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Perceptions of the “anorexic voice”: A qualitative study of healthcare professionals

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Abstract

People with anorexia nervosa (AN) often report experiencing a highly critical inner voice (AV) focused on their eating, shape and weight. There are promising preliminary findings for its role in the treatment of AN and the support of staff is vital for the AV to be embedded in treatment, but their views remain unknown. The aims of this study were to undertake a qualitative exploration of the perceptions of the AV among healthcare professionals (HCPs) in specialist eating disorder (ED) services. A thematic analysis was applied to interviews with 15 HCPs, including nurses, therapists, psychiatrists, healthcare assistants, psychologists and dietitians. Two overarching themes were identified: – “The AV is a vehicle for increasing compassion” and “It’s not a one-size-fits-all.” The AV was seen as a means of developing and sustaining compassion, but participants noted that it does not resonate for all clients. All HCPs in this study believed that there was potential benefit in utilising the AV in their work with people with AN, and it is likely that doing so would help to reduce burnout and frustration within clinical teams.

Key Practitioner Message

- People with a diagnosis of anorexia nervosa often report experiencing an internal ‘voice’ that personifies the eating disorder and drives its severity.
- It is an established research finding that mental-health staff who work with people with eating disorders find the work difficult and this can lead to burnout/compassion fatigue.
- Staff believe there is potential merit in working with the ‘anorexic voice’ to develop empathy for, and increase self-compassion among, people with eating disorders.
- Caution is needed to avoid fragmenting clients’ sense of self, or undermining their autonomy.
- The findings highlight the importance of employing the anorexic voice in staff supervision and training as a vehicle for increasing compassion.

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Key words: Anorexia nervosa, anorexic voice, staff perceptions, qualitative interviews, thematic analysis, compassion.

Introduction

Staff often find it challenging to work with people with eating disorders (EDs) (Davey, Arcelus, & Munir, 2014; Pemberton & Fox, 2013; Seah, Tham, Kamaruzaman, & Yobas, 2018). One factor that has been associated with improved recovery is a positive therapeutic relationship between healthcare professionals (HCPs) and people with an ED; this can be achieved by staff expressing feelings of solidarity, being open, and engendering trust (Salzmann-Erikson & Dahlen, 2017). However, people diagnosed with AN can be perceived by HCPs as manipulative and challenging because they may reject help, ignore advice, and seek to maintain their disordered eating behaviours (King & Turner, 2000; Ramjan, 2004). This stems from the positive qualities service users attribute to their ED (Higbed & Fox, 2010).

Furthermore, people with AN have described experiencing a highly critical inner voice that dominates and berates the self (Higbed & Fox, 2010; Jenkins & Ogden, 2012; Lamoureux & Botorff, 2005; Tierney & Fox, 2010; Williams, King, & Fox, 2016; Williams & Reid, 2012; Wright & Hacking, 2012). This is often defined as the “anorexic voice” (AV), a term that is employed within this paper. The AV appears to be orientated around shape, weight, eating and their implications for self-worth, and to emerge during illness onset (Pugh, 2016). Pugh and Waller (2016) have argued that the AV is non-psychotic because individuals with AN recognise it as internally generated. Although the AV is not a necessary feature of AN, it has been widely reported in the literature (e.g., Noordenbos et al., 2014); people with bulimia nervosa have also reported critical inner voices (Broussard, 2005). The presence of powerful self-reported “voices” is positively associated with illness chronicity and negative eating attitudes (Pugh & Waller, 2016, 2017).

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The AV may have positive functions, including providing a sense of identity and superiority (Higbed & Fox, 2010), offering companionship, and facilitating emotional avoidance (Tierney & Fox, 2010). These AV features may help individuals with AN to manage under-developed identities (Espindola & Blay, 2009; Stein & Corte, 2007) and low self-esteem (Duker & Slade, 1990). However, the AV may slowly but steadily become more critical and start to dominate the individual, especially during times of attempted recovery (Tierney & Fox, 2010; Williams & Reid, 2012). Despite depicting its growing ferocity, service users often continue to value the AV (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams et al., 2016). Tierney and Fox (2011) have compared their relationship with the AV to that between victims of domestic abuse and partners who erode their self-esteem and turn them against significant others so that they are afraid to leave. Thus, the AV may help to account for the high rates of treatment-resistance and relapse among people with AN (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams et al., 2016).

