with the AV helped individuals to build confidence in themselves and to develop their new self-identity. Repeatedly ignoring and defying the AV led to the AV “subsid[ing]” and becoming “muted”.

“Usually, I do the exact opposite of what it [the anorexic voice] is telling me to do, just show it how much it is not going to affect me”

Altering the perception of AN or the AV (# 2, 9): Altering their perception of AN or the AV appeared to assist recovery. Individuals spoke about beginning to view AN or the AV as “evil”, “a thief” or “no longer helpful”. This often produced new feelings of “anger”, “hate” or “resentment” towards AN or the AV. This shift in perception paved the way for changes in behaviour.

“She began to envisage her AN voice as ‘Nazi Brunhilde’, ‘evil’, and as a thief”

Creating distance or separating from AN or the AV (# 2, 3, 5, 7, 9, 10): Individuals spoke about “externalising”, “separating”, “letting go” of and “disconnecting” from AN and the AV, resulting in the development of a healthy separate ‘self’. This was also sometimes framed as “giving up” or “rejecting” AN. Individuals learned how to differentiate their true, authentic self from the AV. Acknowledging and naming the AV or an “anorexic thought” when it arose helped individuals to establish distance in the relationship with AN/AV and to develop a more congruent perception of themselves. Creating a new identity for themselves separate from AN/AV fostered individuation and recovery. Some participants only defined themselves as “recovered” once they no longer considered AN part of their identity.

*“…almost like someone else was having the conversation and I was just listening-in thinking “that is such a stupid idea”... It was no longer *my* conversation - it no longer belonged to me... I've started to become able to separate my thoughts”*

Gaining control over AN or the AV (# 2, 3, 5, 10): Gaining or re-gaining control over AN/AV was an important stage in the recovery process which often resulted in people feeling that AN/AV had lost its power over them allowing them to “reclaim” their own power. Having control over the AV was considered by some to be a true marker of recovery.

“The women commented that once they gained control over the voice, it had gradually begun to lose its power”

The self

Understanding the self (# 1, 3, 5, 9): Getting to know themselves was a key ingredient to recovery for participants. This included figuring out their wants, needs and boundaries. It often occurred at stages of increased independence such as leaving home or starting college. Making their own choices helped them to decide who they wanted to be. As they began to understand themselves better they were able to begin prioritising their own needs, rather than sacrificing their emotional wellbeing to other’s needs. Knowing themselves better made them less likely to internalise criticism from others, as they were more assured in their sense of self and self-worth. It also enabled them to maintain a more robust sense of self in relationships with others.

“I’m learning how to take care of me. And I’ve never done that. And that comes along with meeting my own needs, identifying what my needs are, and having the courage and strength to go ahead and meet them”

Modifying self-perception (# 2, 3, 4, 5, 6, 7, 8, 9, 10): Altering their self-perception to view themselves as someone who was loveable, good, competent and worthy increased their self-respect, self-confidence and advanced them along the path to recovery. It allowed them to see their intrinsic value regardless of body shape or weight. They began to base their self-worth on other personal qualities and abilities. Acknowledging their self-worth appeared to be an essential step in the recovery

process. Observing their resilience and ability to overcome difficulties amplified their belief that they would be able to overcome their AN.

“Seeing value in themselves was a process that supported the women’s sense of competence, effectiveness, and meaningful contribution. This learning took place in therapy and in everyday life events such as succeeding at school, participating in yoga, developing meaningful relationships, and expressing opinions that were accepted and valued.”

Self-acceptance and self-compassion (# 2, 3, 4, 5, 9): Unconditional self-acceptance and self-compassion increased feelings of worthiness. Accepting themselves as they were, including their flaws and mistakes, and acknowledging rather than disregarding their positive qualities was important for recovery. Becoming less self-critical and more self-nurturing reduced negative feelings towards themselves. Self-compassion often made it easier for individuals to engage in vital self-care.

“Participants described themselves as less self-critical, more assertive, more accepting of their bodies and more likely to take credit for personal successes and accomplishments”

Reclaiming the self (# 2, 3, 4, 5, 7, 9, 10): Participants spoke about reclaiming or developing their identity, often by “shedding” AN and revealing the “real me”. This process involved reconnecting to emotions, discovering their own likes, beliefs, desires,

opinions, values and goals and developing new social roles. This enabled them to increase their sense of self and develop an authentic relationship with themselves. Their identity had previously been significantly interwoven with AN and by not allowing AN to define them anymore they were able to reconnect to their true selves. Some described that this involved “resolving dichotomies” within themselves and “becoming whole” again. Discovering previously unknown parts of themselves and allowing new parts of themselves to “grow” left less room in their identity for AN, enabling them to let go of it. By reclaiming the ‘self’ they were able to create an authentic, healthy identity for themselves that was distinct from AN or the AV.

“Learning how to “strip away” the AN and reclaim their identity was described by the women as an important aspect in the recovery process”

Third order interpretation

Synthesis of the first- and second-order constructs resulted in three third-order constructs: ‘initiating, maintaining or re-connecting to nourishing relationships’, ‘transforming or distancing oneself from difficult relationships’ and ‘nurturing the relationship with the self’. The three constructs are shown below in Table 4 along with the first- and second- order constructs they were generated from. These constructs represent the resultant 'line of argument' synthesis which was established from data presented in the original papers, however it is important to hold in mind that they represent the synthesiser's interpretation of that data.

Table 4: Third-order constructs

#	Third-order construct	First- and second-order constructs
1	Initiating, maintaining or re-connecting to nourishing relationships	*-Healthy relationships* *-Developing trust* *-Letting people in* *-Unconditional love, support and acceptance* *- Expanding their social network* *- Spending time with people not focussed on dieting or weight* *-Open, honest, supportive peers* *-Good therapeutic alliance*
2	Transforming or distancing oneself from difficult relationships	*-Distance from destructive or unhealthy relationships* *-Setting boundaries and being assertive* *-Challenging AN or the AV* *-Ignoring or refusing to listen to the AV, non-compliance* *-Altering the perception of AN or the AV* *-Creating distance or separating from AN or the AV* *-Gaining control over AN or the AV*

3	Nurturing the relationship with the self	*-Understanding the self* *-Modifying self-perception* *-Self-acceptance and self-compassion* *-Reclaiming the self*

Initiating, maintaining or re-connecting to nourishing relationships

This construct describes how healthy, nourishing relationships can facilitate recovery. This was achieved by either maintaining or re-connecting to healthy relationships, or by developing positive new relationships. Healthy, supportive relationships provided the emotional support and assistance needed for recovery. Letting people in and expanding the social network increased sources of support. Developing trust enabled individuals to consider alternative beliefs and engage in the tasks of recovery. Unconditional love, support and acceptance encouraged new ways of healthily expressing distress. Spending time with people that were not concerned with dieting shifted focus to other aspects of life. Having honest, supportive peers and good therapeutic alliances provided an arena for change to occur in treatment.

"In general, from these findings one may conclude that in order to improve the treatment outcome in the long run, one should stimulate the patients' social contacts"

Transforming or distancing oneself from difficult relationships

This construct describes how the negative influence of difficult relationships on recovery can be mitigated through transformation or distancing from them. Resolving conflict,

setting boundaries and learning to be assertive were key to transforming interpersonal relationships. If change was not possible many individuals enhanced their recovery by removing themselves form harmful environments or creating distance in unhealthy relationships. The two most significant relationships in this construct were the relationship with AN and the relationship with the AV. Recovery was supported and facilitated by changing the nature of the relationships with AN and AV. Beneficial changes included not listening or complying with AN/AV, altering the individuals' perception of AN/AV, challenging AN/AV, gaining control over AN/AV and separating or distancing from AN/AV.

"Finding me" is a turning point at which women begin to distance themselves from the AN to identify that it is no longer helping"

Nurturing the relationship with the self

This construct describes how nurturing and developing the intrapersonal relationship with the 'self' aids recovery. Cultivating self-knowledge and understanding increased an authentic sense of self and helped individuals to begin the process of developing or reconnecting to their true self-identity. Modifying their self-perception from entrenched negative judgements to more balanced perceptions that incorporated strengths bolstered their self-esteem. Self-acceptance and self-compassion increased their feelings of worthiness and allowed them to engage in vital self-care. Individuals engaged in a process of 'reclaiming the self' whereby they discarded AN from their identity allowing them to uncover the "real" them and become "whole again". By

reclaiming the ‘self’ they were able to create an authentic, healthy identity for themselves that was separate from AN or the AV.

“recovery means jettisoning anorexia and embracing life... discovering a new identity, the person hidden behind the layers of starving and self-harm and self-hatred. I'm getting there.”

4.Discussion

The findings of the meta-ethnography will be discussed in relation to each review question below.

Do relationships facilitate recovery from anorexia nervosa?

The results of this ME suggest that healthy, supportive relationships are facilitative to recovery. This is in line with previous research suggesting that relationships are pivotal in the recovery process (Nilsen et al., 2020; Bezance & Holliday, 2013; Beresin et al., 1989). Individuals with active AN often have smaller, less supportive social networks and they are frequently socially withdrawn (Tchanturia et al., 2013; Tiller et al., 1997). By initiating, maintaining or re-connecting to nourishing relationships they can increase the amount of emotional support available to them whilst they engage in the difficult tasks of recovery. Some individuals with AN even define recovery as the ability to create and maintain meaningful, loving interpersonal relationships (Darcy et al., 2010).

Which relationships are important to recovery?

The studies brought together in this synthesis suggest that both inter- and intrapersonal relationships are important to recovery. Relationships important to recovery included family, partners, friends, peers, healthcare staff alongside the relationship with AN, the AV and the relationship with the 'self'.

Relationship with family of origin and own family were deemed important. In line with previous findings, parental support and involvement helped recovery for adolescents

(Nilsen et al., 2020; Woods, 2004). However, relationship characteristics and style of relating appear to be crucial, as unhealthy relationships with family can impede recovery (Salerno et al., 2015). Children were also mentioned as a motivating factor for recovery (Mitchison et al., 2016). Concurrent with earlier research, healthy relationships with boyfriends, husbands, wives and other romantic connections boosted recovery (Mitchison et al., 2016; Hsu et al., 1992)

Many of the papers reviewed reported that friends were an important recovery factor. Nilsson et al. (2006) identified it as the “most useful” factor for recovery, reported by 43% of participants. Individuals with AN report small friendship circles that can often reduce even further when AN progresses (Patel et al., 2016). Additionally, poor quality friendships have been linked to more severe eating pathology and higher levels of body dissatisfaction (Sharpe et al., 2014). Self-reports from individuals who have experienced AN suggests that staying in touch with friends, reconnecting with friends or making new friends are important aspects of the recovery process (Nilsen et al., 2020). Supportive friends are also associated with greater levels of motivation to recover (Malmendier-Muehlschlegel et al., 2016). This ME additionally highlighted the importance of spending time with friends who were not concerned with dieting or weight. Similar to previous research findings, peer relationships with other individuals with an ED were beneficial to recovery if the relationships were open, honest and supportive (Eli, 2014; Offord et al., 2006).

