How do individuals with anorexia nervosa (AN) experience the voice dialogue method in the context of experiencing an internal eating disorder voice (EDV)? A Thematic Analysis.

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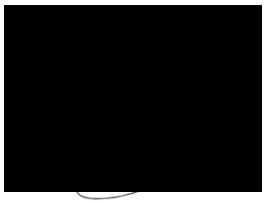
Thesis declaration form

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

Signature: 

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Overview

This three-part thesis examines the application and efficacy of chairwork techniques, and patients lived experiences of this intervention.

Part 1: Literature Review. A systematic review of the literature on the application, efficacy and patients' perspectives on chairwork was conducted. Results are presented and narratively synthesized to enhance current understanding on the application of this method, and to inform future research. The review revealed that chairwork is a versatile treatment for a range of psychological difficulties, however more research is needed to determine the efficacy of chairwork outside of emotion focused therapy and as a stand-alone intervention.

Part 2: Empirical Paper. The empirical research examined the acceptability of using voice focused interventions in the treatment of AN. This was determined by understanding how patients with a diagnosis of anorexia nervosa experienced a single voice dialogue session as a way of working with their internal eating disorder voice. This project was jointly conducted with another trainee clinical psychologist (see Appendix 06 for an outline of each trainee's contribution to the joint study). Post voice dialogue interviews were analysed using Thematic Analysis (TA). Preliminary results suggest that participants found voice dialogue to be an acceptable approach for

working with their EDV, and that voice focused interventions may hold promise in the treatment of AN. Future directions for research and clinical practice are described.

Part 3: Critical Appraisal. The critical appraisal sets out a number of reflections on the research process. This includes reasons for undertaking research in this area, methodological issues and further elaboration on the clinical and research implications for this work.

Impact Statement

Chairwork is increasingly utilized within psychotherapy to help alleviate the psychological suffering associated with various mental health difficulties. Its empirical efficacy is most established within the context of emotion-focused therapy. Other evidence-based therapies such as cognitive behavioural therapy and compassion focused therapy have also incorporated chairwork as a part of their treatment repertoire. This thesis provides two studies to expand on the knowledge and application of using chairwork in psychotherapy.

The systematic review compiles research on chairwork to further our understanding on the clinical application and efficacy of chairwork in alleviating various forms of psychological difficulties. The mechanism of change of chairwork is also presented, including perspectives from patients' direct experience of this intervention. Patients perspectives are valuable as they can help shape and inform clinical practice.

The empirical paper further expands our knowledge by exploring the potential chairwork holds in treating eating disorders, specifically anorexia nervosa (AN). This study examined whether patients with AN would find voice dialogue (a specific form of chairwork) acceptable as an approach for managing their internal eating disorder

voice (EDV); a phenomenon implicated in the development, maintenance and recovery of AN. Our study also addresses a gap in the recovery literature for AN by being the first qualitative study to explore patients direct experience of this intervention.

On the whole, this study sought to improve the poor treatment outcomes associated with eating disorders by investigating more innovative methods for healing and transformation. Preliminary results suggest that chairwork may be utilized safely with individuals with AN. Findings from this study may be used (i) for educational purposes; research findings can be disseminated for training purposes at services and may be submitted as a potential journal article, (ii) to inform existing evidence-based and person centred treatments for AN, (iii) de-stigmatize voice-hearing experiences commonly reported in eating disorders, (iv) encourage further research to strengthen the value of using voice dialogue for treating AN and the EDV, and explore the feasibility of using voice dialogue for other forms of eating disorders (such as binge eating disorder, bulimia nervosa etc.) and finally, (v) to inform clinicians, clients and caregivers on the role the EDV plays in the development, maintenance and recovery of AN.

Table of Contents

List of Figures

Part 1: Literature Review

List of Tables

Part 2: Empirical Paper

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Part 1: Literature Review

Applications, efficacy and patient perspectives on chairwork:

A narrative systematic review

Abstract

Background. Chairwork refers to a collection of experiential interventions where chairs, movement and dialogues are used to facilitate psychological change (Pugh & Broome, 2020). The clinical literature on chairwork has grown over the last forty years; however, no previous study has systematically reviewed this work. **Aims.** This narrative review appraises the evidence base regarding the application, efficacy and patients' perspectives on chairwork. **Method.** Relevant peer-reviewed journal articles were obtained through three database searches: PsychInfo, MedLine and EMBASE. 182 articles were identified. 29 articles met the inclusion criteria for the review. **Results.** 26 quantitative studies, 1 mixed method study, and 2 qualitative studies were retrieved from the search. Chairwork has undergone rigorous empirical evaluation within the context of emotion focused therapy. Findings suggest that chairwork can help clients resolve unprocessed emotions and psychological distress resulting from interpersonal trauma and other mental health conditions such as depression. Chairwork appears to facilitate change by enhancing individuals' self-awareness and emotional processing capacities. Patients' perspectives on chairwork provide valuable insights into the benefits and limitations of this approach. Most notably, chairwork enhanced patients' metacognition and emotion regulation skills. However, the emotional intensity of chairwork can become a barrier to engagement if an optimal level of emotional arousal is absent. **Discussion.** Chairwork appears to be effective in treating a range of psychological difficulties. However, more research is needed to determine its efficacy

as a stand-alone intervention and as an intervention within therapeutic approaches other than emotion-focused therapy.

Introduction

Chairwork refers to a collection of experiential interventions where chairs, movement and dialogues are used to facilitate psychological change (Pugh & Broome, 2020). Chairwork is based on the idea that an individual's personality is composed of multiple inner modes or selves (e.g. the part of oneself that wants to change and the other part of oneself that is too afraid to change), and that psychological suffering can be alleviated by giving voice to these different selves which animate the body with their own mental and emotional characteristics (Kellogg, 2019). In principle, change is facilitated by helping the individual explore, externalize, and ultimately transform conflicting and distressing inner dialogues and feelings.

Chairwork is most commonly used in the following ways: multi-chairwork (the client uses multiple chairs to give voice to different parts of themselves), empty chairwork (the client engages in an imaginal dialogue with a significant other who is placed on an empty chair), single chairwork (the client gives voice to a specific part of themselves (e.g. the inner critic) or uses the chair to disclose an unspoken experience) and chairwork role plays (enactments of intrapersonal and intrapsychic interactions based on past, present and future interactions) (Pugh, 2017; Pugh & Broome, 2020; Kellogg, 2019).

Drawing from the schools of psychodrama (Fox, 1987), gestalt therapy (Perls, 1973) and voice dialogue (Stone & Stone, 1989), chairwork has been increasingly

utilized in the treatment of various psychological difficulties. This includes: depression (Greenberg & Watson 1998), eating disorders (Dolhanty & Greenberg 2007), psychosis (Chadwick 2003), post-traumatic stress disorder (Butollo, Karl, Konig & Rosner, 2016), generalized anxiety disorder (GAD) (Murphy et al., 2017), social anxiety disorder (SAD) (Shahar, Kalifa & Alon, 2017), personality disorders (Pos & Greenberg, 2012), and childhood trauma (Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010). Chairwork has also been utilized in group therapy for anxiety and depression (Robinson, McCague, Elizabeth & Whissell, 2014) and for incarcerated men (Pascual-Leone, Bierman, Arnold & Stasiak, 2011).

Chairwork and Evidence Based Therapies

Chairwork has been incorporated into many evidence-based therapies such as cognitive behavioural therapy (CBT) (Pugh, 2017) and schema therapy (Young, Klosko, & Weishaar, 2013); however, its empirical efficacy has been most examined within emotion focused therapy (EFT) where specific chairwork tasks were developed to complement the objective of this approach (Greenberg, 2011). EFT is a form of experiential therapy that combines person-centred relational principles (Rogers, 1951) with more evocative and experiential techniques (Greenberg, Warwar & Malcolm, 2008). The use of psycho-dramatic enactments, especially chair dialogues, is a central technique used for evoking emotions for the purposes of emotional processing and transformation (Greenberg & Watson, 2006). EFT aims to help clients restructure the

maladaptive emotions that underlie their symptoms by teaching them how to relate to their emotions in more adaptive ways (Greenberg & Watson, 2006).

Despite a growing interest in the field, only a limited number of studies have examined the existing literature on chairwork (Pugh, 2017; Kellogg, 2004). Moreover, a systematic review of the literature is missing. The objective of this review is twofold: (1) appraise and present an overview of the research on chairwork, specifically examining the application, efficacy and patients perspective on this intervention, and (2) expand the current understanding on how chairwork could be utilized in psychotherapy and highlight future direction for research.

Methods

A systematic search was conducted following Cochrane Collaboration methodology (Higgins & Green, 2011). The output of the search was intended to identify (i) peer review journal articles that used chairwork as an intervention, and (ii) peer review journal articles that examined patients' self-report on their experiences of chairwork.

Design

The following inclusion and exclusion criteria were set to help with the screening process.

Inclusion criteria

Eligibility criteria for considering studies was specified using three parts of O'Connor, Green & Higgins (2011) PICO criteria: 'Participants', 'Intervention', and 'Outcomes'.

- **Participants:** Adults engaged in psychotherapy and who are dealing with a clearly defined psychological difficulty (E.g. depression, internal conflict, etc.).
- **Intervention**: Any psychological intervention where chairwork techniques were explicitly mentioned and utilized in one or more therapy session.
- **Outcome:** Peer reviewed journal articles examining chairwork quantitatively or qualitatively. Peer journal articles should have at least four participants to enhance the validity and reliability of the findings.

Exclusion criteria

- Dissertations, clinical case studies, and book chapters.
- Peer reviewed journal articles that only highlight the theory and process of chairwork without any quantitative or qualitative findings.

- Interventions that did not include chairwork as a core intervention for a specified psychological difficulty.
- Peer reviewed journal articles examining chairwork quantitatively or qualitatively with less than four participants.

Search Strategy

Three electronic databases, PsychInfo (Ovid Interface), MedLine (Ovid Interface), and EMBASE (Ovid Interface) were searched from August 2019 to October 2019. Initial search terms were piloted and refined to ensure that the search captured all relevant key words.

The following key terms were chosen after going through key articles on chairwork. Database terms included: "chair work", "chairwork", "voice dialogue", "two chair* dialogue*", and "empty chair* work". To ensure that the search incorporated all possible terms, Boolean operators were used to construct the search. Truncation was also used in order to ensure all possible derivatives of key words were included in the search (E.g. Two chair* dialogue). The search strategy aimed to identify papers that have examined chairwork for a range of psychological difficulties. The final search strategy is presented in Figure 1. The search strategy aimed to identify papers that reported on the application of chairwork within psychotherapy to provide insight into the aim of the paper. The paper selection process is presented in Figure 2.

Figure 1

The search strategy

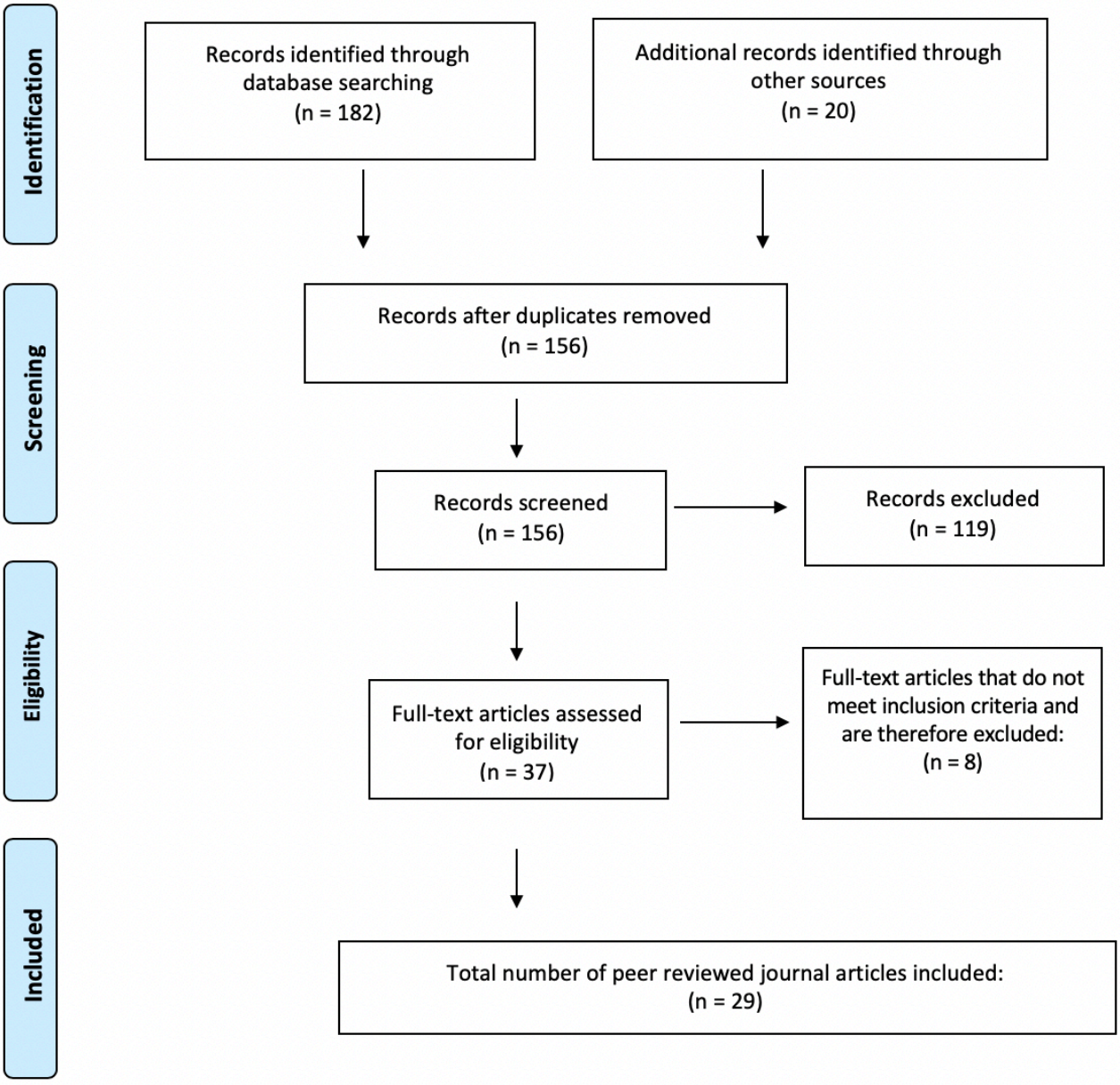
Search terms	**Databases**	**Number of articles**
Chair work or chairwork or voice dialogue or two chair* dialogue* empty chair* work	PsychInfo EMBASE Medline	n = 106 n = 34 n = 22
	Total number of articles without duplicates	**n = 182**

After the initial search, relevant papers were bookmarked and saved. In addition, relevant research was further identified by hand searching the reference lists of included studies. The Peer Review of Electronic Search Strategies (PRESS) checklist (McGowan et al., 2016) was used to guide the search strategy to ensure that a comprehensive search was conducted.

Results

Figure 2

Prisma Flow Diagram of the paper selection process (based on Moher, Liberatti, Tetzlaff & Altman 2009).



Papers (n = 29) identified were empirical papers that examined (i) the application and efficacy of chairwork with adults presenting with various psychological difficulties and (ii) patients' perspectives on chairwork. Papers include the use of chairwork for depression (9 papers), intrapersonal conflict resolution (e.g. indecision) (7 papers), interpersonal trauma (7 papers), other psychological difficulties (2 paper), group therapy (2 papers), and qualitative findings on patients' perspectives on chairwork (2 papers). This review provides an account of the research on the application and efficacy of chairwork, before highlighting mechanism of change of chairwork, where patients feedback will also be reported.

