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RESEARCH ARTICLE

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Interviewing anorexia: How do individuals given a diagnosis of anorexia nervosa experience Voice Dialogue with their eating disorder voice? A qualitative analysis

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Abstract

A proportion of individuals given an eating disorder diagnosis describe the experience of an eating disorder 'voice' (EDV). However, methods for working with this experience are currently lacking. Voice Dialogue (Stone & Stone, 1989) involves direct communication between a facilitator and parts of the self to increase awareness, understanding, and separation from inner voices. Adapted forms of this method have shown promise in working with voices in psychosis. This study aimed to explore the experience and acceptability of Voice Dialogue amongst individuals with anorexia nervosa who experience an EDV. Nine women participated in a semistructured interview following a single Voice Dialogue session. Interview transcripts were analysed using interpretative phenomenological analysis (IPA). Three overarching themes were identified as follows: (i) "separating from the EDV"; (ii) "better understanding of the EDV"; and (iii) "hopeful, motivated, and afraid of recovery". The majority of participants found Voice Dialogue acceptable and helpful for exploring their EDV. Whilst preliminary, the results suggest that Voice Dialogue has potential in terms of helping individuals establish a more constructive relationship with their EDV and motivating change. Further research is needed to build upon these findings. Implications for addressing the EDV using voice-focused interventions are explored.

KEYWORDS
anorexia nervosa, chairwork, eating disorder voice, eating disorders, Voice Dialogue

1 | INTRODUCTION

Anorexia nervosa (AN) is a potentially life-threatening experience, which a significant proportion of individuals find difficult to overcome (Arcelus et al., 2011; Blake et al., 1997; Halmi et al., 2005; Knowles et al., 2013). Unfortunately, existing approaches often have unsatisfactory effects (DeJong et al., 2012; Knowles et al., 2013; Rance et al., 2017; Watson & Bulik, 2013). Accordingly, there exists a need to develop innovative and more effective interventions for engaging and working with individuals with AN.

1.1 | The eating disorder voice

Voice experiences, their association with psychological distress, how they are understood transdiagnostically and in the context of individuals' life experiences has begun to change over recent decades (e.g., Aleman & Laroi, 2008; Longden et al., 2012; Schnackenberg, Fleming, Walker, & Martin, 2018; Toh et al., 2015; Waters & Fernyhough, 2017). Rather than being a meaningless phenomenon, voices are understood to be an important source of meaning-filled information regarding personal threats, vulnerability, and unresolved trauma (Romme & Escher, 2000; Steel et al., 2020). Furthermore,

voices may serve a protective function insofar as it is psychologically advantageous to experience internal conflicts as voice-like (Corstens et al., 2012). These ideas indicate that the content of voices is both relevant and worth engaging with.

A significant number of individuals with eating disorders experience an eating disorder voice (EDV) (Pugh et al., 2018) or, in the context of AN, an "anorexic voice" (Tierney & Fox, 2010). Somewhat distinct from the more typical anorexic or self-critical cognitions observed in eating disorders (Noordenbos et al., 2014), the EDV describes a hostile second- or third-person commentary related to eating, shape, and weight (Pugh & Waller, 2016), experienced as internally generated yet separate from the self (Fox et al., 2012): a "subself" containing "needs, feelings, perceptions, and behavior that have been dissociated from the patient's total self-experience" (Sands, 1991, p.37).

Existing studies suggest that nonconstructive relationships with EDVs may play a role in developing, maintaining, and recovering from AN (Pugh, 2020). For example, research has associated the severity of disordered eating with EDVs perceived to be more powerful than the self (Pugh & Waller, 2016, 2017), as well as ambivalence about change and recovery (Tierney & Fox, 2011). Accordingly, changing the ways individuals relate, respond to, and understand the EDV may support recovery and prevent relapse (Jenkins & Ogden, 2012; Tierney & Fox, 2010). Given that studies examining EDV interventions have reported promising outcomes (e.g., Dolhanty & Greenberg, 2007; Hibbs et al., in press; Mountford & Waller, 2006), developing voice-related interventions may be an important direction for working with individuals with eating disorders.