In alignment with research into recovery in mental health difficulties in general, good therapeutic alliance with staff was linked to recovery (Osborn & Stein, 2019).

Preceding research has highlighted the importance of therapeutic alliance in AN specifically (Button & Warren, 2002; Beresin, 1989).

This review also highlighted the importance of the relationship with AN, the AV and the 'self'. These relationships required transformation to achieve recovery. This concurs with prior research suggesting that positive alterations to the relationship with AN, the AV and the 'self' can advance recovery (Stockford et al., 2019; Duncan et al., 2015; Williams & Reid, 2012).

What relationship characteristics facilitate recovery?

Negative relationship dynamics, such as excessive pressure or derogatory comments, have been identified as a trigger for AN (Hutchinson & Rapee, 2007). In accordance with this, healthy relationship dynamics were conversely associated with recovery. The studies included in this review mentioned authenticity, consistency, attentiveness, loyalty, support, understanding, acceptance, non-judgemental attitudes and unconditional support and love as relationship characteristics that benefit recovery. This expands on previous research that emphasised the importance of support, understanding and non-judgemental attitudes (Espíndola & Blay, 2009; Colton & Pistrang, 2004, Beresin et al., 1989).

Are changes in relationship dynamics necessary for recovery from AN?

Transforming problematic relationships was key to recovery. This was relevant in the context of both intra- and interpersonal relationships. Beginning to let people in and

accept support was one important facet of the recovery process, which has been observed in earlier research (Nilsen et al., 2020). Developing trust appears to be integral to recovery, as it allows individuals to let go of AN and begin relying on other sources of support both in others and within themselves (Munro et al., 2017). Evidence suggests that people with AN tend to prioritise other people's feeling over their own, in addition to avoiding expressing their emotions (Arcelus et al., 2013). Learning how to set boundaries and communicate needs assertively facilitated recovery by counteracting this, allowing individuals to honour their own needs and feelings. The need for assertiveness has been echoed in earlier AN research (Behar et al., 2006).

Distancing oneself from non-transformable difficult relationships was identified as a crucial recovery step in the present ME. Strober et al (1997) described how recovery from AN can be impeded by aversive or hostile social environments. In the present study it was observed that individuals benefitted their recovery by removing or distancing themselves from unhealthy social environments and relationships that could not be transformed.

The present ME identified the relationship with AN or the AV as pivotal to the recovery process. As has been noted in earlier research, altering the relationship with AN and, if present, the AV can promote recovery (Hibbs et al., 2020; Smethurst & Kuss, 2018). In line with previous findings learning to ignore or refusing to listen to AN/AV, challenging it's claims and refusing to comply is associated with recovery (Williams & Reid, 2012; Tierney & Fox, 2010). Individuals described how recovery progressed when their

perception of AN/AV changed. Concurrent with earlier research, this was often from seeing AN/AV as helpful and powerful to viewing it as “evil” or ineffective. (Pugh & Waller, 2016). The balance of power in the relationship with AN/AV was also identified as crucial to recovery. Gaining or regaining control over AN/AV was named as an important step in recovery (Jenkins & Ogden, 2012). A prominent feature of recovery was distancing or separating from AN/AV (Keski-Rahkonen & Tozzi, 2005). Changing the relationship in this way helped individuals to connect with their true selves and forge a new identity that was not bound to AN.

The relationship with the ‘self’ also appears to be vital to recovery (Amianto et al., 2016). During active AN the relationship with the ‘self’ was often problematic, and in order to recover individuals had to nurture and transform the relationship with themselves (Williams et al., 2016). Transformation of this relationship included understanding the self, modifying the self-perception, fostering self-compassion and acceptance and reclaiming the self. Transforming and nurturing the relationship with the self in these ways facilitates recovery from AN (Espíndola & Blay, 2009, D-Abundo & Chally, 2004). This concept of reconnecting with the true self is echoed in research into recovery from other mental health difficulties (Jacobson & Greenley, 2001).

5.Limitations

This ME contains a relatively small pool of studies, this is a reflection of the evidence base in which qualitative studies of the lived experience of recovery from AN are scarce. The studies that were synthesised predominately consisted of women from non-Black, Asian and minority ethnic (BAME) groups, which may impact the transferability of the findings to other genders and ethnic groups. Every effort was made to ensure a robust and extensive search strategy, but relevant literature published after the completion of the review may not have been included.

The studies included in this review showed some methodological weaknesses in areas assessed by the CASP checklist (n.d). It was often unclear if the relationship between the researcher(s) and participants had been adequately considered. Therefore, it is possible that some of the studies included in this review may have been affected by respondent bias. In light of this, constructs surrounding relationships with healthcare staff may need to be interpreted cautiously. Some of the studies did not give comprehensive detail regarding ethical processes, however it is possible that robust ethical procedures were followed but insufficient detail was reported about this in the article. A small number of studies gave insufficient details about data collection and/or analysis, indicating that the data sources or analysis could potentially be invalid, however this only affected a small number of studies in the ME.

6.Clinical implications

The findings of this ME suggest that consideration of relationships and relational factors in treatment could be beneficial (Lindstedt et al., 2018; Patel et al., 2016). This could encompass including the person's support network in treatment alongside extending and strengthening their social network in general (Nilsson et al., 2006). The nature and qualities of relationships appear to be key, therefore teaching and encouraging healthy interpersonal skills such as assertiveness, boundary-setting and conflict resolution could assist recovery (Mitchison et al., 2016). Encouraging self-understanding, a balanced self-perception and development of an authentic self-identity that it not defined by AN also appear to be crucial targets for treatment of AN (Espíndola & Blay, 2009, D-Abundo & Chally, 2004). The relationships with AN and the AV are particularly important, and treatments that maintain a focus on these and encourage transformation in these relationships would appear to be beneficial (Tierney & Fox, 2010; Williams & Reid, 2012).

7.Research implications

Repetition of this review when more literature becomes available would be beneficial, particularly with respect to qualitative studies with more diverse gender and BAME groups. Further research into the relationship with AN, the AV and the 'self', and how these relationships interact with the recovery process would be beneficial.

There were some methodological flaws identified in the review articles. As the literature base grows, it would be beneficial to identify and review studies that give sufficient

details regarding the relationship between the researcher(s) and participants, ethical procedures, data collection and data analysis.

Transforming or distancing from difficult relationships was identified as a key recovery factor in the present ME. The relationship with the AV was frequently highlighted as particularly important, and many of the studies described how modifying the relationship with the AV was pivotal for recovery. Therefore, it would be beneficial to investigate the specific role of the AV in the process of recovery from AN.

8.Conclusion

This review aimed to shed light on the role of relationships in recovery from AN, from the perspective of recovered individuals. The current body of qualitative evidence was synthesised used a meta-ethnographic approach. The findings of this meta-ethnography concur with previous research suggesting that recovery appears to be in some ways a relational process that happens within the context of close, supportive relationships (D'Abundo & Chally, 2004; Garrett, 1997). Weight restoration, AN symptom reduction and psychological shifts are unmistakably vital for recovery (Bamford et al., 2014; Fenning et al., 2002), but healthy, supportive relationships and transformation of problematic relationships appear to be vital to the recovery process (Patel et al., 2016; Harney et al., 2014). The findings of this ME suggest that relationships family, partners, friends, peers, healthcare staff, AN, the AV and the 'self' are particularly important to recovery.

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Emma Peskett MSc, BA

Major Research Project

Part B: Empirical study

Voices from the past: A qualitative analysis of the “anorexic voice” in treatment and recovery

Word count: 8600

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N.B. All names and identifiable personal information of participants have been anonymised to ensure confidentiality.

Abstract

Background and aims: Many people with a diagnosis of anorexia nervosa (AN) report an 'anorexic voice' (AV). Research has indicated that the AV plays an important role in both the development and maintenance of AN and is associated with severity of eating psychopathology. This report presents the results of a qualitative study designed to investigate the experience of the AV for people in recovery, exploring if and how it changed in treatment and recovery.

Design: Reflexive Thematic Analysis was used to evaluate semi-structured interviews with participants who were in recovery from AN.

Method: Fourteen adults with a prior diagnosis of AN were interviewed. Participants were recruited from online eating disorder support groups and via social media with assistance from The National Centre for Eating Disorders. A flexible interview topic guide was used, and interviews were conducted online using videoconferencing software. An inductive, data-driven approach to analysis was employed.

Results: Five themes were identified in the data: *1. Allegiance, 2. Relationship becomes toxic, 3. Realisation & motivation, 4. Recovering from the AV, 5. Reclaiming life.* The results suggest that individuals often move through a series of stages in their relationship with the AV. Initially the AV is a comforting and supportive presence, but the relationship soon becomes abusive and toxic. A catalyst occurs which prompts realisation and provides motivation for change, providing the impetus for recovery. Recovering from the AV is a complex and gradual process, which includes dialoguing with the voice, learning to modify responses to it, building a different relationship with the voice and separating from it. Recovery is often followed by an ongoing period of reclaiming life from the influence of the AV.

Conclusions: The results of this study suggest that individuals often move through a series of stages in their relationship with the AV. Recovery is complex and multifaceted, and treatments that encourage dialogue with the voice, that target both the perception of the AV and the relationship with it can aid recovery.

Keywords: anorexia nervosa, eating disorders, anorexic voice, eating disorder voice, voices

1.Introduction

Anorexia nervosa (AN) is a debilitating eating ‘disorder’ (ED) typified by intense fear of eating and gaining weight, a distorted perception of one’s body shape and weight, and self-induced starvation leading to extremely low body weight (American Psychiatric Association, 2013). The prevalence of AN is between 1-4% in the general population and it has the highest mortality rate of all mental health difficulties (van Eeden et al., 2021; Keski-Rahkonen & Mustelin, 2016; Smink et al., 2012). Evidence suggests that between 10-25% do not recover (Löwe et al., 2001), with relapse rates between 35-41% (Berends et al, 2016).

Written descriptions of AN date back to 1689 (Morton) and AN has traditionally been viewed as a female ‘disorder’ (Sharan & Sundar, 2015). There have been criticisms of the medical model and ‘diagnosis’ of AN (Levine & Smolak, 2013). For example, The Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018a) challenges the validity of clinical diagnoses and offers an alternative understanding of distress based on the operation of power and threat responses. The PTMF draws parallels between experiences of different ‘disorders’, including psychosis and AN, suggesting that the expression and interpretation of distress, often routed in trauma, can be heavily influenced by gender and other societal concepts and influences, as opposed to being biologically-caused ‘disorders’. Feminist authors suggest that patriarchal influences in Western culture put pressure on females to supress their “dangerous” appetite and have “open, accessible” bodies, and that AN symptoms are sometimes a direct response to this pressure whereby women create closed, undesirable bodies as a

trauma or threat response (MacSween & MacSween, 1993). Similarly, Larson (2021) argues that “fat stigma” is a product of patriarchal norms that imply women with bodies that are not thin are somehow deficient, and that these views can be internalised by females and hook into feelings of shame and low self-esteem, with starvation thereby becoming the tool with which to self-harm and punish themselves for their ‘deficiencies’. Within these understandings, AN could be viewed as a threat response to trauma and problematic patriarchal power, that is more likely to be experienced by females due to cultural and societal influences of patriarchy and misogyny.