Key Forms of Chairwork in the Literature

Chairwork was used within the framework of EFT in twenty eight of the twenty-nine studies, and only study examined chairwork within the context of Compassion Focused Therapy (CFT).

Chairwork and EFT

EFT is marker-guided, and process driven; meaning that specific interventions are used according to the specific behaviours (i.e. marker) a client displays during a session (Shahar, Kalifa & Alon, 2017). In this way, the therapist remains responsive to the client's momentary states and do not structure their sessions in advance (Goldman, Greenberg & Angus, 2006). Four main experiential techniques are used in

EFT in relation to the client's cognitive and affective state. In brief, two-chairwork is used when a client expresses an internal conflict, empty chairwork is used when a client expresses unresolved emotions toward a significant other, systematic evocative unfolding is used when a client expresses confusion around a personal reaction they find problematic, and focusing is used to help clients deepen their felt sense of an experience (Greenberg et al., 2008; Pos et al., 2003). A more elaborate description of how two chairwork and empty chairwork are applied in EFT is provided below.

Two Chairwork (TC)

TC is used in EFT when a therapist detects an intrapsychic conflict in the clients speech. For instance, when a client makes the following statement: 'I would like to change, but I am afraid of trying something new.´ The therapist begins TC by guiding the client to represent their two opposing views onto two different chairs. The client is asked to alternate between the two chairs (perspectives) and enact the emotions and needs associated with each side through a dialogical process. This process enables the client to more directly experience and transform their emotions related to the conflict. TC assumes that a more adaptive response is achieved by facilitating direct communication, negotiation and integration of the two opposing parts of the self (Greenberg and Webster, 1982). TC is commonly used to target intrapsychic conflicts, such as self-criticism and indecision, in the treatment of depression, social anxiety, and trauma.

Empty Chairwork (EC)

EC is used in EFT when a client expresses having unresolved feelings towards a significant other (Greenberg & Foerster, 1996). For example, the therapist is prompted to utilize EC as an intervention when a client says: "I am so angry at my Mother, but I am too scared to let her know how I feel". The therapist begins EC by asking the client to imaginine that their significant other is seated on an empty chair across from them in the room. The client is then guided to engage in an imaginary dialogue with their significant other by expressing their unresolved feelings (such as feelings of anger and hurt) directly to the empty chair where the imagined other is seated. This process enables the client to get in touch with their avoided emotions and unmet attachment needs so that they can be explored and restructured within the therapeutic relationship (Paivio and Greenberg, 1995). EC frequently used with clients who experienced interpersonal trauma.

Application and Efficacy of Chairwork

A summary of the research on the application and efficacy of chairwork is presented in this section. Research findings are discussed in the following order: chairwork and depression, chairwork and intrapersonal conflict resolution, chairwork and interpersonal trauma, chairwork and other psychological difficulties and chairwork and group therapy.

Chairwork and Depression

Results were organized into three categories. The first category explored the relationship between chairwork and emotional processing. The second category examined the additive effects of adding chairwork to client-centred relations. The third category examined the effectiveness of EFT (involving chairwork as a key intervention) versus cognitive behavioural therapy.

Chairwork and Emotional Processing

Four studies compared EFT against client-centred therapy (CCT) for facilitating emotional processing in the treatment of depression (Pos, Greenberg, Goldman & Korman, 2003; Stiegler, Molde & Schanche, 2018a; Greenberg, Auszra & Hermann, 2007; Boritz, Angus, Monette, Hollis-Walker & Warwar, 2011). Chairwork was used as a central intervention in EFT. TC was used to target self-criticism, and EC was used to target unfinished business. Sample size ranged from 8 to 34 participants across the four studies. All participants met criteria for major depressive disorder on the Structured Clinical Interview for the DSM-II-R (SCID; Spitzer, Williams, Gibbon, & First, 1989). Participants experienced higher and more productive levels of emotional processing after participating in EFT (The Experiencing Scales, EXP; Klein et al., 1969; Client Expressed Emotional Arousal Scale-III, CEAS-III; Warwar & Greenberg, 1999; Productivity Scale, Greenberg et al., 2004; Emotion Episodes, EE; Greenberg et al., 1993; Korman, 1991). Effect sizes were moderate to large (d = 0.59 - 0.74) indicating

that changes in emotional processing were more significant after EFT. Additionally, the depth of processing (Greenberg et al., 2007; Boritz et al., 2011) and the timing of one's acquired emotional processing capacity also served as predictors of better treatment outcomes (Pos et al., 2003). These findings suggest that EFT is more effective than CCT in facilitating emotional processing when treating depression. However, the direct impact chairwork had on emotional processing remains unknown as EFT involved other components such as systematic evocative unfolding for problematic reactions.

Effects of Adding Chairwork to Client Centred Relations

Two dismantling studies examined whether the addition of specific emotion focused tasks (such as chairwork) to a client-centred relationship would enhance treatment outcomes for depression. CCT was compared against EFT in both studies, and participants were adults with major depressive disorder (n=34; n = 38) (Greenberg & Watson, 1998; Goldman et al., 2006). CCT focused on providing the participant with a genuinely empathic and validating environment to promote self-exploration and the strengthening of self (Greenberg & Goldman, 1999). Meanwhile, participants in EFT spent the first three sessions building a safe and trusting relationship with their therapist before emotion focused tasks, such as TC, EC and systematic evocative unfolding were introduced. All participants met diagnostic criteria for major depressive disorder based on a structured clinical interview (SCID; Spitzer et al., 1995) and were randomly assigned to one of the two treatments.

Although both treatments alleviated depressive symptoms, patients in EFT experienced greater reduction in symptomatology (BDI, Beck Ward, Mendelson, Mock & Erbaugh, 1961) (Greenberg & Watson, 1998; Goldman et al., 2006). A moderate to large effect size was reported for the BDI (d =.69), indicating that EFT led to more substantial treatment effects than CCT. Therapeutic gains were also maintained at 18 month follow up and were superior to patients who engaged in CCT. Patients also experienced less depressive relapse, improvements in self-esteem (Rosenberg Self-Esteem Inventory, RSE; Bachman & O'Malley, 1977) and interpersonal functioning (Inventory of Interpersonal Problems, IIP; Horowitz, Rosenberg, Baehr, Euro & Villasensor, 1988) (Ellison et al., 2009). This implies that treatment outcomes may be enhanced when emotion focused tasks are added to CCT. However, the specific effects of chairwork remains questionable as chairwork was not the only emotion focused technique used in EFT. Furthermore, no attempts were made to ascertain how much of the reported outcomes were attributed to chairwork. Thus, it is not possible to determine with certainty whether chairwork can be directly associated with these treatment effects.

Another study examined the efficacy of chairwork as a stand-alone intervention in alleviating depression (n = 21) (Stiegler et al., 2017). This was a multiple baseline study which consisted of two phases of treatment, baseline and an active phase. The baseline treatment focused exclusively on establishing an empathically attuned relationship with the patient and did not include any chairwork interventions. The

active phase of treatment included adding five sessions of TC to five to nine sessions of baseline treatment. Participants reported significantly larger reductions in symptoms of anxiety and depression (Beck Depression Inventory II, BDI-II; Beck Steer, & Brown, 1996; Beck Anxiety Inventory, BAI, Beck et al., 1988) after TC was added to the baseline condition. This suggests that TC was more effective at alleviating depression than when a client-centred approach was used on its own. Although better treatment outcomes were associated with the addition of TC, these improvements may also be explained by placebo effects. For instance, the authors hypothesized that the unusual nature of TC (such as the movement between chairs) might have led clients to expect an added treatment effect and this could have influenced their self-report on the BDI-II and BAI. Future research should conduct more detailed observations and microanalysis of the clients' change processes in both phases to rule out the possibility of any placebo effects (Stiegler et al., 2017).

EFT and Cognitive Behavioural Therapy

One study examined the effectiveness of EFT (involving chairwork as a core intervention) against Cognitive Behavioural Therapy (CBT) in the treatment of depression in a randomized clinical trial (n=66) (Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003). All participants met the DSM-IV (SCID-IV; Spitzer et al., 1995) diagnostic criteria for depression and were randomly assigned to either treatment.

Both groups achieved similar outcomes in depression (Beck Depression Inventory, BDI; Beck et al., 1961), self-esteem (Rosenberg Self-Esteem Inventory, RSE; Rosenberg, 1965), and general distress (Symptom Checklist-90-Revised, SCL-90-R; Derogatis et al, 1976). Treatment effect sizes were also small (d= .05 – 0.3) between both groups across all outcomes measures. Interestingly, there was a significantly greater decrease in clients' self-reports of their interpersonal problems (Inventory of Interpersonal Problems, IIP; Horowitz et al, 1988) in EFT than in CBT. For example, clients in CBT reported no change in their level of assertiveness, while clients in EFT reported being significantly more self-assertive. The authors argue that these differential effects may be attributed to the emphasis EFT places on interpersonal conflict resolution through the use of chairwork. However, these differential effects cannot be solely attributed to chairwork as EFT included other treatment components such as focusing and systematic evocative unfolding. On the whole, results suggest that both treatments are effective in treating major depression. However, the actual impact chairwork had on treatment outcomes remains unclear and requires further research.

Chairwork and Intrapersonal Conflict Resolution

Four studies examined the differential effectiveness of TC as a stand-alone intervention for managing intrapersonal conflicts. Two analogue studies compared TC against empathic reflection (n = 16) and focusing (n=42). Clients were randomly

assigned to either treatment conditions. TC showed superior effects in increasing clients depth of experiencing (The Experiencing Scale, EXP; Klein et al., 1969), and self-awareness (based on clients' self-report) when compared against empathic reflection (Greenberg & Clarke, 1979). Similar results were replicated when TC was compared against empathic reflection using a clinical sample (n=42) (Greenberg & Dompierre, 1981). TC was also superior than focusing at increasing clients depths of experiencing (EXP; Klein et al., 1969). However, both treatments were equally effective at eliciting changes in self-awareness (based on clients self-report) and in facilitating progress (based on clients' self-report; progress was assessed one week after treatment) (Greenberg & Higgins, 1980). TC was also more effective at helping counselling clients resolve a conflictual decision (Adapted form of the Scale of Vocational Indecision, Osipow, Carney & Barak, 1976; Assessment of Career Decision Making Part IV, Harren, 1979) when compared against a cognitive behavioural problem-solving approach and a no treatment group (n=48; 16 participants in each condition) (Clarke & Greenberg, 1986).

These findings suggest that TC is an effective approach for helping clients resolve an internal conflict. However, the generalizability of these findings are limited as most studies relied on an analogue design and did not utilize a control group (Greenberg & Clarke, 1979, Greenberg & Higgins, 1980). Most of the outcomes (e.g. shifts in awareness and client's progress) were also based on clients' subjective self-

report, implying that social desirability effects may be present. Yet, this was neither acknowledged or controlled for in the studies.

Chairwork and Interpersonal Trauma

Five studies examined the effectiveness of using EFT to help clients manage their interpersonal traumas (e.g. childhood abuse and unresolved anger toward a significant other). EC was used as the core intervention to target clients unfinished business in these studies.

Two such studies compared EFT, where EC was used as the central intervention, with a psychoeducation group. All participants were screened and selected on the basis of having an unfinished business with a significant other as their clinically predominant issue (e.g. betrayal, abandonment etc.). Participants were randomly assigned to an EFT or the psychoeducation group (PG). The first study had 34 participants (Paivio & Greenberg, 1995), and the second study had a total of 46 participants (Greenberg, Warwar, & Malcolm, 2008).

Although clients in both groups showed improvements, clients in EFT reported more significant reductions across all measures (Paivio & Greenberg, 1995; Greenberg et al., 2008). For example, clients showed clinically significant reductions in interpersonal (Inventory of Interpersonal Problems, IIP; Horowitz et al, 1988) and intrapsychic distress (Unfinished Business Resolution Scale, UFB-RS; Paivio &

Greenberg, 1995), key presenting symptoms (Symptom Checklist-90-Revised, SCL-90-R; Derogatis, 1983), target complains, (Target Complaints, TC; Battle et al., 1966), (Paivio & Greenberg, 1995, Greenberg et al., 2008), and an enhanced capacity for forgiveness (Enright Forgiveness Inventory, EFI; Enright, Rique & Coyle, 2000) (Greenberg et al., 2008) The between treatment effect size was .66, which shows a moderate to large effect for EC over the PG (Greenberg et al., 2008). These results suggest that EFT (involving EC for unfinished business) was more effective than PG at helping clients manage their interpersonal traumas.

EC was used as a form of imaginal exposure in a version of EFT for 32 Adult Survivors of Child Abuse (EFT-AS; Paivio & Shimp, 1998). EFT-AS aimed to address the emotional dysregulation commonly observed across different types of childhood abuse (Paivio & Neuwenhuis, 2001). Patients achieved better outcomes than a delayed treatment group on multiple levels of functioning: current abuse-related problems, global and specific interpersonal problems (The Inventory of Interpersonal Problems, IIP; Horowitz et al., 1988; The Resolution Scale, RS; Singh, 1994), and general and specific symptomatology (The Symptom Checklist-90-Revised, SCL-90-R; Derogatis, 1983; The Target Complaints Discomfort Questionnaire, TC; Battle et al., 1966). Treatment effects were maintained for nine months following treatment. Pre-post effect sizes for EFT-AS was large (d=1.53) across all the measures, indicating that the changes participants achieved through EFT-AS was significant (Paivio & Neuwenhuis, 2001).

These findings were replicated in another study where the efficacy of two forms of EFT for trauma was evaluated (n=45) (EFTT; Paivio & Pascual-Leone, 2010) (Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010). Each version of EFTT adopted a different re-experiencing procedure. EC was used as a form of imaginal exposure and was compared against empathic exploration of trauma material. Clients were randomly assigned to each treatment condition. Although both procedures were equally effective at producing change, greater clinically significant change was observed in participants who used EC as the re-experiencing procedure. Better outcomes were achieved across all measures of symptoms distress (Impact of Event Scale, IES; Horowitz, 1986; State-Trait Anxiety Inventory, Spielberger, Gorsuch, & Lushene, 1970; BDI-II; Beck at al., 1996; Target Complaints Scale; TCD; Battle et al., 1996), self and interpersonal problems (Rosenberg Self-Esteem Scale, RSE; Rosenberg, 1989; Inventory of Interpersonal Problems, IIP; Horowitz et al., 1988) and abuse resolution (Resolution Scale, RS; Singh, 1994) (Paivio et al., 2010). These results indicate that EC was more effective than emphatic exploration as a re-experiencing procedure when treating trauma.

Although EC was the primary intervention for managing unfinished business in these studies (Paivio & Greenberg, 1995; Greenberg et al., 2008; Paivio & Neuwenhuis, 2001; Paivio et al., 2010), the presence of other treatment components in EFT makes it

hard to determine which in session processes EC impacted, and how much of the changes observed can be associated with EC alone.

The last study provides some evidence that EC could be used to arouse vulnerable emotions in the context of treating secondary unresolved anger (n = 29) (Diamond, Rochman & Amir, 2010). Two different interventions were compared sequentially. Relational reframe (participants talked about their unresolved anger) deriving from attachment-based family therapy (Diamond, 2005), was followed by EC enactments (participants expressed their unresolved anger directly to their significant other as if they were in the room). Emotional arousal was measured by analysing changes in participants' speech and voice. Although both conditions led to increased arousal of sadness, participants experienced more vulnerable emotions, such as fear and anxiety, when they shifted from relational reframe to EC. Presumably, participants experienced more fear and anxiety during the switch as the experiential nature of EC could have evoked an anticipatory fear of being rejected by their significant other.

These findings suggest that relational reframe may be combined with EC to help clients tolerate and express their attachment needs, and in doing so, promote a more adaptive behavioural response. However, the generalizability of these results are limited as the study relied on an analogue design. Furthermore, as EC was delivered after relational reframes, further research is needed to determine how clients would

respond to EC as a standalone intervention. Such investigations may help illuminate the in-session processes EC impacts and reveal contraindications to using EC.