Key Practitioner Message

- The internal eating disorder voice (EDV) appears to play a role in the development and maintenance of anorexia nervosa.
- Few studies have examined methods for working with the EDV.
- Voice Dialogue may help individuals understand and relate to their EDV in helpful ways.

1.2 | Chairwork and the voice dialogue method

Chairwork refers to a collection of experiential procedures which use chairs, positioning, movement, and dialogue to facilitate change (Pugh et al., 2020). A central premise of chairwork is that the self is composed of multiple "parts," "voices" or "I-positions." These include self-related representations (internal I-positions such as one's "inner critic") and representations of other individuals (external I-positions such one's "rejecting parent") (Hermans & Gieser, 2012). Far from being pathological, self-multiplicity describes a normal (and often helpful) aspect of psychological experience (Carter, 2008; Kurzban, 2010). Chairwork aims to facilitate here-and-now dialogical exchanges between these parts of the self, represented and concretized by chairs, for therapeutic purposes. Chair-based methods are used in several evidence-based therapies, including cognitive behavioural therapy (Pugh, 2019a, 2019b), compassion focused therapy (Bell et al., 2020), emotion-focused therapy (Greenberg, 2015), and schema therapy (Young et al., 2003). Moreover, research indicates that chairwork can be beneficial for individuals who experience voices. For example, two-chair dialogues with EDVs have produced positive effects (e.g., Dolhanty & Greenberg, 2009). In addition, two-chair role-plays in which individuals develop and rehearse assertive responses to voices appear to be helpful for people given a diagnosis of psychosis (Hayward et al., 2017).

Chairwork has been subdivided into a number of key procedures. These include "dialogues" (using chairs to facilitate conversations between two or more parts of the self), "depictions" (using chairs to map and measure relationships between parts of the self), "dramatizations" (using chars to recreate real or hypothetical scenes from the client's life), and "interviews" (using chairs to question parts of the self) (Pugh et al., 2020). Voice Dialogue (Stone & Stone, 1989) is both an "interview" style of chairwork and a distinct therapeutic method, which seeks to facilitate expression and build awareness of parts of the self through direct communication (Stone & Stone, 2007).[1] The process of Voice Dialogue involves the client changing location (either by moving their seat or switching to another chair) and adopting the perspective of a part of the self. Questions are then put to the part by the facilitator, such as its reasons for being, wants and needs, and relationship with other parts (for further examples, see Corstens et al., 2012; Pugh, 2019a; Stone & Stone, 1989). Once fully expressed, the client returns to their original position with enhanced awareness of the part. Through this cycle of embodiment and decentring, Voice Dialogue helps individuals differentiate understand, and assimilate inner voices. In doing so, choice and flexibility over which parts of the self are acted upon is enhanced. Furthermore, insight into the developmental origins, functions, and intentions of parts of the self is acquired.

Therapeutic approaches such as schema therapy (Arntz et al., 2013) and cognitive behavioural therapy (Pugh, 2019a) incorporate interventions that are similar to Voice Dialogue, as do approaches for voice-related experiences (e.g., Heriot-Maitland et al., 2019). "Making Sense of Voices" (MSoV; Corstens et al., 2012; Romme & Escher, 2008/2013) (also referred to as experience focussed counselling; Schnackenberg, Fleming, & Martin, 2018) is one such approach, which incorporates interviewing procedures to facilitate communication between voices and the voice-hearer. In the context of MSoV, voices represent important reactions to significant life events and a valuable source of knowledge (Corstens & Longden, 2013; Longden, Corstens, et al., 2012; Schnackenberg & Martin, 2014). Accordingly, the aim of talking with voices is to comprehend the biography, meaning, and intentions of voices and resolve voice-hearer conflicts (Corstens et al., 2012). Studies suggest that, for people experiencing psychosis, Voice Dialogue provides understanding and increased control over voices and reduces voice-related

distress (Longden, Corstens, Morrison, et al., 2021; Longden, Corstens, Pyle, et al., 2021; Schnackenberg, Fleming, Walker, & Martin, 2018; Steel et al., 2020). However, research is yet to explore the applications of Voice Dialogue to voices experienced in other groups.