People suffering from AN often describe an ‘anorexic voice’ (AV) (Jenkins & Ogden, 2012; Wright & Hacking, 2012; Tierney & Fox, 2010), which criticises their eating, weight and body shape, often passing harsh judgement on their self-worth in relation to these characteristics (Pugh 2016). The experience is a common feature of AN and EDs in general, with between 33% and 96% of people with an ED reporting the experience (Wentz et al., 2001; Noordenbos et al., 2014; Noordenbos & van Geest, 2017). Dissimilar to auditory hallucinations experienced in psychosis, individuals with a diagnosis of AN are usually aware that the AV is a part of them, whilst at the same time feeling phenomenologically separate and distinct from their sense of self (Hampshire et al., 2020; Fox et al., 2012; Williams & Reid, 2012). It has been hypothesised that the function of the AV is to provide defence and support in the face of highly distressing situations and emotions (Pugh & Waller, 2017; Graham et al., 2019). The AV is frequently described as critical, powerful, and a key driver of eating disordered behaviours (Maisel et al., 2004). The AV has been implicated as a key psychological

component of AN that drives both the development and maintenance of AN (Ling et al., 2021). The AV is associated with weight-related concern and weight-loss behaviours (Higbed & Fox, 2010; Tierney & Fox, 2010). The evidence-base suggests the AV encourages unhealthy preoccupations and attitudes towards weight, motivating people to engage in harmful weight-reduction practices (Pugh & Waller, 2017, 2018; Pugh et al., 2018). AVs that are perceived as more powerful than the self are associated with more negative attitudes towards eating and longer duration of illness (Noordenbos et al., 2014; Pugh & Waller, 2017). Consequently, there has been a growing interest amongst researchers and clinicians as to how people experience, respond to, and manage this voice.

Although the experience of an AV appears to be a common feature of AN, relatively few studies have attempted to explore the phenomenon directly. The small pool of qualitative studies examining the AV in AN (Tierney & Fox, 2010; Tierney & Fox, 2011; Williams & Reid, 2012) often describe how people are drawn into a relationship with the AV at a difficult time in their lives. Initially the AV is experienced as benevolent and fulfils positive functions, such as helping with decision-making, distracting from painful emotions and offering a sense of comfort. Over time, however, the AV becomes an increasingly powerful, controlling, abusive force, which prompts them to adopt increasingly extreme eating behaviours. The AV is often described as becoming unremitting, eventually causing other negative consequences such as social withdrawal and low mood. The AV has also been pinpointed as a barrier to recovery (Hampshire et

al., 2020). Research also suggests the AV may play a role in relapse, wherein the individual is 'enticed' back to their ED by the voice (Fox et al., 2012).

Given these findings, it seems that changing the way people relate and respond to their AV represents a crucial step towards breaking free of AN. Former research revealed that people with AN would like greater recognition of and intervention for the AV (Tierney & Fox, 2011). Several authors have suggested that beginning to "defend against" the power of the voice, such as by challenging its messages or distancing oneself, may play an important role in recovery (Dolhanty & Greenberg, 2009; Lock et al., 2004; Simpson, 2012). Recovered and recovering individuals have similarly reported that beginning to challenge and control their AV was important in reducing its power and dominance over them (Jenkins & Ogden, 2012). NICE guidance currently recommends CBT-ED (Cognitive Behavioural Therapy for Eating Disorders), MANTRA (Maudsley Anorexia Nervosa TReatment for Adults) or SSCM (Specialist Supportive Clinical Management) for the treatment of AN (National Institute for Health and Care Excellence, 2017). These treatments do not include a focus on the AV as an explicit treatment component.

Despite the important role the AV appears to play in recovery, few studies have attempted to explore how sufferers' themselves experience and operationalise their relationship with the AV. This will be the first study to date which has specifically explored the AV in treatment and recovery. It is hoped the findings of this study will contribute to the development of treatments and interventions which empower sufferers

to overcome both the AV and their ED, in addition to identifying important areas for further research. This study is part of a programme of research studies, including the R2V(ED) Trial, focusing on the relationship with the AV.

1.2 Research aims

This exploratory study will explore experiences of the AV in treatment and recovery from the perspective of individuals who have successfully overcome their ED. Specifically, the research questions are:

i) In participants' personal experience, did their experience of and relationship with the AV change over time?

ii) In their personal experience, which styles of relating/responding to the AV facilitated their recovery?

iii) If change occurred, which factors did participants feel were responsible for bringing about changes in their experience of the AV and their relationship with the AV?

iv) In their personal experience, which techniques and strategies were most effective for managing their AV in recovery?

v) Was working with the AV an important aspect of treatment for participants in their personal recovery journey?

2.Method

2.1 Design

Qualitative methodology was deemed appropriate due to this being an exploratory study in a novel research area, with research questions that aimed to gain in-depth understanding of participants' experiences. Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2019) was used to evaluate semi-structured interviews with participants in recovery from AN. RTA was chosen because it can be applied across different epistemological and theoretical approaches, and it is possible to produce detailed, rich interpretations with this method. RTA can also be used with large datasets and it acknowledges researcher subjectivity and encourages reflexivity.

2.2 Participants

Fourteen people with a past diagnosis of AN were interviewed. Demographics are shown in Table 5. All participants were female UK residents and most of the sample were White British. The mean age was 29 (*SD* 8.9) and mean global score on the Eating Disorder Examination Questionnaire (EDE-Q) (Appendix A) was 1.9 (*SD* 1.5). Mean duration of illness was 3.6 years (*SD* 2.9), ranging between 1-9 years. On average participants had received 2 courses of treatment (*SD* 0.8). Data regarding type of psychological treatment was not collected, however during interviewing most participants reported that they had received CBT-style treatment, with others reporting having received integrative therapy, group therapy, Dialectical Behaviour Therapy (DBT) and psychotherapy.

Table 5 – Participant demographics

		N	***Percentage (%)***
Gender	Female	14	100%
	Male	0	0%
Ethnicity	White British	11	79%
	White other	2	14%
	BAME	1	7%
		***Mean* (*SD*)**	***Range***
Global EDE-Q score		1.9 (1.5)	0.26 – 3.91
Age at interview (years)		29 (8.9)	18 – 43
Age at diagnosis (years)		19 (4.7)	14 – 29
Duration of illness (years)		3.6 (2.9)	1 – 9
Courses of treatment		2 (0.8)	1 – 3

2.3 Inclusion & exclusion criteria

Table 6 – Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
A self-reported previous diagnosis of Anorexia Nervosa (including all subtypes)	The inability to comprehend or understand written English (due to learning disability and/or fluency in English)
The participant no longer met diagnostic criteria for an eating disorder (a global score on the EDE-Q of <4 (within 1 standard deviation of community norms 2.77 *SD* 1.52, Fairburn & Beglin,1994; Aardoom et al., 2012)	Individuals still undergoing active treatment
The capacity to read the information contained in the information sheet, and to provide informed consent to participate	Individuals who continued to meet diagnostic criteria for any eating disorder and/or had a global score of >4 on the EDE-Q.
Willingness to reflect on their experience of treatment for anorexia nervosa	
Identified with the notion of an anorexic voice	
They were not currently in treatment	
UK resident	
Age 18+	

2.4 Transcription

Interviews varied between 27 and 59 minutes in length (mean 45 minutes). The audio-recorded interviews were transcribed verbatim by the student researcher. Transcription was viewed as an interpretive process that is not atheoretical (Lapadat & Lindsay, 1999). A critical-realist epistemological understanding of the process was adopted. A systematic approach to transcription was used, aiming for thoroughness and

consistency. All verbal and non-verbal communications and acts were recorded. Identifiable information was removed during transcription in the interests of confidentiality to ensure anonymity.

2.5 Service user involvement

Feedback was sought from an ED campaigner and vlogger who is in recovery from AN, who reviewed and gave feedback on the study documents.

2.6 Procedure

Information and Consent: Digital versions of the Participant Information Sheet (PIS) (Appendix B) and Consent Form (CF) (Appendix C) were created using Qualtrics software (Qualtrics, Provo, UT.). The PIS detailed aims, risks and benefits of participation, and the CF sought explicit written consent for participation. Participants were emailed a link to the documents. If participants returned a signed CF, they were then emailed a link to the screening questionnaire, which was also administered digitally via Qualtrics software.

Recruitment: The research advert was kindly shared by The National Centre for Eating Disorders on their social media pages. Participants were also recruited from online ED support groups. Group leaders and moderators were asked to share the advert (Appendix D) with members of their group.

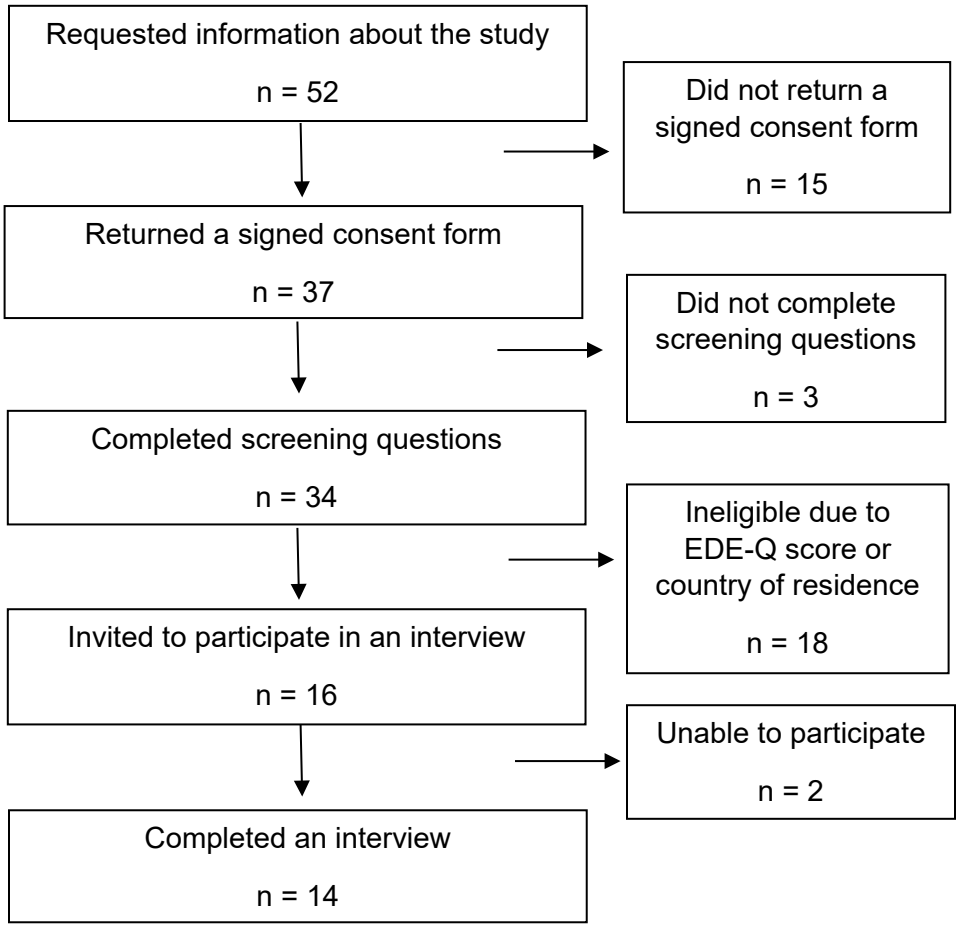
Screening: The screening questionnaire collected data related to the inclusion/exclusion criteria; including name, age, gender, ethnicity, country of residence, confirmation of diagnosis, date of diagnosis, details of treatment and date treatment ended. The EDE-Q was administered to ensure that participants did not currently meet criteria for an ED. The EDE-Q is a widely used self-report questionnaire, based on the Eating Disorder Examination (EDE) interview (Luce & Crowther, 1999). Research has shown good concurrent validity and acceptable criterion validity (Mond et al, 2004). If participants did not meet inclusion criteria, they were informed by email and offered a supportive sign-posting conversation.