Chairwork and Other Psychological Difficulties

Chairwork was used in two studies as a key intervention for treating adults with social anxiety disorder (SAD) (Shahar, Kalifa & Alon, 2017) and adults with high levels of self-criticism (Shahar, Carlin, Engle, Hegde, Szepsenwol, & Arkowitz, 2012).

The first study involved 11 treatment seeking individuals with a primary diagnosis of SAD (Mini International Neuropsychiatric Interview, Sheehan et al., 1998). Participants were randomized to wait 4, 8 or 12 weeks before their first therapy session. Treatment involved the usual components of EFT, namely a client-centred relationship, TC for self-criticism and EC for unresolved feelings and focusing (Shahar, Kalifa & Alon, 2017). TC and EC was alternated dependent on the presence of specific markers. For example, TC was used when patients displayed signs self-criticism. In contrast, EC was used when patients displayed unresolved feelings toward an attachment figure. This procedure was controlled for all clients. Measures were completed once every two weeks during the waiting period, before the first therapy session, and before the start of each session when they were receiving treatment, when treatment ended, and at follow up (6 and 12 months post-treatment), The majority of participants no longer met criteria for SAD (Social Phobia

Inventory, SPIN; Connor et al., 2000; The Liebowitz Social Anxiety Scale, LSAS; Liebowitz, 1987) by the end of therapy. Participants were also less self-critical, and their ability to reassure themselves significantly improved by the end of treatment (Forms of Self-Criticizing/Self-Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles & Irons, 2004)). Effect sizes were medium to large across all measures by the end of treatment and at follow up (d= .65 - 1.52), indicating that the changes were significant. These results suggests that EFT holds promise in treating adults with SAD. However, no conclusions can be drawn about the efficacy of chairwork for treating SAD, as EFT involved other components, and the actual impact of chairwork was not assessed in this study,

TC was examined as a stand-alone intervention for reducing self-criticism in a pilot study (Shahar et al., 2012). 10 participants were screened using a self-report measure for self-criticism (Forms of Self-Criticizing and Self-Reassuring Scale, FSCRS; Gilbert et al., 2004) before and during their first TC session. Findings suggest that TC was associated with significant increases in self-compassion and self-reassuring (Self-Compassion Scale, SCS; Neff, 2003), and significant reductions in self-criticism (FSCRS; Gilbert et al. 2004), depression and anxiety symptoms (Beck Depression Inventory-II, BDI-II; Beck et al., 1996; Beck Anxiety Inventory, BAI; Beck et al., 1988; Depressive Experiences Questionnaire, DEQ; Blatt et al., 1976). Effect sizes were medium to large by the end of therapy and at 6 month follow up (d = 0.71 – 1.54).

These findings they suggest that TC holds potential in reducing self-criticism and could improve clients ability to self-soothe. However, these results should be interpreted with caution, as they were based on a pilot study which used a small sample size with no control group. Furthermore, validated measures of treatment adherence were also absent.

Chairwork and Group Therapy

Two studies explored the efficacy of two kinds of EFT groups where chairwork was included as a core intervention. The first studied explored whether an EFT group (Relating Without Violence, RWV; Wolfus & Bierman, 1996) could reduce recidivism rates in a group of incarcerated men with histories of domestic violence (n=250). EC was used as a key intervention, alongside other experiential techniques such as focusing, and eye movement desensitization (EMDR; Shapiro, 1995). 66 men completed the treatment and were compared against 184 men from the same prison who did not participate in treatment. The treatment and control group were matched on 19 pre-treatment variables to ensure that the profile of both groups were well matched and did not differ significantly on measures such as age, sentence length, general risk level, employment and education. The group occurred over 12 weeks and aimed to address the psychological and emotional factors contributing to domestic violence, and to help offenders develop better conflict resolution skills (Pascual-Leone et al., 2011). Participants in the EFT group achieved markedly lower

offence rates (reviewing participants' conviction records from the local ministry of community and safety correctional services up to 3 years post release) when compared to participants in the control group at 12 months post-release (Pascual-Leone et al., 2011). Although treatment effect sizes were small (d=.25-.28), they were comparable to the average effects of other approaches used to treat intimate partner violence (Babcok et al., 2004). On the whole, these results suggest that the EFT group holds potential in reducing recidivism rates for incarcerated men. However, the actual impact EC had on lowering offence rates remains unknown as EC was used alongside other interventions in the group. Future research needs to provide more information on how EC was implemented in the EFT group, and the frequency of when EC was applied to clarify the specific impact EC had on lowering offence rates. Qualitative research may also be used to gain insight into which treatment component participants found most beneficial.

Another study explored the efficacy of a nine-week pilot EFT group on 8 participants presenting with moderate to severe symptoms of anxiety and depression (Robinson et al., 2014). Chairwork was used as the primary intervention in the EFT group. The first session focused on group introductions, pre-measures and psychoeducation on emotions. Subsequent sessions consisted of updates from individual group members; single participant chairwork session (45 minutes) (participants observed the lead therapist facilitate chairwork with a group member, while the co-therapist observed the group members for reactions) and post chairwork

reflections. Post measures were administered during the final session of the group. Results indicate that participants experienced significant reductions in emotion regulation difficulties (The Difficulties in Emotion Regulation Scale, DERS; Gratz & Roemer, 2004), improvements in depression (Beck Depression Inventory-II, BDI-II; Beck et al., 1996) and anxiety symptoms (Beck Anxiety Inventory, BAI; Beck et al., 1988) (Robinson et al., 2014). Effect sizes were moderate (d = 0.40 – 0.59) across all measures suggesting that the changes were significant after participating in the EFT group. These results suggest that EFT can be applied to group settings and potentially produce good treatment outcomes for patients with depression and anxiety. However, no firm conclusions can be drawn about the effectiveness of the group due to a small sample size and low statistical power. Further research is needed to strengthen these preliminary findings. For example, by using a larger sample and a control group, and by examining the specific impact of chairwork on changes in depressive and anxiety symptoms and emotion regulation.

Mechanism of Change

The following section highlights the mechanism of change of chairwork from an empirical perspective, including patients' direct experience of chairwork.

The Three Phase Model of Change for TC

The three-phase model of change for TC was proposed by Greenberg (1980) and was constructed through intensive analysis of TC dialogues where resolvers were

compared against non-resolvers on in-session behaviour, depth of experiencing and voice quality. According to the model, an individual had to undergo three specific phases during TC to achieve successful conflict resolution. These are: 1) The harsh critical side of the split needs to express its standards and values to the opposing more submissive or experiencing self. 2) The experiencing self needs to express its needs and wants, and finally, 3) the previously harsh inner critic needs to soften its stance towards the experiencing self. Phase 3, the softening of the previously harsh inner critic, was the critical process that accounted for successful conflict resolution.

Three studies tested the validity of the hypothesized model. Participants were adults seeking therapy in private practice and at a university counselling centre regarding a decisional conflict (e.g. divorce decision making). The first studied composed of 21 adults (Greenberg, 1983). The second studied composed of 28 adults (Greenberg & Webster, 1982), and the final study consisted of 8 adults (Bea, 2002). Structural analysis of social behaviour, depth of experiencing and voice quality were used to compare successful conflict resolution dialogues from unsuccessful dialogues. Results gave moderate support to the 3 phase model. Findings suggest that in the context of a good working alliance, conflict resolution performances follow a particular path, and that successful resolution occurred only when contact between the experiencing and critical self was made and when the inner critic softened. However, not all participants could engage in the different phases proposed by the model. This was especially the case when participants were

unable to process their emotions somatically or achieve a good felt sense of the conflict (Bea, 2002).

Mechanism of Change for EC: The Five Components

The mechanism of change for EC was explored in one study where 11 successful EC dialogues for unfinished business were compared with 11 unsuccessful dialogues (Greenberg & Foerster, 1996). Participants were outpatients who sought therapy for a variety of concerns related to interpersonal difficulties. Task analysis of taped EC sessions revealed that resolution usually consisted of five in-session processes: (1) The client needs to express their blame, grievances and hurt to the imagined other for their problems. (2) The client must enact the behaviour of the imagined other as he or she imagines the other to be (e.g. dismissive). (3) The client must express intense primary emotions (e.g. sadness or anger) when they are blaming or expressing their hurt to the imagined other. 4) The client must express their previously unmet interpersonal needs to the imagined other. Finally, (5) the client must experience a shift in how they view the imagined other. For example, the client softens their view toward the imagined other

The validity of these change processes were examined in one study. 26 clients who suffered from various forms of interpersonal problems and childhood maltreatment participated in EFT, involving EC. The study examined whether successful

resolution of unfinished business contained the specified in-session processes as outlined in the resolution model (Greenberg & Foerster, 1996). Results were supportive of the resolution model. Clients achieved better outcomes (e.g. improvements in overall levels of distress, self-awareness and interpersonal problems) when the core components of successful EC dialogues were present. For example, the degree of emotional arousal, articulation of previously unmet interpersonal needs, and a shift in one's view of the significant other discriminated resolvers from non-resolvers (Greenberg & Malcolm, 2002).

Patients' Direct Experience of Chairwork

Patients' direct experience of chairwork were evaluated qualitatively in three studies. The first study examined how 18 patients with depression and anxiety experienced TC for reducing self-criticism (Stiegler, Binder, Hjeltnes, Stige & Schanche, 2018b). The second study examined how 12 patients with depression experienced a compassion-focused chairwork intervention that targets self-criticism (Bell, Montague, Elander & Gilbert, 2020). The third study examined how 8 patients' with moderate to severe depression and anxiety experienced an EFT group where chairwork was used as the main intervention (Robinson et al., 2014). Three similar themes were found across these three studies.

(1) Accessing and embodying different selves: The chairs helped participants to embody and access the cognitions and emotions associated with their critical and

criticized self with more ease. They also enabled them to process and experience their avoided emotions in a more meaningful way.

(2) Movement, metacognition and motivation: The movement between chairs facilitated perspective-taking and created psychological distance between the participant's critical and criticized self. It also enabled them to gain a better understanding of the self-perpetuating cycle of self-criticism. Participants were surprised by how negative their critical self was; this recognition seemed to motivate participants to change their relationship with their inner critic and treat themselves with more compassion.

(3) Emotional Intensity and Emotional Regulation: Participants described gaining more emotional mastery and emotional regulation skills after chairwork. While most participants found chairwork to be "cathartic", "productive" and emotionally transformative some participants also found chairwork emotionally "overwhelming" and could not continue with the therapeutic task.

Together, these results provide valuable insight into the mechanism of change of chairwork from patients' perspectives. They also highlight the strengths and contraindications of using chairwork which can help inform clinical practice.

Discussion

This narrative review appraised the research on the application, efficacy and patients' perspectives on chairwork to enhance the existing knowledge and research direction of this field. Research on emotion-focused and compassion-focused chairwork support the idea that chairwork can be used to promote psychological change through improving clients' emotional processing skills, self-awareness and depth of experiencing. Chairwork appears to contribute to the alleviation of a range of mental health difficulties such as depression, social anxiety and self-criticism within the context of EFT. However, the specific impact chairwork had on treatment outcomes remains unclear as EFT included other treatment components such as focusing and systematic evocative unfolding.

Although dismantling and stand-alone studies were conducted, they were limited in number and were either analogue or pilot studies that relied on small samples, no control group, and inconsistent treatment fidelity checks (Greenberg & Clarke, 1979; Greenberg & Dompiere, 1981; Greenberg & Higgins, 1980; Shahar et al., 2012). Further, better treatment outcomes may be mediated by placebo effects and potential social desirability and allegiance effects (Goldman et al., 2006). Future research should control for these effects and examine which in session processes chairwork impacts in the treatment of various psychological difficulties. The mechanism of change for chairwork also requires further examination. Proposed models of conflict resolution for TC and EC only received moderate support from a

limited number of studies which were conducted using small samples (Bea, 2002; Greenberg & Malcom, 2002).

Meanwhile as most studies examined chairwork within the framework of EFT (Pos et al., 2003; Stiegler et al., 2018a; Greenberg et al., 2007), the therapeutic value of chairwork outside of EFT remains unknown. It also remains unclear if chairwork can be incorporated into other forms of therapy and produce equally beneficial outcomes. However, preliminary studies that have integrated chairwork into CBT and CFT show promising results (Pugh, 2017; Bell et al., 2020).

Qualitative feedback from patients experience of chairwork complements existing findings. For example, patients' accounts further confirmed that an optimal level of emotional arousal is needed for chairwork to bring about therapeutic change. Their reports also support the finding that chairwork can help enhance individuals emotional processing capacities. These findings suggest that chairwork may be used as a transdiagnostic approach to target key psychological processes (such as self-criticism and poor conflict resolution skills) that are known to maintain certain psychological disorders such as depression (Carver & Ganellen, 1983).

This review identified several strengths of chairwork that can inform clinical practice. Results consistently showed that patients developed greater self-awareness and emotion regulation skills when they externalised their avoided emotions and internal conflicts onto a chair and engaged in a therapeutic dialogue with it (Bell et

al., 2020; Stiegler et al., 2018b). These findings suggest that chairwork can encourage de-centering, and reduce the psychological distress associated with entrenched patterns of negative self-evaluation and unprocessed emotions. Chairwork can also facilitate vicarious emotional processing when utilised in a group setting (Robinson et al., 2014); suggesting that chairwork may be effective at facilitating group learning, cohesiveness and universality (Yalom & Leszcz, 2005). However, more studies with a larger sample size and a control group are needed to enhance the generalizability of these findings.

The review also identified some contraindications to starting chairwork. For instance, some patients found it challenging to tolerate the "overwhelming" emotions elicited during chairwork and were unable to engage further with the intervention (Bell et al., 2020; Stieger et al.,2018b; Paivio et al., 2010). This indicates that chairwork could be emotionally dysregulating for patients who do not have emotional regulation skills. Such findings also align with existing research which suggests that an optimal level of emotional arousal is needed for patients to benefit from chairwork (Greenberg et al., 2007; Pos et al., 2003).

These contraindications contain several clinical implications. To ensure maximum benefits and minimum patient harm, therapists should inform patients of the experiential and emotional nature of chairwork in advance. They should also assess patients' readiness and emotional processing capacity beforehand. Therapists should also debrief their patients after chairwork so that the patient feels emotionally

contained. Some adaptations to chairwork may also be used to help clients scaffold their capacity to experience and regulate their emotions. For instance, an increased use of the therapeutic relationship, dialectical empathic reflection and the use of genuine humour were identified as helpful strategies that can guide clients with poorer emotional regulation skills to safely experience and express deeper emotional states during chairwork (Pos & Greenberg, 2012).

Limitations

The limitations of this review should be kept in mind when considering the reported findings. Firstly, the systematic search only retrieved 29 articles that met the study's inclusion criteria. Therefore, the findings from this review are limited to the information within the retrieved studies. There was also a lack of negative findings associated with chairwork in the literature. This may be because most studies focused on evaluating EFT as a whole intervention rather than assessing the specific impact chairwork had on influencing change. Future research should determine which in-session processes chairwork impacts and assess for contraindications. This can help clarify the mechanism of action of chairwork and inform best practice.

The retrieved studies also differed in their quality. Some utilised more thorough treatment integrity checks to ensure that adherence to the treatment protocol was achieved, while others were less clear about how adherence was measured. Moreover, chairwork was facilitated by therapists with different levels of clinical experience, training and qualifications; a mixture of masters and doctoral

students in clinical psychology and qualified clinical psychologists were employed to implement the interventions.