In summary, voice-like experiences represent a transdiagnostic phenomenon. Research suggests that chairwork-centred methods such as Voice Dialogue help individuals develop new understandings of voice experiences, enabling them to relate and respond to these in positive ways. Furthermore, experiential approaches to working with voices may be advantageous due to their immediacy, memorability, and multisensory nature (Bell et al., 2020; Pugh, 2019b). Research is needed to determine the acceptability and utility of interventions for voice-like experiences in EDs, with the Voice Dialogue method being a promising candidate.

This is the first study to investigate the use of Voice Dialogue in the context of disordered eating. Given its exploratory nature, a qualitative methodology was adopted to provide a rich account of the experience and acceptability of talking with EDVs amongst individuals with AN. Interpretative phenomenological analysis (IPA) was the chosen as the analytic method due to its emphasis on exploring lived experiences that are complex and emotionally laden (Smith & Osborn, 2015).

2 | METHODS

2.1 | Ethics statement

This study received approval from The London Bloomsbury National Health Research Ethics Committee.

2.2 | Participants

Participants were recruited from four specialist public health eating disorder clinics in Greater London (United Kingdom). Participants were identified via within-service advertisements or by their lead professional. Inclusion criteria were a self-reported EDV and currently receiving input for AN. Nine individuals agreed to take part in the study. Table 1 summarizes their demographic information. All identifiable information has been anonymized. The age range of participants was 20–31, and their mean body mass index (BMI) was 17.3. The average self-reported duration of disordered eating was approximately 13 years. All participants were attending outpatient therapy sessions. Two thirds of the sample described their ethnicity as White British. All participants provided informed consent at the point of recruitment.

2.3 | Procedure

Prior to data collection, the first (NCYL) and third (SBS) authors, who were trainee Clinical Psychologists, received approximately 15 h of training and self-directed study in the Voice Dialogue method, provided by the second author (MP). MP is a Clinical Psychologist with an interest in chairwork and has trained in Voice Dialogue. Training in this study included didactic teaching, demonstrations, personal Voice Dialogue facilitation, and practice role-plays.

NCYL and SBS conducted the Voice Dialogue sessions and post-intervention interviews; these took place sequentially and during the same meeting with participants. Voice Dialogue facilitation guidelines and the postintervention interview schedule are summarized in a study protocol (Pugh, 2019c). Demographic information was collected at the start of the meeting. A single Voice Dialogue session followed, which lasted between 45–90 min (mean = 60 min), followed by a postintervention qualitative interview that lasted 20–60 min (mean = 45 min). Participants were offered a short break between the Voice Dialogue session and the postintervention interview.

Voice Dialogue sessions were semistructured and divided into four phases. In the first phase, participants were asked general questions about their EDV, such as when and how they experienced this part of the self. In the second phase, participants moved to a different location (either by changing seats and moving their chair into a new space) and adopted the perspective of their EDV. After welcoming it, exploratory questions were put to the EDV, such as its feelings