Increasing staff understanding of the AV is vital in light of evidence that working with people with AN elicits strong negative emotions (Ramjan, 2004; Thompson-Brenner, Satir, Franko, & Herzog, 2012); many HCPs have stigmatising views of this client group (Bannatyne & Stapleton, 2017; Fleming & Szmukler, 1992; Ramjan, 2004), and experience of ED stigmatization is associated with more severe ED symptoms (Griffiths, Mond, Murray, & Touyz, 2015). HCPs have expressed anger, frustration and a sense of professional failure due to the non-adherence to treatment of service users with AN (Burket & Schramm, 1995; Franko & Rolfe, 1996; King & Turner, 2000). Length of time working with AN does not seem to reduce the tendency of HCPs to regard the disorder as self-inflicted (Bannatyne & Stapleton, 2017).

Furthermore, concerns have been raised that the training of psychiatrists and nurses working with these clients is inadequate (Jones, Saeidi, & Morgan, 2013; Ramjan, 2004).

This is concerning given that ED mental-health literacy promotes help-seeking by those affected (Mond, 2014). It is likely that the AV is not discussed in either staff training or supervision; HCPs with little awareness of the AV may struggle to fully appreciate the ambivalence those with AN feel, meaning they may not sensitively support them to take painful steps towards recovery (Tierney & Fox, 2010). The present study aimed to address this gap in the literature by exploring the perspectives of HCPs working in specialist ED services towards the AV. It also investigated whether participants believed the AV could be a useful focus for intervention.

Methods

Design

The study was conducted from a critical-realist ontological standpoint, according to which there is an independent reality that is only accessible through individual perceptions (Ormston, Spencer, Barnard, & Snape, 2013).

Setting and participants

Participants were recruited from four adult ED services. Twenty-seven HCPs agreed to take part. Purposive sampling was employed: attempts were made to ensure variety within the sample in terms of professional background, geographical location and gender, to provide a range of perspectives. The inclusion criteria were: routine involvement in the direct care of adults with AN in a specialist ED service; at least six months' experience of direct work with people with AN, and ability to speak English.

Table 1 summarises demographic data for participants, whose names have been changed to maintain anonymity. None reported having had an ED themselves. Therapists

worked from a range of theoretical orientations, including integrative, psychodynamic and cognitive-behavioural.

Table 1 goes about here

Procedure

Participants completed a brief questionnaire on their age, gender, professional role, and length of time working with people with AN. This questionnaire was used to explore possible links between the findings and characteristics of participants (Braun & Clarke, 2013). Semi-structured interviews were used to facilitate exploration, via follow-up questions, of issues that had not been considered in advance.

Data collection

Seven service users with a diagnosis of AN co-designed the semi-structured interview topic guide with the first author. As part of the interview, a definition of the AV was read and given to all participants in case any were not familiar with the concept. The topic guide underwent several revisions over the course of data collection. For example, following the first three interviews and discussion among the research team, the wording of one question was changed to explore how participants “made sense of” the AV. Interviews lasted between 32 and 67 minutes (average = 47 minutes). All were audio-recorded, transcribed verbatim, and anonymised. Data were collected between May and September 2017.

Analysis

A bottom-up, inductive analysis was employed to generate themes grounded in the data. To ensure rigor and replicability, the six-phase process recommended by Braun and

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Clarke (2006) was observed: (a) all transcripts were read and re-read to facilitate immersion in the data, and initial ideas noted; (b) each transcript was coded in its entirety using NVivo; (c) the most salient codes were clustered to generate potential themes and sub-themes; (d) the candidate themes and sub-themes were reviewed with reference to relevant collated excerpts and the original transcripts; (e) the themes and sub-themes were defined, and (f) the themes were elaborated in the analytic narrative. Throughout, the analysis was reviewed and discussed within the research team. Methodological integrity was ensured by following Elliot et al.'s (1999) guidelines. Member checking was also conducted; the results section was emailed to all participants to give them an opportunity to verify whether it captured their experiences and offer feedback. One participant said she felt her experiences were reflected in the analysis; no other feedback was received.