Many studies also relied on small analogue samples; while this maximises internal validity, it reduces the generalizability to real clinical settings (Cook, 1979). Studies also differed in the degree to which the researcher's biases were acknowledged. Some studies did not recognise the potential impact of biases introduced by the researchers pre-existing beliefs and experiences, while other studies were more contextualised. Finally, although most studies included participants from a range of backgrounds (e.g. marital status, education levels, employment and income), participants in the studies were predominantly Caucasians, and participants from ethnic minority groups were under-represented. As such, the findings did not provide insights into any cultural variations and barriers that might contraindicate the implementation of chairwork. Thus, it remains unclear if chairwork would be equally beneficial across different ethnic groups.

In spite of these limitations, this review has enriched the current understanding on how chairwork can be utilized in psychotherapy, while also highlighting future direction for research. In conclusion, chairwork is a versatile treatment that can be used to treat a wide range of psychological difficulties. However, more research is needed to examine its mechanism of action, and its application and efficacy outside of EFT and as a standalone intervention.

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Part 2: Empirical Paper

How do individuals with anorexia nervosa (AN) experience the voice dialogue method in the context of experiencing an internal eating disorder voice (EDV)? A Thematic Analysis.

Abstract

Objective: The internal eating disorder voice (EDV) has been implicated in the development and maintenance of anorexia nervosa (AN). However, limited research has examined interventions for this phenomenon. This study expanded the literature by exploring the acceptability of using such interventions by exploring how women with a diagnosis of AN experienced the voice dialogue method as a way of understanding and managing their EDV. **Method:** Nine women participated in the study. Data was collected through semi-structured interviews upon the completion of a single voice dialogue intervention. Thematic Analysis (TA) was used to understand how participants experienced the voice dialogue method and its relevance for treating AN. **Results:** Three main themes were identified: "externalizing and separating from the EDV", "better understanding of the EDV" and "recovery: hopeful, motivated and afraid". **Conclusions:** Participants found voice dialogue to be an acceptable approach for working with their EDV. Preliminary results suggest that voice dialogue might hold promise in the treatment of AN. However, more research is needed to verify these findings and determine the effectiveness of voice dialogue in treating AN. Implications for addressing the EDV using voice focused interventions are explored.

Introduction

Anorexia nervosa (AN) is a serious mental health disorder that can become life-threatening (Arcelus et al., 2011). With a lifetime prevalence of up to 4% (Smink, Van Hoeken & Hoek, 2013), AN is known to have the highest mortality rate of all psychiatric disorders (Gorwood et al., 2016). A number of factors are associated with the development and maintenance of AN including maladaptive beliefs about one's shape and weight, clinical perfectionism, low self-esteem, pro-illness beliefs and emotional and interpersonal dysregulation (Serpell, Treasure, Teasdale & Sullivan, 1999; Schmidt & Treasure, 2006; Waller, 2012). AN is known to be one of the hardest psychiatric disorders to treat (Halmi et al., 2005), with many suffers reporting low motivation and ambivalence about change (Blake, Turnbull & Treasure, 1997; Tierney and Fox, 2011). Unfortunately, existing treatments have yielded poor outcomes, with high dropout and relapse rates (DeJong, Broadbent, & Schmidt, 2012; Watson & Bulik, 2013; Rance, Moller & Clarke, 2017; Knowles, Anokhina & Serpell, 2013). These challenges highlight a pressing need for more innovative methods for engaging and treating individuals with AN.

The Internal Eating Disorder Voice (EDV)

Many individuals suffering from an eating disorder (ED) experience an internal eating disorder voice (EDV) (Tierney & Fox, 2011; Noordenbos, Aliakbari, & Campbell,

2014), sometimes referred to as the 'anorexic voice' in AN (Tierney & Fox, 2010). Paradoxically, the EDV is experienced as being a part of the self (composed of one's thoughts and feelings about shape, weight and eating) and yet phenomenologically separate from the self (Fox, Federici, & Power, 2012). Distinct from more typical anorexic or self-critical cognitions, the EDV has been described as an attacking second and third-person commentary related to one's eating, shape and weight (Tierney & Fox, 2011; Pugh & Waller, 2016). It is often experienced as a hostile and oppressive inner voice that commands the individual to act on increasingly destructive behaviours that are difficult to resist (Higbed & Fox, 2010; Jenkins & Ogden, 2012; Maisel, Epston, & Borden, 2004; Tierney & Fox, 2010; Wright & Hacking, 2012; Williams & Reid, 2012). Consequently, many individuals describe feeling restricted, dominated and undermined by their EDV (Williams & Reid, 2012; Tierney & Fox, 2011).

Existing studies suggests that the EDV plays an important role in the development, maintenance and recovery from AN. The severity of disordered eating has been related to the presence of a more powerful EDV in some individuals (Pugh & Waller, 2016). The EDV has also been associated with treatment resistance and ambivalence (Forsen Mantilla, Clinton & Birgegard, 2018; Tierney & Fox, 2011). Accordingly, learning to defend against the EDV is seen as a critical step in recovery and may help prevent relapse, especially when individuals feel drawn to listening to the voice during more challenging times in their lives (Williams & Reid, 2012; Fox, Federici & Power, 2012; Dolhanty & Greenberg, 2009; Lock, Epston, & Maisel, 2004;

Simpson, 2012; Jenkins & Ogden, 2012; Tierney & Fox, 2010). Taken together, these findings indicate that better treatment outcomes may be achieved by helping individuals understand, relate and respond to their EDV in a healthier and more balanced way. In spite of these striking findings, limited research has explored how the EDV can be treated in AN.

Chairwork with voices: Voice dialogue method

Chairwork refers to a range of experiential interventions which uses chairs, their positioning, movement and dialogues to facilitate psychological change (Pugh & Broome, 2020). Chairwork has been incorporated into evidence-based therapies including cognitive behavioural therapy (Pugh, 2017), emotion-focused therapy (Greenberg & Watson, 1998), schema therapy (Young, Klosko, & Weishaar, 2013), and compassion focused therapy (Bell, Montague, Elander & Gilbert, 2020). Research indicates that chairwork is effective in working with voices in other disorders (Chadwick, 2003, Butollo, Karl, Konig & Hagl, 2014; Steel, 2017) and may hold promise for individuals with AN (Dolhanty & Greenberg, 2009). Chairwork dialogues have also been shown to reduce self-criticism and depression (Shahar et al., 2012; Newman et al., 2011), and increase self-awareness, emotional regulation and self-compassion (Neff, Kirkpatrick & Rude, 2007).

Voice dialogue (Stone & Stone, 1989) is a form of chairwork which involves the client changing locations and speaking from the perspective of an internal voice (E.g.

the inner critic). In this way, the client is asked to give voice to parts of the self so that they can be better understood, reflected upon and assimilated. Voice dialogue posits that the individual's personality is composed of multiple voices or selves, and that each voice has a unique world view that animates the body with a distinct mental and emotional energy. As an approach, voice dialogue aims to help clients explore, manage, and understand their inner voices, and enhance their self-awareness (Stone & Stone, 1989).

During voice dialogue, the client is asked to change seats and embody the perspective of the voice they would like to explore. The therapist then interviews the voice as though it were a separate entity and enquires about its origins, goals and intentions (e.g. What do you do for Jane? When did you first come into Jane's life?). Next, the client is asked to decentre from the voice by returning to their original chair. The therapist provides a summary of what was heard, and the client witnesses and reflects on what the voice had said from a distance. The same procedure is repeated if the client would like to give voice to another part of themselves in response to what was heard (e.g. the criticized self might want to speak after hearing what the inner critic said). In this way, the client develops more metacognitive awareness around their different selves and can begin to respond to them in more adaptive ways.

Unlike voice hearing in psychosis where a range of voices and sounds are reported, such as whispering and laughing, as well as environmental sounds such as rattling and clicks (Nayani & David, 1996), the EDV is experienced as a specific voice

that commands an individual to behave in increasingly damaging ways in relation to their eating, weight and shape. Additionally, patients tend to describe the EDV as an internally generated phenomenon, whereas patients with psychosis often report hearing voices and sounds from varying spatial locations – external to the body, internal to the head or a combination of these (Pugh & Waller, 2016; McKague, McAnally, Puccio, Bendall, & Jackson, 2012).

Voice dialogue has been adapted to help patients with psychosis cope with distressing voices. For example, by helping the client explore the voices motives and by teaching them how to establish a healthier way of relating to them (Talking with Voices, TWV; Corstens, Longden & May, 2012). Meanwhile, elements of voice dialogue have been used in experience focused counselling, alongside other coping skills, to help individuals with AN manage critical internal voices (Dolhanty & Greenberg, 2009). Both approaches coincide in their non-pathologizing view of voice related experiences in psychosis and AN. Rather, treatment focuses on helping the client develop a new understanding of their voices, and how they can reclaim control and ownership of these experiences (Steel, 2017; Schnackenberg & Fleming & Martin, 2018; Dolhanty & Greenberg, 2009).

Although the EDV has been implicated in the recovery of AN, no studies have examined whether targeting the EDV would facilitate recovery when compared to other approaches. Furthermore, while voice focused interventions have been suggested as a potential way to improve the treatment of eating disorders (Pugh &

Waller, 2017), research has yet to determine whether individuals would benefit from such an approach. In addition, while the therapeutic value of other forms of chairwork (such as two chairwork and empty chairwork) have received much empirical attention, the voice dialogue method remains neglected in the literature. To date, only a small number of qualitative studies have sought to understand patients' lived experiences of chairwork (Bell et al., 2020; Stiegler, Binder, Hjeltnes, Stige & Schanche, 2018). While quantitative findings are important, there is an equally important need to understand patients' lived experiences of voice dialogue. Such explorations provide more nuanced findings regarding the acceptability of voice-focused interventions for eating disorders, generate hypotheses about their mechanisms of action, and elucidate factors which facilitate and obstruct its application in anorexia nervosa."

Research aims

The present study, therefore, aimed to understand how individuals with AN experienced the voice dialogue method as a way of understanding and managing their EDV, and whether they would find voice dialogue as an acceptable approach for working with their EDV. The main research question was: *How do individuals with AN experience the voice dialogue method in the context of experiencing an EDV?*

Methods

Context

Participants were recruited from four specialist eating disorder services providing inpatient and outpatient treatment for adults. Research presentations were provided to the multidisciplinary teams at each site prior to recruitment to help staff members identity potential participants. The presentation highlighted the study's aims, background and inclusion and exclusion criteria. Information sheets and a copy of the research protocol was also given to the staff members.

Recruitment

Participants were recruited in one of three ways. First, patients who gave their consent to be contacted about the research study at the point of their initial assessment and who fulfilled the inclusion criteria were contacted directly by the research team. Second, therapists at the host sites provided patients who were undergoing treatment and who fulfilled the study's criteria with information sheets. Potential participants were invited to contact the research team directly or provide their consent to their contact details being shared with the research team to discuss the project further. Lastly, information about the study was provided via posters at the host sites. Potential participants were invited to contact the researchers directly. All potential participants were contacted via a telephone call. During the call, the researcher gauged the participants interest in the study, responded to their questions, and scheduled an appointment for the voice dialogue session.

Ethical Considerations

Ethical approval for the study was obtained from the Bloomsbury Research Ethics Service Committee (REC reference 19/LO/0793; Appendix 01). Informed consent was obtained from all participants. The study's information sheet and consent form can be found in Appendix 02.

Participants

Sixteen participants expressed an interest in the study. Five participants withdrew from the study before an appointment was made due to various reasons. For example, some participants decided that they were not ready to engage in the study. Two participants had an appointment arranged; however, this was cancelled due to the onset of the coronavirus outbreak. Further recruitment was also suspended due to the pandemic, which meant a slightly smaller sample than planned. However, the target sample size (n = 8 -12) for the study was still achieved. As there is no formal process for determining appropriate sample size for qualitative research (Braun & Clarke, 2006), the sample size was set at a minimum of 8 and a maximum of 12 participants, as this was deemed large enough to find patterns in the data, and was suitable for the scope of the project, resources available and type of analysis. The final sample consisted of nine women. Seven women had a diagnosis of the restrictive subtype of AN, and two had the binge purge subtype. Participants were aged 20-31

(mean age: 26 years) and had an average Body Mass Index (BMI) of 17.3 kg/m^2. The majority of women participating in this study were White British (n = 6). The ethnicity of other participants were: White Irish (n=1), British Pakistani (n =1), and White Other (n=1). The average self-reported duration of illness was 13 years. Of the nine women, one was receiving inpatient treatment and eight were receiving outpatient treatment. Participants demographic details are shown in Table 1.

Inclusion and exclusion criteria

In order to be included in the study, participants needed to be at least 18 years of age, had a diagnosis of AN, were undertaking assessment or treatment at an eating disorder service (including patients in treatment who are weight restored), describe experiencing a persistent, internal EDV at the point of recruitment, and had the capacity to read the study information sheet and provide informed consent to participate. The exclusion criteria were - diagnosis of an eating disorder other than AN (and associated subtypes); inability to understand written English; concurrent diagnosis of learning disability, emotionally unstable personality disorder, or psychosis; high risk behaviours such as suicidal or parasuicidal behaviour; and still awaiting assessment within the service.

Table 1

Participants' demographic details

Alias	Age	Ethnicity	Diagnosis (AN subtype)	BMI (kg/m^2)	Current Treatment	Previous Treatment	Duration of AN (self-reported)
1. Gwen	20	White British	Anorexia Nervosa (restrictive)	14.4	Schema Therapy	CBT[1]	2 years
2. Maia	31	White Irish	Anorexia Nervosa (restrictive)	16.6	Inpatient, CBT, & family therapy	Outpatient counselling, dietetics, & 4 inpatient treatments	20 years
3.Audrey	28	White Other	Anorexia Nervosa (restrictive)	16.5	CBT	CBT & supportive clinical management	14 years
4. Yana	20	White British	Anorexia Nervosa (restrictive)	17.8	Inpatient & cognitive analytic therapy	CBT	3 years
5. Shona	27	White British	Anorexia Nervosa (restrictive)	17.9	CBT	CBT & 4 inpatient treatments	16 years
6. Isabel	31	British Pakistani	Anorexia Nervosa (binge purge)	18.1	CBT	CBT, psychotherapy, & 2 inpatient treatments	15 years
7. Eisha	20	White British	Anorexia Nervosa (binge purge)	19.2	CBT	CBT & 2 inpatient treatments	7 years
8. Hilda	28	White British	Anorexia Nervosa (restrictive) & Obsessive-Compulsive Disorder	17.9	Nurse monitoring	CBT & 1 inpatient treatment	18 years
9. Jenna	28	White British	Anorexia Nervosa (restrictive)	17.9	CBT and dietetic consultation	None	18 years

[1] CBT: Cognitive Behavioural Therapy

Researchers and Voice Dialogue Training

This was a joint research project conducted by the present author, Natalie Chua (NC) and another trainee clinical psychologist, Sarah Burnett-Stuart (SS). SS used the transcripts on the voice dialogue session for her thesis (Burnett-Stuart, 2020), and NC used the transcripts on post voice dialogue interviews for her thesis. An outline of each trainee's contribution to the study is provided in Appendix 06.

Both researchers facilitated the voice dialogue intervention and post dialogue interviews. SS facilitated 2 voice dialogue sessions and post dialogue interviews and NC facilitated the remaining 7. Both researchers are trainee clinical psychologist in their final year in a professional doctorate program. Both researchers had an average of 5 years of clinical experience. 15 hours of training in the voice dialogue method was provided by Dr Matthew Pugh (Senior Clinical Psychologist). This included didactic teaching, video demonstrations, practice role plays, supervision and self-study.

Semi-Structured Interviews

Individual interviews

Participants were interviewed using a semi-structured interview protocol developed for this study (Appendix 03). MP (research supervisor) developed the first version of the interview schedule. This was later revised by the research team under MP's supervision, with reference to feedback provided by three experts by experience. The interviews were semi-structured, and this allowed the researchers to cover the

essential topics while also allowing flexibility for the researchers to deviate from the structure and engage spontaneously with the emerging issues in the session.