Interviews: Data for this study was generated by semi-structured interviews. Semi-structured interviews were chosen because they allow rich descriptions, encourage participants to reflect, and allow for novel topics to emerge. Interviews were completed between May and November 2020. The Interview Topic Guide (Appendix E) was developed for this project and consisted of broad open-ended questions and prompts about the experience of the AV and how this changed over time. To encourage natural discussion and allow additional topics to emerge, the topic guide was used flexibly. If participants raised other points that were relevant to the AV experience, they were encouraged to talk more about that topic. Interviews were conducted online using videoconferencing software. All interviews were conducted by the same interviewer and were audio-recorded with an encrypted dictaphone.

2.7 Participant flow

Fifty-two people requested information about the study and were sent a PIS and CF. Thirty-seven people returned a signed CF and 34 people completed screening questions. Eighteen people were screened-out because they did not meet inclusion criteria, primarily because they had a global score of >4 on the EDE-Q or were not a UK resident. Sixteen people were asked to participate in an interview, 14 of whom completed an interview. Two people did not take part in the interview because of current difficult personal circumstances.

Figure 2 – Participant flow



2.8 Method of analysis

Braun and Clarke's (2021) reflexive six-stage approach to thematic analysis was used to analyse and identify themes within the data, encompassing an inductive, data-driven approach to analysis. In line with an inductive method, literature on the AV was not fully engaged with until after coding. The student researcher familiarised herself with the dataset, through transcription and re-reading of transcripts. Transcripts were transferred into NVivo (Version 12 Pro) to aid organisation. The student researcher undertook iterative reflexive coding of semantic content, searching for common, recurring or pertinent codes. Illustrative data extracts were highlighted and linked to each code. At this stage 147 codes had been created, the majority of which were semantic in nature. The codes were then collated and reviewed, and initial themes were searched for and created from the codes. These initial themes were then reviewed against the dataset, and the project supervisors and consultant reviewed the codes and offered feedback. As themes developed, they became more latent. The themes were then named and defined, and a detailed description was developed for each one. The final five themes consisted of 69 codes that were deemed relevant to the research questions and illustrative of the recovery journey commonly described by participants.

Theoretical stance: A critical-realist approach was adopted, because it incorporates a realist ontological perspective and a subjectivist epistemological perspective, allowing a thorough search for true knowledge and meaning whilst acknowledging that the researcher played a subjective role in interpretating the data. Thought was given to the researcher's background, theoretical perspectives and biases, and a reflective journal

and bracketing interviews were used to bring awareness to these influences. A critical-realist approach encourages the researcher to search for causal mechanisms and tendencies (Gorski, 2013), whilst acknowledging the role of both individual agency and contexts (Fryer, 2020), allowing a rich and multi-faceted understanding of the topic to develop. It also seems important to acknowledge participant subjectivity, as by participating in the interview participants brought their own interpretative resources into play on the topic.

2.9 Quality assurance and reflexivity

A variety of quality assurance and reflexivity methods were used. A topic guide with broad, open-ended questions was developed as opposed to an interview schedule, to reduce bias and leading questions (Sargeant, 2012). Bracketing interviews (Gearing, 2004) were completed with a peer prior to interviewing, and before data analysis once all interviews were completed. A reflexive journal (McGrath, 2021) was kept throughout the research process, and a clear account of how data was collected, analysed and coded is provided in this report. Researcher reflexivity is considered a critical element in qualitative research, key to ensuring that possible biases are recognised and addressed (Watt, 2007). Braun and Clarke (2020) created a quality assurance tool specifically designed for evaluating RTA research, that tool has been used as a guideline for ensuring this project meets the quality expectations of an RTA project.

Mays and Pope (2000) recommend making personal characteristics and biases explicit when reporting research findings. I am a White-British female which to a large extent

mirrors the typically reported demographic profile of AN (Keski-Rahkonen & Mustelin, 2016; Zipfel et al., 2015). However, this was not apparent in the recruitment advert, and therefore should not have biased recruitment. I have a professional interest in voice-hearing experiences and EDs and I have worked in both areas, which is what attracted me to conducting this research project. My professional experience in EDs dates back to the mid-2000s, and the unit that I worked in did not place emphasis on the AV, so my professional contact with the concept prior to this project was limited. I had more recent experience of working in a Voices Clinic, delivering therapy for distressing voice(s) to individuals with a range of difficulties. This sparked an interest for me about the voice-hearing experience, in particular parallels and differences across different mental health difficulties, and whether similar treatment approaches can be effective for different difficulties. This led to a conversation with my placement supervisor about voices in eating 'disorders' and the programme of research studies he was involved in, resulting in this research project.

During bracketing interviews it became apparent I had a more favourable opinion for therapeutic approaches that I had used with clients myself, so I endeavoured to keep this bias present in my awareness whilst conducting the analysis.

2.10 Ethical approval

Ethical approval for the study was granted by The Salomons Ethics Panel, Salomons Centre for Applied Psychology, Canterbury Christ Church University (Appendix F).

3.Results

Firstly an overview of the experience and interpretation of the AV will be given, followed by characteristics of the AV described by participants. Following this the results of reflexive thematic analysis will be presented. This will consist of a summary of the analysis followed by a detailed description of each theme.

Experience and interpretation of the voice

Most participants reported a singular AV that persisted through all episodes of their AN, with just one participant reporting multiple voices and another who experienced a different voice when they became unwell a second time. Participants described their AV in varying ways, from “thoughts”, “my own voice in my head”, an “internal monologue”, “a voice in my head”, “voices in my mind”, “an external voice in my head”, “something narrating my life”, “a whole separate little person in my head”, to “something very external and separate”. Most participants experienced the AV either as their own voice, or as an ‘anonymous other’, with a small group (3 participants) identifying the voice as someone that they knew, however this realisation commonly occurred after therapy when they recognised the similarity of the content. There was variation in how participants understood the AV, some seeing it as themselves or an aspect of themselves and others viewing it as entirely separate, and this often changed over the course of their recovery journey. Most participants acknowledged that the AV was internally generated. One participant had experienced episodes of both AN and psychosis. When describing the voices that occurred, she commented that they were “completely separate” and concerned with different things. The voices she experienced

in psychosis did not comment on her eating or body, they were strictly bound to episodes of psychosis, and when her psychosis resolved her AV remained. She described the experiences as qualitatively different, the psychosis voices felt like “hallucinations” that affected all of her senses, whereas her AV was more of a running commentary in what felt like a grounded and otherwise “normal” reality.

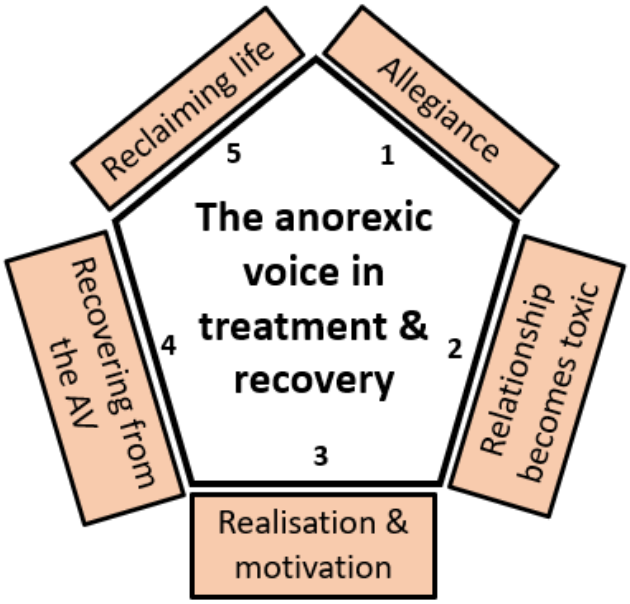
Characteristics of the voice

Most participants described their voice as female, with a small minority (2 participants) experiencing a male voice. Nearly half of participants mentioned that their AV was very obsessive and meticulous about numbers and amounts, and a third of participants described their voice as a “perfectionist”. There was a lot of variation in other descriptors used about the AV; including “driven”, “determined”, “self-conscious”, “omnipotent”, and “a panicker”.

Reflexive Thematic Analysis

The five themes identified in the data are shown in Figure 3 below.