TABLE 1 Participant demographics

Alias	Age range (in years)	Ethnicity	AN subtype	BMI	Self-reported duration of eating disorder (years)	Current treatment setting
Gwen	18–24	White British	Restrictive	14.4	2	Outpatient
Maia	25–44	White Irish	Restrictive	16.6	20	Outpatient
Audrey	25–44	White Other	Restrictive	16.5	14	Outpatient
Yana	18–24	White British	Restrictive	17.8	3	Outpatient
Shona	25–44	White British	Restrictive	17.9	16	Outpatient
Isabel	25–44	British Pakistani	Binge/purge	18.1	15	Outpatient
Eisha	18–24	White British	Binge/purge	19.2	7	Outpatient
Hilda	25–44	White British	Restrictive	17.9	18	Outpatient
Jenna	25–44	White British	Restrictive	17.9	18	Outpatient

towards the participant, typical comments, concerns and intentions, developmental origins, and appearance. In the third phase, the EDV was thanked for its contribution and the participant returned to their original ('central') position, thereby separating from their EDV. The facilitator then supported participants' awareness and separation from their EDV by summarising what the voice had conveyed in the third-person. In the final phase, participants shared their reflections on what the EDV had conveyed and responded to it if they wished (see Pugh, 2019c).

2.4 | Data collection

The fourth author designed the draft facilitation protocol and post-intervention qualitative interview schedule. The draft was reviewed by three service-users with lived experience of AN who were receiving care at the research sites. Revisions included referring to the EDV as a voice or a self, depending on each participant's preference. The protocol deviated slightly from "classical" Voice Dialogue insofar as participants were given the option to respond to their EDV towards the end of the session. This component was added in light of other voice-related research, suggesting that dialoguing with voices is associated with reduced voice-related distress (Nayani & David, 1996).

Postintervention interviews aimed to generate a descriptive account of the experience of Voice Dialogue and its acceptability. Interviews were semistructured in order to explore and elaborate emerging issues. Postintervention interviews were audio-recorded and transcribed verbatim by NCYL and SBS using audio transcription software (Trint), who concurrently checked for accuracy and removed identifiable information. The length of the postintervention interviews ranged from approximately 2000–6500 words.

2.5 | Data analysis

Interviews were analysed using IPA (Smith et al., 2009). IPA provides a rich account of how individuals make sense of complex experiences such as Voice Dialogue and so aligned with the study's aims. The first author conducted the analysis according to the five-stage process described by Smith and Osborn (2003). Interview transcripts were read and reread multiple times to build familiarity with participants' accounts (stage one). This was followed by line-by-line coding to develop initial themes (stage two). Next, initial themes were refined to form salient emergent themes (stage three). Similar or related themes were then clustered to create superordinate themes (stage four). This sequence was repeated for each interview transcript. Finally, superordinate themes were compared across the transcripts to identify shared and discrepant experiences amongst the participants (stage five). To ensure the credibility of themes, individual case analyses were audited by the fourth author. Direct quotations from interview transcripts have been provided so that readers can assess the reliability and plausibility of the analysis (Vetere & Dallos, 2005).

2.6 | Reflexivity

As the analytic process of IPA is inherently interpretative (Smith et al., 2009), reflexivity is needed on behalf of the researcher (Smith et al., 2009). As the primary analyst, the first author constantly reviewed her expectations and interpretation of the data, monitoring their impact and noting how the analytic findings altered them. The researcher acknowledges her role as a Chinese Singaporean female trainee clinical psychologist working within an eating disorder service and how her own experiences of chairwork have the potential to influence the interpretation and analysis of data (e.g., assuming that Voice Dialogue is beneficial). An example of reflexivity, when this assumption was apparent, the transcript, was re-analysed so exceptions could be explored.

3 | RESULTS

The analytic procedure yielded three superordinate themes and 14 subthemes (Table 2).

TABLE 2 Summary of themes

Main themes	Subthemes	Participants reporting theme
1. Separating from the eating disorder voice	a). Meta-cognition: Less identified with the eating disorder voice	8/9
	b). Less inhibition talking about the eating disorder voice	8/9
	c). Eating disorder voice as a part of the self that needs to be understood	8/9
	d). Surprise at ease of engaging in voice dialogue	8/9
	e). Voice dialogue feels uncomfortable	3/9
2. Better understanding of the eating disorder voice	a). More compassion towards the self and the eating disorder voice	8/9
	b). Recognising the negative impact of the eating disorder voice	9/9
3. Hopeful, motivated and afraid of recovery	a). Eating disorder voice as an increasingly ego-dystonic phenomenon	8/9
	b). Motivation to challenge the eating disorder voice	8/9
	c). Conflicting emotions about recovery	8/9