The semi-structured interview explored participants' experiences of engaging in voice dialogue with their EDV. Key areas of discussion include:

- What was it like to dialogue with your EDV?
- What was helpful and unhelpful about the experience?
- How do you understand your EDV now after voice dialogue?

Dialogical Interview Schedule for Eating Disorders (DIS-ED)

The dialogical protocol (Appendix 05) for the study was written by MP and later refined by the research team. The dialogical intervention departed slightly from classical voice dialogue in that participants were given the option of responding to their EDV after giving voice to their EDV. This component was added after considering the research on other voice focused interventions which suggests that dialoguing with voices can help improve the relationship between the voice and the voice hearer (Corstens, Longden & May, 2012; Steel, 2017; Schnackenberg & Fleming & Martin, 2018).

Service User Consultation

The research study was reviewed by a small number of service users with a diagnosis of AN. This was valuable in ensuring that the study was satisfactory from the participants' perspective. Revisions to the protocols were made according to their

feedback. For example, some service users preferred referring to their EDV as their "eating disorder self". Accordingly, participants were asked if they preferred using the term "eating disorder voice" or "eating disorder self" during the process of voice dialogue.

Data Collection

Post session interviews were held at the respective ED services where the participants were seen for their research appointment. Interviews took place immediately after the voice dialogue session (45 minutes to 1 hour) was completed. Participants had the option of taking a ten-minute break before participating in the interview (30 mins – 1 hour). Participants were reminded that they could decline answering any questions and end their participation at any time they wished. Interviews were recorded on an encrypted audio device.

Participants received a support card (Appendix 04) at the end of the research interview which explained the different avenues of support available to them, including out of hours support. For example, the support card encouraged participants to speak to their treating clinician after their research appointment if they needed additional support, and it also included details of a helpline run by the charity 'Beat', which provides support to people affected by eating disorders outside of working hours. Participants were provided with a monetary voucher as thanks for their participation.

Data Analysis

Data was analysed using the principles of thematic analysis (TA). Thematic analysis is a research method that involves identifying, analysing and reporting recurring patterns (themes) within the data (Braun & Clarke, 2006). Data can consist of any written or verbal material which contain meaning such as poems, interviews, media reports (Maxwell, 1988). As TA is not wedded to any specific theoretical and technological orientation, it can be used flexibly to meet the intent of one's research. For example, TA can be used to understand how individuals make meaning of a particular experience or it can be used to examine how different social contexts can influence how an individual experiences an event.

In the case of this research, TA was used to help the researcher understand how patients experienced a single voice dialogue session. TA was deemed appropriate for this research as it would allow the researcher to handle the large body of texts in a clear and consistent manner, which is strength of TA (Flick, 1998). For example, it would provide the researcher with a way to systematically analyse and pick out similarities and differences across participant's experience of voice dialogue, and aid in the identification of more dominant and less dominant themes. In addition, TA is also commonly used to understand patients experience of AN treatment (Rance et al., 2017) the EDV (Tierney & Fox, 2010), and chairwork (Chadwick, 2003).

Interviews were analysed using Braun and Clarke's guidelines on thematic analysis (2006). Analysis began with transcription. Patient information was anonymized during transcription, and interviews were transcribed in verbatim using Trint, an audio transcription software package. The researcher then conducted multiple reading of the transcripts and revisited the audio recordings to familiarize herself with the data. Initial ideas were noted down during this phase. Initial 'broader' themes were developed by systematically going through the transcript to identify key data that were relevant to the research question. Initial themes were further conceptualized and refined to form more salient themes, for example, through assigning more meaningful names to the themes. Salient themes were then categorized to form more superordinate themes. This process allowed for less relevant and prevalent themes to be dropped, and more dominant themes and subthemes to emerge. This sequence was repeated for each interview, before clustering the superordinate themes across all nine interviews to identify similarities and differences across cases. The themes were consistently refined during this process, by relating the themes back to the transcripts, and relating them back to the research question to ensure that the themes make sense in relation to the coded extracts and the entire data set.

Researcher's reflexivity

As the analytic process of TA is inherently interpretative the researcher's background serves as a necessary means to understand the phenomenon in question, and as a potential source of prejudice and bias. Thus, transparency and the researcher's reflexivity is vital (Braun & Clarke, 2006). As the primary analyst, the researcher constantly reviewed her expectations and conclusions, monitoring for their impact whilst also noting the way in which the analytic findings altered them. The researcher acknowledges her role as a Chinese, female trainee clinical psychologist, in her late twenties, working within an eating disorder service and her own experiences using chairwork, and the potential this has to influence interpretation and analysis. For example, the researcher's own positive experience with chairwork might cause her to anticipate and expect participants to have a similar response to this approach. In addition, sharing a similar gender to the participants might lead the researcher to feel more connected to certain topics related to women, such as the subject of body image for example, and may cause her to approach the data with less objectivity.

The researcher's ethnicity as a Chinese woman may also introduce cultural presuppositions during the analytical process; for instance, by influencing the researcher's interpretation of participant's verbal and emotional expression. These characteristics were placed in 'brackets' during analysis to ensure that the data was viewed as objectively as possible (Fischer, 2008). For example, the researcher would

note down when such similarities or assumptions were encountered during analysis and set them aside her first set of interpretations. The transcript would be revisited and re-analyzed with these assumptions in mind so that exceptions to the researcher's initial perspective and interpretations could be explored.

Credibility Checks

Individual case analysis was audited by the researcher's supervisor (MP – who has extensive knowledge of chairwork) who systematically reviewed sections of the transcripts to ensure credibility of themes, and the clustering of emergent themes into superordinate themes. Themes were refined accordingly until consensus was reached. The themes presented in this study have been 'grounded' in direct quotations drawn from the interview transcripts to provide readers with the opportunity to evaluate their reliability and plausibility (Vetere & Dallos, 2005).

Results

Participants' experience of voice dialogue was captured by three main themes and 11 subthemes. A summary of their occurrence and significance are presented in Table 2.

Table 2

Summary of Themes

Main Themes	Sub-themes	Participants mentioning this theme
1. Externalizing and separating from the EDV	a) Meta-cognition: Less identified with EDV	8/9
	b) VD feels embarrassing	1/9
	c) Less inhibitions about talking about EDV	8/9
	d) EDV as a self that needs to be understood	8/9
	e) Surprise at ease of engaging in VD	8/9
2. Better understanding of the EDV	a)More compassion toward self and EDV	8/9
	b) Recognizing the negative impact of the EDV	9/9
	c) Expressing emotional pain	9/9
3. Recovery: hopeful, motivated and afraid	a) EDV as an increasingly ego-dystonic phenomenon	8/9
	b) Motivation to defend and challenge the EDV	8/9
	c) Conflicting emotions about recovery	8/9

Theme 1:
Externalizing and separating from the EDV

Participants found using different chairs to represent the voice (EDV) and the voice hearer, and the movement between chairs (i.e. perspectives) to be a salient part of their experience. The chairs seemed to create a concrete physical and psychological boundary between the voice (EDV) and the voice hearer, and this appeared to help participants to externalize, personify and relate to their EDV as a separate entity. This separation allowed participants to articulate their experience of the anorexic voice with more ease, connect with a healthier part of themselves which was distinct from their EDV and differentiate their thoughts and feelings from their EDV. This appeared to be a novel way of relating to the EDV for most participants. For example, Shona and Gwen explained:

> … giving it a chair and a voice, and sort of separating it from me was really powerful […] I find that [talking about the EDV] usually … really hard to talk about or to like give words to like, it sort of makes sense in my head but then it doesn't come out. (Shona)

> I like how you have to switch chairs, cause that helps with … making it a whole separate entity for me … I think I'm more able to … see where the line is between me and the voice […] I think it helped me vocalise the different thoughts and…kind of put it into different categories […] Like, my thoughts and feelings, and whether they're actually mine or the voice's. And…to think through the logic of what the voice sometimes says. (Gwen)

Subtheme 1a, Meta-cognition: Less identified with EDV:

As Shona and Gwen highlighted, the different chairs seemed to deepen participants' ability to witness their EDV from a more meta-cognitive and objective perspective. As Jenna describes below, participants were able to use this new perspective to understand their EDV better, identify less with it, and gain some respite from the all-consuming nature of the voice.

> …it was nice having the separation between the two and also just feeling that kind of a bit a sense of relief afterwards. Being like: 'Ah ok this is actually happening.' It kind of consolidates what's going on? Because it's so easy to get so consumed in this world that, you know is not normal but it's just so your norm and it becomes your reality and it becomes your every minute of every single day. (Jenna)

Subtheme 1b, VD feels embarrassing:

In contrast to the majority, Hilda found the use of different chairs to be an unnecessary procedure; she felt that it would not have made a difference to the "ease" at which she could speak as her EDV. In fact, this process felt rather "embarrassing" for her. Hilda explained:

> I don't think I really needed to move chairs. I know that that's kind of a technique that is used, like I've had to do that before but um…it … wouldn't have made a difference if I'd sat here or if I'd sat over there… […] I think this can work for some people. But to me it's always felt quite like condescending, like... I'm some like freak patient … And then I have to kind of get over the step of

> like, ok this [representing her EDV on a different chair] is embarrassing but … this is what you have to do. (Hilda)

Subtheme 1c, Less inhibitions about talking about EDV:

Participants also felt less inhibited about disclosing their relationship with their EDV when they could externalize, visualize and embody their EDV on a different chair. This seemed to allow participants to expose the voice's characteristics, and in doing so, reduce the "control" their EDV would usually have over them. This appeared to help participants speak about their struggles more openly.

> Well like when I'm talking about it…to people and I am like trying to defend it… I'm always careful with what I say [T: ahh] …but like, yeah when…you're talking about it and it's a completely separate thing and it's in first person, [T: mmm] … it's like you can just talk about it freely… (Eisha)

Similarly, Isabel spoke about how externalization helped to reduce the control her EDV had over her; she seems to hint that externalizing her EDV could help her EDV express itself in less maladaptive ways (e.g. through starvation):

> Because when it's been inside of me, it's [pause] a … bullying, secretive thing where… [pause]… the only thing it usually has contact with is me…it's got power in that… no one else gets to hear it or see it. But it also wants to talk about it but through… the starvation and stuff. Like yeah and I think, where it was then sitting here and talking, it almost lost that control a little bit? (Isabel)

Subtheme 1d, EDV as a self that needs to be understood:

Participants also valued "the space" to acknowledge and listen to the perspective of their EDV during voice dialogue; an experience that seemed rare in their treatment. Participants reflected on how it could be beneficial to dialogue with their EDV more frequently during treatment as it would help them feel less "attacked" and more understood by professionals and their loved ones. Participants gave voice to how they imagined using voice dialogue as a supportive process in their recovery:

> I liked that my ED had airtime, and I liked that I got to step back from the ED and hear what you heard from it … I felt that he (EDV) was listened to. And that's often what my ED needs and doesn't get … because it just gets pushed down all the time […] I'm definitely going to bring in that technique (voice dialogue) to all the therapy sessions, and with mum and dad at home… cause… when they're talking to me, I sometimes feel like it's a personal attack (Maia)

Subtheme 1e, Surprise at ease of engaging in VD:

Interestingly, while most participants were able to speak from the perspective of their EDV, many participants felt "sceptical" about their ability to do so. Some participants also worried that they would feel emotionally overwhelmed when they had to "face" their EDV and speak as their anorexic voice. Participants were therefore surprised when they could speak as their EDV with ease, and when they were able to interact with their EDV without feeling overwhelmed. Their accounts also suggest that

they were willing to tolerate a degree of uncertainty in order to participate in the dialogical process. For example, Shona and Eisha explained:

> Cause before I was like, I'm not going to have anything to say. Like, what am I supposed to say? So yeah, it was like quite … well, really surprising that I was able to vocalize it… Yeah, like how natural it is. I guess because it's been here for a really long time… so it's actually quite easy … like I'm mimicking someone I know that I talk to all the time. (Shona)

> I wasn't keen on like focusing…so much on like anorexia itself because you spend like so much time in therapy trying not to focus on it as much. And, to kind of try to ignore it, so the thought of like… letting it just kind of take over … I was yeah dreading it a bit… I thought it was going to be a lot more damaging than it was [laughs] but it wasn't at all. It's like it's fine. (Eisha)

Theme 2:
Better understanding of the EDV

Voice dialogue seemed to provide participants with a better understanding of the underlying function and intention of their EDV. For example, some participants described a new understanding of their EDV as a "false sense of security" that protects them from their vulnerability and the challenges of daily life. As Isabel explains below, this realization seemed to encourage participants to see their EDV as an entity they need to move away from.

> It comes from a place of pain and hurt and all of that, and it's grown stronger in trying to protect me from things … And it's trying not to let me out in the big, bad world. Just in case I get hurt… But… I see it as something that I need to… move away from [pause]. Because yeah, like I need that independence, I need to … become myself out of that. (Isabel)

Subtheme 2a, More compassion toward self and EDV

Meanwhile, some participants felt "surprised" when they discovered that their EDV was "well-intentioned", in that their EDV seemed to care a great deal about their well-being and survival. This revelation contrasted sharply against how they typically experienced their EDV: a hostile and malevolent voice. This seemed to help participants feel more compassion and sympathy towards their EDV. Yana explained:

> I do kind of see it in a different light I think… I kind of see it as nicer, as more caring than I thought it was. Like seeing it as less evil as something that just wants to starve me to death. But something that is just trying its best to…like get me through life, but it's just struggling as much as I am really … and that if I ended up dying because of it, then it's lost me, and it needs me as well in order to get to feel fulfilled. (Yana)

Subtheme 2b, Recognizing the negative impact of the EDV

At the same time, participants became more aware of the extent to which their EDV was causing harm in their lives. The dialogical process seemed to help participants admit that their EDV was a problem they could no longer deny.

> In terms of seeing it for what it is and making me realize that it is a disorder. Because sometimes it's easy to dismiss. […] I didn't quite see how big it was in terms of like an actual being and part of me and really toxic… I hadn't taken any of that into account before… (Jenna)

> … I guess it's in a way owning that I do have a problem…and that it's not…just a battle in my head. It's actually something real. And, I guess that yeah, I can't really go along in life in denial […] It's certainly myself that seems to be under an illusion that things are alright … (Yana)

Some participants also began to liken their relationship with the EDV to an "abusive" and "co-dependent relationship" when they were reflecting on their compelling attachment to the voice. As Isabel and Shona described below, voice dialogue appeared to stimulate participants to look for similarities between their intrapersonal and interpersonal relationships.

> … I definitely needed it [EDV] at that time but… now it's kind of like I go back to it out of habit … and like not knowing other [pause] channels or other things that I could do [to regulate my emotions], and it's like an … overprotective, kind of self-serving abusive relationship. (Isabel)

> There was a quote I read online that said, the longer you hold onto anorexia, anorexia will start holding on to you. And that makes a lot of sense to me. It becomes this like co-dependent relationship, you and it, and it feels like it's desperate not to let you go. It won't let you go. Like even if you're in hospital,

on bed rest being tube fed, it still won't let you go. It will still tell you that you can't eat, that you can't gain weight. (Shona)

Subtheme 2c, Expressing emotional pain:

This recognition seemed to cause participants to challenge and devalue the EDV's advice. It also seemed to elicit a healthy emotional response from participants, where they began to express their frustration, anger, and sadness about their internal struggle with their EDV.