Reflexivity

The first author (M.G.) is a white British, 33-year-old female clinical psychologist who subscribes to the biopsychosocial model of distress and has no direct experience of working with people with AN. To assist with owning her perspective and bracketing assumptions, she kept a research journal to record reflections on reviewing the literature, designing the study, recruitment, data collection, and analysis. She discussed the data and developing themes with the remaining authors, who have an academic interest in the study of EDs and/or clinical experience of working with people who have AN.

Results

There was consistency in participants' perspectives across professional, geographical, and service divides. All presented the AV as a potentially useful and powerful means of developing and sustaining compassion as a clinician, and supporting highly self-critical

clients to cultivate self-compassion. Many also emphasised that the concept was not applicable to all service users, and most portrayed it as synonymous with other terms. The analysis yielded two themes and six sub-themes, which are visually represented in Figure 1.

Figure 1 goes about here

Theme 1: The “anorexic voice” is a vehicle for increasing compassion

Participants described the AV as a means of helping HCPs to be more compassionate towards people with AN by enabling them to comprehend clients’ internal struggle, adopt a non-blaming stance, express empathy, and empower service users to make changes.

Sub-theme 1: Comprehending the internal struggle.

Interviewees described the AV as helping them to appreciate the distress that people with AN report experiencing:

[The AV says] really, really horrible, horrible things. Like really bullying. Really abusive. (Susan, clinical psychologist)

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

They highlighted how the concept of the AV helped HCPs to empathise with service users in the context of behaviours and reactions that can seem incomprehensible to those without lived experience: “I’m imagining if you’re trying to eat a baked potato and this voice is screaming at the front of your head, ‘Don’t eat that, you don’t deserve that; you’re going to get fat’” (Yvette, occupational therapist). Participants described how extreme dietary restriction and over-exercise could be understood as being driven by the AV’s unyielding demands, which caused immense suffering:

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The shin splints and the fractured pelvis and the compressed discs and the broken toes, they're still running, running, running on the treadmill, to get away from the voice. (Sarah, art psychotherapist)

By helping participants to appreciate service users' pain and vulnerability, the AV was presented as supporting them to appraise people with AN as deserving of help even when not following their advice.

The AV was also portrayed as a means of understanding the ambivalence that most service users exhibit towards treatment. Participants identified numerous positive functions of the AV for someone with AN, including conferring a sense of control; blocking negative emotions; providing reinforcement, and furnishing a sense of identity. It was noted that these qualities were particularly prominent in the initial stages of the illness:

I think early on it's that whisper of: "You can control something in your otherwise difficult and challenging life." (Sarah, art psychotherapist)

Some people will describe it as a friend, as a comforter, as "Oh well, if I do this, I don't have to experience the anxiety." (Rosie, nurse)

Therefore, despite the distress evoked by its criticism, participants noted that the AV is frequently experienced by people with AN as an ally that is "reliable" and "doesn't not pick up when you call it to comfort you" (Michelle, clinical psychologist). HCPs reflected on how clients' attachment to the AV, and/or identification with it, explained why they might hold on to their behaviours:

Having a bully is better than having no one and people have talked to me a lot about, "If I take that voice away, what I'm left with is kind of emptiness." (Jessica, clinical psychologist)

Thus, the AV was presented as rendering “anorexic behaviours” more explicable for those without lived experience by providing an insight into service users’ inner turmoil and their motivation.

Sub-theme 2: A non-blaming stance.

Participants argued that the concept of the AV could support service users to recognise that they are not to blame for their behaviours:

The feedback I’ve had from people is it’s like it’s not another criticism of them, it’s almost something different that’s happening to them rather than they’re creating it.