3.1 | Superordinate theme 1: Separating from the EDV

Most participants reported that using chairs to represent the EDV, alongside movement between seats, was a salient aspect of Voice Dialogue. The chairs created a physical and psychological boundary between the voice (EDV) and the self, helping participants to concretize, personify, and relate to their EDV as a distinct entity. The process of separation also allowed participants to voice this part with greater ease, differentiate their thoughts and feelings from those of their EDV, and connect with other parts of the self, such as those not identified with AN.

> *I like how you have to switch chairs […] 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.* (Gwen)

3.1.1 | Subtheme 1a: Metacognition: Less identified with the EDV

Most participants felt that using different chairs enhanced their ability to witness their EDV from a more meta-cognitive, "observing" perspective. Consequently, they understood their EDV differently, identified less with it, and experienced "relief" from its narrative.

> *It was nice having the separation between the two and also just feeling that kind of a bit a sense of relief afterwards […] 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.* (Jenna)

3.1.2 | Subtheme 1b: Less inhibition talking about the EDV

Some participants also reported feeling less inhibited about discussing their experience of the EDV when this part was located and embodied in a different chair. Participants were then able to speak about their struggles more openly and relate to their EDV in innovative ways.

> *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 […] When you're talking about it and it's a completely separate thing and it's in first person, it's like you can just talk about it freely.* (Eisha)

Similarly, Isabel felt that separating from the EDV helped reduce its perceived power. Allowing the EDV to express itself directly also seemed to reduce the likelihood that it would attempt to communicate in other ways, such as through restricted eating:

> *It's a bullying, secretive thing, where 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. […] When it was then sitting here and talking, it almost lost that control.* (Isabel)

3.1.3 | Subtheme 1c: EDV as a part of the self that needs to be understood

Most participants also valued having "space" to acknowledge and listen to the perspective of their EDV, an experience which was rare in the care they had received to date. Participants wondered if it could be beneficial to dialogue with their EDV more frequently during their therapy sessions, helping them feel less "attacked" by the voice and understood by professionals and loved ones.

> *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 [the EDV] was listened to. And that's often what my ED needs and doesn't get […] I'm definitely going to bring in that technique (Voice Dialogue) to all the therapy sessions.* (Maia)

3.1.4 | Subtheme 1d: Surprise at the ease of engaging in Voice Dialogue

Interestingly, while most participants were able to speak from the perspective of their EDV, many were initially "sceptical" about their ability to do so. Some participants also worried that they would feel overwhelmed when "facing" their EDV and speaking from its perspective. Participants were, therefore, surprised when they could embody and interact with their EDV without becoming acutely distressed.

> *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 […] The thought of like, letting it just kind of take over, I was 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.* (Eisha)

3.1.5 | Subtheme 1e: Voice Dialogue feels uncomfortable

For a minority of participants, Voice Dialogue felt uncomfortable at times. For example, one participant (Hilda) felt that the use of different chairs was unnecessary; rather than increasing the "ease" with which she could speak as her EDV, the use of chairs felt "condescending" and "embarrassing."

> *I don't think I really needed to move chairs. […] 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.* (Hilda)

Others also found that speaking as their EDV was emotionally demanding: two individuals described feeling considerable anger and disgust towards the EDV after Voice Dialogue. For example, although Audrey spoke as her EDV with ease, she described feeling "horrible" after "being the illness" (EDV). Her account suggests that, while beneficial, dialoguing as the EDV can stimulate uncomfortable feelings such as disgust towards the voice of her eating disorder.