…like it's a massive manipulator. So it will be like: "Just do what I say and then you can have everything you want in life." When actually if I do what it says, I'm going to lose everything. So, I have to remind myself of that. Because it's not like I'll just be this beautiful thin person that's got the perfect life. Doesn't work like that. (Shona)

… I guess, sometimes, the voice feels like it's this person that I want to get angry back at. Shout at, and just say: "Shut the fuck up, I don't need you in my life." (Gwen)

It actually [pause] reminded me just how much damage it has done to me and how… ridiculous the whole thing is, this stuff that it does say, because it's just not true. While I do understand the role it played, how it has lasted so long I just… I just don't know […] Like it just [pause] makes no sense, it makes no sense. (Maia)

Theme 3:
Recovery: hopeful, motivated and afraid

Participants described feeling more empowered, open-minded and hopeful about recovering from AN after-voice dialogue. For example, Shona describes feeling more optimistic about discovering an identity outside of her EDV after gaining a felt sense of a part of herself that was distinct from her anorexic voice:

> Because sometimes… I think… this [EDV] is just me. Like, maybe there is no anorexic voice. Maybe this is just the way I am… But actually, to separate the two…makes me feel like this hope, like I can get rid of this, because at the moment I'll be thinking I can't get rid of this. Like obviously this is me, and this is me until I die. But this is something, this isn't me. And there's the opportunity for this to go in time, I hope. (Shona)

Subtheme 3a, EDV as an increasingly ego-dystonic phenomenon:

As with Shona's account, participants seemed to experience their EDV as an increasingly ego-dystonic phenomenon. As Audrey explains below, participants felt more curious and motivated to discover the potential of freeing themselves from the voice's control:

> I'm really happy for this [voice dialogue], because… I need…to face, sometimes, what it did before, what it did to me, how much I went through, how hard I work, still, and I need to work, still… And, I really want to find out, if there's any chance to remove it forever, from my life… (Audrey)

Subtheme 3b, Motivation to defend and challenge the EDV:

Some participants also described having a stronger understanding and awareness of how they can begin to defend themselves against their EDV. Their accounts suggest that they saw this skill to be key for their recovery. Jenna and Eisha explained:

> When I say, for instance, throw bits of my food secretly in the bin or when I'm trying to restrict or… convince myself I'm not hungry because I have no … hunger cues still… I'll just remind myself of that [voice dialogue], and just remember that it is very powerful as a whole being basically, and that it completely consumes me and that I need to really really fight against it even when my body is trying to trick me, my mind is trying to trick me. (Jenna)

> I will try to keep more of an open mind when [pause] the people around me who care about me makes suggestions [pause], rather than just straight away be like: 'No I'm not doing it, I refuse to do it.' Like, I realize now that's not. Like that's just anorexia trying to kind of hold its grip on me. So I'll try to be more open [T: mmm] to trying new things. (Eisha)

Some participants also felt more "empowered" after expressing their needs and concerns directly to their EDV as they often assumed a more submissive role in the relationship. As Isabel and Maia explained below, although speaking to the EDV was emotionally provocative, it gave them the opportunity to stand up for themselves and challenge the perceived power of the voice. This seemed to help strengthen the part of themselves which they experienced as being distinct from their EDV.

…This was, again, really powerful because…I wasn't talking from a weaker point of view. I was talking at an equal's kind of point of view and getting my point across but also showing that appreciation in a genuine way… […] Like me hearing it and understanding it gave me like, I feel like an equal status like to it rather than like a lower who's being bullied. It's like, ok I'm here now, and we're at the same level. (Isabel)

[About responding to the EDV] That didn't come as easy. Cause I felt a bit silly at the start. But what I said, I really meant. So that was kind of empowering. The more I spoke… the easier it got. But at the start, I was like: "God, what do I say to him?", kind of in fear of the response. But there was no response because he was there [on a different chair] and I was here. (Maia)

Subtheme 3c, Conflicting emotions about recovery:

Meanwhile, although Shona felt more powerful after challenging her EDV, she also experienced a strong sense of fear and guilt after doing so. Her account suggests that compliance with the voice often ensued as a dysfunctional way for her to cope with these troubling emotions:

… that [wanting to get rid of the EDV] makes me feel very guilty … I just get terrified of like, making it angry… And then, what would come next? Which would probably be, I would feel so guilty that I'd start listening to it and then I'd lose weight and then I go back to hospital. […] I don't like it when it gets angry because that's when I end up doing what it says. And then that leaves me in a bad situation. (Shona)

As with Shona's experience, voice dialogue appeared to provide participants with a medium to process the conflicting emotions associated with their recovery. It was apparent that whilst participants felt more motivated to become independent from their EDV, they also felt highly anxious about letting go of their anorexic voice. As Yana and Isabel described below, participants felt scared and uncertain about their ability to cope with life without the voice's guidance (even after clearly acknowledging its detrimental effects). Thus, voice dialogue also helped participants to become more conscious of the complex relational dynamic between themselves and their EDV.

> … Yeah I just think [sniffles, pause] as much as I don't want it, it is my friend [T: mmm] [pause, wipes tears from her eyes]. Like I'm scared to let it go [T: yeah] [pause, sniffles]. Like I don't know because I feel like I've been [sniffles] like, like I don't know disillusioned by it, like it's the only way forward. When rationally I know it's not … Like it's made me feel like I don't actually know how people cope with day to day life without having something like this to like rely on. (Yana)

> Empowering [to speak to the EDV] because… I just need to say to it as like this is my intention [to move away from you], just to let you know kind of thing? But also, scary because [pause] I'm still very scared to be without it …. Because I've not known a life without it for a very long time ... It's very much like I'm leaving like this protective house and going to go live by myself and it's, it's a bit scary. (Isabel)

Discussion

This study examined the acceptability of using voice-focused interventions in the treatment of AN by exploring how individuals with AN experienced a single voice dialogue session as a way of understanding and managing their EDV. Overall, all but one participant found voice dialogue to be an acceptable and therapeutic approach for working with their EDV.

Most participants appreciated the use of different chairs as it allowed them to externalize their EDV, perceive it as a separate entity, and relate to it from a more objective perspective. The movement between chairs also increased participants' ability to decenter from the voice, connect with a healthier sense of self, and identify less with their EDV. These findings support existing studies which have demonstrated that chairwork can facilitate clients' metacognitive capacities (Chadwick, 2003), reduce over-identification with a maladaptive part of their personality (Bell et al., 2020) and that the physicality of chairwork (i.e. externalizing and movement) can help individuals organize, explore and understand their inner experiences in a more adaptative way (Stiegler et al., 2018; Bell et al., 2020). Creating psychological distance between the self and the EDV is seen as a critical task in AN recovery (Higbed & Fox, 2010; Forsen Mantilla et al., 2018), and in helping individuals discover an identity outside of their ED (Jenkins & Ogden, 2011). Thus, voice dialogue may be a potent way of teaching individuals how to decenter from their EDV and strengthen one's connection with a

healthier sense of self. However, these hypothesis would require further examination, as this study only examined the acceptability and not the effectiveness of voice dialogue as an intervention in facilitating change.

Notably, participants had a vivid experience of multiple selves during voice dialogue; they were able to switch between different roles and perspectives when each self (i.e. EDV and the voice hearer or the self that was distinct from the EDV) was externalized onto a chair and assumed a different position in the room. These observations are supportive of the theoretical assumptions of voice dialogue (Stone & Stone, 1989) and the dialogical self (Hermans, 2001), which posits that the individual personality is composed of multiple voices, and that each voice contains a unique world view and temporal and spatial characteristics (Hermans, 2001). This means that an individual can assume different selves according to the position they occupy within a certain space and time, and that each self can be engaged in dialogical relations. Preliminary findings from this study suggests that the dialogical self may be used to conceptualize patients' experience of the EDV, and that voice dialogue may be used to encourage professionals, caregivers and patients to understand the EDV in a less stigmatizing way (Chin, Hayward & Drinnan, 2009). A less stigmatizing approach may encourage individuals to be less secretive about their voice-related experiences and feel less isolated in their struggle (Holt & Tickle, 2014; Vilhauer, 2017).

Echoing previous research, our participants felt that it was important for their EDV to be acknowledged and managed in their treatment (Tierney & Fox, 2011; Davies, Parekh, Etelapaa, Wood, & Jaffa, 2008). They believed that continued dialogue with their EDV could provide them and their clinicians with a fuller understanding of their eating difficulties, help their carers attribute less blame toward them by seeing their EDV as separate entity, and support them in addressing the power imbalances in their relationship with the EDV. Our findings also add to the literature which indicates that the EDV is often neglected in AN treatment (Rance et al., 2017), and that voice-focused interventions, such as voice dialogue, may help clinicians understand how the EDV interacts with eating psychopathology (Pugh & Waller, 2016, 2017), and provide individuals with a healthier way of communicating with their inner voices (Corstens, Longden & May, 2012).

The dialogical process also enhanced participants understanding of the function, purpose and harshness of their EDV. First, participants recognized the vulnerability and unmet needs behind the hostility of their EDV and this seemed to help them feel more compassion toward themselves and their EDV, supporting findings from a similar technique (Bell et al., 2020). Participants were also surprised by how malicious their EDV was after voice dialogue. This seemed to motivate participants to re-evaluate their relationship with their EDV, as they realized that the temporary relief gained from complying with the voice would only further damage their lives in the longer term. This reflects prior findings that chairwork can help individuals

recognize the negative content of their inner dialogue and realize that they possess the capacity to change their relationship with their distressing voices (Steigler et al., 2018; Robinson, McCague & Whissell, 2014). On the whole, our results add to the findings from existing therapeutic approaches for voice hearers, which suggests that better therapeutic outcomes can be achieved by supporting individuals in understanding the function and purpose of their inner voices, rather than perceiving their voices as a symptom of their illness that needs to be eradicated (Romme & Escher, 2000; Romme et al. 2009).

Reflecting findings from a similar chairwork technique (Bell et al., 2020), voice dialogue seemed to encourage participants to draw parallels between their intrapersonal and interpersonal relationships. Specifically, some participants compared their relationship with their EDV to an abusive and co-dependent relationship, echoing the experiences of women who have associated their EDV with a toxic relationship (Tierney & Fox, 2011), and other voice-hearers who described having a subordinate bond with their voices (Birchwood, Meaden, Trower & Plaistow, 2000). Although participants felt more motivated to free themselves from their EDV, they continued to feel emotionally attached to the voice as it provides them with a familiar sense of security. This supports the idea that attachment processes are involved in the maintenance of EDs (Olofsson, Oddli, Vrabel, & Hoffart, 2020) where the EDV may function as an introjected attachment figure that provides the individual with a degree of comfort and safety (Tierney & Fox, 2010; Forsen Mantilla et al., 2018; Dakanalis et

al., 2014). Such an observation may be one of the reasons why individuals with AN often feel ambivalent about or resistant to change.

These findings highlight the crucial need for clinicians and care-givers to support the individual in defending themselves against the EDV, and in developing alternative means to fulfil their attachment needs as this can reduce their reliance on the EDV as a source of support during times of elevated distress (Leehr et al., 2015; Vansteelandt, Rijmen, Pieters, Probst, & Vanderlinden, 2007; Olofsson et al., 2020). It also suggests that voice dialogue may be used to enhance clinicians' understanding of the individual's attachment relationship with their EDV. Such an understanding may provide a reframe on treatment resistance; resistance could be understood as a fear response about losing a valued albeit unhealthy relationship. This understanding might help clinicians overcome any frustration they may feel when working with patients who seem unwilling to change (Tierney & Fox, 2010; Graham, Tierney, Chisholm, & Fox, 2019). It would be interesting to understand whether patients who experience an EDV would favour such an approach and if it would augment treatment engagement and outcomes.

Participants also felt more hopeful about changing their relationship with their EDV after voice dialogue. The dialogical process provided participants with the opportunity to respond to the voice more assertively. Consequently, participants felt more motivated and capable of defending themselves against their EDV, and they also

started to relate to their EDV as an increasingly ego-dystonic phenomenon. These findings support the idea that dialogues between selves can facilitate self-innovation (Goncalves, & Ribeiro 2011; Chin et al., 2009) and help the voice-hearer establish a healthier relationship with their inner voices (Corstens et al., 2012). It also suggests that voice dialogue may be used to target treatment ambivalence and enhance patients' motivation to change.

Despite feeling more motivated to change, participants also felt fearful and apprehensive about turning away from their EDV as they felt uncertain about their ability to cope with the demands of life without the voice's guidance, mirroring previous findings that the process of giving up one's EDV is emotionally challenging (Tierney & Fox, 2010). The heightened emotional arousal participants experienced was associated with increased emotional tolerance and regulation, confirming that chairwork techniques are effective in facilitating emotional processing (Robinson et al., 2014; Stiegler et al., 2018). As emotional processing difficulties (e.g. emotional avoidance) are known to maintain eating disorders (Oldershaw, Startup & Lavender, 2019), voice dialogue may be effective in helping individuals with AN process their avoided emotions and manage their emotional distress.

Of note, one participant found voice dialogue to be reminiscent of role plays, an approach she was averse to. Given this context, it was unsurprising that she found voice dialogue to be a patronizing and embarrassing approach she did not expect to

benefit from. Although a minority view in this study, her experience provides valuable insight that can help inform clinical practice, in terms of reminding ED practitioners that this approach can evoke strong feelings and may not be suitable for everyone.

Clinical Implications

Clinicians should take time to explain what voice dialogue would entail and use their clinical judgment to ascertain if this approach would be suitable for their patients to ensure maximum benefits. For example, clinicians should ensure that their patients have the capacity to tolerate the emotional intensity of the intervention and go over their expectations and concerns about using voice dialogue. If patients do not respond well to initial attempts at dialoguing with their EDV, the clinician may enquire about any in session processes that may be challenging for the patient. For instance, clinicians can assess for the presence of any emotional avoidance or awkwardness prior to voice dialogue; such factors have been associated with poorer engagement when using chairwork (Robinson et al., 2014; Stiegler et al., 2018). This would also help the clinician to deliver voice dialogue in a more attuned and sensitive way and avoid unnecessary therapeutic ruptures. Clinicians should routinely assess and enquire about the EDV and consider how it fits into the patient's formulation. It would be interesting to examine whether such an addition would enhance the therapeutic alliance and patients' motivation to change; this could be a potential avenue for future research.

Research Implications

Although the majority of participants achieved benefits from participating in a single voice dialogue session, at the time of the interview, most participants had also received a substantial amount of talking therapy (e.g. CBT), and had been in treatment for a significant period of time (average self-reported duration of AN = 13 years). Moreover, all participants in this study were women with AN. These considerations put fourth several questions that could inform future research: How do participants' past therapeutic experiences mediate their experience of the voice dialogue method? For instance, would participants who received less talking therapy find voice dialogue to be as acceptable as an intervention? Would males respond similarly or differently to females when dialoguing with their EDV? From the standpoint of early prevention and intervention, could children and adolescents benefit from voice dialogue? Given that the EDV is increasingly acknowledged as a phenomenon within EDs, it would also be interesting to understand whether voice dialogue could be useful for other forms of EDS (such as Bulimia Nervosa etc.).

Limitations

The following factors potentially limit this study. First, the credibility of the themes could be enhanced by conducting testimonial validity checks. Testimonial checks involves participants confirming whether the researcher's interpretation of data

accurately described their experience. Unfortunately, time constraints disallowed for such checks.

The study's inclusion criteria may be refined. Specifically, a limit for BMI was missing as we were recruiting participants at various points in their treatment. Thus, the final sample consisted of one individual who had a healthy BMI (19.2kg/m^2). Future studies should specify the parameters for participants BMI to ensure a more homogeneous sample. Interestingly, this participant reported a strong EDV despite being weight restored. This finding suggests that the EDV may persist even when an individual is at a healthy weight. Accordingly, ED practitioners should continue to enquire about the individual's EDV, and understand how it interacts with their recovery, even after the individual achieves a healthy BMI.