(Elizabeth, nurse)

When you’re talking about this anorexic voice, it’s highlighting that it’s a separate thing to them and it’s not their fault. (Lisa, healthcare assistant)

HCPs suggested that this non-judgmental framing of service users’ experience could increase self-compassion, and empower service users to make positive changes. Similarly, participants reported that blaming the AV or AN rather than service users for non-adherence helped staff and loved ones to remain compassionate in the context of high levels of frustration:

It reduces blame and frustration. There's a sense that it's coming from a disorder, from something separate that they're fighting with rather than from them personally.

(Jessica, clinical psychologist)

Hence, the AV was presented as a tool they could use as HCPs, and with family/carers, to counteract negative judgments.

Sub-theme 3: Expressing empathy.

While HCPs emphasised that they would be led by clients’ views of their experiences (see theme 2), the AV was perceived as a means to communicate to the client that they have some understanding:

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People think, “Yeah she does get this, she understands what it is.” And then you start to get more stuff out. (Victoria, consultant psychiatrist)

People will come in and they’ll feel really embarrassed or ashamed or guilty, or “People can’t understand why I would get upset about having a white sandwich as opposed to a brown-bread sandwich.” So to validate that for somebody is really important. (Rosie, nurse)

Participants contrasted the value of expressing empathy via the AV with the reality that clients are frequently met by incomprehension and stigmatisation:

I’ve heard staff before saying things like, “Well there’s people dying of cancer and they’ll just not allow themselves to eat.” (Tina, nurse).

The AV was thus presented as a “helpful shared language” (Victoria, consultant psychiatrist) for HCPs to demonstrate understanding of how criticised service users can feel and how conflicted about the recovery process they may be, thereby increasing service users’ confidence in staff and prompting them to engage with treatment.

Sub-theme 4: Empowering service users.

Alongside identifying how the AV could be used to reduce self-blame and promote engagement, participants argued that the concept could be employed to help clients recognise a choice regarding whether to engage in the anorexic behaviours the AV was seen to promote:

Being able to start externalising it and get distance on it may mean that they might be able to be a bit more judgemental of it, or critical of the critical voice in itself.

(Michelle, clinical psychologist)

HCPs described using the concept to help clients separate from the ED and appreciate themselves as having a range of qualities, interests, and options. In this way, the AV could be employed to enhance motivation and help clients reconnect with the “bits of them that

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want something more” (Victoria, consultant psychiatrist). Participants noted that when service users build up other aspects of their lives, “the voice becomes less important” (Susan, clinical psychologist).

Participants also described how they could support clients “to make the AV the annoying little thing in the back of your head that you can bat away and not compulsively respond to” (Laura, dietetic assistant). They did this by challenging the voice themselves, coaching the client to do so via chair work, or borrowing strategies from cognitive-behavioural therapy for psychosis. Linked to this notion of relating differently to the AV, HCPs highlighted the importance of providing a secure, compassionate therapeutic relationship that the client could internalise:

They interiorise the therapeutic dialogue....This can help soften the voice. (Selena, consultant psychiatrist)

By showing consistent compassion through a non-blaming stance and expressing empathy, HCPs could increase clients’ self-compassion and empower them against the AV.

Theme 2: “It’s not a one-size-fits-all”

Participants tended to depict the AV as one of several metaphors for AN, and a potentially helpful construction rather than a real entity. The importance of listening to clients and being led by their experience was emphasised. Imposing the HCP’s view of AN was seen as uncompassionate.

Sub-theme 1: Wary of imposing the AV.

Many HCPs stated that while the AV resonated with some clients, others did not relate to it:

She went through therapy and they were talking about the anorexic voice and she came home really upset saying, “I don’t think I’ve got anorexia because I don’t have the anorexic voice.” (Lisa, healthcare assistant)

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Reasons suggested for some clients not relating to the AV were: viewing their experience in different terms (e.g., as thoughts or as biologically based); seeing AN as part of their identity; regarding the AV as an over-simplified concept; struggling to think in abstract terms, and not wanting to be exposed to stigma:

I think people think, “Gosh, am I going mad? And what will this individual think if I say I am hearing a voice?” (Elizabeth, nurse)