> *I felt so disgusting after, I don't know, after being the illness. […] It was horrible to feel like that, but at the same time, maybe it was more helpful than not helpful.* (Audrey)

3.2 | Superordinate theme 2: Better understanding of the EDV

Voice Dialogue provided participants with insights into the functions and intentions of their EDV. For example, many participants described having a new understanding of their EDV as a "false sense of security", which protected them from pain, vulnerability, and the challenges of daily life. Often, this realization prompted participants to see their EDV as an entity they needed 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 […] 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.* (Isabel)

3.2.1 | Subtheme 2a: More compassion towards the self and the EDV

Many participants were "surprised" by discovering their voice was "well-intentioned", insofar as it was concerned for their well-being and survival. This revelation contrasted with their everyday experience of the EDV as a hostile and malevolent voice. Consequently, participants felt more compassion and sympathy towards their EDV.

> *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. [The EDV] is just trying its best to, like, get me through life, but it's just struggling as much as I am.* (Yana)

3.2.2 | Subtheme 2b: Recognising the negative impact of the EDV

At the same time, Voice Dialogue made participants more aware of the problems associated with their current perception and ways of relating to the EDV, which they felt required urgent attention.

> *I didn't quite see how big [the EDV] 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)

For many participants, these realizations led to a spontaneous challenging of the EDV's advice. It also elicited adaptive emotions, such as anger and sadness related to their struggles with self-attacking and disordered eating.

> *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)

Voice Dialogue also led participants to identify similarities with interpersonal relationships. For example, some participants likened their relationship with the EDV to an "abusive" and "co-dependent relationship" in which they felt compellingly attached.

> *I definitely needed [the EDV] at that time, but now it's kind of like I go back to it out of habit. It's like an over-protective, kind of self-serving abusive relationship.* (Isabel)

3.2.3 | Superordinate theme 3: Hopeful, motivated, and afraid of recovery

Participants described feeling more empowered, open-minded, and hopeful about their recovery after Voice Dialogue. For example, Shona described how the dialogue allowed her to experience a part of herself that was distinct from her EDV, thus giving her optimism that she might rediscover an identity outside of her ED.

> *Sometimes I think this [the 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 [the EDV].* (Shona)

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

After Voice Dialogue, most participants experienced their EDV as more ego-dystonic. This was associated with increased curiosity and motivation to change how they related to this part of the self.

> *I'm really happy for [Voice Dialogue], because I need to face, sometimes, what it [EDV] did before, what it did to me […] And I really want to find out if there's any chance to remove it forever from my life.* (Audrey)

3.2.5 | Subtheme 3b: Motivation to challenge the EDV

Most participants felt able to establish a more constructive relationship with their EDV after Voice Dialogue and maintain healthy boundaries. Their accounts suggested that this was a critical skill for their recovery.

> *When I say, for instance, throw bits of my food secretly in the bin […] I'll just remind myself of [Voice Dialogue] and just remember that [the EDV] is very powerful […] 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)

Many participants also felt more "empowered" after expressing their needs and concerns directly to their EDV, which contrasted with the more submissive role they usually adopted in the relationship. Although speaking to the EDV was challenging, participants felt that this brought about important changes in the status quo.

> *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 appreciation in a genuine way […] I feel like an equal status to it, rather than like a lower who's being bullied. It's like, "Okay, I'm here now, and we're on the same level."* (Isabel)

3.2.6 | Subtheme 3c: Conflicting emotions about recovery

Finally, Voice Dialogue provided most participants with a medium to explore their conflicting emotions around recovery. It was apparent that whilst most participants felt more motivated to become independent from their EDV after the dialogue, this also brought concerns about their ability to function without it to the fore.

> *I just think [sniffles] as much as I don't want it, it is my friend. Like I'm scared to let it go […] 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)

4 | DISCUSSION

This study sought to generate preliminary insights into how individuals with AN experienced Voice Dialogue in the context of living with an EDV. Overall, most participants found the Voice Dialogue method acceptable and beneficial, both in terms of understanding their voice(s) better and motivating changes to their eating disorder.