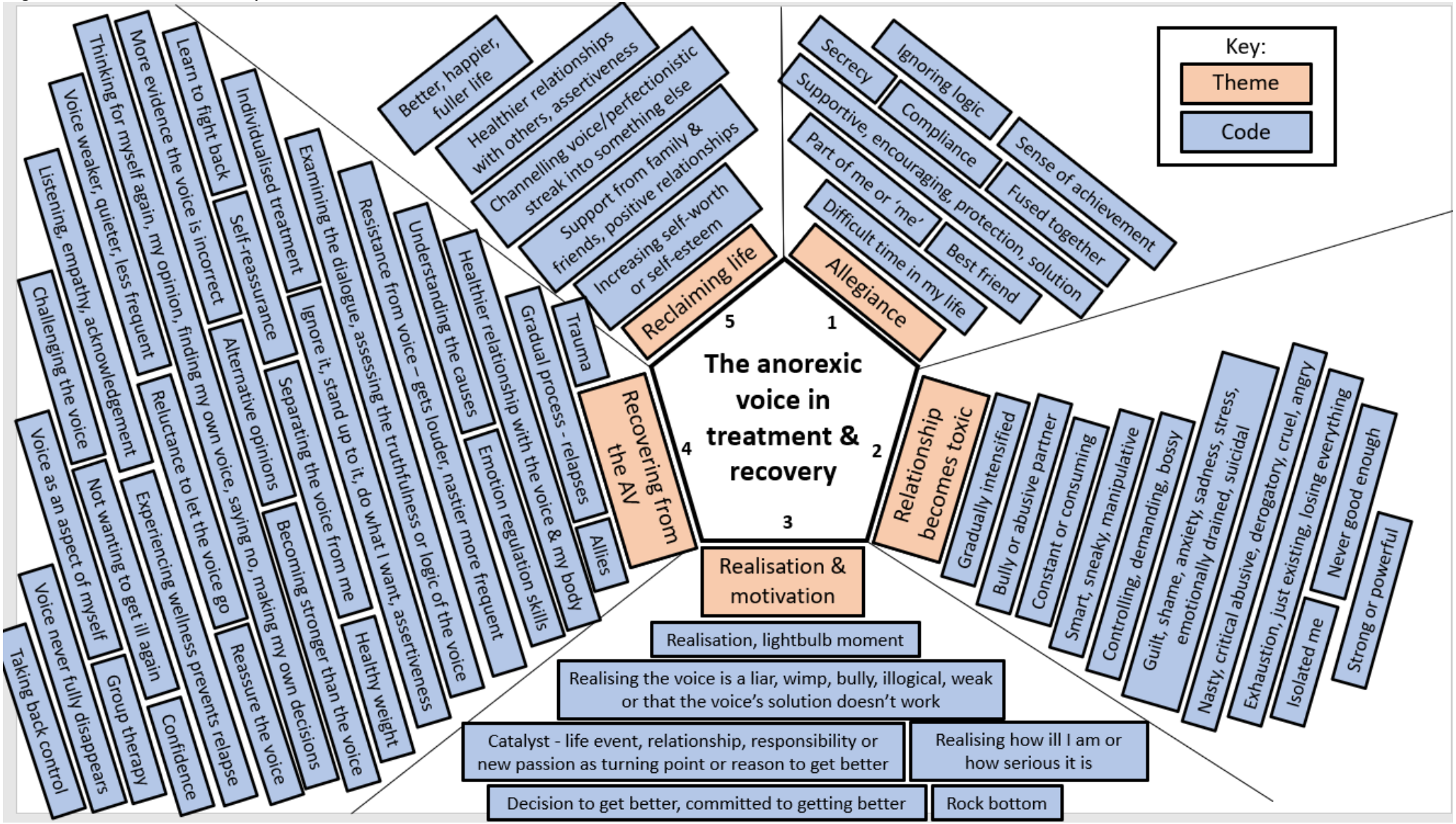
Figure 3 – Thematic map with themes only



These themes were selected because they appeared to illustrate a recovery journey described by most participants. Participants described moving through a series of stages in their relationship with the AV. Initially the AV was comforting and supportive, but the relationship soon became abusive and toxic. A catalyst occurred which prompted realisation and provided motivation for change, providing the impetus for recovery. Recovering from the AV was a complex and gradual process, which included dialoguing with the voice, learning to modify responses to it, building a different relationship with the voice, separating from it, and reconnecting with their authentic selves and reclaiming their lives from the influence of the AV.

A full thematic map including codes is shown in Figure 4 below:

Figure 4 – Full thematic map



Allegiance: All participants reported the AV started at a difficult time in their life. Participants described how the voice initially felt like a supportive, encouraging presence that either offered protection, relief or a solution to their emotional distress. Many participants referred to the voice at this time as a "best friend", and there was often a positive emotional reaction to the AV in the beginning. They complied with the AV and kept it secret, often ignoring "logic", "reality" or other people's opinions. Many participants said that in the very beginning the AV felt like them, "me", or an aspect of themselves, but eventually they felt fused with the AV and could not differentiate between themselves and the voice.

"That voice came into my head and offered me a way out, a way to cope with what, what I was, what was happening for me, so it was almost like she was my saviour."

(Participant 2, female, aged 42)

"I was anorexia and anorexia was me."

(Participant 10, female, aged 30)

Relationship becomes toxic: All participants reported that their relationship with the voice soon became toxic, often within a few months of it starting. They described its comments as nasty, critical, abusive, derogatory or cruel. The AV was also described as "controlling", "demanding" or "bossy". Many participants described it as "smart", "sneaky" or "manipulative". The AV was often labelled as "strong" or "powerful" at this point. Most participants likened their AV to a "bully" or "abusive

partner", who isolated them and made them feel that nothing they did was ever good enough. All participants said the AV gradually increased and intensified, eventually becoming a constant presence. At this point all participants described very negative emotional reactions to the AV such as guilt, shame, anxiety, sadness, feeling completely emotionally drained and sometimes even suicidal. This experience often left participants feeling exhausted or like they were "just existing". Some participants described how it led them to lose everything that they valued in their life.

"When I looked in the mirror it would be like "oh my god you look disgusting"…It just used to be like, so critical of my body."

(Participant 5, female, aged 19)

"It controlled everything, down to the time I woke up, the amount of breakfast I could eat, the amount of calories I was allowed to have in one day."

(Participant 1, female, aged 38)

Realisation & motivation: Most participants pinpointed a moment of realisation that acted as a turning point and provided motivation to change their relationship with the AV. There was variation in the trigger for this. Many participants reported that it occurred when they realised that the voice was a "liar", "wimp", "weak" or "illogical", or that the AV's solution to their emotional distress did not work. Other participants reported that realisation occurred when they hit "rock bottom" or felt that they could not continue with things as they were. Some participants experienced realisation

when it became apparent how unwell they were or how serious the situation was, and some participants experienced it almost like a “lightbulb moment”. Multiple participants identified a life event, relationship, responsibility or new passion as a catalyst for getting better, providing them with the motivation they needed to propel themselves towards recovery. At this point several participants reported making a commitment to get better.

“As I say realising that you know, I know now that he lies. I know now that he is smoke and mirrors and that you know in many ways I see him a little bit like the erm, the Wizard of Oz, a little man behind a big screen… but also recognise that he's not necessarily right and just because he shouts the loudest doesn't make him right. But yeah, so pulling him apart and realising that you know, he does lie and if he's lying…you know that he is moving the goal post, he’s not necessarily always right and he is a bully… The problem is that you follow the solution and you follow the rules, and you get there and you are still covered in mud, and that's where over time I realised…his solution is rubbish, it’s not real, it's just a fairy story that he sells you.”

(Participant 4, female, aged 38)

*“I think the final point was when I lost absolutely everything…and I think if you haven’t hit rock bottom you don’t know what it feels like, you know what I mean?... Literally like you’ve got nowhere else to go but up or stay there…and I was like “I’ve gotta get up, *laughs*, I can’t stay here””*

(Participant 9, female, aged 30)

Recovering from the AV: Recovery from the AV was described as a gradual process that took time and included cycles of relapse. Some participants mentioned that experiencing wellness helped to prevent relapse cycles, as they noticed improvements in their mood and energy levels during periods of wellness. Most participants cited not wanting to get ill again, or to lose their privacy or autonomy as a strong motivating factor to keep working on their relationship with the AV and stay well.

Recovery from the AV commonly involved dialoguing with the voice, often with the assistance of allies such as therapists or healthcare workers. Through this dialogue participants began responding differently to the AV, thereby modifying their relationship with it. This modification of the relationship frequently involved a shift in the power dynamic resulting in them taking back control and becoming more assertive. Participants spoke about separating themselves from the AV, and in doing so they were able to reconnect with their true selves again and honour their own wants and needs.

If the AV was spoken about during treatment, most participants reported this had been helpful, especially acknowledgement of its existence, its strength and the role it played in their difficulties. Participants appreciated staff members that allowed space for the AV to be discussed, who listened and empathised with their experience. There was variation in how participants preferred their AV to be spoken about. Those

who considered their AV to be very real did not appreciate it being spoken about in a dismissive manner, as if it was unimportant or not real; and those who believed the AV to be an aspect of themselves found it “weird” when it was spoken about as if it was a separate entity. Indeed, half of those interviewed cited individualised treatment for the AV as important for recovery. Some participants felt they needed someone to “argue with” the AV for them initially, and others wanted support to begin countering the AV themselves. Most participants appreciated “allies” who reinforced an alternative, healthy opinion to the AV. A third of participants reported that they were unable to even think about their relationship with their AV until they had achieved a healthy weight, as they “couldn’t think clearly” when their weight was low. Half of participants interviewed said that learning to deal with their emotions in a healthy way was a crucial step to breaking free from the AV, as they no longer had to rely on it for emotion regulation. Additionally, half of participants valued the opportunity to understand the root causes of their AV. Some also cited treatments for trauma in tandem with, or subsequent to working on the AV as helpful. A quarter of participants found group therapy particularly helpful, as it normalised the AV experience and gave them the opportunity to connect with others who understood what they were going through.

Regardless of the method of change, all participants reported that they began responding differently to the AV during their recovery. This was often by ignoring it, disproving it’s claims, standing up to it, challenging it, being assertive or less commonly by reassuring the AV. The most commonly cited strategy was calmly but

assertively “talking back” to the AV with a counterargument based on logic or what the participant really wanted or thought, and then following through with their decided action. Many participants reported that the AV became nastier, louder or more frequent initially when they began doing this, however, they also reported that the more often they did this the easier it became, and the AV often became less frequent in the long-term as a result. Many participants described how they began reassuring themselves that they did “deserve to eat”, that their opinion was valid, and that their appetite and food preferences were justified and reasonable. Some participants linked this to increasing self-esteem, which made them feel confident enough to “fight back”. Participants reported that engaging in these changes helped to provide more evidence that their AV was incorrect and untruthful, thus strengthening their own opinions and new alternative beliefs. Many participants spoke about beginning to feel stronger and more powerful than the AV, and that it started to lose its power allowing them to take back control.

Participants described a process of separating the voice from themselves as an important aspect of recovering from the AV, and in doing so they were able to find their own voice again. Participants described how they began thinking for themselves again, saying no, expressing their own opinions and making their own decisions.

Some participants described a reluctance to let the voice go, because it still felt like a friend in some way. Through the process of recovery some participants came to

understand the AV as an aspect of themselves, whilst a minority viewed it as completely separate to them.

Although most participants said that their AV has never fully disappeared, all participants described it becoming weaker, quieter and less frequent. Most participants described a healthier relationship with their AV, one where they felt more empowered, in control and able to say no. Some participants talked about also developing a healthier relationship with their body by learning to re-connect with it in a healthy way. Often this was through a physical hobby such as yoga, dance or going to the gym, and developing an appreciation for what their body can do when they are well.

"I realised, cos I feel like for so long I just thought the voice was me. And then when I kind of like learnt to like, counter it, it was like different from me in a way, if that makes sense?... I separated myself from the voice…I feel like it was like that up and down until I like, separated the voice from me, and that's when it was like, I could actually think outside it."