HCPs noted that while the AV can be usefully employed to promote compassion, using the concept with clients who do not relate to it would be uncompassionate. Concern was also expressed that the AV, or externalisation in general, could lead to clients disowning responsibility for changing their behaviour:

As long as it doesn't get too externalised....to the point: “Well it's nothing to do with me or I can't take responsibility for it.” (Susan, clinical psychologist)

Some participants suggested that using the AV carried a risk of fragmenting service users' sense of self, which linked to a wider point about not unnecessarily imposing your view of AN, or goals, as a HCP because to do so could evoke extreme distress and disengagement::

I hear the voice of one client who's going, “...It is just part of me so actually to separate it from me feels a bit....dissecting.” (Yvette, occupational therapist)

It can be very, very risky if you....push someone too far, because their self can become fragmented. They lose sight of who they are. (Thomas, consultant psychiatrist)

Related to this, some participants reflected that it is important to highlight to clients who identify as having an AV that while it may feel separate, it is ultimately coming from them:

Let's talk about the anorexic voice, let's talk about this wasp, this Labrador, this monster, but then let's bring your attention to the fact that this is coming from you; this is not an actual bully, this is your thinking. (Lucy, drama therapist)

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Two participants noted the utility of clients taking an observer stance in relation to their internal experiences – be they conceived as voices, thoughts, or otherwise. Observing these experiences was seen to facilitate choice in how to respond. Above all, HCPs stressed that it was important to be guided by individual understandings:

If they don't relate to it, then try something else....It's not a one-size-fits-all. (Yvette, occupational therapist)

Sub-theme 2: Different words for the same thing.

Most participants used the terms “anorexic voice” and “anorexic thoughts” interchangeably, or highlighted that they viewed them as the same concept. They also employed other concepts as metaphors for AN, including a battle, a pit you have fallen in, a wasp, an aggressive plant, or an abusive boyfriend who “can be lovely and safe and something that's familiar....but that can also completely turn around and be vicious and mean and cruel and not let you do things” (Laura, dietetic assistant). Hence, the AV was presented as one of many metaphors for the experience of AN, and in this regard more as a potentially helpful construction than a literal truth:

Some participants questioned the concept of the AV, arguing that it was not an external voice and/or questioning how it differed from a psychotic experience:

It can get to such a strength that you think, if you're really talking about hearing an external voice, what is it that makes that not psychotic? (Katherine, counselling psychologist)

Several noted that professionals may have introduced the AV to clients. Many adopted the pragmatic stance that it is a concept “that works” (Victoria, consultant psychiatrist) for staff and some service users in terms of promoting understanding, engagement, and positive changes. However, the fact that effective therapy is possible

without using the AV was raised during the interviews, and it was suggested that certain therapeutic models incorporate similar ideas with different names:

I don't come from a standpoint of if you're not considering that in the treatment then you're missing something huge. (Jessica, clinical psychologist)

In compassion-focused therapy, the talk is very much of the inner self-critic and that's the same sort of concept. And then...[in] a CAT [cognitive analytic therapy] approach, you're thinking about self-to-self relating. (Susan, clinical psychologist)

Discussion

Although participants had different views about whether the AV was a true experience or a proxy for this, all felt that it was useful in developing and maintaining compassion for this client group. There is a growing evidence base for the role of compassion in the treatment of EDs, such as within compassion-focused therapy for eating disorders (CFT-E, Goss and Allan, 2012) and within multi-disciplinary teams (e.g., Pemberton and Fox, 2013). In many ways, participants' views of the AV corresponded closely to Atkins and Parker's (2012) model of acting compassionately, which involves noticing suffering; appraising it (deciding whether those suffering are deserving of help, and whether one has the resources to provide assistance); feeling empathic concern, and responding to the suffering.

In line with the first stage of Atkins and Parker's (2012) model, participants depicted using the AV as a means of appreciating the distress service users experience – given its abusiveness and relentless demands (Tierney & Fox, 2011) – and the immense courage they must show to engage in treatment (Vitousek, Watson, & Wilson, 1998). This is important in light of evidence that people who do not have lived experience of AN underestimate the

suffering experienced by those who do (Bailey & Frampton, in press, as cited in Gregertsen, Serpell, & Mandy, 2017).