Much like other clinical groups who describe voice-like experiences (e.g., individuals diagnosed with psychosis; Longden, Corstens, Morrison, et al., 2021; Schnackenberg, Fleming, Walker, & Martin, 2018), satisfaction with Voice Dialogue was generally high amongst individuals in this study. Participants felt that the dialogical process provided insights into the functions, intentions, consequences, and vulnerabilities underlying their EDV. Many participants were relieved to talk openly about, and directly to, their EDV, sometimes for the first time. Communicating with voices also appeared to bring about positive changes in how participants related to their EDV, inspiring both compassion and more assertive boundary setting. Positive outcomes have been reported in other voice experiencing groups following Voice Dialogue, including increased control, reduced distress, and insight into the meaning of voices (Steel et al., 2020). Interestingly, participants in this study did not report that establishing links between voices and autobiographical events was a feature of Voice Dialogue. Previous studies suggest that EDVs may be related to traumatic childhood experiences (Pugh et al., 2018) and that clarifying the origins of voices can be helpful (Corstens et al., 2012). Situating voices in a developmental framework may require additional Voice Dialogue sessions or could a less important issue for individuals with AN.

The positive effects of Voice Dialogue appeared to extend beyond just immediate changes in how individuals interacted with their EDV: most participants also described feeling more motivated and optimistic about their recovery postdialogue. Ambivalence about change is common in AN (Nordbø et al., 2012), while readiness to change is a robust predictor of outcome (Vall & Wade, 2015). Voice Dialogue appeared to bolster participants' motivation and optimism in two ways. First, participants reported that dialoguing with voices highlighted the potential risks of behaving in accordance with the EDV and the potential benefits of different ways of relating and courses of action (Tierney & Fox, 2010). Second, separating from the EDV helped individuals connect with an identity distinct from their eating disorder. Indeed, rediscovering and strengthening one's "true self" represents a vital task in recovery (Bruch, 1988; Oldershaw et al., 2019; Williams et al., 2016) and is emphasized in therapies for AN (Schmidt et al., 2015).

Given these beneficial effects, it is unsurprising that many participants were keen to dialogue with their EDV again following the intervention. Voice Dialogue is typically provided over multiple sessions in other voice experiencing groups, such as individuals with psychosis (Joachim Schnackenberg, personal communication, August, 2020). As well as benefitting the individual, some participants also felt

that additional dialogues might help their clinicians, family members, and friends develop a fuller understanding of the nature of their eating difficulties. Previous research has highlighted that service-users desire greater acknowledgement and intervention for the EDV (Davies et al., 2008; Tierney & Fox, 2011), though this is often unfulfilled (Rance et al., 2017). Overall, these findings suggest that Voice Dialogue is mainly acceptable to individuals with AN and could augment existing psychological therapies, as well as helping professionals better appreciate the lived experience of AN (Graham et al., 2019).

Voice Dialogue was not without challenges, however. Two participants reported that talking with the EDV generated anger and disgust, motivating rejection of this part of the self. For others, separating from the voice aroused fears about losing connection with their EDV. Emerging evidence suggests that the EDV may represent a key attachment in AN (Forsen Mantilla, Clinton, & Birgegard, 2019) and fulfils important needs such as guidance and companionship (Williams & Reid, 2012). Accordingly, distance from this part of the self may be accompanied by feelings of grief (Tierney & Fox, 2010). Attachment to the EDV was made more apparent during Voice Dialogue, raising questions for participants about its function, the needs underlying these, and other ways they might be fulfilled.

It is worth noting that while many participants were initially sceptical or apprehensive about Voice Dialogue, most were pleasantly surprised by the ease and meaningfulness of the intervention. Other studies also indicate that individuals do not experience Voice Dialogue as stressful or artificial (Schnackenberg, Fleming, & Martin, 2018). That said, not all participants in this study experienced Voice Dialogue positively. Accordingly, it is important to respect individuals' attitudes towards chairwork; rather than adopting an expert-led framework, we agree that clinicians should approach Voice Dialogue collaboratively and consider the needs and preferences of those they work with (Steel et al., 2020).