(Participant 5, female, aged 19)

*"So if that comes up anytime then I can say "well look, we've decided *laughs*, and you've had your chance…you're not welcome now" kind of thing, so in a way that's, that happens in like a split second… yes definitely I don't let them get the better of*

me and I do talk back to them you know? There is a fight… there's a comeback you know? There's, I'm just not going to let it sit there and tell me what to do."

(Participant 11, female, aged 43)

Reclaiming life from the influence of the AV: As recovery progressed there was an ongoing process of becoming stronger and more confident, improving and repairing aspects of themselves and their lives that the AV had affected such as self-esteem, relationships, work and how they spent their free time. Some participants described this as a process of "building up" other parts of themselves and their life, creating a new identity for themselves distinct from the AV. Participants reported that supportive, nurturing relationships aided them in this process. Many participants reported that their relationships with others became healthier, and that felt more able to be assertive with others. A few participants recognised their AV as the perfectionistic part of their personality and spoke about channelling that part of themselves into something more positive and productive.

"Before I didn't have a life, I couldn't do anything…I couldn't even concentrate on anything and now at least I, I've recently passed my driving test which I'm quite happy about…and then I'm trying to start my own business…so I've been doing stuff and I can actually like enjoy my children that much more, whereas before I couldn't do anything, I couldn't join things cos I was too weak and the whole voice it was just consuming my whole day."

(Participant 12, female, aged 35)

*"I'd still say that I have a bit of a perfectionist streak in me, but I don't turn it towards food anymore because that's not useful *laughs*…I realized that it was a clever voice, but it was being used in the wrong way. So I started going like, "well, how can I take the cleverness of this voice, and use it in a way that's actually beneficial to me instead?"… going "well, I've made this voice up, so what can I do with this voice to actually make it help me rather than hinder me?""*

(Participant 3, female, aged 30)

4.Discussion

Does the relationship with the AV change over time, including within treatment and in recovery?

Participants described how their relationship with the AV changed over time, shifting through a series of stages associated with different phases of illness and recovery. Similar to previous research, participants reported that the AV began at a challenging time in life and fulfilled useful functions, particularly in the early stages of AN (Tierney & Fox, 2010; Higbed & Fox, 2010). Initially the AV was supportive but the comfort and security once provided by the AV gave way to a critical, dominant voice that consumed thoughts, drove disordered-eating behaviours and triggered negative emotions when rules and expectations were not met (Duncan et al., 2015; Tierney & Fox, 2010; Williams & Reid, 2012). Participants often described their AV as "powerful" at this point, which has been linked to more negative attitudes about eating, compensatory behaviours and higher distress levels (Pugh et al., 2017, 2018; Birchwood et al., 2017), indicating why disordered-eating behaviours may have

intensified at this stage. Treatment and active recovery represented a transitional period in the relationship, where individuals began dialoguing with the AV and modifying their responses to it. Many participants reported that the AV became more frequent and abusive when they did this, but with persistence and practice it eventually abated becoming weaker and less frequent. In line with previous research participants reported that the AV does not always disappear, however with recovery it does commonly become weaker, less frequent and therefore more manageable (Pugh, 2020; De Giacomi, 2019; Tierney, 2008). Where they had once felt fused with the AV, participants began to separate themselves from it and create a new identity for themselves. This newfound distance within the relationship often created a shift in the power balance putting them back in control. Recovered individuals described a less intense relationship with the AV. Interaction was less frequent and they felt in charge and able to assert their own wants and needs.

Which styles of relating/responding to the AV facilitate recovery?

Several authors have suggested that beginning to “defend against” the power of the AV, such as by challenging its messages or distancing oneself, may play an important role in recovery (Dolhanty & Greenberg, 2009; Lock et al., 2004; Simpson, 2012). In the present study dialoguing with the AV allowed participants to begin modifying their response to it. A range of responses were cited as helpful including ignoring the AV, disproving it’s claims, challenging it and responding assertively. The frequently used strategy of calmly and firmly “talking back” to the AV, as opposed to angrily disputing its comments, is supported by research in both EDs and psychosis

which emphasise the importance of compassionate assertiveness (De Giacomi, 2019; Hayward et al., 2017). Modifying their response to the AV changed participants' understanding and perception of it, often reducing their perception of its power, truth and effectiveness. This supports prior research findings that modifying the way a person understands, relates and responds to their AV aids recovery and helps to prevent relapse (Eaton, 2019; Jenkins & Ogden, 2012).

Which factors do participants feel are responsible for bringing about changes, including treatment-related factors?

Many participants described a turning point when they realised that their AV was weak, ineffective or untruthful. The cognitive model of auditory hallucinations suggests that appraisals of voices determine their emotional and behavioural impact rather than the voices themselves (Chadwick & Birchwood, 1994). Indeed, research specific to EDs found that appraisals of AVs are linked to eating psychopathology (Pugh & Waller, 2016, 2017). The shift in perception described by participants may have led to a modified appraisal of the AV's power, effectiveness or wisdom, paving the way for recovery. Many participants cited a life event, relationship, responsibility or passion as their turning point. This is in line with research suggesting that positive emotions and experiences can challenge negative biases in AN, creating motivation for change (Leppanen et al., 2021). Also, that "tipping points" are created by positive aspects of life, positive experiences in treatment, good relationships, loss or the risk of loss of something valuable, or by having something valuable to "stay well for" (Fogarty & Ramjan, 2017; Hay & Cho, 2013; Dawson et al., 2014).

Empathetic treatment that acknowledged the AV and its strength and helped individuals to understand and modify their response appeared to instigate change. Similar to findings in psychosis research, participants appreciated when others helped them to understand the experience and its root causes (Romme & Escher, 2000). Understanding the AV and its role in AN can foster compassion in individuals who experience an AV (Graham et al, 2019). Having “allies” who offered alternative healthy opinions and taught them how to counteract the AV often supported change. Learning alternative healthy emotion-regulation strategies was a helpful step for many participants as it meant they no longer had to rely on the AV to deal with negative emotions. Some participants disclosed that dealing with underlying trauma was key to breaking free from the AV.

Participants described a process of separation from the AV, which corresponds to studies citing processes of externalisation as facilitative to recovery (Higbed & Fox, 2010; Williams et al., 2015). Research suggests that separating from the AV empowers people to decide whether they want to continue engaging in anorexic behaviours and encourages them to reconnect with themselves (Ling et al., 2021; Graham et al., 2019). Separation was often achieved by examining the dialogue and assessing the truthfulness or logic of their AV. This kind of testing and evaluation of beliefs has been previously highlighted as useful (Pugh 2020). Concurrent with research illustrating links between low self-esteem and the AV experience

(Noordenbos et al., 2014), increasing self-esteem was identified as fundamental to change.

Weight and BMI have been refuted as sound markers of recovery from AN because they do not necessarily equate to psychological recovery (Fichter et al., 2006). However, weight restoration was highlighted as an important factor for change in the present study because it facilitated cognitive improvements that allowed participants to think more clearly and challenge their AV.

Modifying responses to the AV allowed participants to accumulate more evidence against the AV's claims. Another key element was rebalancing the power dynamic and beginning to feel stronger and more powerful than the AV. This emphasises the importance of addressing appraisals of the AV's power (Hormoz et al., 2019).

Which techniques and strategies are most effective for managing the AV in recovery?

Recovery research has revealed that many do not experience an 'endpoint' where they feel fully recovered, instead they continue progressing on a recovery journey that encompasses later stages and continuing progress (Hancock et al., 2013). Similarly, in the present study participants described an ongoing process of healing and reclaiming their life back from the influence of the AV. Several factors were deemed helpful for managing the AV in recovery.

Similar to previous research findings, changing their relationship with the AV created space for participants to reconnect with themselves, their interests and personal qualities (Scott et al., 2013). In turn, this process of building up other aspects of their lives caused the AV to become less important (Graham et al., 2019). This fits with the notion that positive life elements and experiences help to promote and sustain recovery from AN, especially with regards to factors that increase quality of life (Williams et al., 2010; Fairburn, 2008). Participants in the present study likened this to a process of "building up" other parts of themselves, creating a new identity for themselves distinct from the AV. Some participants spoke about re-channelling the perfectionistic part of their AV into something creative and useful as an important step in this process of reclaiming their life from the AV.

The self-reassurance described by some participants holds parallels with compassion-focussed approaches, suggesting that compassionate self-talk may also be a helpful strategy for managing the AV (Kelly et al., 2017; Pugh 2016). Continuing to increase self-esteem allowed participants to persist in "fighting back". Participants described how they began thinking for themselves again, saying no, expressing their own opinions and making their own decisions. Sustaining their modified responses helped to provide even more evidence that their AV was incorrect, thus strengthening their new alternative beliefs.

<u>Is working with the AV an important aspect of treatment?</u>

Participants thought that working with the AV was an important aspect of treatment. If the AV was discuussed during treatment most participants reported that this had been helpful, especially acknowledgement of its existence, its strength and the role it was playing in their difficulties. Participants appreciated staff that allowed space for the AV to be discussed, who listened and empathised with the experience and who tailored their language to the participant's own individual understanding of their AV. Individualised treatment was frequently flagged as an important aspect of treatment.

Gender, trauma & dissociation

Societal and cultural influences, including gender and patriarchy were discussed earlier in the paper. In this study all participants were female, lending evidence to the suggestion that AN can be a highly gendered phenomenon. Participants described how their AV would often comment on the size and shape of their body, which could potentially link to internalised patriarchal notions of feminine beauty, alongside fat stigma (Larson, 2021; Stice, 2002). Additionally, some participants spoke about the importance of body-image work, giving credence to a potential link with societal ideologies about feminine bodies and beauty (Culbert et al., 2015). Many participants identified that their recovery from the AV involved finding their own opinion, beginning to think for themselves, gaining confidence to say no and learning to be assertive. Feminist writers have noted patriarchal pressure for females to be submissive and acquiescing (Malson, 1997; Orbach, 1986), which is the opposite of

what these women described as facilitative to their recovery. The changes that participants described involved rejection and opposition of patriarchal ideals of submissive compliance. Indeed, treatments that involve feminist approaches challenging patriarchal influences have proven effective for EDs (Holmes et al., 2017). It has been established that women experience EDs disproportionately more than men (Qian et al., 2021), and whilst the ED literature base emphasises that EDs are biopsychosocial in origin with multifactorial causes (Culbert et al., 2015), issues of societal and cultural feminine ideologies do appear to be important. However, the evidence base shows an increasing prevalence of EDs amongst males, transgender and gender non-confirming individuals (Grammar et al., 2021; Diemer et al., 2018; Varnado-Sullivan et al., 2013) so it appears that the picture is rapidly changing, and it is likely that societal and cultural influences also play a role for these groups.