The second element of Atkins and Parker's (2012) model is appraisals that determine whether one has an empathetic response to suffering and acts to alleviate it. Such appraisals appeared to determine whether compassionate care was provided by clinicians working with non-adherent patients with diabetes (Tierney, Seers, Reeve & Tutton, 2017), another client group that HCPs may experience as exasperating (Wens, Vermeire, Van Royen, Sabbe, & Denekens, 2005). Given that appraising others as responsible for their distress leads to anger and aggression rather than compassion and support (Rudolph, Roesch, Greitemeyer, & Weiner, 2004), it is unhelpful for staff to view service-user's non-adherence as wilful (Gregertsen et al., 2017).

Participants argued that by viewing non-adherence as caused by the AV, via a process of externalisation, they were able to appraise clients as deserving of help, thereby remaining compassionate. This is in line with evidence that externalisation is commonly employed with AN to this effect (e.g. Wright & Hacking, 2012; Zugai et al., 2018), and that having a framework for understanding promotes less blaming attitudes towards people with AN (Bannatyne & Stapleton, 2017; Crisafulli et al., 2008; Crisafulli et al., 2010), and individuals with other stigmatised mental-health diagnoses such as schizophrenia (Kellett et al., 2014) and Personality Disorder (Kerr, 1999). Team discussion of, or training in, the AV may encourage HCPs to reflect on the inner turmoil experienced by clients who have AN, prompting them to respond with a desire to help, rather than judgment and blame. This may reduce the risk of burnout and compassion fatigue.

In promoting a non-judgmental stance, the AV is conducive to the authenticity and transparency that people with AN desire in their therapeutic relationships (Rance et al., 2015). However, care is needed to honour the understandable ambivalence of many people

with AN; portraying EDs as the “enemy” risks invalidating the positive functions they are perceived to fulfil by many service users (Oyer, O’Halloran, & Christoe-Frazier, 2016, p127). A potential risk of externalisation is that if the AN is viewed as entirely separate from the service user, it could perpetuate the tendency for professionals to solely focus on physical and behavioural aspects of the condition and elide the internal conflict, rather than follow service-user preference and consider psychological functioning (Duncan, Sebar, & Lee, 2015; Sibeoni et al., 2017). That said, in the present study the AV was portrayed as a means of facilitating consideration of clients’ inner experience.

In addition to the question of whether an individual deserves help, the Atkins and Parker (2012) model suggests that another appraisal that can promote or inhibit a compassionate response is whether one has the resources to help. Compassion can be compromised by stress in healthcare settings (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017), with higher therapist caseloads associated with negative reactions towards people with EDs (Franko & Rolfe, 1996).

In the present study, the AV was described as a common language through which staff could express empathy, corresponding with the third phase of the Atkins and Parker (2012) model. Empathy has been found to reduce treatment-resistance among people with AN (Abbate-Daga et al., 2013), and is valued by clients (Gulliksen, Espeset, Nordbø, Skårderud, Geller, & Holte, 2012). Participants also reported that they used the concept of the AV to empower service users to make positive changes, which fits with the emphasis on acting to prevent and alleviate suffering in Atkins and Parker’s (2012) model and other contemporary accounts of compassion (e.g., Gilbert, 2005, 2017). HCPs presented the AV as a means of helping clients to gain some distance from anorexic behaviours and connect with other interests and qualities, in line with previous research (Scott, Hanstock, & Patterson-Kane, 2013). They also suggested that acknowledging the voice in treatment could assist

service users to become critical of this element of AN; hence, the AV could be used to “[mobilise] anger towards the illness” (Forsén Mantilla, Clinton, & Birgegård, 2017, p.12) and help service users to mount a “resistance” to it (Maisel et al., 2004, p.12). In this way, empathy for the client’s experience can be used to facilitate behavioural change in AN.