Elucidating the mechanisms of action underlying dialogical interventions is a key task for research (Pugh & Bell, 2020; Steel et al., 2020). Participants valued using chairs to concretize identification and separation from the EDV. Literal and metaphorical distance from the voice also enabled participants to mindfully "witness" this part of the self from afar and created space for the emergence of innovative internal voices (Hermans & Gieser, 2012; Stone & Stone, 2007). These findings support the assertion that space and movement are important processes in chairwork (Pugh & Bell, 2020), which appear to enhance individuals' metacognitive and attentional capacities (Pugh, 2019a), reduce overidentification with parts of the self that are experienced as distressing (Bell et al., 2020), and challenge problematic conceptualizations of the self as fixed and monolithic (Chadwick, 2003). Embodying and dialoguing as the EDV also generated "action insights" into the nature of voices which were previously unknown or unarticulated (Kellerman, 1992). More generally, participants' accounts are consistent with the theoretical assumptions of Voice Dialogue (Stone & Stone, 1989) and dialogical self-theory (Hermans, 2001): that the self is composed of multiple internal voices, an understanding of which offers increased choice and flexibility regarding subsequent action.

4.1 | Limitations

This study has several limitations. While most participants were underweight, one individual was not, potentially limiting the validity and generalisability of the findings. However, all participants reported an active EDV and were significantly underweight at the outset of their current care. In line with previous studies, this suggests that EDV is not a weight-dependent phenomenon (Pugh et al., 2018) and the relevance of Voice Dialogue is not weight-contingent. In line with IPA guidelines, the sample size was small but sufficient to generate a rich understanding of the experience of Voice Dialogue. In order to test the validity and generalisability of our results, future research should utilize a more diverse sample, including both males and females, as well as ethnic minority groups. Collecting additional data regarding participants' experiences of voices (e.g., self-reported length of voice-hearing, level of voice-related distress) would also help contextualize the findings. In addition, the time between the Voice Dialogue session and the postintervention interview was short in this study. Multiple sessions may have generated richer and more nuanced data, as well as helping determine if Voice Dialogue translates into changes in voice frequency, voice distress, and eating behaviour. Quantitative studies incorporating pre-intervention and post-intervention measures are now needed to measure the effects of Voice Dialogue. In addition, task analytic studies (Pascual-Leone et al., 2014) would help clarify which aspects of Voice Dialogue generate change (e.g., dialoguing as the EDV or separating from the EDV).

4.2 | Clinical implications

This study suggests that Voice Dialogue can be a valuable intervention for some individuals who experience an EDV. It is plausible that Voice Dialogue could also benefit individuals with eating disorders who do not report voice-like experiences. In this situation, the invitation might be to speak as "the part that dislikes eating" or "the part that does not eat". In terms of targets, Voice Dialogue has both formulation- and change-orientated applications. From a formulation perspective, speaking with the EDV can provide new understandings or "constructs" regarding the content, meaning, and intentions of voices (Romme & Escher, 2000). From a change-orientated perspective, Voice Dialogue enables individuals to separate from inner voices, relate and respond to these experiences differently, and cultivate parts of the self that are distinct from their eating disorder. Individuals also appreciated the opportunity to respond to their EDV towards the conclusion of Voice Dialogue, suggesting that this may be a valuable adjunct to the "classic" method. In addition, individuals may find it helpful to talk with their voice over multiple sessions, perhaps with the involvement of friends or family, to maximize the benefits of this method.

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ENDNOTE

[1] It should be noted that, in the context of Voice Dialogue, voices do not refer to auditory hallucinations. Rather, inner voices rather to the dynamic, state-like components of personality sometimes referred to as inner "selves," "ego-states," "modes," and "minds-in-place."

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