As the same researcher conducted the voice dialogue sessions and post session interviews, participants may have refrained from sharing any negative or unhelpful aspect of the interventions to please the researcher. Future studies should control for social desirability effects by using different facilitators for the voice dialogue sessions and post dialogue interviews. This might allow participants to share their experiences more openly and allow for new data regarding the implementation and contraindications of voice dialogue to emerge. Future research could also examine if participants would have different insights about voice dialogue if post-session interviews occurred a few days later, as this might give participants more time to process and reflect on their experiences.

There is a likelihood that the EDV was not sufficiently distinguished from more established pro-illness beliefs or disordered eating cognitions (Pugh, 2016) as we did not use a standardized criteria to assess participants self-report of the EDV. Future studies should include a screening procedure to discern voice-related experiences from more typical self-critical cognitions related to AN. Of note, a new scale (Experience of an Anorexic Voice Questionnaire, EAV-Q) was recently developed to help clinicians assess and understand patients' anorexic voice (Hampshire et al., 2020). The EAV-Q may be incorporated as a screen in future studies to help clinicians and researchers distinguish the anorexic voice from more typical self-critical or disordered eating cognitions. The EAV-Q was not used in this study as it was not available during data collection.

There is a chance that the insight participants gained from voice dialogue were not unique to the intervention. For instance, participants may have already acquired some understanding of the EDV from their previous treatment. Accordingly, future research should look into this, as this would help clarify the specific impact voice dialogue has when targeting the EDV and generate ideas about the kinds of therapies voice dialogue might complement.

The generalizability of our results are also limited by the following factors. Firstly, due to the resources available and type of analysis chosen for the study, our sample size was kept small (n= 9) and this inevitably limits the generalizability of our findings. All participants were at different points in their recovery, had different self-

reported length of AN (average self-reported duration of AN = 13 years) and have been in treatment for different amount of times. Participants also had different treatment histories, for instance some patients have received inpatient treatments, whilst others have not. Furthermore, most of our participants had the restrictive subtype of AN. As such, the findings from this study should be interpreted with caution. More research is needed to understand whether individuals with other forms of AN (e.g. atypical AN, AN binge purge subtype and early onset AN) and treatment histories would benefit equally from voice dialogue and express the same opinion about the acceptability of this intervention before any further conclusions about the feasibility of this intervention can be determined.

Conclusion

As the first study applying voice dialogue to EDs, our findings have addressed a gap in the literature by demonstrating that voice focused interventions are an acceptable approach for working with the EDV. Further research is now needed to determine whether voice dialogue can be effective at bringing about changes in AN recovery, and to understand whether such techniques can be utilized with patients on a longer-term basis. Such research would also help to clarify if there are other contraindications associated with using voice dialogue, and aid in understanding how the EDV may be integrated within current AN treatment and maintenance models.

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Part 3: Critical Appraisal

Introduction

I will begin this appraisal by discussing my interest in the research topic and how the research process had altered and enhanced my understanding of AN, voice dialogue and the EDV. I will then discuss the methodological limitations and challenges I encountered during the research process before expanding on the clinical and research implications for this work**.**

Researchers perspective and process

I was drawn to the research topic as I have a special interest in experiential therapies, understanding voice-hearing experiences, and eating disorders (EDs). Before my clinical psychology training, I worked extensively with adolescents and young adults with eating disorders at a partial hospitalisation program and an outpatient program in America as a clinical assistant. These experiences helped me to realise that recovery was not a linear process, and that a patient, creative and holistic approach was needed to work effectively with individuals with EDs. Therefore, the opportunity to explore more innovative methods for treating EDs was enticing. I was also keen to understand how patients experienced an EDV and how they would respond to the voice dialogue method. Specifically, I wondered how patients would experience a less conventional approach that included a somewhat transcendental element. I also looked forward to educating myself on the literature on the EDV and chairwork.

The research process was exciting and challenging, and it has enhanced my understanding of voice dialogue, AN and the EDV, while simultaneously altering some of my prior knowledge of these subjects. For instance, I was struck by how easily most participants could embody and personify their EDV and organically come to understand the function of their voices through voice dialogue. I was also struck by how each participant's EDV shared similar purposes: to protect the individual from their vulnerability and emotional pain. Although research had informed my understanding of the therapeutic benefits associated with talking with voices and chairwork, I gained a more concrete and in-depth understanding of these findings after facilitating the voice dialogue sessions and post-session interviews.

One of my assumptions prior to the research was that participants would find chairwork engaging and helpful. This assumption was informed by my own experiences, both reading about chairwork and having brief encounters with this modality in personal therapy. Therefore, it was challenging and fascinating when one of my participants found voice dialogue embarrassing and unhelpful. Although this view was only expressed by one participant, I really appreciated hearing her view as it enhanced my understanding about the approach, and it also highlighted my own biases. It also got me to think about the other participants I did not manage to see due to the pandemic, and if they would share similar views.

I was also fascinated by the imagery participants associated with their EDV, when they were asked the question: "If I could see you [EDV] as you are, what would you look like?". Although each participant's imagery was different, they were all incredibly vivid and striking. One participant's imagery remains particularly salient in my mind. She described her EDV as having two parts: on the one hand, her EDV was a dementor, sucking her soul and happiness, on the other hand, her EDV took the form of a nurturing mother whenever she abided in its instructions. I imagine that such information can be extremely useful for clinical practice. For instance, clinicians may elicit and remind patients of the imagery associated with their EDV to encourage more separation and less compliance with the EDV.

I also found it interesting that some participants preferred to refer to their EDV as a self rather than a voice during voice dialogue. For instance, one participant preferred to refer to her EDV as a self as she experienced her EDV as an integral part of her identity. Meanwhile, another participant chose to refer to her EDV as a voice, as it seemed to more accurately capture her experience of the phenomenon. It would be interesting to understand if there are any psychological and somatic differences between patients who experience their EDV as a voice rather than a self, and vice versa. Of course, it is also possible that this is a mere reflection of linguistic preferences.

As the majority of participants in the study were White British, I wondered if there might be any cultural variations and barriers for using voice dialogue with patients from different cultures. Although the only individual from our study who was from an ethnic minority background responded favourably to voice dialogue, it would be valuable to apply voice dialogue with more patients from other ethnic groups and assess whether such approaches would be equally beneficial and acceptable.

My interest in chairwork and the dialogical self-theory (DST) has definitely grown after conducting this research. For example, I was surprised to learn that chairwork actually refers to a variety of experiential interventions, rather than one single intervention. It was news to me that there were different forms of chairwork that could be utilized for different purposes. I was especially surprised by the similarities chairwork and the DST shared with aspects of certain eastern psychological approaches I practice (e.g. Buddhist Psychology and Yogic Psychology). For instance, both approaches seek to help the individual overcome suffering, understand the self, expand one's consciousness through specific analytical procedures, and facilitate self-actualisation. These learnings will continue to inform my work as an aspiring clinical psychologist, the human psyche, and my conceptualization of voice-related experiences.

I feel incredibly honoured and privileged that my participants somehow trusted me, a total stranger, to hold space and witness the unfolding of their EDV during the dialogical process. I am so grateful to have had the opportunity to listen to their stories, their struggles and triumphs, and to have facilitated the voice dialogue sessions and post dialogue interviews with them.

Methodological limitations and challenges

The research study has several methodological limitations and challenges. First, we did not specify the classification system (e.g. DSM-5 (American Psychiatric Association,2013)) for AN in our inclusion criteria. Future studies should specify a classification system to ensure homogeneity of the sample. Interestingly, only 16 participants expressed an interest in the study over five months of recruitment. Given that the EDV is commonly reported by individuals with EDs (Noordenbos, Aliakbari, & Campbell, 2014), one might expect that we would have recruited more participants across the four ED sites. Thus, it remains unclear if all individuals with AN identify with experiencing an EDV, and if there were other barriers that might have prevented participants from expressing an interest in our study. As many participants in this study expressed an initial apprehension about giving their EDV "air-time" in fear of being "overwhelmed" by their EDV, perhaps similar anxieties might have prevented other participants from partaking in this study.

The final sample of nine women were largely drawn from the two ED services where my research supervisors were based. This observation may be explained by various reasons. For instance, our research study may have been prioritized at our supervisors' ED services as we have a more personal connection with the ED team through our supervisors' presence. Meanwhile, our research study might be given less priority at the other ED services where we were less acquainted with the ED team. Perhaps, recruitment at other sites could be improved by re-visiting the MDT teams and presenting our research study again. However, this was not possible due to time constraints.

As a joint trainee research project, the data for this study was collected by two independent researchers. Although we had initially agreed to recruit and see an equal number of patients between the both of us, my co-researcher was unable to collect more data due to personal reasons. While I appreciated the opportunity to facilitate and transcribe more voice dialogue sessions and post-session interviews, it was also strenuous to have taken on work designated for two researchers. Despite this challenge, I am grateful that we reached our target sample size and data saturation before the onset of the coronavirus which led to recruitment ending prematurely.

To make the workload more manageable, specifically, transcribing both voice dialogue sessions, and post voice dialogue interviews, I took the recommendations of

my supervisors and utilized an automated transcription software (Trint). I was initially worried that this process would cause me to be less familiar with the data, as I assumed that listening to the transcripts and transcribing them by hand would allow me to immerse myself in the data more fully. Interestingly, I still had to manually listen and go through every transcript as the automated transcription was only accurate 60-70% of the time. Thus, I was still able to thoroughly immerse myself in the data even though an automated transcription software was employed.

Further clinical implications

The intervention used in this study deviated slightly from the classic voice dialogue method, in that, participants could respond to their EDV after the facilitator summarised what they heard. Our findings suggest that participants valued this extension. For example, most participants appreciated the opportunity to converse with their EDV as it allowed them to relate to their EDV less submissively. These results are supportive of previous findings on voice-related experiences: the relationship between the voice and voice-hearer is inherently relational and dialogical, and that voice-hearers experience less distress when they can appraise and respond to their voices in more adaptive way (Romme, Escher, Dillon, Corstens & Morris, 2009; Corstens, Longden & May, 2012; Nayani & David, 1996). Thus, clinicians should consider how they can support individuals with establishing healthier boundaries with their EDV, perhaps, through more frequent dialogues in therapy.

As voice dialogue encouraged participants to draw parallels between their intrapersonal and interpersonal relations, clinicians should routinely enquire about clients' significant interpersonal relationships and understand how they might be influencing the way their clients are relating to their EDV. Such an exploration could enhance the client's case formulation. Accordingly, clinicians should also explore how their clients can change their relationship with their EDV (e.g. taking a less submissive or compliant position) by helping them modify their interpersonal and social schemas (Hayward, 2003). Assertiveness training, group identification and problem-solving interventions are potential approaches that can help voice-hearers modify their interpersonal and social schemas and lessen the distress among voice-hearers (Romme & Escher, 1993; Erickson, Beiser, & Lacono 1998). These findings imply that patients may be able to build a more adaptive relationship with their EDV by widening their social context, having healthier interpersonal relationships and better interpersonal skills.

Clinicians should also be aware of the potential disadvantages associated with externalizing AN as a voice; this includes diminishing the individual's responsibility over their behaviour and recovery (Wright & Hacking, 2012). Although research suggests that these concerns are overstated (e.g. externalization interventions are proven to be effective and non-harmful for the treatment of other voice-related

disorders (Chadwick, 2003; Corstens, Longden & May, 2012)), clinicians, should still be cautious, and routinely examine whether their patients are avoiding responsibility for their recovery by exclusively blaming their EDV for their eating difficulties.

Notably, participants related to their EDV using different pronouns. Some participants referred to their EDV as "it", while others referred to their EDV as "he" or "she". This indicates that participants had preferred gender identities associated with their EDV, while some experienced their EDV as being gender neutral. This finding also confirms previous research that voices can have personal characteristics (Nayani & David, 1996). Clinicians may enquire about the personal qualities associated with the individual's EDV, as this might help the individual to concretize their experience of their EDV during voice dialogue and aid in separation. Such information may also inform case formulation.

Further research implications

There are a plethora of directions for future research. Future research could explore whether it would be more beneficial and appropriate to introduce the voice dialogue method during the assessment or intervention phases of treatment. It would also be interesting to examine if additional voice dialogue sessions would have additive effects, and if voice dialogue could be combined with other therapeutic approaches such as enhanced cognitive therapy (CBT-E) (Fairburn, 2008) to augment

treatment outcomes. As our study has demonstrated the acceptability of using voice dialogue with a small number of participants, future research is now needed to further these findings by examining the effectiveness of using such interventions for promoting change and recovery in the treatment of AN.

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Appendices

Appendix 01: Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

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REVISED & REISSUED - 30 July 2019

Dear Dr. Serpell

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Interviewing 'Ana': Qualitative Analysis of Voice Dialogues with the Internal Anorexic Voice and Participants' Experiences of Voice Dialogues**
IRAS project ID:	**251510**
Protocol number:	**EDGE 119684**
REC reference:	**19/LO/0793**
Sponsor	**UCL Joint Research Office**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **251510**. Please quote this on all correspondence.

Yours sincerely,
Matt Rogerson

Approvals Specialist

Email: hra.approval@nhs.net

CC Suzanne Emerton

Appendix 02: Study Consent Form and Information Sheet

University College London Hospitals NHS
NHS Foundation Trust

IRAS ID: 251510

Centre Number:

Study Number: 1/1

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: An analysis of voice dialogues with the internal anorexic voice

Names of Researchers: Dr. Lucy Serpell, Dr. Matthew Pugh, Sarah Burnett-Stuart, Natalie Chua Yi Ling

Please initial box

1. I confirm that I have read the information sheet dated 20/06/2019 (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. (If appropriate) I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐
4. I provide consent for the researchers to ask my named clinician for my most recent body mass index (BMI) measurement. ☐
5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Speaking with the internal anorexic 'voice' or 'anorexic self'

Invitation and brief summary

Many people with eating disorders describe experiencing an internal eating disorder 'voice' which comments on their eating, weight and body image. For other individuals, eating difficulties are represented less by a voice and more by an 'anorexic self' or 'anorexic part' of their personality. We would like to invite you to participate in this study to help us understand the internal anorexic 'voice' or 'anorexic self' better.

We will be using a therapeutic method called 'chairwork' to speak directly to the individual's anorexic 'voice' or 'anorexic self'. We hope this will help us understand these experiences better and how they might be related to eating difficulties. We are also interested in learning what it was like for you to converse with your anorexic 'voice' or 'anorexic self', so we will be asking some questions after the 'chairwork' to understand your experience.

Why am I being invited?

You are being invited to take part in the study because you are a client at an Eating Disorders Clinic involved in the research, and have described experiencing an internal anorexic voice.

What's the purpose of this research?

This study aims to help mental health professionals and other individuals to understand anorexia better and to help improve treatments for anorexia. Research suggests that around 90% of people with an eating disorder experience an internal 'eating disorder voice'. There hasn't been much research into the internal anorexic voice. We believe that developing our understanding of the anorexic voice could help to improve treatment.

'Chairwork' is a therapy technique that can involve using chairs to speak with internal voices. The person with anorexia sits in one chair and talks to the therapist as if they were the internal voice.

What would taking part involve?

If you have consented for the researchers to phone you about the study, you can expect a phone call from Sarah Burnett-Stuart or Natalie Chua Yi Ling in the next couple of weeks. During this phone call, you will have a chance to ask questions about the study. If you are interested in participating, you will be able to arrange an appointment for participation and Sarah or Natalie will then send you a consent form via email (or post if email isn't convenient). You would be asked to read this information sheet and the consent form and, if you consent to take part, to bring a signed copy of the consent form to the appointment. If you decide that you don't consent to the terms on the consent form, you can contact the researchers via phone or email to cancel the appointment.

The appointment itself may last up to 2 hours, will take place at the eating disorders service where you are receiving treatment, and will be with either Natalie or Sarah. You will have the option of having a break part-way through. The appointment will be audio recorded,

and the recording will be stored securely and deleted after the study has been written up. Transcripts will be anonymised and stored on an encrypted device so that nobody outside the study team can access your interview.