The results of this study point to links with trauma and dissociation. Some participants indicated that after therapy they realised that the content of their AV was related to past interactions with bullies or abusive parents or ex-partners. All participants described the content of their AV as abusive, and some described trauma therapy as vital to recovery. This is in line with authors who posit that the content of voices carry meaning and are often linked to earlier traumatic experiences (Romme & Escher, 2000; Feary et al., 2022). Indeed, a recent study of voice-hearers indicated that they believed traumatic experiences were the main causal factor of their voice(s) (Tolmeijer et al., 2021). The fact that some participants identified the content of their AV as echoes of earlier traumatic experiences, alongside most

participants acknowledging that their AV was internally generated points to the possibility that trauma-related dissociation may play a role. Trauma-dissociation models of voice-hearing (Longden et al., 2012), including AN-specific models (Pugh et al., 2018), do indeed suggest that voice-hearing experiences may be dissociated content from earlier traumatic experiences. This has led to suggestions that therapy with individuals who experience an AV should address underlying trauma and resulting unhelpful schemas (Pugh, 2020; Pugh et al., 2018).

5.Clinical implications

Participants conveyed that working the AV was a valued aspect of treatment. They emphasised the importance of its existence being acknowledged, alongside recognition of its strength and the role it played in their difficulties. Listening and empathy were highlighted as particularly important, as were tailoring language to the individual's understanding of their AV and whether they perceived it as separate to themselves or an aspect of themselves. Helping individuals to understand the AV and the root causes of this experience appears to be a helpful step in the recovery process. Despite criticisms of a purely physical approach to treatment, the results of this study suggest that weight restoration is an important aspect of treatment as it increases cognitive resources enabling individuals to reflect on and alter their relationship with the AV.

The results of this study suggest that both the experience of and relationship with the AV can change during treatment and recovery. More specifically, the results suggest that individuals who experience an AV often move through distinct stages in their relationship with it, and that making changes to the relationship can facilitate recovery.

The results suggest that individualised treatment that helps people modify their responses to the AV can aid recovery. In particular, learning to ignore the AV, disprove it's claims, challenge it and respond assertively are beneficial. Dialoguing with the AV with the aim of altering the dialogue, and having allies in this process appears to help, particularly when alternative opinions are offered and strengthened. Compassionate assertiveness appears to be a valuable style of relating to the AV, which helps to rebalance the power dynamic in the relationship and has secondary gains in increasing self-esteem and reconnecting with the true self. Beginning to practice self-reassurance and compassionate self-talk assists recovery. Modifying the individual's appraisal of the AV appears to be fundamental to bringing about change, particularly appraisals of the AV's power, truthfulness and effectiveness. Reconnecting with the true self and building up other aspects of life appears to decrease the importance of the AV, paving the way for the creation of a new identity distinct from the AV.

Additionally, increasing self-esteem, addressing underlying trauma and learning healthy emotion-regulation strategies appear to facilitate recovery. Methods of achieving a healthier relationship with the body, for example physical exercise, yoga or dance, also appear to be advantageous.

Participants described how making changes allowed them to accumulate more evidence against the AV's claims, and testing and evaluation of beliefs were also highlighted, suggesting that CBT techniques may be helpful in combatting the AV (Mountford & Waller, 2006). Another key element named by participants was rebalancing the power dynamic and beginning to feel stronger and more powerful than the AV. This emphasises the importance of addressing appraisals of the AV's power (Hormoz et al., 2019). Self-compassion appears to be useful strategy for managing the AV, suggesting that compassion-focussed approaches could be beneficial for this client-group (Kelly et al., 2017; Pugh 2016). Participants spoke about the usefulness of changing their relationship with the AV, often by dialoguing with it, modifying their responses to it, increasing their assertiveness skills and 'separating' from the AV. This indicates that relationally-based therapies such as AVATAR Therapy, Relating Therapy and Talking with Voices (Longden et al., 2021; Ward et al., 2020; Hayward et al., 2018) could be beneficial for individuals that experience an AV.

6.Limitations

Participants were predominantly White-British (79%) and female (100%). Lack of data from males, gender-diverse individuals and people from BAME backgrounds may limit the transferability of the findings because people from these groups may experience the AV and its relationship to recovery differently. Diagnosis was self-reported by participants and not verified, and possible co-morbid difficulties were not screened for and excluded.

The sample was self-selecting so the study may have only attracted individuals with an interest in the concept of an AV. Additionally, the Information Sheet mentioned that many individuals experience the AV as “bullying”. This may have inadvertently introduced bias by attracting individuals that experienced their AV as bullying and deterring those with a different experience of the AV. The use of this word may also have biased the information given during interviewing by priming participants to think that was the aspect of the AV experience I was interested in hearing about. In hindsight, it would have been better not to have described a type of AV experience in the participant documents, and to instead have given a neutral description of the AV and invited participants to describe their unique experience of it, without prompts or suggestions about the type of experience they may have had.

Most of the participants in this study had received CBT-style treatment. This may have skewed the feedback given regarding what helped them to overcome the AV, as the approaches used in this method are the only ones they had been exposed to

and tried. It is possible that other approaches and techniques may have helped them to recover had they received a different style of treatment.

It is difficult to condense and summarise a complex topic, and the findings may not apply to all people who suffer from AN. Indeed, some people with AN do not even experience an AV (Graham et al, 2019; Noordenbos et al., 2014). Additionally, by trying to standardise the recovery journey for those who do experience an AV we risk undervaluing individual differences. However, it is hoped that the findings provide a useful insight into the AV and its relationship with recovery.

7.Research considerations

Further research investigating the themes with a more diverse sample would enable exploration of experiences that may differ for males, people from BAME backgrounds and gender-diverse groups. Future studies could benefit from checking medical records to confirm diagnoses. The results of this study suggest that the relationship with the AV changes during treatment and recovery, further research that determines if targeting the relationship with the AV in AV-focused interventions supports recovery would be valuable (Dolhanty & Greenberg, 2007; Hibbs et al., 2020). Voice experiences have been reported in other EDs, therefore research exploring ED voice experiences in other EDs could prove beneficial (Pugh et al., 2018).

8.Conclusion

Participants described a journey of recovery from the AV that progressed through stages of allegiance, toxicity of the relationship, realisation & motivation, recovery from the AV and reclaiming life from the influence of the AV. The AV often began at a difficult stage in life and offered comfort and solutions. The experience intensified quickly with the AV becoming increasingly critical and abusive. Participants reported a catalyst that motivated them to change their relationship with the AV. Recovery was aided by treatments that encourage dialogue with the AV, and that target both the perception of the AV and the relationship with it. In particular, participants called for empathetic, individualised treatments that acknowledge the AV and its strength and impact, that assist them in modifying their response to the AV. Improving self-esteem, learning emotion regulation strategies and dealing with trauma were also helpful to recovery. Recovered individuals described a relationship with the AV that was less intense, with less frequent interaction, where they felt in charge and able to assert their own wants and needs.

9.References

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Part C: Appendices of supporting material

Appendix A – (EDE-Q 6.0)

Appendix removed for copyright reasons

Appendix B Participant Information Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Information about the research

Voices from the past: A qualitative analysis of the "anorexic voice" in treatment and recovery

Part 1 of the Information Sheet

Hello. My name is [redacted] and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. Please talk to others about the study if you wish. You are under no obligation to take part in this study. If you would like to speak to me and find out more about the study or have any questions, you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me [redacted] and leave a contact number so that I can get back to you.

This project is supervised by:

-[redacted]

-[redacted]

-[redacted]

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

What is the purpose of the study?

Many people with anorexia nervosa describe experiencing “anorexic thoughts”. Some people also say that they experience these thoughts a bit like an internal “anorexic voice”. I am interested in talking to people who have experienced an anorexic voice and exploring how it changed during treatment and how they relate to this voice now that they are in a better place. I am also interested in learning about what you feel has helped you to overcome your anorexia in terms of changes to your anorexic voice, and how you think treatments can be improved based on these experiences.

Why have I been invited to take part?

You have been invited to take part in this research because you were given a diagnosis of Anorexia Nervosa in the past, but you are now in a better place. All research participants are being recruited through charitable organisations, support groups, social media and eating disorder conferences.

Do I have to take part?

No. It is up to you to decide if you would like to participate in the study. If you do decide to take part, I will ask you to sign a consent form before your interview. You are free to withdraw from the study and you can end your interview at any point during the discussion. You can request to withdraw your data from the study up to a month after the interview.

What will happen to me if I take part?

Participating in this study will involve taking part in an interview which will be done via Zoom, telephone or in person. Before your interview, I will ask you some questions to ensure that you are eligible to take part in this study. These screening questions will focus on your current eating and health. At the start of your interview, you will be asked your gender, age, ethnicity, which treatments you have completed, time since last treatment, marital status, work status, and education history.

Your interview will probably last around 45 – 75 minutes, but you would be free to take a break whenever you wanted to during the discussion. There are no right or wrong answers during the interview as I am interested in knowing about your own personal experiences. Your interview will also be audio-recorded so that it can be typed out after your interview for analysis and to make sure that I have understood what you have shared with me fully.

What are the possible disadvantages and risks of taking part?

Taking part in this study is unlikely to cause you any disadvantages. The interview will last around one hour which might be an inconvenience for you, or which you might find tiring. There is also a chance that discussing your experiences might be upsetting or distressing. Should you require support after taking part in your interview, I will give you a list of sources of support that you can access. You are also free to take a break during your interview, or to stop the interview at any time.

What are the possible benefits of taking part?

It is hoped that taking part in this study will help professionals better understand anorexia nervosa, and help us to develop new and effective treatments in the future. We cannot promise the study will help you, but we hope that discussing your experiences of treatment and recovery will be a useful experience for you in highlighting what has helped you to get better and what has helped you make these changes.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the Information Sheet

What if there is a problem? Concerns and Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me [Emma Peskett] and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology - fergal.jones@canterbury.ac.uk.

Will information from or about me from taking part in the study be kept confidential?

All information which is collected from or about you during the course of the research will be kept strictly confidential, and your information will not be shared with anyone else apart from the researchers carrying out this study. Participants have the right to check the accuracy of data held about them and correct any errors.

I will make sure that your information is kept confidential. The recording of your interview will be kept on a password protected computer. I will also make sure the information that you provide us is kept anonymous by not including any information which might identify you when we type up your interview (for example, your name will not be included in your transcribed interview). The personal information which I will ask you to provide at the start of the interview will also not be included in your transcribed interview. The audio file of the interview will be destroyed when it has been typed up. Your data will be stored for 10 years, as recommended by the Medical Research Council. After 10 years, the data will be disposed of securely.

If as a result of something you told me, I were to become concerned about your safety or the safety of someone else, I would discuss my concerns with you. I will also provide information about who you should contact for support. In the first instance this would normally be your

GP or previous care team. This may vary between individuals, but I will support you to make contact with the appropriate person.

What will happen to the results of the research study?

I will use the results of this study to write a research article, which will be published on the University's website and possibly in a scientific journal. No personal information about you would be reported in this article, but anonymised quotes from your interview may be used. If you would like a copy of this article (when it has been written), I would be very happy to provide you with a copy.

Who is sponsoring and funding the research?