Participants described the AV as a tool to promote self-compassion, being kind rather than critical towards oneself (Neff, 2003), in the context of the low self-esteem that characterises AN, which can lead to service users feeling unworthy of help (Duker & Slade, 1990). Participants argued that the AV can facilitate self-compassion by enabling service users to regard themselves as victims of a force beyond them, in line with previous reports of the effect of externalisation of AN (Wright & Hacking, 2012). This can empower people to reject the punishing demands associated with AN and be kinder towards themselves (Forsén Mantilla et al., 2017). This use of the concept aligns with the goals of compassion-focused therapy for EDs (Goss & Allan, 2014), and evidence that higher levels of self-compassion are associated with lower levels of psychopathology (MacBeth & Gumley, 2012). Some interviewees also described supporting clients to “speak back” to the voice, a key task within emotion-focused therapy (Dolhanty, 2006) .

Clinicians’ perception that some people with AN do not identify with the AV is in line with previous research (Noordenbos et al., 2014). One study highlighted that people with stronger AVs are more likely to have the binge-purge subtype of AN (Pugh & Waller, 2016). Concerns among HCPs about use of the AV fragmenting clients’ sense of self link to evidence from qualitative studies that service users regard AN as part of who they are (Higbed & Fox, 2010; Williams & Reid, 2012), at least intermittently, and the notion that it is potentially harmful (Vitousek, 2005) to distinguish between a mental illness and the self. Participants also highlighted that just as it is limiting to view oneself as defined by the AV or AN, it is damaging to view the problem as so separate that one is disempowered to do

anything about it, a concern raised in previous research (Vitousek, 2005; Wright & Hacking, 2012). One solution to both issues (fragmentation and reduced responsibility) was offered by participants who suggested conveying to service users that they are not the AV, nor their thoughts, but the observer of both, a concept from Acceptance and Commitment Therapy (Fletcher & Hayes, 2005). A key component of this therapy is mindfulness, which as defined by Neff (2003) could be a means of acknowledging the AV without seeing oneself as inseparable from, or completely separate from, it.

In adopting a pragmatic view of the AV as a concept that works for many clients rather than a literal truth or demonstrably different from anorexic thoughts, most participants presented the AV as a social construction. The AV was portrayed as one way of understanding AN and its treatment in the context of multiple, simultaneously occurring perspectives (Goren-Watts, 2011; Maisel et al., 2004). Participants argued that what matters is whether a construction is conducive to understanding and recovery for individual clients. However, other metaphors employed by participants (e.g., an aggressive plant) arguably differ from the AV, which in client accounts appears more connected to the individual and to be experienced as a real entity that has invaded their being (Tierney & Fox, 2010; Williams & Reid, 2012).

Strengths and limitations

A strength of this study is that a wide variety of participants were recruited, from across the multidisciplinary team, and they all had at least 2 years' experience of working with people with EDs. It is important to note that all participants demonstrated compassion towards service users. However, in line with previous research (Gulliksen et al., 2012; Ramjan, 2004), some reported experiencing frustration, and many described high levels of judgment and misunderstanding among their colleagues. It is possible that participants had

experienced negative reactions to service users but did not disclose them because they were not asked directly about them or because they did not feel safe to voice pejorative views. In accordance with the findings of this study, it is also feasible that thinking about the AV made clinicians adopt a more compassionate stance during the interviews than they would generally.

Future directions for research

Future research could qualitatively examine service users' experiences of use of the AV in treatment, and evaluate outcomes. Another avenue of research is exploring whether the AV could be used to help clinicians appraise non-adherence as a reflection of the strength of the AV rather than a professional failure, and thereby increase their resilience. It would also be valuable to study perceptions of the AV among clinicians working with children and adolescents with AN.

Conclusion

The AV is a concept HCPs can use to help them understand the inner worlds of clients living with AN, which may support them to deliver compassionate care, underpinned by a motivation to alleviate suffering. However, the AV should not be considered the only means of representing the struggles that individuals with AN experience. Furthermore, it should be employed with caution in therapeutic settings to avoid fragmenting clients' sense of self, or denying their autonomy. In summary, the AV is a social construction that can support HCPs in their work with people who have AN, but it should not be applied if a client fails to identify with this concept.