At the beginning of the appointment, you will be asked some questions about you and your eating disorder. The researchers will also ask your consent to request your most recent body mass index (BMI) measurement from your named clinician following the appointment. This information will be stored in a locked filing cabinet on [redacted] and will be securely disposed of after the study ends. When the study is written up, no details of individual participants will be included so that you will remain anonymous.

In the first half of the appointment, the researcher will have a conversation with your internal anorexic 'voice' or 'anorexic self' (whichever term you prefer) using 'chairwork'. Chairwork can be described as an experiential process using chairs to facilitate the conversation between you and your internal 'anorexic voice' or 'anorexic self'. For example, you might be invited to move from your original chair to a new chair and be asked to speak with your 'anorexic voice' while you are seated in your new chair. You may than be invited to return to your original chair and respond to what your 'anorexic voice' or 'anorexic self' might have expressed.

The second half of the appointment will focus on how you experienced this conversation between the researcher and your anorexic voice. There are no right or wrong answers, we are just interested to hear your perspective.

Do I have to take part?

You do not have to take part, and should not feel under any pressure to do so. Your decision to participate/not participate in the study will not affect your treatment in the eating disorder service.

What are the possible benefits of taking part?

We hope that taking part in this study may help to develop your understanding of your anorexic 'voice'/ 'anorexic self' and your eating disorder more generally. You will carry on with the treatment you are having with your eating disorder service and this will not be affected by your decision to take part or not.

What are the possible disadvantages of taking part, and how have these been addressed?

Participating in this study will involve attending one appointment at your local eating disorder clinic, which may last up to 2 hours. You will have the option to take a break half way through the appointment.

There is always a small risk that some individuals may find the research interview upsetting as it concerns potentially sensitive and private topics. However, the appointment is designed to be a comfortable as possible and you can choose to stop or take a break at any point.

Additionally, your clinician and treatment team will be informed of when the research appointment is taking place so that a member of staff who you are familiar with can be available to provide any support you need after your appointment. You will also be given a 'support card', explaining the different avenues of support available to you, including a helpline run by the charity 'Beat', which offers support outside of working hours.

As with any study, there is a very small risk of breaching confidentiality. However, careful safeguards have been put in place to prevent this. Research appointments will take place on NHS premises in private consultation rooms. Audio recordings of research interviews will be stored on encrypted devices and deleted after the study has been written up. Transcripts will be anonymous, leaving out any identifiable information. Completed consent forms and anonymised demographic information (e.g. gender, age, BMI) will be stored in separate locked filing cabinets on [redacted] Anonymity will be maintained when the study is written up. The only situation in which confidentiality should be breached is if a participant discloses a risk of harm to themselves or others, as this information would need to be passed on to their clinician in the eating disorders service.

More information about UCL policies on processing personal data during research is available at the following link: https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice.

Who has been involved in planning, funding and reviewing this study?

This research is being carried out as part of two doctoral theses at University College London (UCL). UCL has provided the funding to reimburse participants for their time. Individuals using the Eating Disorders Services at [redacted] have reviewed the design of the study. The project has been reviewed and approved by staff at UCL, as well as the 'Joint Research Office' on behalf of UCL (the study's 'sponsor'), and 'Research and Development' Departments at all of the NHS trusts involved [redacted]

and [redacted]. The study has also received ethical approval from an NHS Research Ethics Committee.

What if I don't want to carry on with the study?

We don't want to put any pressure on you to participate, and you have the right to withdraw from the study at any point.

Deciding to withdraw from the study would in no way impact your treatment in the eating disorders service. If you decide to withdraw part way through, your data will not be used in the research.

What will happen to the results of the study?

The researchers will present the results of the study to staff and service users at Vincent Square Eating Disorders Service. If you are a client at a different eating disorders service, you would still be welcome to attend this presentation.

The study will be written up for two doctoral theses at UCL. The researchers also hope to publish the research in a peer-reviewed academic journal and to present the findings at eating disorders conferences.

Legal information

Data protection

The study is compliant with the requirements of General Data Protection Regulation (2016/679) and the Data Protection Act (2018). UCL is the sponsor for this study based in the United Kingdom, so will be using information from you in order to undertake this study and will act as the data controller for this study. This means that UCL is responsible for

looking after your information and using it properly. The only identifiable information about you that would be retained after the study finishes would be your signed consent form, which would be securely stored on a password protected file on a UCL computer for 10 years after the study ends. All other identifiable information about you would be securely disposed of immediately after the study finishes. Anonymised transcripts of research appointments and demographic information about the sample as a whole will be securely archived at UCL for 20 years after the study ends.

You can find out more about how we use your information at https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice or by contacting data-protection@ucl.ac.uk.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your research doctor if you would like more information on this.

In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to Dr. Lucy Serpell, who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then

pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Further information and contact details

The researchers would be happy to answer any additional questions that you might have about the study. Contact details are below:

Students running the project:

- Natalie Chua Yi Ling: [redacted]
- Sarah Burnett-Stuart: [redacted]

Supervisors overseeing the research:

- Lucy Serpell: [redacted]
- Matthew Pugh: [redacted]

Phone: 020 3315 2104 (ask to speak with Sarah Burnett-Stuart, Natalie Chua Yi Ling, or Matthew Pugh)

Appendix 03: Semi Structured Interview

(post voice dialogue interview)

PHASE FIVE - Reflecting on the DIS-ED

The participant is asked if they would like to take a break before discussing their experiences of engaging in the DIS-ED.

You did a great job. Well done. Before we explore what your experience of talking with your EDV/S was like, would you like to take a break? About 10 mins

Wherever possible, the participant is encouraged to elaborate on their responses during the phase four interview (e.g. "Can you say more about that? Can you give me an example of that?").

Sample interview questions:

- How did you experience the interview? What stood out to you?
- What was it like to speak as your EDV/S?
- What was it like to respond to your EDV/S?
- How do you understand the EDV/S now? How do you feel towards it?
- How do you understand your eating difficulties after the interview?
- What was helpful or unhelpful about the interview we've had?
- What did you like or dislike about the process?
- What do you think you will take away from this experience?
- Overall, how would you describe your experience of this interview?

Appendix 04: Support Card

University College London Hospitals NHS
NHS Foundation Trust

Support Card

If you feel stressed or worried after taking part in this study, support is available to you. The following individuals / services can offer you support around any of the concerns you might have. Some of these services are able to offer help outside of normal office hours.

1. **Request to speak to your clinician or a member of staff that you are comfortable with:** If you have any questions or concerns after the appointment, you can ask to meet with your clinician or a member of staff in your treatment team. This might be your initial assessor or your therapist.

2. **Contacting Beat:** To access support after working hours (i.e. 5pm), you may choose to contact Beat, England's leading eating disorder charity.

   - Beat offers three different helplines that are open 365 days a year from 12pm – 8pm on weekdays and 4pm – 8pm on weekends and bank holidays. You will be speaking to a trained support worker.

     Helpline Contact Information:
     - **Adult line: 0808 801 06777**
     - **Student line: 0808 801 0811**
     - **Youth line: 0808 801 0711**

     These helplines are free to call from all phones. If the lines are busy, you can opt to chat online with a trained support worker.

     One to one web chat:
     - https://www.beateatingdisorders.org.uk/support-services/helplines/one-to-one

3. **Contact the Samaritans:** For 24/7 support, you may choose to contact the Samaritans. The Samaritans is a registered charity that provides support to anyone who is experiencing emotional distress throughout the United Kingdom. Samaritans Helpline Contact Information: **116 123**. This helpline is free to call from all phones.

4. **Contacting your General Practitioner (GP):** If you feel that you require additional support, you may also choose to contact your GP.

Appendix 05:

Dialogical Interview Schedule for Eating Disorders (DIS-ED)

Dialogical Interview Schedule for Eating Disorders (DIS-ED)

INTRODUCING THE DIS-ED

The DIS-ED begins with a brief introduction to the interview and its aims. Talking with internal voices and self-parts is not for everyone - engaging in the DIS-ED should always be consensual. Individuals are encouraged to discuss any questions or concerns about the approach before the interview before it begins.

Shall I begin by explaining the aims of this interview in a bit more detail?

Research suggests that many individuals experience an internal eating disorder voice. Other individuals describe experiencing not so much a voice, but rather a particular experience of the themselves linked to their eating disorder - what we might call their 'anorexic self' or 'anorexic part'. Internal voices and the experience of being made up of different selves, parts, or subpersonalities is very normal.

The aim of this interview is to simply get to know your 'eating disorder voice' or 'eating disorder self' better. We can do this by asking your eating disorder voice some questions. Do you see this part as more of a voice or more of a self? There are no right or wrong answers to these questions. I hope you will find this process of speaking with your eating disorder voice or self (EDV/S) very natural.

The interview is divided into three parts. First, I will ask you some very general questions about your experiences of your EDV/S. Afterwards, I will ask you to change seats and to speak from the perspective of your EDV/S. Last of all, I will ask you to return to your origin seat and reflect on what your EDV/S has said. I'll help guide you through this process.

Once we have completed the interview, we will take short break. After this, I would like to ask some very general questions about how you found the interview and the process of speaking with your EDV/S.

Do you have any questions?

Would you like to give it a try?

PHASE ONE - Exploring experiences of the EDV/S

The DIS-ED begins by exploring the individuals' general experiences of their EDV/S.

Would it be ok if we begin by talking a little about your EDV/S?

Sample interview questions:

- Tell me about your experiences of your EDV/S. What is it like?
- How do you feel about it?

PHASE TWO - Dialogue with the EDV/S

Dialogue with the EDV/S involves the client speaking from the perspective of their EDV/S. Dialogues with the EDV/S can be either direct (inviting the individual to change seats and speak as their EDV/S) or indirect (inviting the client to convey, in the third person, what the EDV/S is saying).

DIRECT DIALOGUE with the EDV/S: If you feel ready, I'd like to speak with your EDV/S for a little while. All you have to do is change seats and speak as that part of your self. If at any time you want to stop, we can. Does that sound ok?

- (You can either stay in the same chair and move it to a different spot/position, or you can change seats and speak as your EDV/S).

INDIRECT DIALOGUE with the EDV/S: I'd like to ask your EDV/S some questions. When I do, I'd like you to relay these questions to your EDV/S and to let me know how it responds. For example, I might ask you to say "hello" to the EDV/S on my behalf and to let me know what it says back.

Irrespective of whether dialogue is direct or indirect, the client is asked to place a chair representing the EDV/S somewhere in the room which feels appropriate and comfortable.

Where would you like the chair for your EDV/S to be? [*Individual locates chair in the room*].

- Give them the option of staying in the same chair and moving it or using a different chair.

It can sometimes be helpful to check whether there is anything the individual would like to ask or explore with the EDV/S.

Before we begin, is there anything particular you would like me to ask your EDV/S or things you'd like to know?

It is important that the interviewer communicates with the EDV/S in a manner which is respectful, curious, and non-confrontational. The EDV/S needs to feel secure and understood during dialogue. It can be helpful to think of the dialogue as being like getting to know an interesting stranger at a party.

DIRECT DIALOGUE with the EDV/S: I'd now like you to now change seats and to adopt the perspective of your EDV/s. [*Client changes seats*]. In this chair, I'd like you to speak as your EDV/S.

- Mirror your voice to match your clients voice/tone/pace.
- Be genuinely curious, as though you are meeting someone for the first time: e.g. Canyou give me an example? Mmm.. That's interesting… that makes sense… oh really?

Sample interview questions for the EDV/S:

Slow down, and give time for embodiment.

- So, [participant] is over here and you are his/her eating disorder voice.
- It's nice to meet you.
- Tell me a bit about yourself. What's your role in this person's life? What do you do? (Function)
- What situations tend to bring you out? (Content)
    - How about when it comes to eating?
    - How about when it comes to the way this individual looks?
- What do you tend to say in situations like that? (Content)
- When did you first come into this person's life? Do you remember when you came to be? (Origins)
- What were your reasons for becoming a part of their life at that time? (Origins)
- Did you learn this role from anyone? Who do you take after? (Origins)
- What's it like playing this role for this person? Do you ever run into problems? (Relationship)
- How do you feel towards this person? How do you think this person feels towards you? (Relationship)
- Are you aware of any difficulties you might be causing this individual? (Relationship)
- Why do you do this for this person? (Intent)
- What do you want for this individual? (Intent)
- What's important to you? (Intent)
- What do you want for this individual? (Intent)
- What concerns you? (Underlying feelings)
- What do you think might happen if you weren't a part of this person's life? (Underlying feelings)
- If I could see you as you are, what would you look like? (Imagery) – *drop this qn if you feel like you are losing them*
- What would you like to be called? (Ask at the end!)

The dialogue ends with the interviewer thanking the EDV/S for speaking and inviting it to share any parting words.

Thank you for taking the time to speak with me today. It's been interesting getting to you know you better. Is there anything else that you would like to say or that I need to know before we draw this talk to a close?

PHASE THREE – Decentring from the EDV/S

The third phase of the DIS-ED invites the individual to 'step back' and observe the EDV/S from a new, decentred perspective (known as the 'witness state' in Voice Dialogue). The individual is first asked to return to their original chair and to separate from the EDV/S.

> I'd like you to return to your original chair now. As you best you can, leave your EDV/S in the empty seat and connect with your self again as you change chairs. [*Individual moves seats*].

Some individuals may need a little time to ground themselves when switching perspectives (e.g. stretching, attending to their breathing, walking around their chair, etc.).

> Let's take a moment to separate from your EDV/S by bringing attention to the breath. Find a rate of breathing that feels calm, soothing, and grounded. Focus on the experience of the air moving in and out of your body.

At this point, it is helpful to 'check-in' with the client and establish whether they have been able to separate from the EDV/S

> How are you feeling? Do you feel a little more separated from that side of your self?

Once the client has separated from the EDV/S, they are invited to stand beside the therapist, who then provides a summary of what this self has conveyed.

> Can you come and stand beside me? I'd now like to provide my understanding of what I have heard your EDV/S share with us…

Once a summary has been provided, the therapist draws attention to the decentred and observational nature of this new perspective.

> And now notice how, from this position, you can step back from the EDV/S and reflect upon it from more of a distance. [*Gestures to the empty chair*]. Witnessing what is happening between these parts of your self without needing to be involved.
>
> **When reflecting, refer to the patient standing next to you as (You), the EDV (in the chair), and original chair (patient's name, e.g. Leslie).**

The client then returns to their first chair.

PHASE FOUR - Reflecting on the dialogical process

The final part of the interview provides an opportunity to reflect on the dialogue and their impressions of the EDV/S.

Sample interview questions:

- What do you make of what the EDV/S (***use the name participant has given to the EDV)*** has said?
- Is there anything you would like to say to the EDV/S?

Whilst the aim of this phase is not to facilitate a dialogue between the individual and their EDV/S, sometimes individuals will want to respond to their EDV/S directly. If statements seem to be directed at the EDV/S, rather than the interviewer, the individual can be invited to convey these to the empty chair ("Would you like to try saying that to your EDV/S?").

Appendix 06:

Outline of Each Trainee's Contributions

This joint research project consists of two independent research questions. The present author, NC, was responsible for analysing the data for part two of the study, and her co-researcher, SS, was responsible for analysing the data for part one of the study.

Part One:

Part one of this study aims to explore how the anorexic voice is implicated in the development and maintenance of anorexia nervosa from a novel perspective: that of the anorexic voice. The specific research question related to this is:

1. What insights can the anorexic voice offer on its role in the onset, development and maintenance of disordered eating?

Part Two:

Part two of this study explores the subjective experience of participating in voice dialogues. The specific research question related to this is:

2. How do individuals with Anorexia Nervosa (AN) experience the voice-dialogue method? An interpretative phenomenological analysis.