The research is sponsored and funded by Canterbury Christ Church University.

Who has reviewed the study?

All academic research is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University, who gave approval for the study to go ahead.

You will be given a copy of this Information Sheet and a signed Consent Form to keep.

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me [redacted] and leave a contact number so that I can get back to you.

Canterbury Christ Church University

Salomons Institute for Applied Psychology, One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Name of Researcher: [redacted] Participant Identification number for this study:

CONSENT FORM
Voices from the past: A qualitative analysis of the "anorexic voice" in treatment and recovery

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw up to a month after the interview without giving any reason.	☐
3. I understand that taking part in this research study will involve an interview where I will be asked about my experiences of anorexia; the treatments I have received; and what I feel has helped me to get better.	☐
4. I understand that I will be asked to provide some personal information about myself and my treatment(s) at the start of my interview. I also understand that data collected during the study may be looked at by the research supervisors [redacted]. I give permission for these individuals to have access to my data.	☐
5. I agree that my interview can be audio-recorded, and that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings.	☐
6. I agree that my data can be used to answer additional research questions in the future	☐
7. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Research Study

The 'anorexic voice'

in treatment and recovery

Were you diagnosed with anorexia nervosa in the past?

Many people with anorexia nervosa describe experiencing an internal "anorexic voice". Often described as an "inner bully" that comments on the person's eating, weight and shape and tells them to restrict or exercise.

I am interested in talking to people who have experienced an anorexic voice about their treatment and recovery

Why am I doing this research?

We want to learn about the experience of the anorexic voice and if it changes during treatment and recovery. We would like to find out what helps people to overcome anorexia in terms of the anorexic voice.

This research is part of my Doctorate in Clinical Psychology, at Canterbury Christ Church University.

Who can take part?

-Age 18+
-UK resident
-Previous diagnosis of anorexia nervosa
-Not currently in treatment

What will happen if I take part?

A brief online questionnaire

An interview on Skype or Zoom which will last for about an hour

If you would like to find out more

Please contact me on [redacted] or [redacted]. I will send you an information pack with more details about the study.

Best Wishes,

[redacted]

INTERVIEW TOPIC GUIDE

Introduction
Thank you very much for talking with me today. My name is [redacted] and I am a Trainee Clinical Psychologist. You have been invited to this interview because I am interested in exploring your experiences of anorexia nervosa and finding out if you experienced something like an 'anorexic voice'. If you did experience a voice, I would like to explore with you how the voice has changed during your treatment and now that you are in a better place with your eating disorder. I am carrying out this study to get a better understanding of the role which the anorexic voice might play for some people who have an eating disorder.

The interview should take around 1 hour and I have a topic guide that I will be using the guide our discussion.

During this interview I will be asking lots of different questions about your experiences of what we think of as the anorexic voice. Please do be as honest as you can, and as descriptive as you like. The more you can tell me the better! Also, please remember that there are no right or wrong answers. I would like to gain an understanding of what your own personal experiences have been. You may find some of the questions I ask are similar or a bit repetitive. This is because I want to make sure that I have understood everything you have said and have a complete understanding of your experiences.

Before we start, I would like to remind you that everything we talk about today is confidential and will not be shared with anyone else apart from the researchers carrying out this study. However, if I am concerned that you or someone else may be at risk of harm, I may need to share this information. I would always endeavour to discuss this with you first.

As I mentioned in the Information Sheet, I will be audio-recording the interview on a Dictaphone. This is so I can transcribe it afterwards. Is it ok to start that now?

Begin audio-recording.

Please do ask me to repeat any questions which are unclear, or ask if you would like to take a break. If at any point you would like to stop the interview, or if you feel upset, please let me know and we can end.

Do you have any questions before we start?

TOPIC GUIDE

Background information
Distress
Who would you like me to contact if you become distressed during this interview?
Anorexic voice
A lot of people who have suffered from anorexia nervosa describe experiencing an internal 'anorexic voice'. I would like to ask you some questions about this.

-Have you experienced something like an 'anorexic voice'?
Prompt: Some people describe this voice as 'an inner bully' that criticises and insults them, and encourages them to engage in eating disorder behaviours

-If so, are you happy to tell me more about it?

The questions I ask will relate to periods of time: before treatment, during treatment, after treatment and now. I will start off now with some questions about your experience of the anorexic voice before you received any therapy/treatment.

Anorexic voice - before therapy/treatment
-Was the voice present at this time?

-What was the experience of the anorexic voice like at this time?
Prompt: content, frequency, comforting/supportive, critical, distressing

-How were you in relation to that experience?
Prompt: emotions, thoughts, beliefs

-How were you understanding and responding to the experience at that time?
Prompt: What/who did you think it was, did you agree, did you comply or resist, did you tell anyone about it or keep it secret

Anorexic voice - during therapy/treatment
-Was the voice present at this time?

-What was the experience of the anorexic voice like at this time?
Prompt: comforting/supportive, critical, distressing

-How were you in relation to that experience?
Prompt: emotions, thoughts, beliefs

-How were you understanding and responding to the experience at that time?

Prompt: What/who did you think it was, did you agree, did you comply or resist, did you tell anyone about it or keep it secret

-How did the voice respond to you engaging with treatment?
Prompt: Frequency, content

-Did you notice any changes in your voice over the course of treatment? -If so, can you tell me some more about that?

-Did you notice any changes in yourself over the course of treatment?

-How did you make sense of those changes?

Anorexic voice - after therapy/treatment
-Was the voice present at this time?

-What was the experience of the anorexic voice like at this time?
Prompt: comforting/supportive, critical, distressing

-How were you in relation to that experience?
Prompt: emotions, thoughts, beliefs

-How were you understanding and responding to the experience at that time?
Prompt: What/who did you think it was, did you agree, did you comply or resist, did you tell anyone about it or keep it secret

Anorexic voice – now
-Is the voice present now?

-What is the experience of the anorexic voice like now?
Prompt: comforting/supportive, critical, distressing

-How are you in relation to that experience at the moment?
Prompt: emotions, thoughts, beliefs

-How are you understanding and responding to the experience now?
Prompt: What/who did you think it was, did you agree, did you comply or resist, did you tell anyone about it or keep it secret

-If there have been changes in your experience of the anorexic voice, is there anything that you miss? Anything that the voice did for you which you would like back?

-Are there things that you would like to be different about the voice-hearing experience in the future?

-What advice would you give professionals who try to work with the anorexic voice in treatment?

Terminating the interview
-We've now reached the end of the interview. Thank you so much for your help and your answers. It has been extremely interesting and informative.

-Do you have any questions for me?

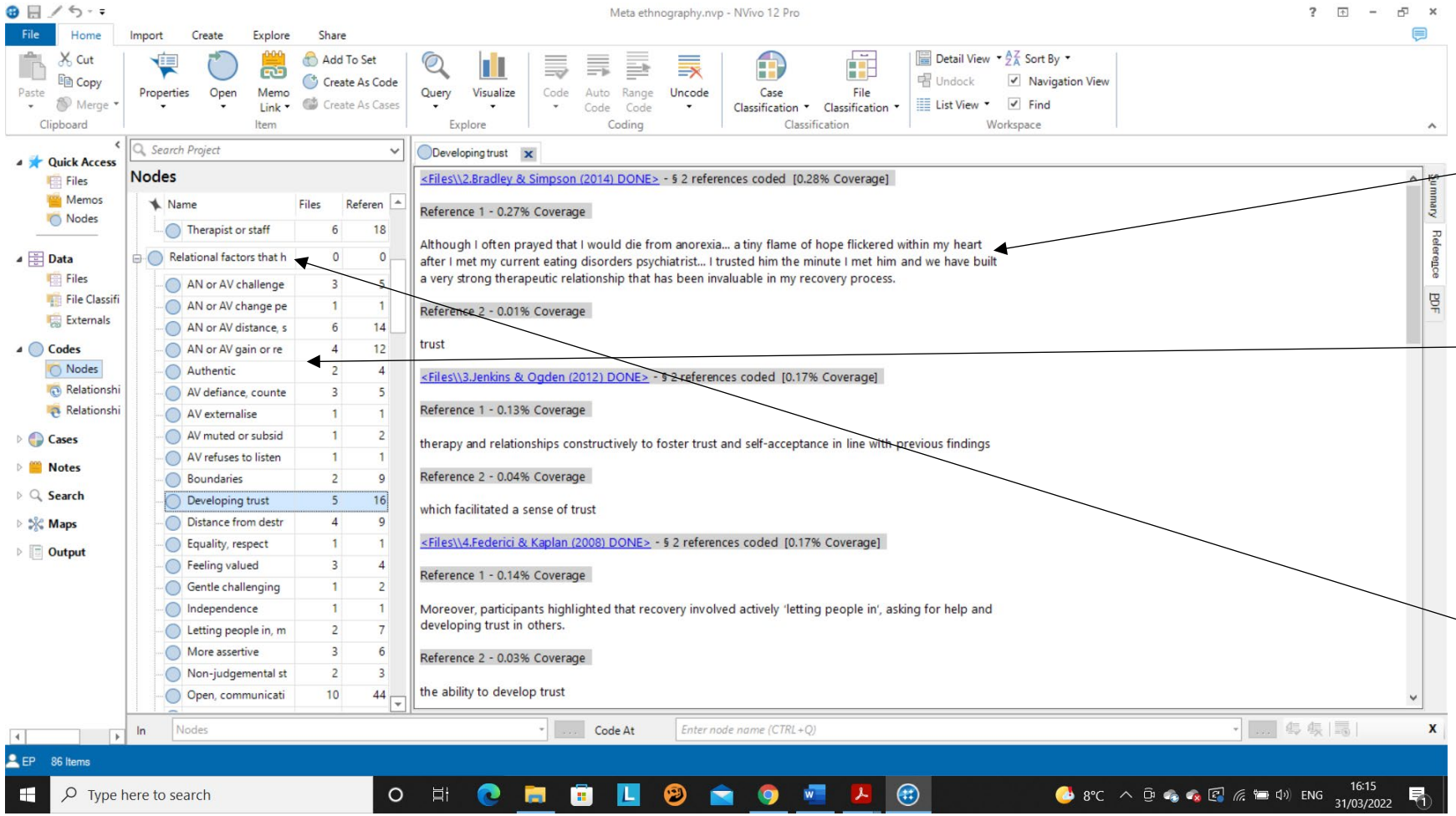
Appendix F Ethical approval

Appendix removed for confidentiality reasons

Appendix G Excerpts from coded transcripts

Appendix removed for confidentiality reasons

Appendix H Screenshot of the meta-ethnography synthesis process



Development of third-order constructs:

1.Excerpts that illustrate meanings, metaphors and categories are highlighted and saved.

2.Excerpts are grouped into existing or new themes and categories.

3.All categories are examined, compared and contrasted to produce third-order constructs – which can be likened to over-arching themes or explanations. The new third-order constructs are reviewed against the original papers, excerpts and themes in an iterative process of development.