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Staff views of the anorexic voice

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Staff views of the anorexic voice

Table 1: Participant demographic and questionnaire data

| Participant pseudonym | Professional role | Gender | Age range (in years) | Years working with AN | Work in inpatient, outpatient or both |
|-----------------------|-------------------------|--------|----------------------|-----------------------|---------------------------------------|
| Sarah | Art psychotherapist | Female | 45-64 | >5 | Both |
| Tina | Nurse | Female | 25-44 | 2-5 | Inpatient |
| Victoria | Consultant psychiatrist | Female | 25-44 | >5 | Inpatient |
| Michelle | Clinical psychologist | Female | 25-44 | >5 | Both |
| Yvette | Occupational therapist | Female | 25-44 | 2-5 | Both |
| Rosie | Nurse | Female | 45-64 | >5 | Inpatient |
| Laura | Dietetic assistant | Female | 25-44 | >5 | Inpatient |
| Elizabeth | Nurse | Female | 45-64 | >5 | Outpatient |
| Lisa | Healthcare assistant | Female | 18-24 | 2-5 | Outpatient |
| Susan | Clinical psychologist | Female | 25-44 | 2-5 | Outpatient |

Staff views of the anorexic voice

| | | | | | |
|-----------|-----------------------------|--------|-------|-----|------------|
| Katherine | Counselling psychologist | Female | 25-44 | 2-5 | Both |
| Lucy | Drama therapist | Female | 25-44 | 2-5 | Outpatient |
| Selena | Consultant psychiatrist | Female | 45-64 | 2-5 | Outpatient |
| Thomas | Consultant psychiatrist | Male | 25-44 | >5 | Both |
| Jessica | Clinical psychologist | Female | 25-44 | >5 | Both |

Staff views of the anorexic voice

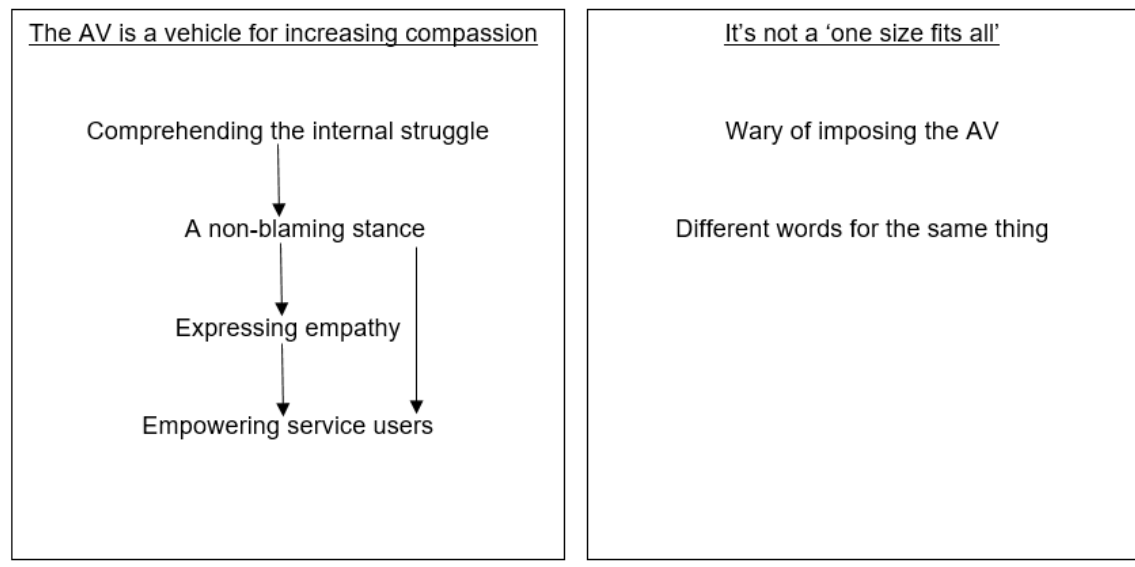


Figure 1. Illustration of themes and sub-themes